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Disability Claim Management

Track: Health Disability Income

Moderator: PAUL GEORGE ZIOBROWSKI

Panelists: ANDREW BERNSTEIN†
ROBERT A. BONSALL, JR.‡
JOE BRAZ§

Summary: Claim management is one of the most complex yet critical components of managing a block of disability business. Many aspects of successful claims management involve actuaries, including:

- *Claim settlements*
- *Litigation*
- *Performance management*
- *Reserving assumptions*

MR. PAUL ZIOBROWSKI: Claims management has a profound impact on the profitability of a block of disability income insurance. It is a management tool that is often not well understood by disability actuaries. The poor claims results of the late '80s through mid '90s caused many disability insurance (DI) carriers to increase their focus on claim administration.

We have three experts in the field of claim management. They're going to help us understand some of the key issues in claims today. Our first speaker will be Mr. Robert Bonsall, the president, CEO, and chairman of the board of Disability Management Services, Inc., a company he co-founded in 1995. Bob will give an overview of some key concepts in claims management.

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† Mr. Andrew Bernstein, not a member of the sponsoring organizations, is principal at Bernstein, Bridges and Lagravinese, Inc. in South Portland, ME

‡Mr. Robert A. Bonsall, Jr., not a member of the sponsoring organizations, is president, CEO of Disability Management Services in Springfield, MA

§Mr. Joe Braz, not a member of the sponsoring organizations, is executive claims consultant with DCG Resource Options in Portland, ME

Our second speaker will be Mr. Joe Braz. Joe currently holds the position of executive claims consultant with DCG Resource Options in Portland, Maine. Joe has over 22 years of experience in claims administration. In his current role, he provides consulting services to both individual and group disability income carriers.

Our third speaker is Andy Bernstein. Andy is a principal in the law firm of Bernstein, Bridges & Lagravinese, Inc. He provides consulting and testimonial services to clients in the insurance and self-insurance arenas. He is a frequent speaker at insurance industry and legal seminars. Andy is going to cover hot legal issues in claims administration today.

MR. ROBERT BONSALL: As Paul mentioned, I'm with Disability Management Services, Inc. The company was founded primarily to focus on disability income claims management, primarily on the individual product line side. I'm going to talk about managing expectations, and it's a significant issue and topic for me because, as we talk about claims management, what we're really talking about is managing claim outcomes. To do that effectively, I firmly believe that we have to be able to effectively manage expectations of claimants. What I want to talk about is what that looks like, how we think about it, and how we accomplish it. But first I want to focus on the companies that issue products and talk about how actuaries, for example, might think about expectations.

We start with assumptions, and when we're talking about claim experience, we're describing expectations with terms that you're probably familiar with. Incidence is an expectation that refers to the number of people in a population of risks who would become disabled over a given period of time. Duration refers to the length of disabilities. Another term that could be used interchangeably with duration that you might be familiar with is termination rates—the frequency with which claims turn over. So we start with a set of assumptions and a set of expectations about claims and we feel pretty good over time if our assumptions bear out in claim experience. We would define success if we could look at actual claim experience and it matched up well with what we projected, or if it was better than what our expected experience was. I think we'd say, "Okay, we're successful in terms of what our expectations were."

But what does it mean when the expectations don't pan out? Starting sometime in the late '80s right through the late '90s, on an industry-wide basis, experience in the individual disability insurance market was really poor and much worse than expected when companies were putting together pricing assumptions and designing products.

To try to understand those things, we look at risk management and we try to better manage the expectations that we have. We could do things that have to do with policy design of new issues, new products that are developed, tightening up provisions, definitions of disability, and the like. We can change rates and we can alter pricing. We have to be careful with promotional materials and activities

because, even though we have a way of thinking about products and we have expectations about products, we have people who are distributing products who might set different expectations out there. We always have to be careful about what kinds of representations are made. We have the whole risk selection and underwriting process that we know is important and there are things we can do to tighten up there. We also have claims management.

My company focuses exclusively on closed blocks of business, but with claims that will run off over a period of years because it's primarily non-cancelable business. We're focusing on expectations that relate to claims management and, obviously, a lot of the things that we talk about have to do with risk management that we don't have any control over once the policies are on the books, so managing expectations becomes particularly important in claims. Many things impacted poor claim experience over time and we looked at and reacted to things that we had control over. Those included the design and the pricing, the underwriting, and how we manage claims and so forth, but there are other things that are external to our operations that have to do with consumers and their expectations.

I would argue that there was a significant shift in the expectations of consumers over the late '80s and early '90s in terms of what policies would do for them and whether or not they were entitled to benefits and how policies worked.

If you look at, for example, experience that emerged in the early '90s, there was a significant increase in the frequency, or incidence, of physician claims, and everybody pointed to changes in how managed care affected physicians in their ability to earn income, and so forth. We know that it wasn't a matter of more people in the population getting sick or hurt that was driving that claim experience. There was no good reason to assume that more doctors were getting sick or hurt than they did 10 years before, so something else was going on there and a lot of it had to do with the shift in expectations—the way that they thought about their policies, the way that they thought about the claims process, and the way that they thought about the duties of insurance companies. There were other things that were going on as well.

When we're thinking about the expectations that they have, we talk about the incidence and duration—all the things we expect about population or risk. We know consumers have their own expectations. As a claims organization, we want to understand what those things look like to be successful and we know fundamentally that claimants want to be treated fairly. That's pretty straightforward. They want to be taken seriously. They want to be informed about where they stand. They want to know what's going on with their claim. They tend to want hassle-free service.

I can remember a time at a claims industry meeting when an executive stood up in front of a group and said, "Claim time is no time to ask questions." I thought,

"That's a little misguided." Obviously, there are an awful lot of questions that have to be asked at claim time. There's a lot of information we need. But I think the point he was really trying to make was that consumers pay their premiums and they're entitled to benefits. When they file a claim, they don't deserve to be hassled and consumers really do expect hassle-free service. They don't want to have to jump through hoops to get a claim paid, particularly when they're having to deal with all kinds of problems related to their disability. And they typically want to be paid right away. So we know that they have expectations, and we also know that we can't necessarily always meet those expectations for one reason or another.

We hope that consumers are treated fairly, are informed, and receive hassle-free service. But prompt payment doesn't always happen and we know that when some of these things don't happen, consumers will act out and let us know. That unhappiness manifests itself in their expression of dissatisfaction, and they will file complaints, which sometimes take the form of litigation. We know that this process is a very uncertain and a very expensive process, and one that causes us to focus a lot of energy and resources, sometimes with unfortunate consequences.

We also know that consumers learn by their experiences, and even if they file complaints and they don't get what they want, they're still policyholders of ours. We know that sometimes we have to deal with them again and again. If it's for claims that are not meritorious, then that can complicate matters. But the bottom line is that conflict is inherent in the claims process because we can't always meet expectations and that conflict has very serious consequences for us, as we take our obligations seriously. We know that there's a lot at stake, there's a lot of liability, and that individuals are dealing with significant problems that are of concern to them. If we can't match up in terms of expectations, then we have to deal with conflict and we have to be good at dealing with it.

