WRITTEN TESTIMONY
BY RONALD LEEBOVE, CRC, DABFC
FOR THE U.S. SENATE FINANCE COMMITTEE
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Key Findings

Do private long-term disability group policies provide the protection they promise?" The answer is "No."

There are many tricks and tactics used by the insurance companies to deny claims.

This testimony discusses two cases. In one case, a nurse with severe psychiatric problems was denied benefits, even though the Human Resource Manager said that patients would be put at risk if the claimant was allowed to return to her job.

In the other case, the insurance company continues to investigate whether the claimant can work even though Social Security–which has the strictest criteria in the industry--has concluded that she cannot work.

Private long-term disability insurance for groups of employees of an employer are covered under ERISA. It is evident that ERISA limits due process, and that legal remedies under it are extremely limited. For example, the claimant is not entitled to a jury trial.

Introduction

I hereby submit written testimony to the U.S. Senate Finance Committee. This document and its contents represent my understanding of rehabilitation management and the vocational rehabilitation process, including, but not limited to, career counseling and job placement services for the physically and/or mentally challenged individual.

I have been working in the field of vocational rehabilitation for approximately 30 years and have maintained a private practice in Scottsdale, Arizona since 1989. I perform comprehensive vocational rehabilitation evaluations of patients who have disabilities with limitations/

restrictions. The limitations and/or restrictions are severe enough to limit the individual's ability to perform life activities, including employment.

Frequently, I have rendered vocational opinions that a patient would be unable to return to their usual and customary occupation but would benefit from vocational exploration, training and job placement services. On the other hand, there are those individuals who are so severely disabled that they are unable to perform the essential functions of any occupation in the U.S. labor market. I cannot stress enough the importance of a team approach to evaluating the needs for people with disabilities. The professionals that I use for completing an evaluation can include, but are not limited to, physicians, therapists, vocational test evaluators, special needs counselors, and human resource people.

From an ethical and professional standpoint, I have always strived to provide the very best services to the people I serve with passion, humility and respect. Patients are advised from the outset of their rights and responsibilities in completing the vocational rehabilitation evaluation process. I always let them know how important they are to me, their friends and family.

An individual can sustain a disability at any time of their life without notice. Disability can occur as a result of an illness, disease and/or by physical trauma.

The Americans With Disability Act (ADA) and People With Physical Disabilities

The Americans With Disabilities Act (ADA) has a three-part definition of *disability*. Under ADA, an individual with a disability is "a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; or (2) has a record of such an impairment; or (3) is regarded as having such an impairment."

A *physical impairment* is defined by ADA as "any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine."

The definition of *work disability* is "a loss or reduction in functional capacity to meet behavioral expectations, e.g., employment as a result of impairment and functional capacity limitations attributed to a condition beyond the control of the individual, such as a medically definable impairment." The different categories of work disability include the following:

1. No work disability (absence of disability)

2. Secondary work disability, (aka secondary work limitations), i.e., limited in the kind and amount of work that can be performed, but able to work regularly at a full time job and able to do the same kind of work as previously done.
3. Occupational work disability. Able to work regularly but unable to do the same work as before the onset of limitations or unable to work full time.
4. Severe work disability. Unable to work altogether or unable to work regularly.

(Source of reference: U.S. Census Bureau)

As part of my vocational rehabilitation practice, there are five very important questions that need to be answered to determine whether a person has a "work disability" and what type. They are as follows:

1. Does the health or condition limit the kind and/or amount of work the person can perform?
2. Does the person's health or condition keep them from working altogether?
3. Is the individual able to do the same kind of work that was performed before the onset of their health or condition?
4. Is the individual able to work full time, or can they work only part time?
5. Is the individual able to work regularly, or can they only work occasionally or irregularly?

The answers to these questions, including the definition of "work disability" can be traced back to the vocational rehabilitation evaluation that is objectively performed by me on a daily basis with the patients that I serve.

