

DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER SPECIAL DISABILITY CLAIMS PRACTICE I

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Don't Shoot The Messenger

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As we begin a new year at DCS I thought it appropriate to start the Newsletter with articles describing internal claims practices common to all disability insurers. Unfortunately, most insureds see only the end result of a long list of internal claims review practices which may or may not result in the approval or payment of a disability claim.

As a former claims specialist I blew my whistle long and hard when I was asked by Unum management to sign my name to written letters and communications for denial decisions I strongly disagreed with. Although most insureds believe claims decisions are made by the claim specialist, I can assure you they are not. Claims handlers, specialists, and other claim administrative personnel responsible for processing claims are at the bottom rung of a long ladder of claim review hierarchy. Although handlers are responsible for processing claims and chasing down paperwork, rarely are they given the autonomy to make claim decisions on their own.

Claims specialists are responsible for chasing paperwork, i.e. requesting medical records and then pushing the claim through the sometimes endless internal review process of roundtables, medical and vocational walk-ins, and financial review. At the end of the day, however, all claims decisions and approval/denial letters are reviewed ("validated") by middle claims managers representing the "business interests" of the disability insurer. At this level of review, most managers and directors have access to financial reserve values and are held responsible by executive management for "rolling in those financial targets" at the end of a month, quarter or year.

It's not as though claims specialists are ignorant of the process, however. Handlers are held accountable for initial claims "recommendations" as to whether the claim should be paid or not. If a claims specialist is asked to deny a claim when the claim should be paid, the claims handler is quite aware an unfair claim denial has been made at the expense of the insured.

Claims specialists must prove to management they can and will support the internal review process. Although all written communications received by insureds come from pre-approved canned templates, letters need to be changed to address issues relative to each claim situation. Letters are initially written and copied by the claims specialist in draft, and are then forwarded to a manager or supervisor for review. If the reviewing manager doesn't like the letter, he/she rewrites the letter and gives it back to the claims specialist for their signature.

Not giving claims specialists the authority to make claims decisions creates an horrible Customer Service problem within any claims organization. When a customer calls to find out the status of a claim, the claims handler cannot communicate a status which has not yet been approved by the consultant or manager. Claims handlers have to make up excuses, "I forwarded the claim to my manager for review", or "We haven't made a decision yet." This process gives the insured the impression that no one knows anything---until the denial letter arrives in the mail! Horrible customer service issues result from this kind of process.

Bottom line, the claims specialist is most likely not the person who constructed the letter the insured received in the mail yesterday. As a consultant who frequently reviews claim files, I am constantly amazed at how many times a consultant or manager rewrites letters for the claims handler and then gives it back to them for signature. If the claims handler disagrees with the changes or decisions made by the supervisor, he/she is still required to sign the communication and support supervisory decisions.

Why the scrutiny? Supervisory personnel are not as much concerned about communicating a claim denial as they are concerned with getting the denial through any ERISA appeal or litigation resulting from the denial. Therefore, denial letters are not generally constructed to support the denial, but to completely support the future denial upheld by the appeals department.

In fact, the Vice President of the Psyche/Cardiac unit never congratulated me for a claim denial, but she always sent me a written "thank you" when the claim denial was upheld in appeals. No disability insurer wants to reopen and pay claims once they have been denied. And, it takes a manager's know-how to make that happen.

Claims specialists do not have access to financial reserve information. I think Washington calls it "plausible deniability", but the supervisors and managers who make actual claims decision DO have access to information concerning the claims potential contribution to profitability through the reserve.

Claims specialists may be the messengers of bad news, but they are not final decision-makers. You need to look a few rungs up on the ladder to get to the real culprit.

A Primer on Financial Reserves

“Financial reserves” are monies set aside by the disability insurer representing a “reserve” liability to pay a claim when application is made for payment. Financial reserves are required by the individual states, in which any disability insurer does business, as a cash protection afforded to the insured that the disability insurer is solvent enough to pay a claim after it is investigated and approved for payment. The money set aside as a financial reserve is unavailable cash flow which could otherwise be used to pay corporate bills, employee payroll, or used for portfolio investment to further reduce the costs of doing business. Financial reserves are also indications of the amount and extent of potential future liability on the disability insurer’s Balance Sheet.

Although there are several different “financial reserve” figures computed for each claim and block of business, the figures most commonly used by the claims area consisted of several variables including historical actuarial information incorporating age, impairment, occupation and income as well as claim value. Simply put, the higher the monthly benefit due to the claimant, the higher the state regulated reserve figure.

