DAILY JOURNAL NEWSWIRE ARTICLE
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Staff writer Evan George takes a look at California's disability insurance and finds that insurers wrongfully deny claims, despite findings by treating doctors and the federal government that they are too sick or hurt to hold a job.
The first in a two part series, the story shows that insurers create incentives for employees to turn down claims. Once denied, workers must navigate a complicated bureaucracy that takes years.
Of the cases that reach trial, judges found in nearly half the cases that the insurance companies had no legitimate reason to deny the claims. But because the injured workers can't sue for damages, there is no peril for the insurance companies to repeatedly deny costly claims.

OCTOBER 12, 2009 | LITIGATION

Ill Workers Denied Benefits Face Fight Alone
Disabled Workers, Wrongfully Denied, Can't Sue for Damages

By Evan George

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LOS ANGELES - The pain had become unbearable for Marianne Dilley. Despite a surgery that was supposed to fix her degenerative disc disease, crushing pain throbbed in her neck, numbness settled in her left arm, and every nerve felt rubbed raw.

Her doctor prescribed large doses of Morphine and advised the Bay-area resident to stop working until her condition improved.

Thankfully, she thought, she was covered.

Dilley, a 27-year employee of Bank of America had signed up for a group policy that would replace 60 percent of her $80,000-a-year salary if she ever became disabled.

Metropolitan Life Insurance Co. approved her claim and began sending checks.

But when weeks turned into months of disability, MetLife balked.

"The medical information we have received does not support your inability to perform your duties as a client manager," MetLife said in a denial letter in May 2005.

A physician MetLife paid to review her file disagreed with her specialists and the Social Security Administration: She was fine to go back to work, the insurer's doctor said.

"I can barely handle life," Dilley wrote the company in one of a series of handwritten letters after it cut off her benefits. "I miss my job. I am not enjoying any part of this."

Dilley is one of thousands of U.S. workers who have been denied the private disability insurance coverage their middle-class jobs supposedly afford them. Among them are injured workers who have had to battle improper denials at the same time that they struggled with health problems and the financial strain they had sought to avoid.

An investigation by the Daily Journal, which included a review of 576 lawsuits filed in federal court in California against the seven largest disability insurers, found:

Insurance companies regularly deny, or terminate, benefits to people even after they are found disabled by the federal government and approved for Social Security checks. The companies hire contract doctors who routinely reject the opinion of treating physicians without ever having seen the patients.

Some insurers provide incentives to employees to deny and terminate claims, tying performance evaluations to meeting money-saving goals.

No regulatory agency has taken responsibility for these cases. Consumers who complain to the Department of Insurance are ignored or told to contact the federal Department of Labor because workplace benefits are controlled by federal laws. But the Department of Labor does not investigate, or track, the complaints either. Officials say the only thing the law provides is the chance to sue in federal court.

Those who choose to fight the insurance companies wait years. Plaintiffs waited two years and eight months on average from the time they became disabled before their cases resolved, the Daily Journal found. One man has been waiting 10 years for benefits.

In nearly half the cases reviewed by the Daily Journal that reached court, judges find that the insurance companies had no basis to deny benefits. Judges who consider the companies' patterns of practice side with workers even more often, one survey found, nearly 70 percent of cases.

Because federal law does not allow for any damages, there is no peril for the insurance companies to repeatedly deny legitimate claims. Judges often find that the insurers wantonly denied or arbitrarily stopped paying benefits to disabled workers. Yet the most the companies will have to pay is the original amount, plus, in some cases, legal fees.

"There is really no downside for an insurance company to cut these people off," said Alice Wolfson, an attorney who chairs the board of the nonprofit United Policyholders. That group advises consumers who have trouble getting any kind of benefit from insurance companies.

Wolfson said the insurance companies bank on many people giving up after a claim is denied the first or second time.

"Some people will get lawyers and some will fight," she went on, "but then the company still has a choice to settle the case for pennies on the dollar."

The total number of insured workers snared in this insurance limbo is unknown, but is likely to grow as baby boomers age and insurance agents continue a slowly gaining sales push.

Already, about 42 million Americans - a third of the full-time workforce - have enrolled in disability insurance through their employers, according to the Bureau of Labor Statistics. For white-collar workers, the rate is even higher: 40 percent.

Once an after thought to life insurers, disability insurance is now a $13.4 billion industry. "Overall, the disability business is profitable," said Jimmy Bhullar, an insurance analyst at JPMorgan Chase. "It's not like long-term care where companies have lost money."

Insurers insist that they pay the vast majority of claims, and only deny the small fraction that they believe are fraudulent or improper.

The Council for Disability Awareness, a nonprofit advocacy wing for the top insurance carriers, reported that the industry paid $7.9 billion in claims to 573,500 policyholders in 2008.

