

RECORD, Volume 22, No. 2*

Colorado Springs Meeting

June 26–28, 1996

Session 67PD

Claim Management For Disability

Track: Health

Key words: Disability, Disability Insurance

Moderator: DAVID A. NIXA†

Panelists: PAMELA MORMINO‡

Recorder: MICHAEL L. RASMUSSEN

Summary: Claim management experts will describe state-of-the-art claim management theories and practices for disability coverages.

Mr. David A. Nixa: Our first speaker is Pam Mormino, who is with ITT Hartford. We're going to be presenting "Claim Management for Disability." Mike Rasmussen from Towers Perrin in St. Louis is our recorder. We will give an overview of "Claim Management for Disability." We are going to focus primarily on non-occupational disability management along with a little occupational disability management. There are a lot of similarities that are beginning to show up in disability management between the occupational and non-occupational side. Before we get into this, however, I would like Pam to take you through a case study to give you an illustration of what claim management for disability can do.

Ms. Pamela Mormino: It was determined that a social worker, in her mid-thirties, was totally disabled due to major depression. The woman had a good work history and had previously worked in a drug treatment unit. Her continuous disability was substantiated by her attending physician. The insurance company decided to have a psychiatric consulting physician contact the attending physician to discuss the actual case and to look at what the future treatment would be.

*Copyright © 1997, Society of Actuaries

†Mr. Nixa, not a member of the sponsoring organization, is an AVP, Strategic Initiatives of ITT Hartford in Hartford, CT.

‡Ms. Mormino, not a member of the sponsoring organizations, is Director, Claim Services of ITT Hartford in Weatogue, CT.

The consultant determined that the person was totally disabled and was receiving the proper treatment for the first six months of care. However, after six months the claimant did respond to the treatment protocols and was able to return to the work force. As a matter of fact, she opened her own practice out of her home as a social worker. At this time the patient was considered in remission and the case was closed. This is just one example of how managed disability can return a person to the work force earlier, save money for the employer, and reduce the reserves. Managing disability does work.

The objectives for this session are to provide you with the basic understanding of claim management for disability, specifically, why disability case management is necessary, what the key elements of an effective claim management program are, and to identify for you the value associated with disability claims management techniques. We will contrast the handling of claim management for non-occupational illnesses and injuries with that of workers compensation claims.

Mr. Nixa: In the workers compensation arena, carriers have control over medical care and can largely limit indemnity costs by increasing the emphasis on medical management. On the non-occupational disability side, carriers have little or no control over the medical care. Management must come from either the contracts or contract languages, the administration of them or through the managing of the disabilities themselves. First, let's take a look at some of the statistics being presented on aging in America. The number of Americans who are in the over-50 age category are continuing to rise dramatically.

Ms. Mormino: In 1995, 26.4% of Americans were over age 50, while in the year 2010, we can expect that to rise to 33.8%. What does that mean for disability claims? The rate of disablement for age 50 and older is significantly higher than those age brackets 50 and lower. Thus, the number of claims will proportionately rise. There remains a very large segment of our society that is unmanaged and uninsured.

Mr. Nixa: So what's the size of each of these markets? Where's the potential for management and where's the value both for the insurers and for the employers? The short-term disability (STD) market is really where the greatest opportunity lies. The total market is approximately \$24 billion. Generally this excludes sick-pay programs, meaning the first five to ten days. There's a lot of opportunity for improvement here. The reason for this is that STD programs, which include extended sick-pay programs, salary continuation, as well as the formal insured and self-funded programs, are largely unmanaged today. Also, most small employers offer limited or no STD at all. The real trick is to catch and manage the claims

before they become long-term disability (LTD) and before people get caught in the welfare cycle that LTD and even workers compensation tend to promote.

The opportunity in the LTD market, which is approximately \$11 billion, is obviously not quite as great. The reason for this is that the market is more mature. Smaller employers have more of a tendency to offer LTD coverage and programs to their employees. But still over half of the market is either uninsured or unmanaged. LTD management is a bit more common. The product has matured and some of the techniques which we will talk about have been in place for quite sometime.

The workers compensation numbers, excluding self-funded programs, is about a \$30 billion market. There is quite a bit of management already underway in this market. The primary reason for that is because the employers control the market. This is a mandatory coverage. There has been a lot of emphasis on controlling claims costs as a result of the company crisis by introducing medical management techniques or managed-care techniques.