The question comes down to, "How do we do it, given that inherent conflict in the process?" First, we have to understand what we're dealing with, so I'm going to take a step back here and just talk about for a second what a claim is by definition. I think the process in claims "way back when" was set up to be pretty simple. Claim forms were used for consumers to be able to make their claims, and insurance companies were supposed to respond to them. Then the attending physician would certify disability and the insurance company would pay. We found out that wasn't very efficient or very effective.

We know that a claim is a demand for something rightfully or allegedly due, and that's the perspective of claimants when they have an expectation of getting paid. It's a statement of fact that may be called into question and we see it as fundamental to the process to be able to challenge assumptions and question claims. If somebody makes a claim, it doesn't necessarily mean it's legitimate or meritorious, but it's our obligation to determine the relative merits of the claim. So we recognize that our primary objective is to gather information necessary to prove the factual basis for the claim to the extent that liability is reasonably clear.

Decisions are not necessarily black and white. The information is not always crystal clear. We're trying to get it to a point of reasonableness where we can accept it, and we're trying to establish a factual basis for the claim.

We also know that there are issues related to the process itself that complicates the matter even further, such as multiple parties to the claim. We're not just dealing with a claimant; we're also dealing with claimants' physicians and medical providers. Sometimes they have representatives, sometimes they're legal counsel, sometimes they're accountants, sometimes they have an agent involved in the process, sometimes they're a collateral, and sometimes it might be a spouse who has an interest in the claim. The multiple parties that have an interest in the claim sometimes have conflicting interests and we have to be able to recognize what the relative interests of the parties are. There are time frames that can impact our ability to do this. The states all say that we have a certain amount of time to respond to things and to make decisions, and there are logistics that have to do with the distance between us. Sometimes we have claimants on one coast, and we're operating on the opposite coast. They're somewhere across the country and we have to be able to try to get good high-quality information in order to make decisions. We can't always be there to observe, or to see them, and that just makes matters that much more difficult. It makes the opportunity for conflict that much greater.

We recognize that, given that framework, and understanding what a claim is, and what the inherent difficulties are, we better have an approach that helps us meet our objectives. We think about how we're managing claims, and we have an approach that really has three elements to it: objectification, early intervention, and communication with claimants in our operation.

We've adopted a very direct and personal approach to claims handling and claims management.

Objectify. The simplest definition I've been able to find is the Webster's definition, which is "to make objective or concrete." In other words, to try to find a factual basis for the claim. We're looking to prove the claim. We're looking for facts. We're looking for source documentation. We're not taking surface information. We're not taking subjective information if we can help it. We want objective, factually based information, and that's important to us because information is very helpful in resolving conflict if you can just stick to the facts and not the innuendo.
How do we objectify claims? One thing we do is establish a frame of reference which usually relates to a period of time just prior to the disability commencing. You must understand a person's functional capacity at that time, their occupational requirements, their financial condition, and things like that.

We want to independently verify information so if somebody asserts something in a claim, we want to make sure that there's a factual basis for it. We're going to check multiple information sources, not just one, so that we can make sure we

have consistency in terms of what the story is. We're going to cross-validate information the best we can to help assure that the consistency is there and that the information lines up and points us to an answer that's reasonable. We're always going to apply a reasonableness test to the information we get. We're not necessarily going to get absolutes. We're going to have to apply a test that says, "We think that this makes a lot of sense based on the information we have, and we've checked out different sources. We cross-validated information; we think it's reasonable."

The kinds of areas that we're looking at include medical. It's about their impact on an individual's ability to function in specific ways in a work setting—in an occupation. We have to understand exactly what the occupational requirements are. Just because somebody says, "I'm a trial attorney" or "I'm a brain surgeon," doesn't necessarily mean we have a good understanding of what that means to them occupationally. We want to make sure that we have a very distinct and succinct understanding of what that means. We want to understand their functional capacity and how that's changed from a period prior to disability to a period post-commencement of disability. Sometimes the best way to do that is to observe somebody in their environment, when they're not paying attention or aware that they're being observed, so that it's independent and unbiased. There's the financial condition because there should be a financial impact of disability that's measurable. It doesn't always work out that way, but, in many cases, if an individual's ability to function in their occupation is significantly impaired, there should also be a financial impact that we can measure. We're going to look at situational factors that impact one's motivation to claim disability, because we know that there are often things that happen in individuals' lives that have impacts on their ability to function at work and impacts their financial condition, and those things are often resolved over the course of a claim. When the medical issues are also addressed appropriately, there is sometimes still an impediment to an individual getting back to work. So we want to understand what the situational factors are that impact the individual's ability to function in the workplace and get back to work. There are contractual issues, too, and they don't just relate to what the insurance policy says. There are things that can override contract language and definitions of disability, which include state statutes and regulations. State statutes are statutes that define disability or other rules and regulations are information that can have an impact on terms of how disability is interpreted in the context of an insurance policy.

The early intervention piece of the approach is just as important and, perhaps, maybe more important, when we talk about managing expectations because claimants and consumers who file a claim for disability benefits also have a preconceived notion about what the policy will do and what they're entitled to because, typically, representations have been made. But as quickly as we have an opportunity to, we want to establish what's expected of them in the claims process and what the orientation is, which, for us, looks like recovery and return to work. That should be the focus of what the policy is about. If we have an opportunity to resolve any kind of disconnects early in the process then we're going to have a

better opportunity to manage their expectations long term.

We know we're going to get better quality of information the earlier we get involved in investigating and developing information necessary to manage a claim outcome. Things have a way of changing. Information has a way of evolving over time, and so the earliest point in time that we can get information and understand it and assess it, the better off we're going to be. We also want the ability to precede decisions that sometimes claimants start making when they're dealing with a situation that can impact their life in a profound way. Sometimes they're thinking about things that have to do with selling off a business, relocating their family, or doing something that once you've done, there's no turning back. These situations can have a significant impact on an individual's motivation to go back to work. If they have an inconsistent expectation or a wrong expectation about what disability means or what a policy will do for them, then we have a real problem managing the outcome of the claim down the road. We want to make sure that we're dealing with those issues as early as possible.

The last thing, direct and personal communication, is also important. We know that communicating through the mail via letter campaigns and so forth in order try to meet expectations or communicate with claimants is not particularly effective. We want to be direct, we want to be upfront, and we want to share information with consumers. We want to let them know where they stand. We think that we can enhance understanding that way. We think we can avoid misunderstandings, which is just as important because a lot of conflicts that arise in the claims process arise when there are misunderstandings about what claimants are really doing or able to do and how insurance companies are thinking about their claims. If they're not talking enough, often times there's room for misunderstandings to come about. We can be more efficient in communicating. We can get information back and forth a lot more quickly to help meet their expectations for getting paid promptly, and we think there's a lot more "customer-friendly" feel to those direct communications rather than sending letters that are much less personal.

Even if we do a good job of those things and even if we have good objective information, we work to establish expectations upfront. We want to make sure that we've communicated where people stand and what the claims issues are about. Often times, we get claims that we refer to as speculative in nature, which means that they're gray, they're not black and white. It may not be a question of, "Is the person disabled or not?" It may be more of a question of, "How disabled are they and what impact does their condition really have in their ability to function?" "How motivated are they?" Often times that puts us in a position where we feel that if we can't get to the point where we feel that the liability is reasonably clear, then we have a conflict that we have to deal with. Speculative claims often times present opportunities. They certainly present conflicts that we have got to be able to respond to.