Each disability claim has an established financial reserve figure integrated into the insurer’s payment system - When a claim is approved, the financial reserve for that claim is realized, or opened, creating the corresponding liability. Conversely, when a claim is recorded as closed or denied on the system, an immediate profit is realized, and the liability is removed thereby freeing up cash flow which can be used by the corporation for other purposes.

Of course it is in the insurer’s best interests to keep claim reserves as low as possible and not admit that they exist, or, that claims personnel even have access to the actual figures. Most of the yearly projected targets and sales are calculated using unit and department claims financial reserve figures.

Once insureds and attorneys really understand that everything inside the claims review process involves financial reserves, it’s just a matter of sitting back and watching how the corporations strategize the process to deny claims.

It’s the biggest bang for the buck. The higher the claim reserve value, the more profit resulting from any future denial.



Attorneys working for the disability insurer do not have the authority to tell a claims supervisor to pay a claim. Since the floor supervisors are held accountable for financial reserve targets, internal legal staff can’t tell claim managers what to do. Even when a claim is in litigation, or when a settlement is offered, attorneys often have to call executive management for approval of litigation settlement amounts.

Always Use the Right Words

A claim that has never been paid is said to be denied. A paid claim for benefits is said to be terminated. A person with an IDI claim is called the insured. Persons with ERISA claims are called claimants. The employer policyholder is the insured, while the employee is a claimant certificate holder.

An ERISA claim file is called the Administrative Record, but an IDI claim file is simply referred to as the claim file.

Is Your Claim a Target? It May Be.....

It’s probably general knowledge by now that all disability insurers “target” groups of claims with the deliberate intent of denying as many as possible. After all, disability insurers make their money by limiting the amount of actual paid claims presented at any given point in time. The payout rate used by most insurers is around 60% which is a recognized “breakeven” point for most companies. Claims paid over the 60% mark represent losses, so it is essential for management to identify potentially deniable claims within a short period of time. The following groups or classes of claim are generally targeted by most insurers:

- 1. High value claims or claims with high financial reserve values.*
- 2. Claims with subjective impairments such as fibromyalgia, multiple sclerosis, lupus, chronic fatigue, Lyme disease, depression, and low back pain.*
- 3. Claims with short recovery periods.*
- 4. Claims for those who intend to return to work within a short period of time.*
- 5. Claims from the southern part of the US, especially for those with very low reading and education levels.*
- 6. Claims of persons with known financial challenges especially just before the holidays.*
- 7. Paid claims between 9-18 months for any occupation investigations.*
- 8. IDI claims with Lifetime benefit riders or expensive COLA provisions.*
- 9. Claims with “red flags”.*
- 10. IDI claims paid for “Residual Disability” because of part-time work.*
- 11. ERISA claims for Nurses.*
- 12. IDI claims for physicians, especially Chiropractors.*
- 13. Unfortunately, 9/11 claims or other disaster claims such as mass shootings at place of employment.*
- 14. SSDI claims with recovered overpayments.*
- 15. IDI claims less than 2-years for contestability.*

The Assembly Line of Disability Claims...an excerpt from Linda's Book entitled, "The Disability Rainmakers"

Most people mistakenly believe the job of claims specialist is a professional administrative position- middle management type job. This stereotype couldn't be more wrong. The actual job of performing in a disability claims organization as a claims examiner at all levels is more in tune to the automation of manufacturing of widgets than it is to any type of administrative or sedentary work.

Picture a moving assembly line on which new, initial claims are automatically placed at the beginning of the belt in a continuous fashion. As the claim folders move down the assembly line, direct labor resources in the form of claims specialist reviews, medical inspections, vocational assessment and managerial oversight, as well as all others who actually "touch" the claims are applied as raw material. Overhead is also applied in the form of training, executive and human resource services.

At the end of the assembly line there are four large bins into which claims fall from the line. The preferable bin is the "claim denied, or terminated" bin. These are claims for which the costs of raw materials (resources) and direct labor (specialist and managerial oversight) have been profitably applied resulting in the denial or termination of claim benefits. Claims in this bin are archived and are not reviewed again in the process, representing the pure profit of the disability business. It's the end of the line.

The second bin contains claims which, although they have received costly labor and overhead, have also been awarded Social Security Disability Income (SSDI) benefits. These are claims which the disability organization concedes are payable claims to duration. Claims from this bin are eventually filed in a permanently and totally disabled (PTD, EDU, SHU) section of the company and receive minimal applied resources for the remaining duration of the claim. These are claims from which the disability insurer receives profit through the federal subsidy of SSDI benefits and retroactive lump sum repayments.

