2015 AAIM TRIENNIAL

INTRODUCTION TO DISABILITY INSURANCE

(UNDERWRITING AND CLAIMS)

Joel Weiner, MD, FACP
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Northwestern Mutual®

Major Differences Between Life Insurance and Disability Insurance

Issue	Life Insurance	Disability Insurance
Length of existence/ experience	**~1800's**	**~ mid 1900's (1960)**
Perspective / Focus	• Histories: bursitis, tendonitis, who cares negative evals gen. favorable • Medications-NSAIDs, who cares • Occupation-less relevant • Wider demographic: pediatric and individuals > 65	• Histories: bursitis, tendonitis– DI cares negative evals (functional) • Medications-NSAIDs- DI cares • Occupation-very relevant • Ages 18-65 (in general)
Sources of Underwriting	• Medical Requirements *[medical history questionnaire, blood, urine, saliva, medical records, paramedical and medical exams, EKG, GXT]* • Unique Life Requirements: functional assessment in older individuals	• Medical Requirements *[medical history questionnaire, blood, urine, saliva, medical records, paramedical and medical exams, EKG, GXT]*

Major Differences Between Life Insurance and Disability Insurance (cont.)

Issue	Life Insurance	Disability Insurance
Standard Setting	• Well-established mortality methodology • Clinical literature can be very helpful • Significant amount of available data on common underwriting issues	• No universally accepted morbidity methodology • Clinical literature is not as beneficial as in life insurance • In general, less data is available due to less years in existence as well as fewer morbidity studies
Factors affecting claims	• Health • Avocations • Accidents	• Health • Avocations • Accidents **PLUS** • Occupational duties • Financial factors (loss of income) • General economy • Contract language • Motivation • Job satisfaction

Major Differences Between Life Insurance and Disability Insurance (cont.)

Issue	Life Insurance	Disability Insurance
Outcome	• 1 possible outcome, 1-time only • Endpoint is well-defined and straightforward	• Multiple potential endpoints (partial, total, total for own occupation) • Individual can come in on claim more than once for the same or different impairments • Endpoint is not always clear or straightforward
Who Benefits	• Income replacement for beneficiary/ies	• Income replacement for the individual (in general) • Potential for secondary gain

Major Differences Between Life Insurance and Disability Insurance (cont.)

Issue	Life Insurance	Disability Insurance
MD role	• **Underwriting:** Assessing the mortality risk of health impairments, signs/symptoms, test results through standard setting and case consultations • **Claims:** Very limited claim involvement-- suicide, accidental, early payment benefit	• **Underwriting**: Assess the morbidity risk of health impairments, signs/symptoms, test results through standard setting and case consultations • **Claims:** Assess whether there is medical support of limitations/restrictions A different MD may perform the underwriting function and claims function

DI UNDERWRITING

DI Underwriting - General

- Products include individual (IDI), multi-life, DOE (disability overhead expense), Buyout, Keyperson, Group, Guaranteed Issue
- Beginning Date (BD): 31, 61, 91, 181, 366 days
- Typical duration to age 65 or 70
- Common benefits include:
  - APB (additional purchase benefit): the applicant can increase the benefit amount by a given value, provided they financially qualify
  - FIB (Future Increase Benefit): benefit amount increases when not on claim (commonly 3-6%, cost-of-living adjustment)
  - IIB (Indexed Income Benefit): benefit amount increases when on claim (commonly 3-6%, cost-of-living adjustment)

Potential Medical Underwriting Actions

- Standard (Best class)
- **Ratings**: extra premium charge; may or may not impact the benefit period
- **Medical exclusion rider**: contract provision that limits disability coverage for a well-defined morbidity risk, e.g., lumbosacral spine rider (no extra premium charge)
- Combination of ratings and rider/s
- Decline

Ratings vs. Riders

Riders

- Medical Exclusion Riders: contract provision that exclude a specific medical risk from coverage
- Riders do not incur an extra premium charge

Ratings

- An extra premium charge: the higher the rating, the higher the charge
- Ratings can be associated with limited benefit periods (commonly 5 year and 2 year)

Medical Exclusion Riders

- Used for well-defined, stable conditions and/or localized findings, e.g., biopsy-proven Barrett's esophagus, cataract
- Symptoms should be well evaluated, stable with limited or no treatment
- Complications of the condition should be covered under the umbrella of the rider, e.g., Barrett's-- esophageal cancer,
- In general, only the condition and currently affected area can be ridered. *Example*: musculoskeletal conditions
- Need to consider relationship between the rider and its occupational impact, e.g., dentist with CTS *[is a rider alone sufficient?]*

Medical Exclusion Riders (Cont.)