When you have conflict, what's the best way to resolve it? We believe that

negotiation, or working with claimants to try to resolve the issues central to their claims, if not the claims themselves, is going to give us the best chance of being successful. We know that if we're going to be successful in the resolution process we have to be able to meet their needs at some level, which typically means that there needs to be some kind of give and take, some kind of compromise, and that's what we're going to work towards when we're working on these claims that fall between the margins. If they're legitimate claims and we feel comfortable that we have a degree of reasonableness, we're going to pay those claims. If they're clearly not payable, we're going to deny them and we have to deal with the consequences. If they're in the middle somewhere, we're going to work with claimants and we're going to try to resolve those through compromise.

That leads us to my final point, which is what compromise looks like. Often times it looks like a settlement, or it looks like a resolution that has to do with looking outside the terms of the policy because policies typically describe the black and white scenario. If you get paid, you get this amount of money per month for this period of time. If your disability doesn't rise to that level where it's payable, then you don't get paid anything. Often times we know that this leads to conflict, we know that it leads to litigation, other complaints, or bad feelings. If we have an opportunity to do something in between, then we're talking about the value of the claim and what we can do about it. The question becomes, "What is the value of a claim?" This is something that there's no real science to, it's more art, but we have to assess the merits of the claim. We have the facts that we're going to focus on and our understanding of the impact of the condition upon the individual's ability to work. We have alternatives we can identify because we know what happens if we pay. We have a claim that we don't think is legitimate that we're paying dollars for, and once we start paying we're not sure there's ever going to be an end to it. We validated the claim. We know that if we say "No," then we're perhaps faced with litigation and we know what the cost and the uncertainty associated with that are.

What about the probability of successful alternatives? There's the cost associated with each alternative and there are other risk factors that we have to take into account that are going to impact the kind of settlement offer we might make or what kind of compromise we might be willing to seek. Those things are going to fall over a pretty wide spectrum. They have to be handled on a case-by-case basis. In individual disability we have found that there are a pretty significant number of claims that fall in the margins that I would call gray area claims, and there are a significant number of claims that we discuss with claimants with issues we try to resolve. If we can't resolve the issues, sometimes we talk about resolving the claim, the value of the claim, or about settling the claim. We do that because we believe that gives us the best chance of managing the expectations of the claimant— meeting expectations at some level, and also allowing us to get the best outcome that we think that we can get. That can have a significant impact on claim experience in the aggregate. We tend to try to work with people and deal with them directly as best we can. If we're successful we hope that the actual experience better mirrors what our expectations are as well. And if our

expectations and the claimant's expectations are lining up, then life is pretty good. If our expectations don't line up, it's more work and more difficulty.

MR. JOE BRAZ: I'm going to talk about something that kind of piggybacks on what Bob's been talking about. How many people here are not or have only limited involvement in disability? Pretty much everybody here has involvement in disability. That's good. I'm going to talk about something very different, but something that's important to me, and it's important in the management of a disability claim block.

The process of evaluating a disability claim, as Bob has just discussed, is really a complex process, especially when you're dealing with professional-level people. You're dealing with a doctor who's filing for residual disability, and you have all these factors that have to be analyzed. And the long and short of it is that some claims are going to get denied, some claims are going to end up being resolved by way of a disputed settlement, but the majority of claims are going to be paid. Most of those claims are going to be paid for a period of time and then they're going to go off the books, but a significant number of claims are going to go on the books and they're going to stay on the books. If you have coverage to age 65, or if you have lifetime coverage and you have a 25-year-old who has a total impairment disability, you have quite a liability on your hands. It's the block of business within your claims that consists of the permanent total disability claims that really comprises the biggest percentage of our reserves.

Now we have a choice. We can sit there and just honor the contract, which, of course, we want to do, and make our monthly payments and watch that reserve gradually rise until it peaks, and then gradually diminishes and we feel the weight of all these reserves on our business, or we can consider some options. What I want to talk about is commutations—settling some of these claims at their discounted value so that we get some bottom-line gain in the process. What I would argue also is a wonderful offering for claimants who otherwise are locked into a contract that only pays if the contract says it will pay. What might have made a lot of sense for them at the time they applied for that policy might no longer make any sense for them at all now.

I've been in the business a long time, I've worked for a lot of different companies, and it's been interesting watching the evolution of settlement philosophies. For a lot of years companies didn't do any settlements, at least on this block of claims. They reserved their settlements for disputed claims and there were a lot of reasons for it. Some companies just had a paternalistic attitude. Their approach was that this guy contracted with us for $5,000-a-month benefit to age 65, that's what's in his best interest, and we're not going to do anything to change that. Others decided that they didn't want to proceed to settlements on this block because of legal concerns. They were concerned about allegations that the company enticed or coerced the individual into taking the settlement. The concern was that the person would take the money, squander it, and then comes back with an aggressive attorney who would force the company to put the person back on claim in addition

to the monies they already paid out in the form of a lump-sum settlement. Over time, these attitudes have changed.

There are still some companies that are very conservative and don't want to approach settlement, but increasingly, companies are seeing the light and realizing that, yes, those are legitimate concerns but they can be resolved. The legal concerns are something you can work around through the process in which you lay out your settlement offering. In the end, they realize that the ultimate in the service offering for a policyholder or for a claimant is to provide them with options. It's one thing to have a nice monthly benefit that's going to come in for the rest of your life or to age 65. For most people that is the best thing. Settlement isn't for everybody, but there's a subset of people out there who really have other needs that could be served through a settlement. Even though the contract doesn't speak to it, for an insurance company to come forward and offer this as an option can really be viewed positively.

There are advantages and disadvantages to both the claimant and the insurance company going through with a settlement of a known liability claim. For the claimant there are some obvious things. They would have the use of tomorrow's money today. That, for some people, is huge. It just opens up a whole new world for them. They're thinking, "The rest of my life I'm locked into this insurance company and these checks that are coming in every month, and maybe they meet some of my basic household needs, but there are other things I could be doing if I just had some capital." A lump-sum settlement can provide that for them. We've used settlements to help people fund all kinds of business ventures over the years, to fund the educational responsibilities for their children, or for themselves. Some people just want to be free of the insurance company. It's not necessarily the most comfortable thing to have to go to your mailbox every month hoping that check is going to be there. People just don't like that feeling and, of course, it's almost like life insurance for them. It does provide their family with some protection against an unexpected or premature death.

The advantage to the company (and music to an actuary's ears) is that reserves are freed up and, hopefully, there's going to be some bottom-line gain along the way too, because you're going to be paying less money than you're releasing reserves. You're eliminating a significant amount of administrative expenses associated with the ongoing review of these claims year after year, the paying out every month with a check, expenses that add up significantly over the course of the years with a large block of these claims. And, as I mentioned previously, from the company's perspective, you're in a position where you're offering something extra contractual. It's a good thing, it's an option, and it's giving people the opportunity to consider alternatives that they never would have considered previously.