Into the third bin falls claims that have received the "lion's share" of materials and resources along the assembly process, but have been identified as having a quality defect and cannot be credibly denied or terminated at the first pass along the line. These claims are taken from the third bin and are re-entered at the beginning of the assembly line for another review and correction of quality defects. These claims incur additional costs which reduces the insurer's profit margin.

From a managerial perspective, the third bin is executive management's worst nightmare. Claims re-entering the assembly line again from the beginning for long periods of time contribute to the growth of blocks of business, which if not controlled, can over run a claims department to the point of complete and utter chaos. In addition, repeating the application of resources over and over again becomes expensive in terms of financing and time allocation in order to achieve the favored result – claim denial or termination, PTD, or settlement. These claims represent potential significant losses since more and more money must be applied to the claims in order for them to eventually fall into the first bin as denied claims.

The last bin is the least favored bin, that is to say, those claims which are determined to be approved and payable. These claims will remain in the fourth bin for an undetermined amount of time, but then are re-entered on the assembly line whenever management determines it needs more claims in the first bin (denied claims) for business profit. At the point where the old paid claims are re-entered into the process, they become actively managed and eventually fall into the third bin where over time they become burdensome and need to be "resolved" in some fashion.

The last bin is the worst bin for the disability insurer. Each claim in the red bin represents money lost to the disability insurer, and it is essential that these claim return to the third bin where additional money and resources must be applied to deny the claims at all costs.

The ultimate job performance expectation of any claim specialist is the ability to manage his/her block of business at a "zero growth level". This means the same number of new claims entering the block of business at the beginning of the week must go out of the block at the end of the week. (A block of business is simply the combined number of claims given to any claims specialist to manage at their desk.) Since anywhere from 3-6 new claims are assigned to a claims specialist on a weekly basis, it is essential that the same number of claims exit the block either by denial or termination, settlement, or transferring to PTD.

If this were not the case, over a period of time, the number of claims managed by the claims specialist continues to increase to an unmanageable level. Only a very small percentage of experienced claims specialists can actually achieve this high quality level of claim management. In a unit of 12 claims handlers, the average of volumes of claims realistically ranged somewhere between manageable, backlog, and chaos at any given point in time.

Reviewing disability claims has nothing to do with people. It's all about the assembly line of managing large numbers of claims presented for payment in order to achieve the highest levels of corporate profits possible. Unfortunately, this is the reality of processing claims. It's all about numbers, and there's nothing "human" about it.

(Linda's book is expected to be published in 2008. Please stay tuned.)



I'd like to take a moment and introduce the new logo and website for Disability Claims Solutions. We are starting out the new year with a newly designed website which includes two new services available to insureds – settlement negotiation for both disability and health claims, and health claim management including appeals. These new services go very well with disability claim case management and professional mediation for family and small business. The new logo has been added to all correspondence including letterheads, faxes, business cards as well as any other informational brochures that may also be available during the year.

The new website contains a description of the various services available to insureds and attorneys. The website may be a work in the making for awhile, but stay with us, and continue to check back often. For those of you who are not clients of DCS, there is a link on the website where you can read the latest version of the DCS Newsletter. In addition, visitors will have immediate access to the Group LTD 101 Manual I wrote several years ago.

As DCS moves into 2008, additional articles will also appear on the website which may be informative to all readers. Please accept our invitation to visit the new website often and stay tuned for frequent updates. Clients of DCS may also suggest topics of interest to appear on the website and I will try to address these topics when I can.

I want to take this opportunity to thank all of our clients and readers of the DCS Newsletter which only began in third quarter 2007. We received a great deal of feedback and telephone calls letting us know how valuable the information has been.

Administratively, other changes will take place in first quarter 2008. Clients of DCS may receive newly written Powers of Attorney to update their files. If you do receive an updated POA, please have the document notarized and return to me as soon as you can. As always, if there are any questions, please let me know. Other case management changes will be discussed on a case-by-case basis as the year continues.

We are also thankful for other readers of the DCS Newsletter who are not clients. We know our Newsletter appears in several locations on the Internet and attracts a wide variety of readers including attorneys, physicians, brokers/agents and consultants. Our goal is to continue to provide claims review information to all those who have an interest.

Again, we want to thank everyone who has contributed to the success of DCS by making referrals to our services. Our success since 2002 can be directly attributed to those individuals who have continued to support DCS and the scope of our client and attorney services.

Please feel free to visit the new website which is still located at:
<http://www.disabilityclaimssolutions.com>

Best wishes in 2008.

Linda