THE UNUM LEGACY

From “Lighthouse to the World”
to
“Outhouse Failure”

DEDICATION

This book is dedicated to the millions of working Americans who depend on disability benefits for financial protection during times of unexpected sickness or injury.

It is also dedicated to thousands of individuals who find themselves employed by corporations that “just don’t give a damn” about crossing the lines of ethics for profit and greed.

INTRODUCTION

Disability insurance is a multi-million dollar a year industry. Most employers in the United States offer group short-term and long-term disability protection to their employees with the expectation of providing financial benefits during periods of unexpected sickness or injury. Unfortunately, this false sense of security presented to the American worker is often bashed by our government and industry, which allows large corporations to scheme and rob American workers of disability payments to which they are entitled for profit. It is unfortunate, that while some progress has been made, our federal and state regulators have not pulled the plug on the disability insurers who have demonstrated they are clearly not able to regulate themselves.

My writing is about the disability claims process, or simply put, how the disability insurance companies evaluate, pay, and deny claims. It is not even about UNUM Life Insurance Company of America or UNUMProvident in particular since the claims processes described in this book are typical of nearly all disability insurers. The process strategies devised by major disability insurers to deny legitimate claims for profit is evident nationwide.

Attorneys relax. I am not a lawyer and this book is not about the law, nor does it reference any judicial cases or precedents, not explained in public. That's your job. Any references to the Employment Retirement Income Security Act of 1974 (ERISA) are strictly given from the point of view of a former employee claims specialist and consultant in private practice, and certainly there is no intention on my part to interpret or define the law as it pertains to contracts, policies, or any federal or state law. This book is about a *process,* not any law or interpretation of it.

This book is also not about me as a former employee of both UNUM Life Insurance Company and UNUMProvident. Although I am often described by UNUMProvident as a "disgruntled employee, the "whodunits" aren't relevant to the discussion of a claims process gone rogue with greed. Telling my story, however, is also part of UNUM's story. What happened to employees as management continued to make decisions to increase the profitability of the company at the expense of insureds as well as employees is indeed a tale to be told.

Additionally, I have no problem with anyone past or presently employed by UNUMProvident or Unum Group since we all did what we had to do in order to keep our jobs. Therefore, there are few real-life names mentioned in the text, other than descriptions of individual claims and cases, which are entirely fictional accounts typical of many cases I managed while still an employee of UNUMProvident.

I have no ax to grind with UNUM, and this book is not an effort on my part to "get back at anyone". But, the telling of a story can sometimes be very important in order to gain complete understanding of what happened to what once was, "The Lighthouse to the World", and its descent to the backyard Outhouse.

As previously indicated, the disability claims processes described in this book are direct and personal observations, not perceptions. Either I was actually present during the claims activity, or I personally participated and observed the overall process in its entirety, or was instructed by management to perform my job in a certain way. As a disability claims consultant, I also had the opportunity of reviewing numerous group STD and LTD claims with nearly all of the major disability insurers and third-party administrators. I was there, and personal observation is a powerful resource. Most of my statements are backed up with illustrations in so far as I had them, and kept them.

In all fairness, the discussion of unfair claims review practices would not be complete without mentioning evidences of malingering and attempts by some claimants to obtain secondary gain by filing fraudulent claims for disability. Although unfair claims practices and abuses by disability insurers is currently "in the news", it should also be noted that between 10-15 percent of all claims presented for payment are fraudulent, and that another 20-30 percent of claims should legitimately not be paid.

In short, not all disability claims presented for payment are, or should be paid. Personally, I never had a problem denying a disability claim that legitimately and rightfully should be denied. At least in theory, my job as a claims specialist was to review each claim objectively and fairly on its own merit, and pay those claims which should be paid, while denying those claims which should be denied. In so far as I was permitted by management to have autonomy to make fair claims decisions, I made them. What I did have a problem with, however, was participating in a claims review process directing claims specialists and managers to "stack the deck" against insureds with legitimate, payable claims in order to meet corporate targeted financial profits. This type of process, as communicated to me by those "in the know" is against the law.

The final objective of this book is intended to inform. In my opinion, the more knowledge and information available to American employers and employees about their disability benefits and other employer provided welfare plans, the less likely unscrupulous insurance companies will be able to successfully deny payable claims. Knowledge and information about disability policies and coverage is essential to the prevention of insurance industry fraud. This book is also important to current Unum Group employees who may not understand the dilemma they are in.

Finally, let's not forget that although this story is about an industry "gone rogue" with targeted profits, it's really a very *human* story. It's about people. It's about millions of American workers suddenly faced with sickness and injury resulting in temporary or permanent cessation of productive work, and who are often forced to give up their homes and financial security because the benefits on which they depended are denied by the very company who collected millions of premium dollars with the expectation of paying benefits when needed.

Factory workers, administrative secretaries, firemen, policemen, 9/11 victims, nurses, physical therapists, and even claims specialists depend on the financial coverage of group disability insurance in case of an unexpected sickness or injury. On those occasions when disability benefits are unjustly denied families are forced to seek relief from town and state resources.

What state insurance commissioners and prosecutors fail to realize is that the transference of financial responsibility from the disability insurer to government welfare agencies and Medicaid places undue financial burdens on state taxpayers. Unfortunately, disability insurance companies are already transferring part of their financial liability to pay claims to the federal government through Social Security, Workers' Comp and Retirement Plans.

Clearly, our federal and state regulators must recognize the need to enact legislation to hold all insurance industry management accountable for their actions, and agree to prosecute those who willfully and deliberately devise claims processes which annually produce millions of dollars in profit by depriving the American worker of the financial security to which he/she is entitled to in time of need.

In order to fully describe Unum Group today, it's necessary to tell the story of Unum Life Insurance and the internal culture of luxury and lavishness following the demutualization of Union Mutual, as well as the merger/takeover of the Provident Companies and Paul Revere. Corporate culture is as important to the recording of history as the devastating failures ultimately resulting from unfair claims practices.

I may be the only one left brave enough, or frankly alive, to tell Unum's story from the cultural perspective of those who worked there, those who were/are terminated unfairly and discriminated against, and the self-serving external legal community looking to take advantage of the most vulnerable in our society.

Unum's history is actually significant, and it's really quite a story.

CHAPTER 1

The Early Days
In the Beginning…… A Culture of Smoldering Embers

In 1996 UNUM Life Insurance Company was located on an impressive, high-mounded campus surrounded by well-groomed lawns, trees and landscaped gardens. Overlooking Route 22, also referred to as the outer Congress Street location, UNUM consisted of two buildings affectionately referred to as Home Office I (HOI) and Home Office II (HOII). Plans for the ultimate in multi-complex buildings, HOIII was already in the works in 1996 despite several other well-placed urban locations in the greater Portland area including buildings in Scarborough, Stroudwater, Portland, and Westbrook. Money was no object; UNUM Life Insurance flourished with abundance.

Set against a beautiful backdrop of blue sky and bright green golf course mowed lawns, Unum's cornerstone marker adorned the entrance with its "Lighthouse to the World" stone promising insureds disability insurance second to none. Every day employees were reminded of their value to the company, as they turned into the buildings complex. As CEO Jim Orr III, told our graduating group in 1996, "UNUM is depending on you to do your job. Without you, there is no company."

In 1996 UNUM Life had six offices: NYRB in New York (First UNUM) New York Regional Benefits, MARB (UNUM America also in Tarrytown) Mid-Atlantic Regional Benefits, (MWRB in Chicago Mid-Western Regional Benefits), SRB in Atlanta (Southern Regional Benefits), NERB in Portland (North East Regional Benefits), and WRB Western Regional Benefits in Glendale CA.

In 1994 there was also UNUM UK, UNUM Japan, and UNUM South Africa. UNUM continues to operate in the United Kingdom today although it no longer offers Individual Disability, only Employer Group Plans.

Unum was asked to leave Japan due to questionable claims practices, or so the story goes. I believe the Japanese people's reluctance to buy insurance that pays for doing nothing was probably the real cause of Unum's retreat from Japan.

I have no idea why UNUM Africa never materialized.

Each of the regional US offices received initial liability claims for covered individuals within their defined geographical regions, and was responsible for making the initial liability decisions in that location. Active Claims Management (ACM), defined as claims for which liability had been already accepted, was also managed at the local level.

All of the Disability Benefit Specialists located at the regional offices specialized in Initial Liability determinations, or on-going management (ACM).

Central Benefits Administration (CBA), located in Portland, ME managed only those claims with approved Social Security Disability Income (SSDI), therefore, it was presumed that even this group of approved SSDI claimants could be successfully risk managed.

Corporate organization was extremely complicated for employees and included Unum America, Unum Enterprise, Duncanson & Holt, and Unum Life Insurance Company of America. As an employee initially hired to work for the Vice President of Compensation, I worked for UNUM Life Insurance, was paid by UNUM America, and was assigned to UNUM Enterprise.

In 1994 UNUM Enterprise consisted entirely of Corporate Headquarters in Portland, Maine where CEO Jim Orr III and the top twenty-six Executive Vice Presidents maintained offices. Unum America and Unum Life Insurance were on-paper entities only and outside the claims area were not mentioned to any great extent. In fact, I suspect many employees never realized that although they worked for Unum Enterprise, their checks came from Unum America.

Major players, and the most historic characters in the history of Unum Mutual after its November 19, 1986 demutualization included Jim Orr III as CEO, Steve Center, President, and Elaine Rosen, President (1997-1999, Executive Vice President 1999-2001.)

Alone, these three highly controversial characters set the cultural tone internally for the next decade of UNUM operations. Jim Orr III's liberal humanizing and sympathetic diversity philosophies balanced by Steve Center's and Elaine Rosen's strict, highly critical, often demanding management styles, established a code of conduct that although made the company "look good" created smoldering embers both culturally and financially.

UNUM's downward trek most likely began shortly after demutualization, in November 1986 as Orr, Center and Rosen set up their chess board kings and queens with strategies that later proved to be the company's downfall.

UNUM's Culture – Welcome to Camelot

In 1986, headlines in the Portland, Maine papers read, "Arnold Palmer Won Over Maine Fans Winning at Purpoodock, [Cape Elizabeth's Golf Course], in the PGA's Union Mutual Senior's Golf Classic." Arnold Palmer won $38,000.

In the same time period, Union Mutual was also sponsoring a sailboat in the America's Cup trials and funded athletes participating in the Junior Olympics. The company's public image soared as the new Unum Life Insurance

Company of America made its presence known pouring millions of dollars into the creation of a public image.

It is not unreasonable to say that in 1994 UNUMProvident was the most coveted employer in Maine. It was also rumored in Maine the company was "picky" about who it hired, and only the smartest and most chic workers would ever see the inside of an Unum Life building.

After all, in 1849 Unum actually sold life insurance policies to those heading west over the Rockies as part of the gold rush. How many of those lost along the way would actually file claims? You have to hand it to Unum, it always was very, very clever.

I had to "RAC" for my job, and had to appear before a panel of Unum managers, take psychological, math, and algebraic tests, and participate in the typical "rowboat scenario." At the time, Unum did not discriminate in employment with respect to age and sex, and since I was transitioning from Unum Enterprise as a Compensation Specialist, I probably had an edge over other candidates.

At that time, Unum's employee benefits were second to none and included 100% paid health and dental benefits, and contributory life and disability insurance.

However, it was the extra benefits Unum offered that tipped the scale: subsidized cafeteria, 38.5-hour work week [1-hour lunch period], employer contributed 401k pension plan, option to receive up to one-third of yearly salary in a lump sum, annual bonus, child care subsidized or provided on campus, subsidized education and many other perks not generally heard of today.

Included as part of Unum's own "Occupational Health Program" and "Employee's Assistance" Unum offered employees a "Wellpower Program" that included onsite and staffed fitness facilities in Maine and South Carolina. Included was a wide range of health education, screening and immunization counseling.

Additionally, UNUM's Employee Assistance Program included reimbursement, childcare referral services and other policy formation to promote employee health. The vast array of programs was designed to help employees stay productively at work and prevent disability. Unum Life insurance walked the talk and the company was publicly recognized as a model workplace.

Reportedly, Unum's total budget for its 1998 Integrated Health, Safety and Disability Management programs was $1,680,470 with another $192,571 allocated for the Fitness Facilities. Overall results for the program were eventually reported as a saving of $2.72 for every dollar invested in the programs.

It was very clear that Jim Orr III's dedication to employees remained at the top of the company pyramid.

Not one unit or department meeting, and there were many, took place without catering with bagels, cream cheese, sodas, fruit or any other request authorized by department managers. In fact, administrative assistants were told to automatically order the "bagel snacks" when meetings were scheduled. On the floor, in working areas, bowls of chocolates and hard candy were readily available, particularly during training sessions where lunch would also be served.

Claims handlers were "gifted" with free lunches several times a week consisting of pizza, or meat/sandwich platters, chips, sodas, fruit plates, and cake of all kinds. In fact, I attended a retirement party for one of our Unum Enterprise employees, which seemed more like King Arthur's wedding than a retirement.

There was a literal tower of jumbo shrimp, tacos, and every imaginable type of food, cake and snack set up in a large conference room. The food alone must have cost the company several thousands of dollars. A video of the employee's 25 years with the company ran on large overhead screens, with a champagne toast at the end. Estimated total bill around $10,000!

Those who have seen the movie, "Office Space" may remember the scene of singing "Happy Birthday" to a peer who no one really knows or cares about. Yet, every employee at Unum received a birthday cake and a very dull, off-key monotone Happy Birthday sing-along from co-workers. It was silently acknowledged that singing "Happy Birthday" and looking like a gigantic idiot was generally worth an afternoon piece of cake.

Incredibly, the creators of "Office Space" also nailed the cubicle culture of corporations including one of my managers who divided "tha…anks" into two syllables, and repeated her gratitude all day long – as annoying in reality as it was portrayed in the film.

The CEO and top twenty-six Executive Vice Presidents were periodically awarded Stock Options and received additional perks, particularly later when golden parachutes were hurriedly put together not long before the merger.

The Vice President of Human Resources received paid nanny benefits when she adopted her children. Included in executive perks paid for by Unum were roadside service, gratuitous trips on the corporate jet, free financial planning services, stock options, deferred compensation and paid life insurance policies.

Executive perks were normal and customary as were the annual bonuses given out company wide in March of each year. (More about this later.) Apparently, money was no object and management kept the façade of profitability working in its favor.

For example, the Vice President of Compensation, a rather tall, sheepish man, schooled in Reiki massage, and tribal drum beating, was petrified of the Vice President of Marketing. A lover of the movie "Forest Gump" and all things "hippie", Roger (not his real name), quickly became a nervous poodle around the VP of Marketing. His mea culpa included yearly expensive lunches and forever groveling conversation to make amends for whatever it was he did.

However, while the executives drained the company of monetary resources, within the ranks of the corporate elite, members often quaked in their boots around each other. Hard feelings and fear of instantaneous demotion did not always work to promote solid relationships within Unum's closely guarded management team. Nevertheless, Unum's elite sidestepped and walked on eggshells around each other, but individually their pocketbooks and wallets were as fat as ever.

Overdressed but Still Awful

Although there was no scarcity to Unum's cash outlays, both public and companywide, employee culture aggravated by Steve Center and Elaine Rosen's strict adherence to formality dressed up Unum's employees resembling Stepford wives and guys brought to mind, "Oops, all dressed up with nowhere to go."

Men were required to wear suits, or at a minimum sports coats, shirts and ties. Women also were required to wear business suits, panty hose and high heels. Most women chose to wear the crisscross white blouses, with the most god-awful large white choke beads, resembling the plastic "pop beads" kids used to play with in the 50's. Most of the women's accessories were cheap, fake imitations of expensive jewelry especially the "pins" women wore on their suit jackets. God forbid, if any female "forgot" the pin to complete her outfit.

It was rumored that Steve Center, then Unum's President, lined up the female staff along the wall and examined their panty hose and high heels for scruffs right before important meetings. I wonder how he would have been able to get away with that today! Nevertheless, Unum's three thousand employees looked like they "dressed up in their Sunday go-to-Church best", with senior fashion critics waiting at the door. Those who didn't conform to the mandatory dress code were sent home. My boss became adamant when I wore a polyester jacket to work. I was asked not to wear it again.

Unum's internal corporate culture also determined the "pecking order" in each department. For example, managers always had windowed offices; Vice Presidents were given round tables with a chair; and, executive VP's had a vase and an extra chair around their tables. The décor was a sign that the individual who occupied the space had been awarded a selective place in the hierarchy of corporate management.

Exempt employees were always given greater cubicle floor space than non-exempt employees. The difference between these two classes of employees represented a clear and obvious positional bias toward Administrative Assistants and other clerical personnel. It was believed by management that non-exempt employees were "less smart" than exempt, and could never transition upward in the company.

It also got back to me from a non-exempt administrative assistant that several of the tenured female exempt employees in Compensation complained when I was given a too big cubicle to put three-ring binders together – conversation that was regarded as an attempt at "keeping the Admin in her place."

In fact, it was accepted that non-exempt employees could never advance to exempt status within the company because they just weren't skilled, or smart enough. Therefore, non-exempt employees were looked down upon as the lowest rung of Unum's ladder, complete with very small offices and everyone else in the unit telling them what to do. The under current of resentment of Unum's non-exempt status bias permeated the company like a silent earthquake about to happen as the "I'm smart, and you're not" attitudes festered.

Management's strict adherence to image put forth a company philosophy that superficial appearances in attire, workspace, and status resulted in excellence with both product and efficiency, which of course was ultimately not the case. Both Steve Center and Elaine Rosen believed that "looking the part" created efficiency and top performance.

As the luxurious, Camelot public image continued, the less Unum Life Insurance Company of America flourished. CEO Jim Orr III found himself faced with decreasing profits and a company overladen with extravagant perks, bonuses, and extremely well dressed disgruntled employees. Apparently, the "let's get them all dressed up and they'll function efficiently" philosophy wasn't working as well as hoped.

CHAPTER 2

The Disappointing 1998 People Goals and Goals Stock Option Plan

In the decade following demutualization (1988-1998), Unum worked very hard to become a successful leader in the group STD/LTD insurance industry. In 1992, the Vice President of Human Resources articulated the overall corporate-wide goal as "61592", meaning: to earn six dollars per share with 15 percent return on equity by 1992.

Having achieved the 61592 financial goals ahead of schedule, and recognizing the power of goals as a powerful employee motivator, Jim Orr III and his team set about to announce the new Unum vision by 1993.

As the HR Vice President explained, *"By 1991 we had, through growth and acquisitions become a much more complex organization and the chairman recognized that a single focus on financial results would be difficult to communicate effectively and would not reflect the diverse challenges of the corporation. Consequently, he decided that we needed a set of goals that would be meaningful to all employees that would focus their energies on improving customer-facing performance and would improve further shareholder returns. In short, he wanted a balanced set of measures that would reflect the interests of all Unum's stakeholder groups."*

The VP continued, *"The Chairman told the team that he wanted financial, customer, employee and productivity targets, gave it a budget, and most importantly, his whole-hearted support. He made it clear that this was absolutely vital for the long-term success and growth of the company."*

As a result, the Unum Corporation developed what in 1993 was called the "Unum Balanced Scorecard" consisting of four major "visions and values."

For the next four years (1993-1997) Unum employees completed annual surveys asking questions about unit performance, efficiency, operations, work environment, and management skills. The "goal" per se was to achieve at least an overall score of 70% in all categories of internal efficiency.

In order to achieve shareholder success, management touted the 1998 People Goals as the path to better operations with employee exceeds efficiency. "Work harder, stay longer, come in on weekends" was the message to ensure Unum's future success, including assuring the annual bonus was "earned" and received in March of each year.

As Jim Orr II said in 1998, *"We continue to make solid progress to our 1998 goals – goals that have served Unum well over the past five years. Because of these aggressive goals, Unum is closer than ever to its vision-and ultimate goal- of world leadership in disability and special risk management."*

Apparently, Jim Orr III's Balanced Score Card and implementation of company wide "Visions and Values" was seen as a monumental success. As a result, Unum Corporation launched the 1995 Goals Stock Option Plan wherein each employee received a grant of 150 shares of stock options with a grant price of $18 per share and current market value of $55.

Shortly thereafter, Unum's stock price hit $60 and Unum's Board of Directors authorized a 2:1 stock split by issuing another 150 shares to employees totaling 300 shares with an issue price of $30 per share. ($60 per share market

value.) Although the original issue vested in 9 years, employees were permitted to sell their options at the time of the 1999 merger.

Not surprisingly, by 4th Quarter 1998 Unum employees hyped with excitement and pride after five years of working toward achieving Jim Orr's promise of a "balanced scorecard" of employee, customer and shareholder success, looked forward to the promised celebrations. After all, employees had already received stock options, including a stock split, encouraging the notion of personal ownership in the company. Empowered, employees couldn't wait to share in the company's success.

While employees rallied for the inevitable celebrations that were promised and scheduled to take place in 1st Quarter 1999, there was no indication to employees the company was in trouble financially. However, by early 1998 when no last survey appeared, Unum's management went dark and silent and then…. Harold Chandler stole the company's cheese.

Since then, there has been a great deal of speculation concerning at what point Jim Orr III and his senior management knew of the merger with the Provident Companies. In hindsight, many employees surmised the stock option awards were given deliberately to encourage employee loyalty with the company when it became known there was to be a merger. It was also suspected that Elaine Rosen and John Roberts, well-liked by employees remained with the company to maintain employee loyalty during the transition to UnumProvident.

After the fact, employees regarded the 1998 People Goals as a perfect example of what happens when employees place their loyalty and trust with a corporate employer. At the time of the 1999 merger with the Provident companies, including Paul Revere, the price of Unum stock eventually dropped to $5 per share. Employees still on board were told to hold on to their stock options because it was anticipated the stock price would go back up.

Well, it didn't. Employee mistrust over the 1998 People Goal debacle resulted in the sale of approximately 5% of employee stock options when the price was still just under $60 per share. Most employees lost the value of their options entirely, threw their hands up in the air and left the company. If I were an Unum employee today, I wouldn't put too much stock into Unum Group, and yes, that's a deliberate pun intended.

By 1999 Jim Orr III had retired from the company and was heard to say, "I hope I didn't let the employees down." In the end, Unum Life's employees never saw what was coming and clearly didn't know what hit them.

Jim Orr III and his "Vision and Values" that resulted in the sale of the company to Provident henchmen ultimately determined the fate of one of the best employers in the country. Unum Life was definitely let down.

Whatever Happened to Robert Crispin?

(Lindanee's Blog Article - March 18, 2013)

The atmosphere in Unum Enterprise (Executive Offices) in mid to late 1994 was one of cloak and dagger secrecy. Every one was aware President Steve Center was retiring to his wife's Scarborough antique shop, and Jim Orr III had already begun his new "1998 People Goals" project in hopes of improving internal performance.

During the four-year period from 1994-1998 Unum Enterprise became a hubbub of golden parachutes, sales of stock options, and severance "chutes" for the top twenty-six executive vice presidents. Of course, only top-level executives understood the need for parachutes at the time, but in retrospect, it might have appeared that the pending merger with The Provident Companies might have already been in the works.

Amid the secrecy and clandestine meetings other tactical changes took place as well. Jim Orr III, despite pleadings from the governor and major of Portland, moved the company's communication center to Columbia, SC. Economically, Maine suffered from the move, but Orr remained steadfast in reducing costs and moved the Unum communication center to Columbia, SC.

Enter Robert W. Crispin, recruited by Unum as a replacement for Steve Center and potentially Jim Orr III who was thought to be looking to retire from Unum within the year.

Mr. Crispin, a former and prestigious Vice Chairman from Travelers Insurance Companies was offered a generous sign-on package including $250,000, stock options, and other deferred compensation. Telephone calls and meetings to bring Mr. Crispin on board were handled with the utmost secrecy.

Although Robert Crispin was paid a salary of $500,000 a year (in 1996) and additionally received 266,884 stock awards, he remained a somewhat silent figure and maintained a low profile in the executive offices. Steve Center did in fact retire to his Antique Barn on Route 1, and shortly thereafter, the VP of Compensation began work on parachutes and severance packages for Jim Orr III and his executive management. Jim Orr III walked away with a very generous golden parachute and $50 million dollars.

In retrospect, it appeared Unum was well aware of the pending merger with Provident and Paul Revere although employees were continually encouraged to look forward to achieving the "1998 People Goals". Celebrations were promised, and employees looked forward to bonuses and unit days off. Instead, in an unprecedented move, Unum awarded 150 shares of stock options to all employees of record.

Again, in retrospect Unum's stock option attempt to maintain employee loyalty during the merger backfired when stock prices plummeted and never regained its former $60 per share value. Despite promises of regaining Unum's stock price values, it never happened and employees quit camp quickly.

Through all the turmoil, reorganization, and secrecy, to this day I don't know what happened to Robert Crispin. I always felt bad for the guy since having been so passionately recruited one would have expected he would be given a major role in the new company. Apparently, Harold Chandler, the new wise guy from Chattanooga had other plans.

As far as I can research, Robert Crispin disappeared from Unum in 1997 (just prior to the merger deals) with a salary of $416,154 and having 684,849 stock awards. It's my personal opinion Mr. Crispin was recruited prior to merger plans, and was left broadsided when the company merged with Harold Chandler and the "good ol'boys" from the south.

Mr. Crispin is a good lesson in remembering that even top executives can get thrown under the bus in the corporate race of holding companies and profitability. Although Mr. Crispin was no doubt well compensated for his trouble, he is one of the least known Unum executives from Unum's past.

Clearly, Harold Chandler pinched Mr. Crispin's cheddar cheese.

