SUMMER 2010

International Claim Association

ICA news

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ICA CALENDAR

OCTOBER 3–6, 2010
Annual Education Conference
Renaissance Austin Hotel
Austin, TX

JANUARY 26-28, 2011
Winter Meeting
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Chandler, AZ

OCTOBER 2–5, 2011
Annual Education Conference
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ICA NEWS
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President's Remarks

Marlon D. Nettleton
FLHC, FLMI, FFSI, CLU, ChFC, HIA, ACS
State Farm Insurance Companies

The Annual Education Conference registration booklet was recently released and I hope you're planning on attending the 101st Annual Meeting October 3-6 in Austin, Texas. The committees have done another outstanding job creating over 65 workshops and roundtables covering life, disability, law, fraud, management and compliance. In addition, we have an outstanding keynote speaker and numerous networking opportunities. You will also have the opportunity to get to know Austin "the live music capital of the world" as we have arranged bus transportation to the 6th Street area on Monday evening.

International Claim Association's primary purpose is to provide educational opportunities. The Annual Education Conference is obviously one of our major efforts; however, as you know we also sponsor the ALHC and FLHC designation programs. On July 1st, we are changing our testing service from CEU.com to Cambridge eLearning Services. We are looking forward to making additional announcements about our ALHC and FLHC courses at the conference. We also hope to be able to make additional announcements about other courses including the mandatory courses we all are required to take.

In this rapidly changing environment, it's important to say on top of issues in our profession. I know of no better way than attending the Annual Education Conference. I look forward to see "Y'all" in Austin. ■

ICA Committee Report

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The Law Committee is busy working on its 2010 agenda. The committee is researching and writing its annual law report on divorce and beneficiary. This topic has not been updated since 2003. It is anticipated that there have been new statutory and case law developments in this area. The Law Committee is also preparing a 50 state survey on whether a formal court declaration is required when an insurer rescinds a contract. Both the law reports and the survey are expected to be available on the ICA website before the annual conference.

The committee will be hosting five workshops at the Annual Education Conference in Austin, Texas this fall. Look forward to a session on giving trial and deposition testimony and presentations on rescission and misrepresentation, bad faith under the unfair claims practices acts, the duty of the insured to cooperate in an investigation, and the attorney-corporate client privilege. We look forward to seeing everyone then! ■

Roundtable Conference Calls

The Quarterly ICA conference calls are scheduled to be held on the following days. Watch for topics to be announced in future ICA Newsletters and on the ICA website.

All of the Roundtable calls are scheduled for Wednesdays at 2 pm in the eastern time zone.

August 18, 2010 ....Law
November 17, 2010..............Life

TEST YOUR KNOWLEDGE

Claim Q&A

Questions provided by the ICA Education Committee

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) preempts most state privacy laws unless they are more stringent than the HIPAA rules. Health insurers and others governed by HIPAA must comply with certain laws. Select the statement below that is <u>not true</u>:

HIPAA requires employers to:
a. Train employees on the HIPAA privacy requirements
b. Create an external complaint process
c. Develop procedures for information sharing
d. Arrange for security measures for the protection of information

Life and Health Insurance Law, McCann Page 319 & 320.

2. Sometimes a life insurance policyowner collaterally assigns some of the ownership rights of the policy in order to secure a loan. Under most collateral assignments, the assignee of the policy has the right to:

a. designate and change the policy beneficiary
b. receive all policy dividends
c. collect any disability income benefit that becomes payable under the policy
d. elect an optional settlement mode

Claim Administration Principles and Practices, Lightcap Brown, Herrod, Maxwell, Third Edition, pg 166 Figure 8-6.

3. Separation of an employee from an organization can result from retirement, layoff, discharge or resignation. Which type of separation does the following sentence describe?

An organization has no work for an employee to perform but expects to recall the employee when work becomes available.

a. Discharge
b. Retirement
c. Layoff
d. Resignation

Management Claim Department Operations, Lightcap, page 231 & 232.

4. Metastatic carcinoma means that:

a. The tumor has spread to a secondary location
b. Lymph nodes are not usually affected
c. Tumor is localized

The Language of Medicine, Davi-Ellen Chabner. Page 770.

Answers: 1[b] 2 [b] 3[c] 4[a]

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How to Effectively Manage Competing Death Benefit Claims

LEGAL NEWS

A Creative Alternative to Classic Interpleaders

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INTRODUCTION

In theory, interpleaders are simple. There is no question that a benefit is payable, and there usually is no dispute about the amount that should be paid. The only obstacle to making a prompt payment is a set of competing claims that, in most cases, the insurer does not have to resolve. In light of the competing claims, the insurer can instead pay the benefit to the court and force the claimants to litigate (or settle) their differences without further involvement by the insurer.

In practice, interpleaders are messy. For several reasons, they can be particularly messy when they involve the proceeds of a life insurance policy. For example, the claimants almost always are highly emotional, especially if they are still grieving over the insured's death. If the insured's intent to benefit one claimant seems well-documented, that claimant may quickly dismiss a competing claim as a posthumous attack on the insured's judgment. If a claimant views the beneficiary designation as a symbol of the insured's desire to provide for him or her, a competing claim sometimes will be viewed as a challenge to their beliefs about how much the insured loved them. When that challenge is made by another family member, there may be some deep-rooted and pre-existing animosity that prompts both claimants to oppose the other out of spite, if not some genuine suspicion that the other claimant tried to take advantage of the insured shortly before his or her death.

Managing those circumstances can be difficult. Indeed, the competing claimants often have no legal counsel, do not appreciate the legal "technicalities" of each other's positions and – quite simply – are not ready to listen to each other.

The traditional approach – filing a complaint in interpleader – eventually forces the claimants to address each other's claims. However, it also adds fuel to the fire by forcing the claimants to become unwilling parties to a lawsuit. When they hire attorneys and realize that the attorneys need to be paid — either out of the proceeds or independently — competing claimants often resent the insurer for filing a lawsuit. In turn, they tend to be uncooperative about letting the insurer conclude its role in the lawsuit and stubborn when asked to stipulate that some portion of the proceeds be used to reimburse the insurer for its litigation expenses. Too often, then, the result is a complicated and expensive lawsuit that consumes an inordinate amount of time and energy to manage.

As explained in this article, there is an alternative that will promote the chances of promptly resolving benefit disputes without litigation. When properly executed, it also will focus the competing claimants on the dispute that separates them, reinforce the insurer's role as a disinterested stakeholder, and ultimately maximize the insurer's chances of concluding any related litigation in a timely and cost-effective manner.

Step 1: Offer to Help the Competing Claimants.

