

the SOURCE

SUMMER 2009

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Poor Economy Means More Work For Special Investigation Units

By: Jennifer Agger, CDS Special Investigations Unit
Coordinator

The following article appeared in the the May 18, 2009
issue of National Underwriter

Desperate times often lead to desperate measures.

During difficult financial times, employees know that losing their jobs through layoffs, attrition, shutdowns and closures is a strong possibility. The uncertainty of today's economic climate, coupled with the burden of having limited personal resources and savings to draw from in the event of becoming unemployed, may lead some employees to file fraudulent disability claims. These employees may feel that they have nothing to lose. While employers and employees in insurance special investigation units, or SIUs, and fraud divisions are always vigilant, their role and importance becomes magnified during difficult economic periods.

The National Association of Insurance Commissioners' model anti-fraud law requires insurers to include the following statement on all applications and claim forms, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison." Not all states have enacted the law, and some states have their own version of this wording, but it does provide at least a baseline for what constitutes fraud.

Those who file fraudulent claims represent a broad spectrum of people, and are not limited to one industry or occupation. We often find fraudulent claims filed by real estate agents, sales representatives, and other commissioned employees. We are seeing individuals from these sectors come up with creative ways to supplement income to make up the revenue they lost from the poor economy.

Employees may now consider filing a disability claim for ongoing medical conditions they may have worked with for years, especially if this means that a disability benefit may supplement their sudden loss of income and save them from foreclosure on their home.

Here's a hypothetical case of a construction worker who specializes in home additions. A few years back, this construction worker was in high demand and booked with jobs more than two years in advance. However, today, this same worker does not have any jobs booked and is not pulling in nearly the same amount of income.

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Our construction worker also has rheumatoid arthritis (RA), but he has always found a way to work. Now with no jobs and a reduced income, our worker decides he can't work with RA anymore. He decides to file for disability knowing that his benefits will be based on his higher income levels from previous years. It is certainly possible for medical conditions to worsen over time. However, fraud units and claims examiners need to review filed claims to ensure that the insured truly cannot work and that insureds are not filing to make up for the lost income. While disability benefits only pay a percentage of pre-disability earnings, under some policies this percentage may be based on past months' (even years') income and could be more than the employee makes in today's market.

No matter how difficult their financial situation may become, the majority of people would never consider filing a disability claim. However, as finances become tight, they may opt to reduce the amount of income they spend on medications, physician visits and appropriate treatment for their ongoing conditions. Over time, employees choosing this route will undoubtedly put their health at risk.

In a recent study conducted by the NAIC, it was discovered that 22% of consumers surveyed had reduced their number of physician visits in order to save money. We could now begin to see an increase of legitimate disability claims filed because medical conditions have deteriorated from the lack of proper medical attention. Although these individuals are not thinking of filing a possibly "fraudulent" claim, additional reviews and investigations are initiated.

We ask the question, "What has changed in the insured's treatment and condition that has them having to stop work?" While the claims examiners assigned to the disability claims are the ones responsible for making a decision on the claim, fraud unit resources and investigative vendor support conduct treatment/pharmacy canvases, surveillance, field visits and onsite interviews. In addition to individuals filing new fraudulent disability claims, during periods of economic decline, existing disability claims also have potential for fraud. We have seen increases of malingering, the intentional omission of information, and employees exceeding the expected recovery duration.

For example, an insurance agent is out on LTD as a result of a back injury, which required surgery. The expected duration is 3 to 6 months. At the 6-month recovery mark, the sales agent is clinically expected to recover. However, now the economy is bad, sales are slow, and the industry is bottoming out and our sales agent decides that it is better to remain on claim and 'chooses' a co-morbid condition like depression, fatigue, or lack of conditioning to remain on claim. Our sales agent is malingering (loitering). Our crafty sales agent may even plan to return to work for another employer while malingering to collect both a disability benefit check and a pay check.

Case In Point

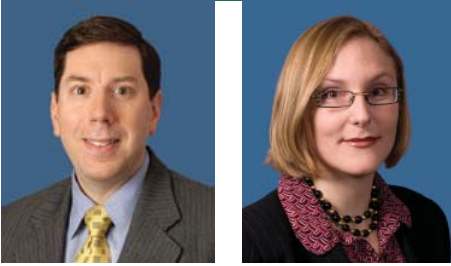
In early 2008, we heard about the case of the former Albany, N.Y., teacher. She was well respected and even nominated for a national teaching award. She informed her employer and the community she was dying of cancer and collected over \$100,000 in health and disability checks. She even went to such lengths as to shave her head so that others would buy into her story that she was dying and receiving chemotherapy.