Prior to submitting this written testimony to the U.S. Senate Finance Committee, I provided substantial evidence, including patient case files, regarding people with disabilities who have long-term disability claims with private insurance companies. These materials identify the abusive behavior and disregard for people with disabilities. In my written testimony to follow, I will identify the dirty secrets and various tactics used by these companies to deny claims. Moreover, these large insurance carriers operate under a shroud of secrecy and deceit.

Non-ERISA Versus ERISA Disability Policies

In order to understand the ramifications of ERISA, it is important to identify the differences between non-ERISA and ERISA long-term disability policies.

An article entitled "Disability Benefit Claims" at www.disabilitybenefitattorneys.com explains the differences between non-ERISA and ERISA, quoted as follows:

1. *Non-ERISA disability cases are governed by state law.*

   Holders of individual disability policies have significant advantages over those whose benefits are provided through an employee benefit plan. When you purchase a disability insurance policy from an insurance broker, you are entering into a contract with an insurance company. If the insurance company later denies your claim for benefits, your claim is governed by state law. You have the right to file a lawsuit in state or federal court, and the dispute will be resolved by a jury of your peers. You have the right to bring witnesses to the court to support your claim. In addition to the claim for breach of contract, you might be able to raise additional claims if the insurer's refusal to pay constitutes bad faith. Many states, including North Carolina, have state consumer protection statutes that allow recovery of treble damages and attorney's fees. Punitive damages may be available if the insurance company's conduct is bad enough.

2. *Employee benefits are controlled by ERISA.*

   A different law applies when disability benefits are provided by an employer. Disputes are governed by a federal law, called ERISA, which stands for the Employee Retirement Income Security Act of 1974. A law that deals with "employee retirement security" sounds friendly, but in reality ERISA provides significant advantages for the employer or insurance company. The claimant is not entitled to a jury trial. Usually, there is no trial at all.

   In an ERISA case, the court typically does not decide whether the claimant is disabled. Rather, the court's role is limited to reviewing the plan document and the claim file to determine whether the claims administrator abused his or her discretion. Under this limited standard of review, the claims administrator's decision will be upheld if it is reasonable. The claims administrator does not have to give greater weight to the claimant's treating physician, and may decide to accept the evaluation of one of its own staff physicians, even if that doctor never examined the claimant.

   ERISA restricts the court's review to documents that were available to the claims administrator at the time it issued its final decision. Evidence obtained after the claimant has exhausted his or her administrative appeal cannot be considered by the court. Therefore, it is of paramount importance that the claimant fully develop the evidence in support of his claim, and submit such evidence to the claims administrator during the claim process.

To summarize, the differences between non-ERISA and ERISA, it is evident that ERISA limits due process, and that legal remedies are extremely limited.

It is important to point out that the claimant in most cases is responsible for providing proof that they are totally disabled and unable to work. In contrast, unfortunately, the private long-term disability insurance companies and, more specifically, their claims departments will, in most cases, use deceptive and dirty tactics to deny claims.

The article further states:

> *Generally, disability coverage offered by an employer will provide that a claimant will be considered disabled if he is unable to perform "the material and substantial duties of his occupation," or sometimes "each and every material duty of his occupation." The meaning of those phrases is sometimes not readily apparent. The term "occupation" is broader than "job." Job duties that are not generally required to perform the occupation will be disregarded in assessing disability. The definitions of total disability are sometimes construed so that the claimant will not be considered disabled if he is able to perform some, but not all of his job duties. Therefore, when the appeal involves the "own occupation" definition, the starting point should be a detailed job description and an assessment of whether the claimant is unable to perform each of the duties on a full time basis.*
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> *Employee benefit plans usually provide that after two years the claimant will be considered disabled only if he is unable to perform "any occupation for which he is reasonably suited by reason of age, education or experience." This is a harder definition to meet, as it requires proof that there is no job that the claimant can do.*
> *Insurance policies frequently limit benefits for mental illnesses to two years. It is important to distinguish between true mental illnesses and cognitive problems caused by physical conditions such as traumatic brain injury, hypoxia or stroke syndrome. The terms of the coverage will differ depending on the policy language.*

The terms and limits for long-term disability policies are similar from one company to the next.

