



DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER INDIVIDUAL DISABILITY INCOME

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Own Occupation Policies – Better than Sliced Bread? by Linda E. Nee, HIA, DIA, DHP, CMP

December's newsletter focuses on current issues and claims review practices involving "own occupation" Individual Disability Income Policies purchased by self-employed professionals and highly paid executives. You may recall these policies are most often purchased from a licensed insurance agent and are NOT provided to a person as an employee benefit as a general rule.

The word "Individual" refers to the fact that these types of policies are "individually underwritten" (as compared to employer-sponsored group plans that are underwritten by characteristics of the group), and premium is paid based on actuarial information supplied by the insured at the time of application such as age, sex, income, occupation, and previous medical history.

Nearly all disability insurers in the US offered IDI policies in the 1980's because it was assumed "professionals" such as physicians, CEO executives, lawyers, dentists, and the self-employed did not file claims for disability very often. Hence, there was very little risk of having to pay fraudulent claims, or claims for secondary gain. Insurance companies aggressively marketed professionals and other executives who could afford the expensive monthly premium. At the time it seemed the perfect insurance product with profit potential.

Crazed with the idea of future exorbitant profits, disability insurers further liberalized underwriting standards and created the "own occupation" definition of disability which literally guarantees the insured a benefit if he/she is unable to perform all or some of the material and substantial duties of the occupation performed just prior to the date of disability. Convinced they were about to hit the mother lode of low-risk profitability, disability insurers also added other policy provisions such as Future Income Options, Life Time Benefits, Cost of Living, Business Overhead and Social Security Disability Income Riders.

What disability insurers did not anticipate was the development of HMO's and the implementation of medical managed care. In order to treat patients, physicians were required to cap fees and agree to scheduled "point of service" fees for procedures such as surgery and outpatient care. What the insurance industry knows for sure is that between 1985 to 2000 the numbers of "own occupation" claims filed by the "low-risk" professional group was staggering. So much so, that the industry literally "lost its shirt" to the point of no longer offering the "own occupation" product by definition.

Underwriting Contestability

I once read in a deposition transcript a claims specialist reported an insured to the state attorney general for fraud because he never disclosed in his application for coverage that he regularly took Advil for headaches. The claims specialist made the decision that this incidental non-disclosure by a an insured constituted "fraud" and testified as such in litigation. This shows the extent to which claims specialists are trained to look for possible reasons to rescind policies under contestability provisions.

In their heyday the own occupation policy was sold as the "best policy money could buy." Many clients tell me Paul Revere and The Provident Companies did such a good job of marketing their "own occupation" product, they actually bought more than one policy. Sold to insureds as "better than sliced bread", IDI policies were viewed by professionals as the best protection money could buy for unexpected disability, especially for the self-employed professional, executive, physician or attorney.

Currently, IDI policies still in force are aggressively risk managed by insurers because they represent significant potential future liability to the company. IDI monthly benefits range anywhere from \$2,000 to more than \$20,000 per month, often representing more than \$4,000,000 or more per claim in financial reserve.

Obviously, companies like Paul Revere do not want to pay such expensive claims if they can possibly avoid it, and herein lies the basic concept of "Bad Faith." In addition, IDI policies are subject to the laws of the state including the ever-popular consumer protection statutes which make deliberate bad faith lawsuits possible under state law.

December's issue of our newsletter deals with some of the more popular current questionable claims practices employed by most US disability insurers in an attempt to limit benefit payments on a IDI insurance product that nearly drove the insurance industry into bankruptcy.

Not only did "own occupation policies" NOT turn out to be "better than sliced bread", they often didn't put the bread on the table at all since they are often denied by disability insurers for illegal out of contract reasons. Bad product all the way around.

What is Bad Faith?

The laws in most states imply a duty of good faith and fair dealing on behalf of the insurance company. This duty expects the disability insurer to act reasonably in the handling of claims submitted to them by the insureds. Even though disability policies do not contain specific language in the insurance policy concerning the duty of good faith and fair dealing, it will be enforced by the courts as if it were.

In general, in order to prove an insurance company has violated their duty with respect to good faith and fair dealing, the insured (plaintiff) must show: 1) the disability insurer acted intentionally; 2) the disability insurer either denied the claim, failed to pay the claim, or delayed payment on the claim without a reasonable basis; and 3) the insurance company was aware it had no reasonable basis to act, or it failed to conduct a fair and objective investigation to determine if its actions were in fact reasonable.