Examples Where Riders Work Well

- Stable, biopsy-proven Barrett's esophagus
- Isolated, senile cataract
- Well-controlled, stable low back pain

Example Where Riders Typically Don't Work

- Functional disorders (IBS, fibromyalgia, vestibular hypofunction)
- "Symptoms in Search of a Diagnosis"

Reconsideration on Cases with Adverse Underwriting Action (Rating, Rider, Declination)

Factors to Consider

- Natural History: Isolated vs. recurrent intermittent vs. chronic
- Duration of symptoms when active
- Severity of symptoms when active
- Relationship of risk to the occupation
- Degree of diagnostic findings (e.g., x-ray findings, biopsy findings)
- Presence of co-morbid conditions

Reconsideration (Continued)

Reconsideration

- If reconsideration can be offered, when to offer (how many years)
- Terms of Reconsideration [explicit]
  - Interim history
  - Symptom and treatment-free
  - Symptom free on a stable treatment regimen
  - Interim testing
  - Interim visit to a specialist

DI CLAIMS

Who Determines Disability?

- **The “claims” MD?**
- **The treating MD?**
- **The affected individual?**
- **The disability claims analyst?**

Restrictions versus Limitations

Restrictions are Risk-Related

- Recommend avoidance or modification of principal duties based upon **probable** recurrence, exacerbation or progression of diseases if duties are resumed [“imminent risk”]

Limitations are Loss-Related

- Inability to perform a principal duty due to disease/injury

Restrictions versus Limitations (Cont.)

Restrictions

Activities the individual "should not" do
(Safety threat to self or others)

- **New onset seizures-driving**
- **Occupational asthma-exposure to the inciting agent**
- **Syncope of unclear etiology-- flying**

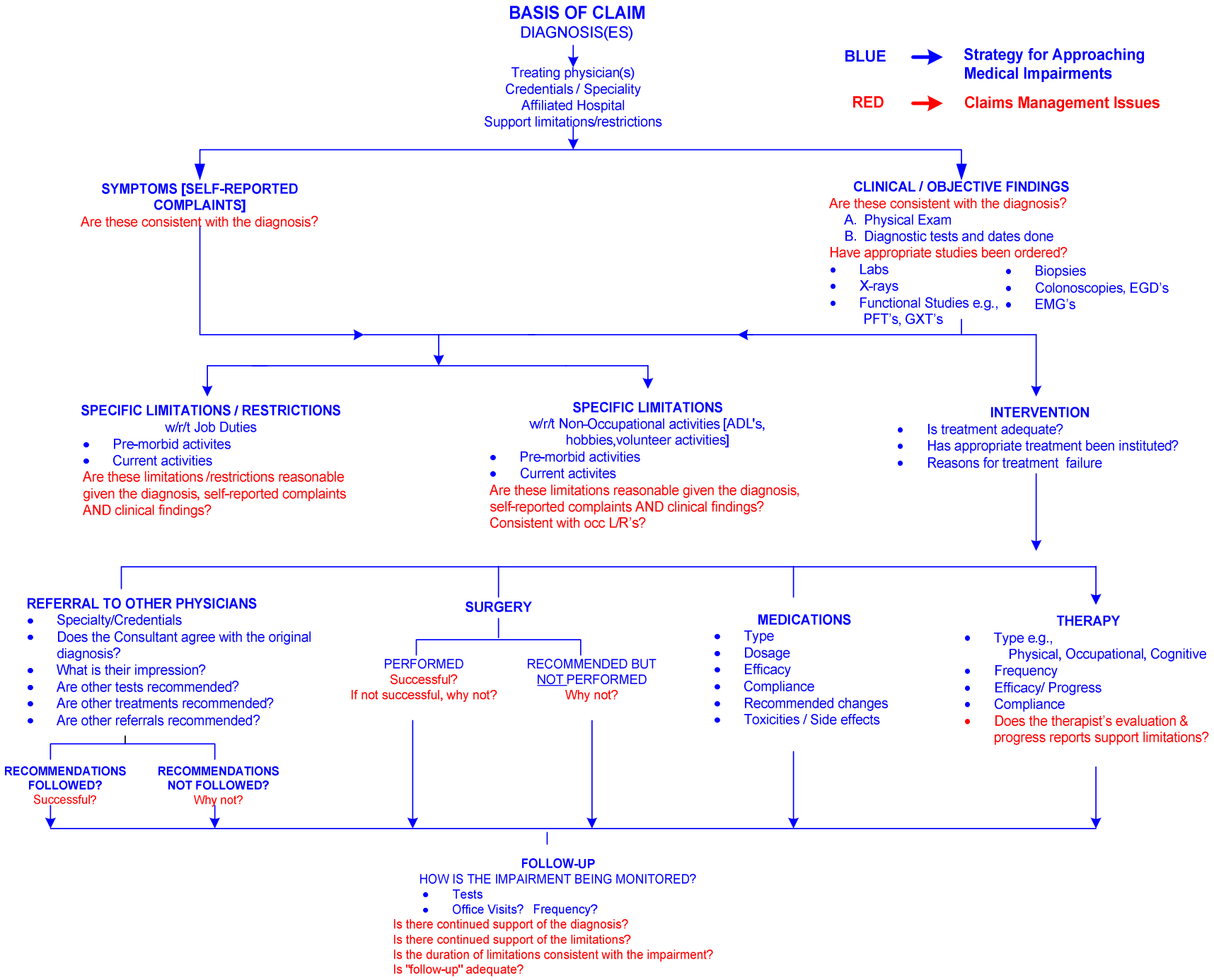
Restrictions versus Limitations (Cont.)

