

Good Faith

T

aking on the giants of the disability world is not for the faint of heart.

The cases are complicated, emotionally taxing and terrifically expensive to prosecute, and time is the carriers' friend. Carriers know sick people don't fight hard and can't shoulder a long, drawn out courtroom battle. It takes hard-earned respect on both sides of the table to get these cases resolved. However,

recent reforms in the industry have made the claims process more efficient and fair for both sides.

We have come a long way since the 1970s, when most disability contracts were oversold, underpriced and offered overly generous individual disability benefits. Life was good, the economy was roaring, the individual disability market was a billion-dollar premium pie, and everybody got more monthly benefits than they could ever dream of using.

By the 1990s, however, all that had changed. HMOs were now in charge of medical care, and they and other insurers began tightening the purse strings. Wall Street grew angry at missed corporate projections and investment income tanked, paving the litigation highway with anger. Carriers scrambled. They couldn't change the economy, couldn't cancel their non-cancelable policies and couldn't raise their premiums because the contract renewals were guaranteed.

Policyholders began making claims, lots of claims, that when denied stacked up in overburdened courthouses. Pounded deep into the claims mud, policyholders turned every nickel-and-dime disability case into an institutional bad-faith cause. And though some insureds surely brought unfounded claims, many more suffered insurance nullification by litigation as the disability market itself literally became disabled.

The meltdown of the disability market yielded blockbuster punitive damage awards and lessons learned the hard way on both sides of the claim table.

Carriers removed local claims handlers and then sought relief in federal court on diversity grounds. For this, they were rewarded with "the genuine dispute doc-

By FRANK N. DARRAS

trine" that allowed them to avoid bad-faith and punitive damage awards by simply creating a genuine factual, medical or financial dispute. The result left the insured with just a breach of contract action for past due interest and benefits. The Supreme Court decision in *Campbell v. State Farm* further scaled back punitive damages when it set a guideline of a single-digit multiplier on compensatory damages.

To enhance their profitability, many of the surviving carriers rewrote their contracts with additional restrictions. Some stopped offering non-cancelable policies, curtailed the duration of benefits arising from an inability to perform the important duties of one's occupation, reduced the maximum monthly benefit amounts, and added fraud to their contestability clauses.

Today's carriers have created new policies with more favorable premiums that have enabled them to finally turn the corner on profitability. This required careful planning, a strengthening of corporate reserves, revamping individual disability product lines and adopting entirely new underwriting criteria. With more corporate players returning to the individual disability market, policyholders have more product options and carriers face downward pressure to handle claims fairly.

A key to the improved disability market is a new set of good-faith claim objectives adopted in the November 2004 multi-state Regulatory Settlement Agreement by UnumProvident, the industry leader. Its dominant market share brought UnumProvident problems when state regulators began examining the volume of lawsuits filed against it and the company's claim practices. The multi-state market conduct examination of UnumProvident's claims-handling practice was led by insurance regulators in Maine, Massachusetts and Tennessee.

The agreement is sweeping in its scope and includes the company and its subsidiaries (including UNUM, Paul Revere and Provident), 48 state insurance commissioners and nationwide market conduct regulators. It changes the way disability cases are evaluated and implements greatly improved claim guidelines that should result in policyholders getting the benefits they

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richly deserve. Good faith is always good business for insurance companies; it prevents needless lawsuits and makes for happy policyholders.

The primary components of the agreement include enhancements to UnumProvident's claims-handling procedures and additional corporate governance to support oversight of the reassessment process and improved claims-handling practices.

Most significantly, the agreement also implements an unprecedented feature: the claim reassessment process, in which UnumProvident agreed to reopen and reconsider in excess of 215,000 individual and group long-term disability claims that were denied or closed since January 1, 1997. This is a clear indication that UnumProvident has turned the good-faith claim corner. Many of these previously denied claimants will be able to revive their claims under new claim objectives. If UnumProvident determines the claimant is disabled under the new objectives, the insured will receive all back benefits, interest and attorney fees and will be returned to claim paying status on a monthly basis. Naysayers heaping trash from the bleachers may say, "New claim objectives won't change the denial;" I say "wrong."

As someone who represents thousands of disadvantaged and disabled claimants, I see every day that the agreement is working to provide the truly disabled the benefits they deserve. This is due in part to UnumProvident's agreement to enhance its claim procedures by adding a series of "new good-faith claim objectives."