There are disadvantages. Again, they're obvious. The claimant loses that comfort and safety of the monthly benefit—that paternalistic attitude. There's reality to that.

If somebody has enough money coming in to cover their expenses and keep their lifestyle going, it's a big risk for them to give that up in order to start another business that may or may not be successful. Another disadvantage is that they are accepting a discounted value on the claim. We're not giving them full value on that claim. There would be no business reason to do that because we're assuming risk when we settle a claim. So they have to accept the fact that, had they stayed on claim until age 65 or for the rest of their life, they would have ultimately received more money than they're going to receive on a discounted basis today.

There are the disadvantages of those legal implications for the company. For the most part, I've never seen a claim become a problem. I think this is because of the way we choose to approach these settlements. We make sure that people understand this is optional—it's just an exploration. You don't have a claims person sitting down with the person and enticing him to take some money that he has no idea what he's going to do with, or going to the wrong person—a claimant who has psychiatric problems and can't manage money and coercing him or her into taking this settlement. We don't do that. We're very, very careful. We make sure, and the industry has to make sure, that the insured has legal representation. If there is some psychological basis to the claim, you're going to also want to have a sign-off not only from an attorney, but also from the doctor saying that this person is capable of managing this sum of money. Another disadvantage to the company is the same thing that's an advantage to the insured—nobody knows what's going to happen from day to day. You could step off the curb and get hit by a cab tomorrow and you just paid out $3 million to settle a $5 million claim. That doesn't look too good. Again, some things you can't control and you have to be as careful as you can in picking out these claims and accept the fact that there are certain events in life that you're not going to be able to foresee.

There are other business actuarial considerations, especially if you get a very aggressive settlement program with this block of claims. I was in a company that had that. One concern is just cash outflow. If you're really doing a lot of these settlements and you have a block of high-level professional claims and you're paying out $600,000 here, $1 million there, that can become a consideration for the company and a concern for the company. There are significant effects on the underlying assumptions of the block when you start to ferret out this whole chunk of claims that are considered total and permanent. You're looking at claims that don't really have significant mortality issues associated with the diagnosis, so that leads to overstatement of reserves on the underlying block because you're getting rid of all these claims that really are under-reserved. Those are the claims that are going to duration and they have no real significant mortality, so they're under-reserved as opposed to those newer claims coming in the door that tend to be over-reserved because of assumptions that they're going to be on claim for a certain period of time. It's going to affect your termination rates because you're terminating this whole block of claims that wouldn't have been terminated. They would have gone to duration, so you're going to have a higher termination rate in your block. Mortality is also going to be affected because you're taking out this

whole block of claims that really don't have much mortality issue associated with them, so there are considerations from an actuarial standpoint.
Once you've decided, "I don't care, we're going to do it, we're going to go for it, we think this is the best thing to do," we have to get to how we're going to assess the value of a claim. We have reserves, obviously, and we have present value and timing issues. Everybody knows what the reserve is and it involves looking at the benefit amount, the age of the claimant, and the duration of the benefits. But other considerations are going to be taken into account, such as the fact that there's going to be likelihood of future recovery, the effect of mortality factors that are specific to the diagnosis on this claim, and the probability on the group side of offsets to benefits. But that number is going to differ from the true value of that claim that you're looking at. The reserve has all kinds of built-in assumptions about recovery for all the claims. But if you're looking at a claim that you've already decided is going to be payable to age 65, and there are no mortality issues on it from the perspective of that claimant, they don't care what your reserve is. What they care about is the present value of the benefits, which is today's dollars at a flat discount rate that's going to pay my benefit until age 65 because I am going to live to age 65. The present value is higher than the reserve. It just doesn't have those built-in assumptions of recovery in it. So you're already at a disadvantage when you go to try to settle these claims because you're looking at two different numbers.

If you have a claim with a known liability, your present value is highest day one and it gradually diminishes until you get to the point of payout of the claim. The reserve, of course, follows a very different trajectory. It starts low and gradually increases. It starts low because of assumptions of return to work, but as the claim ages, the assumptions of somebody going back to work start to diminish, then the reserve rises and eventually it peaks and then kind of comes down along parallel with the present value. How do you assess the real value of a claim and how do you take care of that disparity between the numbers that the claimant is looking at and your reserve that represents your liability on your balance sheet? There's no easy answer for that. You can choose to not consider settlement of these claims until some point in time where the reserve has peaked as close to present value as it's going to get. And then when you're talking about a discount, an amount to the insured, you're talking apples to apples because you're working from the same number.
But what happens when you have a claim that's in the first year and it's a reserve that's still on its way up, but you know it's a total and permanent claim, yet an opportunity presents itself to settle that claim? Different companies take different approaches on that and most companies are pretty conservative. They're not going to pay more than the reserve on that claim. In fact, they're only going to pay a certain percentage of that reserve. A number of years ago when they started to do settlements, most companies would look at 50 to 60 percent of the reserves. Most realized that they couldn't get too many people to be interested in settlements because when you know you have the reserve being lower than the present value and you're discounting that reserve, if you offered 60 percent of the reserve, you might be offering 45 to 50 percent of the present value and nobody

was very interested in it. If you had a claim early on and the reserve was still rising, and even if you had an opportunity to settle it, if the settlement amount was going to exceed that reserve, there's no way in the world any company would do it. If you have a reserve that's currently $300,000 and you can project that within two years it's going to be $600,000, with the present value at $800,000, serious consideration has to be given to whether it's worth paying out more than that reserve right now to get rid of that claim because you're going to be benefiting the company and making a good financial decision. Yet, on the short term, you're going to be showing a loss on your income statement, and that's a real difficult thing to reconcile for a lot of companies that are short-term focused and quarter-end focused. But it's something that every company has to decide individually whether or not it's in the best interest to do it or not.

And, quite frankly, a lot of the opportunities come early in the claim when you can quickly establish that a liability exists, you realize that it's going to be permanent, and you haven't had time to create any animosity with this insured. If you don't take advantage of it then, you may never be able to take advantage of it. Again, companies have to choose how much of a gain they need to see. If you're going to just pay a percentage of the reserves, do you need to have a 30 percent gain? Do you need to have an 80 percent gain to make this worth your while? Again, it's an individual decision each company has to make. Increasingly, most companies have gotten to the point where they're up to the 75, 80, even 85 percent of the reserve to consider settlement of these, figuring they still have a 15 to 20 percent gain on their balance sheet.

Different companies have different ways that they approach these settlements. Some go out and negotiate them pretty freely. Some companies don't feel that's the best way to handle a subset of claims that are all considered known liability claims. They feel that you need to treat everybody fairly in this block and, therefore, they just go out with a flat amount giving you 75 percent of the reserve. They will say, "If you're interested in it, give us a call and we'll talk about it and we'll settle it for that amount, no negotiation at all." Again, they don't want to get into a situation where they pay one person 80 percent and another one 65 percent when they're all known liability claims. Others set a very small, but fair range to allow for some negotiation, which I think is the best way to do it because when you send out a settlement agreement, or a settlement suggestion letter, or you call somebody up and say, "Look, this is what we can offer you," they expect to negotiate. You're suggesting that they're going to put it into the hands of an attorney and their attorney is going to try to get a couple of extra bucks out of you. If you're not willing to negotiate at all, you end up losing some opportunity so I think there should be a little range of negotiation, but a limited one.