Limitations

Activities the individual "cannot" do

- **Amputation of dominant UE-surgery**
- **Acquired monocular blindness-cardiothoracic surgery**
- **Traumatic brain injury with documented significant cognitive impairment-- any job requiring executive functioning**

Disability Claims Algorithm


BASIS OF CLAIM
DIAGNOSIS(ES)
Treating physician(s)
Credentials / Speciality
Affiliated Hospital
Support limitations/restrictions
BLUE
Strategy for Approaching Medical Impairments
RED
Claims Management Issues
SYMPTOMS [SELF-REPORTED COMPLAINTS]
Are these consistent with the diagnosis?
CLINICAL / OBJECTIVE FINDINGS
Are these consistent with the diagnosis?
A. Physical Exam
B. Diagnostic tests and dates done
Have appropriate studies been ordered?
Labs
X-rays
Functional Studies e.g., PFT's, GXT's
Biopsies
Colonoscopies, EGD's
EMG's
SPECIFIC LIMITATIONS / RESTRICTIONS
w/r/t Job Duties
Pre-morbid activites
Current activities
Are these limitations /restrictions reasonable given the diagnosis, self-reported complaints AND clinical findings?
SPECIFIC LIMITATIONS
w/r/t Non-Occupational activities [ADL's, hobbies,volunteer activities]
Pre-morbid activities
Current activites
Are these limitations reasonable given the diagnosis, self-reported complaints AND clinical findings?
Consistent with occ L/R's?
INTERVENTION
Is treatment adequate?
Has appropriate treatment been instituted?
Reasons for treatment failure
REFERRAL TO OTHER PHYSICIANS
Specialty/Credentials
Does the Consultant agree with the original diagnosis?
What is their impression?
Are other tests recommended?
Are other treatments recommended?
Are other referrals recommended?
RECOMMENDATIONS FOLLOWED?
Successful?
RECOMMENDATIONS NOT FOLLOWED?
Why not?
SURGERY
PERFORMED
Successful?
If not successful, why not?
RECOMMENDED BUT NOT PERFORMED
Why not?
MEDICATIONS
Type
Dosage
Efficacy
Compliance
Recommended changes
Toxicities / Side effects
THERAPY
Type e.g., Physical, Occupational, Cognitive
Frequency
Efficacy/ Progress
Compliance
Does the therapist's evaluation & progress reports support limitations?
FOLLOW-UP
HOW IS THE IMPAIRMENT BEING MONITORED?
Tests
Office Visits? Frequency?
Is there continued support of the diagnosis?
Is there continued support of the limitations?
Is the duration of limitations consistent with the impairment?
Is "follow-up" adequate?

Claim Tools Used to Assess Disability

- Phone interview with the claimant
- Claimant's forms [disability claim kit, continuance forms, symptom and activity logs]
- Formal job description
- Medical Records
- Attending Physician's Statements (APSs)
- Pharmacy scans
- Clarification from treating MD (MD-MD phone call/written responses from treating MD)

Claim Tools Used to Assess Disability (cont.)

- Metrics to quantify work duties/hours (CPT codes, billable hours, employer letter)
- Interviews between home office and the claimant
- Paper review with appropriate expert
- Independent Medical Exam (IME)
- Surveillance (independent verification of activities)
- SIU (Special Investigative Unit)—court records
- Tax returns

DI Claims Guidelines

- The disability claims doc does not own the claims decision; opines on limitations/restrictions, speaks to the evidence and provides medical rationale for their opinion
- Disability claims doc-know your limitations—do not opine on issues outside of your expertise
- Disability claims doc-keep responses neutral, direct and address the questions being asked
- “Can’t do what because of what?” or “restricted from doing what because of what?”
- Most individuals want to work
- A diagnosis is not synonymous with limitations
- Lack of a diagnosis does not equate to “absence” of limitations

DI Claims Guidelines (cont.)

- Don't limit the focus to the accuracy of the diagnostic label, assess the severity of the symptoms
- Disability is contextual (e.g., tremor)
- Medical records may not provide sufficient detail/quantification to assess the need for limitations-need to use the other tools to seek clarification
  - Corollary: "limiting symptoms" should be documented in the medical record
- **CONSISTENCY** is vital
  - In general, limitations that impact occupational activities will impact non-occupational activities (consistency)
  - Reported, expected and observed behaviors should be consistent

DI Claims Guidelines (cont.)

- **CONSISTENCY** is vital - *continued*
  - ❖The level of care and treatment should be consistent with the severity of the condition/symptoms
  - ❖Reasonable accommodations/simple remedies should be pursued
  - ❖There should be consistency across providers if more than one is being seen
  - ❖In general, the expert for the "limiting condition" should be completing the paperwork and addressing the need for restrictions/limitations

Corollary: Inconsistencies need to be clarified/resolved