These objectives include giving significant weight to the awarding of Social Security disability benefits, whether received before or after the claim was denied,

Taking on insurers isn't easy. But improved claims procedures help the disabled get their benefits and industry leaders avoid needless litigation.

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as well as to both objective and subjective evidence of impairment, along with appropriate consideration of the treating doctor's opinion.

They also include adoption of a series of other good-faith claims factors that should help those who deserve benefits get them. One such factor is a collective evaluation of co-morbid claims (physical and mental) looking at all of the medical conditions contributing to the disability, including medication side-effects. A second factor is a requirement that all independent medical examiners selected by the company be unbiased, financially disinterested, fully trained and skilled.

A third factor is a requirement that all in-house company physicians be skilled, trained and have all the insured's medical information in hand before rendering impairment findings. The fourth and final factor is a mandate that all claims personnel undergo rigorous training on the new claim objectives to ensure best claim practices with vigilant corporate monitoring and oversight.

In October 2005, UnumProvident reached a similar, more expansive agreement with the California Department of Insurance, which was performing its own examination into disability claims-handling practices and wanted further claim improvements.

The principal features of the California agreement include enhancements to UnumProvident's claims-



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CALIFORNIA INSURANCE COMMISSIONER JOHN GARAMENDI ANNOUNCED A SETTLEMENT AGREEMENT WITH UNUMPROVIDENT AT AN OCT. 3, 2005, PRESS CONFERENCE IN LOS ANGELES. AS PART OF THE AGREEMENT, UNUMPROVIDENT AGREED TO CHANGE ITS CLAIMS-HANDLING PROCEDURES AND TO REASSESS THOUSANDS OF DENIED CLAIMS.

handling procedures and a reassessment of certain denied or closed claims. In addition, UnumProvident agreed to change certain claims practices and policy provisions specific to California.

Most importantly, the California agreement redefines “total disability” as the inability to perform with reasonable continuity the substantial and material acts necessary to pursue the insured’s usual occupation in the usual and customary way. “Any occupation total disability” is the inability to engage with reasonable continuity in another occupation in which the insured could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life and taking into consideration his physical and mental capacity.

The agreement also eliminates policy language delegating discretionary authority to the insurance company to determine eligibility for benefits and to interpret policy language. This eliminates the deferential “abuse of discretion” standard of review in long-term ERISA preempted cases. UnumProvident also agreed to limit offsets in long-term disability cases, offsetting Social Security disability benefits actually received by the claimant (not estimated or due in the future). The company agreed to not exclude conditions “contributed to or by” the pre-existing condition, requiring the medical condition to have actually existed or been diagnosed prior to the effective date of coverage. It also applies the limitation after the termination of any physiological-

based disability, discontinues the use of the “self-reported condition” limitation and makes rehabilitation provisions voluntary.

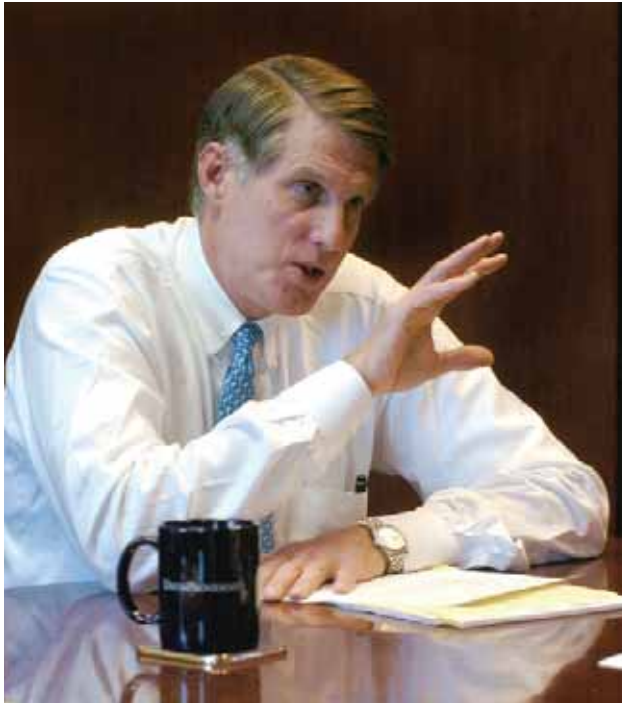
The California agreement not only benefits previously denied policyholders but also raises the legal bar to hold other carriers doing business in California to a higher good-faith standard. And that is good for consumers. With the industry leader stepping up to correct past problems and agreeing to consumer-friendly changes on a national basis, the rest of the disability carriers would be wise to follow. Any time an industry leader commits to bright-line, good-faith standards, the policyholder comes out on top.