There are differences in group versus individual disability. I've handled settlements on both sides of the house over the years for a number of different companies. On the group side, you have some additional challenges that generally have taxability issues. On the individual side, if the premiums are being run through the

corporation, you're going to have the taxable benefit. On the group side, a significant percentage of the benefits are taxable. People aren't real interested in taking even 75 or 80 percent of the reserve, which might be 60 percent of the true present value of their claim, knowing that they also have to turn over a huge chunk of it to Uncle Sam. You get third-party influences with group claims. A lot of employers of the group policyholders don't want us to do them.

Let's look at the claim settlement evaluation process. You might have a claim where the person has been denied Social Security disability, which is an offset to the contract, so you have a full benefit amount that you're paying and you're evaluating the settlement on that full amount. It's not to say that person can't go back at some point down the road and reinstitute that Social Security claim and, perhaps, end up getting a benefit. In effect, you'd be overpaying the claim in that scenario. You also tend to have many more situations where you have "any occupation" clauses in the contract so that a person might be disabled and appear to be disabled for any occupation right now, but things can change. You're paying the claim based on total and permanent disability, but they could end up eventually finding a way to get back to another occupation. That would have led to an offset under your contract, again, leading to the fact that you essentially overpaid that claim.

There are some ways to overcome those obstacles and, unfortunately, the disability industry has been pretty slow to respond appropriately to it. Several companies have responded appropriately by using structured settlements on taxable benefit claims. This seems like the best process right now that's out there—assigning assumption reinsurance agreements with another carrier who will take over payment on a pre-prescribed formula that you negotiate with the claimant through an assumption reinsurance agreement. This allows companies to settle group long-term disability (LTD) taxable claims without there being what's called "constructive receipt of the money to the insured," which is what triggers taxability. If I were to give a lump sum on a taxable benefit to anybody, then they're going to have to pay taxes on it in that given tax year.

With a structured settlement, I could take that money and provide it to this other carrier as part of an assumption reinsurance agreement. The reinsurer assumes the future payout that I have negotiated with the insured. Suppose a person has a claim that pays $5,000 a month to age 65, and he and his wife have three other disability policies. The wife works and has a wonderful career and has a lot of income, so they can do without our benefit right now. I might set up a structured program where I stop the benefits and five years from now a lump sum becomes payable at the time that the first child goes to college. And then maybe it's four years of lump-sum payments during the four years the child is in college, then there are no payments again. And then 15 years from now, when the person turns 65, he starts to get a guaranteed payout for, depending on the period of time, I could say 15 years certain plus life, which means guaranteed payments for 15 years whether he's alive or dead, or to the end of his life, which if he's lucky, could go 30

or 40 years. So it's a wonderful alternative that can be very attractive to people if they have the ability to do without the money today. Why take a lump sum of money that would fund that future stream of payment? Again, give it to this other carrier and they assume the responsibility for making those payments. We get around the tax issue because there wasn't constructive receipt of the money to the insured at the time I turned that lump sum over and they only have to pay taxes on the money as they are distributed it in the given taxable years in the future when those payments become due. So it's a way around it. Some of the tax issues seem to be a wonderful service offering to insureds.

MR. ANDREW BERNSTEIN: I'm going to give you some sense of the perils and pitfalls of disability claims management which occur sometimes through no fault of the insurance company. I want to start with one particular case from May 2001 in Tampa federal court. I'll start with a number—$36.7 million. Federal court juries are usually much smarter than state court juries because they come from pools of registered voters, not from pools of drivers, which is how most states state courts get their jury pools.

An eye surgeon who claimed disability originally due to a back and neck injury, and then from Parkinson's Disease, was denied by an insurance company. The Tampa federal court jury was unhappy with this insurance company. The claim was for an $8,000-a-month benefit. They awarded him his benefits and they awarded him $36.7 million in punitive damages, which is a number that, if I were the CEO of that company, would make me stand up and take notice. It wasn't particularly egregious either. There were some bad facts to the claim. I'm not going to go into those because I don't think that would be appropriate, but it wasn't a particularly bad case or horrible case. It tells you what can happen when insurance companies are either forced to try these cases because they can't settle them for the right number, or when they choose to litigate these disability cases in this individual disability policy with bad faith punitive damage exposure. Sometimes you win, sometimes you're okay with the outcome even if you lose, and sometimes you get hit with a big number. It's likely that number will be reduced by the court on a motion by the insurance company as being excessive, but it's also possible that ultimately, something significant will hold up on appeal and that insurance company will probably then try to settle it at some time in the process. That just gives you a flavor of what can happen with a very well meaning insurance company trying to do the best job it can with a claim situation.

I will tell you from very strong personal experience, many of these juries say, "You paid your premiums, you're entitled to benefits. I don't care about the issues. I don't care about whether you've got a legitimate basis to say this person's not disabled. You pay your premiums and you're entitled to benefits." This gets to reasonable expectations. When an insured is unhappy, sometimes those reasonable expectations that people have are not what a reasonable expectation would be from someone with an expertise in the disability insurance industry.

With that in mind, let me talk about a couple of these cases to give you a sense of the hot trends in the industry. These cases all fall into the rubric of "Bad facts make bad law," but they also stand for the proposition that insurance companies and increasingly plaintiffs, are getting much more sophisticated and creative in the way they approach these disability claim disputes.

The first is the objective medical evidence. I agree with what Bob Bonsall said about trying to objectify the claim. I think that it is absolutely the right way to manage the claim. The difficulty though, is what you do with it once you have objectified it. Do you write a denial letter as an insurance company that says, "We've reviewed your claim and based on our full evaluation, we have determined you're not fully disabled," and then lay out the entire factual basis for that, and the facts supporting that conclusion? Or do you write a letter that says, "We've reviewed your claim. Here are the things we've done and we've determined that there's not objective medical evidence to support your claim, therefore, you're not disabled. Therefore, your claim is denied." Those are two very different ways of communicating your decision.

The first letter is fine because it doesn't impose the risk that the second one does. The first one gives the insured all the facts you based your decision on and says, "You're not totally disabled." And the second says, "We based this on the facts," but then the conclusion says, "which are, you don't have objective medical evidence to support your claim." I don't think any of you work for insurance companies that have a policy that says, "Claim is deniable if there's a lack of objective medical evidence, or only objective disability claims will be paid." All policies say, "Disability claims will be paid if the person is totally disabled," and total disability is, "you are unable to perform the material substantial duties of your regular occupation as a result of an injury or sickness." Sometimes it's any occupation. But injury or sickness is not defined in most policies, and I don't know a single policy that defines it to be limited to objective injuries or sicknesses.