CHAPTER 3

Unum Life Insurance Claims Practices – Already Really Bad

The lavishness and favorable treatment of Unum employees under Jim Orr III indeed served its purpose in producing a claims staff who would indeed do anything they were directed to do for the next ham sandwich, chips and coke, extravaganza. Unbeknown to insureds and claimants, Unum Life Insurance Company was already engaging in some of the most deceptive claims practices later discovered as part of the Multi-State Settlement Conduct Market investigations.

While Jim Orr III touted and publicly popularized the "Lighthouse to the World" logo, internally the company's core business deliberately targeted high value reserve claims and denied legitimately payable claims to bolster profitability. It was Unum's way or the highway for claims handlers who knew what they were doing was wrong, but couldn't bring themselves to leave Camelot and the better than average salaries for communities in Maine, or North Carolina for that matter.

From 1996 – 1999 Unum's group STD/LTD claims process was flagrantly unfair and designed to maximize denials for a variety of out-of-Plan reasons. Although central to the process was "consensus of medical opinion" managers schemed to create strategies that outwardly appeared legitimate while at the same time created financial hardship for claimants who didn't have a clue they were being scammed.

What is This Job Anyway?

(Article Re-printed from 1999)

After four weeks of intensive disability policy and contract training, my first assignment as a Band 8 Disability Benefit Specialist (DBS) was Central Benefits Administration, affectionately referred to as CBA. The department consisted of five managers each having approximately ten DBS' as direct reports. Also contained within CBA were the medical and vocational staff, a small buy-out section, and finally an overpayment section responsible for collecting lump sum retroactive payments from those awarded social security disability benefits.

In addition, separate settlement and complex claims units were located on the third floor such as the SIU or Special Investigations Unit, and CCU or Complex Claims Unit receiving referrals for specialized claims, questions and complex issues. All in all, CBA represented a qualified collection of well-trained employees ready and willing to provide fair and objective claim reviews. Or, so I thought. Boy, was I wrong. Nothing could have been farthest from the truth.

My first day in CBA was jubilant. Although I couldn't quite figure out the reason for the obvious celebration, all of the new DBS' were included in the pizza, soda and chips extravaganza. Columns of flat boxes of Domino's pizza of every topping and type covered the long tables complete with bottles of assorted soda, bags of chips, Dorito's and pretzels.

CBA's managers stood behind the long rows of tables serving employees their pizza of choice on white paper plates with plastic forks and knives. When I inquired of a "seasoned" DBS what the reason was for the free lunch, she led me to an inside wall and pointed to the poster thermometer on the wall. "We made our target, isn't that great?" I looked at the poster and saw the thermometer indicated millions in financial reserve dollars easily filling up the glass tube nearly to the top.

"I guess so", I shrugged even though I didn't have the foggiest idea what she was talking about. I can still picture myself standing in front of the red CBA thermometer staring at handwritten names of claimants painted in red. Although the pizza was delicious, it wasn't long after this I learned the hard way there was no real "free lunch" in UNUM Life's claims departments.

Within a week of joining CBA I was given my first block of 185 claims. It was customary at the time for the veteran DBS' to select "discards" from their own blocks and "contribute" to the newer blocks of employees starting work on the floor. Naturally, it wasn't unusual then for me to wind up with the most difficult claims to manage, largely LTOC and LTIP [1] claims. These claims contained definitions of disability which made them "own occupation" policies within the group LTD category. However, for a new claims handler looking for experience this was probably the best block of business to start out with.

My first manager, a somewhat rigid, and self-disciplined Scots woman with short carrot blond hair, allowed me to get acquainted with my claims for the first several days as a short orientation to the daily activities of the claims area. Then, toward the end of the first week, I had my initial manager/direct report one-on-one meeting, an experience that forever took the enjoyment and pride out of being a claims specialist.

The woman sat stiffly behind her round office table, and after introducing herself and her 18 years of claims experience, handed me a piece of paper indicating that as a Band 8 I had the responsibility of "bringing in" $275,000 of financial reserves representing controllable closures and $27,000 in claim settlements per month. Furthermore, I had 18-24 months to prove to CBA management that I could contribute to "unit results" at this level on a consistent basis. If I was found to be deficient in my "results" it would become a performance issue and at the end of 24 months, I would be asked to leave the claims area and find another job within the company. Bands 9 and 10 had much larger reserve targets, and therefore if I were promoted after 12 months, I would be expected to "contribute" at a much higher level.

At first, I couldn't figure it out. What in the world was this woman talking about? The trainers never mentioned reserves and claim denials in DBS school. *What in the world*? Suddenly, like the old cliché of a light bulb turning on, it came to me that I was expected to indiscriminately terminate claims at a certain level each month in order to meet performance expectations set by the managers of CBA.

"Now, how was I going to do that?" I thought, staring at the blank screen of my computer. What have I gotten myself into? So, what is this job *really* about? Sadly, it took me six years of involvement in the UNUM Life and UNUMProvident claims organizations to understand it completely. I had applied for the DBS job naively thinking the objective was to provide "quality" claims management to customers submitting disability claims. Funny, it never really occurred to me at that time that the overall goal was NOT to pay claims.

[1] LTOC (Long Term Own Occupation) and LTIP (Long Term Income Protection). Both types of definitions of disability are "own occupation", however, the claimant is allowed to work during the elimination period under the LTIP definition.

" Hey, I'll Take a Lawn Chair and a Beach Ball!"

(Lindanee's Blog 2004)

All corporations provide employees with some type of incentives whether in the form of financial rewards, job incentives, promotional advancement or social events. In this regard UNUM Life Insurance was an exceptional employer. Since the claims specialists were located at the top of the priority pyramid in terms of relative corporate importance in achieving profits, the lion's share of incentives was ultimately awarded to those who "touched" claims.

However, the most popular UNUM Life employee incentive was the yearly companywide "bonus" awarded to all employees of record as of October 15th of the previous year. Both executives and employees, exempt and non-exempt, qualified for the bonus awarded by February 15th, by the Corporate Compensation Committee. The amount of the bonus ranged from 2 to 6 percent of each employee's annual salary which for most claims specialists was somewhere in the range of $2,400 - $3,000. One of the Vice Presidents in Executive HR once commented to me that you could tell it was bonus time at UNUM Life by noticing all of the new cars in the parking lot the next day.

Of course, claims managers used the opportunity of the yearly corporate bonus to entice employees to give more of their time and energy to support the company agenda even though UNUM sold itself as one of the best employers for "work-home balance." Like busy worker bees, employees scrambled to give UNUM Life what it wanted – more and more profit. The UNUM Life corporate annual bonus was a very successful incentive and produced tremendous growth as a result of the sacrifices made by nearly every employee, who at the time were still working toward the 1998 People Goals.

Management spun the bonus like a top. On the day the incentive bonus was to be announced, speculation rumored the possibility of no bonus at all. Unthinkable! How could that be? Employees gossiped all morning in the halls trying to guess the bonus percentage, while managers remained closed-mouthed and out of sight. Finally, around noon, the message came down from corporate there would be a bonus after all. Shouts of approval were heard from all locations as employees cheered for UNUM Life and its management.

Within an hour special mail deliveries were made to managers at each UNUM location and bonus checks were distributed to employees along with a solid hand shake and a very polite "thank you for a job well-done." At least for the moment, everyone felt appreciated for their hard work and were willing to concede UNUM Life Insurance Company was the best damn employer in the United States!

Immediately, elaborately decorated cakes, pizza, shrimp and seafood platters were placed in company lobbies. Grateful Vice Presidents and managers adorned with white chef hats stood behind cardboard tables and served employees food with a smile. A few managers ordered pizza and celebrated privately with members of their unit while most employees left the buildings to deposit their checks as quickly as possible often standing in long teller lines protruding out of the doors of local banks. Clearly, on bonus day very few employees were left to "mind the store". By 2 o'clock only a skeleton crew remained in the UNUM buildings to answer calls. The celebration was nearly over.

The surrounding communities of Portland and South Portland also fêted UNUM's bonus day by keeping their establishments open later than usual to accommodate anxious buyers looking to spend extra dollars on new clothes, necessities, cars and electronics. It all seemed to work together as the influx of corporate money kept local business enterprises prosperous. Neither government nor local business dared criticize UNUM Life Insurance Company as extra cash flowed from UNUM's treasury to employee's pockets and into local cash registers.

My motivation in describing UNUM's bonus day activities is to illustrate what employees will actually do for money, gifts and amenities on the job. In order to promote competition and motivation among the claims specialists to terminate as many claims as possible, CBA managers provided an endless supply of $25 movie tickets, $50 dinner-for-two gift certificates, "spot" awards, shareholder value awards, peer appreciation awards, dollar awards from UNUM's gift catalog, gas cards, Border Book Store cards, as well as pizza lunches, and off-site social events. These incentives, if you will, were intended to keep employees "focused" on achieving financial results for the company.

During an end of the month claim denial "blitz" two of my friends were chatting just outside my office doorway when one of the senior managers passed by in the hall.

"Ladies?", he said somewhat sarcastically, "have you denied a claim in the last five minutes?"

"Not yet", one of the women answered.

"Well, why don't you go deny one?" And, so it was in the disability claims arena.

During the end of a month or quarter in CBA the working environment was nearly unbearable as managers grew more and more stressed when there was a good probability financial targets would not be met. I can't honestly say I actually didn't hear the word "blitz" [2] used at UNUM Life Insurance, but we did have "focus days" to deny claims – same activity different name.

In an attempt to achieve financial target results, *and* keep the disability claim terminations coming, the managers of CBA devised "focus day" activities offering claims specialists the opportunity of "winning" theme related gifts. For example, in the summer, an award area on the floor was decorated with lawn chairs, smoker grills, beach balls, towels and umbrellas, expensive suntan lotions, free tanning services and all kinds of gift certificates related to beach activity.

In order to win, claims specialists were told to write their name, and the names of the terminated claimant, on white pieces of paper each time a claim was denied and place it in the "fish bowl." Near the fishbowl was a bell which we rang every time an insured's claim was denied. On the half-hour one of the managers withdrew a name from the fish bowl and the lucky lottery winner was able to choose from the large selection of gifts. My first summer in CBA I actually won two lawn chairs, a beach ball, and two $25 restaurant gift certificates for denying claims to meet the financial targets of my unit, CBA, and ultimately corporate UNUM Life Insurance Company of America.

It is appropriate at this point to keep in mind that the constant sound of ringing bells on the floor in CBA signaled the denial of disability benefits to many claimants without proper cause and investigation. Although management viewed these activities as necessary motivating factors in achieving financial targets, many group LTD claimants were deliberately harmed and were not treated fairly in the review process. Unfortunately, due to the manner in which internal claims strategies were positioned at UNUM, *any knowledgeable*, experienced claims specialist could choose a group LTD claims at random, and after a period of time, deny benefits to an unsuspecting claimant. It wasn't that hard to do given the defined claims review process at the time.

Nevertheless, company incentives, gifts and "fishbowl lotteries" continued on a daily basis. My recollection is that within a relatively short period of time in CBA, I received the following as rewards for denying as many claims as I could from my block, which also resulted in a promotion to Band 9 after 18 months of service in CBA.

$500 in gasoline cards
4 $500 Shareholder Value Awards
$150 in Border gift cards
3 Dinner for Two Gift Cards at local restaurants ($75 value)
2 Lawn Chairs, a Smoker Barbecue, and a Beach Ball

[2] The "blitz" activity was more of a Provident tag than a UNUM one.

A UNUM umbrella, 4 UNUM coffee mugs from the UNUM gift catalog
4 $200 spot awards

I also looked forward to receiving a birthday cake every year on my birthday [3], and participated in as many Hawaiian shirt, jean, and dress down days as I felt appropriate. Incentives appeared to be endless, and management kept them coming.

Looking back, it is clear employee monetary incentives produce the desired result in claims processing areas within the insurance industry. However, in my opinion, anytime corporate financial targets are integrated with employee performance evaluations, and claims liability decision-making, the temptation to deny legitimate claims is ever-present. Over time the fine line between ethical and unethical conduct became more and more difficult to distinguish as Unum's top brass continued to up the ante year after year making the financial targets, essentially unattainable.

Therefore, while Jim Orr III openly sold Unum's "Lighthouse to the World" to the public, internally the company ran one of the most unfair schemes to NOT PAY claims that legitimately should be paid – a hypocrisy that all benefitted from except insureds and claimants.

[3] Birthday cake celebrations were for everyone; however, the practice was discontinued by Provident after the merger.

Financial Reserve Targets – Unum's Source of Profitability

(Lindanee's Blog Article 2006)

"Financial reserves" are monies set aside by the disability insurer representing a "reserve" liability to pay a claim when application is made for payment. Financial reserves are required by the individual states, in which UNUM did business, as a cash protection afforded to the insured that the disability insurer is solvent enough to pay a claim after it is investigated and approved for payment. The money set aside as a financial reserve is unavailable cash flow which could otherwise be used to pay corporate bills, employee payroll, or used for portfolio investment to further reduce the costs of doing business. Financial reserves are also indications of the amount and extent of potential future liability on the disability insurer's Balance Sheet.

Although there are several different "financial reserve" figures computed for each claim block of business and purpose, the figures most commonly used by the claims area consisted of several variables including historical actuarial information incorporating age, impairment, occupation and income as well as claim value. Simply put, the higher the monthly benefit due to the claimant over time, the higher the state regulated reserve figure.

Each disability claim had an established financial reserve figure integrated into UNUM Life's payment system - CPS (Claims Payment System) and later BAS (Benefit Administration System). When a claim is approved, the financial reserve for that claim is realized, or opened, creating the corresponding liability, and when a claim is recorded as closed or denied on the system, an immediate contribution to profit is realized, and the liability is removed thereby freeing up cash flow which can be used for other purposes.

During the time I was employed in CBA, claims managers were given specific financial targets for their units depending on the Band levels of their direct reports. In other words, UNUM claims managers were held accountable for "bringing in "specific financial reserve targets on a monthly, quarterly, and yearly basis. They, too, were held responsible from a performance perspective, to achieve the targets set by executive management. To consistently fail to meet these specific targets usually cost the managers their jobs.

The problem with UNUM Life's financial reserve targets was that as soon as the current yearly reserves were brought in by the managers, executive management upped the ante. There never seemed to be a comfortable profit margin that the claims managers could manage, making each successive year figures unattainable.

Employment tension and stress flowed down to the claims specialists who actually carried out the functions of approving and denying claims. The UNUM Life DBS' had complete autonomy to make claims decisions in order to meet the unrealistic reserve expectations held over the managers by executive management. In reality, managers of CBA were the "cheerleaders" while the claims specialists implemented the processes necessary to create profits for the corporation by reducing financial reserves.

The concept of financial claims reserves was taught and known by all who "touched" claims throughout UNUM Life Insurance Company. Not only was job performance related to the reserve value of the claims the specialists denied, but computations of amounts offered for settlement were derived from the financial reserve values taken from a system called EIS on the UNUM LAN. All claims specialists had access to the settlement screens and used reserve figures in normal daily practice to determine maximum amounts which could be offered a claimant as full settlement.

Although later in 2000, Provident management persistently denied the existence of claim financial reserves, claims handler's performance still depended on how well each claim employee used "financial reserves" to contribute profit to the company.

For example, I received the following performance evaluation as a new Disability Benefit Specialist in 1996.

Addendum to 1996 Annual Review
Results for 7/1/96 through 12/31/96 [4]

Name: Linda Nee

Controllables:	**Number:**	**Reserve Gain:**
Not TD	5	$214,366
RTW	4	$93,728
No Proof	2	$17,334
AP&C	4	$73,712
Claim Withdrawn	0	0
Other	1	$64,443
Total	**16**	**$463,583**

[4] Taken from documents found within personnel file obtained from UNUM Human Resources in 2002.

Settlements:

Known	7	$96,000
Compromise	1	$89,186
Total	8	$186,087

Summary of Counts by Quarters:

Controllable Closures:	3Q	4Q	Total
Known Liability Settlements:	7	9	16
Compromise Settlements:	1	-	1

My 1997 Midyear Performance Review stated the following:

Shareholder Value – 30% *(Ability to contribute to the financial results of the company.)*

During the first two quarters of 1997, Linda had 16 controllable closures and 4 settlements, 2 of which were compromise settlements. Linda was awarded a Shareholder Value award (given to the CBA claims specialist who terminated the most claims) for her strong financial contributions during the first quarter. She has made a very nice contribution to the unit's financial results for the first two quarters of 1997.

Linda had 3 reopens based on receipt of new information. In both instances, there were extenuating circumstances. In one case, there was an issue of an employee being in an incorrect class for a specific M&N limitation. In the other, there was a difference of opinion among our risk resources as to the severity of the claimant's condition. A third claim was reopened in that M&N vs physical was not fully explored before the denial. (This section emphasizes that "reopens" are seen as adverse performance since financial reserves experience an increase.)

Linda continues to meet the challenges of difficult claims scenarios. She deals with issues head on and is not reluctant to do whatever needs to be done to resolve claim issues.

Obviously, all UNUM claims personnel had to have an in-depth knowledge of financial reserves in order to understand how they were to be performance evaluated, and in particular the computation and determination of claim settlements. UNUMProvident's attorneys later attempted to allege in depositions I knew nothing about financial reserves, but performance reports disclosed that all claims handlers had to know about financial reserves not only to do their jobs, but to understand how they were performance managed.

In order to offer settlements to insureds/claimants, claims handlers would have needed to know financial reserve figures and have the ability to look them up. UNUMProvident's attorneys may not have realized the extent to which financial reserves were known by claims specialists.

At one-point, national group account employers complained that UNUMProvident was offering disabled employees low-ball settlement offers. At the time, actuarial financial reserve figures were compiled using age, sex, impairment and historical insurance statistical information to formulate claim reserves.

UNUM's employer customers complained that they were paying premium on one set of reserve figures and their employees were offered settlements on much lower figures. Eventually, UNUM's finance department began using future claim value as financial reserve figures on which settlements were to be offered. In fact, it became ludicrous for UNUM's attorneys to later allege claim specialists "didn't know anything about financial reserves."

In fact, in Provident's anxiousness to claim UNUM Life completely botched its blocks of business, Provident's management completely underestimated the experience and expertise of the UNUM Life claims staff. This fact alone proved to be fatal error on the part of Provident's executive management when approximately 80% of the qualified claims staff shortly after the merger, left the company.

However, UNUM Life's use of claim financial reserves permeated daily activity at the desk of all claims personnel. Claims Specialists received a UNUM "profs" email, sent out by the VP of CBA, or one of the senior managers, listing the names of all department claims specialists, the names of claimants with claims terminated the previous day, followed by the reserve value of each claim.

My peers and I looked forward to seeing this report everyday because it created a "competition" within the ranks, which we all suspected was deliberate on the part of the managers. One could easily see *who* in the department was terminating "big dollar reserve" claims. A very clever strategy. Another obvious reason for disseminating such a list was probably to bring the unit managers up to date with needed information to determine how far off departmental targets were on a daily basis.

The ultimate end result of communicating reserve lists in the claims department was to create the "biggest bang for the buck" mentality with the claims specialists. Unfortunately, in order to become one of the "in-crowd" in CBA all I needed to do was ask the EIS program on the LAN to give me a list of claims in my block sorted by financial reserve in descending order. And, there I had it, a list of all claims in my claim block sorted from highest financial reserve to the lowest. Then, I'd go after the claims with the highest reserve value, and terminate them. I met my individual claim reserve targets nearly every month, just by using recommended resources such as EIS and available technology.

The "biggest bang for the buck" mentality was also reinforced by unit managers who provided similar lists to the claims specialists in crunch times; that is, before the end of a month or quarter. Invariably, my manager provided me with several lists of financial reserves in my block in the course of a day as a reminder of which claims to pull and walk-in to resources for documentation which otherwise could be credibly used to terminate claims. There is no doubt but that these claims were targeted for *cessation* of benefits. And, for what reason? *UNUM Life needed to meet certain standards of profitability, commonly known as "financial targets."* In order to "cover" or conceal the denial objectives, UNUM used the term, "shareholder value", or "contributing to shareholder value."

All we need to do is add up the figures. [5] Assuming there were 5 claims units in CBA consisting of 1 Band 10, 5 Band 9s, and 4 Band 8s. Let's assume the following for the purpose of this calculation:

	Performance Expectation
Senior DBS (Band 10)	$500,000 in controllable closures and $120,000 in settlements per month.
Disability Benefit Specialists (Band 9)	$350,000 in controllable closures and 75,000 in settlements per month
Disability Benefit Specialists (Band 8)	$275,000 in controllable closures and $27,000 in settlements per month.

Financial Reserve Targets for 1 Unit:

1 Band 10	$500,000 in closures $120,000 in settlements
5 Band 9s	$1,750,000 in closures $375,000 in settlements
4 Band 8s	$1,100,000 in closures $108,000 in settlements

[5] Figures are approximate for demonstration purposes and are not intended to be exact.

Total Reserve Gain per Month	$3,953,000 per Unit of 10 DBS'.
$3,953,000 x 5 Units in CBA = Gain per	$19,765,000 Departmental Reserve month or $237,190,000 per year.

Remember, CBA managed group LTD claims, which had been awarded SSDI.[6] Therefore, just for this block of business UNUM was able to recover an approximate reserve gain of $237,190,000 per year. This figure, by the way, does not include the recovery of social security lump sum overpayments which were also managed in CBA.

All processes and strategies in a disability claims organization are centered on financial reserves. Once you understand this, it is just a matter of sitting back and watching how management turns disability insurance into a billion dollar a year industry.

NOTE: In later years, usually during depositions, Unum's attorneys attempted to discredit my knowledge of financial reserve information even though my ability to substantially contribute to "Shareholder Value" was a considerable part of my performance reviews. I was also trained as a Settlement Specialist, which required me to have considerable knowledge of financial reserves and how to make reserve "gains" happen. It was impossible, however, to brush the truth under the rug, especially since claims handlers' knowledge of financial reserves was so blatantly well connected with their performance reviews.

The Claim Widget's Assembly Lines

Most people mistakenly believe the job of a claims specialist is a professional administrative position. The stereotype couldn't be more wrong. The actual job of performing in a disability claims organization as a claim examiner at all levels is more in tune to the automation of manufacturing of widgets than it is to any type of professional administrative work. Reviewing disability claims is assembly line work.

Picture a moving assembly belt on which new initial claims are automatically placed in a continuous fashion. As the claim folders move down the assembly line, direct labor resources in the form of DBS review, medical inspection, vocational assessment and managerial oversight as well as all others who actually "touch" the claims are applied as raw material. Overhead is also applied in the form of training, executive and human resource services.

At the end of the assembly line there are four large bins into which claims fall from the line. The preferable bin is the "claim denied, or terminated" bin. These are claims for which the costs of raw materials (resources) and direct labor

[6] Social Security Disability Income

(specialist and managerial oversight) have been profitably applied resulting in the denial or termination of benefits. Claims in this bin are archived and are not "touched" again in the process, representing the pure profit of the disability business.

The second bin contains claims which, although have they received costly materials and resources, have also been awarded Social Security Disability Income (SSDI) benefits. These are claims which the disability organization concedes are payable claims to duration (age 65).
Claims from this bin are eventually filed in a permanently and totally disabled (PTD), or Extended Duration Unit (ERD) section of the company and receive minimal update resources for the remaining duration of the claim.

Into the third bin falls claims which, although they have received the "lion's share" of materials and resources along the assembly process, have been identified as having a quality defect and cannot be credibly denied or terminated at the first pass. These claims are taken from the third bin and are re-entered at the beginning of the process for another review and correction of quality defects.

From a managerial perspective, the third bin is executive management's worst nightmare. Claims re-entering the assembly line for long periods of time (ACM claims) contribute to the growth of blocks of business, which if not controlled, can over run a claims department to the point of complete and utter chaos. In addition, repeating the application of resources over and over again becomes expensive in terms of financing and time allocation in order to achieve the favored result—claim denial or termination, PTD, or settlement.

The last bin is the least favored bin, that is to say, those claims which are determined to be approved and payable. These claims will remain in the fourth bin for an undetermined amount of time, but then are re-entered on the assembly line whenever management determines it needs more claims in the first bin (denied claims.) At the point where the new paid claims are re-entered in the process, they become ACM claims and eventually fall into the third bin where over time they become burdensome and need to be "resolved" in some fashion. ("Resolved" is a UNUM word, which essentially means the claims, are either denied, or placed in PTD where the claims specialists no longer expend time and money attempting to bring about claim terminations.)

Claims received in CBA came directly from the so-called second bins of assembly lines in the various geographical regions of UNUM Life Insurance. Our department represented UNUM's second line attempt to deny or terminate claims which had been awarded social security before transferring the claim to PTD. Each claims specialist managed a block of claims ranging from 185-250 group LTD claims and applied aggressive medical and vocational resources in order to "resolve" the claims and terminate benefits.

The ultimate job performance expectation of a UNUM claim specialist is the ability to manage his/her block of business at a "zero growth level". This means the same number of new claims entering the block at the beginning of the week must go out of the block at the end of the week. Since anywhere from 3-6 new claims are assigned to a claims specialists' block per week, it was essential that the same number of claims exit the block either by termination, settlement, or transferring to PTD.

If this were not the case, over a period of time, the number of claims in each claim block continues to increase at an unmanageable level. Only a very small percentage of experienced claim specialists actually achieved this level of expertise. Everyone else's numbers were somewhere between manageable and unmanageable at any given point in time. However, the ever-watchful eye of unit managers usually caught the override, and in times of panic, simply pulled large numbers of claims from the shelves and transferred them to PTD - a short-term fix for a long-term problem.