Ms. Mormino: We also have other issues that are influencing claims management. We have increasing claims due to company downsizing and outsourcing. As the employees of companies feel less secure within their jobs, they are more apt to go out on a disability claim. New disabilities are turning up, such as acquired immune deficiency syndrome (AIDS), carpal tunnel syndrome, stress, fibromyalgia, which have self-reported symptoms that are difficult to document with clinical data. There are influences due to the workers compensation changes, changes in their benefits, in their laws, managed care, and the incentives. If individuals cannot get workers comp benefits, they will frequently apply for disability benefits. Also, some statutory laws create cost shifting from disability workers compensation because the benefits are richer in the non-occupational field.

Mr. Nixa: A quick scan of the company environment shows that there are other issues and factors that are driving disability management for workers comp. You may be asking why we are focusing on the company environment in a session that is primarily under the medical heading. The reason, as I mentioned earlier, is that we want to, first of all, familiarize you with the key differences and similarities between workers compensation disability management and non-occupational disability management. Also, there is an increasing awareness and use of the so-called 24-hour-type products that utilize resources and management techniques as both lines are managed together.

There has been rapid consolidation and restructuring of the medical delivery system. There are multiple issues to managed care because virtually all workers compensation lost-time disabilities result from a medical event. Also, the increasing

availability of workers compensation specialty networks, with discounts for referrals to those networks, are driving local, regional, and even national relationships between the providers of these services and the insurers, employers, or third-party administrator (TPAs) on behalf of employers.

Regulation in many states has begun to mandate managed care. In a few states, work-related illness or injuries can be directed to specialty networks or to providers at the choice of the insurer or the employer where discounts have been negotiated and care is specialized for workers compensation. Employers have long focused on workers comp lost time and medical expense. As a result of this experience, they have increasingly pushed their workers compensation programs to include specific cost containment strategies and features. And, in fact, most insurers and major TPAs are instituting these programs and making product offerings, which include very specific cost-containment strategies. They are required on the company side and given in order to be a player in the market.

Ms. Mormino: Managed medical care is also a factor on the non-occupational side. With the medical arena swiftly changing to managed care, this creates an environment where there are limited choices. The American Disabilities Act (ADA) has also been an influence. There are many issues that have come up due to the ADA. Definitions of disability are often not the same, causing some difficulties with claims. ADA defines disability as not being able to perform a major life function. Disability carriers define disability as not being able to perform your job due to some physical or mental impairment. For instance, a person might be unable to walk and would then, therefore, qualify under ADA. However, in a non-occupational disability plan, if you had a sedentary job, the fact that you could not walk would not be an issue and you probably would not be considered disabled. On the other hand, requirements to modify the workplace for disabled employees has been a big plus for the disability carriers.

As you can see there are several external factors causing a rise in the number of disabled workers. For this reason a solid, managed-care program is essential. The primary objectives of the managed-care program is to return as many employees as possible to gainful employment. The other objectives of disability management are to contain cost and reduce employer costs. The direct costs are your medical expenses, your medical leave, and your social security costs. However, there are a lot of hidden costs that are not taken into account. These include your wages for your replacement workers, your retraining and hiring costs, lower productivity, and your claims administration cost. Dave, how does this compare to the workers comp market?

Mr. Nixa: On the company side, business managers frequently have control of company costs as a key element of their compensation programs and are directly rewarded or, conversely, punished for the financial performance of the company program. The objective on the company side is to control costs and bring value to the customer through very specific programs that start before the illness or injury ever occurs with loss-control-type programs or risk evaluation programs that focus on prevention and inventories of current injuries to focus on prevention activities. Early intervention is another component; professional nurse case managers direct injured or ill workers to occupational medical networks that actually participate with the case manager. In many cases utilizing occupational nurses on the employer's side and integrating and working together in the management of the medical treatment facilitates a very strong focus on return to work.

On the company side, in some respects it is antithetical to the approaches that are beginning to emerge in managed care, because the company objective is to return individuals to work, and that is also the objective on the non-occupational side. So frequently medical treatments could be more costly, because the outcome is earlier return to work and, thus, a reduction in lost-time costs. There are also formal, return-to-work programs, such as vocational rehabilitation and alternative employment.

Ms. Mormino: Another objective is to improve employee relations. The employees who feel that they have a partnership with their employer are more motivated to return to work. We also must consider ease of administration, especially in an integrated short-term and long-term disability environment. For example, with combined products, even including workers comp, the expenditures of administrative dollars can be minimized at the same time the claim dollars are being saved.

The fourth objective is to increase productivity. Fewer disabled workers and an early return-to-work time frame results in increased productivity. The decrease in productivity due to replacement workers, which often is not considered as a problem at first, is easily recognized once a disabled worker goes out on claim and must be replaced by a replacement worker. Also, returning workers generally take a bit more time to get back to their pre-disability performance.

