

IDENTIFYING THE DISABILITY CLAIMS PRACTICES THAT DRIVE BAD FAITH ALLEGATIONS

Douglas K. deVries
deVries Law Firm
1792 Tribute Road, Suite 480
Sacramento, CA 95815
Phone: (916) 473-4343
Fax: (916) 473-4342
dkd@dkdlaw.com

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I. INTRODUCTION

This article focuses on identifying disability claims practices that currently drive bad faith allegations. It discusses the practices stemming from industry-wide changes that have been implemented by disability insurers in the last 10 years or so. In addition, the article identifies common threads in the successful prosecution of disability insurance cases by plaintiff attorneys. Lastly, the article discusses the sometimes unappreciated relevance of bad faith claim handling practices in ERISA cases and their potential impact.

A. Changes In Claim Handling Practices

It is well-known that industry-wide changes seen in disability insurance claims practices have been most widely identified with, and closely examined in conjunction with, the UNUMProvident companies - Provident Life & Accident Insurance Company, Paul Revere Life Insurance Company and UNUM Life Insurance Company of America. It seems that all of these significant changes in disability claims practices have been reflected at one time or another in claims practices implemented by UNUMProvident.¹

Other disability insurers are quick to point out in litigation that they are not UNUMProvident, and further claim not to be anything like UNUMProvident. The other companies have implemented changes, however, to one degree or another, and no company has been completely immune to the pressures exerted on the industry that motivated changes at UNUMProvident. In the prosecution of insurance bad faith cases,

¹ As a direct result of claims practices adopted from and after approximately 1995, the UNUMProvident companies have been the subject of multiple punitive damage verdicts, an adverse Multi-State regulatory settlement with State insurance commissioners and the U.S. Department of Labor acting jointly, and with the California and Georgia insurance commissioners independently.

plaintiff attorneys will seek to determine whether, in any given company, these changes in claims practices have been implemented, how they have been implemented, and whether they have affected the claim handling or the particular claim at issue; they are discussed in Section II below.

Thus, the industry-wide changes in the disability insurance industry have provided a road map for the bad faith allegations plaintiff's have pursued, including more widespread and penetrating discovery of company organization and company management practices. Correspondingly, there has been an increase in the incidence of punitive damage verdicts in disability insurance bad faith cases in the last 5 to 10 years.

B. Common Threads in Successful Insurance Bad Faith Cases

The common threads in successful prosecution of bad faith claims in long-term disability cases by plaintiffs include positives relating to the clients, doctors and medical conditions combined with negatives relating to frequently seen claim handling weaknesses and errors; these are detailed in Section III below.

C. Impact of Bad Faith In ERISA Cases

As a result of significant United States Supreme Court decisions, it has been established that plaintiffs in ERISA cases are limited to the remedies provided under the ERISA statutes. Nevertheless, State law may play a role in ERISA cases as the basis for "rules of decision" under which the courts adjudicate ERISA claims. In addition, claim handling that would constitute bad faith claim handling practices supporting a bad faith remedy are still highly relevant in the trial of ERISA cases for two primary reasons. First, unreasonable claim handling can directly impact the standard of judicial review, and the review itself. Second, unreasonable claim handling can have an effect on discretionary awards of pre-judgment interest and attorney fees, both of which can be substantial, depending on the case. These topics are discussed in Section IV below.

II. IMPACT OF INDUSTRY-WIDE CHANGES ON BAD FAITH CASES

A. The Phases of Change

Based on extensive discovery and litigation experience, including trials, it is fair to say that clearly identified industry-wide changes have occurred in the disability field over the last 10 to 15 years. There appear to have been four identifiable phases, as follows:

1. The “feeling the pressure” phase, or “Oh my, what were we thinking?”
2. The “gearing up” phase, or “We’ve got to do something radical, but what?”
3. The “getting down” phase, or “That’s it, let’s turn claims departments into profit centers, brilliant!” and
4. The “dumbing down” phase, or “You can’t teach old dogs new tricks - so, out with the old, and in with the new!”

B. Feeling the Pressure

In the initial “feeling the pressure” phase, the claims departments of disability insurance companies started to come face-to-face with the fact that during the high-interest, fight-for-market-share period in the late 1970's to early 1990's, the companies had liberally expanded long-term disability coverages and benefits in an attempt to expand sales and market share and bring in higher premium income to take advantage of favorable interest rates and other investment opportunities.²

On the individual disability side, the companies aggressively marketed policies to high-earning individuals, including doctors, lawyers, entrepreneurs, CPA's, chiropractors, dentists, executives, etc.. Also, there was a large increase in the number of individuals covered by group policies sold to employers. While the group coverages were not as large or liberal as the individual coverages, they covered more people. Not surprisingly, as time has gone by, the expanded sales of, and benefits in, disability

² In addition, life insurers experienced stagnation in the traditional life insurance market as they were losing ground to the mutual fund industry in the competition for retirement-related and estate planning-related assets.

insurance has resulted in more claims. Increase in the number of claims directly related to prior increased sales and benefits was also accompanied by increases in the types of claims and complexity of claims. Disability insurance claims based on mental and nervous disorders and musculoskeletal or soft tissue conditions rose substantially. In addition, new complex illnesses and diagnoses arose as the bases for claims - for example, fibromyalgia, environmental allergies, multiple chemical sensitivity, chronic pain syndromes and chronic fatigue syndrome.