One of the hardest concepts for a new DBS to learn was that "the clock never stops ticking." The moment a new trainee sits back in their chair, thinking all is under control, he/she finds 6 new claims on their desk the next day, and the whole assembly process starts again. There is always an endless supply of claims entering the constant moving assembly line, and therefore, the actual process of the assembly line never shuts down.

Those who can control their "block" figures are allowed to remain on the line and continue to process the endless stream of LTD claims. Those who can't manage the numbers are asked to leave the job. It's all about the numbers, not about the claimants.

As an aside, one should take note there is no mention in the disability claims process of fairness and objectivity. The priority goal of claims processing is to manage the numbers to produce the expected profit figures. Although the DBS' did interview claimants on a daily basis, in "crunch" times claims were terminated not respective of any human emotion, circumstance or "unique circumstance of the claim."

This is a pretty sad testament to the disability insurance industry and the integrity of the claims process, but unfortunately it is the reality of processing voluminous numbers of claims presented for payment on a daily basis.

The Miraculous XL Policies and the Mysterious "Blue Memos"

Claims managers at UNUM Life were charged with the responsibility for creating and implementing departmental strategies in order to meet annual financial targets. Delegated increases over and above previous years financial reserve targets made it more and more difficult for managers to deliver expected profits. Therefore, in order to keep up with increased numbers of claim denials, management was forced to create innovative ways to deny claims outside of policy language. Hence, the invention of the "blue training memo."

"Blue training memos", referring to the blue paper they were printed on, were typically distributed to all group claim specialists and gave specific instructions to the DBS on how to deny claims without contractual policy language giving authority to the denial.[7]In effect, blue memos informed the claim specialist how to deny group LTD policies using out-of-contract criteria devised solely by UNUM Life's management.

Two examples of management's blue memo instructional training included changing the XL policy's "gainful percentage" from 80% to 60%, and the direction to deny claims after 30 days if a claimant had part-time work capacity, but didn't return to work.

UNUM Life's old XL and XLL series polices generally did not have provisional definitions of what constituted "gainful" when identifying alternative occupations after the change in definition at twenty-four months of benefits. But, since the definition of disability required at least a 20% earnings loss, gainful was assumed to be 80%. What this meant was that the vocational specialist could document alternative occupations expected to provide an income of at least 80% of pre-disability earnings, and the claim could be denied after the 24th month, stated as the change in definition.

The definition of 80% gainful only produced denials for lower to middle benefit claimants, in fact it was really hard to deny a claim while the percentage attributed to "gainful" remained so high. Claimants with higher pre-disability incomes were more difficult to deny based on a definition of 80% gainful, therefore, management changed the 80% gainful definition to 60% so that more claims could be denied under the XL policies. *Where does it say in the XL policy that the gainful percentage is 60%? Well, it doesn't.*

The second infamous blue memo training involved the denial of claims for individuals who had part-time work capacity. Basically, the memo directed claims handlers to actively seek part-time work releases from physicians and then give claimants 30 days to get a part-time job.

---

[7]Of particular note, many attorneys outside the company never really knew that previously "blue memos" were actually "yellow." To my knowledge no one really subpoenaed "yellow memos", a real shame.

If they didn't go back to work within the allowed 30 days, the claim was denied. *Where does it say in the XL or XLL policy that claims can be denied after 30 days if the claimant didn't go to work part-time? Well, not all of them did.* (Interestingly, UNUM Life eventually closed this loophole in the new CXC series policies.)

Blue memos caused a great deal of consternation for the claims specialist. The problem was in the writing of the actual denial letter. Since there was no real policy provision supporting the denial, what policy disclosure could possibly be made to the claimant to explain why benefits were being denied?

In reality, the blue memos didn't produce legitimate reasons why the claim could be denied and the reasons given to the claimant at the time were a lot of hocus pocus. We just hoped no one would notice, and that we'd get away with it. Sometimes the "error" was picked up on an ERISA appeal, most of the time it wasn't – a victory for UNUM's management and their creativity. In the end, the "blue memos" directed claims handlers to engage in breach of contract and deny claims.

A fitting ending to the "Blue Memo" fiasco was a change to "yellow paper" when litigating attorneys began to pick up on the scheme. "Yellow paper" memos were never really noticed, but UNUM fixed the problem by changing the color of the paper.

The Miraculous "90 Codes"

(Reprinted from 2004)

Another Unum Life strategy to manipulate financial reserves was using the payment system to "90 code" claims when it was expected the claim could be denied within 90 days. Actually, this practice was ingenious since any claims manager could direct those managing claims to "code" files with high reserves.

It is extremely important to think about this. The effect of claims with 90 codes is that claims were denied immediately in order to reduce financial reserves, which in turn produced financial gains and immediate contributions to profit. This was extremely helpful to claims managers pressured to meet profitability targets at the end of a month, quarter, or year.

Claims specialists would have 90 days to "make good" on the denial, or be forced to reverse the code, once again increasing reserves creating liabilities on the Balance Sheet, something managers wanted to avoid at all costs. Sometimes claims denials could be supported (backed-up) in 90 days, sometimes they couldn't.

The overall effect of 90 codes was that unrealistic, and unsubstantiated reserve gains contributed to profit figures when needed, but reversals of 90 coding had devastating consequences. Furthermore, insureds and claimants were never informed their claims had been terminated until Unum was able to deny them legitimately 90 days in the future.

Interestingly, when Provident put an end to the 90 codes after the merger, the company began placing claims on Reservation of Rights status – another way of achieving the same hits to profitability, but in a way, that escaped regulatory scrutiny.

Unum – Financial Reserves and Reservation of Rights

(Lindanee's Blog November 3, 2019)

Disability financial reserves are generally defined as "a monetary estimate of what a claim will cost." The reserve represents money set aside for the eventual payment of claims and is not otherwise available to pay operating costs such as salaries, expenses and other overhead costs. Since the financial reserve actually represents the future obligations of an insurer to pay the cost of claims, from an accounting perspective, reserves are classified as liabilities on the company's balance sheet.

Financial claim reserves are clearly important in determining the insurer's financial health. "Under reserving" suggests the disability insurer may not have sufficient funds on hand to pay future claims and presents a false picture of the company's financial stability. Investment brokers who set insurance bond ratings as well as federal and state regulators look to insurance financial reserves to determine the financial ability of an insurance company to pay for future claims.

Although financial claim reserves can theoretically be said to be the future value or anticipated cash payout of claims, reserves generally include actuarial and historical experience data kept by each individual company.

It is customary for insurance companies to hold several different reserve amounts, depending whether accrued interest is included or not. Some insurers include estimates for claim expenses in the reserve amount; others establish a separate reserve for the claim and a separate reserve for anticipated expenses.

Therefore, most experts would agree to the following definition of insurance financial reserves:

"Financial reserves are the amount of funds (or assets) necessary for a company to have at any given time to enable it, with interest and premiums paid as they accrue, to meet the financial obligation of all claims on the insurance in force."

Although financial reserves are theoretically regulated by the state, one can clearly see that it would be in the best interests of the disability insurer to limit or "set aside" *the least* amount of financial reserves, preferring to use available cash to pay operating expenses or to generate portfolio investment income to offset the cost of claims.

Simply put, federal and state regulations require all disability insurers to set aside financial reserves to pay future claims creating a potential loss situation, but when disability claims with open reserves are then closed (or reduced), the opposite is true and there is an immediate CONTRIBUTION TO PROFIT.

Regulators, investment bankers, attorneys, even the SEC needs to stop a moment and think about this. If the insurance company has a vested interest in "under reserving" what claims practices could be put into place that would appear credible yet keep total financial reserves at a minimum, or actually produce contributions to profit at certain periods of the year i.e. quarter or year-end profits?

Unfortunately, neither federal nor state regulators know enough about the internal claims review processes of most insurers to identify strategic practices intended to reduce financial reserves when profits are needed. Regulators need to take a better look at the realistic claim reserve figures and determine what internal claims practices are routinely put in place to keep financial reserves at a minimum, potentially under amounts required by federal and state regulators.

Generally, nearly all U.S. disability insurers can understate financial reserves by integrating their benefit pay system with the company's overall financial claim reserve figures. The financial reserve figure associated with each claim goes up when the claim is approved, and profits are made when the reserve is reduced or eliminated as in the case of a claim denial.

Each disability insurer maintains an electronic "benefit payment system" from which benefits are paid and offsets recorded. Therefore, each insurer can manipulate the amount of financial reserves simply by coding offsets such as primary and family social security, retirement income, worker's comp etc. Interestingly, certain insurers can also "create" special pay status' such as reservation of rights and SSDI presumptive that, when coded, will also reduce claims reserves and contribute to profit at any time.

Therefore, if an insurer integrates the following with their internal benefit pay system; financial reserves can be seriously under-reserved:

1. Coding of Reservation of Rights status.
2. Coding of SSDI presumptive such as blindness, end stage renal disease, loss of limbs etc.
3. Coding of estimates for primary and family SSDI.

4. Coding of other expected offsets to benefits prior to realization.
Coding of actual SSDI award amounts.
Deliberate omissions of contract payment obligations such as revenue income protection provisions.
Coding of Advance Pay & Close.

Disability insurance management is very clever. Unfortunately, deliberate attempts at under reserving literally "pulls the wool over" regulator and brokerage houses' eyes since the company is not as financially sound as reported to these entities.

Making matters worse, some states allow the insurance company to recover amounts paid to the insured while on ROR status if it is later determined the company does not have liability for the claim. Presently, most insurers agree only to pursue monetary recovery only in cases of fraud. To do otherwise would be to draw attention to the strategy of "under-reserving" since recovering the benefits would certainly cause financial hardship and complaints to regulators.

For disability claims, Reservation of Rights status is defined as a pay status whereby an insured is notified in writing the disability insurer may not have liability to pay the claim in the future. ROR notification actually allows companies like Unum Group to investigate a claim to determine if it has liability to pay the claim without waiving its right to later deny coverage based on information obtained as a result of the investigation.

Although ROR status protects the interests of the insurer, it should be regarded as an alert to the claimant that some fact or element of the claim has been brought into question, which could be used at a later time to deny the claim. But, that's not the entire story.

Once a claim has been coded on the benefit payment system as "paid under reservation of rights", the system automatically adjusts the financial claim reserve downward (referred to as a financial reserve gain) producing an immediate contribution to profit. This is why a large percentage of claimants are notified of ROR status just prior to year-end. There is no indication that insurers have changed ROR status coding in 2019.

This would suggest that something "changed" in the claim challenging the future payment of benefits. Not so. Claimants are placed on ROR status for no other reason than the say-so of a manager or consultant who simply says, "I think we can deny this claim in the future."

Theoretically, insurance companies have an obligation to produce actual claim documentation (or lack of it) proving it is likely the company will not have liability to pay the claim in the future. This is why DCS, Inc. advises clients to challenge the assignment of ROR status by asking the company to produce file documentation or specific cause for ROR status.

In the absence of documentation challenging future liability for the claim, the assignment of ROR status has no other value than to reduce the financial reserve causing an immediate realization of profit to the company.

For example, here are some of the inappropriate reasons Unum places claimants on ROR status:

Any occupation investigation. Regulators should really pay attention to this. Unum begins "any occupation" investigations between 9-18 months of paid benefits. Updated medical information needs to be obtained and reviewed, vocational reports should be completed, and "gainful" needs to be documented. There is absolutely no proof 9-18 months before the results of the "any occupation" investigation is completed, that Unum will NOT have future liability for the claim. However, if Unum codes a "ROR" status on the pay system for the claim, it receives a premature "contribution to profit" when the outcome of the investigation has not even been received! In a sense, to record ROR status before receiving a TSA identifying alternative occupations, is actually pre-determining the outcome of a claim, or put another way, targeting a claim for the certainty of denial. Unum receives approximately 450,000+ group claims per year. If all of the claims were to be placed on ROR status between 9-18 months, can you guess how under reserved the company is?

Our medical opinion doesn't agree with your medical opinion. I think we can all agree insurance companies generally buy physicians who "rubber stamp" denial decisions. Insurance physicians who have been in the business for a while learn the lingo of claim denial very quickly. Of course, it is very easy and convenient to deny disability claims when the only opinions considered are its own. If the medical opinions of Unum's physicians differ from that of the primary care physicians, a manager may place the claim on ROR status particularly at the end of a quarter or year. This was the case for 2008.

Any manager say-so. Managers and Directors have a great deal of responsibility to "roll out" certain levels of profit for the corporation. This is what they get the big monetary incentives for. Since the multistate settlement agreement Unum has no doubt "bumped up" reserve accountability to senior management such as vice presidents and other top executive personnel. However, managers are aware of claims reserves and how the denial of claims produces profit. A manager would have to be the dullest knife in the drawer not to know that.

Insufficient medical evidence to support payment. Of course, the insurance company is the entity who decides what is "sufficient evidence" to support a claim (discretionary authority), which is having the fox in charge of the hen house so to speak. The insurance company can, at any time, arbitrarily decide there is NEVER enough evidence to support a payable claim.

Reservation of Rights status is supposed to be a relatively short-lived pay status, however, getting a disability insurer to remove the ROR status after having benefitted from it by reducing the financial reserve, is very difficult since claims reserves increase again (reserve loss) reducing profit once the status removed. Therefore, most disability insurers will delay removing the ROR status, or at best, procrastinate removing it to avoid the inevitable reserve loss.

Bottom line, if a claimant receives a letter from their disability insurer informing a pay status of Reservation of Rights, please note the following:

- It means the insurance company is notifying you it has begun an investigation of your claim because they either do not have sufficient proof of claim, or there is evidence to suggest the company will NOT have liability for your claim in the future.
- The insurance company is nearing the end of a quarter (March, June, and September) or yearend (December) and needs to reduce the amount of financial reserves to show targeted or expected profits.
- If the insurance company has not told you in writing it will only attempt to recover amounts paid for cases of fraud, it can attempt to recover any monies it has paid you as of the date of the letter. (Actually, paid benefits from the date of ROR notification to the date of the denial letter.)
- The insurance company made a profit from your claim even though it actually paid you while the investigation was going on.
- The insurance company may have pre-determined to deny your claim at a later date.
- If the investigation is favorable to the insured and the claim is approved and paid, the insurance company understated its liability for the claim for the period of time it took to obtain what it felt was lacking.

ROR status for “any occupation investigations” presumes (incorrectly) what the outcome of the Transferable Skills Analysis will be for longer periods of times perhaps as long as 18 months. If it was later determined the insured met the definition of disability after 24 months, then the claim was under-reserved for as long as 18 months, assuming the company removed the status promptly, which may or may not happen.

Regulators should exercise more oversight into the manipulation of financial claim reserves by using the actual claims process and pay system to adjust claim reserves. It is very likely the indiscriminate use of ROR pay status by disability insurers could cause disability insurers to be under-reserved to the point of not being able to cover future claims. Remember, Reservation of Rights is only one of several ways in which disability insurers manipulate financial reserves.

Prior to June of 1999 it was alleged Provident's management integrated Expected Recovery Dates (ERDs) with Unum's benefit payment system to reduce and increase financial reserves based on "anticipated" (informed guesses) recovery dates. We know ERDs were coded into BAS (Benefit Administration System) and these "expected recovery dates" could not be changed without manager approval.

Although ERDs were initially determined by RNs and other medical staff, it became apparent financial reserves could easily be manipulated via the ERDs, when made determinations when they were not qualified to do so.

There is no evidence to suggest that Unum today is integrating financial reserves with ERD status, but yet I'm still hearing from employees that Unum continues to manage claims using financial reserve figures. It's not a secret that Unum continues to use financial reserves in their management of claims.

It is also alleged the more conservative financial reserve achieved prior to June of 1999 may have contributed to the attractiveness of the merger between Unum Life Insurance Company and the Provident Companies.

However, integrating varying expected dates of recovery with financial reserves did NOT work and caused several financial reporting problems:

"Expected dates of recovery" are not certain. Human beings do NOT recover by planned, textbook definition of impairments, symptoms and recovery. Unum tried to use an online MDR (Medical Dictionary of Recovery), but still claimants blew the established ERDs into the water causing frequent fluctuations in financial reserves as ERDs had to be changed. Income and profit reporting was not consistent.

ERDs caused Unum to be grossly under-reserved. Subsequent to the Multi-State Settlement Agreement and introspection of regulators at the time, Unum subsequently contributed to its reserve figures to bring it more in line with regulation and investment requirements.

Since the ERD experiment failed miserably, sometime in 2001, it is believed Unum disconnected ERDs from financial reserves and allowed senior claims handlers to make adjustments to the dates of recovery. Eventually, ERDs were done away with, or at least in the context they were previously used. There is recent evidence, however, that ERDs in some format is still used in the claims review process.

Clearly, federal and state regulators look only at the big picture, or macro view, of financial reserve compliance. If Unum, for example, reports $X dollars for financial reserves and the figure is within the required limit, very little inspection is given to the company's internal processes to determine how deductions in reserves are actually accomplished and whether the reserve amounts actually equate with realized liability. In other words, the bottom line isn't always the bottom line.

This Consultant has been recommending to federal and state regulators since 2002 that a more micro inspection of actual claims processes and pay system integrations with offsets and reserve deductions be undertaken to reconcile actual liability for claims with financial reserve figures. It is likely further investigation may discover all disability insurers are under-reserved.

From an accounting and investment perspective, recording under-valued liabilities (financial reserves) is actually engaging in "off-balance sheet financing" since the true liability for future claims does not appear on the statement. Those investment brokerages that public bond ratings etc. should take particular interest in whether or not financial claim reserves are under reported on the financial statements.

Audits are performed; but the problem is in not comparing the full realized value of what financial claim reserves "should be" vs. "what they are", and not investigating the extent to which disability insurers manipulate reserves by integrating reserve gains (and losses) with the benefit payment system and strategic processes deliberately put in place to indiscriminately place claims on ROR status.

As long as comparisons are not made by regulators and auditors between reported financial reserves and the ability to manipulate reserves by engaging in "off-balance sheet financing" *via the benefit payment system*, disability insurers will continue to grossly under-reserve future liability of claims and report profits which are largely Aesop's Fables.

By the way, I rarely see other insurers putting claims on ROR status. What do they know that Unum doesn't?

The Hierarchy of Unfair Claims Review (1994-1999)

(Lindanee's Blog Article 2006)

All group disability claims submitted to the insurance company for payment are investigated and reviewed to determine whether the claimant does or does not meet the conditions of eligibility written in policy provisions. If the insured is found to meet the conditions of the definition of disability as written, then monthly benefits are paid. If the disability insurer finds the insured does not meet any condition of the policy, benefits are denied.

This process requires the application of an objective and fair evaluation of the eligibility and medical circumstances of each claim at the time of the investigation. Unfortunately, since the disability insurer (UNUM Life in this discussion) is the sole recipient of profits resulting from claim denials, management sponsored claims processes may be implemented which deprive the insured of a fair review of the facts of the claim for profit.

In order to accomplish the desired corporate profits, all claims specialists must learn to manage, or strive to manage, blocks of LTD claims at a 0-growth level. This means the number of new claims entering the block [8] must equal the number of claims leaving the block on a weekly basis. The DBS' received anywhere from 2-6 new claims per week, therefore, the same number of claims must resolve [9] *from* the block in order to maintain manageable numbers. Therefore, the primary question for the DBS is then *"How am I going to get these new claims off my desk and out of my block?"* Later, under the UNUM Provident Claims Organization the question "*when*" was added.

The answer to the first question is called the "File Plan" or "Primary Plan Direction". All weekly new claims were required to have a written plan documenting the steps the DBS needed to take in order to deny or resolve the claim, commonly referred to as a file plan. Once devised, the file plan was expected to be followed without change unless a manager approved the "change in file direction". Therefore, a great deal of thought and planning was needed in setting the primary plan direction in the first place.

[8] A block of claims is simply the total number of LTD claims assigned to each claims specialist.
[9] The word "resolve" as used in a claims context means deny, terminate, or otherwise remove from the claim block of business.

Despite what many new trainees believe there are only 11 ways in which group LTD claims can be denied, or removed from a UNUM claim block. Please consider the following:

Primary Plan Objective (denying or removing LTD claims from any claim block)	**How to Achieve the File Objective**
Eligibility	EP, pre-existing, eligible class etc. For CBA, these issues were resolved at the regional levels.
Claim Withdrawn	Unexpected and generally unplanned
Not Totally Disabled	Work the claim to deny based on not meeting the definition of disability in the policy.
Advance Pay & Close	Deny and pay in advance in anticipation of the claimant being able to return to work full-time.
RTW	DBS works the claim to obtain a medical release to return to work, or it is known the claimant intends to return to work full time. Part-time work is not a plan direction since the claim stays in the block and doesn't do the DBS much good in terms of "resolutions."
90 Codes	End of the month or quarter is approaching and the DBS is within 90 days of denying the claim
Deny at Change in Definition	Denials are planned as the result of an any occupation investigation at the change in definition.
Settlements	Negotiation with claimant will probably result in closure of claim due to settlement.
SSDI Award/Extended Duration Unit	Refer claim to Extended Duration Unit
Claimant Dies (does not generally count toward meeting financial goals.)	Technically, this shouldn't happen if a claim has remained active in a block. These claims should be immediately referred to EDU.
Mental and Nervous Limitation (does not count toward targets)	Claim payments automatically end at the end of 12 or 24 months.

The first step, then in creating a File Plan is to set the expected type of denial or resolution given the circumstance of the claim, and then determine *how* the DBS is going to bring it about and make it happen.

All of the above is perhaps overly simplified, but the point I'm trying to make is that the overall denial direction is determined first, and then the DBS fills in the necessary internal steps needed to be taken to achieve the desired result. *And*, the desired result is always removing the claim from the DBS' claim block, or the assembly line as quickly as possible. As mentioned, UNUMProvident also added "*when*" by requiring the claims specialist to set Expected Recovery Dates shortly after the 1999 merger with UNUM Life.

Remember, the disability claims review process is all about the numbers, not people, impairments, or the inability to work. New claims come into the units every week, and claims must go out every week. The type of denial is set first, and then the DBS determines what steps need to be taken in order to actually deny the claim. This is the first priority step in terminating legitimate payable group LTD benefits –first you determine *what* you are going to do, and then you figure out *how* you are going to do it using all of the internal resources available to you as a claims specialist. Finally, through the ERDs, the managers determined *when*.

It should be obvious how important the File Plan is in terms of claim documentation since it "lays out" how the claims specialist intends to deny the claim. I learned the hard way how critical this file document was when one of the managers happened by while I was preparing a copy of a claim to send to an attorney who had requested it.

> "*What* are you doing?" the manager remarked, looming over my shoulder. "You aren't going to send them the whole claim file are you?"
>
> I wasn't sure. The manager, one of the more senior ones I might add, pointed under my desk and said "Hand me that wastebasket."
>
> "Here, you don't want them to have *this,* do you?" she gasped, pulling documents out of the claim file copy.
>
> I shrugged. In the can, the document went.
>
> "And what about this?" she said pulling out the File Plan.
>
> "Never send *these*", or *this* or *this*", pointing to papers documenting conversations I'd had with members of the complex claim unit.

> "Got the idea? Go through the claim and pull out what you think is internal confidential information and give the rest to me for review before you send it out."

I didn't realize at the time this was my first lesson in how to "sanitize" a claim file copy, but it did drive home how important the File Plan is. In addition, this was one of my first indoctrinations to the concept *"it's OK to do what we're doing, we just don't want anyone else to know about it."*[10]

So, what is the first step in denying LTD claims that should be paid? You plan it. It's deliberate, and willful, and documented. UNUM defended the practice with the statement "each claim is reviewed and determined on its own unique circumstances." This statement may make for good marketing, but it certainly wasn't truthful at the time, and it still may not be truthful today.

After the file plan is written and placed in the Administrative Record, the DBS "utilizes resources" to obtain what appears to be credible claim file documentation written by internal resources attesting to the fact the claimant has work capacity and therefore does not meet the conditions of disability as written in the policy. In effect, all liability claim denials are the result of the accumulation of review documentation from internal and external resources rendering opinions favorable to the insurance company.

Although the specialist may not deny benefits without written documentation obtained from qualified internal resources, it is believed the more documentation there is, the more credible the denial will be on appeal. LTD claim denials do not take place over night since it takes time to walk the claim through the predetermined steps in the file plan.

In CBA, resources available to the DBS included physicians (OSP), nurses (RN), vocational experts, social security experts, special investigation unit representatives, complex claim unit personnel, and financial and settlement unit specialists. Claim specialists were instructed to use as many of the resources as possible to obtain written opinions from credentialed staff. Claims could be "walked-in" for review during certain hours, or referrals could be made for more formal reviews.

UNUM Life, and later UNUMProvident, employed staffs of medical resources with "board certified" credentials and psychiatric specialties as well as outsourcing other medical reviews to local physicians. Vocational specialists were required to have CRC, or Certified Rehabilitation Counselor credentials and Masters Degrees, while members of other specialized units consisted of experienced claims specialists with 15+ years experience in some cases.

---

[10] Sanitizing claim files continued until 2001 when investigators found out about it, and the practice was stopped.

In fact, UNUM Life often boasted of predominately tenured employees, not just in the claims areas, but company wide. Experienced and well-trained claims personnel used to be UNUM Life's greatest and best resource.

Between 1994 - 2001 the insurance industry was really big on credentials. In documenting claim files, the best credentials the industry could buy support the credibility of the entire claims review process. Internally acquired medical and vocational credentials are marketed to the general public as an assumed standard of review, but in reality, both medical and vocational resources receive the same incentive bonuses (and, at higher levels) than anyone else, thereby giving these internal resources a clearly defined "vested interest" to tote the company line and implement management's claims strategies.