There is decreased reliance on Social Security. The Social Security Administration is currently undergoing major reengineering and the outcome of this is something of an unknown at this point. Presumably there will be a reduction in benefits and approval levels. Existing Social Security claims are also receiving greater scrutiny.

Just what is disability claim management? It is a program of disability management that enables an early return to work using a humanistic approach, reducing costs for the employer, and increasing productivity. Actually it can have different meanings to different people, usually by what degree of management is invoked on the claim. While managed disability borrows concepts from the medical arena, it differs in that there are no mandates to use specific providers that will give you monetary incentives. Insurance carriers usually will use many different approaches in providing a disability managed-care program. Some have in-house programs where they have their own nurses, rehab counselors, and medical directors, while others will outsource all of these practices of management. And others will use a combination in order to effect the best management on a claim. Claim payment practices in the 1980s involved fast claim service, automatic check writing, and vocational rehabilitation. In the 1980s vocational rehabilitation was the only claim management technique used. Claim management has evolved to include such things as integrated disability, clinical management, transferable skills analyses, and litigation management to name just a few. In the 1990s, as you can see, the process has become very complex and, as a result, there have been significant cost savings.

Mr. Nixa: Also, for workers comp there's been an evolution to managed care and other cost-containment and cost-management techniques. Insurers in the past were able to simply pass on their additional costs to the employer through increasing the rate. As medical inflation and market competition placed opposing forces on insurers, the workers comp crisis grew very quickly. Many of you may remember that crisis in the late 1980s and the early 1990s. The first attempts to stem that are now beginning to mature and, in fact, are being applied on both the occupational and non-occupational side.

Focusing on early reporting was one of the initial workers comp activities. Simply knowing about the claim sooner enables one to manage it more quickly. Claims management techniques now include direction to occupational providers, recommendations to employers, such as prevention programs and other loss-control techniques. The introduction of case management has actually been a cost-containment technique for workers comp for over two decades.

More recently case management has evolved from simple occupational nurse interventions attempting to get people back to work to very sophisticated systems. For example, a single point of claim reporting system enables early loss reporting and early management of claims through telephonic means. Case management systems allow nurses to document in significant detail the progress of a given claimant regarding their treatment program and return-to-work program. The use of occupational medical management networks, which did not even exist a few years

ago, specialize in the treatment of workers comp injury and illness. The use of vocational rehabilitation is relatively new on the company side.

Other techniques have also been borrowed from the non-occupational side. Also, a technique known as medical bill review, which is currently done by most insurers electronically, essentially involves reviewing medical bills to insure that the discounts are being properly applied and that the treatments that were recommended were actually performed.

More recently, the regulators have gotten involved in limiting or reducing workers comp costs through state-level legislation or regulation. Increasingly states have required that workers comp carriers, plans, and employers themselves manage the medical element of workers comp through the use of managed-care techniques. Utilization review is mandatory in workers comp in several states. It is encouraged and regulated in many more. Where it is used, it must be certified.

For those of you who are not aware, utilization review is either the pre- or post-review of a medical treatment plan. Approval of the plan and the ongoing monitoring of those plans is generally done by an occupational nurse. Additionally, states are beginning to require that managed-care organizations (MCOs) as they're known, be certified to actually provide occupational managed care in order to be able to deliver those managed-care services for workers comp illness or injury in their state. This is an extremely costly and rigorous process that insures quality care and quality treatment from these managed-care organizations. Specifically, state mandates for utilization review include setting dollar thresholds (meaning specific amounts that will be allowable for specific types of procedures), targeting procedures and diagnoses that are typically abused, utilizing treatment protocols and having consistent charges.

Mandates for MCOs include such things as formalization of medical provider networks, meaning that the makeup or composition of those networks must include a significant amount of occupational medicine and be controlled with quality control processes monitored by occupational doctors, and there needs to be free and open access to all injured or ill workers. There is quite an issue around access, because occupational networks are still not that common. They need to be structured in a way that meets the needs of the occupational environment. Also, the case management and utilization review programs of the MCOs are regulated. Frequently these programs have evolved from their medical programs, which use a different approach that tends to look more at cost containment through less treatment or less invasive types of treatment as opposed to the company side, which looks at more robust types of treatment to return people to work.

As I mentioned, medical bill processing essentially enables the insurer or the employer to electronically look at the bills that they are being charged for the services and automatically reduce those bills to the negotiated rates where, in fact, they are being charged a higher amount. Also, virtually all states that regulate MCOs do not allow for what is known as balance billing either to the employer or to the claimant.

