Insurance Robber Barons – Deliberate Strategies
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Statistics published by the Health Insurance Association of America (HIAA) report three out of ten American workers file disability claims before retirement. Of the thousands of disability claims filed in the United States, excluding Social Security, approximately 40% or less will actually be paid as a result of a fair, objective review process.

Left to their own profiteering devices and lack of federal and state oversight, the new insurance "Robber Barons" operate in an unregulated industry which has no clear oversight or knowledge of how to stop these organizations from selling disability policies they have no intention of paying. In addition, the insurance industry has one of the most powerful lobby interests capable of keeping dirty laundry out of the media. Combined with extensive propaganda aimed at convincing regulators of their "good intentions", disability insurers are now in a position to deny more claims with minimal scrutiny.

In the meantime, thousands of Americans continue to be swindled of legitimate benefits to which they are entitled by the policy contract. The question most asked is "How do they do it?" "How is it that companies such as Unum, Prudential, CIGNA, Liberty Mutual and others can actually convince regulators they are "the good guys" and still deny the payment of legitimate claims?

While no one objects to the right of a disability insurer to fully investigate claims presented for payment, everyone objects to deliberate strategies designed to "stack the deck" against insureds in an effort to profit at their expense. What disability insurers insist is a fair review process is really a set of internal strategies hidden in the claims and payment systems such that it would take a knowledgeable person to expose them. Unfortunately, unless federal and state regulators know exactly what they are looking for, claims review abuse remains undetected and therefore unprosecuted.

Make no mistake. Internal claims strategies designed to deny disability claims are calculated and deliberate and are not the result of negligence or internal administrative chaos. Management attended, week long, off-site meetings put key personnel behind closed doors for a week of brainstorming the review process, looking for loopholes. The "roll off" of ideas resulting from such off-sites takes place at the claims manager and above levels who then present the new strategies to claims specialists as company policy.

Insufficiently trained, naïve claim specialists, intent on keeping their forty to fifty thousand dollar a year jobs, then implement the strategies without clear understanding due to companywide propaganda distribution methods claiming the new strategies are designed to "provide better customer service to the insured." Claims specialists are, for the most part, kept deliberately dumb about management objectives, financial reserves, and liability acceptance rates in an effort to give the company a source of respectable "deniability" during investigations of wrongdoing.

In effect, disability insurance strategies are always deliberate, and are the result of a clearly designed strategy with an agenda to deny more claims. It is a sad testament to the insurance industry as a whole, but true nevertheless.

This paper discusses actual strategies designed to reinforce the credibility of unjust and often illegal claim denials made only for the intended purpose of increasing the profitability of the disability insurer at the expense of the insured. These ARE the strategies that cause harm to those who pay disability insurance premiums.

Deliberate/Planned Internal Strategies

The crucial internal strategies designed to "stack the deck" against insureds are as follows:

Accumulation of paper

Disability insurers spend millions of dollars each year hiring credentialed persons for the purpose of accumulating what appears to be credible documentation in support of claim denials. Registered nurses, physician consultants, vocational specialists, outsourced medical specialty reviews, CPAs, IME physicians as part of an IME Network paid by the disability company, "rubber stamp" decisions used as "credible back-up" to support unjustified and often illegal denials.

Of course, the premise here is that the more documents added to the record by highly credentialed persons, the more credible and right the denial decision appears. What is surprising, though, is that this strategy *actually works* to convince regulators and auditors the denial is justified due to the volume of paperwork contained in the file.

Let's take a closer look at why that's true.

All of the points described below are required to be mentioned or discussed in medical reviews completed by a disability insurance-paid physician. Since all of the strategies described below can be identified in any medical review regardless of the insurer, the practices can be reasonably assumed to constitute a "pattern of practice" used in ALL medical disability reviews. Medical reports from Prudential, Unum, CIGNA, etc. all contain the same wording and narrative style.

Any reader of an insurance medical review completed by a physician should be able to quickly identify the following strategy requirements from the actual document:

1. The new medical review begins with **a listing or discussion of all medical documents in the claim file.** Whenever a new medical document is added to the official file, it must contain a listing or discussion of all other "proof" reviewed supporting the claim decision, including all proof submitted by the insured's physician in favor of the insured. This makes what is currently being written in opposition to the evidence appear more credible. "Documents reviewed include the following……" The longer the list of other records, the more credible the medical review will appear to an outside reader.