On the group side, while approximately 70% of claims fall under the insurer-favorable Employee Retirement Income Security Act of 1974 (ERISA), approximately 30% are exempted from ERISA under such things as the governmental plan exemption and the church-affiliated plan exemption (29 U.S.C. §§ 1003.b.1 and 2) and the U.S. Department of Labor “Safe Harbor” Regulations (29 C.F.R. § 2510.2-1(j)). On the individual side, the high-earning baby boom buyers of the liberalized individual disability insurance policies have grown to be aging big-boom claimants, again not surprisingly.

While making the promises in the liberalized disability insurance policies was good at the time because it served the short-term goals of market expansion and premium income increase, keeping the promises in the long-run proved to be, well, not so good. The increased number of claims and the increased dollar amount of claims inevitably put pressure on company reserves, due not only to open disability claims, but also anticipated future disability claims. There was the sense that not only were the reserves that had to be set on open claims putting pressure on company financials, but the predictable claim trends did not compare favorably with predictable income trends, which are interest-rate sensitive and have remained relatively flat since the early 1990's. In other words, due to a flattening of sales and investment return on the one hand, and an upwardly trending claim expense burden on the other hand, there was financial pressure knocking on the door and a lot more on the horizon.

C. Gearing Up

The “gearing up” phase was essentially a mobilization within individual companies, and among and between companies, in an attempt to protect the bottom line. Insurers evaluated, and selected from among, alternative corporate strategies - what might be referred to as manifestation of the “fight or flight” reflex in the disability insurance business. The three main alternate categories of strategy were (1) either sell blocks of business to other companies (in order to dump expenses) or acquire blocks of business from other companies (to increase efficiencies of scale), (2) merge with other companies in an attempt to outgrow the problem, or (3) go to the re-insurance market, either through re-insurance treaties on the business kept by the company or the transferring of risk to a re-insurer for run-off management.

Whatever strategy was chosen at the corporate level, it was apparent that closing claims would be good for the bottom line, and this was part of a “run-off” mentality that set in as a reaction to claim-driven financial pressure. In other words, the blocks of business that had been sold with liberalized and expanded coverages and benefits were now identified and isolated as constituting a problem block of business. The companies stopped selling the liberalized products, and tightened up on the benefits and coverage offered in new products. The problem blocks were no longer part of ordinary business, but rather were seen and treated as a run-off of problem claims that had to be carefully and aggressively managed as never before.

D. Dumbing Down

The “dumbing down” phase is not a general reference to replacement of smart people with stupid people; rather it is a reference to management’s decreased emphasis on knowledge specific to insurance. Executives in charge of disability insurance companies concluded that some aspects of the old insurance model they had been operating under might well bring them to ruination in the face of these new challenges. The way out of the problem was not merely to sell more insurance and continue to handle disability claims as usual. Insurance companies had tightened down on disability

coverage and benefits in their new disability insurance products, but that alone was not going to solve the problem, and it was not likely to result in substantially higher premium income either. What was going to be needed was not only aggressive claim expense management, but also, potentially, the sale of the business, mergers and acquisitions, and other forms of reorganization aimed at achieving better and more efficient access to capital markets. Executive level changes followed the perceived needs, and executives experienced in insurance marketing and management gave way to executives on the financial side of the company, and in some noteworthy cases infusion of new executive leadership from other financial sectors outside the insurance sector, such as banking and finance.

Some of the management changes involved implementation of more vertical “command and control” company-wide, thus imposing tighter organizational discipline from the top. As occurred at the executive level, this engendered changes at the claim manager level and the claim adjuster level as well. It became increasingly common in the industry that claims adjusters were neophytes who had little or no claim experience, and correspondingly, as far as disability insurance claim handling was concerned, had “uncluttered minds.” Directed training in new claims philosophies and techniques occurred, some of which will be discussed below. Claims adjusters were re-named “claim service representatives,” “customer care specialists,” “disability benefits specialists” or the like, and they were taught to handle claims strictly by the policy terms and task-specific new claims manuals. Substantive legal matters or concerns and their impact on claim handling were to be left to the law department, and lawyers became more routinely involved in the direction that day-to-day claim handling was to take.

