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Ms. Mila Kofman, Chair
Consumer Protections & Innovations Working Group
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

RE: "Best Practices" in Disability Insurance

Dear Superintendent Kofman:

The American Council of Life Insurers (ACLI) appreciates the opportunity to comment on your request to participate in the Working Group's discussion on the disability income claims "best practices" presentation from the 2008 June San Francisco Working Group Meeting. ACLI is the principal trade association of life insurance companies, representing 353 member companies that account for 93 percent of total assets, 93 percent of the life insurance premiums, and 94 percent of annuity considerations in the United States. ACLI member companies provide the majority of disability income insurance coverage in the United States.

What appears to be the concern that has led to this initiative, that claims are handled promptly and properly, is an objective shared by the industry. We believe that the Unfair Claims Settlement Practices Act adopted in 48 jurisdictions provides the framework to achieve that objective. In fact, all the states represented on this Working Group have adopted various versions of the model act. Because of this, it would not be necessary to list all the requirements in this letter as "best practices".

Companies, including insurance companies, come in all sizes and have different methods of organization. There is a high degree of variability in business form and organizational structure that is significantly influenced by size and a company's multiple and varying product offerings: these factors do not lend themselves to a uniform, one-size-fits-all, "best practices" approach to the manner in which disability claims might be managed and adjudicated. Therefore, it is extremely difficult to add to the list developed from the June presentation.

We do, however, have concerns with the proposed list of "best practices" as it appears that many of the suggestions were remedial measures agreed to by one carrier in order to settle its market conduct examination findings. It is problematic to develop a list of practices, a "same mold" one might say, to apply to an entire industry especially when the set of circumstances surrounding an individual company can be and are completely different from that of each other company. Moreover, even within a company, every claim is different and there is no singular approach on what must be absolutely done on every claim.

Training – We believe training is very important and encourage companies to provide the appropriate training. Each company establishes as appropriate training procedures for claims examiners and guidelines for the evaluation and investigation of claims. We would, however, caution as to what appears to be micro-managing of the process as currently outlined in the proposed list.

Claim Organization – Overall, each company should be allowed to design a claims organization that will work best within its structure. Accordingly, we have concerns with several of the suggested "best practices":

- *Experienced claim staff should "sign-off" on claim denials and terminations of benefits*.

  This guideline is somewhat vague. It seems to add an extra and unnecessary administrative process that could possibly delay the claim determination and add cost (e.g., if an experienced analyst makes an initial claim determination, why must another experienced claims analyst repeat the process?). In addition, some denials or closures may be so basic as to require little experience (i.e., closure due to the end of the maximum benefit period, actual work earnings exceeding an amount specified in the policy).

- *Companies should create a separate compliance-accountability function involving highly experienced claim staff to be involved in the more complicated claims prior to a denial or termination decision.*

  While having more experience claims staff evaluate more complex claims makes sense, requiring a company to create a separate compliance-accountability function impermissibly interferes with a company's ability to structure its operations and could impede the provision of superior customer service to group customers who expect regular interactions with a dedicated team or representative.

- *Companies should create a claim audit function, reporting to senior management and ultimately the Board of Directors, to evaluate compliance with claim procedures and law*.

  Having claims/compliance/audit managers report to a board of directors is wholly inappropriate and inconsistent with what a board does. The chief executive and other senior management is charged with running the business, while the board manages the CEO and other senior management and sets overall policy and strategy for the organization.

Corporate Organization - Due to the fact that corporations differ in size and have differing corporate hierarchies in their organizations, we would suggest that it would be best for the organization to decide the extent of appropriate board involvement. Again, boards of directors are primarily charged with oversight of the CEO and corporate strategy, not day-to-day operational or compliance issues. Accordingly, the following two "best practices" should not be included:

- *The organization's commitment to compliance should be reinforced by establishing a Board of Directors function responsible for monitoring compliance*.
- *Senior management, claim management, compliance management and the claim audit leadership should regularly report to this Board committee*.

Claim Procedures – Overall, we agree that there should be adequate claims procedures in place but question the following "best practices" as overly detailed and inappropriate in some cases:

- *A code of conduct should be adopted for all medical professionals used by the company which includes a commitment to provide fair and reasonable evaluations considering all available medical, clinical, and/or vocational evidence, both objective and subjective, bearing on impairment. With each determination the medical professional should certify that he or she has reviewed all the evidence provided.*

  Typically it is inappropriate to give medical professionals "all available vocational evidence". They are asked to render a medical opinion regarding limitations and restrictions the claimant's medical conditions may impose. Whether a claimant can perform their own or any occupation is

ultimately a decision for the analysts. While physician reviewers may be provided with appropriate portions of the claim file, they are asked to review the medical information and offer a medical opinion.

- *Claim staff should provide the medical professionals with all available medical, clinical and/or vocational evidence in the claim file, both objective and subjective, concerning impairment*.

  See our comment immediately above. To the extent that claim staff determines that it is appropriate to provide such information, then all information is provided. We are also concerned about using "subjective" and "evidence" in the same sentence as it could be used to argue that subjective evidence necessarily has the same weight as objective evidence. While insurers do consider subjective complaints, oftentimes the objective medical evidence does not support the claimant's reported (subjective) level of impairment.

- *Significant weight should be given to the fact of a Social Security Disability Insurance award absent an error of law, inconsistency with applicable medical evidence, or inconsistency with the disability definition in the policy*.

  Best practices should not create rules of evidence, particularly these. SSDI awards should be considered just like any factor, but just as more weight is not *ipso facto* given to a treating physician's opinion, more weight should not be given as a rule to an SSDI award. It should also be kept in mind that the SSDI program has its own set of standards which may vary considerably from what is in the private insurance contract, and that the SSDI claims examiners may often be evaluating different evidence than what the private insurer has.

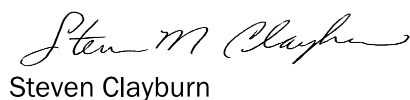
- *When co-morbid conditions are present, claim staff should ensure that all diagnoses and impairments are considered and afforded appropriate weight in developing a coherent view of the claimant's medical condition, capacity and restrictions/limitations*.

  This is implicit in any claims determination but one should also remember that some co-morbid conditions can be afforded no weight if the diagnosis has not been established by credible medical information.

In summary, we agree that a covered insured's claim should be handled promptly and properly. Disability income insurers want to help the covered insured in any way possible to restore lives the way they were before the disability by paying benefits and working with the employer and the insured to help the insured get back to work. No one set of practices for any of these issues can or should be the exact same for all companies, and companies themselves will constantly want to improve on any of their own guidelines to help differentiate themselves in the marketplace. Finally, any fixed set of guidelines will not be able to keep pace with changes and innovations made in the marketplace.

The ACLI and its members companies welcome a strong working relationship and open communication with the NAIC's Consumer Protections & Innovations Working Group. We believe that the Unfair Claims Settlement Practices Act reflects and addresses the spirit of the issue that this group is studying and we welcome every opportunity to provide you with the information you need for your analysis. Please call upon us to help with your ongoing reviews. We look forward to working with this Group.

Sincerely,



Steven Clayburn

cc: Tim Mullen, NAIC Staff
Consumer Protections & Innovations Working Group Members