Social Security Administration Definition of Disability

The Social Security Act defines disability (for adults) as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or expected to last for a continuous period of not less than 12 months" (Section 223 [d][1]). Amendments to the Act in 1967 further specified that an individual's physical and mental impairment(s) must be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a

specific job vacancy exists for him, or whether he would be hired if he applied for work" (Section 223 and 1614 of the Act). Social Security disability programs only pay for total disability and not partial or short-term disability.

Therefore, there are substantial differences with regard to the definition of disability by the Social Security Administration and the one that is offered by private long-term disability insurance companies. Social Security's criteria are the strictest in the industry.

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

I am in receipt of a letter from the Senate Finance Committee confirming my testimony on September 28, 2010 at 10 a.m. The subject to be discussed is "Do private long-term disability policies provide the protection they promise?" In order to answer this specific question, there needs to be an understanding of how private long-term disability insurance companies operate their claims departments. More specifically, "Do they act responsibly in evaluating each claim?" My response to that question is "No." There are many tricks and tactics used by the insurance companies to deny claims. They may include, but are not limited to, the following:

1. The medical records are not completely reviewed by the claim examiner and/or records are omitted.

2. Insurance companies hire physicians to perform Independent Medical Exams (IMEs). These examinations are performed by physicians who are paid by the insurance companies to write negative reports and identify that there is no permanent disability that warrants benefits. I have attended and observed over 100 IMEs in the past 15 years. The interviews and physical exams are extremely limited. In comparison, I had one case with 400 pages of medical records to review, whereas the doctor performing the IME had only 30 pages to review, and the insurance company selected the 30 pages that they wanted the doctor to read.

3. It is a common practice for insurance claims examiners to bombard patients and their treating physicians with claim forms to be filled out. The patient is unaware that on many of these forms, there are trick questions and that their responses likely will result in denial or termination of benefits. Many of the questions that are asked of treating physicians on claim forms are very suspicious and are leading questions. An example of a leading question may be, "Doctor, you would agree that your patient will be able to return to work within a short period of time, correct?"

4. Another tactic used by claims examiners to deny claims is to send a disability report form to the treating physician and require a response within 14 days. If the physician has not responded in that period of time, the claims examiner will likely omit and/or not include those medical records as part of the claim review.

5. It is always the responsibility of the patient to prove their disability status. More specifically, claims examiners will tell the patient, "You must prove to us your functionality or lack of." In contrast, when a patient visits a medical doctor, the doctor does not begin by assuming that the patient is disabled or not disabled.

6. Insurance companies will refer claimants for Functional Capacity Evaluations (FCEs). This form of testing takes approximately three to four hours to complete and requires the patient to perform various types of physical activity over a three to four hour period. Sometimes, the patient is required to return for a second day of testing. It is important to point out that Functional Capacity Evaluations are frequently used by insurance companies as a tool to distort a patient's true functional limitations. More specifically, there is actually a component of the testing that purportedly identifies if the patient is a malingerer. Moreover, claims examiners will schedule patients for FCEs with very little advance notice and will not notify the treating physician that the testing has been scheduled. If the patient does not show up, the patient can be deemed noncompliant and charged for a no-show.

7. One of the most grievous tactics used against a claimant is surveillance. Even though the claimant has demonstrated that they have a severe disability with limitations and restrictions, the carrier will use hidden cameras and electronic devices to devise some scheme that purports to show the individual is faking their medical conditions, so that benefits can be denied or terminated.

8. It is interesting to point out that some, if not all, long-term disability insurance companies are having claimants fill out and sign a supplemental information form. What the claimant may not know is that by signing the document, they are giving blanket authorization to the insurance company to request and obtain all records from any source without the claimant's knowledge. These can include medical, psychiatric, drug, alcohol, employment, financial, credit, Social Security, and all other forms of data pertaining to activities. The claimant is advised when reading the form that if they do not sign and date it, their benefits can, or likely would be, terminated. Therefore, the claimant is faced with a very difficult choice. Moreover, some claimants who are not capable of understanding the form are asked to sign it.