2. **A statement about the non-existence or to what extent "objective evidence" exists to support the medical condition**. Even though disability policies do not require proof of loss supported by the "objective evidence standard" all insurance medical reviews contain some statement concerning the lack of "objective medical evidence" even for mental health impairments where no such evidence exists. The strategy is to "**state the negative**" so that reviewers will perceive a lack of evidence exists even when it is not true and not relevant to the claims decision. It makes what is currently documented appear more credible if the negative is emphasized, even when not crucial to the claim decision, or required in the policy contract.

3. A statement as to the extent the cause of disability is "self-reported" or **somatoform**. Insurance physicians frequently document the insured's disorder is a "somatoform disorder." Wikipedia defines Somatoform disorder as *"a psychological disorder characterized by physical symptoms that mimic disease or injury for which there is no identifiable physical cause."* A diagnosis of a Somatoform disorder implies psychological factors are a large contributor to the symptoms' onset, severity and duration which can be extremely useful to a disability insurer looking to deny claims under the 24-month mental and nervous provision of the policy. Likewise, claimed self-reported symptoms such as pain, headache, dizziness, vertigo, tinnitus are those symptoms for which no "objective evidence exists." The problem here is that federal and state regulators are not medical doctors and are not skilled in distinguishing between **conscious malingering and factitious disorders** and may perceive "somatoform disorder" as a credible reason to deny claims. If the insurance physician documents "somatoform" in the record, it is considered favorable to the insurer. Conversion disorder is also used as a "medical review tag" in an effort to say there is "nothing wrong with the insured except what is in his/her head."

4. **A statement that medical treatment providers have "over restricted" or have not provided medical restrictions and limitations precluding work.** It is interesting to note that ALL of the US disability insurers depend on the fact that physicians are not skilled at knowing, or writing medical restrictions and limitations, but internally require R&Ls as proof of claim. If the insured's physician(s) provide medical restrictions and limitations, the insurance physician makes a statement the insured has been "over restricted". In the absence of documented restrictions and limitations provided by the insured's doctors, the insurance physician can simply say there "is no medical evidence to support the claim." Either way the insured's claim is headed for denial decision, and it looks credible since "there is no proof of claim."

5. Statement that the **"medical evidence reviewed does not support the claimed disability."** Internal or outsourced insurance-paid medical reviews must always conclude with a statement alleging the medical evidence contained in the claim file does not preclude working to some capacity, or that medical restrictions and limitations do not support the claim. This of course is the "rubber stamp" portion of the physician review. An estimated 10% of insurance physician medical reviews actually support the insured's claimed disability. The "Impression" or summary portion of the report must always favor the insurance company.

6. Signature or statement the reviewing insurance **physician is board certified in a specialty.** It should be noted that not all US disability insurers can afford the "board certified" credentials, nor do they care. Unum actually sells the credibility of the medical credentials it hires; Prudential and CIGNA do not. Nevertheless, there is a presumption the review's credibility is in direct proportion to the higher credential held by the reviewer. The board certification is an attempt to "top off" family physicians that render recommendations in favor of disability.

   A summary view of the statement requirements of an internally generated medical review is as follows:

   - A comprehensive statement as to what documents in the file have been reviewed.

   - The review must contain a statement as to lack of "objective evidence" to support a claimed disability even when no objective evidence exists for certain impairments such as mental and nervous.

   - The review must contain a statement as to the "self-reported", somatoform, or conversion aspects of the claim. "It's all in his/her head."

   - Medical reviews must contain statements the insured has been either "over restricted" by their treatment providers, or no medical restrictions and limitations have been provided. (There is no proof of claim.)

   - Summary conclusion must support the view the insured's medical condition does not preclude working in some capacity.

   - The report must document the "board certified" or higher specialty credentials of the physician reviewer.

Any insurance medical review will contain the same major elements attempting to create the semblance of fairness in the claims process.

Of course, Independent Medical Evaluations (IMEs) are always part of any disability insurer's strategy to purchase medical opinions with which to "stack the deck" against insureds. It is very interesting these exams were named "Independent Medical Evaluations" when in reality they could have been called: Medical Impairment Evaluations (MIE), Disability Assessment Evaluations (DAE), or even Insurance Liability Evaluations (ILE).

The use of the word "Independent" is deliberate and attempts to say the medical evaluation is "unbiased" when in fact the word "independent" only signifies the insured does not have a prior medical history of treatment with the IME physician. Judges, attorneys, employers and many other deciding entities are taken in by the use of the word "independent" in the nomenclature and actually believe the insured obtains a fair medical assessment of his/her disability by attending an IME.

Individual Disability Income and group policies also contain the following language relevant to IMEs:

"We may require you to be examined at our expense as often as is reasonable to do so."
