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Can a Rehabilitation Provider's Contract Knowledge Improve LTD Dispute Outcomes?

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

Pre-Disposing Case Factors

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.

> *"...having advance knowledge of the types of claims that cause the most pressure on insurer financial results can give insights into settlement potential... "*

To that end, engaging providers who have LTD expertise can be sound strategy in that there is a team understanding of insurer interests having a bearing on the motivation to re-consider a denial, re-instate benefits or settle on a lump sum basis.

Similarly, having advance knowledge of the types of claims that are depressing insurers' financial results can give insights into case settlement potential.

It will come as no surprise that the two factors that most influence 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 improve earnings. Adverse loss ratios, on the other hand, depress earnings.

Once an LTD application for benefits is approved, the insurer's single most pressing objective on a non-terminal claim is to manage

duration by exercising the insurer's 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.

So 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. Recent industry data, for instance, implies that insureds whose impairments are mental health or "nervous" related (e.g. depression, anxiety etc.) have 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 the reserves held by insurers for a claim can easily reach the high six or low seven figures, and that higher-than-expected reserve charges are a drag on insurer earnings.

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

With adverse claims experience comes a greater pre-disposition to deny and terminate; in other words, the pressure to avoid new reserve charges or to "release" (i.e. bring back into earnings) open claim reserves is greater, and the risk of misjudging claimant reactions, higher.

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 is a Challenge for Insurers

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 non-standard specifications-such as the definition of disability.

Product variability can make equitable adjudication of claims challenging for insurers owing to the ambiguity that one sometimes finds in the contract language itself. This heightens the risk of disputes on what are otherwise eligible claims.

Training claims staff to adjudicate the claims fairly and in accordance with variable contract provisions is a challenge not unlike the one 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.

Provider Knowledge Matters

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

Depending on the reasons for a negative insurer decision in the first place, independent, objective providers can help facilitate a denial reversal, re-instatement or lump sum settlement. It often comes down to the type of functional and/or vocational evidence that might exist, or could be obtained, but which may not have been advanced by plaintiff counsel to counter the reason for the decision.

For instance, what are the functional abilities-cognitive or physical- that are alleged to be so high by the insurer as to disqualify one from benefits? If the contractual "any occupation" definition 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 that precludes the claimant from earning at least X% of his or her pre-disability income, the knowledgeable provider immediately recognizes that he or she is working with a two-tier eligibility threshold. Both conditions must be satisfied for a termination to hold up.

The provider may then recommend an Employability Assessment whose assessment scope aligns with each of the two 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 have 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 variable contracts.

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

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

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 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.

Are Win-Wins Possible?

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 claimants eligible for continuing benefits by virtue of lowered earnings capacity.

One could refer to the foregoing 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.

(This is an updated version of the LTD Newsletter issued in April 2017) *Ed.*

info@rehabfirst.ca
1-888-REHAB-90