

**NAIC WORKING GROUP ON
DISABILITY CLAIM BEST
PRACTICES**

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- GROUP FORMED IN MID 2008
- DRIVEN BY MEDIA ATTENTION, CONSUMER COMPLAINTS AND PLAINTIFFS' ATTORNEYS AGAINST NUMBER OF INSURERS.
- GROUP DEVELOPED A WORKING DRAFT, RECEIVED COMMENTS FROM MULTIPLE SOURCES AND HELD PUBLIC HEARINGS.
- FOLLOWING THESE ACTIONS, THE GROUP PUBLISHED A SET OF REVISED "SUGGESTED BEST PRACTICES" FOR DISABILITY CLAIMS.
- THIS TALK WILL DISCUSS THESE PROPOSED PRACTICES AND HOW THEY MAY AFFECT THE INDUSTRY

NAIC WORKING GROUP – BEST PRACTICE SECTIONS

- THESE SUGGESTED BEST PRACTICES ARE DIVIDED INTO 5 SECTIONS:
 - TRAINING
 - CLAIM PROCEDURES
 - CLAIMS ORGANIZATION
 - APPEAL PROCEDURES
 - CORPORATE ORGANIZATION

NAIC WORKING GROUP OUTLINE OF EACH SECTION

- TRAINING:
 - CLAIM STAFF TO BE TRAINED IN SAME WAY.
 - TRAINING MATERIALS REGULARLY UPDATED AND RETRAINING PROVIDED.
 - ADVERSE BIAS AND PREDISPOSITION IS PROHIBITED.
 - ADDRESS APPLICABLE LAW, REGULATIONS, BULLETINS AND COURT DECISIONS.
 - SAFEGUARDING PROTECTED HEALTH INFORMATION.
 - EVERYONE IS RESPONSIBLE FOR ADHERING TO WITH WRITTEN CODE OF COMPLIANCE.
 - DOCUMENT EACH PERSON'S SUCCESSFUL COMPLETION OF TRAINING.

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- CLAIM ORGANIZATION:

- EXPERIENCED CLAIMS STAFF SIGN OFF ON EACH BENEFITS DENIAL AND TERMINATION.
- EFFECTIVE QUALITY REVIEW PROGRAMS TO ASSESS SAMPLE OF CLAIMS FOR COMPLIANCE AND CUSTOMER SERVICES.
- SEPARATE COMPLIANCE FUNCTION STAFFED WITH EXPERIENCED CLAIMS PERSONNEL TO SIGN OFF ON COMPLEX CLAIM DENIALS.
- CLAIMS AUDIT FUNCTION REPORTING TO SENIOR MANAGEMENT.
- CLAIMS PERFORMANCE NOT EVALUATED BASED ON NUMBER OF CLAIMS CLOSED OR CHANGES IN RESERVES.
- ANY REWARDS BASED ON COMPLIANCE WITH LAW AND CLAIM PROCEDURES.

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- CORPORATE ORGANIZATION:
 - ESTABLISH BOARD OF DIRECTORS COMMITTEE RESPONSIBLE FOR MONITORING CLAIM COMPLIANCE.
 - SENIOR MANAGEMENT, CLAIM MANAGEMENT, COMPLIANCE MANAGEMENT AND CLAIM AUDIT GROUP SHOULD REGULARLY REPORT TO THIS BOARD COMMITTEE.
 - MECHANISMS ESTABLISHED FOR REPORTING ETHICAL CONCERNS ANONYMOUSLY.

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CLAIM PROCEDURES:

CLAIM PROCEDURES:

- FAIR AND TIMELY SERVICE, INCLUDING ALL APPLICABLE LEGAL STANDARDS.
- COB AND OFFSETS, INCLUDING FAIR AND EQUITABLE APPLICATION OF THE SSDI OFFSET FOLLOWING A FAVORABLE SSA DECISION.
- FAIR AND PROMPT DISABILITY DETERMINATIONS AND TIMELY PAYMENTS
DUE UNDER POLICY. CLAIM FORMS AND AUTHORIZATIONS SHOULD BE CLEAR AND EASY TO FOLLOW WITHOUT BEING INVASIVE OR BURDENSOME. INSURERS SHOULD GATHER NEEDED INFORMATION AT THEIR OWN INITIATIVE AS MUCH AS POSSIBLE.
- PROVIDE CLAIMANTS OPPORTUNITIES TO SUBMIT COMMENTS, DOCUMENTS AND OTHER INFORMATION.
- ENSURE CLAIM DETERMINATIONS ARE MADE IN ACCORDANCE WITH THE
POLICY AND APPLIED CONSISTENTLY.
- IMES SELECTED ONLY ON OBJECTIVE AND PROFESSIONAL CRITERIA. SHOULD BE CERTIFIED IN APPROPRIATE SPECIALTIES AND SHOULD BE

