

For Immediate Release  
Friday, March 27, 2009

Grassley works to strengthen Social Security disability program  
Senator seeks agency response to backlog caused by insurance community

WASHINGTON --- Senator Chuck Grassley said his survey of private insurers has found that some are needlessly contributing to the Social Security disability backlog, and he urged the Social Security Administration to recommit itself to preventing disability benefit application fraud and to work with the Inspector General to penalize and prosecute those filing false disability claims.

Grassley also asked the Social Security Administration and the Federal Trade Commission for status report on their evaluation of private insurance practices in this area.

“Fraud against the Social Security disability program and delays made worse by private insurance company policies diminish the effectiveness of the disability program for those who have to rely on it,” Grassley said. “What I’ve found with my own survey builds on other findings, including those of the Government Accountability Office. The Social Security Administration needs to address these issues with a renewed effort.”

Grassley’s said his conclusions about the way private plans are burdening the public program are based on his review of responses from nine major insurance companies to an inquiry he made late last year about private insurers’ policies and practices concerning disability insurance claims.

Every insurer surveyed by Grassley said it “encouraged, requested, required, expected, asked or suggested that long-term disability claimants apply for Social Security disability payments once a claim is approved. One private insurer requires that individuals apply. All nine of the insurers’ policies reduce claimants’ disability benefits by the assumed amount of Social Security disability insurance benefits unless it granted an exception. Four private insurers provided information to Grassley about approval rates for Social Security disability claims. Of those four, three had approval rates generally below all disability claims processed by the Social Security Administration.

Whistleblowers have filed two False Claims Act lawsuits alleging that private insurers required policy holders to file for Social Security disability payments even when there was no basis for a claim or even evidence that such a claim would be rejected. One case is scheduled for trial this year.

Grassley detailed his findings and recommendations in a letter sent this week to the Social Security Commissioner. The text of the letter is below. Its attachments are posted with this letter at <http://finance.senate.gov> and <http://grassley.senate.gov>.

March 24, 2008

The Honorable Michael J. Astrue  
Commissioner  
Social Security Administration  
6401 Security Boulevard  
Baltimore, MD 21235

Dear Mr. Astrue:

As the Ranking Member of the Committee on Finance (Committee), it is my duty under the Constitution to conduct oversight of industries and practices that affect the Social Security Administration's (SSA) Old-Age and Survivors Insurance, Disability Insurance, and Supplemental Security Income Programs. In November 2008, I wrote to the SSA regarding troubling press accounts and court filings documenting a federal court jury finding that the Unum Group (Unum) defrauded the United States in a False Claims Act case, *U.S. ex rel. Loughren v. Unum Provident Corporation*, C.A. 03-11699 (D. Mass.).

This letter is based on a comprehensive review of hundreds of pages of documents that my Committee staff obtained. Portions of these documents were received by the Committee in response to letter requests to Aetna Life Insurance Company (Aetna), CIGNA Corporation (CIGNA), Hartford Financial Services Group (Hartford), Lincoln Financial Group (Lincoln), Metropolitan Life Insurance Company (MetLife), Prudential Insurance Company of America (Prudential), Reliance Standard Life Insurance Company (RSL), Standard Insurance Company (Standard), and Unum. Additionally, this letter contains information that my Committee staff obtained through interviews conducted with, among others, representatives of the aforementioned parties.

## **I. Background**

A *New York Times* reporter wrote that the SSA is choking on paperwork and spending millions of dollars a year screening dubious applications for disability benefits from private insurers.<sup>[1]</sup> She also reported that whistle-blowers filed two False Claims Act lawsuits alleging that private insurers required their claimants to file Social Security Disability Insurance (SSDI) benefits even if they had no good faith basis for believing that the claimants were eligible for SSDI, or may even have evidence to the contrary. Furthermore, since December 2007, the Government Accountability Office (GAO) has issued four reports that address SSA's continued delays in processing disability claims and persistent backlogs.<sup>[2]</sup> Based on this information, I opened an inquiry into these allegations regarding private insurers' policies and practices concerning disability insurance claims.

### **A. Disability Insurance Programs**

Private disability insurance policies differ from SSDI in several important respects. Private insurers sell individual and group short-term disability (STD) and long-term disability (LTD) income products that provide insurance protection for workers in the event they are unable to perform the duties of their own occupation as a result of illness or injury. The group disability insurance policies typically contain language mandating that the claimant apply for

SSDI benefits at the insurer's request. Private insurance policies also authorize the insurance companies to reduce a claimant's benefit by the estimated amount of his or her SSDI benefits. For every disability insurance claim that the private insurer receives, the private insurer must create a reserve under state regulations to cover its liability for the expected duration of the claim. In some cases, private insurers may be allowed to reduce their reserves when the SSDI claim is filed, regardless of whether the SSA approves or denies the claim.