In a perfect world, an insurer can promptly make payment to the person(s) its policy identifies as the primary beneficiary without fear that someone else may claim those proceeds for themselves. When a competing claim arises, though, holding onto the proceeds indefinitely may not be a workable solution. See, e.g., *United Investors Life Ins. Co. v. Grant*, No. 05-CV-01716-MCE-DAD (E.D.Cal. 2/15/2007) [awarding $1 million in extra-contractual damages for delay in interpleading proceeds]. The insurer facing competing claims therefore must make a hard choice: (1) pay the proceeds to one claimant and risk having to pay the proceeds a second time to the competing claimant; (2) ask the claimants to reach an agreement about how the proceeds should be paid; or (3) hire outside counsel to file and prosecute an action in interpleader.

Continued on next page.

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An insurer which has not received notice of a competing claim to the subject proceeds may be able to avail itself of the first option. Indeed, many states have statutes which fully discharge an insurer that pays the named beneficiary before written notice of a competing claim is received in its home office. See, e.g., *Cal. Ins. Code* §10172. However, proceeding in that way still involves some risk that the insurer will be forced to join a lawsuit, even if only to assert and establish its statutory right to be discharged.

Most insurers therefore choose to interplead, sometimes after inviting the claimants to communicate with each other about their competing claims and exhaust the possibility of reaching some agreement about how the proceeds should be paid. Usually, though, the competing claimants are too emotional to engage in meaningful settlement discussions. Likewise, unless they receive good legal counsel, the competing claimants usually fail to appreciate that they will be forced to participate in expensive litigation if a mutually acceptable agreement cannot be reached. When left to their own devices, then, competing claimants rarely are able to put aside their differences and agree to a compromise that will yield them anything less than full payment.

In that situation, the competing claims would greatly benefit from the involvement of a mediator who is familiar with insurance benefit disputes, understands how interpleaders are handled in the courts, and can help the competing claimants see the wisdom of reaching an agreement about how the proceeds should be paid.

To that end, an insurer which faces competing claims should consider retaining outside counsel who is equally skilled at mediation and litigation. The insurer should then instruct its retained counsel to offer his or her services as a mediator to the competing claimants – at no cost to them — before filing a complaint in interpleader.

Proceeding in such a way offers the insurer numerous advantages. First, it reminds the competing claimants that the only obstacle to the insurer's payment of the proceeds is a dispute between them in which the insurer has no interest. Second, it provides the insurer with an opportunity to explain (through the mediator) that the alternative to a negotiated resolution is litigation that will prove costly to both claimants. Finally, it makes the insurer part of the competing claimants' solution by giving them access to a knowledgeable intermediary who can help them explore the possibility of resolving their differences.

Step 2: Reinforce Your Role as a Disinterested Stakeholder.

Mediation is a largely unregulated process. Nevertheless, an attorney who will be handling an interpleader action in the absence of a settlement should not mediate the underlying benefit dispute until his or her role has been clearly explained to the competing claimants.

Those disclosures can (and should) be made to the claimants in the initial written communications about the benefit dispute resolution program in which they are being asked to participate. Specifically, each claimant should receive a written communication which identifies the attorney the insurer has retained in connection with the benefit dispute, explains that the insurer has asked the attorney to mediate their dispute, and explains that the same attorney will be representing the insurer in any litigation that may take place after the mediation. To eliminate any claim that the attorney has a conflict of interest, the insurer should also formally offer to pay for the mediation and waive any claim against the proceeds for the related costs. In that way, the written documentation will establish that the mediation will not involve any claim by the insurer but, instead, only the competing claims being made to the proceeds.

After those disclosures have been made, the claimants should be asked to agree in writing that the insurer's attorney may conduct the mediation. If the parties refuse to mediate under those circumstances, the insurer will have lost only the modest cost associated with making those disclosures. At the same time, though, it will have gained another set of documents that its attorney can use in an interpleader action to establish that the only obstacle to the insurer's payment of the proceeds is a dispute between the claimants in which the insurer has no interest.

If the parties agree to mediate and fail to resolve their differences, the insurer will have lost some additional costs associated with the attorney's service as a mediator. Importantly, though, the insurer will have gained the opportunity for its attorney to communicate directly with the competing claimants about the consequences of a failed mediation: specifically, the likelihood that an interpleader action will be filed, the costs associated with serving the summons and complaint, and the wisdom of stipulating to a judgment in interpleader that discharges the insurer before the litigation expenses for which it will seek reimbursement become substantial. Even in the absence of a settlement, then, the competing claimants' participation in a benefit dispute resolution program that is sponsored by the insurer can make any related litigation less costly and hasten the insurer's dismissal from the case.

Finally, if the parties agree to mediate and reach a resolution, the insurer's attorney can contemporaneously memorialize their agreement in a set of documents that is acceptable to the insurer. He or she also can forward those documents directly to the insurer so that the proceeds can promptly be paid in accordance with the claimants' agreement. Thereafter, the insurer's file regarding the competing claims can be closed without having to resort to the courts.

Step 3: Be Prepared to Follow-Through.

If the competing claimants cannot (or will not) resolve their differences — whether by themselves or with a mediator's assistance — the insurer should be prepared to proceed with an action in interpleader. Under such circumstances, there is no reason for the insurer's attorney to file and serve the complaint, then allow the competing claimants time to reassess the landscape of their disputes. Rather, once a complaint is filed, the insurer's attorney should serve it on the competing claimants, along with a proposed stipulation which provides for the entry of both a judgment in interpleader and an order directing that a portion of the proceeds be used to reimburse the insurer for the attorneys' fees and costs associated with filing and serving its complaint.

If the proper groundwork was laid during the mediation, the competing claimants should realize that their best chance of economically concluding the interpleader action involves signing that stipulation. In that event, the insurer will have ended its involvement with the dispute in an extraordinarily prompt (and cost-effective) fashion. If a stipulation that makes the insurer whole (or nearly so) is not forthcoming, though, the insurer's attorney should promptly file a formal motion that seeks the same relief, as well as reimbursement for any additional expenses the insurer incurs for the attorney's work on that motion. See, e.g., *Cal. Code of Civ. Pro.* §386.6.

In most cases, copies of the non-privileged letters and other documents relating to the insurer's benefit dispute resolution program should be filed in support of that motion. Indeed, each of those documents should be designed to clarify that:

Continued on next page.

1) The insurer explained to the competing claimants that the only obstacle to its payment of the proceeds is a dispute between them and in which the insurer has no interest;
2) The insurer explained to the claimants that the alternative to a negotiated resolution is costly litigation, then paid for (or at least offered to pay for) a mediator to help them resolve their differences; and
3) Despite the insurer's efforts to help them resolve their differences, the claimants still make competing claims to the proceeds.

Adding documentation about the claimants' refusal to stipulate at the outset of the case to a judgment in interpleader which would have preserved more of the proceeds also should maximize the chances of getting a judgment in interpleader that more fully reimburses the insurer for its litigation expenses.

Step 4: Prepare a Litigation Budget with Confidence.