"Allegations of widespread denials or delayed payments haven't been established," said Brad Wenger, president of the Association of California Life and Health Insurance Companies, a Sacramento-based trade group. "I'm sure there are instances where there has been some valid disappointment, but to conclude that it is an industry practice is not accurate."

The groups do not provide denial rates specific to the costliest, long-term claims and neither do the insurers.

Those claims can cost $50,000 or more per year for an indefinite amount of time - in some cases, until the insured reaches retirement age.

Industry watchers agree that profitability hinges on reigning in these claims. In share-holder reports, insurance executives often call this "disciplined claims handling."

Some insurers provide incentives for employees to deny claims, tying denials to performance reviews.

One employee of The Hartford Financial Services Group's claims department received high marks for work that "realized a cost savings of $4,062,185.00 for the team," court records show.

But she was chastised for continuing the claim of a 35-year-old worker, rather than finding that the person could work a less active desk job. "So we've bought the claim for another 30 years?" her boss asked in the comments section of an employee evaluation.

Sun Life Financial's managers went so far as to write a memo telling claims handlers to "kick it up a notch" because the insurer was behind on its goal to "achieve the planned terminations/ denials of 271 by the end of the month."

That 2004 memo, obtained by the Daily Journal, offered a $250 gift certificate lottery that weekend to create "enthusiasm and excitement" to meet "the bottom line financial results."

Suing for Benefits

Many of the denials appear to involve long-lasting illnesses that are hard to prove, such as chronic pain and back problems.

But not all of them. Some claims involve heart disease, blindness, migraines, even cancer.

Donald Bauza thought his disability should have been obvious.

The 52-year-old military consultant, and retired soldier, stopped working in 2006, when a bowel disease he'd had for years flared up.

It started with ulcers, Bauza said, but got so bad he was using the bathroom nearly 100 times a day. Doctors removed his colon, then his rectum.

Five surgeries later, he had lost nearly a hundred pounds and said he was convinced that he was going to die.

"If I got any sleep it was because I decided to sleep in my own filth, which I did," Bauza said. "Psychologically I was wrecked. I was completely disabled."

His physicians and the Social Security Administration agreed.

His insurer, MetLife, did not. After initially paying the claim, it terminated his benefits saying he should be fully recovered.

Not able to work and left on his own, Bauza burned through his savings, went into debt and lost his home. A recent industry study found disabilities caused almost half of all mortgage foreclosures.

After three years, Bauza settled with MetLife for a sum he is not allowed to disclose.

Some companies wind up in court for denials more than others.

MetLife is leading the pack. The New York-based insurance company has seen 177 of these lawsuits filed in California from 2004 to June of 2009. MetLife had 30 percent of the lawsuits filed recently against the seven most prolific disability insurers in the state, but only 12.2 percent of market share as measured by premiums this year.

MetLife, and its lawyers, declined comment for this article.

The next most sued company was Unum with 109 complaints, 19 percent of filed against the busiest insurers and 17.8 percent of market share. The Hartford faced 95 lawsuits, 16 percent of the lawsuits reviewed, but 13.6 percent of the market.

Those three companies sell the most disability insurance policies nationwide, according to a 2008 study by industry research group JHA.

Prudential Financial Inc., CIGNA Corporation, Standard Insuarnce Co. and Aetna Inc. followed with 11 percent or less of the complaints reviewed by the Daily Journal.

But lawyers believe the overall number of lawsuits is significantly smaller than the total workers whose claims are denied, indicating that many policyholders give up.

That is true for government benefits: Social Security denies two-thirds of its initial claims while 60 percent of those who appeal eventually win.

Just how many workers see benefits denied or terminated against their will is unknown because regulators do not track such figures.

No Regulation

Some employees may simply not know where to turn.

Curtis Walker said after suffering chest pains, shortness of breath and a sudden stroke he was left with weakness and pain which made it hard for him to return to his $100,000-a-year job as a tech specialist with Kaiser Permanente.

MetLife denied his claim outright, saying his symptoms were not stroke-related. Walker said he didn't know where to go next. His Kaiser doctors told him not to work. But his work-provided insurance said he was fine. He lost his job and with it his family's medical coverage.

Curtis wrote a letter to the California Department of Insurance asking for help.

In April 2005, he received a form letter saying his complaint against MetLife would be investigated. He says he never heard from the agency again.

That's because the agency doesn't investigate complaints against the dozens of carriers who offer work-related, group disability plans in California, officials told the Daily Journal.

The agency says a federal law, called the Employee Retirement Income Security Act, prohibits them from getting involved. Past high court rulings have said ERISA trumps many states actions when it involves employer-provided insurance. The agency denied a public records request from the Daily Journal to review those consumer complaints.

"These benefits are not anything we can control or have anything to do with," said Leone Tiffany, chief of consumer services for the Department of Insurance. Tiffany said the U.S. Department of Labor oversees those cases.

