

Dealing With Disability Claim Denial

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By Larry Schneider

Over the last several years, the ratio of subjective claims (mental/nervous, soft tissue [back], chronic fatigue syndrome, etc.) to non-subjective claims (broken arm, heart attack, etc.) has increased dramatically, to the point where more than a few disability insurers are no longer operating in the black. Most DI companies are finding that claim outgo is exceeding their income, from both premiums and return on investment, by about 12 to 15 percent.

Insurance company claims departments have been told to tighten up, so they have taken a number of steps, both for the long and short term, to try to stem what they see as a hemorrhaging due to subjective claims. For the long term, some carriers have redesigned their policies to limit MNDA (mental, nervous, drug and alcohol) benefits to two years, and at least one has introduced a two-year limit on back/soft tissue claims.

For the short term, however, claims that might once have been paid, most of which are subjective, are now routinely being denied. The usual reasons now given to deny claims includes non-satisfaction of elimination periods due either to number of days of disability or days not being consecutive, expiration of the benefit period, non-satisfaction of definitions, terms, and conditions for benefits to be paid for both total and residual disability.

But misstatements and/or omissions made on a claimant's original application are also being used as grounds for denial. In some cases, the errors were unintentional, and may have come from unclear or ambiguous wording of the application questions. The incontestability clause, used to give the consumer some protection in the court system, has some of its protection losing ground, and the courts are deciding more frequently in the favor of the carrier.

The most often used excuse to deny a claim, from what I can see, relates to the definition an insurer uses for total disability. For example, the client, a cardiologist, had a sub-specialty in invasive procedures. After his DI policy was issued, he asked the carrier for a specialty letter, because he wanted his occupational sub-specialty as an invasive cardiologist to be specified and to become part of the own-occupation definition for total disability. According to the client, this request was clearly stipulated to the agent when the policy was delivered.

However, when the specialty letter was finally issued, it only mentioned cardiology. When the cardiologist complained to the agent that "invasive cardiology" was not addressed, he was told not to worry. To further compound his eventual problem, the policy only had total disability benefits, and no residual (loss of income) protection.

The first disability claim he submitted was paid, based on his inability to do invasive surgical procedures. He eventually was able to resume doing all of his duties, and so went off the claim. But a few years later, he submitted a new claim, which was denied. Why? Because the carrier judged this claim more harshly, and decided that his disability did not satisfy his policy's own-occupation definition for total disability.

In my opinion, since the cardiologist had made such a big issue of his sub-specialty as a cardiologist who did invasive surgical procedures, the carrier had an obligation to specify in its letter that the specialties for which it insures must be recognized by the American Medical Association (invasive procedures are not).

Insurers are also taking advantage of policyholder misunderstandings, as well as the lack of knowledge and the inability to contest claims due to educational, financial or just plain emotional fatigue. Because of the language of the contract, which can get convoluted, and the various integrating benefits, riders and exclusions, being able to find a way to defend the contract can get arduous.

Another client, a chiropractor, also submitted a claim that was denied. The grounds for denial were that the policy had lapsed. Why had it lapsed? The policyholder had not paid premiums.

This seemed straightforward enough. But the premiums had not been paid because the insured had moved, and had not received any new bills for premiums.

Here, the fault lay with both the client and the agent. The chiropractor had given his change of address to his agent verbally. The agent then called the company to give them that change. The clerk at the company, however, typed the new address into its records incorrectly, so the policyholder never got any subsequent bills for premiums.

The contract clearly stated that all policy changes must be submitted in writing, so although there was fault by both the agent and the client, the decision not to pay was reversed.

The agent should have asked the client for his address in writing, and should have submitted it to the insurance company in writing. However, these are small details, and I think the insurer was just looking for a way out of paying the claim.

Another denied claim came from a sales representative who submitted a claim due to a painful muscle-nerve condition in her leg. On her group LTD certificate, she was paid for 24 months, but then her benefits stopped, even though the policy's benefit period was to age 65.

The benefits stopped because the group carrier didn't understand its own conditions for continuing payment of the claim.

That carrier had used a split definition for total disability in its contract, where for the first two years, it was a pure own-occupation definition, but after that, the definition became "unable to work, given education, training and experience, and prior economic status." In this case, the claimant found it "hard" to work elsewhere because she'd been earning over \$200,000 a year before her claim! She sued and won.

How can we minimize problems for our clients at claim time? One way, when you're researching policies for your client, is to use a carrier which has the best definition for total disability. That definition is: "Unable to do the duties of your occupation." Not all carriers have the same definition for a particular occupation. Be aware that this definition is not always available for all occupations. Shop around until you find a policy that has it.

Also, try to get a policy that states days need not be consecutive. By doing so, clients can have a "stop and go" disability, and the policy can serve the insured better than one in which days must be consecutive in order to count towards the elimination period.

Also, make sure the policy lets both residual and total disability days count towards satisfying the elimination period. Most carriers allow this, but some require that for them to count, a period of total disability must first precede residual.

What can an agent do to prevent or minimize the chance of a denied claim? First, check the completed application carefully. Some critical areas of the application which affect a claim and could be inadvertently answered incorrectly, or dishonestly; have to do with occupation/duties, health, income, and other pertinent facts such as avocations.

Honest mistakes by an applicant might be overlooked after two years, as outlined in the contract's incontestability clause, but what is not overlooked are fraudulent misstatements or omissions, regarding health or income.

Let's not forget the agent's role in completing the application. Did the agent record all answers exactly as they were answered, or was there a hidden motive for writing them down in such a way that the policy would be issued as "applied for" (without a rating or an exclusion)? Did the agent really do the proposed insured a favor, or were these omissions for the agent's own gain?

If there is a claims conflict, there are ways to handle it. First, cooperate fully with all requests made by the claims adjuster. Second, ask for full explanation of all negative responses. Ask a supervisor to verify that inexperience or bias didn't affect the adjuster's decision.

Then, ascertain whether or not the carrier is acting in bad faith, and make sure the investigation was proper. In a flawed investigation, the company will interpret the policy in an unrealistically restrictive manner—the claim subject to dilatory handling, a purposeful delay, or a bad investigation. If all else fails, hire an attorney or an expert witness/consultant who specializes in these matters, and pursue punitive damages.

All of these elements are essential. The biggest concern that I see is if the carrier is contesting a long-term claim of a subjective type, claimants can expect carriers to play hardball.

They can expect surveillance and/or a possible buyout of the claim, and the buyout can be for 20 cents on the dollar.

It has been my experience that there are carriers who will habitually and excessively deny legitimate claims.

Many carriers establish a system to wear down claimants by either overwhelming them with paperwork, or by using the hierarchy.

I believe strongly that these inappropriate carrier denials must stop, so that litigation would only be for claimants' bad faith or claimants' fraud. If current methods of disputing inappropriately denied claims continue, then in most cases the insurance company, with its deep pockets, will surely win.

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