Because the statutes often provide a mechanism by which they can eventually recover some portion of the related expenses, many insurers are content with paying their retained counsel an hourly rate to file and prosecute an interpleader action. To be sure, any good attorney who is retained to file and prosecute an interpleader action works hard to minimize the time and expense associated with successfully concluding it. Despite those efforts, though, most insurers can expect to receive monthly billing statements for varying and unpredictable amounts for so long as it takes to secure a judgment in interpleader.

There is, however, a way to enable insurers to budget a sum certain for all of the work its attorney must perform to resolve each claim involving competing claimants: pay their retained counsel a flat fee for both their efforts to mediate the claimants' dispute and a specified set of tasks designed to secure a judgment in interpleader.

Such an arrangement would give the attorney an extra incentive to help the competing claimants resolve their differences through mediation. If a negotiated resolution cannot be had, a flat fee arrangement also should prompt the attorney to minimize the additional time invested in the case by promptly seeking a judgment in interpleader. If the attorney requires more than the budgeted time to secure a judgment that fully discharges the insurer, the fee arrangement could be structured to let the attorney recover additional compensation from any proceeds the judgment awards to the insurer. Absent exceptional circumstances, then, the attorney will be fairly compensated and the insurer will not be asked to write more than one check for the attorney's fees and costs.

CONCLUSION

If properly structured and executed, the benefit dispute resolution program outlined above can let insurers write just one check to compensate their retained counsel, then effectively wash their hands of the headaches normally associated with competing benefit claims. At the same time, it allows an insurer to don a white hat by offering competing claimants a cost-effective means of ending their dispute before they must hire lawyers or participate in a lawsuit.

By reinforcing the notion that the insurer is a disinterested stakeholder who stands ready to pay the proceeds once the claimants resolve their dispute, such a benefit dispute resolution program also will promote the insurer's chances of concluding any interpleader action promptly and on economically favorable terms. A flat fee arrangement also will give that the insurer's retained counsel an extra interest in efficiently pursuing that result, while ensuring both that the attorney is fairly compensated and that the expenses associated with the insurer's handling of the competing claims are fixed.

ABOUT THE AUTHOR

Rob Pohls is the Managing Attorney of *Pohls & Associates*, a California law firm that he established in 1999 to represent life, health, disability and long term care insurance companies in bad faith, ERISA and other complex forms of litigation. A litigator by trade, Rob has earned a national reputation for his distinctive ability to achieve favorable outcomes in disputes that involve challenging facts and/or novel legal questions. However, he is equally skilled at helping his insurance clients manage their claims litigation and, when possible, avoid litigation altogether.

To find out more about Rob, his firm's practice, or his firm's Fixed-Fee Benefit Dispute Resolution Program, visit their website at www.califehealth.com or send him an e-mail at rpohls@califehealth.com.

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ERISA Claimant May Seek Attorney's Fees Even If Not a "Prevailing Party" Per Se

RECENT NEWS

Tad Devlin and Sheirin Ghoddoucy, Gordon & Rees LLP
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United States Supreme Court Holds Courts Have Discretion Under ERISA Fee-Shifting Statute To Award Reasonable Attorney Fees If Litigant Achieves "Some Degree Of Success on the Merits"

Hardt v. Reliance Standard Life Insurance Co. (2010) 560 U.S. ___;

Claims professionals and administrators handling ERISA disability claims are aware that courts have discretion under ERISA to award attorney fees to claimants. A question of some debate recently is whether the claimant must be a "prevailing party" to receive his or her fees under the ERISA statute. The United States Supreme Court addressed this issue recently in *Hardt v. Reliance Standard Life Insurance Co*. (2010) 560 U.S. __. In *Hardt*, the Supreme Court concluded a litigant need not be the prevailing party under ERISA section 502(g)(1), but instead must achieve "some degree of success on the merits." If so, the trial court has discretion to award fees.

The United States Supreme Court reversed a Fourth Circuit Court of Appeals decision vacating an order from the Eastern District Court of Virginia awarding statutory attorney's fees and costs to an ERISA disability benefits claimant. The Supreme Court held ERISA section 502(g)(1) did not require a claimant to be a "prevailing party" to qualify for an attorney's fees award under the statute. The Supreme Court interpreted 502(g)(1) to unambiguously grant courts discretion to award fees to either party in an ERISA benefits dispute, as long as the party had achieved "some degree of success on the merits."

Plaintiff Bridget Hardt applied for long-term disability ("LTD") benefits under her employer's LTD plan after medical problems forced her to stop working. After exhausting her administrative remedies, Hardt sued Reliance Standard Life Insurance Company ("Reliance"), her employer's disability insurance carrier, for the alleged wrongful denial of her LTD benefits claim.

Plaintiff Hardt and Reliance filed cross-motions for summary judgment. The district court denied Reliance's motion, finding its denial of benefits was not "based on substantial evidence" but on "incomplete medical information." The district court also denied Hardt's motion. The district court found the record contained "compelling evidence" Hardt was "totally disabled," that Reliance failed to comply with ERISA guidelines, and Hardt had not received "the kind of review … she was entitled [to] under [the] law." The district court concluded it was "inclined to rule in … Hardt's favor," but that doing so would be "unwise" without first giving Reliance a chance to remedy the deficiencies in its review of Hardt's claim.

> *The Supreme Court reversed the Fourth Circuit's decision, holding a fee claimant need not be a "prevailing party" to qualify for attorney's fees.*

The district court remanded Hardt's LTD claim to Reliance and ordered it to re-review Hardt's application, "adequately considering all the evidence," within 30 days, or else the district court would enter judgment in Hardt's favor. Reliance did so and awarded Hardt over $55,000 in past-due benefits.

Hardt then filed a motion for attorney's fees and costs under 502(g)(1), which states, "the court in its discretion may allow a reasonable attorney's fee and costs … to either party." The district court granted the motion, in part, concluding Hardt was a "prevailing party" as required under the Fourth Circuit's framework governing attorney fee awards in ERISA cases. The district court awarded Hardt nearly $40,000 in fees and costs. Reliance appealed.

The Fourth Circuit vacated the fees award, holding Hardt failed to establish she was a "prevailing party" as construed by *Buckhannon Board & Care Home*, *Inc*. *v*. *West Wa*. *Dept*. *of Health & Human Res*., 532 U.S. 598 (2001), a Supreme Court decision which defined "prevailing party" as one who has obtained an "enforceable judgment on the merits" or a "court-ordered consent decree." (Brackets omitted.) The Court of Appeals reasoned the remand order did not constitute an enforceable judgment on the merits, because it did not require Reliance award Hardt benefits. Hardt appealed to the United States Supreme Court.

The Supreme Court reversed the Fourth Circuit's decision, holding a fee claimant need not be a "prevailing party" to qualify for attorney's fees under 502(g)(1), and to so interpret the section would be contrary to the ERISA statute's plain text. The provision did not contain the term "prevailing party" or any other language limiting the availability of attorney's fees to a "prevailing party." Rather, 502(g)(1) expressly grants district courts "discretion" to award attorney's fees "to either party."