9. Claims examiners or representatives of the insurance companies have been known to contact claimants and/or their families and chastise or harass them. In one of the cases that I submitted to the committee for review, the individual was contacted telephonically and was told, "You are not disabled. You can work and you had better go out and find a job." This caused the patient great fear and consternation. This patient remains totally disabled and unable to work. He has not been cleared by any of his treating physicians to engage in work activities.

10. I mentioned earlier in my written testimony that insurance company claims departments operate in a shroud of secrecy and deceit. Over the past couple of years, I have tried to find out the credentials and background for claims examiners, including their education. I have directly asked one claims examiner for his credentials and that person refused to give me any information. That being said, I ask what are the qualifications and credentials that enable claims examiners to be judge and jury for insurance companies.

11. Long-term disability insurance companies, and more specifically their claim departments, use the term "noncompliance" for purposes of intimidation, to demoralize, confuse and outright threaten with denial or termination of benefits. There are two distinct definitions for the term "noncompliance" that apply to insurance company usage.

They read as follows:

The situation in which an applicant/recipient fails to cooperate or comply with program requirements (i.e., work or child support requirements).
(Source: www.dhs.dc.gov/dhs/cwp/view.a.1345.g.605720.dhsNay_GID.1728.asp)

The failure to achieve performance criteria of a regulation or authority.
(Source: www.shedsrus.com.au/v/vspfiles/assets/images/diy%20glosary.htm)

I have personal knowledge, verbal and written, from patients and their families regarding the aggressive use of the term "noncompliance." Here is an example. John Smith receives notice from a claims examiner that he must appear for a Functional Capacity Evaluation (FCE). At the same time, the patient's treating physician has not been notified that the testing has been scheduled. Moreover, I am contacted by the treating physician who recommends that the testing not be administered because it could cause significant physical harm and exacerbation of symptoms for his patient. Even though permission was not granted for the testing to be administered, the assigned claims examiner informs John that unless he appears for the evaluation, benefits may be terminated or denied. The explanation for termination or denial of benefits is that John was "noncompliant for not attending a scheduled and mandatory examination."

All of the information that I have just disclosed clearly demonstrates the ruthless and inhumane treatment of people with disabilities. Later in this written testimony, there will be a discussion of two case files that have already been submitted to the committee for review. These case files further indicate my concern with how claims are processed and evaluated at long-term disability insurance companies and, more specifically, in their claims departments.

Allsup, Inc.

I have conducted research regarding Allsup, Inc. On their website (www.allsupinc.com/disability-insurance.aspx), they state:

> *Allsup is the first and largest company to provide nationwide Social Security representation services. Our understanding of the complex Social Security process, coupled with our system capabilities and operational scope, has yielded outstanding results for our clients over the years.*
>
> *Since 1984, we have recovered over $490 million in benefit overpayments and reduced future plan liabilities by more than $5.1 billion for our clients.*
>
> *Allsup wins SSDI awards for 98 percent of the people represented through all levels of appeal. And more than 60 percent of our awards are granted at the Initial and Reconsideration levels, resulting in faster SSDI offsets and smaller overpayments.*
>
> *We recover 86 percent of disability plan overpayments within an average of 14 days from the time the Social Security Administration releases funds to the employee.*

The company goes on to say:

> **Allsup Gets It**℠
>
> *Maximizing Social Security Disability Insurance (SSDI) offsets and overpayment reimbursement can reduce your annual disability claims costs by millions of dollars.*
>
> *However, the process to realize these gains is full of challenges. Employees are ill-equipped to apply on their own. Claims personnel have heavy workloads and limited SSDI experience. Employees often forget they must repay overpayment funds. And recent court cases have further reduced a plan's ability to recover overpayments under ERISA.*
>
> *Since 1984, Allsup Inc. has helped hundreds of companies, local governments, insurance carriers, third-party administrators and law firms properly coordinate employee benefits and workers' compensation plans with Social Security and Medicare.*

Another information section by Allsup at the same website says:

