



SEPTEMBER/OCTOBER 2006

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FAST FACTS

97%

Workers who believe some level of disability income replacement is necessary

37%

Workers who actually have the coverage¹

20¢

The average cost to an employer for short-term disability, per \$100 spent on compensation and benefits.

Long-term disability is even less: only 10¢ per \$100. For comparison, health insurance is \$6.70 per \$100.²

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Employees who consider the benefits their employer provides as “very important” to their job satisfaction³

¹UnumProvident/Harris Interactive Survey, 2006

²U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits Survey, 2005

³SHRM Job Satisfaction Series, 2005

Changing Landscape at California Insurance Department

AS MUCH AS I'D LIKE to be able to write this story complete with its hopefully happy ending for all parties involved, my editor is pressing me to make our deadline. So, you can consider this article the current installment in the continuing story of the California Department of Insurance (DOI) and its efforts to require carriers to amend industry standard disability policy language.

In a newsletter article we wrote at the start of 2006, we summarized the key points of the story up to that time—the October 2005 letter from the DOI stating its intent to require that previously issued and approved policy provisions be modified to conform to current California DOI positions and suggesting that the DOI might even withdraw approval of previously approved forms that did not conform to current DOI positions, and the resulting lawsuit filed in November 2005 by trade organizations to try to prevent the DOI from enforcing those sorts of “underground regulations” without any duly enacted laws, regulations or formal administrative rules to support such action.

Our last article had speculated on the potential “legal and logistical nightmare” facing *continued on page 2*

The Appeals Specialist: Last but not Least

AN APPEALS SPECIALIST HAS A unique opportunity to improve the way a claimant perceives the company. In most cases, the Appeals Specialist is the last person to interact with a claimant prior to their seeking legal counsel, filing a Department of Insurance complaint, or seeking other avenues of resolution. A claimant's experience with the appeals process, and in particular the Appeals Specialist, frequently sets the tone for all future interaction. Even if a claimant believes the wrong decision has been rendered, he or she can and *should* feel respected.

Taking the time to answer questions and explain the appeal review process is as important as the process itself. No matter how much time and effort is put into an appeal review, one of the keys to good customer service is whether or not an individual feels as though they have been afforded a full and fair review. Good customer service can be as basic as providing timely, honest answers to questions and taking the time to keep individuals informed—whether they make an inquiry or not. For most Appeals Specialists, a typical day can range from quietly reviewing files and drafting appeal determination letters to rushing around fulfilling requests for claimants' attorneys, getting file documentation in order for peer reviews, making peer review referrals, requesting documentation, drafting status letters and taking telephone calls. Documentation of such communication is a vital part of a file in demonstrating fair claims practices.

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California Insurance Dept. (cont. from front page)

the DOI if it revoked prior approvals, which is an action rarely taken by insurance departments. We voiced concern with the possible “administrative logjam” that would ensue from the onslaught of re-filings and new filings from carriers intent on retaining access to the market in the country’s most populous state. And we expressed hope that California might implement a filing review process utilizing compliance “certifications” by company officers to expedite reviews and reduce the filing backlog and delays with new product approvals for which the DOI had become notorious in the last 10 years or so.

As most are aware, the DOI lawsuit was resolved in a Settlement Agreement dated July 21st. In the settlement, the DOI agreed to not revoke prior approvals for carriers who agreed to submit revised forms that conformed to provisions as detailed in the settlement within 60 days. The settlement expressed that it was the “intent of the parties that new and amended policies consistent with the terms of the Settlement Agreement will be in place by December 20, 2006 or roughly five months from the effective date of the Settlement Agreement,” and recognized the pricing and administrative implications of the changes by allowing for a “phased-in” approach (i.e. tied to rate renewals) for amending in-force group disability policies. And the DOI agreed in the Settlement that it would not use these re-filings as an opportunity to require amendment or removal of other previously approved provisions not specifically touched on in the Settlement as a condition of approval.

So where are we now?

Well, to quote Mick Jagger, “You can’t always get what you want.” At least not everything you want, anyway. California has not, at least publicly, communicated its plans on how it will manage the wave of filings that the DOI Settlement indicated were due by September 19th. Some of the same key figures at the DOI who have led the recent efforts at “underground regulation” remain at their posts. There really is no way to foretell what will happen once the filings hit the DOI examiners’ desks.