The Supreme Court contrasted the language of 502(g)(1) with 502(g)(2), which governs the availability of attorney's fees in ERISA actions to recover delinquent employer contributions to a multi-employer plan. In such cases, only plaintiffs who obtain "a judgment in favor of the plan" may seek attorney's fees. 502(g)(2)(D). The Supreme Court found the sharp contrast between these two paragraphs indicated "Congress knows how to impose express limits on the availability of attorney's fees in ERISA cases." Because Congress failed to include an express "prevailing party" requirement in 502(g)(1), the Fourth Circuit's decision to add that language more closely resembled "inventing a statute rather than interpreting one." (Brackets omitted.)

Further, the Supreme Court interpreted the statute as requiring the fee claimant achieve "some degree of success on the merits" before a court may award fees and costs. In reaching this conclusion, the Supreme Court interpreted how 502(g)(1) attempted to deviate from the

Continued on next page.

"American Rule," whereby each litigant pays her or his own attorney's fees, win or lose, unless a statute or contract provides otherwise.

The Fourth Circuit improperly applied the Supreme Court's "prevailing party" precedent, *Buckhannon*, which did not apply, because 502(g)(1) does not contain the "prevailing party" language. The applicable standard was set out in *Ruckelshaus v. Sierra Club*, 463 U.S. 680 (1983), a case analyzing a statute (42 U.S.C. § 7607(f)) that authorized fee awards where the court "determines that such an award is appropriate.

Applying *Ruckelshaus*, the Supreme Court pointed to the language of 502(g)(1), which unambiguously allows a court to award attorney's fees "in its discretion … to either party." As in *Ruckelshaus*, here Congress had not clearly indicated it "meant to abandon historic fee-shifting principles and intuitive notions of fairness" in enacting 502(g)(1). Accordingly, the Supreme Court held a fee claimant must show "some degree of success on the merits" to qualify for an attorney's fees award under 502(g)(1).

The Supreme Court held Hardt satisfied that standard. Though Hardt failed to win summary judgment on her benefits claim, she obtained a remand order resulting in an award of benefits. The Supreme Court pointed out that the district court found "compelling evidence" Hardt was totally disabled and had stated it was "inclined to rule in her favor." The Supreme Court determined the district court properly exercised its discretion awarding Hardt attorney's fees under ERISA 502(g)(1). ■

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October 3-6, 2010

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Rehabilitation Assistance Strategies:

Research into Best Practices on Claims with a Psychological Component

OPINION

Paul R. Kirk, AVP of DI Claims Occupational & Vocational Rehabilitation,
Swiss Re Life & Health America

The contents of this paper are solely the opinion of the author and should not be construed as a publication of Swiss Re or any Swiss Re subsidiary or affiliate or any of its employees, officers, directors, representatives, affiliates, parents, or divisions.

Overview

Claims resulting mainly from psychological (psych) disorders comprise a significant portion of many disability insurer's claim blocks. Even when they aren't the primary disabling condition, such disorders may impact a large segment of an insurer's other disability cases. A key task for any disability insurer's Vocational Rehabilitation department is to develop return-to-work strategies for insureds with psych conditions.

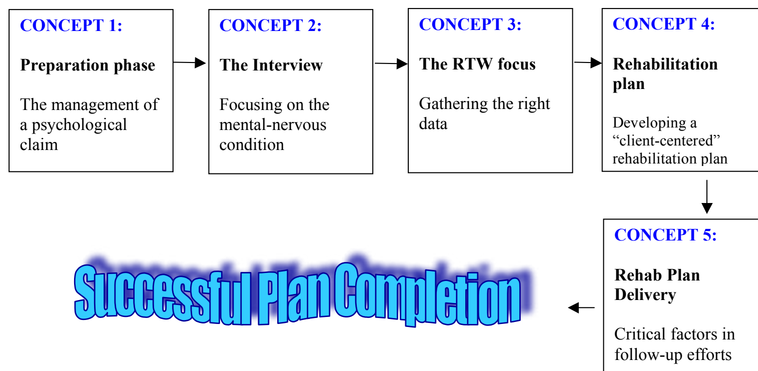
To contribute to the broader claim community's efforts in this regard, this article offers a strategy template for rehabilitating insureds claiming impairment from psych conditions. The strategy consists of a five-concept rehabilitative model that begins upon claim receipt and continues until the rehabilitation plan has been fully executed. It is important to note that the claim professional and the rehabilitation department jointly own and are responsible for the successful execution of this process.

This paper does not address the overall principles of disability case management and claim adjudication. At times, however, typical disability case management techniques are discussed when they further the objectives of the rehabilitative process.

New claims open less than a year are the primary focus of the rehabilitative model this paper explores. Additionally, this article assumes that the psychological diagnosis at time of claim remains the primary and only disabling condition.

This five-concept model does not require expensive or additional resources; it intends to expand upon and refine the existing skills claim professionals apply to their management of psychologically based disability claims. Each of the rehabilitation assistance strategies inherent in this five-concept model builds upon the one before it.

The Five-Concept Model Illustrated



Overview of Psychological Impairment within the Industry

To gain an overall perspective of the prevalence of psychiatric impairment in the United States, it is beneficial to consider public sector statistics before exploring the specialized realm of privately purchased individual disability insurance. The Federal Occupational Health Office, a division of the U.S. Department of Health and Human Services, provides pertinent public sector disability facts related to psychiatric claims. A few of these statistics are as follows:

- A 335% increase in the cost of psychiatric disability between 1989 and 1995.
- There has been a 300% increase in psychiatric disability claims the last decade.
- Depression alone is estimated to cost employers $24 billion a year in absenteeism and lost productivity.
- 1/3 of all disability cases have a primary or secondary psychiatric component.

The Social Security Administration indicates in their Annual Statistical Supplement-2000 that:

- Mental health disorders currently represent the single most prevalent cause of disability under Title II of SSA, encompassing roughly 26.8 % of all awards.

In the private insurance sector, one study concerning long-term disability policies was completed by Unum Life Insurance Company in 1997. This study demonstrates that the acceleration of long-term disability income claims mirrors the trends in statistics on mental health claims suggested by the public sector. For example:

- UNUM found that LTD claims based on mental disorders had risen by 316% since 1989 (compared to a 154% increase for all LTD claims.)

A 1995 survey by the Health Insurance Association of America confirms that in the private sector:

- 9.0 percent of all claims for group long-term-disability (LTD) insurance and 13.1 percent of the dollar cost of all claims were the result of mental disorders.

What are the current "best practices" in the industry for managing individual DI claims with a psychological diagnosis?