After the DBS applied all of the resources or "steps" indicated in the file plan, the desired outcome, a claim denial or resolution, was achieved. A piece of cake. Once the DBS has sufficient documentation from the medical department indicating the claimant's restrictions and limitations were not supported, *as well as* an opinion from the vocational specialist identifying an exertional standard related to work capacity, the claim can easily be denied as not meeting the definition of disability in the policy. As indicated previously, given the time needed to obtain documented opinions from the department resources, any experienced DBS could obtain sufficient documentation to deny an LTD claim. It's not that hard if you know how to use UNUM's strategies to deny claims.

I am often sarcastically asked if UNUM Life Insurance ever "approved" claims and the answer to that is, "Of course they did." Approximately fifty percent or less of the group LTD claims in CBA were paid to duration and were eventually transferred to PTD where they received minimal attention and no risk management activity was applied to them. The paid claims were those with critical and/or terminal disabilities such as end stage renal disease, blindness, loss of limbs, heart transplants, and so on. These approved impairments were generally serious enough such that UNUM Life would appear to be ridiculous if benefits were denied.

In addition, when departmental block numbers grew to an unmanageable size, managers indiscriminately pulled claim files for massive referrals to PTD. These were "the lucky" claimants. At differing times, claims were targeted for those over 50 years of age, lack of a high school credentials, multiple sclerosis diagnoses, and even lack of skills for transfer to PTD. Transfers to PTD remained the manager's "ace in the hole" when the unit DBS's failed to manage the claim blocks at 0 growth level. Keep in mind though, that transfers of claims to a permanently and totally disabled area produced no recognizable profit for UNUM, and therefore were seen as" lost opportunities for resolution and profit."

Tearful Hysteria – the Month End Close

As the end of each month approached, the claims staff in CBA grew more and more apprehensive as managers geared up for the grand finale. Generally, around the 20th of each month, staff meetings were held and all claims specialists received written reports indicating whether unit and departmental financial reserve goals were being met. If it appeared the department had not as yet met the designated financial reserve targets, unit managers laid out elaborate "focus day" plans often asking members of the unit to work on Saturdays to "focus even further."

As the end-of-the-month quickly approached, unit managers became more and more stressed about meeting financial targets. And, no wonder. Managers were given the message from the Vice President, *"you just have to go tell them to deny more claims!"*, or so the story went.

Claimant lists, sorted with the highest financial reserve claims were distributed, with instructions to "work on" only those claims on the list. It is difficult to describe the working environment in CBA at the end of a month. The air itself changes as the claims specialists become quiet, appearing overly busy. The "target thermometer" is ceremoniously placed on the wall again, as managers continuously point to goals and objectives. The never-ending push to deny more and more claims before the end of month produces unbearable stress, ugliness, and intolerance of error. CBA was not a nice place to work during the time of the month, quarter or end of the year close.

As the last day of the month arrived, managers pulled their employees into the aisles, and with breathless voices asked, "What have you got?" meaning how many denials do you have. *Every half hour*. These UNUM Life unit gatherings in the aisles during the month end close were forerunners to "huddles" which eventually became mini-meetings designed to discuss the best strategy to deny claims. Later, the UNUMProvident organization formalized the "huddles" into official departmental roundtables where claim denials were approved with a nod of the head from executive attendees representing the business interests of the company.

Nevertheless, the clock continued ticking. Tick. Tick. Tick. Claims specialists were told to email the names of claimants to unit managers as soon as claims were denied. (My manager always responded with a congratulatory return email stating, "Nice One!", if the reserve amount of the denial was greater than $45,000.) Claims specialists, carrying yellow and red claim jackets under their arms, rushed claims to resources who hurriedly wrote pages of documentation supporting claim denials. Denial phone notifications to claimants were quickly made. The "floor" became a maze of rushing individuals moving faster and faster to process LTD claims for denials before the 5 o'clock bell sounded. And just

when it seemed as though the stress would finally come to an end….out came the 90 codes.

CBA's benefit payment system, CPS, allowed for the coding of a "90" code, if a claim was expected to be terminated within 90 days, hence the name "90 code." Once a claim was coded in such a manner, the financial reserve was shut down, even though the system allowed benefit payments to occur within the 90-day period. In other words, a 90-code allowed UNUM Life to recognize a financial reserve gain 90 days prior to actually denying the claim. Managers loved the 90 codes. Claims specialists hated them.

As the last minute of the last day of the month approached, managers forced the claims handlers to code certain claims in their blocks as 90 codes in order to produce the financial reserve gains needed to meet financial targets. Once coded, claims specialists were held responsible for actually producing the denials within 90 days which was nearly impossible for some claims. Somewhat apprehensive of using 90 codes I informed my manager, "There's no way I can deny this claim 90 days from now", but the only predictable response was "Code it!"

Personally, I disliked 90 codes because for the next 90 days my manager would harass me until I actually denied the claim—sometimes an impossible task. No manager wanted executive management to see a 90 code reopen in the future; therefore, once a code was entered the claims specialist had to deny the claim or face an adverse mark on their performance record.

Finally, the close ended. Relieved of the stress, female claims specialists retreated to the aisles and restrooms and sobbed. Others picked up the pieces of their sanity by turning off their computer screens and just sat there, quietly, before starting the drive home. The end of the month was never really any great consolation to anyone since ever-lurking at the back of one's mind was that in 24 hours, the entire countdown to a month end close would start again. Most people just couldn't take the continuous ticking of the disability claims assembly line. Many wished they could quit in October and return in January.

A Good Case in Point….

CEO Frank McCarthy, notably of McCarthy & Sons Construction, submitted a claim for long-term disability in 1996 claiming disability due to a myocardial infarction (heart attack) and stent placement. Mr. McCarthy, as CEO, purchased a UNUM Life Insurance XL Series LTD policy for himself and his construction crews. As a Class 1 employee, Mr. McCarthy was eligible to receive the maximum of $10,000 in monthly disability benefit. Within 12 months of receiving benefits from UNUM, Mr. McCarthy was also awarded Social Security Disability benefits, and his claim was sent to CBA for further management.

The new claims specialist reviewed Mr. McCarthy's file carefully and opened a new File Plan on the diary system called LEADER. The file plan read:

"Primary Plan Direction is to deny claim as not TD (totally disabled) any occupation at 24-month change in definition. Update medical, refer claim for medical review and then for TSA (transferable skills analysis) and possibly LMS (labor market survey)."

Several weeks later, the DBS' manager stopped by and asked, "What have you got for projections for the close?" The claims specialist reported Mr. McCarthy's claim among others as a probable denial. Due to the amount of Mr. McCarthy's monthly benefit and his age, it was determined denying his claim would produce over a million-dollar reserve gain (profit) which could be used to meet unit targeted projections.

As the end of the month approached, the claims specialist was asked on more than one occasion what progress was being made in processing Mr. McCarthy's claim for denial. Clearly, a TSA and LMS took some time, but if the claims specialist could "walk-in" the claim to the available vocational resource, it was probable the claim could be denied by the last day of the month. The message from the manager remained the same, "Be proactive! Don't wait for the TSA, do a walk-in and see if the vocational representative can document the claim."

On the last day of the month, the claims specialist was able to obtain a preliminary copy of the transferable skills analysis. The report indicated Mr. McCarthy's occupation (as defined in the national economy) was listed on the DOT (Dictionary of Occupational Titles) as "sedentary" in physical capacity.

In addition, the report also identified alternative gainful occupations Mr. McCarthy could perform in his geographical area. According to the documented conclusions, the claims specialist could make a good case that Mr. McCarthy was in fact NOT totally disabled from performing any occupation, and therefore, benefits could be denied.

The claims specialist noted Mr. McCarthy's cardiologist reported restrictions and limitations, which precluded any type of work capacity. The results of a recent cardiac stress test indicated the patient had an Ejection Fraction of 15%. (An ejection fraction is an important cardiac measurement used by physicians to determine how well a patient's heart is functioning. "Ejection" refers to the amount of blood pumped out the main pumping chamber during each heartbeat. "Fraction" refers to the fact that even in a healthy heart some blood always remains within this chamber after each heartbeat. In essence, an ejection fraction is a percentage of the blood within the chamber that is pumped out with every heartbeat. An EF of 55 to 75 percent is considered by most cardiologists to be normal. Ejection fractions of less than 40 percent may indicate heart failure and other cardiomyopathies.)

Therefore, an ejection fraction of 15% suggests that CEO McCarthy may experience breathlessness during any type of physical exertion. Yet on paper, and according to UNUM's vocational specialist, he was capable of sedentary work capacity in some other occupation. Mr. McCarthy's claim was denied because the "documented process" of a disability insurer provided written file documentation which validated and lent credibility to the fact that Mr. McCarthy had work capacity, even though in reality, Mr. McCarthy probably couldn't catch his breath walking to the bathroom.

This case is an excellent example of how the reality of a physical disability is often not considered in the process of evaluating claims for payment. Unum relied on medical records and information reported by the primary care physicians, but internally, a claims process is put in place which produces what appears to be credible proof that the insured can, in fact, work. Each file document signed by an employee with credentials to render qualified opinions suggests to federal, state, and other regulators that the denial was in fact justified. Unjustly, the "internally devised system" provided for the interests of the disability insurer to make a profit rather than the interests of a disabled person who in reality could no longer perform productive work.

This philosophy of evaluation of claims clearly is suggestive of an adversary, not a fiduciary, and all too sadly, many claimants with group LTD insurance are left hanging without financial resources they are legitimately entitled to. What "should be" and "what is" were often two different things in the disability claim processes in place at UNUM Life.

In my opinion, it probably still is today.

Unum's Insider Trading and Expected Recovery Dates – A History

(Lindanee's Blog Reprint - November 5, 2010)

From 1996 to 1999 Unum Life Insurance ran a tight claims operation that included actively engaging in claims practices it knew were out-of-contract, unfair and potentially illegal. Still, the company played the numbers until it got caught in late 2002 when *60 Minutes* and *NBC Dateline* aired exposes eventually leading to the Regulatory Settlement Agreement in 2004.

Prior to 1999 the Provident Companies had already merged with Paul Revere and Harold Chandler and his henchmen including Ralph Mohney and Tim Arnold turned their sights to Unum Life Insurance as a viable take-over opportunity since the company had not been doing well since at least 1996. The word "take-over" was actually never used by management who preferred "merger" when speaking to employees.

Under the former leadership of Jim Orr III and the failure of the 1998 People Goals to bolster profit targets, Unum Life Insurance was indeed an easy target. As far back as 1996 Unum America and Unum Enterprise (Unum's executive subsidiary) were putting together executive golden parachutes in anticipation of the merger or takeover that was inevitable.

The make-up of the "chutes" included generous grants of stock options, treasury stock, insurance and pension guarantees as well as other executive deferred compensation benefits. You may remember Unum granted employee stock options when Unum's stock was selling around $60 per share. Shortly thereafter the company approved a stock split increasing the number of options, but diluting the market price to $30 per share. Most of the vice-presidential parachutes were heavily vested in stock options and Unum's pension plan was also generously funded with Unum stock.

In 1996 news of the pending merger appeared to have leaked out when sales management personnel attempted to engage in cash stock option exchanges resulting from inside information. As the compensation specialist who actually transacted these cash-ins on behalf of the executives with Smith-Barney it quickly became obvious information about the future of Unum Life Insurance as inside information was prompting a large volume of requests to sell or cash-in on Unum stock options.

SEC rules at the time dictated a waiting period of 6 months before entering into any stock transaction resulting from inside information. (People like Martha Stewart actually go to jail for that!)

Eventually, Unum's Vice Presidents were forced to leave the company taking with them parachutes which now were grossly undervalued due to the stock split, insider trading, and financial upsets due to the 1999 merger with Provident. Eventually, the VPs and other management entered into a class action lawsuit against Unum regarding the devaluation and misrepresentation of stock value afforded to them. In truth, all employees got screwed with respect to Unum's stock options since management kept telling people the value of the stock would go back up when in fact the stock price eventually plummeted to $5 per share.

Ralph Mohney's "hungry vulture" claims management philosophy permeated Unum Life Insurance quickly with announcements that all claims decisions would be made without the consideration of any information from the claimant's physicians. This "philosophy" apparently continues today as part of Unum's misdirected "fair and equitable claims review". From 1999 forward claimant's physicians were left out of the claims review process.

In addition, in an effort to manipulate its profit reporting to stockholders and bond rating investors, it is probable Unum concocted a way of integrating its BAS payment system with financial reserves by establishing Expected Recovery Dates (ERDs) which when coded would decrease or limit its balance sheet liability and increase profitability on its Profit and Loss Statements. Therefore, after the 1999 merger UNUMProvident was able to create a fairytale of profitability by under reserving its financial reserves.

Expected Recovery Dates, in theory, were sold as the expected date the insured or claimant would "recover or get better". In reality, ERDs quickly became identified with "expected dates of claim denials" and management used the ERDs to budget and plan unit financial reserve targets that were expected to be "rolled in". In other words, ERDs were set by medical personnel and were approved by claim management who could then plan which claims were intended to be denied and in which month.

ERDs were actually input into the BAS payment system. For example, a claimant would be assigned an ERD of 12/10/2010. Instead of Unum recognizing the full financial reserve liability of the claim to age 65, the payment system only recorded a financial reserve to the ERD date. Quite clever actually, since Unum was able to engage in "off balance sheet financing" by not disclosing the full value of its liabilities for claims. Investors who determine bond ratings as well as federal and state regulators were fooled into thinking UNUMProvident was much more solvent than it really was.

Eventually, the integration of ERDs with financial reserves ended when it became obvious there was too much fluctuation (highs and lows) in the financial reserve. It is also suspected the system was changed in 2002 when the company was exposed on 60 Minutes and management may have feared further exposure.

However, ERDs were still assigned to each claim since the process gave management a way to manage their unit financial reserves and target claims that were "supposed to have been denied" as of specified dates.

Claims specialists were held accountable to deny claims on or before the set ERD dates and the entire process remained an endless race to collect documentary evidence so that claims could be denied as of the date set by the ERD. Potentially, ERDs can be set to any arbitrary date coinciding with monthly, quarterly or year-end profit reporting.

There is evidence in Unum claim files that ERDs are still being used today as a management device in the claims system. While it is doubtful Unum's management continues to integrate ERDs with its financial reserves, its ability to target the denial of claims in contradiction of the insured's actual medical condition or ability to return to work is obvious.

Unum's use of ERDs also led to the use of MDA, a software medical recovery management program which sets arbitrary dates of expected recovery based on historical data of thousands of impairments and diagnoses.

What is astounding in all this is why regulators continue to allow Unum to engage in deliberate manipulation of its claims review process and why employers continue to purchase group STD/LTD plans from a company which has no intention of providing a disability benefit to its employees. Its clear decisions made by Unum's claim management actually have nothing to do with the claimant or his/her medical disability, but only how quickly, and when the claim can be denied and profit realized.

Unfortunately, Unum's setting of ERDs is only one in a long list of internal strategies used to target and deny claims that should be paid. Insureds who are NOT clients of DCS should begin to ask their claim specialist what their ERD date is. If it's earlier than age 65 you will get a good idea of when Unum plans to deny or terminate the claim.

Don't be surprised though if the claims specialist refuses to tell you. UNUM Life Insurance had a long history of keeping its claims strategies hidden in the basement with its oily rags.

The Best and Worst of UNUM Life

As one of the major disability insurers in the United States, UNUM Life had a reputation among brokers, litigators, and regulators for being aggressive, but fair-minded. This likely stemmed from the fact that on those occasions when UNUM was found to be in error, especially in litigation, the company reversed its overly aggressive decisions and paid claims fairly.

In fact, training sessions at UNUM Life included the following statement to new trainees: *"Our customers may not like the fact we denied their disability claim, but at the same time they will appreciate the manner in which we conducted our business.*" (Elaine Rosen) Although there is no question but that UNUM Life Insurance engaged in unfair claims practices, in the end UNUM's customers certainly did not regard the company as a "robber baron" in the industry. Jim Orr III, having done an excellent job selling the company to the public, encouraged nationwide support for Unum since inside information about the egregious claims activities was not yet known.

For the most part, UNUM Life Insurance of America operated its claims process overtly. Claims specialists were well trained in the areas of contracts, process, and the importance of financial reserves. Nothing in the claims process was hidden from view since it was essential to the success of the company that *all* who touched claims supported the company *and* the process. New customers were told upfront "we aggressively manage claims', and those employers who purchased UNUM Life's products understood UNUM Life intended to "pay only those claims which should be paid and not a penny more", as one of UNUM's Presidents so aptly put it. (Elaine Rosen)

UNUM Life encouraged experience, training and tenure among its employees. At the time, I was employed by UNUM Life Insurance Company of America the average tenure of the LTD claims staff, including managers, was 10-15 years while the average age of the employee base in CBA appeared to be 35-50 years old. Those who remained loyal to the company were respected and listened to while "trainees" were treated like Marine grunts needing constant supervision.

Unum Life Insurance did not discriminate among its employees. Under Jim Orr's leadership the company highly valued experience, knowledge, diversity of age, sexual orientation, diversity of ethnic origin, and respected all employees on their own levels. (Exempt vs. non-exempt being the exception.)

Clearly, management took all the necessary steps to encourage employees to remain employed within the claims area. Experience, knowledge, and tenure of all UNUM Life's employees was one of the best management decisions UNUM Life made in the implementation of who conducted the claims review process. Efforts made on the company's behalf to retain well-trained and experienced employees served the company well. I mention this in light of the extreme changes that took place in the future under Provident's leadership in 1999.

In addition, UNUM Life Insurance provided a lavish work environment and considered all employees as the most important assets to the organization. Additionally, the company was praised nationally as a "supermodel employer", having put "employees first with benefits at unprecedented levels.

And yet, management of its core business, namely Group STD/LTD, was conducted in the most deceptive way using strategies that included out of Plan and contract violations, deliberately targeting legitimately payable claims, breach of fiduciary duty, and other deliberate activities to essentially engage in racketeering to increase profitability. Despite its outward public appearances, Unum Life Insurance did not conduct fair and equitable claim reviews and many claimants were financially harmed as a result. This was later validated by the Multi-State Settlement Agreements nationwide, including the State of California.

Did Jim Orr III ultimately let the employees down? The obvious failure of the 1998 People Goals and future decreases in stock value disappointed many employees who mistrusted management long before it became known a merger with Provident/Paul Revere was to take place. Jim Orr's build-up of the importance of the "Goals" to company success ultimately laid the groundwork for the collapse of employee morale and trust just prior to the Provident/Paul Revere mergers in 1999.

Let's face it, Unum Life created a lavishly compensated employee base, but in return demanded employees do bad things to financially harm claimants and insureds. There were no real "free lunches" or "beach ball awards" that claimants, UNUM's customers, didn't actually pay for. In the meantime, both management and the employee "deer in the headlights" acted as though there wasn't anything wrong with what they were doing. It all seemed pretty normal to most, and it should not have been.

Those of us who remained with the company prior and subsequent to the 1999 merger had no idea how bad things were going to get. Unfortunately, UNUM's "Lighthouse to the World" was now headed straight for the "Outhouse."

We never really knew what hit us.

CHAPTER 4

Unum Goes Dark – The Calm Before the Storm

In the year directly preceding the 1999 merger with the Provident/Paul Revere companies, internally, Unum Life's Insurance claims process went underground to say the least Claims managers were silent and hushed giving their unit claim specialists the impression something sinister was afoot. The air of secrecy and silent disapproval from managers created a nervous workforce, particularly after the employee "let down" following the failure of the 1998 People Goals.

If you've ever had the feeling that something had gone disastrously amuck, but no one wanted to talk about it, the atmosphere within Unum's claims department felt exactly like that- quiet, hushed, and somewhat apologetic. In fact, some employees just got up and walked-out when they'd had enough of the "we'll never tell" environment, and yet, the claims process continued in a somewhat hushed, and covert manner.

In addition, an unmistakably dark cloud descended over the company as strange new protocols were put into effect to increase claim denials and better manage paid claims. Employees who remained loyal to the company suspicioned the loss of their jobs, and sought answers to what was going on; but, management was "buttoned up" and no explanations were forthcoming. In fact, the most unsettling aspect of this time period was that managers had no answers, but

frequently exchanged silent looks between each other signaling their own disapproval and helplessness to avoid changes.

One of the new claim directives included “trial periods” using Consultants and informal Roundtables. This was followed by the creation of Expected Dates of Recovery (rather, expected denial dates) that required management approval to set, and to change. Those “tenured” employees who had knowledge of financial reserves put two-and-two together and realized ERDs had been integrated with financial reserves, but still no one was talking.

Consultants were put in charge of “validating” claims decisions, and whether the regular claims staff realized it or not, autonomy to make claims decisions on their own was forever cancelled before anyone really knew what happened. In the pre-merger days, so-called “Consultants” were seemingly picked at random from among the senior claims-paying staff causing resentment from tenured staff that saw themselves better qualified to be “in charge.”

In an instant, new rules from management required all claims staff to obtain “sign-offs” for nearly every action taken on claims creating a large volume of unmanageable backlogs of claims. Claims were not “touched”, which meant that profit from potential claims was lost. Overall, the claims process was stopped in its tracks while managers and staff tried to figure out what was going on. There never seemed to be a Ah….ha moment!

Changes to the claims process were sold to employees as “trials”, or “let’s see what happens”, but clearly the demeanor of the managers told a different story. Processing of claims became confused and disorganized. In early 1999, approximately 80% of the claims paying staff (including most of the STD department) had already deserted the company. No one seemed to know anything, and at the time, the impending merger with Provident was still a well-guarded secret people knew but, never dared talk about.

The new “claims process” was instituted in Portland upon the recommendation of Harold Chandler based largely on practices in use by Paul Revere and the Provident Companies. Because of this, the takeover giants became known as the “hungry vultures”, a name that derived from Provident’s awards to claims handlers. Claims specialists in Portland, ME quickly became the new wave of hungry vultures led by the merged practices from the good ol’ southern boys from Chattanooga.

UNUM Life’s claim organization was divided using departmentalization, such as dividing STD, LTD, Life Waiver of Premium (LWOP), and within LTD, separate departments for “Initial Claims” and ACM, or Active Claims Management. Claims Specialists were assigned to these separate Departments, and with time became specialists in their individual areas. Claim specialists from STD had no idea how to manage LTD claims and vice versa.

Every department had their own levels of expertise and the lines did not cross, nor was training provided to cross train into other areas.

The department-based organization was to completely change, however, and although employees didn't know it at the time, managers were already told that most of the changes "tried" were to be permanent, with many more coming in the future, including "Impairment-based departmentalization". In retrospect, the only thing claims managers knew for certain was that they had to "obey" a new voice of authority coming from Chattanooga. Or, so the story went.

Still, no one was talking

CHAPTER 5

The Pre-Merger Feeding Frenzy and $300 Saturdays

Looking back, the June 1999 merger of Unum Life Insurance and the Provident companies, including Paul Revere, was never officially announced to employees ahead of time until an actual date was known sometime in early June 1999. However, from 1998 – 1999, Unum Life Insurance evolved into a hellish feeding frenzy to find claims that could be denied before the official Provident management take-over.

It was rumored and surmised by employees that if Unum Life was embracing a merger it made sense for the company to garner any profits it could before an official signing took place. And so indeed, management began one of the most intensive all-inclusive STD/LTD claim hunts to locate, identify, and process deniable claims. Every conceivable action was taken by management to deny as many claims as possible regardless of claim merit, or policy or Plan provisions in order to produce as much profit for Unum Life Insurance prior to the merger.

In fact, it was during this time that I was ordered by another manager to deny a claim that had not yet been medically reviewed. I can't really do descriptive justice to the look on this manager's face when I said, "No, I won't. It hasn't been properly reviewed." Her reaction was one that suggested she was completely shocked and unaccustomed to hearing the word "No". Her response of, "Uh, um, well, OK then", said it all, as she turned her back and walked away.

In order to do that ALL claims had to be reviewed for denial vulnerability, therefore, employees were offered $300/day for both Saturday and Sunday to make calls to claimants about SSDI, and to process denials through the existing claims process of resources. Claims managers essentially went into frenzy in order to roll-in last minute profits attributable to Unum Life Insurance. Claims specialists knew exactly why they were there and worked hard to meet managers' newly directed expectations.

Frankly, Unum got more than their $300 a day's worth of profitability from employees willing to give up their weekends "to help Unum".

To say that pre-merger Unum Life Insurance was in a chaotic mess is an understatement. New executive orders were still coming from Chattanooga while at the same time managers in Portland, Maine struggled to "fit" Provident's way of doing things into Unum Life's old risk management directives. It wasn't working, and the claims review process turned into a backlogged mess!

INTERLUDE

The Reader is asked to remember that although this book is written from my own personal recollections it is nonetheless an accurate presentation of the activities that went on at Unum Life and subsequently UNUMProvident as I was aware of them. I was there, a member of Unum's claims staff, who observed what it was like to descend from Jim Orr's "state of employee grace" to Harold Chandler's "leave if you don't like it, and don't let the door hit you in the ass" perspectives. I actually observed Unum's actions, was told to handle claims in unfair ways, or was involved in the process of managing claims that targeted legitimately payable claims for profit.

Personal perception or not, the pre-merger environment of Unum Life and the new company that followed was one big mess. What managers knew, and when they knew it was not known to employees who continued to do the best they could to meet the changing demands placed upon them. It was tough working for Unum during the transition just prior to the merger, and without Jim Orr III having employees' backs; management began to run targeted groups of its own employees out of town.