Basically, disability insurers may not ignore the duty to investigate fully all of the facts of a claim before making a liability determination. If a claim is not fully and objectively investigated, the disability insurer may later be prevented from saying it had a good reason to act in 'good faith'. Additionally, a disability insurer may not conduct an investigation favoring its own interests above those of the insured. Instead, the disability insurer is required to consider the interests of the insured at least equal to its own.

In order to prove an insurer has committed "bad faith" the insured must prove: 1) the insurer is guilty of violating the duty of "good faith", and therefore has committed "bad faith"; and 2) and the insurer's acts of "bad faith" were the cause of any damages suffered by the insured. When the insured is successful in winning a "bad faith" lawsuit, he/she is generally entitled to recover: 1) actual damages; 2) general compensatory damages; and 3) punitive damages.

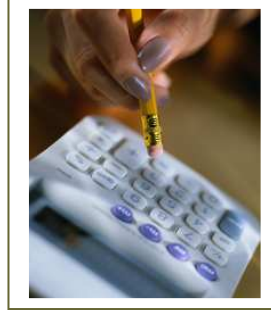
In order to win compensatory damages, the insured must prove to a jury that the facts of the claim are more probably true than not. This is very different from beyond a reasonable doubt, which is a much higher standard used in criminal cases. The concept of "more probably true" means that the insured's facts and evidence need only "outweigh" the defendant's evidence by even the slightest margin.

In contrast, in order to win punitive damages, the insured must provide proof of clear and convincing evidence, which is more than "mere probability", but less than "reasonable doubt." The insured is required to show the insurance company acted with an "evil state of mind" which is defined as: an intent to cause harm; or conduct motivated by intentional ill will; or willfully ignoring the substantial risk of harming the insured or others.

Awarding punitive damages is left entirely to the jury. Members of the jury may choose to consider: the character and motive of the disability insurer's motives, the degree of harm it caused, and the standard of reported wealth of the company.

Disability insurers may also be sued for breach of contract, which arises when the administering insurer does not abide by the express written provisions of the policy issued, a very, very common strategy. Disability insurers can get very creative with internal review procedures designed to deny more claims than are approved.

Newsletter Title



A financial disability claim reserve is the amount of corporate cash flow required by state and federal regulators to be "reserved" as an available cushion of funds required to pay claims. This money is unavailable for payment of operating expenses or portfolio investment. Claim reserves represent the value of future liability required to pay claims, and creates a liability on the financial statements of the disability insurer. When you file a claim, the reserves are immediately set aside. However, when a claim is denied, there is an immediate contribution to profit. The greater the claim reserve the more likely an IDI claim will be targeted, risk managed, and eventually denied.

"Residual vs. Total Disability"

One of the most egregious claims practices related to IDI claims is the disability insurer's attempt to claim the insured is only "residually disabled" rather than "totally disabled." In general, total disability requires the insured to be unable to perform (all) material and substantial duties of his/her own occupation (or specialty), and be under the care of a qualified physician. "Residual disability", on the other hand, requires the insured to be working and performing some, but not all of the material and substantial duties resulting in at least a 20% earning loss.

"Residual vs. Total Disability" is an area of internal review practice determined and supported by management in an effort to limit financial reserves associated with high-value IDI claims. A typical scenario would be for the insurer to state (as a result of an internal medical review or IME) that it was of the opinion the insured could work part-time and perform some of the occupational duties he/she was performing just prior to the date of disability. Although the policy generally requires the insured to actually be working in order to be "residually disabled", the insurance company arbitrarily decides an insured could work and therefore pays a reduced benefit. These decisions are, of course, a breach of contract.

One former client of DCS was told by a Unum claims specialist that their Physician Consultant determined he could perform some, but not all his material and substantial duties and therefore going forward Unum would only pay a 50% benefit. No where in his policy did it say Unum could do that.

When challenged Unum actually paid the insured what it called a "100% residual benefit." When I asked Unum to tell me the difference between a "Total Disability" benefit and a "Residual" benefit paid at 100% the company suddenly got tongue-tied. Clearly, companies such as Paul Revere and Provident wind up telling the insured, "the definition of disability in the policy IS what WE say it is." I call it an Aesop Fable, but legally, it is an out-of-contract decision to pay the IDI claim for less than the insured is entitled to under the terms of the policy. Disability policies are legal contracts and the language of the document should "speak for itself" and means what it says.