But let’s look at this all in context. A year ago, as part of the UNUM settlement, the DOI had required wholesale changes in policy provisions used by the industry leader. The DOI had then widened the scope of its efforts to include the rest of the industry—and not just for new forms going forward, but for existing policies too. And the DOI took these actions without any specific state laws, regulations or rules that specifically addressed the provisions deemed objectionable—which was one of the key points made in the lawsuit the trades filed on behalf of the disability industry.

The result might have led carriers to increase rates significantly,

by perhaps as much as 46% in the opinion of one leading actuarial firm. Several industry standard benefits and provisions were going to be prohibited. A number of carriers could have decided to abandon the California disability market. The impact on consumers (remember them?) would have been higher prices, fewer carriers in the market, restricted product choices and decreased competition.

But in the wake of the Settlement, there are signs that the landscape has changed quite a bit from last October. Most importantly, the DOI has expressed in writing the types of wordings that it deems acceptable for key provisions such as disability definitions, pre-existing conditions limitations and other income benefit offsets. No more “deskdrawer regulation” and “unwritten departmental position” as the basis for kicking back filings. DOI blessing was given to estimating offsets, subject to certain conditions. And at least until California mobilizes legislative and rule-making resources and efforts, the DOI has agreed to not block continued use of provisions such as “additional benefit triggers” and survivor income and pension supplement benefits that the DOI had threatened to revoke approvals for last October. And the DOI agreed to abide by the final outcome of a prominent disability carrier’s lawsuit as the basis of determining what, if any, type of “discretionary authority” wording would be permitted in policies.

...the landscape has changed quite a bit from last October.

The DOI deserves credit for working with the industry to establish for the first time some comprehensive written guidelines and standards for acceptable policy provisions. And the DOI’s apparent intent to hold further hearings and follow the rule-making process for promulgating regulations establishing other policy wording standards is another positive step. Could it be that a new day is dawning in California for disability carriers and their policy provisions?

Is this an overly rosy view? Especially in an election year? Maybe. We will see, starting pretty soon. But things like this make it fun to be a compliance person. And they give us an opportunity to make valuable contributions to our businesses, while demonstrating the value of what we do and what that adds to our businesses. So bring on the next challenge!

We are eager to hear your thoughts and your own experiences in this matter. So feel free to contact me at (860) 751-7160. And tune in to the next newsletter for the next chapter in the continuing story. ■

Mark Murphy is the Director of Compliance for Custom Disability Solutions

Just as it is the last chance for improving customer relations, the appeal review process is also the last chance to perfect the administrative record. The claim file “is what it is,” and should “speak for itself.” That is, an Appeals Specialist cannot

Even if a claimant believes the wrong decision has been rendered, he or she can and should feel respected.

change what is already in the claim file; if documentation is incomplete or inaccurate, it remains part of the file. While you can’t change “what it is,” the Appeals Specialist can, in the appeal process, make sure that when it “speaks for itself,” it reflects fair claims practice. This can include such actions as following through on steps initiated but not completed, documenting the rationale for a change in claim direction, following up on outstanding file documentation, obtaining additional information or perhaps requesting a Labor Market Survey to complement an Employability Assessment.

Communication: Diffusing the Situation

It is the responsibility of the Appeals Specialist to remain objective, to diffuse volatile interactions and to make the most informed determination possible. One way to achieve this is by being open and honest with the claimant. Setting the tone begins with the first encounter, whether it is in writing or by telephone. Trust can often be earned by demonstrating willingness to listen, and by letting the claimant know that his or her claim will be reviewed without prejudice.

While communication from claimants is often emotionally charged, it is often very understandable. Their claim has been denied, or their benefits have been terminated; yet, the claimant feels they are completely unable to return to work. As a result claimants may have feelings of anger, vulnerability, sadness, frustration and mistrust—to mention just a few.

One effective way of developing sound communications with the claimant is to articulate the importance of following policies and procedures to ensure that no details of the case were overlooked. Using variations of the following, is one way of beginning an open and honest dialogue with claimants:

“I am not saying that you are NOT disabled; what I am saying is, we do not have the information on file that is necessary to support your claim.”
“I understand your position; however, we have a responsibility to maintain the integrity of the policy and if information was not on file to support your claim, the person handling the claim had to do what

s/he believed was right in order to administer the policy accurately.”