The teacher's scheme began collapsing when her former colleagues in New York learned of the nomination and read an article describing her thought to be heroic community and school contributions. She was supposed to be at death's door, not teaching. The authorities were called in. She admitted she did not have cancer, nor did she ever. She was convicted and sentenced to prison.

I recently worked on a case where a very ill claimant had been on long-term disability claim for over 8 years for progressive multiple sclerosis, and, due to her condition, we only updated her medical status yearly. During our yearly review of the claim, I requested updated medical records. The claimant's paperwork was returned with a hand written note on it stating the claimant "had deceased." After investigating this further to determine if there were any survivors, I discovered the claimant died more than 10 months ago. The claims examiner confirmed that the deceased continued cashing the disability from the Great Beyond. My investigation concluded the claimant's neighbor was intercepting the mail and fraudulently cashing her checks at the local check cashing corner store. The neighbor had stolen nearly \$12,000 in checks.

If they have not done so already, carriers and SIU divisions across the country can take steps to prepare for the potential increases in fraud by implementing a toll-free fraud tip hotline, include fraud warning paragraphs on all forms they send to claimants and warnings on disability checks. These fraud warnings can serve as deterrents to potential perpetrators. Local, state and federal authorities are taking fraud seriously and I have seen improvements in online fraud reporting, which makes it easier for people to report fraudulent actions. Tighter laws, stricter claim workflows and training around what are potential "red flags" are also helping to increase the identification of suspected fraud.

Fraud is an issue for everyone – insurers and insureds alike – because the costs of disability fraud are eventually shared by everyone involved in obtaining and maintaining a disability policy. ■



MetLife V. Glenn - One Year Later

By: Joshua Bachrach and Edna S. Bailey

INTRODUCTION

Approximately one year ago, the Supreme Court of the United States issued its decision in *Metropolitan Life Insurance Company v. Glenn*. The Court's decision confirmed that where an ERISA plan grants discretion to a fiduciary to interpret the plan and/or make eligibility decisions, courts are required to review the fiduciary's claim decisions deferentially. This is referred to in different jurisdictions as the "arbitrary and capricious" or "abuse of discretion" standard of review.

However, agreeing with the United States Court of Appeals for the Sixth Circuit, the Supreme Court further stated that when the fiduciary has a conflict of interest - such as where the fiduciary makes claim determinations *and* pays benefits out of its own assets - that conflict must be taken into account in determining whether the decision was arbitrary and capricious. Thus, the Court's decision applies to all employee benefit plans in which a plan insurer with discretion is responsible for deciding whether benefits are payable.

IMPACT OF GLENN ON STANDARD OF REVIEW APPLIED BY COURTS TO ADMINISTRATORS' CLAIM DETERMINATIONS

Even before the decision in *Glenn*, most federal courts held that insurance companies that both insure ERISA plan benefits and make claim determinations operate under a conflict of interest. What was less clear was exactly how that conflict affected the standard of review that was applied by the court.

Prior to *Glenn*, many circuits utilized a "sliding scale" or "heightened scrutiny" test, lessening the amount of deference given to the fiduciary's decision in accordance with the weight the court assigned to the conflict - at times to the vanishing point. This is no longer permissible. *Glenn* made it clear that there are only two standards of review that may be applied to the judicial review of a claim determination:

- (1) the abuse of discretion or arbitrary and capricious standard of review when there is a grant of discretion; or
- (2) *de novo* review when there is no discretionary authority.

In general, under the arbitrary and capricious standard of review, the court must uphold the plan's determination unless it was without reason, unsupported by substantial evidence or erroneous as a matter of law. This is true even if the court would reach the opposite conclusion if it was reviewing the claim without deference. Moreover, the court's review has traditionally been limited to the record that was available to the plan at the time of its decision.

Under the *de novo* standard of review, the majority of the circuits confine their review to the record at the time of the decision. However, the question before the court is whether the claim determination was wrong.

POSSIBLE CONFLICT OF INTEREST IS MERELY A FACTOR FOR THE COURTS TO CONSIDER

Under the arbitrary and capricious standard, the conflict is just a factor in assessing whether the plan's decision was arbitrary and capricious. That is, neither the standard of review nor the burden of proof is altered by the presence of a conflict. Only in close cases will the conflict of interest be important to tilt the scale in favor of a finding that the administrator abused its discretion.