We have claims for chronic fatigue syndrome. We have claims for pain. You can't objectify those things. A patient comes in and tells this or her doctor, "I have pain as a result of a degenerative disk." Lots of people have degenerative disks. Anybody over 40 probably has disks that are starting to degenerate. Some people have pain from that and some people don't. The doctor makes a judgment about whether that pain is legitimate and does the x-rays. They show the disk, but they don't show the pain. That person files a claim with the insurance company saying, "I'm disabled because of the pain as a result of this condition." You cannot deny that claim and tell the insured you're denying that claim because there's no objective evidence that you're totally disabled, because pain by its inherent nature is not something that can be objectified unless you've done it in a better way. You've gone out and you've done surveillance and you've seen this guy acting in a manner that's completely pain-free. So you have some verification, some cross-referencing, that gives you some validation for your position. But if you simply go out and say, "Well, medically your x-rays show your disk, but they don't show any

objective proof of your disability," you're going to lose nine times out of ten.

The *Saliamonas vs. CNA* and *House vs. Paul Revere* are two good examples of what happens when an insurance company says, "We're denying your claim because there's no objective medical evidence to support it." The CNA case involved an individual with a cardiac condition—coronary artery disease. His doctor said, "Don't go back to work because if you go back to work, you'll have a heart attack." He didn't have any present symptoms except he claimed chest pain. He wasn't having a heart attack, he wasn't having a stroke, and he wasn't on a pacemaker. He just didn't go back to work because the doctor said not to because the risk of a heart attack is too great. He filed his claim for disability and CNA said, "Well, there's no objective medical evidence. Lots of people have coronary artery disease. You have coronary artery disease, but there's no reason why you can't work. You could have a heart attack as easily at home as you do at work." This is all true, but CNA said in the denial letter, "We're denying your claim because there's no objective medical evidence of your disability."

The court said, "Well, that's real nice, but where in your contract does it say you can do that? There's nothing in your contract that says you can deny a claim for lack of objective medical evidence." By the way, I don't think that any state insurance department would approve that kind of contract, but they didn't have it so the court was angry. It used some very strong language in the decision, as the court in the *House* case did. They said, "The policy is the contract and CNA can't simply choose to add a new term because it wants to, so plaintiff wins." This is something that I've seen in my business—insurance companies increasingly using these kinds of approaches. This is not new, frankly, but it's something that's becoming more prevalent. Insurance companies are denying claims using this "objective medical evidence" or "objective proof" in their language to the insured in their communications. It doesn't mean you can't objectify the claim through good claims investigation, but you can't tell the insured that is the basis for your denial since there's no contractual basis for saying it. There's just nothing in the contract. You have a proof-of-loss provision in your contract that says you must submit proof of loss of your claim to the insurance company, or satisfactory proof of loss, or proof of loss satisfactory to us. It doesn't say objective. The courts don't like you adding a new term. It's a well-settled contract law. You can't add new terms to the contract.

I think this is the beginning of a judicial trend. These are not the only two cases. These are two examples. The *House* case, if you're interested, is *House vs. Paul Revere*. It's a 2001 decision out of the Eighth Circuit, which is Missouri, Arkansas, Iowa, and several other states in the Midwest. I think insurance companies are going to continue to see these, and they have to be careful about the language they use because it's not good for the rest of us.

Let's talk about appropriate care, which is, perhaps, the most interesting of all of these trends. Most newer individual disability and group disability contracts have

language in their policy that says, "You're totally disabled when you can't do the duties of your regular occupation," and, "You are receiving care that's appropriate for your condition from a physician who's appropriate to treat you." I'm paraphrasing the language. Older policies, as you probably know, said, "And you are receiving care or treatment from a physician." This didn't have the appropriate stuff in it. Another policy said, "You're receiving the regular attendance and care of the physician." The newer products are saying that it has to be appropriate care. You can't be treated by a psychiatrist for a broken foot. You can't be treated by an orthopedist for bipolar disease. If you have carpal tunnel syndrome, you have to consider alternatives other than just sitting back there and saying, "I can't work and I don't want to have any surgery." That's what happened in *Provident vs. Henry,* where Provident was successful, and I think, rightly so.

The law has been, up until this *Henry* case, pretty clear in the older cases from the '20s and '30s that an insurance company couldn't force an insured to get certain types of treatment in order to get benefits because it's not a medical insurance policy and it's inappropriate to interfere with the patient-physician relationship. So insureds were pretty successful in the past at saying, "Don't tell me what kind of care I have to get. As long as I'm seeing a doctor on a regular basis, I'm entitled to my benefits." The *Henry* case involved an individual who was a dentist, and he had carpal tunnel syndrome in both wrists. His own doctor, and that was very significant to the judge, said, "Go have the surgery. There's a 95 percent chance of success and there's less than a five percent risk of anything going wrong in the surgery or of you having any problems." He went for a second opinion to the Mayo Clinic in Arizona and they said the same exact thing. He went to find a third doctor who said, "No, we'll treat you conservatively with splints and some anti-inflammatory medication," and that's the choice he took.

And the Provident contract said, "You're totally disabled when, among other things, you are receiving care appropriate for your condition from a physician appropriate for the condition." Provident paid the claim under reservation of rights and filed suit in federal court in the Central District of California for declaratory judgment. They wanted a judgment by the court that they would be right in saying that he was not getting appropriate care because he hadn't gone through the carpal tunnel surgery, which would make him no longer disabled, which had a 95 percent chance of success less than a five percent risk of anything going bad. They wanted a declaration that they could stop paying him until, and unless, he went through that surgery. Both parties cross-motioned for summary judgment, which means they both said to the court, "There are no issues of fact. We all agree what the facts are. We need a legal ruling from you as to whether or not Provident can say this is a condition of getting of benefits." The court ducked having to rule on the motion by saying, "No, there's an issue of fact to the jury about whether or not this is appropriate care." But the Court also said that this may very well be appropriate care to get the surgery, which was a quantum leap from the prior decisions. The idea, again, that insurance companies can say, "If you want my benefit, you have to do something invasive. It's not just taking a pill or going to see the

psychotherapist three times a week. It's having surgery, going under a local anesthesia, having all the risks that surgery entails, and signing the informed consent. But if you want my benefits, this is what you have to do."

The plaintiff argued, "Look, you're forcing my client to get care. You're interfering with his relationship with his doctor." The judge rejected all those arguments and said, "No, this is a contract just like *Saliamonas*. This is a term of the contract. There is a precondition for being totally disabled. It's part of the definition that you have to be under appropriate care. His own doctor said this is appropriate. The Mayo Clinic said this was appropriate. I think it's a reasonable issue for the jury. It's a fact issue for the jury." And then Provident did the smart thing. As soon as they got the decision they liked, they settled the case so they could keep the decision as a published decision. It's out there now and they can use it in other cases. But it raises some very interesting issues.