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CLAIM PROCEDURES (continued):

- CLAIMANTS SHOULD HAVE RIGHT TO REQUEST IME AND INSURER SHOULD NOTIFY THEM OF THAT RIGHT.
- INSURERS SEEK INPUT FROM APS AND THEIR INFORMATION SHOULD BE FAIRLY INTERPRETED AND APPLIED. SIGNIFICANT WEIGHT GIVEN TO AP'S OPINION. OBTAIN AN INDEPENDENT OPINION WHEN INSURER AND AP DISAGREE.
- DEFERENCE SHOULD BE GIVEN TO SSDI AWARD DECISION.
- ALL CO-MORBID CONDITIONS MUST BE FULLY CONSIDERED BEFORE A CLAIM DECISION IS MADE.
- ADVERSE BENEFIT DETERMINATIONS SHOULD EXPLAIN ALL REASONS FOR THE DECISION AND IDENTIFY THE MEDICAL AND VOCATIONAL EXPERTS CONSULTED.
- EXPECTED RTW DATES BASED ON AVERAGE EXPERIENCE SHOULD NOT BE BASIS FOR CLAIM DENIAL.

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APPEAL PROCEDURES:

- AT LEAST 180 DAYS TO REQUEST REVIEW OF ADVERSE BENEFIT DETERMINATION AND ESTABLISH ERISA-COMPARABLE NOTICE AND TIME REQUIREMENTS.
- CONSIDER ALL INFORMATION SUBMITTED BY CLAIMANT AT ANY TIME.
- NO DEFERENCE TO ADVERSE BENEFIT DETERMINATION.
- APPEAL HANDLED BY SOMEONE NOT INVOLVED IN ADVERSE BENEFIT DETERMINATION.
- IF MEDICAL JUDGMENT INVOLVED IN ADVERSE BENEFIT DETERMINATION, REQUIRE CONSULTATION WITH APPROPRIATE HEALTH CARE PROFESSIONAL.
- FEES NOT REQUIRED AS CONDITION OF APPEAL.
- DON'T REQUIRE AGREEMENT TO BINDING ARBITRATION.

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MULTIPLE PROBLEMS AND CONCERNS WITH THESE PROPOSALS. I WILL FOCUS ONLY ON MOST SIGNIFICANT ISSUES:

1. STATE UNFAIR CLAIM AND SETTLEMENT PRACTICES ACTS COVER MANY OF THESE SAME REQUIREMENTS AND ARE WORKING WELL. E.G., TRAINING REQUIREMENTS AND ANNUAL CERTIFICATION REQUIRED BY CA. FAIR SETTLEMENT PRACTICES REGULATIONS.
2. MANY REQUIREMENTS OBVIOUS AND FOLLOWED BY MOST INSURERS. EXISTING STATE LAWS ARE ADEQUATE TO COVER VIOLATIONS.
3. DEFERENCE TO AP OPINIONS IS INAPPROPRIATE AND VIOLATES SUPREME COURT'S DECISION IN NORD V. BLACK & DECKER.
4. THIRD PARTY VENDORS USED TO REPORT ETHICAL CONCERNS ANONYMOUSLY.
5. CODE OF CONDUCT FOR HEALTH CARE PROFESSIONALS.

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MULTIPLE PROBLEMS AND CONCERNS WITH THESE PROPOSALS. I WILL FOCUS ONLY ON MOST SIGNIFICANT ISSUES:

6. RIGHT GIVEN TO CLAIMANT TO REQUEST IME.
7. EVERY TIME AP AND INSURE DISAGREE, INSURER MUST OBTAIN OBJECTIVE, INDEPENDENT TO SETTLE THE DISPUTE.
8. DEFERENCE GIVEN TO SSA AWARD.

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EVEN IF THE NAIC DOES NOT FORMALIZE THIS PROPOSAL INTO A MODEL LAW, AND EVEN IF NO STATE ADOPTS IT:

ALL OF THESE PROPOSED ITEMS WILL BE USED BY PLAINTIFFS ATTORNEYS TO SHOW, PURPORTEDLY, THAT:

1. THEY REPRESENT INDUSTRY STANDARDS FOR GOOD FAITH AND FAIR CLAIM HANDLING.
2. DEVIATIONS WARRANT REVERSAL OF CLAIM DECISION.
3. GREATER EXPOSURE TO PUNITIVE DAMAGES – REMEMBER THAT THESE
RULES WOULD APPLY TO NON-ERISA CLAIMS GOVERNED BY STATE LAW.