Suggested Best Practices Outline for Disability Insurance Claims Handling, September 8, 2008
for Consideration by the NAIC Consumer Protections and Innovations (D) Working Group

Insurance company claims practices have again recently been the subject of media attention and consumer complaints. The Working Group is considering whether voluntary best practices guidelines could befit both consumers and insurers by raising and clarifying standards for responsible claims practices. We look forward to work closely with the industry to ensure that any standards the NAIC might publish are realistic and consistent with what companies have already shown they are capable of doing. We decided to begin with disability insurance, since this is an area where claims decisions have a significant impact and an area where considerable work has already been done. In July, we exposed an outline for comments, based on a presentation at the Summer Meeting. The changes marked below represent a compilation of suggested additions and revisions that have been submitted for us to consider. We look forward to your continued input on this project.

Training

- All claim staff should be trained in the same way in the same documented procedures.
- Training materials should be routinely updated to reflect new issues and staff should be re-trained regularly.
- Training should emphasize that adverse pre-disposition or bias against a claimant is unacceptable.
- Training should address applicable law, including regulations, interpretive bulletins, and case law. *[CA]*
- Training should emphasize the importance of safeguarding protected health information. *[VT]*
- 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.

Claim Organization

- Experienced claim staff should sign off on claim denials and terminations of benefits.
- Companies should have robust quality review programs that thoroughly evaluate samples of open claims for compliance and customer service. *[Unum]*
- 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.
- 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.
- Companies should set up mechanisms for reporting ethical concerns anonymously, through third-party vendors. *[Unum]*

Claim Procedures

- Companies should develop detailed written procedures for handling claims, with an emphasis on providing fair and timely service. There should be a section identifying applicable legal standards, including statutes, regulations, bulletins, and case law. *[CA]*
- The company's written procedures should describe its practices for coordination of benefits and benefit offsets, including the fair and equitable application of any social security offset that follows a favorable determination of disability by the Social Security Administration. *[VT]*
- Claim procedures should be designed to provide a fair and prompt initial determination of disability and ensure timely payment of benefits due under the policy. Claim forms and authorization instructions should be clear and easy to follow, requesting all necessary medical and employment information as soon as possible without being invasive or burdensome. To the exent possible, company should be responsible for gathering relevant information at its own initiative and expense. *[NE, Unum, VT]*
- Claims procedures should provide covered individuals with the opportunity to submit written comments, documents, records, and other information relating to the claim for disability benefits. *[MD]*
- Claims procedures should contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the insurance policy provisions and that, where appropriate, the insurance policy provisions have been applied consistently with respect to similarly situated covered individuals. *[MD]*

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- Independent Medical Examiners should be selected solely on the basis of objective, professional criteria and without regard to the results of previous reports. Independent Medical Examiners should be certified in professional specialties appropriate to the care they are reviewing. Companies should have procedures for ensuring that examiners are free from influence by the claims department. *[TX, Unum]*
- 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, including any favorable evidence overlooked by the claimant. With each determination the medical professional should certify that he or she has reviewed all the evidence provided. *[Unum]*
- 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.
- Companies should give claimants the right to request independent medical examinations and notify them of this right early in the claims process. *[Unum]*
- Companies should seek input from attending physicians and the information they provide should be fairly interpreted and applied. Significant weight should be given to the treating physician's opinion. Obtain an objective independent opinion when company and attending physicians disagree. *[CA; San Francisco presentation]*
- Absent an error of law, inconsistency with applicable medical evidence, or inconsistency with the disability definition in the policy, deference should be given to the fact of a Social Security Disability Insurance award. *[MD, VT]*
- When co-morbid conditions (*i.e.,* multiple contributing problems) are present, claim staff should ensure that all diagnoses and impairments are considered and afforded appropriate weight in developing a coherent view of the claimant's medical condition, capacity, and restrictions/limitations.
- Claims should not be denied or prematurely terminated based on the type of medical condition without giving full consideration to all co-morbid conditions. *[San Francisco presentation]*
- Adverse benefit determinations should include explanations of the specific reasons for the adverse determination and identify the medical or vocational experts whose advice was obtained. *[MD]*
- Projections from average experience (*e.g.,* expected return-to-work dates) should be used only as a basis for further investigation and should not by themselves be considered grounds for denying or limiting benefits. *[San Francisco presentation]*

Appeal Procedures

- For all claims, whether or not required by law, companies should establish appeals procedures with the following elements: *[MD, Unum]*
  - Allow covered individuals at least 180 days to request an appeal of an adverse benefit determination, and establish consistent notice procedures and time requirements that are at least as favorable to the claimant as those required for ERISA claims under 29 CFR § 2520.104b-1(c).
  - Consider all information submitted by the claimant on appeal, whether or not the information was submitted initially.
  - Do not give deference to the initial adverse determination.
  - Require the appeal to be decided by someone who was not involved in the initial adverse determination.
  - If the adverse determination was based in whole or in part on a medical judgment, require consultation with a health care professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in connection with the initial adverse benefit determination.
  - Do not require payment of a fee or other cost as a condition of filing.
  - Do not require the claimant to submit to binding arbitration.

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