The market is jittery, however, with concerns that the upcoming national election will impact consumer efforts to ban clauses that pre-empt coverage under ERISA.

ERISA does not prescribe a standard of judicial review for benefits decisions by plan fiduciaries. The Supreme Court, however, resolved this issue in *Firestone Tire & Rubber Co. v. Bruch* when it explained that denials of ERISA plan benefits should “be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary, discretionary authority to determine eligibility for benefits or to construe the terms of the plan.” Since *Firestone*, provisions conferring discretionary authority on plan administrators have increasingly become a fixture of ERISA plans.

In 2002, the National Association of Insurance Commissioners adopted Model Act 42 prohibiting the use of discretionary clauses in health insurance policies. In December 2004, the association voted unanimously to extend the Model Act’s prohibition of discretionary clauses in disability insurance policies. Many states, including Maine, Minnesota and Oregon, have adopted the association’s Prohibition on the Use of Discretionary Clauses Model Act.

In addition, numerous state insurance regulators have weighed in on the discretionary clause issue by declining to approve policies containing discretionary clauses, finding that such provisions violate their state's insurance laws.



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ABOVE: LED BY PRESIDENT AND CEO THOMAS R. WATJEN, UNUMPROVIDENT HAS WORKED WITH STATE INSURANCE AGENCIES TO REFORM CLAIMS PRACTICES. RIGHT: AUTHOR FRANK N. DARRAS, WHO REPRESENTS POLICYHOLDERS WITH CLAIMS AGAINST UNUMPROVIDENT AND OTHER INSURERS, SUPPORTS THE RECENT REFORMS.

In February 2004, for example, the general counsel for the California insurance commissioner issued a legal opinion finding that discretionary clauses “violate the rights of the insured” and “render the contract ‘fraudulent or unsound insurance’” in violation of California’s insurance laws. The Department of Insurance then issued a notice withdrawing approval of disability policy forms containing discretionary clauses. In March 2005, after a challenge and hearing, the commissioner affirmed and adopted the notice. In March 2006, the commissioner ordered the decision to be considered “precedential.”

The Hawaii insurance commissioner issued Memorandum 2004-13H in December 2004, opining that “[a] discretionary clause granting to a plan administrator discretionary authority so as to deprive the insured of a de novo appeal is an unfair or deceptive act or practice in the business of insurance in violation” of state law. In March 2005, the Hawaii Senate passed a law prohibiting the use of discretionary clauses in insurance contracts.

The Illinois Department of Insurance stated in a 2004 letter that discretionary provisions in insurance

policies violate the Illinois Insurance Code “in that they unreasonably or deceptively affect the risk purported to be assumed under the policy.” In July 2005, Illinois passed a law prohibiting discretionary clauses in disability policies as well as in summary plan descriptions.

In February 2006, the New Jersey Department of Banking and Insurance stated in a letter that it “banned discretionary clauses in all health insurance policies and contracts, including disability insurance contracts.”

In March 2006, the New York Insurance Department banned the use of discretionary clauses in health insurance policies and contracts, including disability income insurance, determining that “the use of discretionary clauses violates [New York insurance law] in that the provisions ‘encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to law or to the public policy of this state.’”

Similar decisions have been reached by regulatory agencies in Indiana, Montana and Oregon. Utah has banned discretionary clauses in individual policies, but it permits them in group policies.

The multi-state and California settlement agreements have changed the world of disability insurance, as have UnumProvident’s new claim objectives. Discretionary clauses are on their way out, and those carriers that have survived should be able to achieve healthy profitability. The framework is laid so that a roaring economy can lead to outstanding investment returns and low



Photo by Hugh Williams

unemployment, allowing those who can work to do so and those who are truly disabled to get paid promptly and fairly, with timely, courteous service provided by good, honest claims people. ■