

# DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER UNFAIR CLAIMS PRACTICES ACTS

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## The Long and Short of It

By Linda Nee, BA, HIA, DIA, DHP

One of the hot topics for those receiving disability benefits in 2009 will undoubtedly involve learning various policy provisions, and having a clear understanding of how disability insurers interpret those provisions to use as denial defenses.

Most disability insurance companies spend a great deal of management's time and effort attempting to devise "interpretations" of policy provisions which can then be used to: 1) persuade claimants its interpretation is the correct one, 2) coerce claimants to perform certain actions for which there is no contractual duty to perform any action, and 3) keep the insured relatively uninformed as to the meaning of policy provisions so that insureds will not attempt an appeal even when the insurance company wronged the insured.

You've heard me say many times that "knowledge is power". Keeping abreast of what your policy actually says versus what the insurance company tells you it means are essential to keeping the disability insurers from cheating you from your benefits.

Right now, there is a great deal of "playing down" any wrongdoing on the part of insurance companies, since most are fairly busy trying to convince regulators "they are the good guys." By industry definition "a good guy" is a company who reviews claims fairly and objectively in a timely fashion, and pays those claims which should be paid.

The problem is in a recessionary economy there are no "good guys" with disability insurers re-reviewing EDU (Extended Duration Claims) looking for that long lost denial potential that may have been overlooked for as much as two years.

DCS, Inc. recommends obtaining a copy of your disability policy as soon as you become effective under the employer's plan, or if purchasing an IDI claim, by the time the first premium is paid. Read the policy, making sure you completely understand what you have a duty to do versus what the insurance company has to do.

We have found Prudential tops the list of "bad guys:" and is virtually operating unrestrained by any generally accepted claims review practice established for the industry. For this reason DCS, Inc. recently requested the State of Connecticut begin a Conduct Market Examination of Prudential and its current claims practices.

Other insurance companies are likely to continue their aggressive risk management strategies in an effort to bolster profitability at a time when profits are not to be found.

On a positive note, efforts are being made to get stories of wrongdoing aired in the media to draw attention to the abuse of discretionary authority. I'm encouraged by the airing of *ABC Morning News* story about Standard and the difficulties getting an MS claim paid. DCS, Inc. has had several issues with The Standard and the manner in which it conducts business.

Hopefully, more stations will resist the demands of the powerful insurance lobby to keep their dirty laundry out of the media and away from regulators. In any case, this newsletter is dedicated to specific topics of interest relating to the contract policy and how the insurance company abuses its discretion. The only defense to this abuse is for the insured to acquaint themselves with the policy and be able to defend it, if necessary.

### *Written Proof of Loss .....Every 90 Days?*

Most Individual Disability Income policies contain contractual provisions called “Proof of Loss” and “Time of Payment of Claims.” Most, if not all proof of loss provisions state “you must give us written proof of loss within 90 days after the end of each period for which we are liable.”

Technically by virtue of the policy language, insureds are NOT required to submit “proof of loss” sooner than 90 days from the period of benefit payment. For example, let’s say a benefit is due in January.

The policy states the insured has until April to submit proof of loss for January; or, May for February; or June for a March payment. The proof of loss provision actually goes on to say the insured can provide proof of loss within one year after the 90 days are expired. In reality, the insured actually has 1 year and 90 days to submit proof of loss for any benefit period.

For the most part, IDI policies DO NOT say the insured is to be paid every 30 days. The “time of payment of claims” provisions have wording which states the insurance company will promptly pay the benefit after it receives proper written proof.

The question is, who defines what is “proper”, or in some policies the wording is “proof acceptable to us.” You got it! The insurance company does. Most insureds want to be paid every month even though the policy doesn’t say monthly benefit payments are required.

So, insurance companies set up elaborate internal administrative procedures which require insureds to submit monthly Claimant and Attending Physician Statements even though the policy doesn’t say that.

No insurance company should threaten an insured with an IDI policy denial for non-submission of proof of loss within 30 days because the policy contract does not define that duty. The problem is, insureds want their money every 30 days and in order to get paid they must submit “proof of loss acceptable to us” in order to get the money every month.



Where in the policy does it say the insured must submit a Claimant Statement every 30 days in order to get paid? Guess what? Policies do not have such a requirement. A Claimant Statement is an internally generated form which is used as a trigger to manually release checks to the insured.. If you want to get paid, you have to send it in, but it’s not contractual either.

In this particular instance, neither party to the policy contract plays by the rules. Why wait to get paid in April for January, and I agree if an insured wants to receive monthly benefits, then it is reasonable to submit proof of loss every 30 days.

My problem with this mutual out-of-contract arrangement is on those occasions when the disability insurer positions the requirement of submission of proof of loss as if it were a contractual requirement.

Having worked as a claims specialist for some time I can vouch for the fact of how easy it becomes to administer claims according to customary internal practices rather than by what the contract actually says. Many claims specialists actually believe the contract says 30 days when it really doesn’t.

This is a situation where neither party actually upholds the policy contract, but if it should ever happen the insurance company tries to hold you to a 30 day update as a contractual duty, you should respond that actually the policy says you have 90 days (in reality 1 year and 90 days) to submit proof of loss. If you want to get paid, you should submit the proof, but there should be some admission from the insurer that “30 days” is not a contractual requirement.

Ask the insurance company to provide you with a photocopy of the policy contract that describes a duty to supply proof every 30 days. Don’t worry; it isn’t there in IDI policies.

This situation only relates to non-ERISA claims since employer sponsored group claims DO have a contractual provision requiring proof of claim within 30 days of its being requested. Group policies don’t mess around. The provisions usually state if proof of claim isn’t submitted within 30 days (at the expense of the claimant) the insurer has the right to deny the claim for “failure to provide proof of loss.”