The Court in *Glenn* emphasized that the relative significance of the conflict - i.e. the weight given to the conflict - may be higher or lower, depending upon the circumstances and facts of the particular case. In fact, the conflict factor may be less significant (perhaps even to the vanishing point) where the plan has taken active steps to reduce the potential for bias and to promote and ensure the accuracy of claim determinations. After *Glenn*, courts have recognized that the following actions reduce the conflict of interest:

- (1) claim examiners give no consideration to the number of claims they have approved or denied,
- (2) compensation for claim examiners is not related to the number of claims approved or denied,
- (3) examiners have access to independent counsel for advice during the claims process,
- (4) the lack of any procedural irregularities during the claim review,
- (5) offering two administrative reviews of the initial determination, and
- (6) involvement of different physicians at each stage of the administrative review process.

CONFLICT MUST RELATE TO THE ACTUAL CLAIM DETERMINATION AT ISSUE

The Supreme Court in *Glenn* further indicated that the conflict increases in importance "where circumstances suggest a higher likelihood that it affected the benefits decision, such as where

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an insurance company has a history of biased claim determinations.” Courts have interpreted this language to mean that a general conflict of interest, without any evidence that it impacted the claim determination, should normally not be given enough weight to act as a tiebreaker.

IMPACT OF GLENN ON SCOPE OF DISCOVERY COURTS WILL ALLOW IN ERISA CASES

The Supreme Court did not address whether a conflict of interest opens the door for claimants to seek and utilize evidence from outside of the administrative record during claim litigation. However, this issue has generated a great deal of discussion following *Glenn*. Prior to *Glenn*, a number of district courts had already allowed claimants the opportunity to conduct discovery on the issues of conflict and bias in cases subject to the arbitrary and capricious standard of review.

These courts have read *Glenn* as confirmation of allowing discovery on these issues. Some courts have permitted discovery on such topics as the number of times an outside reviewer has offered an opinion to the decision maker and the amount of compensation received, service agreements with outside medical review companies, compensation received by claims examiners including whether bonuses are paid, claims manuals and training documentation, and statistical data regarding claims examiner's performance.

Other courts have taken a much narrower view of discovery since *Glenn*. Some courts have stated that a claimant is not entitled to conflict of interest discovery unless it is first shown that the claim decision is a close call. However, even those courts that allow discovery generally limit it to the actual claim determination and do not allow broad fishing expeditions into a company's general finances, practices or procedures.

CONCLUSION - TRANSPARENCY, BUT AT WHAT COST?

While the impact of *Glenn* should ultimately increase the transparency of the decision making processes, thus, improving the reputation of the industry, this will come at a price. Contrary to the Supreme Court's repeatedly articulated goal of speedy and efficient resolution of ERISA benefit disputes and its warning against adding time and expense to a process "that may already be too costly for many of those who seek redress," *Glenn* will likely increase the costs of defending ERISA benefit claims. ■

New Financial and Legal Services Enhance CDS' EAP Offering

We know that work is stressful enough without life's added pressures. Our Employee Assistance Program provides services to help ease life's stresses. We recently upgraded our EAP offering by adding several new Legal and Financial services. Our new services include:

- Legal consultations with network attorneys or mediators - one initial 30 minute face-to-face or telephone consultation per separate legal matter per year within network at no cost
- Discounted rates up to 25% for use of network attorneys or mediators
- Discounted rates up to 10% for use of network attorneys for telephonic and online assistance with legal documents
- Simple Will Preparation Kit: Request forms, fill out questionnaire and return, will is prepared and sent back at no cost. For more complex will preparation a 25% discount is available if a network attorney is used
- Financial consultations with network professionals - one initial 30-minute face-to-face or telephone call per separate tax issue per year within network at no cost
- Discounted rates up to 25% for use of network provider for personal income tax preparation
- Assistance with credit counseling, budgeting, tax planning, retirement and college tuition planning
- Unlimited access to website covering legal and financial topics

For more information on our EAP services and service options please contact us at 1-877-646-8708. EAP services provided by Resources For Living - www.rfl.com

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Elevator Speeches and Value Stories

30 Seconds to Impress

By: Sheri Bonnell, CDS Marketing and Product Analyst



You know the classic scenario - That awkward feeling you get when you step into elevator with one other person. You make eye contact, acknowledge each other's presence and start calculating your credentials in your head in case a conversation strikes to pass those 30 seconds to the next floor. 30 seconds. 30 seconds to impress a stranger, who may or may not be interested in what you have to offer. But, what if they are? What if those 30 seconds lead to a potential business opportunity for your company?