Available information and my experience within the insurance and rehabilitation industry suggest most employers in the United States were primarily in a "reactive mode" over the past ten years in their approach to psychiatric disability in the workplace. Most often, attempts to address psychiatric issues were at the treatment or service utilization levels, rather than incorporating successful workplace accommodation models.

As such, it is not surprising that claim adjudication of psychiatric

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disabilities in the private insurance realm has mirrored this reactive approach. However, some efforts were made to deal more effectively with this subset of disability claims.

In particular, one predominant best practice approach began to surface during the past six or seven years. And, this approach centered around the creation of a "dedicated" psychiatric claims unit within the typical claims adjudication environment. In fact, many insurance companies implemented official or unofficial "dedicated" claim units focused on managing psychiatric claims.

Unum, Aetna, ING Re and our own company, to name a few, have utilized this approach in the management of psychiatric claims. However, specific information on the success of a dedicated unit, if tracked at all, is not readily available and of a proprietary nature. But, these efforts to implement a dedicated psych unit point towards an increasing awareness that psychiatric claims may require a more individualized approach to disability management. At this juncture, the introduction of our rehabilitation assistance strategies and the five-concept model is appropriate.

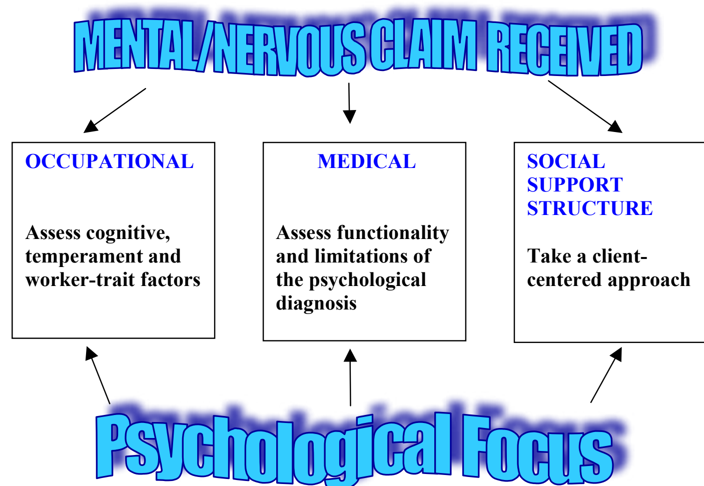
Concept 1: THE PREPARATION PHASE: Collecting data and understanding psychological factors

What is involved?

Assessing key claim factors is an integral component in developing a successful rehabilitation assistance plan. In this regard, each insurance company formulates some general claim questions that can be applied to all incurred claims regardless of diagnosis. The actual content of these questions will not be addressed within the scope of this report. However, it is suggested that claims with a psychiatric diagnosis require a further refinement in this exploration process during the initial "start-up" phase.

Points to Consider

Cognitive, **temperament**, and **worker-trait factors** of both the insured and the occupation are now at the forefront in developing a successful rehabilitation assistance strategy. These primary areas of claims data require a further refinement in approach:



How to Proceed

Mental impairment is addressed In the American Medical Association's, *A Physician's Guide to Return to Work*, as follows:

> *The first step in establishing whether someone has a psychological impairment is understanding how the symptoms interfere with functioning. This requires taking a careful psychiatric history. The history should include a thorough assessment of the person's activities of daily living, social functioning, concentration, ability to tolerate stress, and whether the individual has deteriorated psychologically in any sort of work-like setting.* [2]

In line with the AMA recommendations, it is suggested that the investigation of psychiatric claims requires a different approach.

Managing a Psychological Claim: Areas of Concentration

To better manage a psychological claim, explore the psychological functionality within the **occupational**, **medical** and **social support structure**. This refinement in case management questioning might best address the following:

OCCUPATIONAL	MEDICAL	SOCIAL SUPPORT STRUCTURE
1. Psychological requirements of the job tasks	1. Understand the psychological diagnosis	1. Family, friends and emotional support structure
2. The self-perceived psychological impact of job tasks	2. Clarify the insured's relationship with provider(s)	2. What social roles does the insured miss the most?
3. Determine insured's diminished capacity to work and predisability efforts to correct or resolve	3. Clarify insured's understanding of the diagnosis and treatment	3. What is the insured doing now?

Concept 2: THE INTERVIEW- A FOCUS ON MENTAL/NERVOUS CONDITIONS

What is involved?

The intake and assessment phase of a disability claim sets the future focus for interaction and activity between the insured and the claim department. Usually, an initial detail call with the insured is a first step early in this process.

Under the five-concept rehabilitative model, the areas of concentration suggested in the preparation phase (mentioned above) should be fully integrated into the detail call. In essence, the call can now be considered a claimant interview with a focus on the psychiatric condition. And, critical to the interview, is the need to gain a perspective on what key plan elements might emerge as factors in developing a successful rehabilitation assistance strategy.

Continued on next page.

Points to Consider
- Be fully prepared for the call
- Clarify the "because" of an illness/injury
- Clarify what it is about the occupation that "prevents" a return-to-work
- Know the occupation in detail
- Assess the psychological factors of the insured and occupation
- Keep injury/illness functionality and occupational boundaries clear

How to Proceed
The following are key points to emphasize during the psychiatric claim:

1. Define the pre and post disability timeline and work absence period
2. Research the psychological diagnosis and typical treatments
3. Recognize the common "stigma" associated with mental illness
4. Build trust and rapport
5. Try not to foster dependency
6. Create a return-to-work dialogue
7. Do not set high expectations for the first call

KEY FACTORS ON THE PSYCHIATRIC CONDITION

Concept 3: RTW FOCUS AND DATA GATHERING

What is involved?
The interview is complete and now begins the formulation of future action steps. This is achieved by gathering all the psychologically-focused data into the semblance of a working framework. At this time, it is imperative to assess the gaps in understanding the psychological factors associated with the claim.

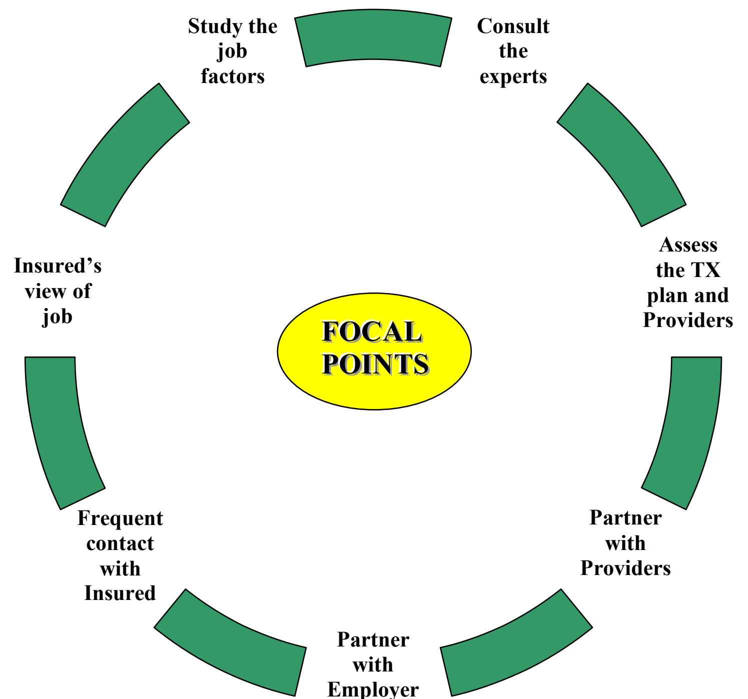
"Focal points" will arise as a result of the preparation and psychiatric interview phases of the five-concept model. These will usually center on the efforts to understand the relationship of the insured, the diagnosis, the employment situation, and the insured's social support structure. These focal points can now be used to develop an emerging rehabilitation assistance strategy. And, this can be crucial in targeting the resources necessary to help complete the current return-to-work puzzle.