Private insurance policies have a much broader definition of disability than the SSA. By law, the SSA has a very strict definition. According to SSA policy, to be eligible for SSDI, an adult must be unable to engage in substantial gainful activity (SGA) because of a medically determinable physical or mental impairment that is expected to last at least 12 months or result in death.<sup>[3]</sup> State agencies called Disability Determination Services (DDS) make initial determinations for disability benefits. If DDS deny benefits, an applicant generally has up to four levels of appeal: reconsideration (also administered by DDS), hearing (overseen by an administrative law judge), Appeals Council, and Federal Court.

### **B. False Claims Act Lawsuits**

In 2003, two whistleblowers filed False Claims Act lawsuits against Unum and CIGNA, two of America's largest private disability insurers. The plaintiffs contend that these companies do not properly screen claimants to make sure they are suitable for SSDI benefits before claimants are required to apply for the government benefits.

According to press accounts and court filings, on October 22, 2008, a federal court jury found that Unum defrauded the United States. Specifically, Unum caused its customers to submit false claims for disability benefits to the SSA even though Unum knew that the claimants were not eligible for the SSDI benefits. The CIGNA lawsuit is scheduled to go to trial in 2009.

### **C. GAO Found Increasing Disability Claims Backlog**

Since January 2003, the GAO has designated the SSA disability program as a high-risk area to bring awareness that the program needs a broad-based transformation to address major economic, efficiency, or effectiveness challenges. GAO reported that SSA continues to struggle to keep pace with growing numbers of disability applications, leading to large claims backlogs and long waits for claimants. According to GAO, in fiscal year (FY) 2006, the total number of backlogged disability claims has more than doubled since FY 2000 to about 576,000 cases. GAO also found the processing time at the initial claims level, the reconsideration level, and the hearings level increased to 89, 72, and 481 days respectively.

## **II. Findings**

Set forth below are my Committee staff's findings with regard to private insurers' policies and practices concerning disability insurance claims.

### **A. Private Insurers Responses to Committee Inquiry**

In July 2008, I sent letters to nine private insurers requesting detailed information about their respective handling of disability claims. Specifically, I asked the insurers to report how many of their claimants they had compelled to apply for SSDI, how many appeals they had required individuals to file, and what methods they had used to screen the claimants prior to submitting an application for Social Security benefits.

As shown in Exhibit A, responses from the nine private insurers suggest that company policies and practices might be placing a burden on American taxpayers who rely on their private disability benefits to meet their financial needs during times of disabling sickness or injury. Specifically, all nine insurers state that they *encourage, request, require, expect, ask, or suggest* their LTD claimants apply for SSDI benefits once a claim is approved for disability payments. In one instance, the private insurer indicated that their contract states an individual *must apply* for SSDI benefits. Indeed, responses from each private insurer indicate that they screen claimants for SSDI eligibility before the claimants are required to apply for SSDI benefits (see discussion in A.1 below). However, based on the data that the insurers provided, it appears that insurer screening processes do not necessarily lead to higher SSDI approval rates (see discussion in A.2 below). Exhibit A also shows all nine insurers' policies reduce a claimant's disability benefits by the assumed amount of SSDI benefits if a claimant does not satisfy the criteria for waiver (see discussion in A.3 below). Finally, Exhibit A also demonstrates that eight of the nine insurers do not have a process to communicate to the SSA when they have determined during the SSDI application process that a claimant is no longer eligible for private disability benefits.

In November 2008, I sent follow-up letters to the nine insurers requesting information on how many STD and LTD claimants who received at least one benefit payment in calendar year (CY) 2007 were subject to a SSDI offset. Based on the insurers' responses, the chart in Exhibit B illustrates that about one-third of all claimants who have received at least one disability benefit payment in CY 2007 were in SSDI offset status - either based on estimate or actual offset (see A.2 below).

### **1. Private Insurers' Screening Process**

Private insurers use in-house specialists or vendors under contract with the insurers<sup>[4]</sup> to screen and assist claimants in pursuing SSDI benefits. According to insurers, these specialists and vendors are experienced disability claims professionals who understand the SSA disability and eligibility guidelines and may have previously worked for the SSA. The insurers indicated that once a claim is approved for disability payment, the claim is referred to a specialist or vendor for evaluation in light of the provisions of the disability plan, SSA regulations governing SSDI claims, and the claimant's disability condition. If the specialist or vendor determines that there is a reasonable basis for the claimant to apply for SSDI benefits, the specialist or vendor will contact the claimant to discuss initiating the SSDI application and provide support to the claimant throughout the SSDI claim process.

