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September 9, 2008

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Dear Ms. Kofman:

I am writing as an individual attorney who regularly represents claimants in disability cases. I appreciate your efforts to implement a list of "best practices" for disability insurers. While the majority of insurers with whom I deal perform a commendable job in adjudicating disability benefit claims, having uniform guidelines will undoubtedly make the process fairer and more predictable for insurers, claimants, judges and those who both represent insurers and those who represent insureds.

The following are my comments with respect to the draft prepared by the working group and promulgated on July 15, 2008.

### **DISABILITY INSURANCE CLAIMS HANDLING BEST PRACTICES DRAFT OF JULY 15, 2008**

#### **Training**

- All claim staff should be trained in the same way in the same documented procedures.
  - Claim staff should be instructed to utilize the documented procedures in every case
- Training materials should be routinely updated to reflect new issues and staff should be re-trained regularly.
  - The training materials should be updated both as to medical *and* legal developments
- Training should emphasize that adverse pre-disposition or bias against a claimant is unacceptable.
  - Training procedures should emphasize that financial considerations; i.e., the size of the claim, should never be considered; and that the insurer owes to the claimant the same and equal duty as it owes to itself.
  - Training should also point out that in cases governed by the ERISA law, the Supreme Court has made it clear that "ERISA imposes higher-than-marketplace quality standards on insurers" in order to achieve accurate claim processing (*MetLife v. Glenn*, 128 S.Ct. 2343, 2350 (2008)). There is no reason, however, to limit that standard to ERISA claims.
- Training should emphasize everyone's accountability for performing consistently with a written code of compliance.
- Successful completion of training should be documented and each student should affirm in writing understanding of and intent to act consistently with the code of compliance.

**-Training should emphasize the duties and responsibilities of claim analysts to weigh and consider all reliable evidence. When a claim analyst is unfamiliar with medical terminology and information in medical records, training should emphasize the need to utilize trained medical personnel, particularly physicians, in assisting in the evaluation of medical evidence**

### **Claim Organization**

Experienced claim staff should “sign-off” on claim denials and terminations of benefits.

**-No claim staff involved in the initial decision should be involved in any subsequent determination; and no deference should be given to any prior determination when a subsequent review or determination is being conducted**

Companies should create a separate compliance-accountability function involving highly experienced claim staff to be involved in the more complicated claims prior to a denial or termination decision.

**-The “compliance-accountability” staff should randomly review selected claim determinations to determine the accuracy of the determination; and if repeated inaccuracies are attributed to the same claim analyst, the analyst should be required to attend additional training**

Companies should create a claim audit function, reporting to senior management and ultimately the Board of

Directors, to evaluate compliance with claim procedures and law.

Senior management should evaluate claim staff based on compliance with claim procedures and not the number of

claims closed or whether benefits paid/reserved are consistent with the business plan.

Senior management should consistently reinforce the importance of claim professionals to the organization and

reward performance based on appropriate standards such as compliance with claim procedures, the training of

subordinates, and compliance with law.

### **Corporate Organization**

The organization’s commitment to compliance should be reinforced by establishing a Board of Directors function responsible for monitoring compliance.

Senior management, claim management, compliance management and the claim audit leadership should regularly report to this Board committee.

### **Claim Procedures**

Independent Medical Examiners should be selected solely on the basis of objective, professional criteria and without regard to the results of previous reports.

A code of conduct should be adopted for all medical professionals used by the company which includes a

commitment to provide fair and reasonable evaluations considering all available medical, clinical, and/or vocational

evidence, both objective and subjective, bearing on impairment. With each determination the medical professional

should certify that he or she has reviewed all the evidence provided.

**-The medical professional should also be required to perform an individualized assessment of the claimant and to articulate specific reasons for disagreement with contrary medical opinions. It is not enough to generalize with statements such as “lack of objective support,” “absence of**

measured functional deficits," or "other individuals with the same condition have been able to work."

**-Claimants should be accorded a reciprocal right to request an independent medical examination when an adverse determination is made with respect to a claim.**

**-Physicians selected to perform independent examinations or evaluations should be doctors engaged in the active practice of medicine and should not be physicians whose livelihood is primarily devoted to preparing reports exclusively for insurance companies**

**-All reports adverse to the claimant shall be provided to the claimant's attending physicians and to the claimant's counsel (if identified) who shall be given an adequate opportunity to respond to adverse findings in writing**

Claim staff should provide the medical professionals with all available medical, clinical and/or vocational evidence in the claim file, both objective and subjective, concerning impairment.

Significant weight should be given to the fact of a Social Security Disability Insurance award absent an error of law, inconsistency with applicable medical evidence, or inconsistency with the disability definition in the policy.

When co-morbid conditions are present, claim staff should ensure that all diagnoses and impairments are considered **in conjunction with one another** and afforded appropriate weight in developing a coherent view of the claimant's medical condition, capacity and restrictions/limitations.

**-Claim staff should not simply accept reports and recommendations of either in-house or outside claim reviewers or examiners. The entire record must be evaluated without particular emphasis on any piece of evidence; and a full and fair review accorded the claim.**

**-When performing a vocational assessment, transferable skills analyses and labor market surveys must take into consideration all documented physical, mental, and cognitive restrictions and limitations**

**-Vocational assessments must be based on a realistic evaluation of vocational opportunities and must take into consideration relevant vocational factors such as the claimant's age, education, work experience, and the claimant's ability to actually perform the identified occupation and not whether the insured *might* be able to perform the occupation if offered some hypothetical accommodation**

Very truly yours,



Mark D. DeBofsky