Individual Disability Income Claims Abuse – Sliced Bread or Burned Toast?

Here is a list of the most frequent IDI claims abuse practices used by most disability insurers who sell IDI policies to professionals. DCS manages issues such as these on a frequent basis. I generally take quite a bit of criticism from consultants who also advocate for insurance companies when revealing the so-called “negative” side of the disability insurer. However, our philosophy at DCS includes statements about “providing insureds with information at least equal to that of the disability insurer” and therefore we believe “honesty in information - works.”

1. **Targeting of claims**—All Individual Disability claims are “targeted” to some extent. This means claims specialists are allowed (and in some cases, required) to apply significantly larger and more expensive risk resources with the intended result of challenging the credibility of the insured so that a claim denial or termination is documented and supported. These risk resources include: extensive in-house medical and vocational reviews, Independent Medical Evaluations, Field Representative visits, Fraud Unit Referrals, Surveillance, Activities Data Base Checks, Tax Return Requests, FICA checks, Settlement Review Referrals, Return to Work Review, CPA Financial Review, Internet Data Base checks, required Team and other Roundtables, and Consultant and/or Director reviews. Individual Disability claims with monthly combined indemnities greater than \$4,000 per month, Lifetime Benefits, and expensive COLA and Future Income Options appear to be more aggressively risk managed since they also carry higher reserve values.
2. **Total disregard for medical recommendations, treatment notes, and/or independently paid-for IME’s submitted by the insured’s primary care physicians.** - In keeping with any disability insurer’s philosophy of total disregard for qualified opinions of external treating physicians, claim documents often indicate no weight, or very little weight is given to the medical information submitted by the insured, and the insured’s qualified medical treatment providers in support of their claim. In numerous cases, primary treating physicians are in disagreement with the disability insurer’s assessment of their patient’s work capacity. Nevertheless, the documented opinions of the disability insurer’s in-house physicians far outweigh evidence submitted by the insured, thereby preventing fair and objective claim review to which the insureds are entitled. Additionally, in the majority of cases, nearly all disability insurers place considerably more weight on the opinions of their paid IME physicians rather than those of the insureds treating physicians. Consensus of medical opinion is not required or even sought in most cases.
3. **Doctor shopping through Independent Medical Evaluations** along with frequent and vexatious medical requests. Patterns of requesting multiple Independent Medical Evaluations in an attempt to obtain sufficient medical documentation favorable to the disability insurer are common. For some claims, IME’s are requested by the insurance company once a year or until sufficient support for a claim denial is obtained. IME physicians are generally members of a Physician IME Group Network and often complete documentation which is not placed within any claim file. Additionally, frequent calls to the offices of primary care physicians often strain relationships between the insureds and their physicians. Common patterns of practices include: daily calls and/or faxes to physician’s offices requesting medical information; frequent calls requesting conference calls (doc to doc calls) and the receipt of misleading communication letters; vexatious calls to the offices of treatment providers requesting medical information which has been previously requested, often several times; and the “rubber stamp” review practices of internal peer physicians.
4. **Untimely claims decisions and delays for inappropriate reasons.** A common pattern of practice within all IDI claim review processes is delaying a liability decision when all available, created medical documentation has been received by the Claims Specialist for review. It is not uncommon to delay claims decisions in order to avoid the adverse financial reserve affects of paying a claim. Since Individual Disability products are not subject to the time notification (status and tolling letters) of ERISA, abuses are evident in this line of business for the intended purpose of delaying the full recognition of the reserve liability of the claim, particularly for large reserve claims. In addition, a common practice resulting from such delays is a breach in industry standards whereby the insureds are forced to seek counsel and litigate claims through the courts in order to recover benefits they are entitled to through policy provisions. Even when provided with sufficient medical information to prove impairment, disability insurers persistently refuse to pay claims.
5. **Abuse of Reservation of Rights (ROR) status.** This is a common pattern of practice whereby insureds are notified the disability insurer has determined the claim is payable, and will begin payments on the claim, but there is insufficient evidence to legally accept liability on the claim. Most companies state it reserves its right to adjudicate any and all provisions of the policy at any time. However, ROR status within the company is also tied to the pay system as a “pay status.” When coded as an ROR claim, 100% of the financial reserve is not realized. Therefore, there is great incentive and potential for claims specialists to “manipulate” and achieve unit individual financial projections by placing claims on ROR status at the end of the month or quarter in order to lower the approval reserve impact. While coding a claim on ROR status places the disability insurer in a favorable financial position, removing the status produces an adverse affect on the unit profitability picture. A common practice is to keep claims on ROR status for long periods of time, often years, so as to avoid the sudden increase in insurance reserve when the status is removed.