Let's go from carpal tunnel syndrome to a psychiatric claim. We have a claimant who's seeing a psychiatrist or a clinical psychologist once a week for psychotherapy for a major depressive disorder. The insurance company does a full and thorough review and they have him examined by an independent medical expert (IME), and they have neuro-psych testing done. They all agree he's got the major depressive disorder, but the IME doctors, the neuro-psych specialist, and the psychiatrist come back and say, "Well, he's not getting appropriate care. Yes, he's seeing a psychiatrist once a week, but if he saw a psychotherapist with more intensive psychotherapy three times a week and he was on this antidepressant medication instead of this antidepressant medication, he'd get better quicker." So can UnumProvident, can Paul Revere, can any of us then say, "You're not under appropriate care, so the claim is being denied." That's an interesting question because I will tell you that insurance companies are doing exactly that. The insured will come back and say, "Wait a minute. The policy doesn't say the most appropriate care. The policy says appropriate care. I'm getting appropriate care. There's no contention that my psychologist isn't doing a good job or that once a week isn't appropriate. I can find five other doctors who will tell you it's appropriate." And maybe this is more appropriate, or you can argue this is more appropriate, but that's what the contract says.

What about the individual who has the degenerative disk and all he needs is a diskectomy. Diskectomy is often done under local anesthesia and it has a very high rate of success. They make a small incision to excise the disk tissue and it's a very quick recovery. What about that? Is that appropriate care if the guy refuses to do it? Can the company then say, "Well, you're not entitled to benefits"? I think this is going to be a big issue, and it continues to be a big issue. There are a lot of cases right now pending nationwide on this very issue where insurance companies are being creative and plaintiffs' lawyers are being equally creative in addressing these issues. Claims are being denied on that basis. So that's something else to keep in mind.

For years the insurance industry has been very good at organizing and helping each other out when it came to litigation. Lawyers talk to each other, both outside counsel and inside counsel, and share information. You should know, as an aside, that in the last five years, plaintiffs' lawyers are becoming incredibly effective in doing the same thing. If you've ever been deposed by plaintiffs' lawyers, and I've been deposed many times, every one of them has all my depositions in their office. They know what I've said about every case. And for everyone I know in the claims operations of these various companies who has testified a lot, there's a library of their depositions in these plaintiffs' lawyers offices. So they all know what you said before you walked in there. That's pretty sobering.

Equally sobering is the fact that they share all kinds of information. They get discovery from the insurance company of all kinds of documents. And when they get documents they think are helpful to them, if there's no confidentiality order, which there often isn't, they share that information around the world and around the United States with plaintiffs' lawyers. The Internet has helped that a lot. They share documents all over the place. You should understand that plaintiffs' lawyers are becoming equally sophisticated and very effective. There are some real good plaintiffs' lawyers who have gone from tobacco litigation to insurance litigation and they think there's a lot of money to be made here; witness the $36.7 million punitive damage verdict. So it's nothing to be scared of, but it's a reality that insurance companies need to recognize.

Let's talk briefly about the risk of future disability as a covered loss. Most doctors who work for insurance companies will tell you that the test for total disability is a two-part test—limitations and restrictions. Limitations are those things that the person physically cannot do because of his or her condition. Restrictions are what they reasonably should not do because of the risk of further harm or death is too great. Risk of future disability goes to that restriction part.

Again, let's look at the *Saliamonas v. CNA* case—the individual with coronary artery disease. He didn't go back to work because of the risk of heart attack. One of the things that the insurance company said in its denial was, "It's a risk of future disability, it's not a present disability, therefore, it's not payable." That is not an unreasonable position or an unreasonable thing to say. The court, however, said, "No, what you want him to do is to have the heart attack before you'll pay him, and that's clearly not what your policy is designed to do. This policy covers restrictions. His doctor has given him a reasonable restriction: don't go back because you might, or will, have a heart attack." There is reasonable probability that you will. And the court said, "No, that's a reasonable restriction, therefore, it's a covered disability."

I'll give you another example. We had a case a number of years ago involving an anesthesiologist who was addicted to the anesthesiologist's drug of choice, fentanyl, which is, unfortunately, a very common thing for anesthesiologists. The American Society of Anesthesiology has a whole protocol on the addicted

anesthesiologist and how to get him back to work. But this guy was addicted to fentanyl. He lost his license. The state of Maryland took away his license. He was fired by his hospital, and he filed a claim for disability. He went into an impaired physician's program with the state of Maryland, he was able to get himself clean, he was in relapse recovery going to Narcotics Anonymous meetings, he was seeing an addictionologist, he was doing all the right things, and he got his license back. My company denied the claim saying, "You have good relapse prevention in place. You're not currently addicted. You're not currently experiencing or taking fentanyl. There's no evidence you're taking drugs. You've been clean on all your random drug screenings. You're getting good treatment. You got your license back. There's no reason why you can't work. You should go back to work." And, as I said, the American Society of Anesthesiology has a whole protocol for getting the person back to work.

We litigated that case in federal court in Maryland, and the judge agreed with us. The plaintiff said, "Look, I'm always an addict. I'll always be an addict. I'm never going to not be an addict and I've always got that risk that I'll see the drug. I'll have access to the drug, and it will happen. I just can't control myself." But the court said, "That's a possibility. There's no doubt about that. But that's not a reasonable likelihood. You have all the right prevention mechanisms in place. You've been clean. You got your license back, and there's no reason why you can't work." And so the court said, "The risk of future disability or the risk of that relapse happening is not reasonably probable, which is the test." So that's an example of the flip side of this. But this continues to be a hot issue, and I think you'll continue to see it be a hot issue.

I want to finish with the changes that you'll see on the group side on January 1, 2002. I'm sure your law departments all know it if you're in the group disability insurance business. The U.S. Department of Labor has enacted changes to ERISA that are effective on claims handling on January 1, 2002. Currently, as an insurance company handling the ERISA disability claim under a group contract, you have up to 180 days to make your claims decision, and then up to 60 days to make a decision on appeal if you deny the claim.

These new ERISA regulations will reduce that to 45 days on the initial decision and to 30 days on the appeal. There are other changes as well that will dramatically increase insurers' obligations to the insured when a claim has been denied in terms of what information has to be provided to the insured. There are limitations on who can handle the appeal, which is required under ERISA. It can't be the same people who were involved in the initial decision. It can't be the same doctor or nurse in-house who was involved in the initial decision. I mention this because it's going to dramatically increase insurance companies' costs of doing business in the group life, health, and disability arenas. The administrative costs are going to go way up, and I'm sure those costs will be passed on to the employers, the policyholders. Come January 1, 2002 there will be a big change happening. I also believe, because of the shorter time periods, you'll see more ERISA litigation even though ERISA doesn't

have the exposure of bad faith and punitive damages yet. You will see more litigation and costs will go up in ERISA claims denials as a result.

I think it's important that insurance companies are prepared for this January 1, 2002. I will tell you that plaintiff lawyers are very prepared for this. You should also know that there are increasing attacks in the courts on ERISA's limitations on punitive damages and bad faith. A decision just came down two weeks ago from the California Ninth Circuit Court of Appeals, which covers the western part of the United States, in which the court allowed a bad faith cause of action against an insurance company on an ERISA claim for invasion of privacy based on the conduct of a field investigator in investigating the claim even though everything was preempted by ERISA. It's something you should be aware of.

Let me go back to the IME topic for a second. There are two recent decisions, the one in Idaho from December of last year and one in March of this year that I didn't give you. The first is *Jones vs. Aetna U.S. Healthcare*, which was from the Central District of California, March 27, 2001, in which the courts have taken insurance companies to task for using independent medical examinations, in their view, improperly. The Idaho case is not a disability case. It's a medical case. It's an HMO case, but it's important because of what the court says about the use of IMEs. In the Idaho case, which involved State Farm, the court found that this particular office of State Farm had a practice of using independent medical examiners who they had used before that had given them lots of favorable outcomes. They kept a database of those people, and they kept going back to them because they liked the decisions they were getting, which was more denials.