Points to consider
- It can be difficult to "nail down" the psychological factors involved in the claim
- Don't expect to obtain all factors during the first interview
- More research will likely be required. Make the next call as required
- Develop the psychological "focal points" when gathering data
- Maintain a return-to-work emphasis at all times
- Fill in the gaps in understanding the relationship between the occupation and current psychological functionality

How to Proceed
The following are ongoing key points to emphasize when gathering data:

1. Concentrate on the psychological aspects of the occupation in detail
2. Integrate the insured's view of the psychological components of the occupation
3. Determine "focal points" in the job vs. injury/illness relationship
4. Maintain frequent contact with the insured
5. Understand the relationship the insured has with treating provider(s)
6. Partnership with the treatment provider(s)
7. Partnership with employer
8. Consult the experts
9. Assess anticipated costs
10. Privacy - Be mindful of privacy issues in any "secondary contacts"

Return-to-Work Focus & Data Gathering



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Concept 4: REHABILITATION PLAN DEVELOPMENT

What is involved in creating a structured rehabilitation plan?
In general, a structured rehabilitation plan (SRP) is a vocational tracking device that clearly projects vocational objectives. In using a SRP, efforts are made to capture key assets, barriers, objectives, and progress points. Importantly, the SRP proposes necessary steps to accomplish a specified (short or long-term) goal within predetermined timeframes. The process is then formalized into a written format that may require the signatures of all participating parties.

The importance of an effective rehabilitation plan can not be overstated. The ongoing use of a rehabilitation plan helps define the mutually beneficial relationship that the insurance carrier has with the insured, as well as all SRP participants.

Points to Consider
- The concept of a SRP can be applied to private disability insurance policies
- Policy language may play a part in a mutually beneficial SRP
- There is significant flexibility in the development of a SRP in this disability forum
- The implementation of a rehabilitation plan will vary from individual to individual
- A common SRP will usually:

1. Identify the occupational or vocational objectives
2. Represent the required services or activities to accomplish each objective
3. Demonstrate the ownership or responsibility of each service or activity
4. Define timeframes for completion of the plan
5. Be a collaborative process that requires the agreement of all participants

How to Proceed
The following should be emphasized when proceeding in the development of a SRP:

- Getting started – The occupation and insured have been assessed and evaluated from the perspective of cognitive, temperament and worker-traits. Focal points have been developed and clarified
- Stay "client-centered" - the approach to data gathering and return-to-work discussions maintains a focus on input from the insured
- The full picture - a working composite of claim dynamics has developed
- The pieces of the puzzle begin fitting together – claim factors take on an increasing "structure" that suggests a SRP can now be formalized

With the above in mind, it is suggested that the following vocational considerations be addressed as a baseline for career exploration and SRP development:

ELEMENTS TO EXPLORE

Point 1	Rule out a return to work in an original capacity.
Point 2	Rule out a return to work in a modified, accommodated, or new capacity with the original employer.
Point 3	Explore present occupational skillsets and functionality as they relate to alternative occupations. Perform a Transferable Skills Analysis.
Point 4	Consider vocational and/or psychological testing to assist in exploring vocational options and RTW functionality.
Point 5	Collaborate on potential career alternatives with the insured, providers and all vested parties as appropriate.
Point 6	Determine what rehabilitative services or occupationally-directed activities should occur to prepare the insured for a return to work in the original, modified or alternative employment capacity.
Point 7	Develop training, retraining, redeployment, or job placement objectives. Consider a Labor Market Survey if pursuing new career alternatives.
Point 8	Assign responsibilities to appropriate parties for specific rehabilitation research and/or occupationally-directed objectives. It is crucial that the insured is given clear assignments.
Point 9	Formulate plan specifics and concise goals. Efforts are "client-centered" and collaborative. Ensure physician support and possible "sign-off".
Point 10	Establish clear timeframes and progress "checkpoints".
Point 11	Formalize the rehabilitation plan. Detail all costs incurred. Signatures may or may not be required.
Point 12	Determine the "plan driver". Determine ownership of each plan phase.

Sample Rehabilitation Plan format
What might an actual rehabilitation plan look like? In the private sector, worker's compensation carriers often use structured rehabilitation plans. Such plans and their inherent structures will vary from state to state and among different worker's compensation carriers As an example, you may wish to review New Hampshire's Individual Written Rehabilitation Plan (IWRP) template which is considered typical of those used in the workers' compensation system.

Individual Disability Policies
The SRP concept can also be applied to private disability insurance claims. However, there can be greater flexibility and less inherent structure when handling this claim type.

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Policy language within the "rehabilitation" provisions of an individual disability policy may specify certain parameters for developing a mutually beneficial rehabilitation plan. The following is an example of such language:

"If while Disabled, You enroll in a rehabilitation program designed to help You return to work, We will consider participating in the costs You incur. The nature and extent of Our participation will be determined by prior written agreement between You and Us. Your participation in a rehabilitation program will not of itself be considered a recovery from Disability."

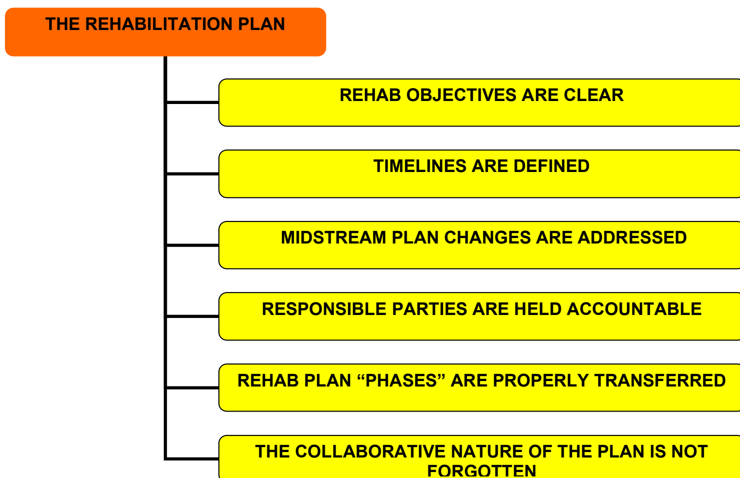
Concept 5: REHABILITATION PLAN DELIVERY –The critical follow-up phase

What is involved?
Follow-up efforts must ensue once a rehabilitation plan has been developed. After completion of the plan, a critical juncture has been reached and without continued vigilance, the future of the plan may become unfocused, stall, or die.