When both parties set the contract aside there is always added risk to the insured of insurance company wrong doing. Still, everyone wants to get paid every month and is willing to take that risk.

**Unfair Settlement Claims Practices Acts.....by Linda Nee, BA, HIA, DIA, and DHP**

Individual Disability Income policies are not pre-empted by ERISA and therefore jurisdiction is given to the states and insureds are protected by state consumer protection laws. In order to standardize what constitutes improper claims practices in the various states, the National Association of Insurance Commissioners put together what is called the NAIC Model Acts which have now been adopted by the states as Unfair Settlement Claims Practices Acts. Although each state may have changed its laws somewhat, the Model Acts are basically the same in all states.

Although there are as many as 20 identifiable unfair claims practices, any acts committed by a company without just cause constitutes an improper claims practice. I may not have room to describe them all here in this writing, but I will continue this article in future newsletters. This discussion is very important to those with IDI policies and claims.

1. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue. Any time an insurance company misquotes a policy provision, or attempts to convince you a policy provision means something not specifically written, it is violating state law. For example, Unum frequently positions its field representative visits as if it is required as a matter of policy or proof of loss. Although some policies do require the insured to meet with field representatives, most IDI policies do not, especially the older policies. Anytime a claims handler misrepresents facts related to a claim, or communicates verbally, or in writing facts which are misleading, it is a violation of state law.
2. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies. Some insurance companies are not able to provide good customer service by returning calls, or being available to take calls from insureds. Anytime an insurance company develops a “pattern of business practice” of not returning calls, or not providing you with answers to your questions about a claim in a timely fashion, it is in violation of state insurance laws.
3. Failing to adopt and implement reasonable standards for the prompt investigations and settlement of claims arising under its policies. All disability insurers are required to have claims administration systems in place which can handle the volume of claims presented for payment; provide accurate and knowledgeable personnel; sufficient resources for the investigation of claims; and an appropriate appeal resource to review claims decisions. In reality, US disability insurers are among the most disorganized and chaotic organizations in the world. Prudential is currently a good example of a company which is not able to manage claims through any kind of recognizable claims review practice. Based on current experiences with Prudential it is consistently in violation of state laws.
4. Compelling policyholders to institute lawsuits to recover amounts due under its policies. If an insurance company deliberately denies benefits through the appeal process when it is clearly obvious and well documented benefits are due it is in violation of state law. UnumProvident was infamous for withholding payment of benefits when it was otherwise clear benefits were payable. UnumProvident has no problem offering settlement on the court house steps after it became obvious the insured “wasn’t just going away.” Insurance companies may not deliberately delay the payment of benefits when liability has been made reasonably clear.
5. Refusing to pay claims without conducting a reasonable investigation based on all available information. Disability insurers love to conduct investigations as long as they don’t “shoot themselves in the foot.” In other words if it looks as though an IME will result in a decision favorable to the insured, no IME will be requested. Or, co-morbidity is ignored. Unum was cited by the multi-state settlement commissioners for not fully investigating all pertinent medical facts of a claim. Focusing on one aspect of a claim favorable to the insurance company while ignoring all else favorable to the insured is in violation of state insurance law.

6. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements has been completed. This is one of the more common violations of state insurance laws. Insurance companies may NOT just hang a claim out in limbo for long periods of time without rendering a claim decision. For many IDI claims, one has to wonder at some point whether ANY amount of medical documentation will be sufficient. It appears as though the insurance company “makes it up as they go along” – first requesting one thing and then another. It is entirely inappropriate for any insurer to have not rendered a claim decision within a reasonable period of time. Delaying claim decisions for long periods of time is in violation of state law.
7. Delaying the investigation or payment of claims by requiring an insured, a claimant, or the physicians of either to submit a preliminary claim report and then requiring subsequent submission of formal proof of loss forms, resulting in the duplication of verification. In order to delay claims indefinitely, disability insurers often keep requesting the same medical information over and over again – sometimes claiming the information was not received at all. Insurers will harass and send repeated requests to physicians, first in the form of office treatment notes, then an Attending Physician’s form, then something else and something else. Repeated requests for the same information over and over again in an effort to delay the payment of claims are in violation of state insurance laws.

These are the more important violations of state insurance laws under the NAIC Model Acts and Unfair Settlement Claims Practices Acts. When filing a complaint with your state Insurance Commissioner you should first look up the actual wording for the laws in your state, and then explain which laws you have evidence the insurance company violated. This way reviewers at the DOI can examine specific violations of laws pertaining to your state.

In the above discussion I used the Illinois Unfair Claims Law & Regulations, but each state should have their own interpretation of what constitutes unfair or improper claims practices. Illinois is also one of several states which declares “discretionary authority” to not be consistent with other state insurance laws and is therefore not permitted.

Many states have already adopted the NAIC Discretionary clauses Model Act by statute including Maine, Oregon, and Minnesota. Discretionary clauses have been found to be in violation of state insurance laws in the states of California, Utah, Montana, Hawaii, Indiana, New Jersey, and Illinois.

A “discretionary clause” is any provision in an insurance policy or contract or an annuity contract that purports to confer on the insurer sole discretionary authority to determine eligibility for benefits or to interpret the terms or provisions of the policy or contract. Simply put, the fox is no longer allowed to watch the hen house, at least in the states mentioned.

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I sincerely hope this information is valuable to you. If you have any questions, please feel free to contact me. DCS clients, please let me know if you have any questions related to this newsletter. In the meantime, I hope everyone is doing well.

Thanks to everyone who submitted statements on my behalf. I am deeply thankful to all those who responded to my request.