In many ways, Unum Life Insurance pulled the rug out from under its remaining loyal workers by secretly merging with Provident and Paul Revere. And, it *was* a very well-preserved secret! Prior to the official signing of the merger in June of 1999, no company announcement or statement was made regarding a merger. When it was finally announced, most employees thought, "Yeah, right. You mean the "take over?"

The failure of the 1998 People Goals and the resulting merger under the leadership of Harold Chandler was a turning point for employees who were about to be put on a black list of terminations because of their age and gender. Benefits, subsidies, and employee preferential treatment quickly disappeared.

In addition, the employee workweek was increased to 40 hours, health and life benefits were decreased including the elimination of the 100% company paid for HMO, replaced by a much cheaper contributory PPO. Although unlawfully discriminative, Unum's management required employees with prior known health issues to complete "Evidence of Insurability Forms" supposedly attaching greater cost of group premium to those employees with serious health issues. Insurability issues also placed employees with health issues on the chopping block.

To their dismay, good claims managers were fired for failures to roll-in profit objectives; and, other claims employees either were, or were not offered their jobs to work for the new company. The mass exodus from Unum Life became tearful with resentment as loyal employees who had been with Unum Life Insurance for a long time were forced to leave with nothing more than a small bag of 300 worthless stock options, and 401(k) pensions that would soon be devalued due to the Enron scandal and Unum's $50 million investment in shady deals.

Employees, particularly females 50 years of age or older with nine years tenure were given the opportunity of voluntary retirement. Most women meeting the criteria accepted what they thought were generous offers of retirement, while many, like myself refused the offer, forcing the addition of my name to a list of "poor performers" who would eventually be made to leave the company anyway under less than favorable circumstances called "poor performance."

When the word leaked that "Chattanooga Consultants" told management Unum Life was paying too many claims, claims handlers were ordered to deny more claims while "punting" through the highly aggressive claims practices suddenly put into practice in Portland, Maine by the "hungry vultures" from Provident and Paul Revere.

The transition of Unum Life Insurance Company into UNUMProvident did not go smoothly and claims chaos with huge backlogs of untouched claims became a major priority with LARs (Liability Acceptance Rates) soaring well above 80%. Management appeared to constantly be in a panic, and no wonder.

Even management's OK to Friday "jean dress down" and informal attire didn't help employees' attitudes toward the new company. Work home balance went right out the window, and employees were expected to put in extra time to straighten out management's mess in creating a new company.

From the very beginning I have to admit the whole persona of Harold Chandler and his people rubbed company employees in a John Gotti, mobbed-up sort of way. Just after the merger, employees were told Chandler would be visiting HOIII in Portland, Maine. Employees were prohibited from using the large parking lot in front of the building to make sure the area was protected.

The day of his arrival found employees lined up along the windows to watch Chandler's ceremonial arrival in the head SUV followed by a long line of other shiny, black, mobster-looking vehicles. Chandler's lead vehicle stopped at the door, but he waited to get out of the car until the doors from the vehicles behind him were flung open and at least ten "Men in Black" bodyguards emerged, speaking into their lapels. The bodyguards followed him into the building.

Those of us watching from the windows turned to each other in disbelief. "Are we working for the mafia or what?", I heard someone say. People shook their heads and returned silently back to their cubicles. What more was there to say when the obvious said it all?

As it turned out, like Humpty Dumpty sitting on a wall, Unum Life had a great fall and was never to be put back together again. In my opinion, and I think in retrospect most people would agree with me, that Unum's downfall was entirely due to the Provident merger and the unfair claims practices that ensued.

Nevertheless, UNUMProvident began its downward spiral under the leadership of a mafia-type management that didn't give a damn about the employees earning them their paychecks, or contributing to shareholder value. Very quickly on it became obvious to all that UNUMProvident's new executive management only demanded from employees that they "think within the new box", obey the unfair directives, and "keep their mouths shut".

Beyond that, there was nothing more to say.

CHAPTER 6

Autonomy Trashed and a Claims Process in Ruins

The ultimate result of the June 1999 merger with the Provident Companies was that the claims process was entirely re-structured from geographical or regional centers/subsidiaries to main office "impairment based" units such as Cardiac-Psych, Cancer, Maternity, Orthopedics, and General Medical. Divisions for STD vs. LTD were done away with and claims specialists were expected to manage claims in areas in which they were entirely untrained. Given the fact that already 80% of Unum's claims-paying staff had jumped ship, claims were redistributed to specialists who had absolutely no idea what they were doing.

For example, claims specialists were expected to manage and process claims from STD through and including active claims to maximum duration, which included Waiver of Premium and Life Waiver.

Those who were experts, for example, managing LTD (Group Long-Term Disability) had no idea how to process STD (Group Short-Term Disability) claims and vice versa. Waiver of Premium was an unknown process to both groups, so most of the waiver claims during this period remained untouched. [11]

Disability claims poured in to Portland, ME from Unum's other locations such as First Unum in New York, Chicago, Atlanta and Duncanson & Holt. These were in addition to those managed in Portland, ME plus the Individual Disability Income claims from Chattanooga, Provident and Paul Revere. It was decided that although offices in Worcester, MA and Glendale would remain, all other regional locations and subsidiaries were done away with, flooding Portland, still the official home office, with voluminous numbers of claims no one knew what to do with.

Very few claims specialists coped well with "new rules", increased workloads, loss of benefits and loss of internal stature. To make matters worse, Unum Life's old diary system, "LEADER" was changed to a new program called "Genesis" requiring more additional training and time away from reviewing and managing new claims. Management kept digging itself into a deeper and deeper backlog of claims and LARs rose to well over 75%.[12]

From a claims specialist's perspective, the removal of autonomy to make independent claims decisions, based on the facts and information from each claim, was the single most devastating change that removed "fair and objective" claim review from the liability determination process.

Up to this point, claims specialists had been well trained and were expected to usher claims through management established referral reviews until a "medical consensus of opinion" was obtained before making decisions to pay or not pay.

Under UNUMProvident's new process, all claims decisions had to be "validated" (reviewed and signed off on) by a Consultant, or Manager. The newly created position of "Consultant", second in authority from the unit manager, placed these individuals in supervisory positions over even the most senior of claims specialists, most of whom had been with the company for a very long time.

Claims specialists resented the fact that UNUMProvident's management mistrusted the ability of their own highly trained personnel to make good, objective claims decisions based on the merits of each claim. But that wasn't the point, was it? Provident's "hungry vulture" review process wasn't about making good claims decisions, it was about denying legitimately payable claims and having credible system processes in place that supported, "getting away with it."

---

[11] Ignoring "Waiver of Premium" was, of course, of benefit to Unum since Group Employers continued to pay premium, and IDI premium was never stopped.
[12] Liability Acceptance Rates should remain at or below 60% in order to produce profit.

From the beginning, Consultant positions were filled, not with the most skilled or knowledgeable specialists, but with unit members who had "drinking buddy" relationships with their managers. In fact, partying with claims managers became the foremost qualification in order to be promoted to Consultant. Although claims managers did go through the motions of employment application and selection, in the end, the person most likely to be able to "get along and drink" with the claims manager was always selected as THE CONSULTANT.

Nevertheless, the role of the "Consultant" was to assist unit managers in achieving profitability goals by "validating" claims decisions "suggested" by the claims specialists who actually investigated claims. The removal of complete autonomy from the claims specialists who actually investigated claims clearly demoted them to little more than glorified "Administrative Assistants".

The position of "Consultant" was offered to me, but I refused the promotion. When I was later asked by Mary Fuller, a Vice President of Claims, why I refused, I said, "Because they do bad things." And clearly, it was immediately obvious that Consultant authority to performance manage others within the unit by either giving validation approval, or validation refusal could make or break the future of any claims specialist in the unit. Consultants became the manager's "right hand man or woman" to assist with targeted profit objectives and I wanted no part of it.

By this time, UNUMProvident's claims process was in complete disarray, disorganization and chaos. Claims Specialists were managing claims literally from cradle to the grave, or STD through Active Claims Management ("ACM"). Each half of the claims paying staff was unfamiliar with other half's job description. Large backlogs of untouched claims began to accumulate with potential for future profitability lost in the archive.

In addition, claims specialists were assigned to "impairment based" units where they were required to have specific medical knowledge about various medical conditions. I was originally assigned to the General Medical impairment unit, but later was reassigned to Psych-Cardiac, as more senior specialists were needed in that area.

Meanwhile, management began to freak and blamed the new company's inefficiency on employment groups based on discrimination factors such as sex, age, health status and time with the company. While most U.S. corporations valued knowledge and expertise of tenured employees, UNUMProvident began informally classifying employees into targeted actuarial groups that eventually could be terminated from the company for "poor performance." After all, "fair and equitable claims review was out", and the creation of the illusion of fairness was in.

Under the leadership of Harold Chandler, older, more knowledgeable employees (mostly female) had to go, and most were terminated over the next several years.

One of the most significant executive announcements made shortly after the merger was that of Vice President of Claims, Tim Arnold[13], who in a companywide announcement, declared that no other medical opinions would be considered within the claims process except those rendered by company MDs.

WOW. No longer would claims decisions be made based on a "consensus of medical opinion" by UNUM and treating physicians, but all decisions would be based solely on the opinions of UNUMProvident MDs leaving treating physician opinions, ignored, and entirely out of the process. This one defining directive deliberately removed fair and equitable claim review from UNUM's disability claims process.

Although many litigating attorneys missed this at the time, UNUMProvident continued to deny claims at accelerated rates from 1999 – 2001 because the company also ordered a re-review of all existing claims using Tim Arnold's new, "only our review" criteria.

Later, as I became more involved with the investigators of the Multi-State Market examinations it became clear that the reassessment requirements of 250,000+ claims came about because of UNUMProvident's claim abuses that took place after the merger and beyond. Provident/Paul Revere's way of doing things was leading the company into oblivion.

Therefore, by the year 2000, UNUMProvident was in full swing denying claims using a "target based biggest bang for the buck" financial reserve review process. By then, Provident and Paul Revere were referred to as "hungry vultures", and had successfully directed a new claims process in Portland, ME that required a process to review claims to "deny" rather than to "pay" – a real first step toward bad faith.

Solving the Mystery of the Unum Claims Manual

Beginning in 2000, the most common question posed to me by attorneys, state regulators, investment bankers, and even the SEC was, "Where is UNUMProvident's Benefit Claims Manual?" The answer was quite simple actually, "The Company didn't have one."

[13] By this time, the former VP of Claims, Mary Fuller had been fired presumably for not "rolling in" significant targeted profit objectives.

Unum Life Insurance maintained several old Basic and COBAL programmed computer systems called EIS (Electronic Information System) and Merlin. These antiquated pay systems, CPS (Claims Payment System) in particular, was an absolute horror show to code and use. Thirty percent of the time spent in training was teaching new claims handlers how to code CPS.

Claims handlers were provided access to these systems and were told if they had any questions to "go look" there for answers. I used both systems extensively to find financial reserve figures and definitions from Unum's old XL and XXL policy forms. Merlin was an old data base system used to keep policy and Plan data on. Surprisingly, it was the most accurate source of information available at the time.

However, to call Merlin and EIS a "Benefit Claims Manual" was far-fetched since neither program provided any assistance by describing the claims process to be used in making liability determinations. I saw one printed copy of Merlin used by the entire department, but the informational program was maintained almost exclusively online. Unum's systems, outdated and unfriendly, were the extent of information given to claims handlers.

EIS was extremely cumbersome and unfriendly to those who had no knowledge of BASIC, FORTRAN or COBOL programming. Users had to have some knowledge base of HTML-like inquiry programming in order to sort to desired topics, or find information. Therefore, most claim specialists ignored the resource and "guessed" when they didn't know the answer to a process or policy provision. These systems were old and clearly were not substitutes for a Benefit Claims Manual.

As an aside, Unum Life's benefit payment system was equally cumbersome until it was changed to BAS, (Benefit Administration System), which was much easier to use. The old claim payment system was based on "line item" data entry, which accounted for the majority of training time for new specialists. PACE, a policy inquiry and payroll program for IDI claims, was also difficult to use since it too was already out of date in 2000.

By the year 2000, state and federal regulators were already conducting investigations into UNUMProvident and its unfair claims practices. In many locations such as California, UNUM's practices were referred to as "criminal", or by John Garamendi, then California's Insurance Commissioner, as a "criminal organization."

Looking to locate a Claims Manual that could be used against the company, Plaintiff's attorneys came out of nowhere by the hundreds demanding that they be provided with copies. By that time, federal and state regulators were also putting pressure on management to "hand over" its Benefit Claims Manual as well.

It was at this point that UNUMProvident went into overdrive and began writing a manual, which was later back-dated to suggest the company had one all along. Up to this point, claims specialists never saw a claims manual and had never been provided with one.

Copies of the sub-standard, hurriedly put together manual were distributed to claims handlers, but it had no redeeming informational value. Frankly, it was what it appeared to be – a hastily written summary of some of UNUMProvident's claim definitions that satisfied regulators that the company did in fact have a Benefit Claims Manual.

The issue of Benefit Claims Manuals from the perspective of someone who actually managed claims was ridiculous. Although all insurance companies have a Benefit Claims Manual, no part of any "claims process", or procedure is ever put in writing. While it is true some claims manuals appear to be quite extensive, it is never possible to use a manual to accurately route a claim through the entire review process from step one to when a liability decision is actually made. Claims Manuals are no more than a misleading formality of probable credibility.

Frankly, insurance companies are smarter than that and cloak their claims process within departmental guidelines communicated verbally in unit meetings. Today I'm told that Unum Group uses computer "Intranet" electronic messaging programs sent directly to desktops.

Nevertheless, from 1999 - 2001 hysteria over a UNUMProvident Benefit Claims Manual went on for some time with management desperately trying to produce a manual it didn't already have to satisfy federal and state regulators.

In short, Unum Life never had an official Claims Benefit Manual because it did not want to put a description of its claims process in writing. When UNUMProvident was forced to come up with one, the result was a non-essential notebook of underlined topics not even close to what was really going on in the claims process.

Female, Over 50 and Out!

Unlike Jim Orr III, Harold Chandler and his cohorts were not respective of "diversity", particularly when it came to women. A year after the merger, the majority of management positions in Portland were already filled with men from Provident and Paul Revere. Unproportioned numbers of female UNUM Life Vice Presidents and managers were terminated such as Cathy Liston from Central Benefits Administration and Mary Fuller, Vice President of Claims.

Other female claims managers who lacked specific employment histories in claims were also not offered their own jobs at the time of merger. One manager

in particular who hailed from underwriting acting as a claims manager took her termination sadly.

In fact, the numbers of female employees over 50 who were terminated by Unum Provident prompted many to seek attorney advice regarding the filing of a class action lawsuit. Tempting, as it was, the fact that "gender discrimination" is hard to prove discouraged attorneys in the Portland area from filing discriminative lawsuits against UNUMProvident.

After the merger, it also became obvious that UNUMProvident was not encouraging tenured employees with claims experience to remain with the company. Accustomed to having autonomy to make independent decisions regarding claims, senior claims specialists had difficulty keeping silent about the abuses of the Consultant overlords and deliberate targeting for denials. Management wanted them gone.

Although employees in general with nine years tenure and nearing fifty years old were offered voluntary retirement, some chose to remain with the company. Several years later, very few remained having been terminated for "poor performance." One way or the other UNUMProvident always seemed to get its way. The result was hundreds of terminated employees based on sex, age, and tenure.

CHAPTER 7

"You Want Us to Do *What*?"

UNUMProvident's new "impairment based, all-in" claims review process began as a complete failure with increasing backlogs of untouched claims. Not only were claims handlers untrained to manage multiple product lines of disability insurance, they were also medically ignorant concerning the management of impairments they were assigned to. With equally untrained Consultants now validating claims and calling the shots, claims were both approved AND denied with no real understanding of the merits of each claim.

Expected Dates of Recovery Integrated with Financial Reserves

Long before the 1999 merger it was suspected by most claims specialists that Provident had prompted Unum Life to integrate Expected Recovery Dates, or "ERDs" with claim financial reserves. ERDs were sold to the claims paying staff as "dates when insureds could be expected to return to work, but this definition was DOUBLESPEAK for "date of resolution, or denial of any claim."

The concept of setting an "expected recovery date" was actually a remake of Unum Life's strategy of having claims specialists "determine" a "Primary Plan Direction" at the initial application stage of a claim. As indicated earlier, new

claims were required to have "a set plan" of claims management that aided managers with planning "roll ins" of target profit goal objectives. Primary Plan Objectives, namely the claim "game plan" was located in the record of the claim file and was somewhat cumbersome for managers to manage in great numbers.

Put simply, UNUMProvident's new process required the assignment of an ERD, or expected denial date, and claims specialists were held accountable for meeting the ERDs by denying claims on the dates set. BAS, Unum's benefit payment system, was changed to include coding for ERDs that when integrated with financial reserves, changed reserve figures based on the expected denials, or as UNUM called them, "resolutions".

The idea of integrating ERDs with financial reserves required managers to approve of each claim ERD determination, and/or approve or deny any changes made to ERDs as claims went through the review process. With an already emerging backlog of unreviewed claims, having managers approve of every ERD, and changes, significantly contributed the chaos of processing claims. Integrated ERDs connected to financial reserves proved to be a very bad idea.

It should be noted here that although UNUMProvident persistently denied the integration of ERDs with financial reserves, its actions suggested differently. See below.

- ERDs were added to BAS and had to be manually entered into the pay system. *Why?*
- ERDs were "validated" by claims managers who were the only ones who could approve, or change an ERD. *Why?*
- Claims specialists were performance managed as to how well they could accurately set ERDs, and work claims toward specific dates of denials. *Why?*

If ERDs were NOT integrated with financial reserves why were they added to the companies pay system with absolute control from claims managers? Interestingly, after the Multi-Statement Conduct Market examinations, claims specialists were permitted to change ERDs without management's approval – an important clue that ERDs had been "disconnected" from the claim financial reserve system.

From 1999 through 2001 at least, ERDs were the top priority when it came to managing claims. Once ERDs were determined and documented, managers could plan and manipulate financial reserves (profit targets) accordingly. However, as the process began to fail due to the inability of claims specialists to "meet" ERD dates, it eventually became obvious that "insured recovery" could NOT be managed or manipulated.

It should also be mentioned that the very existence of ERDs allowed claims specialists and their managers to abuse "objective and fair review" by

putting pressure on claimants/insureds and their treating physicians "to get well on cue." Return to work programs (more on this later) emerged, Advance Pay and Close was more frequently used, and verbal threats to insureds, "if you don't go back to work we're going to close your claim" produced high levels of bad faith, breach of contract, and violations of fiduciary duty. As ERDs failed to plan and produce the denials they were used for, the system broke down.

Although integrating ERDs with financial reserves may have seemed a very clever manoeuver at the time, the unpredictability of claimant recovery and the need to frequently change ERDs caused financial fluctuations and disruptions of "continuity" of UNUMProvident's financial statements. Therefore, after the Multi-State Settlement Agreement, it became apparent with the loosening of manager approvals that ERD integration with financial reserves had been eliminated.

Former Unum Group employees tell me that ERDs are still used, but they probably are not integrated with claim financial reserves.

Unum's Insider Trading and Expected Recovery Dates – A History

(Reprint Lindanee's Blog November 5, 2010)

From 1996 to 1999 Unum Life Insurance ran a tight claims operation that included actively engaging in claims practices it knew were out-of-contract, unfair and potentially illegal. Still, the company played the numbers until it got caught in late 2002 when 60 Minutes and NBC Dateline aired exposes eventually leading to the Regulatory Settlement Agreement in 2004.

Prior to 1999 under the former leadership of Jim Orr III and the failure of the 1998 People Goals to bolster profit targets, Unum Life Insurance was indeed an easy target for a merger. As far back as 1996 Unum America and Unum Enterprise (Unum's executive subsidiary) were putting together executive golden parachutes in anticipation of the merger or takeover that was inevitable.

The make-up of the "chutes" included generous grants of stock options, treasury stock, insurance and pension guarantees as well as other executive deferred compensation benefits. You may remember Unum granted employee stock options when Unum's stock was selling around $60 per share. Shortly thereafter the company approved a stock split increasing the number of options, but diluting the market price to $30 per share. Most of the vice-presidential parachutes were heavily vested in stock options and Unum's pension plan was also generously funded with Unum stock.

In 1996 news of the pending merger appeared to have leaked out when sales management personnel attempted to engage in cash stock option exchanges resulting from inside information. As the compensation specialist who actually transacted these cash-ins on behalf of the executives with Smith-Barney it quickly

became obvious information about the future of Unum Life Insurance as inside information was prompting a large volume of requests to sell or cash-in on Unum stock options. SEC rules at the time dictated a waiting period of 6 months before entering into any stock transaction resulting from inside information. (People like Martha Stewart actually go to jail for that.)

Eventually, Unum's top twenty-six Vice Presidents were forced to leave the company taking with them parachutes that now were grossly undervalued due to the stock split, insider trading, and financial upsets due to the 1999 merger with the Provident companies. Eventually, the VPs and other management entered into a class action lawsuit against Unum regarding the devaluation and misrepresentation of stock value afforded to them. In truth, all employees got screwed with respect to Unum's stock options since management kept telling people the value of the stock would go back up when in fact the stock price eventually plummeted to $5 per share.

Ralph Mohney's "hungry vulture" claims management philosophy permeated Unum Life Insurance quickly with announcements that all claims decisions would be made without the consideration of any information from the claimant's physicians. This "philosophy" apparently continues today as part of Unum's misdirected "fair and equitable claims review". From 1999 forward claimant's physicians were left out of the claims review process.

In addition, in an effort to manipulate its profit reporting to stockholders and bond rating investors, it is probable Unum concocted a way of integrating its BAS payment system with financial reserves by establishing Expected Recovery Dates (ERDs) which when coded would decrease or limit its balance sheet liability and increase profitability on its Profit and Loss Statements. Therefore, after the 1999 merger UNUMProvident was able to create a fairytale of profitability by under reserving its financial buffers.

Expected Recovery Dates, in theory, were sold as the expected date the insured or claimant would "recover or get better". In reality, ERDs quickly became identified with "expected dates of claim denials" and management used the ERDs to budget and plan unit financial reserve targets that were expected to be "rolled in". In other words, ERDs were set by medical personnel and were approved by claim management who could then plan which claims were intended to be denied, and in which month.

ERDs were actually input into the BAS payment system. For example, a claimant would be assigned an ERD of 12/10/2010. Instead of Unum recognizing the full financial reserve liability of the claim to age 65, the payment system only recorded a financial reserve to the ERD date. Quite clever actually, since Unum was able to engage in "off balance sheet financing" by not disclosing the full value of its liabilities for claims. Investors who determine bond ratings as well as federal and state regulators were fooled into thinking UNUMProvident was much more solvent than it really was.

Eventually, the integration of ERDs with financial reserves ended when it became obvious there was too much fluctuation (highs and lows) in the financial reserve. It is also suspected the system was changed in 2002 when the company was exposed on *60 Minutes* and management may have feared further exposure. However, ERDs were still assigned to each claim since the process gave management a way to manage their unit financial reserves and target claims that were "supposed to have been denied" as of specified dates. Claims specialists were held accountable to deny claims on or before the set ERD dates and the entire process remained an endless race to collect documentary evidence so that claims could be denied as of the date set by the ERD. Potentially, ERDs can be set to any arbitrary date coinciding with monthly, quarterly or year-end profit reporting.

There is evidence in Unum claim files that ERDs are still being used today as a management device in the claims system. While it is doubtful Unum's management continues to integrate ERDs with its financial reserves, its ability to target the denial of claims in contradiction of the insured's actual medical condition or ability to return to work is obvious. Unum's use of ERDs also led to the use of MDA, a software medical recovery management program that sets arbitrary dates of expected recovery based on thousands of impairments and diagnoses.

What is astounding in all this is why regulators continue to allow Unum to engage in deliberate manipulation of its claims review process and why employers continue to purchase group STD/LTD plans from a company that has no intention of providing a disability benefit to its employees. Its clear decisions made by Unum's claim management actually have nothing to do with the claimant or his/her medical disability, but only how quickly, and when the claim can be denied and profit realized.

Unfortunately, Unum's setting of ERDs is only one in a long list of internal strategies used to target and deny claims that should be paid. Insureds who are NOT clients of DCS should begin to ask their claim specialist what their ERD date is. If it's earlier than age 65 you will get a good idea of when Unum plans to deny or terminate the claim.

Comedy Central Or Let's Play Musical Chairs– Roundtables

From approximately 2002 – 2004 UNUMProvident "roundtables" quickly became a big issue with plaintiff attorneys and for good reason. Faced with backlogs it could not control, management devised a system of three roundtable reviews [14] that were intended to allow the business interests of the company the opportunity to dictate future review actions that would lead to claim denials.

[14] Team roundtables, MDR, or multi-disciplined roundtables and comorbid claim roundtables.

When challenged about its roundtables UNUMProvident always defended the process as a "learning experience" for claims specialists. In fact, Mary Fuller, the then VP of claims defended roundtables as "necessary training" while at the same time yelling, "Why are we paying this claim?", during a roundtable. In reality, the only role claims specialists had at roundtable was to present the facts of the claim and listen to management's directions on what to do next.

The business interests of the company were represented by claims managers, vocational rehab personnel, claims VPs medical personnel and on occasion, UNUM's lawyers. [15] In other words, any departmental group who participated in UNUM's bonus incentive programs, or those who had anything to do with manipulating financial reserves attended the roundtables.

