

DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER SAD STATE OF DISABILITY CLAIMS

November, 2008
Volume 1, Issue 25



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Bad News On the Horizon

By Linda Nee, BA, HIA, ALHC, DIA, DHP, CPM

Disability Claims Solutions, Inc. has been watching the overall “patterns of business practices” used by disability insurers in the United States for a period of approximately 12 months. This includes companies such as Aetna, The Standard, Prudential, Unum, CIGNA, The Berkshire/Guardian, Northwestern Mutual, Mass Mutual, Jefferson Pilot, DMS, DMA, and Sun Life. This group of insurers fairly represents a select group of disability insurers we have exposure to as case managers.

In the second quarter of 2007 it was evident in the selection of both ERISA and non-ERISA disability claims that management in all companies pushed the escalation of denial strategies internally in an effort to deny more claims to offset losses in a recessionary economy.

Today, as we near the end of 2008, all insurers continue to escalate internal demands for more and more medical information, increased referrals for surveillance and field visits, and for some insurers, illegal limits on the use of Reservation of Rights Status, and refusal to re-open payable claims on appeal.

Individual claims specialists, manager and directors seem oblivious to the near-fraudulent processes they are using to cause their employers to profit at the expense of the insured. Brainwashed with internal propaganda in memos and emails stating, “we have the right to fully investigate claims”, and “insureds must submit proof acceptable to Us”, claims employees defend internal strategies which at best are deliberately not well intentioned.

For years disability insurers have been “dumbing-up” their claims staff by removing accountability for the more complex issues involved with disability claims. For example, financial reserve information has been removed from the claims handlers view, and training no longer includes a complete study of disability contracts except for directives on how the contractual provisions should be interpreted and adjudicated.

Claims specialists have been reduced to administrative secretaries pushing paperwork from one resource to another in an effort to “stack the deck” against the insured with the accumulation of file documentation and paperwork. The idea is that the more documents that can be obtained by seemingly credible resources supporting a claim denial, the more credible the denial is for the insurance company to defend in court before a judge.

Claims normally expected to be “safe” by sending to the Extended Duration Unit are also coming under fire. Apparently, managers have devised projects to identify potentially deniable claims even after social security has been awarded and liability accepted long-term. Those who are used to having their claims reviewed once a year are now being asked to go “back into the mainstream” of risk management by submitting proof of loss every month. Also, not a good sign.

As if the news isn’t bad enough, it also appears judges, particularly in ERISA cases are siding more and more with the insurance companies again. Federal and state judges appeared to be more sympathetic with insureds from 2002-2007, however, there is strong evidence suggesting judges once again are coming in on the side of big money and special interest local lobby groups paid with insurance industry money.

Attorneys seem to have an endless pipeline of information concerning how ERISA cases are doing all over the country. The news isn’t good and what that means for an ERISA insured is that it is even more difficult to find an experienced ERISA attorney who is willing to take the case. Or, if they do, the insured pays attorney fees which can exceed a quarter of a million dollars over the remaining life of the claim to age 65, that is, if they win their case at all.

So, what does all this mean? Well, it means disability insurers have probably cut, or are attempting to cut their “Liability Acceptance Rate (LAR) to less than 50%. Or, to put it another way, companies are attempting to pay less than 50% of claims presented for payment. This figure is only an estimate, but we feel it’s reasonable given what we are currently seeing in the management of claims by US insurers. And, it’s probably going to get a lot worse.

This edition of the DCS, Inc. newsletter should be a wake-up call to anyone who has a disability policy, or is already on disability, or who expects to be unable to work in the future. Insurance companies will be looking to maintain their profitability in a falling economy. This means more aggressive claims management at the expense of individuals who are depending on their disability policies for financial help. Disability insurers are now out of control.

Help! Is Anyone There?

Let's start with the ERISA folks..... The jurisdiction for ERISA claims rests with the U.S. Departments of Labor in the various states. Not all employer-sponsored claims are pre-empted by ERISA, but let's assume the majority of them are.

If an insurance company unfairly denies an ERISA claim, the insured has the right to request an appeal within 180 days of receiving the claim denial letter. If the insurance company engages in unfair tactics during that 180 days, there is absolutely nothing the insured can do.

The DOL does submit a letter to the insurance company informing them of the complaint. Usually, the insurance company sends a response back stating they have done nothing wrong. The DOL then sends the insured a letter saying the case is closed because the insurance company says they did nothing wrong.