6. Abuse of “objective evidence” wording. Although none of the Individual Disability policies managed by most insurers require “objective medical evidence” as proof of disability, companies create an in-house requirement that objective medical evidence must be received as proof of claim in order to qualify for benefits. In-house Physician Consultants frequently document the “lack of objective evidence” in their reports, and use these criteria as cause for non-support of restrictions and limitations which would be otherwise considered impairing. This pattern of practice is particularly evident with regard to diagnoses such as fibromyalgia, chronic fatigue, depression and other mental and nervous impairments for which no “objective” medical evidence exists. Combined with the disregard of medical opinions from external treating physicians, and its own prejudicial pre-determined outcomes, large numbers of claims with the above mentioned diagnoses are often denied.
7. Lack of occupational investigation. For Individual Disability claims, “occupation” is generally considered the occupation or specialty performed by the insured just prior to the date of disability. In-house practices require the Claims Specialists to request appointment books, tax returns; customer lists etc. in order to determine “material and substantial” or “important duties” of the occupation. The most common abuse is for the insurer to claim the insured does not have a specialty occupation, or could perform nonexistent material and substantial duties in order to limit or deny benefits. Currently, disability insurers are engaging in post-underwriting by requiring insureds to submit unreasonable amounts of information about their jobs such as CPT codes written in Excel Formats, and Monthly Profit and Loss Statements in formats required by the insurance company. IDI policies DO NOT require the insured to create additional methods of accounting in order to make it easier for the insurance company to review and the current burden of proof requirements are now burdensome and unreasonable.
8. Documentation Avoidance. Claims Specialists are often cautioned and instructed to “not” document specific information within the claim file thus avoiding the opportunity of providing future Plaintiffs with discoverable information, or identification of doctors and participants who ultimately make claims decisions. Documentation most frequently withheld is: 1) names and credentials of those who attend Team or other roundtables; 2) informal walk-in conversations with medical or vocational staff, Consultants, and Directors; 3) IME Physician Network lists, criteria, payment and incentives; 4) the author and date of handwritten memos and forms; 5) conversations with in-house legal staff; 6) emails generated between parties concerning the facts of the claims; 7) expected dates of recovery, claim projection listings, weekly caseload reports; 8) purging of in-house ACTION LOGS OR ACTION PLANS; SOAP NOTES 9) Imaged, and electronic diary documents; and 10) in-house documentation showing bias or poor pattern of practices.
9. Pre-determined outcomes- Most disability insurers have predetermined internal medical review guidelines directing the insurer’s philosophy in approving claims with certain impairments. Given the number of claims denied with impairments such as Lyme Disease, Multiple Sclerosis, Chronic Pain and Fatigue, SLE and PTSD, it appears reasonable to conclude internal guidelines still exist within the medical review process. In addition, references to the positions of the CDC and MDA ignore the uniqueness of an insured’s ability to recover within prescribed medical guidelines and claims are often denied prematurely by expecting “miracle” recoveries on queue.
10. Rescissions for claimed fraud - Nearly all IDI policies have provisions defining a “contestability” period (generally two years) during which the insurance company may investigate and claim omission, inaccuracy, unrevealed pre-existing condition, or fraud on the part of the insured during the initial application process. When these claims are sufficiently proven, the insurance company may refund premiums (make the insured “whole”) and cancel or rescind the policy. If there is a charge of fraud the insurance company is required to follow state guidelines in reporting such incidents to the respective states attorney general. By definition, fraud requires the “intent to deceive”, which in the legal sense, is often difficult to prove. Once the contestability and rescission door is opened any number of incidental omissions from the original application can be used against an insured to rescind high value reserve claims, saving the insurance company millions in financial reserves. If an insurance company wants to “retire” whole blocks of unprofitable own occupation policies, communicating a strong policy against fraud is a good way to make it happen – eventually.

I hope this information provides clients and others with a wake-up call concerning IDI policies. Make no mistake, “own occupation” policies represent pure risk to any disability insurer and therefore the quality, frequency and urgency of claim review follows that line of potential unprofitability.

As always, if you have any questions concerning Individual Disability Income policies please feel free to contact Disability Claims Solutions. Best wishes and all good things for the holidays!