The process for claims specialists was actually very demeaning. Each claim specialist was forced "to present at roundtable" once a week whether they had a complex claim or not. The preparation for the roundtable included overheads, handouts, the use of presentation skills [16] and a final evaluation, including a grade, for the presentation.

I always had the impression that the "formalized, presentational approach" to roundtables was a front for what was really taking place while management had all of the business reps in one place. Management could always allege that "the roundtable process" was for the purpose of teaching or coaching claims handlers how to investigate claims. I never did buy-in to that though since the outcome of roundtables was always the same – management directives on how to deny claims and get away with it.

After the presentation, however, the claims specialist was treated as though they were completely unskilled in claims management; and, the remaining attendees took over, concluding with a list of steps the claims handler was to take to process the claim for denial. Despite the fact that I was already a Lead Customer Care Specialist, roundtables always made me feel like the worst village idiot the company had. When you're sitting around a table with the Who's Who of UNUMProvident, claims handlers are ignored beyond their administrative role. I always had the impression that the only reason why claims specialists were required to attend was to legitimize the jury process of eliminating claims.

Before long, UNUMProvident's management decided to use roundtables as a marketing strategy to lure employers into thinking the review process was "fair." And sure enough, management put together what was referred to as "mock roundtables".

---

[15] On those occasions when UNUM's counsel was present, the company later alleged the roundtable was, "privileged" and details could not be disclosed.
[16] Claims specialists were "graded" on their presentation skills.

The actual script for the roundtable drama was for management to loudly announce, "Roundtable!" just prior to escorting new potential employers into the claims area. [17] Several Senior and Lead Specialists grabbed a file (any file) and ran to the designated "roundtable room." By the time the new customer arrived at the location, claims handlers began to "present" files, complete with a prepared set of overheads, and the roundtable went live in full view for prospective customers. Play-acting roundtables became somewhat of a regular practice and those of us who participated in them put on our best show.

UNUMProvident did receive criticism for the mock roundtables during the multi-state investigations since the names of claimants whose files were used in the mock roundtable presentations were not redacted or protected in any way. It seemed as though claimants' and insureds' personal data was placed "out there" for all to see and hear.

UNUM continued to sell the process of roundtable reviews as a much-needed source of training for claims handlers, even though the conduct of roundtables was strictly performance managed by those in high authority. In reality, Unum used roundtables as a way of decreasing its growing volume of backlog using the business elements of the business to determine who got paid and who didn't.

The least important person attending roundtables was the claims handlers, who although were forced to present the facts of the claim, had absolutely no authority to act on their own and simply did as they were told.

In the end, UNUMProvident used the Team Roundtables for what management referred to as "quick hits", MDR to assign the direction of all other claims, and MCR to review co-morbid claims. Eventually, the MCR roundtable review was eliminated since the consensus of the procedure was that co-morbid claims should be paid, which of course was contrary to the overall objectives of roundtables.

As an aside, UNUMProvident took potential customer visits to the Portland Home Office very seriously. Prior to the actual visit from the executives at Cocoa-Cola, management confiscated all Pepsi cans and 2-litre Pepsi bottles with promises of compensation or replacement after the Cola-makers left the building.

Although no one really questioned UNUMProvident's intent to "come across in the best possible light", employees also noted among themselves that presentations and best appearances were nearly always deceptive in some way.

[17] "Look-out scouts were positioned on each end of the hallways to signal the approach of building visitors."

Hiding Pepsi cans and bottles became a regular occurrence at UNUMProvident facilities.

The Claims Process and Consultant Validation

UNUMProvident's management created its own worst enemy when it placed "Consultants" and "validation" into the claims process. The removal of decision autonomy from claims specialists and requiring Consultants to "validate" suggested decisions, contributed even further to backlogs of claims that were never "touched."

The newly found supervisory authority given to Consultants to make or break claims handlers under them literally removed any cohesiveness or trust from within the claims units. Suspicious and on the defense, most of the time, claims handlers began to back-bite their peers in order to "get ahead" and protect themselves from "Consultants" and "Managers" who themselves were forced to produce unrealistic profitability results.

Including the spreadsheet referred to as OMAR, Consultants and Managers used "metrics" to manage claims by manipulating decision-making based on financial reserve amounts and the timing of when decisions could be made to show the most profitable results.

For example, a claim denial could not be made within the same income reporting month because the financial gain would be a "wash" with no reciprocating effect on profit. Therefore, denials were always coded in the next month following the opening of reserve amounts.

One of the most objectionable parts of the UNUMProvident "Consultant" validation process was that claims specialists were forced to sign letters they didn't write. Every written communication that went outside of the company had to be reviewed by a Consultant who audited the letters and re-wrote most of them. Letters were returned to the claims handlers who made the corrections and signed them. It actually offended me to sign letters I didn't write particularly when I disagreed with the claim decision.

If the Consultants had just edited for spelling and typographical errors that would not have been so bad, but to completely re-write the letters in their own style and language and expect claims handlers to sign them as if they authored the letters was, in my opinion, another deception. I openly criticized this practice to management, which pegged me as a "complainer" and one who was bucking the system.

Another unfortunate thing for claimants was that, although UNUM management was aware claims were to be denied after the first of the month; claimants remained ignorant of the eventual claim decision until UNUM was ready to tell them. In the meantime, claims handlers always acted as "buffers", keeping phone calls away from managers who were actually manipulating the timing of claim decision-making.

OMAR "metrics" also included ERDs, claim reserve amounts and numbers of claims received vs. those denied. It was the perfect management tool used by claims managers to not only meet target objectives, but to performance manage claims specialists under their supervision. OMAR spreadsheets were not secret and all specialists had access to not only the physical spreadsheets themselves, but all of the information they contained.

The daily practice in Chattanooga, Portland and Worcester was for managers to "visit" each cubicle with pre-determined target goals taken from OMAR.[18]Targeted claims were reported to managers who frequently followed-up to find out where the claim was in the critical denial path. Managers also held ERDs over the heads of the claims specialists, making sure claims were denied before, or on the current ERD coded on BAS.

Unum – Financial Reserves and Reservation of Rights

(Re-printed from Lindanee's Blog November 13, 2019)

Disability financial reserves are generally defined as "a monetary estimate of what a claim will cost." The reserve represents money set aside for the eventual payment of claims and is not otherwise available to pay operating costs such as salaries, expenses and other overhead costs.

Since the financial reserve actually represents the future obligations of an insurer to pay the cost of claims, from an accounting perspective, reserves are classified as liabilities on the company's balance sheet.

Financial claim reserves are clearly important in determining the insurer's financial health. "Under reserving" suggests the disability insurer may not have sufficient funds on hand to pay future claims and presents a false picture of the company's financial stability. Investment brokers who set insurance bond ratings as well as federal and state regulators look to insurance financial reserves to determine the financial ability of an insurance company to pay for future claims. Although financial claim reserves can theoretically be said to be the future value or anticipated cash payout of claims, reserves generally include actuarial and historical experience data kept by each individual company.

It is customary for insurance companies to hold several different reserve amounts. Some insurers include estimates for claim expenses in the reserve

[18] I still have a year's worth of IDI target sheets distributed to claims specialists at the time.

amount; others establish a separate reserve for the claim and a separate reserve for anticipated expenses. Therefore, most experts would agree to the following definition of insurance financial reserves:

"Financial reserves are the amount of funds (or assets) necessary for a company to have at any given time to enable it, with interest and premiums paid as they accrue, to meet the financial obligation of all claims on the insurance in force." [19]

Although financial reserves are theoretically regulated by the state, one can clearly see that it would be in the best interests of the disability insurer to limit or "set aside" *the least* amount of financial reserves, preferring to use available cash to pay operating expenses or to generate portfolio investment income to offset the cost of claims.

Simply put, regulations require all disability insurers to set aside financial reserves to pay future claims creating a potential loss situation, but when disability claims with open reserves are then closed (or reduced), the opposite is true and there is an immediate CONTRIBUTION TO PROFIT.

Regulators, investment bankers, attorneys, even the SEC needs to stop a moment and think about this. If the insurance company has a vested interest in "under reserving" what claims practices could be put into place that would appear credible yet keep total financial reserves at a minimum, or actually produce contributions to profit at certain periods of the year i.e. quarter or year-end profits?

Unfortunately, neither federal nor state regulators know enough about the internal claims review processes of most insurers to identify strategic practices intended to reduce financial reserves when profits are needed. Regulators need to take a better look at the realistic claim reserve figures and determine what internal claims practices are routinely put in place to keep financial reserves at a minimum, potentially under amounts required by federal and state regulators.

Generally, nearly all U.S. disability insurers can understate financial reserves by integrating their benefit pay system with the company's overall financial claim reserve figures. The financial reserve figure associated with each claim goes up when the claim is approved, and profits are made when the reserve is reduced or eliminated as in the case of a claim denial.

Each disability insurer maintains an electronic "benefit payment system" from which benefits are paid and offsets recorded. Therefore, each insurer can manipulate the amount of financial reserves simply by coding offsets such as primary and family social security, retirement income, worker's comp etc. Interestingly, certain insurers can also "create" special pay status' such as

[19] This is my definition of financial reserves.

reservation of rights and SSDI presumptive that, when coded, will also reduce claims reserves and contribute to profit at any time.

Therefore, if an insurer integrates the following with their internal benefit pay system, financial reserves can be seriously under-reserved:

1. Coding of Reservation of Rights status.
2. Coding of SSDI presumptive such as blindness, end stage renal disease, loss of limbs etc.
3. Coding of estimates for primary and family SSDI.
4. Coding of other expected offsets to benefits prior to realization.
5. Coding of actual SSDI award amounts.
6. Deliberate omissions of contract payment obligations such as revenue income protection provisions.
7. Coding of Advance Pay & Close.

I have to admit it always surprised me that state regulators never had a clue about how insurers manipulated financial reserves and profit. Even before the Multi-State Settlement Agreement, a firm from New York did all of the investigating for the states' Departments of Labor.

Disability insurance management is very clever. Unfortunately, deliberate attempts at under reserving literally "pulls the wool over" regulator and brokerage houses' eyes since the company is not as financially sound as reported to these entities. Making matters worse, some states allow the insurance company to recover amounts paid to the insured while on ROR status if it is later determined the company does not have liability for the claim.

Presently, most insurers agree only to pursue monetary recovery only in cases of fraud. To do otherwise would be to draw attention to the strategy of "under-reserving" since recovering the benefits would certainly cause financial hardship and complaints to regulators.

For disability claims, Reservation of Rights status is defined as a pay status whereby an insured is notified in writing the disability insurer may not have liability to pay the claim in the future. ROR notification actually allows companies like Unum Group to investigate a claim to determine if it has liability to pay the claim without waiving its right to later deny coverage based on information obtained as a result of the investigation.

Although ROR status protects the interests of the insurer, it should be regarded as an alert to the claimant that some fact or element of the claim has been brought into question which could be used at a later time to deny the claim. But, that's not the entire story.

Once a claim has been coded on the benefit payment system as "paid under reservation of rights", the system automatically adjusts the financial claim

reserve downward (referred to as a financial reserve gain) producing an immediate contribution to profit. This is why a large percentage of claimants are notified of ROR status just prior to year-end. There is no indication that insurers have changed ROR status codings in 2019.

This would suggest that something "changed" in the claim challenging the future payment of benefits. Not so. Claimants are placed on ROR status for no other reason than the say-so of a manager or consultant who simply says, "I think we can deny this claim in the future."

Theoretically, insurance companies have an obligation to produce actual claim documentation (or lack of it) proving it is likely the company will not have liability to pay the claim in the future. This is why DCS, Inc. advises clients to challenge the assignment of ROR status by asking the company to produce file documentation or specific cause for ROR status.

In the absence of documentation challenging future liability for the claim, the assignment of ROR status has no other value than to reduce the financial reserve causing an immediate realization of profit to the company.

For example, here are some of the inappropriate reasons Unum places claimants on ROR status:

Any occupation investigation. Regulators should really pay attention to this. Unum begins "any occupation" investigations between 9-18 months of paid benefits. Updated medical information needs to be obtained and reviewed, vocational reports should be completed, and "gainful" needs to be documented. There is absolutely no proof 9-18 months before the results of the "any occupation" investigation is completed, that Unum will NOT have future liability for the claim. However, if Unum codes a "ROR" status on the pay system for the claim, it receives a premature "contribution to profit" when the outcome of the investigation has not even been received! In a sense, to record ROR status before receiving a TSA identifying alternative occupations, is actually pre-determining the outcome of a claim, or put another way, targeting a claim for the certainty of denial. Unum receives approximately 450,000 group claims per year.

If all of the claims were to be placed on ROR status between 9-18 months, can you guess how under reserved the company is?

Our medical opinion doesn't agree with your medical opinion. I think we can all agree insurance companies generally buy physicians who "rubber stamp" denial decisions.

Insurance physicians who have been in the business for a while learn the lingo of claim denial very quickly. Of course, it is very easy and convenient to deny disability claims when the only opinions considered are its own. If the medical opinions of Unum's physicians differ from that of the primary care

physicians, a manager may place the claim on ROR status particularly at the end of a quarter or year. This is was the case for 2008.

Any manager say-so. Managers and Directors have a great deal of responsibility to "roll out" certain levels of profit for the corporation. This is what they get the big monetary incentives for. Since the multistate settlement agreement Unum has no doubt "bumped up" reserve accountability to senior management such as vice presidents and other top executive personnel. However, managers are aware of claims reserves and how the denial of claims produces profit. A manager would have to be the dullest knife in the drawer not to know that.

Insufficient medical evidence to support payment. Of course, the insurance company is the entity who decides what is "sufficient evidence" to support a claim (discretionary authority), which is having the fox in charge of the hen house so to speak. The insurance company can, at any time, arbitrarily decide there is NEVER enough evidence to support a payable claim.

Reservation of Rights status is supposed to be a relatively short-lived pay status, however, getting a disability insurer to remove the ROR status after having benefitted from it by reducing the financial reserve, is very difficult since claims reserves increase again (reserve loss) reducing profit once the status removed. Therefore, most disability insurers will delay removing the ROR status, or at best, procrastinate removing it to avoid the inevitable reserve loss.

Bottom line, if a claimant receives a letter from their disability insurer informing a pay status of Reservation of Rights, please note the following:

- It means the insurance company is notifying you it has begun an investigation of your claim because they either do not have sufficient proof of claim, or there is evidence to suggest the company will NOT have liability for your claim in the future.

- The insurance company is nearing the end of a quarter (March, June, and September) or yearend (December) and needs to reduce the amount of financial reserves to show targeted or expected profits.

- If the insurance company has not told you in writing it will only attempt to recover amounts paid for cases of fraud, it can attempt to recover any monies it has paid you as of the date of the letter. (Actually, paid benefits from the date of ROR notification to the date of the denial letter.)

The insurance company made a profit from your claim even though it actually paid you while the investigation was going on.

The insurance company may have pre-determined to deny your claim at a later date.

If the investigation is favorable to the insured and the claim is approved and paid, the insurance company understated its liability for the claim for the period of time it took to obtain what it felt was lacking.

ROR status for "any occupation investigations" presumes (incorrectly) what the outcome of the Transferable Skills Analysis will be for longer periods of times perhaps as long as 18 months. If it was later determined the insured met the definition of disability after 24 months, then the claim was under-reserved for as long as 18 months, assuming the company removed the status promptly, which may or may not happen.

Regulators should exercise more oversight into the manipulation of financial claim reserves by using the actual claims process and pay system to adjust claim reserves. It is very likely the indiscriminate use of ROR pay status by disability insurers could cause disability insurers to be under-reserved to the point of not being able to cover future claims.

Remember, Reservation of Rights is only one of several ways in which disability insurers manipulate financial reserves.

Prior to June of 1999 it was alleged Provident's management integrated Expected Recovery Dates (ERDs) with Unum's benefit payment system to reduce and increase financial reserves based on "anticipated" (informed guesses) recovery dates. We know ERDs were coded into BAS (Benefit Administration System) and these "expected recovery dates" could not be changed without manager approval. RNs and other medical staff initially determined ERDs, but once it became apparent financial reserves could easily be manipulated via the ERDs, consultants and managers also determined expected recovery dates by review even though they were not medically trained to do so.

There is no evidence to suggest that Unum today is integrating financial reserves with ERD status, and yet I'm still hearing from employees that Unum continues to manage claims using financial reserve figures and ERDs.

It is also fair to say that UNUM continues to adamantly state that ROR status does not reduce financial reserves. If this were so, it is very coincidental that the increase in the placement of claim ROR status coincides with profitability periods such as month-end, end of quarter or year-end. UNUM's defenses defend coincidences? Maybe.

It is also alleged the more conservative financial reserve achieved prior to June of 1999 may have contributed to the attractiveness of the merger between Unum Life Insurance Company and the Provident Companies.

Integrating varying expected dates of recovery to ERDs did NOT work and caused several problems:

1. "Expected dates of recovery" are not certain. Human beings do NOT recover by planned, textbook definition of impairments, symptoms and recovery. Unum tried to use an online MDA (Medical Dictionary of Recovery), but still claimants blew the established ERDs into the water causing frequent fluctuations in financial reserves as ERDs had to be changed. Income and profit reporting was not consistent.

2. ERDs caused Unum to be grossly under-reserved. Subsequent to the Multi-State Settlement Agreement and introspection of regulators at the time, Unum subsequently contributed to its reserve figures to bring it more in line with regulation and investment requirements.

Since the ERD experiment failed miserably, sometime in 2001, it is believed Unum disconnected ERDs from financial reserves and allowed senior claims handlers to make adjustments to the dates of recovery. Eventually, ERDs were done away with, or at least in the context they were previously used.

Clearly, federal and state regulators look only at the big picture, or macro view, of financial reserve compliance. If Unum, for example, reports $X dollars for financial reserves and the figure is within the required limit, very little inspection is given to the company's internal processes to determine how deductions in reserves are actually accomplished and **whether the reserve amounts actually equate with realized liability.** In other words, the bottom line isn't always the bottom line.

This consultant has been recommending to federal and state regulators since 2002 that a more micro inspection of actual claims processes and pay system integrations with offsets and reserve deductions be undertaken to reconcile actual liability for claims with financial reserve figures. It is likely further investigation may discover all disability insurers are under-reserved.

From an accounting and investment perspective, recording under-valued liabilities (financial reserves) is actually engaging in "off-balance sheet financing" since the true liability for future claims does not appear on the statement. Those investment brokerages who public bond ratings etc. should take particular interest in whether or not financial claim reserves are under reported on the financial statements.

Audits are performed; but the problem is in not comparing the full realized value of what financial claim reserves "should be" vs. "what they are", and not investigating the extent to which disability insurers manipulate reserves by integrating reserve gains (and losses) with the benefit payment system and strategic processes deliberately put in place to indiscriminately place claims on

ROR status.

As long as comparisons are not made by regulators and auditors between reported financial reserves and the ability to manipulate reserves by engaging in "off-balance sheet financing" *via the benefit payment system*, disability insurers will continue to grossly under-reserve future liability of claims and report profits which are largely Aesop's Fables.

By the way, today I rarely see other insurers putting claims on ROR status. What do they know that UNUM doesn't?

Remembering UNUMProvident and 9/11 by Linda Nee

(Published on Lindanee's Blog every year for ten years revised)

Here we are nearly 22 years since the tragic event of 9/11. As a former customer care specialist still employed by UNUMProvident, I can still remember the hushed and scared faces of all of us who watched monitors when the first and second planes hit the towers.

It was unbelievable. Most of us didn't quite know what to do, as an announcement came over the intercom, "Anyone who is disturbed emotionally by this morning's events may go home." No one did. I think we were in shock, mostly, and as the day continued it was obvious that we wore our hearts on our faces, and were too saddened to make calls, or conduct our business in the usual way. Some cried, but most just sat at their desks, staring out the windows trying to make sense of the morning insanity.

UNUMProvident, the disability insurer for many of the financial businesses located in the Twin Towers, initially made good, and paid on the very expensive disability policies issued to companies such as Morgan Stanley, and The Mercantile. Most of the employee paperwork of these companies was also destroyed, yet UNUMProvident agreed to pay disability benefits without going through normal processing.

UNUMProvident received a great deal of marketing notoriety because of their "generous sympathy" and swift payment of claims. Senior claims specialists were given the responsibility of managing the 9/11 claims. I was one of them.

Nearly all of the 9/11 claims assigned to me were diagnosed with PTSD, anxiety and depression. One of my claimants was a pregnant woman who was on the 49th floor when the first tower collapsed, and only by sheer will and quickness was she able to exit the second tower in time. Both she and her baby survived, but the nightmare of stumbling down the stairs haunted her peace and prevented her from caring for her baby.

Most of us watching the events on TV saw the thick clouds of debris and smoke when the towers suddenly collapsed. Many of my claimants suffered, not

only from PTSD, but also from severe respiratory illness resulting from breathing the hot smoke and ash. As spectators, we certainly never realized that when the towers collapsed, the pure force of the debris embedded in the bodies of many individuals who were too close. A year later, pieces of steel and debris continued to emerge from the bodies of 9/11 victims. And lastly, there are those claimants who, desperately trying to escape the inferno and smoke, sought refuge in nearby buildings, and were only able to get out after stepping over dead bodies and body parts. We can all imagine what this experience did to our country men and women.

On the anniversary of 9/11, 2002 UNUMProvident literally forced all of its employees into conference rooms for a film replay of the 9/11 events. When the films of the actual planes hitting the towers were shown, many employees left the room. The memories were still too real. The grand finale was the statement by then CEO Harold Chandler, "God Bless the United States and UNUMProvident."

At this point, most of us felt sick at the inappropriate remark. The presumed arrogance of the remark became even more evident a week after the conference room replay of the events. Those of us who were managing the 9/11 claims were called to meeting run by several of the department managers. One manager boldly stated, "It's been a year now since we've been paying on the 9/11 claims. These people can't possible still be impaired from PTSD. We (meaning the managers and consultants) will give you a date for roundtable. Gather up all of your 9/11 claims and present them at roundtable. We want to review all of the 9/11 claims for possible denial."

I really didn't want to present the 9/11 claims at roundtable. I knew what the roundtable was for, and I knew the 9/11 victims didn't have much more time on claim. Hence, I was late getting my 9/11 lists together and claims prepared for the presentation. However, in spite of my attempts of "putting off" the reviews, I was "instructed" by a consultant to prepare the claims and bring them in the following day. I had no choice, and the next day I attended the 9/11 roundtables.

My manager, consultant and medical personnel did everything they could to find cause to deny the claims. I was ordered to deny legitimate claims I knew should be paid. On the way home that night I cried. I felt helpless to do what I knew was the right thing to do. But, in the end, if I wanted to keep my job and support my family I had to do what I was told.

One of my claims was denied because the gentleman had moved to Jersey and "couldn't possibly still have PTSD when he doesn't even have to cross the bridge, or see the site anymore." *Does that really make sense?* Another claim was denied because an insured didn't have money to obtain "appropriate" medical treatment for his depression and panic attacks. My consultant ordered me to obtain additional medical information from a woman who was still so traumatized she couldn't speak with me directly on the phone. I didn't like signing those denial letters, but if I wanted to keep my job, I had to.

As we remember the 11th anniversary of the 9/11 tragedies perhaps we should also consider that for every 9/11 claim denied unfairly, there are hundreds of other disability claims for individuals like you and me that are also denied unfairly. We've been through a long history of the Georgia Conduct Market Examination, the Multi-State Settlement, Elliot Spitzer, The Department of Labor investigations, and we are no further ahead to halting the rampant unethical activity of most disability insurers.

Those of us who hoped for reform, or at best, some sort of chastisement for UNUM were sorely disappointed when the DOL and Elliot Spitzer "sold out" to the powerful UNUMProvident lobby eternally protecting its interests. ERISA laws, originally intended to help insureds, are now interpreted to favor the disability industry and the profits they made from employer sponsored plans.

Information I have still shows there are UNUMProvident 9/11 claims out there in litigation, and my experience with UNUMProvident as an employee tells me they won't be the last. What I regret most is the realization we haven't accomplished a darn thing in forcing the disability insurance industry to be accountable to the people it sells policies to. Somehow, we, our leaders, our government, missed the point on all this. And, that *is* a tragedy to be remembered.

CHAPTER 8

New Leadership and Idiosyncrasies

From the 1999 merger of Unum Life Insurance with the Provident Companies until the November 2002 NBC Dateline and 60 Minutes exposés aired, UNUMProvident denied voluminous claims in what seemed like a feeding frenzy of the "hungry vulture." Although I can't say I ever heard the term "hungry vulture" in the Portland offices, claims managers and their consultants made it their business to deliberately target and deny legitimately payable claims.

Of course, claims specialists, under the new leadership, were made to carry out denials and decisions that were made by the highest levels of claims management including the Vice President of Claims, medical and vocational personnel, and Medical Directors.

Claims from the previous subsidiary locations such as First Unum (NYRB), were shipped to Portland to review. All of the First Unum claims were "round tabled" and most were denied. I attended many of the NYRB roundtables and honestly have to admit the claims had been very poorly managed at that location, if they were managed at all.

Roundtables in general were in full swing with Tim Arnold, the new Vice President of Claims in the Portland Office, in attendance. Ralph Mahoney, the kingpin from Provident and Paul Revere also attended on occasion, but it seemed to me he was "protected" for plausible deniability during that period of time. (More about this later.)

Tim Arnold – A Dichotomny of Good and Bad

After the termination of Mary Fuller, (exodus of middle-aged women, remember), Tim Arnold from Chattanooga, assumed the position of Vice President of Claims in the Portland offices. At this time, Portland, Maine was still considered UNUMProvident's Headquarters. At the time, most employees viewed the offices in Portland as having wheels that would eventually ride the Home Offices in Portland down to new Headquarters in Chattanooga, which eventually happened after a short period of time.