States, of course, are interested in controlling both the cost and the quality of care. In many respects workers comp MCO regulation is stronger than the regulation imposed on medical managed-care organizations, such as health maintenance organization (HMOs). States, of course, must balance their obligation for controlling the workers comp costs and the economic viability of employers with fulfilling their responsibility for employee safety and welfare through fair, high-quality treatment.

Customers have, as a result of their own cost-control efforts, come to expect that various claim management techniques will be provided. Case management for both non-occupational and occupational have become table stakes for doing business with these customers and have created an increasing need for consistent case management processes, including such things as specific documentation services. Customers really want to know, what am I getting for this, when am I getting it, how am I getting it, who is performing this service, how much is it costing me, and what benefit am I getting from it. As well as, how does the plan comply with the regulatory requirements of my state or jurisdiction for each of my locations, and am I protected as an employer against noncompliance. And will it be easy for my organization and my employees to interface with your organization in a way that, given the increasing complexity of these techniques, makes it simple for me.

Ms. Mormino: This sophistication exists also on the non-occupational side. The market is filled with the buzzwords of managed disability. The customer expects a fully managed product with all the inherent savings. To fulfill these expectations, an effective non-occupational disability management program will contain five elements: partnership, prevention, integration, cost containment, and not least of all, management information.

Rehabilitation depends on the cooperation of everyone involved. Rehabilitation counselors are at the core of the effort contacting the employer, the physician, and the claimant to coordinate the plan to return the claimant to work. The claimant must be encouraged to return to work. Everyone must be an enabler. He must think positively. You must get a person to focus on their abilities and not on their disabilities. What they can do, not what they can't do. Of course, the ideal situation is when the claimant returns to work at his old, previous employer.

However, there are times when the workplace or the job itself cannot be modified and other opportunities must be pursued. Often the employer's negative attitude in the process of returning people to work can be the biggest obstacle for a disability carrier in getting a claimant back to work. Of course, the key element to having a person return to work is he must be enthusiastic and motivated. The rehab program must be tailored to the needs, skills, limitations, and feelings of each individual candidate. Successful rehabilitation can be accomplished in a variety of ways using vocational testing and counseling, retraining and continuing education, work-site modification and, ultimately, job placement.

Prevention is another important aspect. Preventing disabilities from ever happening is probably the simplest way to reduce disability costs. Employee assistance programs (EAPs) can reduce the incidence of mental health and substance abuse disability. Often these types of problems can lead to high absenteeism, reduced productivity, and accidents on and off the job. Early intervention by an EAP can help the employer identify the source of the problem and get to the root of their problems and get them under control before they actually turn into a disability claim. Wellness programs emphasize and promote health and injury prevention. Workplace safety reengineering and loss-control programs help reduce accidental and occupational disabilities. Such loss-control programs consist of ergonomic assessment, work environment analysis, and recommended changes to reduce, prevent, and eliminate risk.

Mr. Nixa: As I mentioned before, loss control has been a significant part of workers compensation for many years. Obviously, loss prevention have been used aggressively in the workplace because of the regulation requirements to do so. And, of course, on the comp side it has evolved into many specialists who are experts in assessing employer worksites based on the industry or occupations that they employ and making specific recommendations for improving those work sites. In fact, in many respects, employers are required to make these changes before an insurer will actually write workers comp coverage on their behalf. Or states will come and make sure that the work sites are safe. Obviously, this has a positive effect on rates.

In many respects, you can structure the actual contract itself through the application not only of the prevention techniques, but through formal risk-management programs. There is a focus on prevention, but also the return to work, so that the actual rating plans and reserving structures are based on the willingness of the employer to implement certain prevention programs or make work-site accommodations or safety features that will avoid or minimize injury.

Ms. Mormino: Also, in the non-occupational side, the richness of a plan can also be a factor in prevention. Plans that are too rich actually encourage absence and abuse. The plans needs to be structured to help those who really need it and to make sure that benefits are not being spent on people who are not deserving of benefits.

A study reported in the April 1996 edition of *The National Underwriter* indicates that more than 60% of U.S. employers and carriers are tightening at least one facet of their LTD plans. Some of the cost-saving measures being noted are moving away from benefits in excess of 60%, moving away from maximums of over \$10,000 a month and, also, most carriers are wary of own occupation to age 65.

Another element is fraud prevention. Industry figures say that it represents 10% of all submitted non-occupational claims. Usually they are represented by exaggeration of symptoms, misinterpretation of occupational duties, failure to disclose pre-existing conditions, and nondisclosure of income.

A study conducted by Health Insurance Association of America (HIAA) reports that the number of referrals to law enforcement and convictions is on the rise on non-occupational claims. The use of surveillance has increased and can be an excellent tool when fraud is suspected. For example, one company decided to use surveillance on a gentleman who was out on disability for dizziness and vertigo. One weekend they decided to videotape him and he was up on the roof of his house for six hours. Surveillance certainly came in handy in that situation.