In short, the DOL always BELIEVES the insurance company. When was the last time an insurance company ever documented an admission of wrong doing? Common sense, right? No help there. Besides, the DOL will tell you they don't decide issues of "fiduciary duty" and you have the right to go to court. (But, not within the first 180 days you don't!) The insurance company can jerk you around on appeal all they want during that 180 days and there is nothing the insured can do. Attorneys are not likely to take ERISA cases, so claimants are pretty much out of luck.

IDI insureds suffer the same fate somewhat from the state Departments of Insurance. Complaints are sent to the insurance company where a local insurance mouthpiece writes to the DOL and claims "innocent of all charges." State DOL says, "OK, insurance company must be right." IDI insureds can get an attorney anytime and if they live in a "bad faith" state, counsel is jumping out their chairs trying to get their business. IDI insureds have the right to an appeal reconsideration which is limited time wise to the statute of limitations for torts in their state. Still, there is no help from the departments of insurance who can "pass off" your complaint to the domicile states and not deal with it at all in the state you reside in.

In short, there isn't much help available to victims of deliberate insurance malpractice. The best chance anyone has of actually being paid disability benefits long-term is to ensure your claim is well supported and represented to avoid a claim denial in the first place.

There is no help outside of federal or state court, and even then, recovery of most of the value of the policy is near impossible except in bad faith cases, if successful.



We suspect Unum is attempting to recover losses incurred during the reassessment. Remember their statement, "we pay 98% of claims?" Unum had to convince regulators they transformed into "the good guys" and now management has to go back and re-review at least 30% of claims they overpaid to determine how many of them they can now deny when regulators are no longer watching. Regulators need to get a grip!

So What's The Solution?

Disability Claims Solutions, Inc. has always held a philosophy which provides insurance information to insureds at least equal to that of the insurance company. Some of our peers have criticized us for this claiming we give TOO MUCH UNPAID information, but we believe insureds should be knowledgeable concerning their policies and how claims will be evaluated for payment. Knowledge is power, and helps keep the insurance companies somewhat honest.

We are aware that some of the messages we bring through this newsletter are depressing and not encouraging to someone on claim. But, knowing encourages preparation and that's a good thing.

Medical claims case management is different today than say, a year ago (or it should be) because what we do to provide the insured with the best possible claim is, in part, in response to how the US insurers are reviewing claims. Aggressive "risk management" requires aggressive claim response and claim management in order to protect the insured from out-of-contract demands and unfair settlement claims practices.

Although most insureds are well-intended and want to appear cooperative and congenial, in today's disability claim environment a more assertive attitude is required for the protection of benefits. For example, we receive calls from insureds who want to manage their claims by themselves who in no way can identify the meaning of policy language and misstatements of fact.

Disability Claims Solutions, Inc. has not had a need in the past to actively market our services other than on our web site. The source of most of our business is from word of mouth, referrals from physicians and attorneys, and of course via the Internet.

But, in today's disability insurance market it does seem obvious that insured's best chance of receiving benefits long-term is to retain the help of someone who knows the industry. It can't be done by yourself, anymore.

Our next article focuses on specifics. We hope it is helpful to our readers – clients or non-clients.

Managing the Claims by Linda Nee

Our current economic recession places those who are receiving disability benefits (or those who are about to receive benefits) in a very precarious position. Caught in the catch-22 position of needing financial assistance more than ever insureds are faced with having to deal with insurance companies looking for the slightest reason to deny benefits often without legitimate cause. While we do not recommend to individuals that they attempt to manage the claims process themselves, we offer the following to our clients going forward:

Prevention is the key.

We are of the opinion insureds need to pay more attention to the amount and quality of medical information which can be submitted as proof of claim. It is recommended all insureds and clients prepare a current physician contact list with treatment dates, diagnosis, and treatment plan and forward it to DCS for inclusion in your file. All insureds should remain in “regular and on-going treatment” appropriate to the impairment. If you are not sure as to what that is, please send me an email and ask if we haven’t already discussed it. Physical therapy and pain management clinics generally do NOT constitute “appropriate care” and are known for their reluctance to fill out paperwork. **Physicians who do not fill out disability forms, or who do not document the record well will not assist you in maintaining proof of claim.** You need to move on and seek competent medical care from those who are willing to meet the demands of the insurance company. Going forward, we are asking all insureds to obtain current office consultation notes from their physicians, and to keep up with that on a regular basis. You may send your current office note to DCS as soon as you obtain it. We will keep the notes on file and will send in on a regular basis.

We find insureds are getting somewhat lax and comfortable in just sending the same completed APS statement and are often looking for shortcuts when it comes to the quality of medical records obtained and submitted as proof of claim. **DCS, Inc. is in the process of preparing a brochure which can be provided to your physicians on your behalf to help them understand the process of reporting medical restrictions and limitations to an insurance company.** We will provide each client with copies of the brochure as soon as it is completed. DCS will invite each physician to call us if they have questions concerning the completion of medical forms or doc-to-doc calls. We think physicians are very confused about the process and would appreciate our help as well.

