WHY IS IT SO HARD TO COLLECT ON MY DISABILITY INSURANCE POLICY?

By: Edward O. Comitz, Esq.

> "I retired early because I had Multiple Sclerosis (MS) and could no longer work. Since retiring, my health insurance denied me critical medication and my disability insurance told me that I am no longer disabled. . . . I face a daily battle with my insurance companies."
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> Former hospital CEO, William Blaine of Minnesota
> *The Oprah Winfrey Show*, September 2007

Throughout the 1980's and early 1990's, disability insurance companies aggressively marketed and sold policies known as "own-occupation" or "occupational" disability policies to doctors and other high-level professionals. Marketing efforts were directed at doctors in particular because they were actuarially determined to be less likely to stop working due to physical limitations, even severe limitations, since they had already invested years into their education and training, enjoyed working and were earning high salaries.

In addition to insuring specific occupations (*e.g.*, diagnostic radiology, cardiology), most of the disability insurance policies from the 1990's were non-cancellable and premiums could not be raised. Due to competition in the industry, several insurance companies dramatically reduced underwriting standards on, and underpriced, this block of business. Certain highly advantageous "bells and whistles" were contained in these policies, many of which were available without the doctor completing a long application, providing a detailed medical history or submitting to various medical tests:

- Occupation-specific coverage
- No mental health exclusions or limitations
- Lifetime benefits instead of benefits payable to age 65
- Cost of living increases
- Benefits not offset from other income sources
- No limits or relaxed limits on maximum coverage amounts

Disability insurance companies planned to invest premiums from these policies and earn substantial returns based on the high interest rates in effect during the early 1990's. Although the companies projected that high interest rates would continue, they actually plummeted. This coincided with the emergence of managed care, resulting in a significant decrease in income for most doctors. Many doctors grew frustrated and refused to continue working through their physical limitations, opting instead to make claims for disability benefits on policies that were equal to, or greater than, their modified salaries. As a result, "own-occupation" policies turned into a "bad block" of business that would cost the industry hundreds of millions of dollars.

This acute lack of profitability caused the insurance industry to focus on claim administration. Insurance companies began hyper-scrutinizing the terms of their policies and any claims made thereunder, utilizing novel, creative and often improper theories to justify denial of benefits. NBC's *Dateline* and CBS' *60 Minutes* ran stories about UnumProvident, the

largest disability insurer of its kind in the United States. The *60 Minutes* segment was entitled "Did the Insurer Cheat Disabled Clients?" During the episode, one UnumProvident employee told Ed Bradley that bonuses were awarded to some managers who closed especially large claims. Another employee, Gina Hartley, who was a claims handler, said that her department had monthly monetary savings goals set for them, amounts which they had to hit by shutting down claims. Ms. Hartley said that the pressure to reach these goals often led to the termination of legitimate claims.

As a result of the media attention, UnumProvident became the prime target of repeated investigations by insurance regulators, resulting in a Multistate Market Conduct Examination Report. The Report identified four serious areas of concern in UnumProvident's conduct toward its insureds:

- Excessive reliance on in-house medical professionals
- Unfair construction of attending physician or IME reports
- Failure to evaluate the totality of the claimant's medical condition
- Inappropriate placement of burden on claimants to justify their eligibility for benefits

Ultimately, UnumProvident entered into regulatory settlement agreements with the insurance commissioners of all 50 states, agreeing to promptly, fairly and objectively investigate all claims on a going forward basis. The media interest has considerably waned, but the industry's "bad block of business" remains a serious, outstanding liability. Accordingly, doctors with high value policies continue to have difficulty collecting benefits, notwithstanding any lip service paid to the industry's supposedly reformed practices.

Administration of high-dollar claims remains a billion dollar business, with insurers continuing to lob a seemingly endless barrage of anti-coverage grenades on claimants, including: video surveillance of their activities; field interviews and unannounced investigations; unannounced attending physician interviews; vocational rehabilitation testing; in-house medical evaluations; "independent" medical exams; medical "interventions" and micro-management of medical care; financial auditing; insurance billing audits; re-evaluation of answers on application forms; investigations of prior litigation and board complaints; investigation of circumstances surrounding practice sales; as well as a wide variety of other tactics, all aimed at increasing each company's bottom line.

Doctors must familiarize themselves with their policies and the claims process, and continue paying premiums on any liberalized policies that they may have purchased in the past. Disability provisions vary greatly in the language used, and coverage is often circumscribed and restricted by qualifying words and phrases, which insurance company's interpret to their own benefit. Each policy of insurance must be individually reviewed to determine whether a particular claim is covered and, if so, *how* and *when* that claim is best presented to ensure acceptance and, more importantly, continuing payment. Disability insurance companies are financially capable of expertly and vigilantly protecting their own interests, which often means not paying claims. Doctors need to be even more vigilant in protecting themselves.

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