The court said, "That's all well and good, but they're clearly not independent. They're clearly biased. They're giving you an outcome you want, and we don't find that to be a very fair or appropriate way to be managing a claim. You're placing your interest above the insured, and you should understand that one of the tenets of the duty of good faith and fair dealing is that insurance companies have to consider the insured's interest equally with their own and look for ways to factually prove the claim in order to pay the claim. Look for a reasonable basis on which to pay the claim. You can't engage in tactics that place your interest above the insured's interest." These documents that State Farm had that were produced in the litigation regarding the way they use their IMEs clearly demonstrated, or to this court at least, demonstrated that State Farm was looking for doctors who would give them an outcome that they wanted, basically predetermining the outcome before the exam had even taken place. They were using paper reviews, reviews of medical records, because they thought that would get them a better outcome than using an actual exam of the insured. And, as I said, they were tracking claim outcomes based on the use of IMEs and going back to the well for the doctor that gave them good outcomes. And the jury didn't particularly like it either because it awarded a $9.6 million punitive damages verdict against State Farm, saying that the evidence was that State Farm had a pattern in practice of using medical record reviewers who would routinely reach conclusions favorable to the insurers.

The *Jones vs. Aetna* case is interesting. It's a little bit different. None of that evidence was involved. It was an ERISA case. No bad faith exposure. Jones had two doctors who said, "She's disabled." Aetna had gone out and hired an independent medical examiner who examined the person and said, "Not disabled." The two doctors for the insured and the doctor for Aetna are all very credible experts and specialists in the field. There are no issues about that. Aetna denied the claim based on the IME, whom they found more persuasive. The court said that Aetna was using the IME doctor as a veto power to veto the opinions of the insured's doctors without making any effort to resolve the conflicting opinions.

Many insurance companies have a practice, when they get conflicting opinions between an attending physician and an IME doctor, of having the in-house doctor from the insurance company get on the phone with the insured's doctor and have what's called a doc-to-doc call, and they talk about the issues and they try to come to some resolution. Perhaps it's surveillance to see if the person is doing the activities that they say they can't do. Perhaps it's going and meeting with the insured and discussing settlement as an alternative. But none of that was done in this case, and the court found it very troubling that Aetna was using the IME doctor and just accepting the IME opinion without making any effort to resolve the conflicting opinions. The court called it a veto power and rejected it. The court granted judgment in favor of the insured for disability benefits. I think it's a perfectly reasonable practice for insurance companies in the right cases to use the IME doctor in that way, but obviously this particular court in the Central District of California didn't think so.

The point is, insurance companies have to be smart and careful about how they use these things. The point of some of these cases like *Robinson vs. State Farm* is that documents will kill you, such as the internal documents where you track the results, termination rates, denials, liability acceptance rates, and you track performance in financial ways of your claims operation. They will get out in discovery. Plaintiffs' lawyers are very smart about this stuff now.

The last thing I would just ask, and it's not a question, it's a rhetorical question which does not require an answer, is, as actuaries, are you building any of these trends, any of these approaches to claims, into your actuarial models of disability claims experience? Obviously, this is a small group of claims that get denied. The vast majority of claims get paid, but it's in that margin that many companies are making money or not. So it seems to me it's something you should be considering if you aren't considering it now.

MS. LARA SOLMUNDSON: (Great West Life Assurance in Canada) I have one question and one comment. Joe, I believe you were talking about the settlements. I was just wondering what interest rate you use, or you're forced to use, or choose to use. I'm not sure the way it works.

MR. BRAZ: In the position I'm currently in, I handle work for a variety of different

companies, so I can't really give you a set rate. It's generally in the six percent range, a discount rate.

MS. SOLMUNDSON: So it would depend on current assets, that sort of thing, or is it a rate potentially prescribed by that state?
MR. BRAZ: No, it's not prescribed by the state. It's a company-by-company determination. Sometimes they peg it to a Treasury Bill. It really varies.

MS. SOLMUNDSON: Thank you. The other comment is for Andrew. At our company, and I think in Canada, we do have the objective medical evidence clause. It's in our definition. We introduced it a few years ago and I think it was the result of the same sort of thing happening when we used it in claims situations and it came out that it wasn't a contractual term. So now it does form part of our definition, and I think it's widespread.

MR. BERNSTEIN: Do you deny claims that are subjective in nature?

MS. SOLMUNDSON: The way it's worded is it has to be supported by objective medical evidence. So, something like pain where you can't objectively measure that, you may be able to objectively measure the fact that there is a condition that could cause the pain. You still have gray areas, but I think it helps in some situations.

MR. BERNSTEIN: I think you're right. I misspoke at the beginning. There is at least one company that has a self-reported limitation definition exclusion or limitation on benefits in its policy that says, "For conditions that are self-reported and cannot be objectified by generally accepted medical testing, the claim is limited to two years of benefits." Having been involved in the drafting of that provision, I had grave doubts about its enforceability as it is extremely vague. It depends on how it's drafted. I applaud companies in Canada for doing that. I hope it's enforceable, but I think it will be hard to enforce. It's hard to get a court to recognize that that's a clear enough definition to give you what you want.

MR. ZIOBROWSKI: I can help out on the interest rate. What we've always tried to do is tie it to a new money rate. You discount at the rate the insurance company would have invested it in at that time or tie it to some benchmark like a Treasury, plus a margin.

MR. MARK SELIBER: (MetLife) Bob, I have a couple of quick questions. You talked about your personal communication. First of all, do you communicate at all with the claimants by e-mail, and also do you have any plans to have claim forms available on the Internet?

MR. BONSALL: A good question. We don't send out communications by e-mail to claimants, and I should clarify that I do believe strongly that direct and personal communications make a lot of sense. Obviously, those communications should also

be documented appropriately and so, often times, we do memorialize those conversations and follow-up in writing as appropriate. But we typically do that through the mail. We're not using the Internet as a means of communication today. We don't have forms available through the Internet at this point in time. It's not to say that we won't at some future point in time, but there's nothing in the works right now to do that.

MR. VINCENT DEMARCO: (John Hewitt & Associates) Just as an aside, Andy, you talked about the *Provident v. Henry* case in California. It has come to my attention that the California Insurance Department is looking at whether the use of "appropriate care" language is now an allowable language in the state of California. And I just thought that should be mentioned since it is in current contracts, but may not be available in future contracts.

MR. BERNSTEIN: That's a real good point and that is definitely an avenue that, again, smart plaintiffs' lawyers will take. If they can't get the courts to make the decision they want, they can go to the insurance departments and try to get them to take the position that the insurance company is incorrectly interpreting the appropriate care language that they themselves approved. I would note that in California, I don't believe you need approval of any disability insurance policy form. You can just file them. You can just start using them. You file them and you don't get the formal approval anymore, but that doesn't mean the insurance company can't come in and say, "It's not acceptable."