An approach like this helps to convey a sense of impartiality to the claimant, and helps them understand that decisions are based on contractual obligations, not on personal feelings. Including the claimant in the process helps to keep lines of communication open and honest. In the event that the final outcome is not favorable to the claimant, they will hopefully have the confidence that you were working with them, not against them, and that they were treated with respect.

The Opportunity and the Challenge

The opportunity is to do the right thing; the challenge is to do the right thing by the claimant, your employer, the client company and yourself—all at the same time. It is not always going to be black and white, and there are many shades of gray. It is the responsibility of the Appeals Specialist to weigh and consider all of the information on file; to understand the intent of the Policy; to render a determination that demonstrates knowledge of the claim facts and relevant Policy provisions; and to communicate it in a manner that is clear, concise and objective.

If you handle each claim with the same amount of objectivity, integrity and attention to detail, you can feel confident that you are demonstrating fair claims practices. This means treating everyone as an individual, while treating all individuals the same.

In a small organization, it is a challenge from an appeals standpoint to maintain a sense of autonomy from Operations. One approach to functioning in such a setting is to know and embrace the responsibilities of the position and to reinforce to others that the Appeals Specialists have a certain job to do. Appeals Specialists should realize early on that it is the determination that may make someone unhappy and not the work and responsibilities that they perform on a daily basis. While the Appeals Specialist is certainly not the most well liked position in a claims organization, they perform a necessary function that impacts the entire organization.

...treating everyone as an individual, while treating all individuals the same.

Appeals Specialists have a great opportunity to positively impact the company, the client companies they may serve, the benefit consultants and case managers who have been on the front end of the claim and to the staff members of the Training and Best Practices teams.

The opportunities within the company lie in providing constructive feedback when appropriate and positive feedback when deserved, while identifying opportunities for improvement on both an individual and operations-wide basis. Positive feedback provides a feeling of competence and confidence, which, I believe, encourages overall job satisfaction and dedication. The opportunity to be a source of such feedback is a privilege.

Guiding Principles

Some of the guiding principles I have learned along the way include the following:

- Do the right thing by the claimant, your employer, the policyholder and yourself. This sometimes means ceasing work on a determination letter, going back and doing additional work on claim or further evaluating policy intent, before either completing the letter or rendering a different determination than you previously believed to be appropriate.
- Remember the disability determination is likely to have great impact on the claimants' lives and those around them—it is only natural that they are anxious and emotional.
- Keep your promises
- Take the whole person into consideration
- Remember that while an individual may be rude and insulting, they still may also be eligible for benefits.
- Many of us are but a broken arm away from being on the other end of a claim form; treat others as you would like to be treated.
- Trust your gut feeling, but at the same time, remember the facts on file.
- Only say over the phone or on paper that which you would say to the person's face. This goes for both internal and external customers.
- Remain objective.

There is something to be learned every single day, and very often it comes from the most unlikely of sources. ■

Susan Colinet is a Senior Appeals Specialist at Custom Disability Solutions

Your Feedback Counts!

We are interested in what you have to say about our newsletter and we want to hear from you. Please send your feedback, comments or suggestions to CDS_Marketing@customdisability.com.

CDS News In Brief

On September 25, 2006, Custom Disability Solutions successfully completed the relocation of our offices. A key factor in our decision to move was the positive impact a fresh start in a new facility would have on our employees. Our new address is 600 Sable Oaks Drive, Suite 200, South Portland, ME 04106



Strong leadership is a critical component for building a successful organization. Strong leaders define the culture, values and integrity of a company. Over the last few months, Custom Disability Solutions President and CEO Jerry Bannach has cultivated a Senior Leadership Team that is focused in advancing the mission and business goals of our organization. The Custom Disability Solutions Senior Leadership Team consists of:

- Roxanne Bergland – Director, Business Development
- Brian Cooke – Director, Marketing and Client Management
- Shawn Dutremble – Director, Underwriting
- Keith Lambert – Manager, Underwriting
- Paul Fields – Vice President and Chief Finance Officer
- Tony Michaud – Director, Claims
- Dean Rosingana – Leader, Communications and Public Relations
- Jennifer Simpson – Human Resources Representative
- Bill Sproul – Director, IS Operations
- Tim Meyer – Director, Actuarial Services

Have a Story Idea?

We are always looking for story ideas and guest authors. If you have a story idea or would like to contribute an article to *The Source*, please contact Dean Rosingana, Communications and Public Relations Leader at (207) 400-3553 or via e-mail at drosingana@customdisability.com.



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