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MDs challenged on disability insurance

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Physicians are well-acquainted with the challenges of obtaining affordable medical liability insurance in a climate of spiraling malpractice jury verdicts and premium cost increases. Should a patient be injured, the system appears to protect them quite well.

Should a physician become injured or disabled, however, the system is less eager to offer relief. In the wake of a massive financial shake-up of the disability insurance industry a few years ago, the industry has undergone significant consolidation, policy benefits for physicians have eroded and physicians are experiencing benefit delays and denials, with some resorting to costly and protracted litigation against their insurers.

Some recourse exists if physicians know how to scrutinize their disability insurance policies and learn about the tactics that some insurers have reportedly been using against physicians filing claims.

Causes of the Problem

From the 1980s through the early 1990s, disability insurance companies trying to increase their book of business looked for occupation classes with favorable risk characteristics, says Ann Perry, vice president, senior credit officer for Moody's Investor Service. Physicians had what the insurers were looking for: a strong work ethic and motivation for their occupation, coupled with a need and desire for disability insurance coverage. Companies competed for physician business by offering very attractive policy terms with liberal benefits, Perry notes,

including non-cancelable policies with premiums guaranteed not to increase and narrowly-defined tests of "own-occupation" disability—meaning that policies would pay full benefits if the physician were unable to perform very specialized functions related to his or her specialty, regardless of whether the physician had other income sources.

By the mid-1990s, disability insurance companies began to report a large increase in the overall number of disability claims, as well as an increase in the incidence of claims for conditions with self-reported symptoms for which little objective medical data was available to support, according to Tim Mitchell, national sales director for MetLife, which concentrates on group disability writing for large companies. Such "gray area" claims, which Mitchell says continue to escalate, include Fibromyalgia, Epstein-Barr Syndrome, Chronic Fatigue Syndrome, Carpal Tunnel Syndrome, and various mental- and nervous disorder-type claims.

Aggravating the trend, Mitchell adds, was an older work force than in the past and the movement of the baby boomer population into the 45 to 55-year-old age bracket, which he says produces the highest incidence of disability claims.

Although these claim trends were mirrored by other occupational groups such as attorneys, says Mitchell, insurers' experience with physician claims was particularly negative during the onset of managed care, says Mitchell. "In the past," he says, "physicians with disabilities were so dedicated to their occupation and making so much income that they were willing to work through their disability." Managed care reduced physician income and increased bureaucratic hassle, he adds, leaving disabled physicians less willing to work through a disability. Perry notes that adverse physician claims experience was particularly acute in the California area, where managed care had a head start on the rest of the country.

A less charitable assessment, made by some insurance companies and analysts during the crisis of the mid-1990s, was that managed care had eroded healthy physicians' work ethic and that many found that they could earn a considerable income by cashing in their generously-written disability

policies.

"We probably overinsured physicians as well, and didn't do a good job re-insuring for claims payouts," says Mitchell.

In response to the financial crisis, many insurance companies exited the disability market, while others consolidated. Three of the nation's largest—Provident Life and Accident Insurance Company of America, Paul Revere, and Unum Corp.—are now one company, UnumProvident, which writes some 40 percent of disability insurance in the country, while a handful of companies comprise the bulk of the market, according to Perry.

As of five or six years ago, companies have also repriced their disability products and have added several limitations and exclusions to rein in costly risk exposure, says Mitchell, including eliminating non-cancelable policies; introducing "guaranteed renewable" policies, whose premiums can be raised for classes of insureds by filing for increases with state insurance departments; capping maximum benefits; no longer writing narrow definitions for specialty-specific policies; capping own-occupation benefits at 24 months—if offering them at all; capping benefits to age 65; and mandating participation in rehabilitation programs as a condition of benefits payment.

For "gray area" claims, Mitchell notes, many companies have limited benefits to 24 months unless objective medical data is provided, i.e., blood, X-ray or imaging, which were not required in the past for such claims.

Some companies have also stopped writing coverage altogether for specialties which have had particularly adverse claims histories, says Mitchell, including anesthesiology, cardiology, ob/gyn and neurosurgery.

As a bitter irony, physicians in some of those specialties are the very ones who are being priced out of the medical liability insurance market.

Since the introduction of the revised policies, Mitchell notes, some companies—including MetLife—are again willing to write for those specialties, but with additional policy design

restrictions.

Obstacles to Claims Filing

"Disability insurance companies are now run more like businesses and are much more proactive in looking for ways that a claim can be dishonored," says Philadelphia attorney Mark F. Seltzer, Esq., who notes that it is much harder than it was in the past to get claims paid and to keep payments from being terminated.