It is much better to do what we can to prevent a claim denial than attempt to overturn it at a later time. Most insurance companies are for the most part operating totally unregulated. We don’t necessarily mean this to suggest there are no laws, but when attorneys are reluctant to take cases (except high-end bad faith), and the Departments of Insurance ignore complaints, then the disability insurers do in fact a free run.

Personally, I suspect clients and other readers have dropped out of appropriate care. If you are not sure what constitutes appropriate care, and you are a client, please email me and I will advise you what specialty care you should currently have that best supports your claim. We would love to have this discussion with you and insure you are being treated appropriately for each impairment.

We will keep you informed as to the status of our physician brochure. In the meantime, please prepare the physician contact list and begin obtaining all of your current office treatment notes. When they are complete or up to date, please send to DCS so we can keep them on file if we need to send updates. **Office treatment and consultation notes are key and far supersede completed forms as proof of claim.** Everyone needs to keep their physician informed. If you haven’t already had this conversation with your doctor, we encourage you to do it at your next appointment.

Be Prepared to Solicit Alternative Resources.

You can be assured disability insurers have hired physicians and vocational resources to create documents which can be used to support a claim denial. You can do the same to support your claim. The idea is to never allow the insurance company to have a consensus of opinion about anything. Whatever the insurance company can obtain or pay for to discredit your claim, you can obtain and pay for to favor it. Some people might say, “We shouldn’t have to do this in order to get benefits we are already entitled to”, and they would be right. However, in order to combat the strategies currently being utilized by insurers, claimants need to make sure there is sufficient proof in the file representing their position in support of claim. It makes it much more difficult for disability insurers to deny claims when there is preponderance of medical and vocational information in the file in support of claim. Let’s make that happen. DCS will advise you accordingly when it makes sense to obtain documentation from other sources.

Question..Question...Question.....

If you are currently a client, DCS will do this for you. For example, the trend is for disability insurers to claim, “the policy contract means what WE SAY it means.” Misinterpretation of policy contract language and out-of-contract requests are quite common. If the insurance company is requiring the insured to perform a duty which is not written in the policy contract, then the insured has no obligation to do it. Once you “give in” to such requests the claim is, for all purposes, already denied. Insureds and/or their representatives have a right to question the validity of actions by an insurance company, and don’t let claims handlers tell you not to question their authority. You have the right to be treated respectfully.

Document Everything.

One of the best things we do at DCS is make sure there is more than enough documentation in the claim file which clearly points out all of the questionable activity of the disability insurer. Most of you are well aware DCS is not reluctant to document offenses committed by any disability insurer. Should the claim require litigation at a later date, there will be a plethora of documentation clearly describing all questionable claims practices, requests, and out of contract language interpretations.

Defend Yourself.

Most of you have by now read most of what I’ve written about surveillance. Unum, for example, is conducting surveillance on everyone, and for every impairment. As a result, we are recommending ALL clients keep their eyes open for strange cars and persons on their street, or following behind. As we’ve suggested in the past, insureds should “blow their cover” by telling the PI you are aware of their surveillance. You can also call your local police and request them to ask the investigators to leave. We also suggest using a cell phone or camera to take the picture of the investigator including the license plate of their car. This seems to be enough to encourage the PIs to move away if you are obvious enough. Tell them to, “just say cheese!”

Your Health Is The Primary Good.

The disability claims process has become so corrupt lately insureds are asking questions about what medical information they need to “keep their claim.” Our response is always that health and well-being are, or should be, the primary objective. In other words, there is no point whatsoever in obtaining medical care that is widely accepted by the insurance company, but doesn’t encourage a state of health or well-being. All medical decisions for treatment should be made between the patient and their doctor, not between the insurance company and the insured with a buy in of a physician. It is our thought that all treatment should have the objective of restoring the insured to health regardless of what the disability company is willing to accept. Amen?

I apologize in advance if the message of our November newsletter is less than encouraging. Most of you who know of me, or about me know the philosophy of this company is to keep insureds informed regardless of the message. While we do not want anyone to become discouraged, we also do not want insureds to lose their benefits. This is a time for heads up and awareness of what is happening in the industry.

We also do not want to give you the impression ALL claims are denied either because that’s not true at all. It just takes a bit more medical support and claims savvy to justify a claim for disability in these troubled economic times. **The idea is to prevent a claim denial rather than have to defend it on appeal.**

As always, if anyone has any questions, please do not hesitate to contact me.

Best,

Linda