Knowing your elevator speech is a key promotional tool to implement when selling yourself and your company. This same notion can be used when selling disability insurance.

Disability insurance?

In a highly competitive environment, with prices driving the decision making process, with the lowest costs usually taking the business, you may be asking why an elevator speech, or "value story" will increase your position as a thought leader in the industry and help you proactively offer disability products to clients.

The answer is: Your value story enhances your marketing strategies. Without a value story, how do you differentiate, besides price, from your competitor?

"Over the past 24 months, we've seen a dramatic swing in our clients' sales and marketing staffs' focus on their value stories," says CDS Client Support Services Manager Jim Pocheban. "The competitive environment and its frequent bargain basement rates have prompted savvy brokers to wonder how low-rate carriers can survive and better service their coveted clients in the long run. So a sales rep's ability to deliver a solid and sensible value story has more power and leverage over rate than ever before."

So, what's in a value story? When you can't answer these questions, you may want to start thinking about developing one.

- What do you stand for?
- Do you know what you do?
- Do you know your disability products?
- Do you know the importance of disability?
- Do you know how to answer service questions?
- How important is customer service?

What resources can you pull from when developing a value story?

- Company mission statement
- Company vision
- Claims staff
- Marketing staff
- Product Management staff
- Sales Representatives
- Underwriting staff



While you may have the best price in the market, not fully understanding your product and services could impact a potential client's perception of the value and credibility you bring to their business plan.

CDS Marketing staff has recently added the development of value stories for their clients as a free client support service. By creating, tailoring and explaining disability products and plans in a cohesive package that emphasizes a client's value story, the client's sales team has a guide to use when introducing disability insurance to a prospect's overall benefits mix.

"Once a value story has been developed, it is extremely important that everyone in the company is onboard with the value story and knows each of its key points by heart," says CDS Director of Marketing and Communications Dean Rosingana. *"It could be very damaging to a company's image and ability to sell its products if employees are sending mixed messages to the industry about the company's core values."*

Therefore, at your next management meeting, include a value story on the agenda. Learn your company, know your products and develop a value story to implement into a marketing strategy that benchmarks you with your best competitors. Step on that elevator and welcome the awkward conversation to the next floor, then press the button and continue rising.

Next edition... Marketing Strategy Techniques ■

CDS Partners with the Maine Chapter of the National MS Society to Sponsor Harborfest 2009

In 1982, Merle Hallett of Handy Boat and Dan Wellehan, of Sebago, Inc., organized and launched the first MS Regatta. Twenty-eight years later, the Regatta has grown into a four-day festival of sailboats, powerboats, and tugboats—under the banner of the MS Harborfest—and all for the benefit of the Maine Chapter of the National MS Society.

Since its beginning, the MS Harborfest has attracted hundreds of skippers and volunteers who have raised nearly \$2 million to help end the devastating effects of multiple sclerosis. The MS Harborfest includes the largest charity sailing event in New England. Weekend activities include sailboat, tugboat and powerboat parades, waterfront displays and exhibitions, a charity auction, a tugboat muster and competition, a shoreside festival, a sailboat regatta, a powerboat poker run, and post-event parties and award ceremonies. 2009 marks the 28th Anniversary of the MS Harborfest.

About the Maine Chapter of the National MS Society

The Maine Chapter of the National MS Society, operating from offices in Falmouth and the Bangor area, serves approximately 3,000 families living with MS in Maine. Nearly one in every 400 Maine residents has been diagnosed with MS, a prevalence rate substantially higher than the nation as a whole. The Maine Chapter offers information and education, financial assistance, care management and peer and group support.

About Multiple Sclerosis

MS interrupts the flow of information between the brain and the body and stops people from moving. Symptoms range from numbness and tingling to blindness and paralysis. Most people with MS are diagnosed between the ages of 20 and 50, with more than twice as many women as men being diagnosed with the disease.

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 to *The Source*, contact Dean Rosingana via e-mail at: drosingana@customdisability.com.

Your Feedback Counts!

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