Seltzer stresses that the disability insurers "are not the bad guys," but are instituting business practices to respond to large claims in the face of pressing bottom-line economic realities.

Some maintain that disability insurers pursue cost-containment too far and engage in egregious tactics to minimize or avoid payouts. According to a public records search by Sam Malat, Esq., a plaintiff attorney in Haddon Heights, N.J., the number of disability lawsuits against the consolidated UnumProvident companies since 1992 approaches 10,000, and the rate of lawsuits is increasing each year. The vast majority of those lawsuits, he says, are settled and result in confidentiality agreements that often bar disclosure of settlement amounts or details of the suit, making it difficult to gauge the prevalence of claim delays and denials.

"A ‘terminate and litigate’ settlement tool has the biggest bang for the buck for disability claims," says Malat, who notes that a settlement with a single physician holding a generously-drafted policy could save an insurer $1 million. "Large disability insurers bet that they have a greater ability to endure than a claimant and wind up paying a fraction of the worth of the claim, averaging 35 to 40 percent," Malat adds.

Companies employ a number of methods to look for ways to avoid paying claims, Malat says, including:

• Using surveillance on claimants to look for evidence against the disability claim, which in rare cases involves questioning friends and neighbors, invading a claimant’s privacy.

• Requesting repeated independent medical examinations.

• Using medical consultants who are not expert in the medical condition in question and who are therefore not qualified to determine the extent of the claimed disability.

• Denying claims without an independent medical examination.

• Prolonging denial of a claim to produce protracted and expensive litigation for a claimant.

• Trying to induce a claimant to surrender his or her medical license.

• Refusing to recognize certain diseases as disabling, such as Fibromyalgia, Chronic Fatigue Syndrome, and various mental/nervous disorders.

Other commonly encountered claim denial rationales may or may not be legitimate, but still pose problems for a claimant, says Philadelphia attorney R. Michael Kemler, Esq.:

• Inadequate medical documentation by a claimant's attending physician.

• Paying for residual (partial) disability on a claim for total disability.

• Denying benefits by alleging that a claimant was not under the regular care of an attending physician.

• Excluding coverage because of a pre-existing condition prior to the policy.

• Alleging that the claimant made a misstatement on the initial policy application that affected underwriting, thus voiding the policy.

• Alleging that a premium payment was late, causing the policy to lapse.

First-hand accounts of physician struggles with disability insurers are difficult to obtain, presumably because many of them are squelched by post-settlement confidentiality agreements. **Martin E. Schick, M.D.**, settled claim disputes with Unum and Paul Revere in 1997 and says he is precluded only from discussing the settlement amount.

A former hospital-employed anesthesiologist in North Carolina, Schick says he suffered from depression, anxiety disorder and post-traumatic stress disorder back in 1995, when he was 44 years old. Insured through both Unum and Paul Revere (before they merged), Schick submitted disability claims and was denied by both companies.

According to Schick, both companies said that he did not file his claims in a timely fashion, as per policy requirements. He maintained that he did. The companies also said that he failed to see a psychiatrist before filing the claims, and that his condition was not severe enough to be disabled. To make that determination, says Schick, the companies used their own physician who relied on chart notes of Schick's physician without seeing Schick in person.

The companies challenged Schick to take them to court, joined their cases to defend against his lawsuit, then offered him a settlement.

Schick, now 51, says he is struggling to regain his self-identity. "I could not get better because they said my illness is a sham. My ultimate goal is to prove to myself that I can do it—and that I needed the disability then because I was sick," he says. Schick is retraining as a post-doctoral associate anesthesiologist at the University of Florida School of Medicine in Gainesville, where he observes cases in an operating room environment and is supervised by an attending physician.

Another physician, who had settled a lawsuit against Provident and Paul Revere and is precluded only from discussing the settlement amount, asked that his name, location and specialty not be revealed for fear of retribution by the mega-company (both are now merged with Unum). After becoming addicted to IV narcotics and suffering from severe depression in 1994, he filed disability claims with both companies and received payments for nearly two years, based on documentation by his treating physician.

In late 1996, Provident requested an independent medical examination, after which both companies terminated his payments, claiming that the independent examiner had found that he was not disabled and was ready to go back to work. He filed separate lawsuits against the companies, which lasted

several years, were eventually consolidated and required him to sell his home to finance. Documents obtained through discovery during the lawsuits showed that Provident's independent examiner *agreed* with his own treating physician—indicating that the company had lied in its justification for terminating benefits. The companies offered a settlement in federal court one day before the trial date.