E. Getting Down

The “getting down” phase is marked by the phenomenon of turning claims departments into profit centers for the company. The term “profit center,” as used in this context, is not a statement that the company will affirmatively profit off a claim, but

rather that the organizational efficiency and performance of the claim department was now to be directly measured against the impact on the company's reserves. Thus, claim openings, closings and re-openings, were more carefully monitored and the impact on reserves more closely measured for organizational and management control.

A desire to change the role of treating doctors in certifying the disability of insureds also drove substantial reorganization and "medicalization" of claim departments. In furtherance of this goal, claims departments were reorganized into "impairment units." Under this new claims system, claims would be reorganized by the type of underlying condition that drove the claim, such as psychiatric, cardiac, orthopedic, or other complex conditions. Claims personnel in an impairment unit would only handle claims of that type, and they would be tutored and supported by specialty medical consultants who were either employees of the company or readily available outside consultants.

Not untypically, specialty medical consultants would "scrub in," which is not a reference to disinfecting themselves in preparation for surgery. Instead, the medical consultants come to the claims department, sit in a room, and closely review ("scrub") open claim files. Medical consultants are expected to identify all weaknesses in diagnosis or treatment and raise questions about the claim that might be further explored through additional claim handling activity. Correspondingly, Attending Physician Statement forms no longer sought or allowed for an opinion by the treating physician about whether or not their patient was disabled, and treating doctors were not provided with disability insurance definitions or standards.

"Incentivization" of claim closures was also instituted in some companies. Personnel at the claims management level were given increased access to profit participation. In addition, quantitative, as opposed to qualitative, performance at the claims level provided the measure of claim management success. Some examples include making claims personnel aware that their claim closings are being closely monitored, requiring claims personnel to maintain lists of high benefit open claims,

targeting of high reserve-generating claims for special reviews, and requiring claims personnel to identify potential closures of claims on a quarterly basis.³

III. COMMON THREADS IN SUCCESSFUL PROSECUTION OF BAD FAITH CASES

On the plaintiff's side of the case, there are three main positive factors that are good predictors of success in a disability insurance bad faith case, as follows:

1. a credible, compelling client, with whom a jury will identify and empathize;
2. unequivocal and unwavering support of the client's disability status by an appropriate and well-qualified treating doctor or doctors; and
3. a non-controversial medical diagnosis supported by objective evidence.

On the insurer's side of the equation, plaintiff's bad faith cases are well-served by claim handling weaknesses and errors that appear to be unreasonable, as opposed to being innocent mistakes.

The typical claim handling weaknesses we see frequently in bad faith disability insurance cases often reveal themselves in the depositions of claims personnel, as follows:

1. Little or no claims handling experience on the part of the claims person;
2. Little formal claims handling training;
3. Claims personnel that cannot explain the meaning of policy terms or how they are properly applied to a claim;
4. Claims personnel who cannot explain the medicine or medical conditions that are asserted as a basis for the claim;

³ The processing and discussion of such matters often occurred "off the record," and therefore was not reflected in the permanent claim record.

5. Claims personnel that cannot identify or explain the substantial and material duties of the claimant's occupation;
6. Claims personnel who cannot identify and explain the applicable State law standards, including relevant claims practice acts and regulations (see e.g., Cal. Ins. Code § 790.03(h) and 10 Cal. Code Regs. § 2695.1 *et seq.*; see also U.S. Dept. of Labor claims regulations applicable to ERISA claims - 29 C.F.R. 2560.503-1);
7. Claims personnel who cannot explain what "good faith" and "bad faith" mean in terms of the actual claim handling; and
8. Claims personnel that cannot explain or justify substantively why they took certain claim actions, including especially the claim denial itself.

Typical claim handling errors reflected in the claim file, as well as in claim personnel depositions, include the following:

1. Failure to document activities in a claim file, especially when it is evident from reviewing the file that a specific activity preceded a claim action;
2. Misrepresentation of facts about the claim;
3. Misrepresentation of the meaning and effect of policy terms;
4. Processing a claim under an incorrect policy term, such as using the partial or residual benefit provision to negate a total disability benefit;
5. Failure to obtain medical or other relevant information that could support a claim;
6. Requiring "objective" evidence to support disability when it is not a policy term;
7. Use of misleading or incomplete claim forms to solicit claim information;
8. Selective use of, or biased interpretation of, medical or other documentation;
9. Rejection of treating physician opinions based solely on a paper reviewer

- second-guessing of the treating physician or their patient;
10. Failure to follow through on recommended evaluation-related actions documented in the claim file (e.g., failing to obtain an IME after recommended by a manager);
 11. Failure to consider the “real world marketplace” in evaluating whether the claimant could perform the substantial and material duties under a regular occupation (“own occ”) or any occupation (“any occ”) definition;
 12. An unqualified claim handler attempting to resolve conflicts in the evidence or in expert opinions.