> ***A Source of Hidden Profitability Overlooked in Thousands of Companies***
>
> *Literally, hundreds of millions of dollars are at stake. You can significantly reduce disability, group health and workers' compensation plan liability by properly coordinating with Social Security and Medicare. By transferring liability to these federal programs, employee benefits and workers' compensation costs are significantly minimized.*
>
> *Even if you have a process in place for managing SSDI offsets and overpayment recovery, we can find room for improvement. Our Seamless ORS® process will help you recover the maximum in SSDI offsets. And you only pay for results. We only charge a fee when we win an SSDI award.*

Allsup provides what it calls "Overpayment Reimbursement Service." Under this heading on their website, it says:

> *Maximize Social Security offsets and overpayment reimbursements for disabled participants. With our Overpayment Reimbursement Service, we will:*
>
> ***Screen:*** *Using proven criteria, we will determine if claimants are suitable for pursuing SSDI benefits.*

Represent:	*Complete SSDI application forms, compile medical documentation and represent claimants through appropriate levels of appeal.*
Reimburse:	*Withdraw overpayment funds directly from claimant's bank account using our patented electronic process.*
Track:	*Monitor the disposition of all claimants who have applied for SSDI without Allsup's assistance or who have return-to-work potential.*
Report:	*Inform you of the SSDI application and overpayment reimbursement status for all claimants being represented or tracked by Allsup.*

I find Allsup's information that I have quoted from their website to be extremely troubling. This appears to be a violation of privacy. Moreover, Allsup is telling corporate America, and more specifically the insurance industry, that they are able to manage more effectively SSDI offsets and overpayments recovery. This, they say, can be accomplished by transferring liability to federal programs. What Allsup is really saying is that corporate America can reduce their expenses and at the same time increase profits for stockholders at the expense of the taxpayer.

Long-Term Disability Insurance Company Referrals To the Social Security Administration (SSA)

It has been widely publicized in the media that the Social Security Administration faces financial challenges in the future and that lawmakers are looking to find financial relief for the system. On the other hand, long-term disability insurance companies are looking for ways to reduce their liability while, at the same time, increase profits. Claimants are being forced to apply for Social Security Disability Income (SSDI) even though, in many cases, the carrier knows that the claimant does not meet SSA's requirements for benefits. As a result, the Social Security Administration is being charged with the costs for processing these applications. This is unfair to the taxpayer.

In the event that some of the referrals to the Social Security Administration are approved for SSDI, the long-term disability carrier will reduce their own monthly payout by the amount of the Social Security award. This is called an "offset." Additionally, the long-term disability company will request to receive any retroactive monies that are owed to the claimant from Social Security. These monies are described by the insurance company as "overpayments," but are they really overpayments? The answer is "No." I believe these monies should be rightfully returned to the taxpayer.

It has been brought to my attention that the average cost (at taxpayer expense) to evaluate a Social Security claim is in the range of $600 to $1,500 and that the cost is based on how far along in the system the case is evaluated.

The subject of the hearing is "Do Private Long-Term Disability Policies Provide the Protection They Promise?" Taking into consideration the monies that are recouped by long-term disability insurance companies for offsets and what they describe as overpayments, one has to seriously question whether the insurance carriers are providing protection for disabled claimants, or is the Federal Government covering the price tag at taxpayer expense?

I mentioned earlier that long-term disability insurance companies were flooding the Social Security Administration offices with referrals and that the cost of evaluating each claim ranged from $600 to $1,500. If the insurance companies were required to reimburse the Federal Government for referral and evaluation of claims, would they still make the same large number of referrals to SSA offices? I don't know. It is my opinion that if they continue to request offsets and overpayments, then they should be required to reimburse the Federal Government for Social Security referrals and evaluation of claims.

Case File Reviews

Case No. 1 – Mary F.

Mary F. is a 59-year-old female who was referred to me for a vocational rehabilitation assessment and evaluation. She has a long history of treatment for psychiatric/psychological issues. In May of 2005, Mary was hospitalized in a behavioral health hospital for a suicidal attempt by overdosing on prescription medications. My review of the medical records indicate that the patient has struggled with depression, anxiety and stress for many years. Her treatment for major depression has included psychotherapy and medication. In April of 2009, Mary was hospitalized again in a behavioral health hospital for a major depressive episode with suicidal thoughts.