### **2. Screening Process Does Not Always Improve SSDI Approval Rates**

Based on the data provided by four insurers, Exhibit C shows the number of LTD claimants who made an initial SSDI filing in years 2003 to 2007, and the results from those initial applications. The same table also shows SSA's data related to all SSDI claims for years

2003 to 2006.<sup>151</sup> Five insurers were not able to provide statistical data relating to the number of claims they referred to the SSA because their systems did not track such data. However, these same five insurers stated that they have or planned to begin to track data reflecting a claimant's SSDI status over time.

As illustrated in Exhibit C, three of the four insurers' SSDI approval rates at the initial and final appeals levels from 2003 to 2006 were generally below all SSDI applicants processed by SSA. The fourth insurer's SSDI approval rates were essentially the same as all SSDI applicants. Thus, it would appear that those who are being screened by private insurers are no more likely to be approved than those who are not subject to such screening.

Let me also share with you an allegation sent to me on January 21, 2009, from an individual (Claimant X) regarding his insurance company's (Insurer X) disability claim screening experience. Claimant X's allegation is similar to many allegations received by my Committee staff and reported in the *New York Times* and the two False Claims Act court documentations -- that is, private insurers forced individuals to apply for SSDI benefits even though individuals did not believe they were eligible for government benefits.

Claimant X stated the following in an email (Exhibit D), "***At the onset of my disability I was subjected to terrorizing, abuse and coercion from [insurer x] and their third party administrator...***" Claimant X went on to write that in early 2006, he was diagnosed with a spinal condition that required surgery. [Insurer X] initially denied Claimant X's LTD benefits for approximately three months, restored it, and then denied it again for two additional months before restoring benefits. As a result of these denials, Claimant X's surgery was postponed for months. Approximately one month prior to the scheduled November 2006 surgery, the third party administrator informed Claimant X that he must apply for SSDI and return a signed contract that required him "***to appeal any denials twice to the ALJ level and turn over any SSDI award to [insurer X] as repayment of the loan.***" Claimant X stated that he "***had no choice***" but to comply with the demand because he was told that his [insurer's] "***benefit would be terminated immediately (one month prior to surgery) if [he] didn't sign the contract...***" On January 23, 2009, Claimant X told my Committee staff that SSA found him not eligible and denied his SSDI initial and appeal applications.

Based on Claimant X's account, the insurer's screening practice appears flawed because Claimant X was not eligible for SSDI benefits and yet he was forced to apply for the government benefits. The experience relayed to my staff seems to describe a practice that is unacceptable. In essence, it appears to me that forcing individuals to apply for SSDI to avoid losing their private insurance benefits places the individual at a disadvantage when they are most vulnerable.

### **3. Estimate SSDI Offset To Reduce LTD Reserves**

Most private insurers' group disability contracts allow offset due to various other income sources, including SSDI. Generally, group insurance policies in most states contain a provision that would permit private insurers to estimate the amount of SSDI benefits and deduct such amount from a claimant's benefits. Private insurers will consider waiving their rights to assume receipt of SSDI benefits when a claimant provides satisfactory proof of application to SSDI,

signs a reimbursement agreement, provides satisfactory proof that all appeals have been made, and submits satisfactory proof that SSDI benefits were denied.

Responses from the nine insurers generally state that they estimate the actuarial probability that a claimant might be awarded SSDI benefits in the future when determining the reserve amount that must be set aside, whether or not the claimants have filed SSDI application. According to the Unum False Claims Act lawsuit documentations, a former Unum vice president, Mary Fuller, who was head of one of Unum's claim units, testified that Unum's motive was to reduce its financial reserves based on the filing of the SSDI applications, whether or not the claim had any merit.

## **B. SSA Response**

In light of the Unum verdict, I invited the SSA to brief my Committee staff on what actions the SSA has taken or plans to take to improve program integrity and enforce applicable provisions of the Social Security Act. On December 3, 2008, SSA representatives (Representatives) conceded to my staff that the outcome of the Unum lawsuit was troubling, but stated that the government will not intervene in the lawsuit. The Representatives told my staff further that the rationale for the decision not to intervene in the case was that the SSA disability program has an "open-door policy" and does not prescreen applications. They added that SSA is required to consider all applications and conduct a substantive determination, even those that might seem improbable.