Tim Arnold was a smallish man with brown hair, but he ruled the claims and medical units with an iron hand. At the same time, I found him to be rather pleasant to speak to and "fair" during roundtable presentations. Still, direct reports under him, such as the RNs and medical personnel reported him to be "weird" and strict when it came to running the claims process.

In fact, RNs were asked to work weekends reviewing claims without overtime pay. Of course, that didn't sit well with the medical staff and they protested. But, it was rumored Tim Arnold never gave in and reminded the medical staff they were salaried employees and would not be compensated additionally.

Under Tim Arnold's direction, UNUMProvident's medical staff was pushed to the limit by necessity. One of my friends, a petite red-haired RN, once rushed into my cubicle and huddled in the corner, sobbing uncontrollably. Apparently, she failed to write up an adverse report on an insured with a 15% Ejection Fraction, and believed she was going to be fired. Although she did the right thing by reporting a medical condition accurately, she was "tagged" from that point on as a person who was "adverse" to the goals and objectives of UNUMProvident. She eventually left the company after being pressured to do so. (Yet, another woman forced to leave.)

In addition, to Arnold's weird persona, managers at the time, described how he used to stand in front of the HOIII windows early in the morning observing cars in the parking lot arriving for work. He also noticed later on in the day that cars arriving last, left first. Therefore, a directive went out to managers to make sure that all personnel actually "put in" a 40-hour workweek. Knowing that all personnel were now "under the looking glass" forced managers to keep time records of arriving and leaving employees.

However, Tim Arnold's pet peeves included the fact that he was absolutely opposed to UNUMProvident operating with paper files and stored data in paper format. After looking at "paper cost" financials, he determined that the cost of maintaining files in paper format was astronomical!

In order to eradicate all paper from the company, he then undertook to update the company to the twentieth century by scanning in all claim information to electronic files. Modernizing UNUMProvident's technology may have seemed an excellent idea except for the fact that the current claims process was already in shambles and completely disorganized.

Changes that had already taken place causing the confusion included:

- Reorganization of the claims process from STD/LTD, Waiver of Premium, departmentalization to "impairment based" divisions.

- Requiring claims specialists to process and manage claims for which they had no training or experience with specialized medical impairments or type of insurance.

- Creating a claim review system requiring "validation" by a Consultant that led to backlogs claims specialists were held accountable for. Removing autonomy from claims handers to make their own claims decisions created complete disorganization and loss of leadership over the claims process.

- Integration of new technology in the form of removing "Genesis" and placing "Navilink" as a diary system in the claims management process. New learning curves occupied a great deal of the claims handlers' time, worsening backlogs of claims.

- Creation and distribution of a meager and incomplete Benefit Claims Manual in order to meet regulatory requirements and then holding claims specialist accountable for the memorization and implementation as written.

- Adding ERDs, possibly integrated with financial reserves, placed unrealistic goal objectives on the entire claims staff, creating stress and pressure in the claims areas to meet ERD profit goal expectations.

The new VP's removing of all paper files from the claims process added new tensions and disorganization to an already chaotic company in transition. Still, directives went out from the VP's office that claims specialists were no longer permitted to print out documents, since all files would be eventually scanned and maintained in electronic format. For a long time, nearly all disability claims were partly in paper, and partly in electronic format. In fact, the new paperless directives created "snoops" who observed handlers still printing documents. Some were actually fired for it

Doing away with the "policy" room was particularly devastating since Unum Group today still has problems locating copies of original policies. Still, Tim Arnold's ideas of "updating" the new company with electronic data formats, and doing away with paper files, was viewed as a great modernization even though the claims process was left in shambles until the changes were completely made.

Overall, I actually liked Tim Arnold. I presented at roundtable with him on several occasions and while Mary Fuller was yelling, "Why are we paying this claim? Close it!", Tim Arnold instead ordered additional reviews. I also interviewed with him just before I was promoted to Lead Customer Care Specialist and he was concerned then about problems with the claims process. I liked the man, but then again, he wasn't my direct supervisor and I didn't have all that much contact with him. Those who did report to him found him to be a bit strange and overly authoritative.

Ralph Mohney – Who is This Guy Really?

Although Ralph Mohney hailed from Chattanooga's Provident and Paul Revere offices, we really didn't have much to do with him in Portland, ME. He was somewhat of a suspicious character who never really spoke to claims handlers giving the impression he was so much more important than anyone else.

While Tim Arnold in stature appeared calm, normal, and mouse like Mohney's appearance did in fact have "mobster written all over him." Average in normal height and slightly balding, his beefy size projected power and "in charge" authority whether employees knew it or not. At the time, I had the impression that most people just stayed away from him, but then again, I suspect that since he was upper management, he just stayed out of "on the floor" operations.

Although Mohney seemed to be able to push his weight around with managers, which was considerable, he took a bizarre title of "Vice President of Return to Work Activities" and supposedly ran the company's new initiative of trying to get most claimants back to work. We all knew he was using a bull crap title, but for whatever reason, he remained in Portland, ME for some time and acted his part.

Mohney's "Return to Work" program was, in my opinion, one of the most productive and successful initiatives UNUMProvident ever implemented. He created a process whereby claimants and insureds could be "assisted" to return to work in some capacity thereby increasing the number of claim closures more than any other strategy to date.

I have to admit I had a vested interest in cooperating and "taking on" the Return to Work initiative since RTW denials did not require validation from a Consultant. I can't stress enough how many problems were created by "Consultants" and I was more than happy to work in ways that were beneficial to both insureds who returned to work and UNUM without the harmful discriminative eyes of a Consultant.

Of course, UNUMProvident being UNUMProvident, offered many monetary incentives to claims handlers who rolled out numbers of return to work denials. The program actually worked and many insureds were pleased to be able to return to work in some capacity rather than having fire bell in the night claim denials they didn't anticipate.

Had UNUMProvident continued Mohney's Return to Work programs, the company might be in a better position than it is today.

Ralph Mohney and I got along rather well. In fact, in one incidence I actually saved a claimant's life by contacting a treating physician when a patient/insured threatened suicide on the phone because we were closing his claim. The treating physician called the local EMTs and they found him in time on his living room floor.

Several days later Mohney showed up at my cubicle with a check for $500 as an incentive award for "saving a person's life." Of course, Unum never paid the man's claim, but I received a check for $500. I felt guilty about that for a very long time.

In November 2002, NBC Dateline and 60 Minutes aired exposés publicly disclosing UNUMProvident's unfair claims practices and all hell broke loose. Prior to the airing of these two very explosive programs, UNUMProvident had already been besieged with lawsuits and investigations into the company's claims practices.

Having talked its way reasonably well out of criminal prosecution with federal and state regulators, UNUMProvident found itself managing the ashes of the new UNUMProvident and the mob-ish management style of Harold Chandler.

Information I had at the time indicated Ralph Mohney wasn't going to fare very well in this deal. Nevertheless, Mohney's Return to Work Program remains the most successful, progressive strategy I know of to date.

PART II

Whistleblowers Aren't Heroes and They Aren't Given Any Medals

During the period of time when claims handlers were told to engage in unfair claims practices, I became very uncomfortable with the unfairness of the UNUMProvident claims process and often expressed my opinions to management. By this time, I had been promoted to Lead Specialist and it was part of my job to identify projects that should be done.

Unfortunately, in my search for projects I discovered that the BAS payment system was not calculating or paying COLA to any Unum claimants or insureds. Upon further inspection, I also discovered that BAS was also not providing employer TIA/CREFF retirement contributions as directed by many of the Group Employer Plans for teachers.

Income Revenue Protection provisions required Unum to contribute certain percentages of benefits as part of a retirement plan run by employers. The fact that Unum had not been forwarding contributions was particularly problematic since interest should have been compounding and accruing on payments that had been omitted, in some cases for many years.

Unum not only owed claimants a sum of the missing contributions, but the going market rate of interest that would have been paid had the contributions actually been made was a very expensive correction.

When I brought these issues to the newly appointed UNUMProvident Managers I was immediately regarded as a nuisance. My manager basically said, "Can't you ever find a project that's in OUR favor?" My unit Consultant ultimately decided that we could "correct" BAS errors allowing future Income Revenue Protection to be made, but we were to completely ignore the payment of "interest" issue.

I have to admit I did not accept it very well when the autonomy to make claims decisions was removed from claims specialists. Since the claim specialists were given the responsibility of reviewing and making recommendations to Consultants for validation, I felt that the claims specialists, above all else, knew best what liability determinations should be made. Somewhere along the line it escaped me that this was not the point, but it also felt wrong to force claims handlers to sign letters communicating decisions they didn't agree with.

Over time it became clear to me that my managers, having been spooked by the new leadership, did not want verbal opposition to "the new rules" because it made them look bad. I was very open about my disapprovals with UNUMProvident's unfair review schemes and of course management wanted me to "keep my mouth shut" and said so in the performance probations I later received.

The Portland managers were already under the control of the Chattanooga leadership and took a very dim view of anyone in the rank and file who openly criticized the new claims processes. Thinking outside the box was prohibited under threat of termination and claims handlers were told to just follow orders and keep their mouths shut.

But, Unum had a problem with me. I was one of the top "earners" within the claims department and was rolling in millions in reserves profit. I received many "top earner" rewards as well as awards for being the only claims handler that could manage a block of 250 claims at a zero-growth level. [20] I topped out with Ralph Mohney's Return to Work Program and also received monetary awards from him. Finally, I received substantial raises every year from 1994 - 2002, including the year Unum fired me for "poor performance". Go figure.

Unum placed me on two written probations with a condition of "keeping my mouth shut" and continued to offer me salary increases. Of course, I continued to point out Unum's bad faith to both my manager and the current VP of Claims, Dave Gilbert, and when the *NBC Dateline* and *60 Minute* exposés aired in November 2002, I was Unum's prime suspect for whistleblowing to the press.

Although I actually thought about contacting 60 Minutes, I never had. However, I was contacted by Dave Gelber, one of the producers of *60 Minutes,* the day following my Unum termination. To this day, I don't know how he knew to call me, but he was considering a sequel to the Unum story and wanted to know if I was interested. At the time, I put that one on hold but eventually Saddam Hussein and his revolution pre-empted the story and 60 Minutes moved on.

What happened next was something I could not have anticipated. The following Monday I began to receive calls from attorneys nationwide asking me questions about Unum's claims practices. Unaware of the possible repercussions of providing information I fully disclosed Unum's internal claims practices to as many as fifty attorneys per day.

Taken in by their sly, polite "we appreciate you" rhetoric, I freely gave information to any Plaintiff's attorney who asked, including giving sworn testimony and provided a written Affidavit naming UNUMProvident as an unfair and egregious reviewer. Providing information to attorneys looking to win their cases is probably one of the worst mistakes I ever made in taking care of myself during this period of time.

It was pointed out to me that the Affidavit I provided to one attorney, for free, was posted to the Internet and was used by many other attorneys in their

[20] The same number of claims coming into my block equaled the claims denied and going out.

cases. Although I had no immediate knowledge of this, Unum made sure it was pointed out to me during my depositions. In fact, one attorney named me as an expert in his UNUMProvident case, and "forgot" to tell me. UNUMProvident attorneys didn't hesitate to bring it to my attention.

As Plaintiff's attorneys continued to call me for "whistleblowing" information, my name became a major resource within certain groups. Several attorneys from California informed me that they'd heard there was a "contract" out on me, and another group called ERISA Esq. included me on their list serve, at least initially.

But, "whistleblowing" fame is relatively short-lived. Many attorneys on the ERISA Esq. server accused me of being a Unum mole, while others wanted me taken off the list serve because I wasn't an attorney. Eventually, it occurred to me that I had been used by the anti-Unum legal community and when the "bad faith" information dried up, I was dropped like a hot potato.

What attorneys wanted to know mostly about Unum's internal claims procedures was whether or not claims were targeted for denial as a matter of general "patterns of practice" so that RICO charges potentially could be filed. The idea of treble punitive damages and asset foreclosure danced in front of plaintiff attorney's eyes like the Emerald City.

Targeting, using financial reserves was, of course, Unum Life's primary focus, not to mention the additional "Hungry Vulture" abuses added after the 1999 merger with the Provident Companies and Paul Revere. When tales of fishbowl lotteries, red thermometers for profit keeping tallies, and availability of claim financial reserves were disclosed to regulators, Unum quickly became the whipping post from which millions could be gained in insurance litigation.

In truth, plaintiff's attorneys began falling all over each other to be the first to rake in millions in "bad faith" court awards such as in the highly publicized *Joan Hangartner vs. Provident and Paul Revere* case in June 2004. Most of the high-profile attorneys contacted me for the "insider scoop" and I provided information in hindsight I wish I had never given to them.

When it became known Unum might have been shredding documents to avoid disclosure, one law firm I will not mention located in New York, offered to represent me pro bono during Unum's depositions.

The information about "shredding of documents" was given to me by an elderly Administrative Assistant who worked in my unit at the time. I informed the attorney representing me pro bono that I did not wish to testify to any shredding in order to protect the individual who provided me with where and

when the shredders were placed. I considered information provided to this attorney as "privileged" and never expected him to betray my confidence by calling Unum's attorney and letting him know to ask me about it at the next deposition.

Therefore, prompted and betrayed by my own pro bono attorney, Unum's counsel asked me about the shredding of documents at the next deposition. Although I wasn't untruthful with my answer, I wasn't specific about it either. Later I found out that the pro bono attorney who represented me had hopes of being appointed "lead Counsel" for multi-class action lawsuits against UNUMProvident.

Unum's lawyers were delighted that plaintiff's attorneys were turning me into a mockery and a credibility disaster, which is why to this day I never recommend "whistleblowing" to any former Unum employee.

In the end, plaintiff's attorneys stabbed me in the back as their expert on multiple occasions by refusing to defend me under abusive circumstances during depositions. Unum's attorneys were ruthless and kept me until 9 p.m. on most deposition days. I began to feel afraid to walk in the dark by myself to the parking garage in the middle of Portland, ME, and cried the entire 45-minute ride home. This is something that needed to stop.

Finally, I gave up expert witnessing when the deposition abuse was allowed to continue for so long without objection that I actually stopped one of the depositions and demanded a judge be contacted so I could ask for a protection order. It became increasingly obvious that there was not going to be any "defense" of my person, reputation, or testimony by those attorneys I was actually working for. The objective, I later learned, was to allow Unum to show its abusive nature on video, setting up their cases for the big win, except that it was at my expense.

In the end, it was obvious that my behind was swinging in the breeze with no protection from plaintiff's attorneys. In combination with my affidavits published and used on the Internet without permission, and the criticism from not being specific about Unum's "shredding", my future as an expert witness was destroyed by the very same attorneys who once profited from the information I provided that aided them to make millions of dollars at my expense. I found out the hard way that "whistleblowers" are not lauded, but are used, scorned, and tossed like a piece of garbage, or at least that's how it played out at the time.

In the midst of all this, I had agreed to file a qui tam lawsuit in California with an insurance advocate/agent to change the laws allowing California citizens to bring insurance lawsuits on their own. This case went all the way to the Supreme Court in California, but the judge eventually ruled against us. John Garamendi, then Insurance Commissioner, declined to join forces with us and the forty-eight state regulators to file California's own Market Conduct

Examination. These actions brought by California separately cost UNUMProvident another $8M in fines.

Consecutively, another pro bono lawyer emerged from the Pittsburg area and wanted to represent me in a Sarbanes-Oxley whistleblower action in conjunction with a Maine Human Rights complaint against Unum's discriminatory employment practices. At first, this seemed as though it was a sweet deal for me, but alas, again I got burned when he failed to show up in Portland to represent me during a particularly brutal Unum deposition.[21]

At this point several attorneys with whom I had already spoken to felt sorry for me and volunteered to be telephonically present during future testimonies. After a half-day interview with a representative from the U.S. Department of Labor, I was informed my cases were dropped because of evidence obtained from Unum counsel as a result of threatening my co-workers with termination if they didn't come out against me.

I later found out that UNUMProvident's legal team called in many of my peers and threatened termination if they didn't provide additional adverse information concerning my performance and whistleblowing. After obtaining a copy of my entire personnel file I found evidences that my peers were asked to submit negative performance reviews after I was terminated to further back up Unum's defense against my complaints.

Therefore, my case was not taken seriously by the U.S. Department of Labor, even though several months later a DOL official along with a local attorney again contacted me with requests for more "inside information."

Working for a federal agency such as the U.S. Department of Labor feels like the "spy who came in from the cold" with no protections whatsoever even with the Sarbanes-Oxley whistleblower laws, I had already spoken with an executive of the U.S. Department of Labor and provided documents to it that I understood would be used to investigate Unum. Unum made sure my case was dismissed and the lawyer I had at the time dropped the ball.

However, two weeks before George Bush's re-election (baby Bush) I contacted the Department to request a copy of any files they might have on me. I was told:

"I am not aware of any such investigation, nor would I be disposed to discuss such an investigation, if in fact it did exist."

Was I suddenly in the movie "Apocalypse Now?"

[21] Highly criticized for his lack of actual representation of me, he was fired from his firm when after taking the case pro bono, he informed me he needed a $5,000 retainer to keep the cases going. He severed his relationship with me and refused to speak to me in later years.

I was beginning to wonder what the heck was going on, but it became obvious once it was announced that the U.S. Department of Labor and Eliot Spitzer's office threw in the towel with the forty-eight state regulators resulting in the Multi-State Settlement Agreement. What this meant was that UNUMProvident et al was not to be prosecuted criminally, but would have its hands slapped with a $15M fine. Subsequently, the State of California added an additional $8M as a penalty.

Anxious to help regulators hold UNUMProvident accountable, I walked right into multiple abuses by legal information seekers, members of ERISA Esq., plaintiff's attorneys, regulatory agencies, and of course, UNUMProvident itself. I naively walked right into the "information traps" set for me, which over time held me up to ridicule. It took me approximately ten years of "consulting" practice to overcome the horrible stigma of "whistleblower."

And, I wasn't the only one either. Drs. Feist and McSharry, two of the first UNUMProvident physician whistleblowers, were also "shamed" on the stand by very clever Unum attorneys looking to discredit their testimony as to UNUMProvident's practices and bad faith. The women who actually appeared on the *60 Minutes* exposé were also made fun of by UNUM's attorneys and were overheard to be referred to as the "fat pack" since Unum considered them to be considerably overweight.

One of the women who was interviewed by the now deceased Ed Bradley was promised a full tuition scholarship for her daughter by *60 Minutes* if she appeared on the show. The scholarship never panned out and according to the woman herself she was unpaid for her efforts and was left stranded in Seattle when *NBC Dateline* refused to pay her way home, or at least the story goes.

In reality, my termination from UNUMProvident was not entirely a big surprise. Human Resources allowed many discriminative practices prior to "letting me go" such as moving my workstation outside of my unit area to prevent me from corrupting my peers with anti-Unum rhetoric. I was not given the same level of incentive awards and although I denied my share of claims, Dave Gilbert's "gold chocolate coins" never seemed to come my way.

My peers, many of whom I called friends, were influenced against me when their jobs were threatened if they didn't support Unum's efforts to destroy my credibility. During this period, it was a living hell working for Unum, and the best thing that ever happened to me was to finally be terminated and separated from what was called at the time, "a criminal organization."

What did come, as a surprise was the level of abuse plaintiff's attorneys and other attorneys who used me subjected me to Unum's interrogatory abuse. I was paid very little ($60) to review denied claims and literally handed attorneys their bad faith cases on a silver platter. Even those attorneys I had worked for

ridiculed me after I had given up the entire inside information I had about UNUM.

Honestly, it never occurred to me that "legal counsel" representing those who had been harmed by Unum, could resort to using me to line their pockets. However, I did "wise up" after approximately two years of working for plaintiff's attorneys, and eventually gave it up entirely when it was clear the attorneys I was working for were not protecting me from Unum's abusive deposition tactics.

In fact, I was told by at least one plaintiff's attorney, "You're getting paid for your time, just suck it up! What do you care if they abuse you a little? Take the money and just sit there and answer their questions."

Therefore, the very people I was supposed to be representing in fact destroyed my value as an expert witness. Later, I was literally thrown under the proverbial bus by attorneys who benefitted from me, stole from me, and published documents without my permission. Pro bono attorneys who were supposed to represent me also threw me to the wolves by sharing attorney-client communications with Unum and other opposing counsel.

In all fairness, I have to say that there were a handful of attorneys who provided continuous support and advocated for me, two of which are deceased now. Attorneys Jon Holder from Maine and Gene Anderson from Anderson Kill & Olick in New York stood by my side and defended what little rights I seemed to have. While the ERISA Esq. attorneys banned me from their list serve, Attorney Anderson sent me their posts anyway. Jon Holder did the same and actually came with me during a few of Unum's depositions.

Currently, I have a short list of attorneys I can refer clients to for assistance, but by and large, plaintiff's attorneys basically threw me under the train as soon as it became apparent I had no more "insider" information to give. Whistleblowers are always very popular at first, but when the "inside information" is exhausted, they are not useful and are discarded with reputations of being "snitches". I also found out the hard way that after-the-fact a whistleblower's credibility is non-existent, and no one trusts you for anything. It took me approximately ten years to re-build my reputation as a qualified Consultant.

In 2004 what most plaintiff attorneys who retained me didn't realize was that I, too, was a victim. Unum had falsely accused me of "poor performance" in order to terminate me when I became an uncontrollable critic of UNUMProvident and its management. Still, there was very little effort on their part to afford me legal protection when subjected to unscrupulous Unum attorneys.

The fact that I was one of Unum's most "profit making" claims handlers is easily supported with records of considerable pay raises up to, and including,

several months before I was actually terminated. It was too risky for UNUM to keep me on board, "while I was supposedly giving away all its secrets", and I was eventually fired. As my manager sarcastically said, "You've outlived your usefulness."

Broke and unable to pay my bills I gave up roughly $8,000 in severance pay by refusing to sign a confidentiality agreement barring me from sharing UNUM's internal information. Interestingly, Mary Fuller, a former UNUM VP kept her severance pay AND gave testimony against UNUM since she was able to afford an attorney to protect her interests.

In the end, it was blatantly obvious that the only way I could help insureds harmed by Unum was to provide them with assistance and information about the claims process equal to what Unum was using as back-up to make claim decisions. I was already writing a column for Jim Mooney's "Inside UNUMProvident" newsletter and decided to use my claim expertise to help insureds better manage their claims.

The result was Disability Claims Solutions, Inc.

The Great Comeback

The day I was fired from UNUMProvident, I returned home and sat on my porch in tears assured that the remainder of my future rested in greeting customers at Walmart. However, I have never been a person who "just gives up", and after some thought decided to create "Disability Claims Solutions, Inc.", working only for insureds to help them with their disability claims.

Within two years of my termination, I had already completely given up "expert witnessing" as being valuable only to plaintiff's attorneys and their bank accounts. I regretted my involvement with any legal resource with the exception of Eliot Spitzer's office in New York, who had shown me respect during the criminal investigation. Although Spitzer later made unwise decisions in his personal life, he was the only Attorney General who sought to bring criminal charges against UnumProvident.

Now, wiser more experienced and unfettered with the shenanigans of unscrupulous attorneys, I forged forward with new visions of how to help claimants and insureds get a fair deal in the disability claims review process.

At the time, the deck was already stacked against ERISA claimants and insureds simply because they had no idea what the claims process consisted of, or how the insurance industry was able to deny legitimate claims and get away with it. Unum's impossible game of Texas Hold'em so-called, went all the way back to

Unum Life Insurance as well and it was time for insureds to have a level playing field.

I was never a "disgruntled" employee although I have been accused of it many times. Unum taught me everything I needed to know in order to create my own consulting business, and I've always been grateful for those experiences. In the end, I spent nearly nine years working in the insurance industry, which would be considered a darned good start. My hands-on experience is extremely useful in providing assistance to claimants and insureds.

Additionally, having been through as many as 25-30 insurance medical training sessions, as well as trained medically in the Army, I felt reasonably qualified to provide valuable hands-on advice to manage disability claims. While I had formerly been a part of an insurance industry, dedicated to keeping secrets, I was now letting Unum's dirty linen out of the closet piece by piece and insureds began to benefit greatly from it.

Once Unum began to experience large financial reserves losses because of my expertise, it used the Maine Attorney General's Office to attempt to put me out of business. The then Attorney General, Janet Mills, now Governor, not affectionately referred to by me as the "old prune", did her best to protect Unum and fail small business. Janet Mills, notoriously known as a small business killer in Maine worked closely with Unum to restrict my activities regardless of what Title 24 in the Maine statutes said.

However, years later and $40,000 spent in legal fees a judge finally ruled that I was permitted to do what I am currently doing. Janet Mills eventually became Maine's Democratic Governor placing many more small businesses in danger from closure. Nevertheless, the fact that Unum used the Maine AG's office as its own private attorneys to try and put me out of business was unconscionable.

Looking back, I sometimes wonder how I survived all this. In the eighty-five depositions and testimonies I gave in the two-year period I was an expert witness Unum's attorneys literally tore me apart emotionally with abusive interrogation tactics and abuse.

Having already been discredited by attorneys who had previously hired me as their experts, I turned my attention to a greater good – assisting insureds, and only insureds. The path to success wasn't that easy, but I stayed the course and claim successes began to roll in for thousands of insureds that allowed me the privilege of helping them.

Whistleblowing is a long, torturous trail to walk, and I walked it for nearly ten years. I think I paid my dues.