From a vocational rehabilitation standpoint, Mary has had difficulty maintaining employment. Her most recent job was as a Telephone Nurse Case Manager. A review of the personnel file from the employer identified critical problems with Mary's employment. They included difficulties with concentration, attention, memory and stress. The Human Resource Manager at the company informed me that Mary had to be terminated from employment because of her inability to work with patients and to complete tasks on a timely basis. *The most critical issue expressed by the Human Resource Manager was that Mary would be putting patients at risk.*

Mary had a short- and long-term disability policy with Cigna Group Insurance. She applied for the short-term disability and was terminated after approximately 25 weeks. She appealed for benefits to be reinstated and, if this were to occur, she would subsequently be entitled to long-term disability benefits. Unfortunately, Cigna Group Insurance denied her appeal on the grounds

that her condition is episodic. In other words, she is not permanently disabled. There is a lengthy report from Ms. Susan Heliker, Appeal Claim Manager at Cigna, that contains mistruths and inaccurate or missing information, including omitted psychotherapy treatment notes. The omitted psychotherapy notes are used to argue that her illness was only episodic. I have furnished the Senate Finance Committee two binders with records, including comprehensive psychological and psychiatric records, including my vocational rehabilitation assessment and evaluation report dated March 30, 2010.

Based on the psychological and psychiatric evidence, including my vocational rehabilitation assessment and evaluation, this patient is not capable of performing the usual and customary functions of her job as a nurse. Her treating psychologist and psychiatrist have clearly identified the critical issues that would prevent her from returning to any type of work activity for up to 12 months. Yet, Cigna was willing to put patients at risk and deny Mary her critical income in order to save money.

I will respectfully respond to questions during the hearing regarding Mary F.'s case file and the issues that prevail today regarding her health and denial of benefits by the Cigna Group Insurance Company.

Case No. 2 – Jamie F.

Jamie F. is a 45-year-old female who was referred to me by her ophthalmologist. She has for some time been diagnosed and treated for "optic atrophy and severe visual loss secondary to multiple sclerosis and optic neuritis."

Jamie's distance visual acuity with correction is 20/400 right eye and 20/200 left eye. Thus, she is legally blind. She is only able to read large printed material with the use of visual aids. Her visual fields are limited, as reported by her treating physicians.

Initially, I performed a vocational assessment/evaluation to determine Jamie's functionality and ability to perform competitive work activity. After reviewing the medical evidence, including a consultation with her ophthalmologist and conducting a rehabilitation interview with the patient, it was my opinion that she was too disabled and unable to work.

At the time that Jamie was referred to me, she was receiving long-term disability benefits through The Hartford Insurance Company. Coincidentally, the last job that she performed was for The Hartford Insurance Company.

Jamie was entitled to receive long-term disability benefits from The Hartford Insurance Company, based on her severe physical limitations/restrictions and the fact that she could not perform the essential functions of her usual and customary job. It is also important to point out that she was required by The Hartford Insurance Company to apply for Social Security Disability benefits. Social Security's criteria are the strictest in the industry. She was approved for benefits by Social Security, and the long-term disability carrier deducted the amount of her

Social Security payments from the total amount she would have received for her long-term disability (offset).

At this point in time, Jamie has been informed by The Hartford that there is an investigation being conducted to determine whether she remains totally disabled and unable to work. This is outrageous. From a vocational rehabilitation standpoint, The Hartford Insurance Company is more or less saying that a person receiving Social Security Disability Income (SSDI) is not necessarily disabled under The Hartford's own criteria, even though Social Security's criteria are the strictest in the industry. This is unfair to the claimant.

To summarize, I have submitted to the Senate Finance Committee the file of Jamie F. The medical evidence and documentation is complete, and I will be available to answer questions regarding Jamie's medical status and her inability to perform any competitive work activity at this time.