The SSA Representatives went on to explain that although it is probable that many claimants were required to apply for SSA benefits when they were not suitable for SSDI benefits, it is impossible to say how much of the disability program's backlog problems were caused by private insurance referrals. They added that the alleged practice is not limited to the private insurance industry because other federal and state programs require their claimants to apply for SSDI in order to receive their disability benefits. The Representatives also noted that, the disability claims processing system, in its current form, does not require individuals to reveal whether or not they are receiving other disability benefits. The Representatives believe further that the cost associated with modifying the system will exceed any benefits derived from having that information because it is not of importance to them whether or not an individual was referral to SSA or not. Finally, they stated that SSA lacks both the enforcement authority and staff to prosecute individuals or organizations who submit false information on SSDI applications.

The SSA Representatives also shared a copy of a November 26, 2008, letter from the SSA to the Federal Trade Commission (FTC) (see Exhibit E). The letter states that SSA is concerned with the alleged practices detailed in the False Claims Act lawsuits and request that the two agencies evaluate what can be done to eliminate these practices and ensure disability claims processing system is not clogged with unwarranted applications for benefits.

## **C. Conclusion and Recommendations**

Based on the responses to my inquiry, it seems abundantly clear that some private insurers are needlessly contributing to the Social Security disability backlog. Throughout my inquiry, it became apparent that private insurers are taking advantage of SSA's "open door policy" by compelling their claimants to apply for SSDI even if they believe their customers are

ineligible for those government benefits. Suffice it to say that when you look at this as an aggregate industry practice, there is no question that private disability insurers are causing thousands of unnecessary and meritless SSDI claims to be submitted to SSA each year which in turn are contributing to the backlog that is stressing the system.

As reported in recent press accounts, the SSA plans to hire up to 155 additional administrative law judges to help address the staggering backlog of cases. Unfortunately and based upon my examination of this matter, more needs to be done. In addition to improving both the accuracy and timeliness of disability decisions, SSA needs to recommit itself to achieving comprehensive reform to improve program integrity and enforce applicable provisions (42 U.S.C. 408 §208) of the Social Security Act with respect to disability benefit application fraud.<sup>[6]</sup> Accordingly, I recommend that SSA give serious consideration to the following policies and procedures:

- (1) Require that individuals applying for SSA benefits disclose whether or not they have private or other non-SSA disability coverage or benefits at the time they file their SSDI or Supplemental Security Income (SSI) application;
- (2) Require SSDI and SSI applicants and claimant representatives to attest to the accuracy and truthfulness of SSDI or SSI claim information; and
- (3) Implement information sharing arrangements with private insurers and other non-SSA disability programs to exchange information regarding the status or disposition of disability claims.

I also recommend that the SSA coordinate with the SSA Office of the Inspector General to penalize and prosecute individuals responsible for filing false disability claims.

In addition, I am extremely interested in learning more about the progress made in the proposed joint SSA and FTC evaluation of private insurance practices as described in Exhibit E. Accordingly, please provide my staff with the following:

- (1) An initial briefing on the scope and methodology of your planned evaluation;
- (2) Regular updates on its progress; and
- (3) A copy of your final report(s) as soon as it is available.

In closing please provide a response to the concerns, findings and recommendations contained in this letter by no later than April 8, 2009.

Sincerely,

Charles E. Grassley of Iowa  
United States Senator  
Ranking Member of the Committee on Finance

## Attachments

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<sup>[1]</sup> Mary Williams Walsh, *Insurers Faulted as Overloading Social Security*, New York Times, April 1, 2008.

<sup>[2]</sup> *Better Planning, Management, and Evaluation Could Help Address Backlogs* (GAO-08-40), December 2007; *Federal Disability Programs* (GAO-08-635), May 2008; *Social Security Disability* (GAO-09-149), December 2008; and *High Risk Series: An Update* (GAO-09-271), January 2009.

<sup>[3]</sup> A person who is earning more than the monthly earnings threshold is considered to be engaging in SGA. In 2008, SGA is \$940 per month for individuals with disabilities, not including blindness. For blind individuals, the SGA in 2008 is \$1,570.

<sup>[4]</sup> Private insurers do not pay any fees to vendors if the SSDI applications are not ultimately approved.

<sup>[5]</sup> [http://www.ssa.gov/policy/docs/statcomps/di\\_asr/2007/sect04.xls](http://www.ssa.gov/policy/docs/statcomps/di_asr/2007/sect04.xls)

<sup>[6]</sup> (a) Whoever -

(2) makes or causes to be made any false statement or representation of a material fact in any application for any payment or for a disability determination under this title; or shall be guilty of a felony and upon conviction thereof shall be fined under title 18, United States Code, or imprisoned for not more than five years, or both.