Insurance companies that have fraud prevention programs are benefiting from these programs. Although there is a cost attached to the programs, the benefits far outweigh the costs. Savings have risen from \$9.5 million in 1991 to \$59.8 million in 1993.

The third cornerstone of managed disability is integration of short-term and long-term disability plans. Integration involves bringing together the employee's short-term and long-term plans, as well as coordinating these plans with workers compensation. The advantages of integrated plans are many. To minimize costs we use duration guidelines. By using standard guidelines, allowing a certain length of time out of work for a certain disability, the effectiveness shows a lowering of claim costs on most short-term disability claims.

Another aspect is early intervention for reduction of the disability costs. Often an LTD claim can be averted if the short-term claim is managed from the beginning. At the earliest possible stage we can identify those candidates who will benefit from disability, or psychiatric case management, vocational rehabilitation, or Social

Security assistance programs. Often a claimant can be returned to work prior to an LTD claim. There is a sentinel effect; a person returns to work because the claim is being monitored and questioned. This also allows for early coordination with workers comp to save claim dollars.

Mr. Nixa: Coordination with company can take two different paths. The first is through carrier communications to insure that the correct contract is paying for the claim or paying the appropriate amount for the claim. Most non-occ disability contracts pay portions of lost wages that are not compensated by workers comp, and most disability contracts have provisions that offset workers comp benefits. This type of coordination also prevents or eliminates what we call "double dipping" where a claim is filed for both workers comp and for disability.

The second method is coordination or integration of the claims management and payment services through partnerships of individual providers of services or through single carriers. These include product solutions, such as 24-hour products with single point of claim reporting for both occupational and non-occupational claims, integrated case management and vocational rehabilitation services. Essentially, one individual is trained to do both occupational and non-occupational case management and rehab.

The final, and most difficult, element is the integration of claims payment services. Given the significant difference in regulation and reporting requirements on the company side and the relative simplicity on the disability side, integrating claims payment systems is complex and difficult to accomplish, even with automation.

Ms. Mormino: Another advantage involves retention dollars. Administrative savings from combined plans can be obtained. Claims services are also improved through simple claims administration. The claim information can be combined for more accurate information and more effective claim service with much less duplication of effort. As soon as the STD claim is established and appears to be going into an LTD claim, the claim information can be shared so that the administration is seamless.

Most companies will offer computerized claim systems. If both the short and long term are on the same system, they can utilize shared databases. By doing so the information is consistent and the possibility of duplicate claims being paid is diminished.

Because the LTD investigation can take place while the short-term claim is in progress, there is a continuous flow of benefits that enhances relations between the employee and the employer, as well as the insurance carrier. Having a single claim

manager makes the entire process more user friendly for the disabled workers, who already have their hands full.

It also provides for coordinated renewal. By combining the products, the data for the renewals can be evaluated at the same time for a more effective and more cost-effective program. Plan language can be designed to complement each other. For example, definition of disability is often inconsistent in nonintegrated products. Also, pricing can be taken into consideration. You can consider the fact that the integrated product will have lower LTD claims by managing and avoiding potentially long-term claims.

There is customized and consistent reporting. As long as you customize the reports and have them drawn from the same system, they will be reporting consistent data that can be used for renewals. They can also be used for claim analysis and financial statistics. This also gives customers a better understanding so they can improve their own internal human resource practices. Another benefit is consistent interpretation of short and long-term definitions. There should be no difference in what total disability means. As just mentioned before, separate plans may define disability differently and integration essentially will eliminate this problem.

Another advantage is simplified tax and ERISA (Employee Retirement Income Security Act of 1974) reporting. Again, the integrated reports are valuable for this purpose. Integrated plans enable custom reports for employers on a state and federal level. Reporting needs and statutory requirements vary based on the employer's size. This minimizes unnecessary duplicate reports. There is more opportunity for accurate reserving. Integration between short and long term allows advanced information on LTD claims and duration, thus allowing more accurate reserves.

Another significant area is the personalized attention to the claimant. This should not be overlooked. By working with them, developing their strengths, the claimant perceives the examiner or the case manager as their ally in the process of returning to work. It becomes a very pleasant win-win situation. The claimant's self-esteem remains intact and claim dollars are saved.