Not so, according to federal officials. They do not investigate complaints about private insurers that sell those policies, either.

"ERISA does not create a right to governmental assistance in resolving disputed benefits," said Department of Labor spokeswoman Deanna Amaden.

The result is a rare and gaping absence of regulation in a private insurance market that insures nearly a third of the

nation's workforce.

Former Insurance Commissioner John Garamendi, who is currently Lt. Governor, said that doesn't have to be the case.

Garamendi sued the nation's largest disability insurer, Unum, over denying claims. The probe charged Unum with 25 violations of state law. The company agreed to a multi-state deal in 2004 and a tougher one with California in 2005 that were supposed to end certain practices.

He said the current administration could investigate complaints and do more to enforce rules he brokered to give claimants new leverage in court.

"It can, and should, be a major focus of the California Department of Insurance," Garamendi said.

Since he left in 2005, the department has performed cursory check-ups on disability insurers. It negotiated a $600,000 settlement this month with the Life Insurance Company of North America for taking too long to process claims. The agency said the company would reopen some cases it had denied, but without any additional oversight.

Brietta Clark, a health law professor at Loyola Law School, said regulators could do more. She points out that state regulators routinely vet complaints about work-provided health insurance because of exemptions.

"We saw that had a huge impact on HMOs and making sure people get access to health care in a timely fashion," Clark said. "Here, the legal system is not working and the regulators are not doing their job."

High Bar, Long Delays

Disabled workers who are denied benefits face a complicated bureaucracy. They must appeal not once but twice to the insurance company, a process that takes at least 6 months and requires patients to track down all their medical records and submit every document that they would later want to use in a lawsuit.

After a second denial, the insurer might send a case for an "independent medical review" by a doctor chosen by the insurance company. Court records show some doctors the insurers hire have sided with the insurance company - and against treating physicians - in nearly every case.

Insurers also take active steps to end long-running claims.

Jocelyn Guevarra, 53, worked at CIGNA for 15 years, half that time in the claims department, where it was her job to decide if a person filing a claim was truly too sick to work.

When she gradually developed rheumatoid arthritis, back problems, and chronic pain that force her to wear splints, doctors told her to stop working. CIGNA pulled the plug on her benefits two years later, in 2007. Its investigators captured surveillance footage of Guevarra running errands with her elderly parents. The company pointed to images of her helping her mother out of the car "without an outward sign of pain or impairment...in a smooth and fluid motion" and walking with her arm around her for support.

"I feel betrayed," said Guevarra.

ERISA law and a string of federal court rulings give workers like Guevarra who are unhappy with the insurer's final decision only one remedy: a limited bench trial.

They do not have a right to call witnesses nor have their case decided by a jury.

In most cases, the "trial" is merely a review of the administrative record.

A federal judge decides whether the insurance company acted reasonably based on the company's own records. And

high-court rulings have said the insurance company deserves discretion unless its decision was "arbitrary or capricious" or lawyers can prove there was a conflict of interest.

Despite the slanted odds, a Daily Journal review found that judges in 45 percent of cases that reached trial found that the insurers wrongly denied benefits.

One law school survey in Chicago found that judges who consider outside evidence about the company's behavior find in favor of the plaintiff 68 percent of the time.

Some may not get that far.

Because federal law does not allow people to sue for anything except the original benefits - no damages or pain and suffering that lead to big victories - many plaintiffs' lawyers said they refuse to take ERISA cases. As a result, some people who are willing to fight may not be able to find an attorney.

Of the cases filed, few reach trial. More than **80** percent of those reviewed by the Daily Journal settled out of court.

And the court process takes nearly a year - 344 days, on average - to reach a settlement or trial, the Daily Journal found. In more than half of all cases, a judge granted a continuance to the insurance company, which spanned from 30 days to 3 months.

That wait can be crippling for people like the Dilleys.

Since she fell ill five years ago, the couple burned through their savings and a 401k account.

They couldn't afford to finish renovations to their home they had begun before Dilley fell ill. The master bathroom has no hot water and the back porch leads nowhere, dropping off without any steps.

Though her condition is stable, she said she is in constant pain. Rich Dilley said he had to retire early from a house-painting business to stay home with his wife, because her back and neck pain makes it hard for her to take care of herself. She convulses in her sleep.

Social Security helps them afford food and clothing. They have adapted to coupon shopping. But welfare was not the lifestyle she expected, with a good career and job protection.

"You can't count on that safety net. There are great big holes," Marianne said. "I am in survival mode."

Four years and seven months since her injury - and more than two years after suing - Dilley said she had all but given up hope that she would win.

Then, the same day the Daily Journal asked MetLife for comment on her case the insurer reached a settlement agreement with Dilley.

As a part of the deal, she is not allowed to discuss her case.

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