Points to consider
- The completion of a rehabilitation plan is not the end of the process
- The presentation and delivery of the plan must carry with it the clear goals timelines, and accountability factors necessary to ensure success
- Plan implementation is usually done via telephonic or in-person discussions
- Implementation is followed up via written correspondence (with plan attached)

How to proceed
Care must be taken to establish who will ultimately be responsible for follow up activities. This responsibility can be handled by any number of SRP participants such as a treating provider, claim professional, on-site training coordinator, in-house consultant, original employer, vocational counselor, or other invested party. The following are key points to emphasize when implementing a successful rehabilitation plan:

Plan Follow-up Consideration



Factors to remember during rehabilitation plan development and implementation
There are some common characteristics of a SRP within the realm of managing a claim with a psychological diagnosis. The following should be addressed during rehabilitation plan development and, more importantly, the critical follow-up phase.

Factors to Address During the Critical Follow-up Phase
1. Return to work efforts are seen as therapeutic not intrusive.
2. Confidence issues may need to be addressed
3. Workplace accommodations can be effective
4. A phased-in return to work can be a great assistance strategy for mental/nervous claims

Obstacles and solutions in the development of an effective rehabilitation plan
Many factors can interrupt a successful return to work process. Arguably, there may be just as many inhibiting factors as there are grains of sand on a beach. Therefore, it is important to emphasize that the rehabilitation plan must continually seek out the individualized strengths and potential barriers to a return to productive employment. A few of the more common obstacles to consider might be as follows:

- The enabling provider
- The enabling family member
- The insured has "settled into" a disability lifestyle
- Job no longer available

SUMMARY

The five-concept model recommended will assist in the management of psychological claims. Inherent within this five-concept model is the development and implementation of a "structured" rehabilitation plan (SRP).

Developing a SRP on a psychological claim requires a specialized focus immediately upon claim receipt. It is suggested that the cognitive, emotional, and worker-trait attributes of both the occupation and the insured's own functionality come to the forefront of claim exploration.

The key points to consider in SRP development have been explored and the workflow process reviewed. It is important to note that the nature of private disability policies permits broad flexibility in the development of any type of rehabilitation plan. Perhaps because of this, the development, implementation and follow-up efforts inherent in a SRP may be even more critical than in other disability insurance platforms. ■

Appendix

1. Christopher C. Wagner, Carolyn E. Danczyk-Hawley, Christine A. Reid; *The Progression of Employees with Mental Disorders Through Disability Benefits Systems*, p. 20.
2. *A Physician's Guide to Return to Work*, American Medical Association, 2005, p. 306.

Foreign Death Questionnaire – A Valuable Investigative Tool

Craig Williamson, CFE, ALHC
Special Investigation Unit Manager
Farmers Life®

At Farmers Life® as soon as we are notified of a foreign death a letter is sent to our agent or the claimant explaining our requirements for information, which includes the completion of the Claim forms and our Foreign Death questionnaire. This letter sets the tone for the requirements by addressing the foreign death certificate and the translation of documents. If the insured is reported to have passed away within the contestable period, the letter also addresses the requirement for an interview and the gathering of authorizations from the next of kin and other individuals with knowledge of the insured's medical history and circumstances of death. The contestable aspect of the case is also explained. This letter is sent (with enclosures) on all foreign death cases, usually to our captive agent, so that they can assist us in starting the claims evaluation process immediately. A questionnaire to the agent will follow if they were involved in the application/reinstatement application process.

Our letter requests:

- Claimant's Statement for Proceeds (claim form) form completed and signed by the beneficiary
- Authorization (HIPAA authorization on contestable cases) to Obtain Information signed by the next of kin
- The official Death Certificate issued in the country where the death occurred
- Foreign Death Questionnaire must be completed and should include all pertinent claim information
- A completed Report of the Death of an American Citizen Abroad, if applicable
- Form W-8BEN completed if the beneficiary has not been issued a Social Security Number.
- The return of the original policy

Farmers Life® Special Investigation Unit (SIU) handles all foreign deaths. When SIU receives the file a thorough review of the case is done. A qualified investigative vendor (domestic and foreign if required) is selected to conduct an in person interview and obtain a recorded or written statement and obtain authorizations from the next of kin or beneficiary to start our routine contestable investigation. Once the authorizations are obtained medical records or other pertinent records are ordered to document a history of treatment/activity prior to the taking of the application/reinstatement application.

The SIU evaluates the documents received, orders certified translations of documents and has the investigative vendor verify the documents in the country the death was reported to have occurred. While due proof of loss usually means a certified death certificate in this country, and many others, getting official documents can be problematic and a red flag for further examination. Our foreign death questionnaire requests many other documents that can be used to help verify that the death occurred, such as; funeral services(videos/photos/programs), local news articles, crematory receipts, cemetery records, embalming certificates, body transport receipts, morgue/hospital records, police/medical examiner reports. Pass ports, airline tickets, Death of an American Citizen Abroad form etc. In addition, our investigative vendor will visit with the local sources and relatives to verify the death and to verify the authenticity of the documents received going directly to the source of the document. The verification process and the interviews with sources in a widening circle provides the information necessary to complete the investigation or follow any inconsistent pattern or red flag.

Understanding the country and their customs is crucial in developing verifiable information and following the investigative line. For example, if the insured died in the hospital, what medical professional witnessed or certified the death?… where does the body go after treatment when the insured is deceased; do they have a morgue or do they call a funeral home? Did the family make the arrangements? What services were performed and can they be verified? …transport…embalming…cremation…final ceremonies? If a foreign death questionnaire was completed many of these issues will be addressed.

Medical records and other pertinent records (drivers license suspensions, DUI, felony convictions, drug use/treatment) are reviewed as received to determine if the answers given at the time we received and accepted the application/reinstatement application were true and complete. Occasionally medical records are obtained domestically to document a terminal condition if no records are available in the foreign country. At the point in time that our liability becomes reasonably clear we will conclude our investigation and take final action to either pay or deny the claim. ■

Following is the Farmers Life® Foreign Death Questionnaire →

Interested in joining a committee?

The ICA is always looking for additional members to join its committees.

Being on a committee allows you to have a greater impact on the decisions that mold the future structure of the ICA and its policies, practices and overall success as an association. Please visit the ICA website at www.claim.org to download a Committee Sign-up Form.