Some other advantages are that the rates are usually more stable. You can see the whole picture and not just one segment of a disability experience. This comes from the availability of short-term data when pricing long term and, therefore, more accurate assessment of the claim potentials and the claim experience. There is more flexibility with the benefit structure. The benefits can be tailor made to coordinate with each other, for example, consistency in the long-term disability elimination period and the short-term disability benefit period. Also, plan elements

such as workers comp offsets versus exclusions can be accommodated. There are also better benefits at a lower cost. When these benefits can be tailored, they also could be offered at this lower cost.

Ms. Mormino: Cost containment is the next component of managed disability. The HIAA recently conducted a survey of member companies' rehab case management programs. They found that for relatively small investments the programs can yield significant dividends. From 1991–93 companies demonstrated savings that averaged almost \$30 for every dollar invested. This is a big change from eight years earlier when these figures were 11 to one. The overall objective of managing the entire course of disability is to return the employee to work and to save dollars.

The primary non-occupational disability cost-containment programs are duration management, medical site case management, vocational rehabilitation, and Social Security assistance. On the workers comp side we also have medical bill review, and occupational and medical networks.

In regard to duration management, as we briefly discussed before, there are standard guidelines that can be used to effectively manage a claim. Many companies use vendors for this service and other companies have developed their own in-house guidelines. If there are no extraordinary circumstances that warrant exceeding the disability guidelines, the claim would be terminated at the end of the guideline information. If objective medical information for continued disability is supplied, the length of time allowed for that claim will be extended. But many firms no longer ask doctors whether a claimant is disabled or not. The main difference in today's world is that the claim examiner, along with the medical director, and the nurse case manager, will determine whether a claimant is disabled. It is not enough for a doctor to say a person is disabled. He must give the examiner what the person's abilities and limitations are and how they apply to this person's actual job. And the insurance examiner will determine whether the person is disabled. Approximately 10–12% of all short-term claims are impacted by duration management.

Another important facet of cost containment is medical site management or disability management. This involves intervention of medical staff or a medical vendor to provide coordinated management and early intervention on each person's claim. A critical success factor in the nurse's role is her ability to communicate with the various parties involved in the process. She must involve herself with the claimant and understand the person's feelings about their job and about returning to work. She also must be in contact with a health care provider to clarify the diagnosis and the treatment protocol. Much of this conversation deals with the ability to describe the specific job functions and how the claimant's disabilities or

limitations affect that area. The nurse must also communicate with the employer to discuss possible return-to-work options, work-site modifications, and job modifications. Much of the contact is done over the phone, but nurses also will go on site on an as-needed basis.

The next cost-containment program is vocational rehabilitation. Vocational rehabilitation is done by Master's-degree-prepared counselors dedicated to exploring return-to-work options for appropriate claimants. Rehab programs should be comprehensive and flexible so that they fit the needs of the claimants. Statistically 5–10% of all claimants are appropriate for vocational rehabilitation. The highest success rates are with employers that have active return-to-work programs. Many factors are taken into consideration to identify a good candidate for vocational rehabilitation, such as medical stability, liability, age, education, and experience, but most of all, their motivation. Some of the types of rehab being offered in the marketplace today are vocational counseling, where they offer support and encourage return-to-work options.

Worksite modifications. Building a rapport with the human resources department of employers is very important to enable the worksite to be modified so that the person can return to work. Transferable skills analysis is another area and this is used to determine the work options other than returning the person to his original employment. It is also used to assist the claim staff in assessing disability and eligibility for Social Security.

Job placement services is another area that the counselors will get into. They often work with state agencies to see what is available in an individual's area. Retraining and education are also considered. For those who do not have transferable skills, the goal is to return them to their pre-disability employment levels. Sometimes it is very important to offer education and training to them. This is the most expensive option, however, but it can be effective in returning people to work and reducing reserve dollars significantly. But when exploring this option, the liability of the claim must be looked into very carefully.

The fourth avenue of cost containment is Social Security assistance. Through this program, assistance in obtaining Social Security is offered to the claimant. Qualifying for Social Security is often an arduous process. They are already disabled. They are already having problems and sometimes the bureaucracy can get to them. Assistance can be offered through the rehab counselor, through Social Security attorneys and, also, Social Security advocates who will walk people through the process.

One of the primary goals of this program is to educate the claimant as to the advantages of applying for Social Security. Some of those advantages are: 1) they have been paying into the system all these years and finally are going to get some of the money back; 2) if they do not apply, the time out of work will be considered non-occupational years, and their actual retirement benefits will be reduced. This is one area that most claimants do not understand. They also become eligible for Medicare after two years. Another area that they are unaware of is that they can try to return to work on a trial basis and still receive their benefits for up to nine months.

Mr. Nixa: We've already discussed medical bill review and how that operates. Obviously there's a cost-containment feature on the workers comp side as well as the occupational medical network, so I won't go into that in more detail unless you have questions later.