Judy Morris, M.D., a Massachusetts emergency physician, is involved in a protracted legal battle with Unum. Diagnosed with Chronic Fatigue Syndrome and Multiple Sclerosis, she says that Unum refuses to recognize her as occupationally disabled as an emergency physician and refuses to tell her what kind of test or evaluation it would take to prove her claim. She says that Unum's in-house physicians have never spoken with or seen her, but have concluded that she is not disabled in her occupation after holding conversations with her physicians, despite the fact that her physicians maintain that her illness is disabling. She says that Unum has sent her surveillance videotapes made by private investigators and has questioned friends and family members about her.

Unable to afford hourly attorney fees for a long legal battle, Morris says she has been unsuccessful in finding law firms that can afford to take the case on a contingency basis. She has written to the Massachusetts Insurance Commission, which wrote back saying that Unum's position is justified because it has conducted an independent medical exam. The state Attorney General's office, she said, told her that they don't get involved in a case that is currently under litigation in civil courts.

Morris has written to the U.S. Dept. of Justice and has reported Unum's physicians to the Boards of Medicine in both Massachusetts and Maine (where Unum is headquartered), which she said responded only by sending Unum a copy of the AMA's Code of Ethics. Morris says she is in contact with nearly one hundred claimants battling Unum and she continues to wage a full-time crusade against the company.

UnumProvident declined to be interviewed for this story.

Avenues of Precaution

While a costly lawsuit may be a physician's only recourse, other steps can be taken to reduce the odds that such a path is necessary. Should a physician need to file a disability claim, Kemler recommends possible ways to pre-empt claim denial difficulties:

• Attending physicians should write carefully detailed functional assessment letters, as part of proof of claim, that thoroughly substantiate the diagnosis, etiology and determination of how the pathology impacts on the functional ability of the physician to perform the tasks of his or her own occupation.

• Claimants must make clear that they have been under the regular care of an attending physician and provide evidence such as number of times seen and upcoming appointments.

• Claimants should review a policy's "incontestability clause," which specifies a time interval—typically two to three years after a policy is written—after which an insurer cannot void the policy by alleging that the claimant made misstatements on the initial application. As to policies written in New Jersey, the clause does not cover fraudulent misstatements.

• Claimants must be sure not to stop paying policy premiums or to make a late payment, especially during the pendency of a claim (prior to determination). If a premium payment is late and the insurance company accepts the payment, it has waived the right to cancel the policy.

• Claimants may have protection against ambiguous terms in a policy that a layperson might not find understandable even upon multiple readings, but such protection usually requires enforcement by a judge in a courtroom.

Kemler notes that a claimant may file an unfair insurance practices claim with the state insurance department, but says that they generally will not intervene in matters that can be resolved in the courts.

Physicians shopping for new disability insurance policies should scrutinize their provisions carefully, says Ronald P. Perilstein, president of The Arjay

Group, Inc. in Narberth. Most companies offer "non-cancelable" individual policies, which protect against premium increases, but whose premiums are typically 20 percent higher than policies without this provision, he says. "Guaranteed renewable" policies, which are not widely available, protect against the insurer adding restrictions at a later time, but allow the company to seek premium increases on a class of insureds by filing with the state insurance department, he adds.

"Own-occupation" individual policies, which do not reduce benefits by income earned from another job outside of a physician's specialty, are expensive but still available, depending on specialty. Few companies are still writing "own-occupation to age 65" policies for anesthesiology, emergency medicine, orthopedic surgery, neurosurgery and other surgical specialties, Perilstein says. Most will provide occupation-specific coverage for five years only.

Group policies, usually written through an employer or association, typically cap benefits at 60 percent of salary, with overall benefits typically capped at $7,500 to $10,000 per month, he notes. Group policies are also reduced by Social Security disability and by worker's comp payments, and do not guarantee that premiums won't increase or that the policy can't be canceled, he adds.

All new group policies, and most individual policies, have limitations on benefits for mental and nervous disorders or substance abuse, typically 24 months. Group policies also offer fewer optional benefits than individual policies, such as cost-of-living increases.

Perilstein notes that group plans offer some advantages over individual plans: they are significantly less expensive per person, they typically have no medical qualifications, and they make it easier for the covered group to switch carriers and shop for lower rates.

Industry changes have amounted to reverse discrimination against some high-income specialties in the form of benefit reductions, much higher premiums and even outright refusal by some companies to offer coverage, Perilstein observes. It is sometimes necessary, especially for physicians with higher incomes, to use a combination of group and

individual policies to get the desired level of coverage, although existing group coverage reduces the amount of individual coverage a person can buy in order to prevent overinsurance, he adds.

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