IV. ERISA AND NON-ERISA GROUP DISABILITY - BAD FAITH IMPLICATIONS

A. ERISA

It is widely, and incorrectly, thought that bad faith has no role to play in ERISA cases. The confusion in this regard arises from the fact that the United States Supreme Court, in a number of cases, has clarified that remedies available under ERISA, and therefore monetary recovery, is limited to those remedies specifically provided under ERISA’s civil enforcement scheme - 29 U.S.C. § 1132. Remedies that would otherwise be available to a claimant under State law, such as insurance bad faith, are preempted by ERISA under current decisional law. However, State law may still provide the “rules of decision” under which an ERISA claim must be processed and ultimately reviewed judicially. Common examples are the State law-based notice-prejudice rule - *Unum Life Ins. Co. of Amer. v. Ward*, 526, U.S. 358, 119, S.Ct. 1380 (1999) - and the process of nature rule - *Anderson v. Continental Casualty Insurance Company*, 258 F.Supp. 2d. 1127 (E.D.Cal. 2003). Other possible rules of decision affecting ERISA cases may be

derived from the Fair Claims Practice Acts and regulations adopted by the States that constitute regulation of business of insurance under the McCarran-Ferguson Act. See e.g., *UNUM Life Ins. Co. of Amer. v. Ward, supra*.

Even though not providing a remedy, or a specific rule of decision, bad faith-conduct is still important in the consideration of ERISA claims. The conduct of the insurer is relevant to the analysis of conflict of interest that may affect the standard of judicial review. See e.g., *Abatie v. Alta Health & Life Ins. Co.*, 458 F. 3d 955 (9th Cir. 2006) and *Silver v. Executive Car Leasing LTD Plan*, 466 F. 3d 727 (9th Cir. 2006).

Unreasonable conduct by the insurer in processing and/or denying a claim can have an impact on judicial attitude about a claim, and can have an affect on the judicial determination of unreasonableness and/or arbitrariness that drive the results in ERISA cases.

Further, depending on the jurisdiction, unreasonable or bad faith conduct might play an important role in a judge's discretionary award of prejudgment interest and attorney fees in ERISA cases, which, depending on the case, can substantially increase a claimant's recovery. See e.g., *Landweher v. Dupree*, 72 F. 3d 726 (9th Cir. 1995) (prejudgment interest) and *Hummell v. S.E. Rykoff & Co.*, 634 F. 2d 446 (9th Cir. 1980) (attorney fees).

B. Non-ERISA

When an insurer mistakenly treats a non-ERISA group disability insurance claim as if it is subject to ERISA it usually involves a failure to appreciate ERISA exemptions. Under ERISA, employer provided group disability insurance is subject to exemption if it is a governmental plan, a church-affiliated plan, a franchise or association group plan, or a multiple employer trust that does not involve an employer-employee relationship.

An insurer's treatment of a group disability claim as falling under ERISA when it is not actually subject to ERISA can be characterized as insurance bad faith on a number of grounds including the following:

1. The insurer telling its insured claimant that the claim is subject to federal law, not State law, constitutes a misrepresentation;
2. The insurer ignores, and therefore fails to conform to, State law in the handling of the claim;
3. The insurer tells claimant that they have the burden under ERISA to acquire and produce evidence of disability, when under State law it is the insurer who has the non-delegable duty of investigation;
4. The insurer may tend to over-rely on paper reviews by in-house consultants in order to merely document the claim file as if under an abuse of discretion standard; and
5. The insurer imposes appeals procedures and delays inherent in ERISA that are not provided for in the policy.

V. CONCLUSION

Plaintiff attorneys in disability insurance bad faith cases endeavor in discovery to identify and document changes in the insurer's disability insurance claim practices as well as unreasonable claim activities and decisions. There can be a disconnect between what a company views, from a self-interested perspective, as a good business practice and the duty of good faith and fair dealing imposed by law on the insurer. In this regard, the law imposes on insurers a non-delegable duty to promptly, fairly and thoroughly evaluate claims, and to do so in a reasonable manner that does not place the interests of the insurer above those of the insured.

The post-1995 trends and practices in disability insurance claim handling predicated on aggressively managing and controlling the claim process, and overriding treating physicians' assessments of their patients' disability status, will continue to support bad faith claims. Illustrative of the point, consider this closing thought in the form of sworn deposition testimony obtained from a disability insurer's Vice President of Disability Claims describing how an insurer *should* handle a claim for disability

insurance benefits under the duty of good faith and fair dealing:

“The insurer must act reasonably in its evaluation and give the benefit of the doubt, if there is one, to the insured in the handling of the claim.”

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