Ms. Mormino: Management information is the final cornerstone that I wanted to discuss. Because almost all carriers are computerized, the availability of a wide variety of reports should be possible with most carriers. Some of the reports available should be duration studies, cause studies, diagnostic studies, and reserve studies. As you are aware, these are all important to the underwriters in their evaluation process. The dissemination of information allows the insurance carriers access to a wealth of information that assists them in the rating and underwriting process. Management information is, of course, used to determine the best course of action at the employer level as well.

Stewardship programs insure that plan or policy and benefit-level changes are reflected in their renewal process. This will also drive loss-control and prevention programs as well as focus other claim management efforts, for instance, fraud control. Also, where workers comp and group disability are combined, data can be sliced and diced in many ways to get a better feel for the effectiveness of prevention programs and to focus on individual locations, industries, and problems.

Mr. Jonathan M. Nemeth: Could you go into a little bit more detail on how durational guidelines work? My understanding is when a claim is submitted you'd look at say, the diagnosis, and figure out how long this person's supposed to be disabled. If the person's exceeding that time, what do you do?

Ms. Mormino: The question is to go into a little more detail about what duration management is and the disability guidelines. I think at this point most companies are looking at the fact that a doctor will not necessarily be looking at this particular individual's necessary time off the job due to whatever their medical problem or psychiatric problem might be, so disability guidelines were developed. They are

usually International Classification of Diseases-9th (ICD9) driven so that you have a standard code out there as to what the disability is. The medical professional will look at what is the average duration for that disability.

I think we're all pretty familiar with maternity guidelines where most companies will allow two weeks before maternity and six weeks after the birth of a baby, and that is pretty standard. Unless there is substantiated data to require that person go out early or stay out later than the six weeks, that person's claim would be limited to that window of possibly eight weeks. Usually what will happen is the examiner will look at the guidelines and if they are exceeded, call the doctor to find out why an extension is needed. The nurse case manager will get involved at this point. When the information comes in, it is reviewed by a medical person, as well as the claim examiner. Together they will look at the information and see whether it warrants additional time. Also, medical directors are usually brought in at this particular point. I think you have to remember these are guidelines and not hard and fast rules. There can be person A who can return to work in two weeks after a surgical procedure and person B who needs four.

Mr. Nixa: Just a note on guidelines themselves. I think there is recent confusion about the differences between disability guidelines and medical treatment guidelines. Disability duration guidelines are, in fact, simply that. They are guidelines for the duration of a specific disability based on the diagnoses.

Frequently, there are medical treatment guidelines and protocols, which sometimes include their own durations and are not necessarily the same durations that might be applied by a disability or a company carrier. Those are the durations that are identified as appropriate to that particular medical treatment. Available guidelines are out there today for disability durations, including those that were developed on a proprietary basis by the carriers, as well as the MDA guidelines, and Milliman and Robertson guidelines. There are also several firms out there that are actually changing their medical treatment guidelines to integrate those disability guidelines and then be able to utilize them for both workers comp and occupational disabilities.

Mr. John B. Davenport: One of the questions our claims examiners asked me before I came here was the ethical issue of settlement with your claimants and the response was that we should probably not pursue that in a very active way. Some of the uses that may be found would be if you want to settle small amounts so you don't have to deal with that administration or if the claimant wants to start up a new business and needs capital for it.

Ms. Mormino: I think settlements have their place in the disability arena. Once a person has reached their maximum medical potential and they are not going to have any further improvement and you have a long, long-term claim, there are many instances where the claimants themselves would prefer to have a cash settlement. Perhaps they have a child going off to college and need the capital. It has to be very clear, though, to the claimant that they must seek tax and financial advice as to what to do with that money. Again, this is the settlement for the disability and if they don't have a lot of other income coming in, they have to be very cautious about accepting a settlement. I know when we consider settlements, and the Hartford does consider settlements, we're kind of in the infancy stages of it right now, we will look at many different factors or whether the person has other income coming in. There are very often individual disability policies that might cover their actual financial needs and a lump-sum settlement might be a win-win situation for both the insurance carrier and the claimant.

From the Floor: You mentioned durational guidelines. You happened to bring up maternity as one. Are you seeing any movement toward denying the standard six-week leave for a very routine delivery and are you getting any pressure from clients to do so?

Ms. Mormino: Our experience is that we are not getting any pressure to do so. In the disability arena that we still look at, it is equal to a surgical procedure and still requires the six weeks postpartum. I have had no pressure from any employers that I am aware of.

From the Floor: Do you think it's being treated differently from other disabilities for social reasons?