FARMERS NEW WORLD LIFE INSURANCE
3003 77th Avenue S.E., Mercer Island, Washington 98040

FOREIGN DEATH QUESTIONNAIRE

Part I, Page 1 of 4

DETAILS OF TRAVEL

Insured's Full Name: ______________________

Official Birth Name: ______________________

Insured's home address & phone number in U.S.:
____
____
____

How long at this address: ______________________

Occupation (please indicate duties if "self-employed"): ______________________
____

Last employer's name, address & phone number:
____
____
____

Date insured left U.S. (before death): __________
Date scheduled to return: ______________
Method of travel: ______________
Purpose of trip: ______________
Reason length of stay was longer than intended:
____
____

Travel agency used for foreign travel arrangements (name and address):
____
____
____
____

<u>If the insured traveled out of the U.S. by plane, please attach a copy of airline ticket to this form.</u>

Who traveled with the insured? (Use reverse side of form to list all persons if necessary.)
Name: ______________________
Address: ______________________
City: ______________________
State: __________ Zip Code: __________
Phone number: (____) ______________

DETAILS OF DEATH

Foreign address at time of death: ______________
____
____
____

Phone number for above address: ______________

City, State (Province) where death occurred: ______
____

Date and time of death: ______________
____

How did death occur (Cause of death)? __________
____

Who notified you of the insured's death? ________
____

Phone number of person who notified you and how were you notified? Letter/email/fax: __________
____

Part 1, Page 2 of 4

Who identified the remains? ____________________

Did police investigate insured"s death?
☐ Yes ☐ No. If "No," please explain.

Name of investigating officer, station name, address and phone number: ____________________

Which hospital(s) treated the insured? ____________

Name and address of doctor certifying death: _____

Was an autopsy performed? ☐ Yes ☐ No

Insured's death was due to:
☐ Accident ☐ Illness ☐ Other
Please specify: ____________________
Cause of death: ____________________

Was the insured ever treated in the U.S. for the illness causing death? ☐ Yes ☐ No

If "Yes," where? ____________________

Was the insured hospitalized anywhere in the last 5 years? ☐ Yes ☐ No. If "Yes," give dates, name and address of each hospital. ____________

What is the name, address and phone number of the insured's regular family physician? ____________

Did the insured have any type of health insurance or travel insurance coverage in the last 5 years?
☐ Yes ☐ No. If "Yes," give name and address of insurance carrier.

DETAILS OF REMAINS

Insured was: ☐ Buried ☐ Cremated

Were government documents received to authorize the insured's burial or cremation? ☐ Yes ☐ No.
If "Yes," please provide a copy.

Where did burial/cremation take place? ____________

Name/address of the person who performed the final service:

Were any photos/videos taken of burial or service?
☐ Yes ☐ No If "Yes," please provide a copy.

Name, address & phone number of two individuals who are not family members who were present for final services:
1.____________________

Telephone number: ____________________
2. ____________________

Telephone number: ____________________

Part II, Page 3 of 4

INSURANCE INFORMATION

Did the insured have any other life insurance in force? ☐ Yes ☐ No. If "Yes," please state name of other insurance company(ies):

1. ______________________________
2. ______________________________

Did the insured ever receive Social Security or State Welfare benefits? ☐ Yes ☐ No. Please explain:

____
____
____

FAMILY INFORMATION

Names/address(es) & phone numbers of decedent's parents. If deceased, approximate date and place of death. ______________________________

____
____
____
____

Name of insured's spouse: ______________________________
Name and address of insured's spouse (if applicable): ______________________________

____
____
____

Did the insured have any brothers or sisters?
☐ Yes ☐ No. If "Yes," please state each name, and their phone number:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Did the insured have any children? ☐ Yes ☐ No.
If "Yes," please state the name, address and phone number of each adult child (use additional paper if needed): ______________________________

MISCELLANEOUS INFORMATION

Was the insured a U.S. citizen? ☐ Yes ☐ No.
Was the insured's death reported to the U. S. Embassy? ☐ Yes ☐ No. If "No," please explain.
If "Yes," what date was it reported? ______________

____
____

SUPPLEMENTAL INFORMATION

Did insured have a U.S. driver's license?
☐ Yes ☐ No. If "Yes," which state? ______________
License number: ______________________________
<u>Please provide a copy of the insured's driver's license.</u>

Did the insured have a passport? ☐ Yes ☐ No.
Which country issued it? ______________________________

<u>Please provide a copy of the Insured's Passport along with Travel Stamps, Foreign Drivers License/ID Card and Recent Photo, Funeral Notice or Obituary Notice.</u>

<u>Please provide a copy of the insured's Social Security card.</u>

<u>If the insured was not a U.S. citizen, please provide a copy of their Alien Registration Card.</u>

Did the insured file income tax returns in the U.S. during the two years prior to death? ☐ Yes ☐ No
If "No," please explain.

____
____
____

Other: ______________________________

____
____
____

Part II, Page 4 of 4

The undersigned claimant agrees that Part I and Part II of this Foreign Death Questionnaire, the Claimant's Statement, the Death Certificate provided, the written statements of any physician who attended the Deceased, and all other papers which have been furnished to or may be required by the Company shall constitute a part of the due Proof of Death as stated in the policy. I declare that the facts stated on this form are complete and true to the best of my knowledge and belief. **WARNING:** A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim or makes a statement containing false, incomplete or misleading information may be guilty of a felony or misdemeanor.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any licensed physician, surgeon, medical practitioner, osteopath, chiropractor, dentist, podiatrist, optometrist, psychologist, pharmacy, insurance support organization, group policy holder, employer, benefit plan administrator, an authorized medical officer of a United States Government facility, or hospital clinic, other medical or medically related facility, consumer credit reporting agency or insurance company to release to Farmers New World Life Insurance Company (hereinafter referred to as FNWL) or its representatives, any and all information or records concerning mental and physical history, diagnosis, treatment, prognosis, examination, advice or care provided the deceased named below. Such information includes but is not limited to information relating to mental illness, use of drugs, use of alcohol, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).

I UNDERSTAND the information obtained by the use of this Authorization will be used by FNWL to determine eligibility for benefits under an existing policy, plan or group plan. Any information obtained will not be released by FNWL to any person or organization, except in connection with my claim for benefits or as may be otherwise lawfully required.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

This Authorization is valid from the date signed for the duration of this life insurance claim.

Dated: ____
Month Day Year City, State and Zip Code

Name of Decedent: ____
Please Print

Decedent's Social Security Number: ______________________________________

X ____________________________________ X ____________________________________
Signature of Next-of-Kin or Authorized Representative Print Name of Next-of-Kin or Authorized Representative*

*Relationship to Decedent: ____

X ____________________________________ X ____________________________________
Signature of Witness Print Name of Witness