REHAB FIRST®
Building futures.

# NEWS THAT MATTERS MOST™

## Can Disability Management Professionals Improve LTD Claim Dispute Outcomes?


When it comes to Long Term Disability, the number of disputed claims has never been higher, and with them, the need for expert advocacy backed by independent assessments of claimants' initial and continuing eligibility for core income and ancillary benefits.

An understanding of some of the industry and plan-specific factors contributing to denials and terminations can assist with the innovation of strategies leading to successful resolution for client and counsel alike. To that end, engaging providers who have LTD expertise can be sound strategy to the extent it enhances one's understanding of insurer interests having a bearing on the motivation to approve, re-instate or settle on a lump sum basis.

*"…having advance knowledge of the types of claims that cause the most pressure on insurer financial results can give insights into case settlement potential and the crafting of effective negotiating strategies."*

Similarly, having advance knowledge of the types of claims that cause the most pressure on insurer financial results can give insights into case settlement potential as well as effective negotiating strategies.

It will come as no surprise that the two factors most influencing LTD loss ratios, and therefore business line profitability for insurers, are claim incidence (i.e. frequency) and open claim duration. Loss ratios - claims costs divided by premiums - that are better than those imputed in premiums equate to superior earnings. Adverse loss ratios, on the other hand, depress earnings.

All other things being equal, once an LTD claim is approved, the insurer's single most pressing objective on non-terminal or remediable claims is to ensure that its

duration is managed by exercising its contractual rights of intervention. As a starting point, a claimant must demonstrate that he or she is receiving appropriate, active treatment from qualified professionals, and complying with their prescribed care.

Insurers understandably monitor incidence and duration closely. Sometimes both are wide of expectations for the same risk cohort. By way of illustration, a 20% higher disability incidence rate for a given occupational class, and durations that are also 20% longer than expected for the same class, would be an obvious cause for concern, especially if the insurer (rather than the plan sponsor) were bearing all of the risk. Fairly recent industry data, for instance, implies that insureds whose impairments are mental health related (e.g. depression, anxiety etc.) have both higher than expected incidence and duration. Another observation from the data is that durations of high income earner claims are higher than expected.

Although the reasons for the adverse trends have both technical and non-technical explanations that are beyond the scope of this article, the relevant thing to note here is that in absolute terms, the reserves held by insurers for such claims can easily reach the high six or low seven figures, and in relative terms, the higher-than -expected reserves are a drag on insurer earnings.

With adverse claims

> *"LTD product variability makes equitable adjudication of claims more challenging for insurers because of the ambiguity that one sometimes finds in the contract language…"*

"experience" comes a greater predisposition to deny and terminate. In other words, the pressure to avoid new reserve charges or "release" existing open claim reserves is greatest, and the probability of misjudging claimant reactions, highest.

Another factor contributing to disputes and the risk of litigation is product variability. LTD products, and therefore their governing contracts, have become highly variable at the insurer and plan sponsor levels, and commonly, at the risk class (e.g. occupation) level within the same group.

Product variability has evolved as a response to the competitive environment in which group insurers operate, which itself is influenced by plan sponsors' demands that when switching insurers, the adopting insurer match the existing specifications-such as the definition of disability-exactly.

Product variability can make equitable adjudication of claims challenging for insurers because of the ambiguity that one sometimes finds in the contract language, which itself heightens the risk of disputes on what are otherwise meritorious claims.

Training claims staff to adjudicate the claims fairly and in accordance with variable contract provisions is a challenge not unlike the one that some auto insurers face

with their adjuster workforce. At least adjusters can work with a one-size-fits-all regulated benefits regime, albeit one that has become inordinately complex.

Rehabilitation professionals who combine clinical expertise with expert knowledge of eligibility criteria, both at claim inception and throughout the claim/contract life cycle, can make the difference between a failed attempt at resolution and a successful one.

Depending on the reasons for the decision, on meritorious claims, independent, objective providers can help facilitate a denial reversal, a re-instatement or a lump sum settlement. It comes down to the type of health and/or vocational evidence that might exist, or could be obtained, but which may not have been advanced by plaintiff counsel to counter those reasons. For instance, what are the functional abilities, whether cognitive or physical, that are assumed to be so high by the insurer as to disqualify one from benefits? If the contractual "any occupation" benchmark is the familiar one of being unable to perform any occupation for which the claimant is qualified by virtue of one or more of the conventional criteria, and is also unable to earn at least X% of one's pre-disability income, the knowledgeable provider immediately recognizes that they are working with a two-tier eligibility threshold. Both conditions have to be satisfied for a termination to hold up. The provider may recommend an Employability Assessment whose assessment scope aligns with each one of the conditions.

Mitigation is not only music to LTD claim adjudicators' ears, it is a contractual obligation of the claimant. To soften a carrot-and-stick approach to file closure (claimants might sometimes view this as "damned if I do; damned if I don't"), all large insurers have in-house rehabilitation people or contracted external rehabilitation providers. The problem-and hence the reason counsel are often retained by claimants-is that although insurers have never been better at the administrative part of rehabilitation, they can be poor at the interpersonal and authoritativeness parts. To explain, let's come back to those highly variable contracts.

Many group LTD policies have partial disability benefits and rehabilitation transitional arrangements, which when first introduced in the mid-1980s, were viewed as being competitively disruptive "claims management" innovations. Written and unwritten benefits in this area can range from insurer-paid vocational rehabilitation to functional recovery therapy, and even structured work hardening programs lasting a week or longer.

*"Rehabilitation professionals who combine clinical expertise with expert knowledge of eligibility criteria ... can make the difference between a failed attempt at resolution and a successful one."*

Sometimes the adjudicators don't have a solid grasp of the return-to-work incentives and supports under the LTD

contract, which in itself raises the possibility that a summary termination will be communicated to the claimant at the any/own definition change, when the claimant him or herself knows that he or she may be entitled to transitional benefits, for example. This is a sure recipe for claimant animosity, and it mystifies us why insurers sometimes leave themselves wide open to litigation they don't want by not ensuring that all of their adjudicators have a full grasp of contract provisions and how to apply them to the benefit of both parties on a given claim file.

Engaging the services of independent health professionals for medical, functional and vocational assessments can facilitate not only a re-instatement or lump sum settlement, but as a gesture of good faith, mitigation, up to and including re-entry to gainful employment, even if it is on a basis that leaves them eligible for continuing benefits by virtue of lowered earnings capacity. One could refer to this as a classic win-win, with the restoration of at least partial benefits (or their present value) being supplemented by employment income-albeit on a reduced basis-not to mention the psychological benefits to the client.

Like counsel, rehabilitation professionals want what is best for their clients. In a LTD context that means keeping the objective criteria for eligibility, and therefore the pre-conditions for settlement, at the forefront of one's decision making at all times.

Finally, the skilled provider can be pivotal in bringing the employer on-side with any return-to-work plan requiring insurer and claimant buy in.

How tragic that a benefit that is so simple in name and concept, and for tens of thousands of claimants has made the difference between destitution and income security, has become the source of so much contention having major financial consequences for claimant and insurer alike. There is a better way for all concerned, and it is fitting that the legal community is taking a more active role in lighting the path to more win-win resolutions. ***RF***