Ms. Mormino: Well, maternity is treated differently. I mean, there isn't any other surgical procedure that we allow you to go out two weeks before you have your surgery.

Mr. Nixa: Actually I think you're probably experiencing more internal cultural issues. It's a very difficult benefit to change. There would be significant resistance to changing it, and I suppose you could say there are even moral and ethical issues that could be raised. At least there just doesn't seem to be a lot of movement in that direction.

Ms. Mormino: We're just beginning to have some clients questioning whether six weeks is always necessary, and I agree with you. There are a lot of other issues involved and a great deal of resistance.

Mr. Nixa: And have you asked them if they'd like to experiment with lesser time frames?

Ms. Mormino: Most of them would not like to be the first to do that.

Mr. Nixa: But they'd willingly take the data from someone else.

From the Floor: Right. My other question had to do with what you mentioned about a trend toward benefits of less than the 60%. Could you elaborate on what you're seeing.

Ms. Mormino: Actually you're seeing 50–60%. It's actually 60 and lower that we're seeing now. The 70% that was very popular probably five years ago is changing. I think a lot of it has to do with your residual and your partial benefits. Very often a person can be working part time, and if they have a benefit of 70% income, it doesn't pay for them to return to work even on a part-time basis. So you want to make sure that you're encouraging people to go back to work. It has to be at least monetarily better for them to return to work than to stay in the unemployed arena.

From the Floor: Are you seeing any movement on the part of employers to a lower, say a 40% employer-paid benefit on a buy off and an insured plan. What's your reaction to that buy-up piece as far as the risk?

Ms. Mormino: Well, with the buy up, usually at that particular point if there's a pre-existing clause in the contract, the buy up would be subject to that pre-existing, so the risk itself is probably not much different than when you have your initial policy.

From the Floor: Our workers compensation benefit system is a bit different in Canada, as I'm sure you're aware. We have provincial monopoly. Each province has their own workers compensation board, so I'm trying to understand how in Canada we could perhaps integrate the claims management between the occupational and non-occupational disabilities, whether that would be just at the employer's site or if the workers compensation boards and the insurance companies could work more closely together.

Mr. Nixa: To your knowledge is there any statutory barriers to those types of activities occurring today? Can you put claim payment processes together? Can you put non-occ and case management-type programs together, for example?

From the Floor: To my knowledge there is not, but I wouldn't be surprised if there were.

Mr. Nixa: I would say that the primary methods, of course, are to employ those very obvious activities we discussed. You should certainly be working with the regulators and carriers. Where there's an advantage to the overall cost reduction, demonstrate that on the regulator's side; they certainly are interested in worker safety, protecting the rights of workers, making sure that the employers are essentially not ripping them off or taking advantage of them, and providing the appropriate benefit. There are programs like rehab, for example, as I mentioned, and that's a relatively new program on the company side. Case management, on the other hand, is a relatively new program on the disability side. So those are obvious activities where training internal staff who perform those functions for a carrier or a TPA can actually result in improvements, not only in cost, but also in the efficiency of the system overall, which obviously benefits the employer.

Yet initially my focus would probably be on case-management-type activities because they have the greatest opportunity for improvement in those areas. Certainly regulatory and reporting kinds of issues are much more difficult, particularly for company. In the U.S., the company side is regulated by each individual state, and the group plans tend to be regulated through ERISA, so there's less imposition to regulation on the non-occ side. That doesn't really change the reporting requirements, but they don't tend to have any restrictions towards integrating services as long as people are appropriately trained and certified.

There are significant licensing issues in the U.S. for claim handling and claim adjudication. Many states require their claims not only be settled or handled within a state, but that they also be paid within that state. Many companies have gotten around that by putting a printer in that particular state to issue the check, but it does create significant licensing issues, particularly where you have to have a physical presence in that state in order to approve a claim. So those create some of the barriers to that integration as well.

From the Floor: What impact do you see in states where there's mandated short-term disability, such as California, New York, or New Jersey? How does that impact your duration management? I guess the second part of the question is, what latitude is there for duration management in states with mandated coverage, such as New York and New Jersey?

Ms. Mormino: Actually we have run into some problems with the statutory benefits. Very often if you deny any benefits that are asked for by a physician it goes to an appeals level, especially in New York. If it goes to the appeal level, very seldomly is the denial or reduction in benefit ever upheld. You end up paying the claim and paying a fine to the State of New York. You have to look very carefully as to whether you want to invoke duration guidelines in that environment. What

you would usually do for any type of case management on those types of claims is to really look at your medical costs very carefully. Scrutinize a little bit better for a fraud claim or something like that, because your duration guidelines will be negated by the statutory appeal processes.