The Multi-State Settlement Agreement and The Great Reassessment of Claims

By 2004 I had already been terminated by UNUMProvident and was accepting clients who retained me to assist them with their claims. Although I had very little trouble soliciting business with insureds, attorneys continued to call me with questions and requests to review claim files. As it turned out, attorneys who knew little about UNUMProvident's claims process, but who wanted to profit by UNUM's wrongdoings contacted me privately as the expert.

During this period of time I was able to accept clients from all major insurers nationwide, Canada, and the United Kingdom. Apparently, UNUMProvident was causing as much havoc abroad as it was in the United States, denying IDI claims unfairly. As a result, I was asked to appear on BBC America to "tell my story", which of course I did.

I was already aware that Eliot Spitzer's office and the U.S. Department of Labor had thrown in the towel with the 48 states to hold UNUM accountable for its unfair claims practices. The final document referred to as the Multi-State Settlement Agreement fined UNUM $15M and forced the company to review 250,000 [22] claims that had previously been denied. From 2004 – 2008, UNUMProvident re-reviewed claims and again, according to its own resources paid nearly 90% of them.

While UNUM's management had formerly told state regulators it historically paid 98% of claims, there are many authorities that doubted UNUM's data. Common sense should suggest here that since UNUM was underwriting premium with a 60% liability acceptance rate, any payouts above 60% produced financial losses. I know from working in the claims area that management went ballistic when the LARs (liability acceptance rate) went above 60%.

Also, if the 98% payout rate were actually accurate, UNUM's investors should have run for cover. No insurance company can maintain profitability with payout rates of 98% when chargeable premium was set at 60% payout levels. As I

[22] According to UNUMProvident's sources, the company actually re-investigated approximately double the number of claims required by the Multi-State Commissioners.

said, there were those in the industry who never believed UNUM's alleged payout percentages, which were statistical improbabilities.

During the investigation of UNUMProvident I also received calls from both the SEC and Bond Rating companies who demanded information concerning Unum's financial reserves and how those where mishandled in the claims process. Unum has yet to this day to admit that I had any knowledge of financial reserves even when I can produce written proof that claim reserves were used to performance manage claims staff. Financial reserve lists were also made available to claims handlers through EIS in order to transact settlements.

Nevertheless, UNUM took the reassessment seriously and spent a great deal of dedicated time and money investigating denied claims all over again. To put all this in perspective, UNUMProvident didn't have a choice. With a publicly damaged reputation, and a failing company, management had to dig out of the mess, or go under like Enron had.[23]

The number of lawsuits against UNUMProvident tripled with court decisions that again slapped the hands of a "criminal organization" that denied legitimately payable claims for profit. Please see my article in *Lindanee's Blog* from March 2019 below.

Did UNUMProvident Ever Have A Claims Manual?

One of the most important violations state regulators had with UNUMProvident during the Multi-State Conduct Market investigations was "where is the company's Benefit Manual?" Did UNUMProvident have a Benefit Manual outlining its internal claims practices? Actually, no it didn't.

What Unum distributed to its claims handlers was not an official Benefits Manual describing how to manage claims. In fact, none of UNUMProvident's claims practices was ever put in writing, although there was an instruction book informing claims handlers how to access EIS, the company's computer data base complete with financial reserves.

As far as I can remember, EIS stood for "Electronic Information System" and was not user friendly. Most of my peers gave up on trying to write what appeared to be Basic computer language in order to gain access. On this data base, were certain descriptions, and definitions relating to the claims process, but there was nothing distributed to the claims staff that even remotely resembled a Benefits Manual telling claims handlers how to manage claims.

[23] Harold Chandler invested $50M consisting of employee pension dollars in Enron. When the company failed Chandler sent out a companywide email stating, "…not to worry, we have plenty of money."

At the time of the Conduct Market investigations regulators requested UNUMProvident turn over its Benefits Manual, which it did not have. At this point, in order to save itself, management called in a team of writers and within a very short period of time, UNUMProvident had a claims manual, which it said it had all along.

I was often asked whether UNUMProvident had a claims manual, and I told the truth: "No, it didn't." But, it sure pulled one out of its hat in record time.

Bad Faith, and Bad Faith again….

(Reprinted from *Lindanee's Blog*, March 2019)

If there still exists any optimistic prevailing thoughts that Unum Group learned their lesson via the Multi State Settlement Agreement in 2004, think again. Although not widely publicized (likely suppressed), there is evidence suggesting that in 2008 when the RSA reassessment of claims ended, Unum partied, re-grouped, changed its name, and today engages in bad faith worse than it ever has.

I am referring, of course, to a fairly recent court case (2017), U.S. District Court for the District of Massachusetts, *Ann Rosenthal M.D., vs. Provident Life and Accident Insurance Company*; *and Unum Group*, Case No. 4:17-cv-40064. Interestingly, the case also involved testimony by deposition of claims handlers and middle claims management employees from the Unum IDI Worcester office, some of which were terminated. (Although the names of these individuals are listed in the case documents, I'm withholding them from this work.)

Employee testimony in the Rosenthal case confirms "*Unum sets targets for claims closures of its employees and that Unum requires employees to focus on financial considerations of claims rather than whether a particular claimant, such as Dr. Rosenthal, medically and vocationally qualified for benefit.*"

The Rosenthal case also cites *Merrick v. Paul Revere Life Ins. Co.*, 594 F. Supp. 2d 1168, 1171 (D. Nev. 2008) when the judge's decision slapped Unum's hands very hard for continued bad faith and unfair claims practices. While Unum continued to argue that it reformed its wicked ways, in *Merrick* the judge reiterated that the "*reality is that the bad-faith claims handling addressed by the RSA, continues to this day, despite Unum's contention that the unfair practices ceased.*"

As a former claim specialist, I was particularly interested in the testimony of XXX (2017), who in his deposition stated he was handed status reports containing the insured's name and claim reserve figures. (By the way, Unum now refers to denials as "recoveries" and official status reports as "metrics".) An Unum VP, XX (also terminated), gave reserve reports to her administrative assistant who then distributed the information that was later shredded. Actual

testimony was, "*After reviewing lists of claims, including information about reserves, names of the claimants and other information, he, XXX, discussed the expected "recoveries" with his subordinates and then shredded the documents."*

Testimony of the five employees terminated from the Worcester office completely contradicted Unum's representations made in a letter dated January 31, 2017 to plaintiff's counsel alleging Unum's prior "offenses" are viewed as "institutional bias" rejected by courts and insurance regulators.
Unum's arguments that bad faith occurring a decade ago was not relevant in the administration of Dr. Rosenthal's claim was not persuasive given the testimony of the five second generation whistleblowers.

Specifically, the Rosenthal case included "Weekly Tracking" Exhibits listing recoveries (terminations) and other statistical information such as LARs, or Liability Acceptance Rates. Termination rates exceeded acceptable LARs of LTD (78%-82%), IDI (80%-85%) and were reported as 105% in some quarters. Even claims on Reservation of Rights were part of the "metrics" since removing ROR status has a negative impact on reserves.

For me, reading the depositions in the Rosenthal case was like old home week. Nothing changed. After all of the ruckus of the 2004 RSA, all of the testimony of whistleblowers at the time, hundreds of depositions given (over 50 of them were mine) and cases won, Unum is still operating rogue without state oversight and regulation of its activities.

In my opinion, Unum is operating worse now than its pre-RSA levels, with no accountability or regulatory conscience that the company was caught red-handed in targeting claims based on financial reserves and unfair claims practices.

It's pretty obvious that Unum will never change, revise, or do away with its "biggest reserve bang for the buck" management style that leaves insureds devoid of "good faith and fair dealing". All Unum employees are still pushed to terminate claims while the March 2019 bonus is held over their heads as a beacon to profitability and "exceeds" performance levels.

Despite the untrue assertions Unum's counsel puts out there, cases such as the Rosenthal case, complete with employee testimony, point to continued bad faith and targeting of claims at the expense of insureds who are at the mercy of Unum's bad faith operational style that considers profitability over the merits of cases presented for payment.

The Creation of Unum Group and Bad Ass "Quality Control"

While UNUMProvident fumbled its way through the "reassessment", it became increasingly clear the company was not in any way planning to abide by the Multi-State Settlement Agreement. In fact, in 2008 the company held "one hell of a party" for its employees and re-branded itself as Unum Group.

Ironically, after all of the negative public outcries about UNUMProvident's "criminal" behavior, the company emerged worse than it ever was. Unum Group paid its fine, re-reviewed 250,000+ claims, and failed to "walk the talk" in changing its claims process in good faith and fair dealing.

Although various processes were given new names, additional departments created, and employees terminated, internally, Unum Group persisted with its targeting agenda to deny legitimate claims for financial gain. The norm, "hiding in plain sight", quickly became the disguise to satisfy regulators that Unum was operating fairly.

A good example of Unum Group's "masking" of wrong doing was the creation of "Quality Control", a group of Gestapo-like review and oversight procedures giving a few selective executives control over employees, physicians, and managers. Subject to constant review were claims, medical reports, employee performance reviews and nearly every report that was ever added to any claim file.

Unum's Quality Control henchmen dominated the claims process with oversight process and statistical control so that every action, report, employee involvement and decision was reviewed with feedback as to how to best support liability decisions through legal scrutiny and litigation. Although in theory the idea of Quality Control may have seemed appropriate for Unum Group to keep the company in compliance with the Multi-State Agreement, in actuality, it created a centralized, adverse-finding body of central control over claims and its own workers.

Sometime in 2010 I was contacted by one of Unum's Medical Directors who had recently been terminated because he refused to change one of his medical review reports as directed by Quality Control. At the time of his refusal, he was blacklisted throughout the company and was discredited with his peers.

Other recently terminated Medical Directors also shared that physicians who went along with Quality Control's requests to "write-up" reports in certain ways received greater yearly bonus percentages than those who refused to misrepresent information as directed. All of Unum's physicians were cautioned anyway not to share their annual bonus percentages with each other, but apparently, they did anyway.

Reports from claims handlers indicated that Quality Control audited their work on a regular basis and reported specialists who appeared to have difficulty rolling in denials to meet profitability targets. In listening to the shared reports of one ex Unum Group employee after another, it appeared to me that every aspect of the claims process involved the direct control and oversight of Quality Control.

As I indicated earlier, Quality Control may not have been a bad thing except that it left "good faith and fair dealing claims review" trailing in the dust, not only for insureds, but for its employees as well. I also got the impression that no one at Unum Group was working well under that kind of oppressive micromanagement.

To this day, Unum Group has not been able to change the public's opinion as to its malfeasance and bad faith. By continuing, and worsening the tendency toward unfair and unconscionable claims review practices, Unum Group once again solidified itself in the eyes of the public as a "criminal organization."

Unum – You Be the Judge……

(Reprinted article from *Lindanee's Blog* April 7, 2011)

Unum's response to charges of violation of the multistate settlement and subsequent RSA amendments is an emphatic, "We don't do that anymore", and "don't bring up the past." In fact, one gets the impression all Unum employees have been told to respond the same way to mentions of unfair claims practices. And……we all would like to do that if documented proof of adherence to what the company agreed to in 2004 was available. Unfortunately, it isn't.

In late 2008 when the Unum reassessment of over 250,000 claims came to an end, Unum reorganized into Unum Group and began selling itself as a "people-oriented company." The problem is that in order to re-invent a company with a long-standing history of unfair claims practices Unum has to actually "walk the talk."

There is no evidence to suggest, outside of the Aesop's Fable Unum creates with regulators, that the company actually reviews claims in good faith and fair dealing. If you have an Unum, Provident or Paul Revere policy, what YOU think about how well the company administered and reviewed your claim?

The multistate market conduct examination identified several claims handling practices of concern to the state insurance regulators, including:

- Excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits;
- Unfair evaluation and interpretation of attending physician or independent medical examiner reports;
- failure to evaluate the totality of the claimant's medical condition; and
- An inappropriate burden placed on claimants to justify eligibility for benefits.

In addition, RSA amendments require Unum to consider the opinions of your treating physicians over those of internal paper-reviewers who do not have a treatment history with you. If you live in California, there is a much longer list of violations for which Unum paid $8 M additionally in fines.

Ask yourself these questions:

1. Has it been your claims experience with Unum the company ignored(s) the medical opinions of your own qualified medical providers and continuously cites: "our medical consultant said", "a review by our own internal physician concluded", or "it is the opinion of our own internal physician consultant that you do not have restrictions and limitations…"

2. Have you noticed incidents of "snatching" of key phrases or misinterpretation of key phrases from your medical patient notes that favor Unum at the expense of all else written in your medical records? Has Unum ever documented your medical information inaccurately or misstated medical information it has been provided with? Was it your experience that Unum obtained an IME and interpreted the report in its favor, or that the IME physician was biased?

3. Has Unum completely ignored the fact you are diagnosed with more than one impairment and the totality of the combined symptoms prevents you from returning to work? Are there evidences Unum evaluated each impairment separately and eliminated each one instead of considering symptoms and effects of them all? Are there evidences Unum failed to investigate ALL of your impairments and selectively chose the ones it could easily eliminate to deny the claim?

4. Has it been your experience that Unum continually harassed you and your physician for more and more paperwork and proof of claim even though proof of claim was already made reasonably clear? Has it ever seemed as though no amount of evidence would be convincing enough for Unum's purposes to approve or continue to pay your claim? Is Unum constantly

asking you for information as though the claims handler is making up new requests as she/he goes along?

As an insured or claimant what is YOUR opinion then of whether or not Unum continues to violate the Regulatory Settlement Agreements? Should we believe Unum's management when it informs state regulators, "we don't do that anymore?" What's been your experience? Common sense will tell you that if it, "walks like a duck, quacks like a duck, and eats like a duck, it's a duck."

Of the hundreds of Unum claim files, I read each year, there are strong evidences Unum Group continues to violate the multistate agreements despite insistent claims to the contrary. Unum may choose to continue to insist the company isn't in violation, however, upon actually reading its claim files the company just doesn't "walk the talk."

However, I leave it to you, as an Unum insured, to decide whether the company reviewed YOUR claim fairly and adhered to its RSA agreements. You be the judge.

CHAPTER 9

What's in a Name? – Unum Group

Unum Group began in 2008 with wild employee parties celebrating the end of the "reassessment" and a moving forward without the stigmatizing name of UNUMProvident. However, it's not easy for any organization to just wave its wand and emerge re-branded as a fair insurer.

It continues to be reported that UNUMProvident, now Unum Group, was, and to some extent still is, the worst disability insurance company in the world. Despite spending a great deal of money to cleanse the Internet of negative information [24] UNUMProvident's reputation as an unfair insurance company is as bad today as it was in 2008.

Of course, Unum's re-branding efforts could have been more successful with improved claims strategies, but management actually made matters worse by continuing its targeting for profit schemes worse than it ever did. The ultimate test was that UNUMProvident's change to Unum Group afforded the company no great change in public persona, and for good reason.

Instead of cleaning up it's claims review practices hinting at fair review, Unum Group dug in with bad faith and egregious strategies that existed long before the Multi-State Settlement Agreement. Although the RSA contained

[24] This tidbit came to me from my Unum source in the UK who noticed her articles were disappearing from the Internet.

writings of additional punitive fines if Unum did not change its practices, regulators expressed little interest in "having another go" at Unum Group that continued to report, "We don't do that anymore."

Unum's continued unfair claims practices [25] became evident to me as a practicing Consultant through file reviews, Unum letters, calls from claimants and insureds, conversations with attorneys and, of course, assisting clients through a claims process stacked in Unum's favor. In many ways, the new company, Unum Group, reminded me of UNUMProvident but with more favorably designed deceptive practices.

Social Security Disability Capers

Unum Life, UNUMProvident, and Unum Group have always been paranoid about its contractual authority to reduce its own financial liability through benefit reductions called "offsets." The assumption is that claimants will always have a tendency to conceal and lie about additional money they receive to avoid "offsets" that significantly reduce monthly benefits.

Unum's, and every other insurance company's paranoia about offsets, SSDI [26] in particular, is purely financial since the authority to reduce benefits by additional monies received reduces the company's financial liability for benefits they do pay. Given that "unrecorded" offsets greatly overstate liabilities on the Balance Sheet, in some respects insurer paranoia of chasing down information is somewhat justified.

Unum's assumptions of SSDI concealment are not entirely wrong. There is a large percentage of ERISA claimants who neglect to report SSDI awards, and while DCS, Inc. always recommended to claimants that they "pay back" any money owed, not everyone listens to good advice.

Part of the problem is that claimants often make assumptions about their employer benefit Plans without having actually read them with understanding. Ten years ago, it would not have been uncommon for me to be contacted by a distraught and hysterical mother who said, "Unum can't take SSDI benefits away from my children can they?" My answer was, and is, the same, "Yes, they can if your Employer's Plan says they can."

While I imagine it would be a shock to suddenly find there is less money available from my insurance company, is there actually less money received? The "benefit system" of private disability is designed to pay 50% - 60% of pre-disability earnings.

[25] Patterns of practice subsequent to 2008.
[26] Social Security Disability Income

It has never been the intention of our government or state regulators to allow claimants to "profit" from disability related to, "not able to perform the material and substantial duties of one's own occupation." Persons receiving Worker's Compensation, SSDI, and private disability could in fact make a profit from disability and given human nature, no one in the country would ever want to work!

Therefore, insurers are permitted to reduce their liability for benefits while claimants are only paid 60% of prior earnings to ensure that the majority of people, who CAN work, actually return to work in some capacity.

SSDI – Do the Right Thing

(Reprinted from *Linda Nee's Blog* November 6, 2019)

Most people who read *Lindnee's Blog* contact me because they know I will always tell them the truth about their claim situations and because I have the knowledge and experience to provide accurate answers. This is one of those situations.

I seem to be hearing a lot lately from claimants who either did not give back their SSDI retroactive payments to insurers, or who do NOT want to repay insurers when they get the money from SSA. Although nearly all claimants are asked to sign "Payment Option Forms" where they can opt to receive 100% of the benefit while waiting for SSDI, or have estimates for SSDI awards removed from benefits. Not too many people actually choose estimates.

I completely understand how hard it is to give an insurance company the $40,000+ payment from SSA when it is more money than you've ever had together in one place, ever. People who are disabled are often behind on mortgage payments, medications and are in debt. It's difficult to pay back money that is needed to meet family debts and obligations.

The truth is, insurers "FRONT" you the money and pay you total gross benefits while waiting for SSA to award SSDI. If you did not want to "give back" the overpayment, then you could have opted to have your benefits reduced by an estimate for SSDI. But, of course, no one wants to do that. I've had claimants tell me, "I want my full benefit now and I'll worry about the overpayment later." The problem is, "later" usually means the over payment never gets paid back.

Of course, the usual question that follows is, "What can my insurance company do to me if I don't pay it back?" Well, they can (and will) reduce your benefit to $0 until the overpayment is paid back, or they can sue you. In fact, for a period of time Unum became fed-up with claimants not handing over the overpayment that they changed the Payment Option Form to include a voluntary lien on all property and assets to recover the overpayment.

Unum has since changed the POF again, but the message is clear: **If you promise to payback the overpayment when we front you the money for SSDI approval, then you should pay it back. If you don't, we'll recover it from you by taking your benefit and assets.**

Some insurance companies like The Hartford won't front claimants a full benefit at all, and take estimates for SSDI offsets from the very beginning. The point I am trying to make is that claimants cannot expect insurers to operate in "good faith and fair dealing" when at the same time refusing to pay back what was promised.

My opinion and recommendation are that if you sign the Payment Option Form promising to pay back the retro SSDI award, then you should pay it back. If you don't want to hand it over, opt to have an estimate removed from your monthly benefit.

Claimants cannot expect insurers to operate in good faith and fair dealing while at the same time going back on a promise to repay what was "fronted" while waiting for SSDI to make a decision. Some insurance companies will "make a deal" to have a stated amount removed from benefits, but not all will agree to a minimal payment.

This Consultant believes, and recommends, that claimants have an obligation to obtain copies of their Plans and understand the "offset" provisions (reductions) prior to disability. Nearly all integrated Plans contain provisions allowing insurers to reduce benefits by Primary and Family SSDI Awards.

Many people I speak to on the phone who tell me they don't want to pay the money back do not have a copy of their Plan, and do not understand why an overpayment will exist in the first place.

It is the "WRONG thing to do" to request maximum benefits while waiting for SSA to make a decision, promising to pay back in the future, and then refusing to repay what's owed once the money is received. Insurance companies FRONT you the money with a promise that you will pay it back once SSDI is awarded. In a sense, the Payment Option Form is a separate contract that claimants breach when they don't payback what is owed.

I believe that both parties in the SSDI offset process should be fair and honest.

The SSDI Race to Offset

Like all disability insurance companies, Unum always recognized the profitability associated with making sure all possible Plan offsets are coded on the payment system. This includes workers' compensation, and retirement/pension income as well as social security.

But as with most other claim practices leading to potential profitability, UNUMProvident and its re-brand, Unum Group, began a systematic process whereby ALL claimants with ERISA Plans would be forced to apply for SSDI whether they were entitled to the benefit, or planned to return to work.

Since the coding of SSDI offsets reduces claim financial reserves, the "forcing" of all claimants to apply for SSDI clearly was, and still is, a benefit to meeting profit objectives. You may not be aware of this, but there are times when SSDI and other offsets saved UNUMProvident's backside from showing losses.

The *qui tam* case, *Loughgren vs. UNUMProvident* [27] went on for several years, alleging UNUMProvident was costing the American people millions in costs to review claims UNUM knew would not be approved for SSDI, a violation of the False Claims Act. UNUMProvident profited from forcing all claimants to apply for SSDI due to the probability of error in assessing claims that actually "awarded" benefits to those who, in reality, were not entitled.

Although I was a designated expert in the Loughgren case, at deposition Unum attempted to shoot down the accusation that the company literally badgered all claimants to apply for SSDI. Although the case was ultimately won (sort of), UNUMProvident received little financial penalty and went back to its own practices of threatening "estimates" if claimants didn't apply.

"Offsets", or reductions in monthly benefits for additional income received, or entitled to, actually finance, or reduce the cost of claim liability for all insurers. Financial claim reserves are reduced since offsets such as social security finances a portion of all insurers' future liability for claims. Using federal entitlements such as SSDI, and/or state programs such as Workers' Compensation, and ERISA pension and retirement income to reduce liability is, of course, a major source of profitability to insurers.

While companies such as Unum have a great deal of profitability at stake when "offsets" are not recorded, claimants continue to be harassed about filing for SSDI even when they do not meet the criteria for SSDI approval. Therefore, Unum began what I call the "great SSDI scam of nickeling and diming" claimants, by re-calculating SSDI award overpayments, not once, but many times in order to

[27] *Patrick Loughren vs. UNUMProvident Corporation*, Civil Action No. 03-11699-PBS, United States District Court, State of Massachusetts, February 24. 2009. As best I can remember, the case was initially begun in 2000.

allege money owed that may or may not exist. Despite hardships created for claimants, Unum to this day continues to hunt for that last nickel of SSDI money in order to boost its profitability results.

I don't think anyone would have an objection to recalculation of SSDI offsets ONCE. However, to repeatedly recalculate the same claim over and over again might be presumed to be egregious.

Meanwhile, other insurers can be equally egregious, but Unum's methods are always covert and sold as, "giving claims the best consideration", which we know is a misrepresentation by claims handlers in order to obtain SSDI information that can be used to deny claims.

In order to gain the best financial advantage over its own calculation errors the company retained Lucens (now Claimify) to contact claimants with requests to sign Authorizations allowing SSA to release all financial data from SSDI files. Claimify is not the last of a long list of "third-party paper chasers who contact claimants insisting on obtaining signed SSDI Authorizations allowing the release of SSDI files, or financial information held by SSDI.

Release Point, the most recent I know of contacts claimants and their physicians daily until they get what they want. It is a harassing process to say the least. These "paper chasers" just won't let up, forcing claimants to contact their claims handlers to request the dogs be called off.

Information contained in claimants' SSDI files is also used to deny claims due to mental health listings found on Form SSA-831. This form not only discloses the actual SSA listing the claimant was awarded for, but also contains the name of the SSA DDS (Disability Determination Specialist) who made the final decision. If Unum can get it hands on SSA Form-831, it's likely disability claims will be denied using the 24-month mental and nervous provision, backed up by data from SSA.

In the past, Unum's claims handlers obtained the names of the SSA DDS, got the claimant on the phone and together they contacted SSA on a conference call. This practice is totally egregious, and no claimant should ever agree to such a thing. In essence, Unum's claims handlers use the claimant as an "in" to obtain information about their SSDI awards.

Today, insofar as I am aware, Unum remains dedicated to the pursuit of SSDI awards. Those claimants who are late in applying, or who plan to return to work, eventually find their benefits reduced by estimates for probable SSDI awards. Requests for SSDI files continue as Unum plays a dual role to obtain mental health information it can use to deny claims.

It's also my belief that Unum Group quietly changed its newer policies to say it can offset, "primary and family SSDI awards received, or entitled to be received". This makes it possible for claimants to have their benefits reduced, before they've even applied. In all fairness, Unum's Plans also make mention that IF the claimant keeps the process going through appeals they will NOT take an estimated offset. I wouldn't hold my breath on that one!

Unum's offset claims practices are likely to continue, not only by Unum, but other insurers as well.

This concludes the first half of the final book, "From Lighthouse to the World to the Outhouse Failure" that will be published in December, not only on my website, but in paper format. If you feel this book has value please use the Donation button and contribute.

I hope you've enjoyed reading about Unum's history in so far as I experienced it. I hope to see you back for Part II.