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Unum revisited

Based upon a recent deposition and trial, the disability insurer discredited a decade ago by fraud and bad-faith suits may be up to some of its old tricks

By Terrence J. Coleman

Through its three wholly-owned and controlled subsidiaries – Provident Life and Accident Insurance Company, Unum Life Insurance Company of America, and Paul Revere Life Insurance Company – Unum Group dominates the United States disability insurance market. Previously called UnumProvident Corp., one-third of Fortune 500 companies call on one of the Unum Group subsidiaries to provide disability insurance for their employees.

Many of California's largest law firms do so as well, thanks to Unum's marketing campaigns that target attorneys who can afford to pay high premiums for purportedly high-end coverage. Unum insures the most number of lives and dwarfs its competition in premiums earned, reporting $5 billion in revenue in 2015 just from its U.S. operations. And Unum's growth is escalating. Its annual report to shareholders boasts that Unum "grew faster in 2015 than at any other time in over a decade."

Unum's history of claims handling abuses

This growth is staggering in light of where Unum was a decade ago. Thanks to the tireless efforts of trial attorneys throughout the country who exposed Unum's improper claims handling practices and its corporate culture that encouraged bad-faith claim denials, Unum suffered a string of high-profile trial losses in the early 2000's nationwide:

In 2001, a Florida jury awarded $36.7 million to an ophthalmologist suffering from hand tremors due to Parkinson's disease, finding that the company fraudulently terminated his benefits. (*Tedesco v. Paul Revere Life Ins* (M.D. Fla 2001) No 8.99-CV-2552

In 2002, a California jury awarded a Berkeley chiropractor $7.7 million, including $5 million in punitive damages. (*Hangarter v. Paul Revere Life Ins. Co*. (N.D.Cal. 2000) 289 F.Supp.2d 1105; aff'd, 373 F.3d 998 (9th Circuit 2004)

In 2003, a Marin County jury awarded $31.7 million, including $30 million in punitive damages, to an eye surgeon suffering from hand tremors. Evidence admitted during the three-month trial included testimony that the dollar amount of claims the company expected to be terminated in the coming months, called reserve "recoveries," were calculated by management and distributed within the claims department. (*Chapman v. UnumProvident Corp*. CV-012323 (Calif. Superior Ct., Marin Co., 2003)

In 2004, a Nevada jury awarded $11.6 million, including $10 million in punitive damages, to a venture capitalist suffering from Lyme disease and chronic fatigue syndrome. On retrial of the amount of punitives, a subsequent jury *increased* the award to $60 million. (*Merrick v. Paul Revere Life Ins. Co. 500* F.3d 1007 (9th Cir. 2007, *on retrial* 594 F.Supp.2d. 1168 (D. Nev 2008) (Findings of Fact and Conclusions of Law, post trial)

In the midst of these courtroom losses, Unum was undergoing a multistate market conduct examination by insurance regulators throughout the country. These examinations culminated with a condemnation of Unum's claims handling practices, documented in a November 18, 2004, Targeted Multistate Market Conduct Examination Report; a Multistate Settlement Agreement, whereby Unum agreed to reassess denied claims, implement various claims handling procedures, and pay a $15 million civil penalty; a separate California Market Conduct Examination Report; and a separate California Settlement Agreement whereby Unum agreed to pay an additional civil penalty of $8 million and make additional changes to its policy language and claims handling practices.

After thoroughly auditing claims files, the regulators expressed particular concern with the following areas of Unum's claims handling practices: **"Excessive reliance upon in-house medical professionals."** Unum had invested heavily in staffing its claims department with in-house nurses and physicians to review medical records and disagree with the findings and opinions of treating physicians without ever bothering to conduct an in-person examination as permitted under standard disability policy forms.

In this regard, the Multistate Market Conduct Examination Report found: "The examination team identified numerous instances in which the Companies relied heavily upon the analysis of their in-house medical professionals, and refrained from securing an IME. In many such instances, the Companies discounted or disputed the opinions of claimants' attending physicians, but chose not to invoke the requirement that the claimant attend an IME. *Where there is conflicting medical evidence or conflicting medical opinions with respect to a claimant's eligibility for benefits, the Companies have the ability to invoke the policy provision and obtain an IME, and should do so."* (Emphasis added.) Similarly, the California Settlement Agreement criticized Unum's pervasive practice of "Overruling the opinion of the attending physician after [its] in-house medical personnel have conducted a 'paper review' of the medical file."

Cherry-picking from medical records to support a claim denial. The California Settlement Agreement found that Unum

routinely "Selectively us[ed] portions of medical records and IME findings" to its own benefit. The Multistate regulators likewise condemned Unum for its "inappropriate interpretation or construction of medical reports, to the detriment of claimants." Unum's in-house medical staff was found to "focus upon any apparent inconsistencies in the medical records or other information supplied by claimants, rather than attempt to derive a thorough understanding of the claimant's medical condition."

Rejecting claims for lack of "objective" medical evidence supporting disability. The Multistate regulators identified a "significant number of instances" where Unum denied benefits for lack of "objective evidence" of disability in spite of the fact that its policies contained no such requirement. The California Department of Insurance also found Unum had an improper practice of "Characterizing certain disabling conditions as 'self-reported' (e.g., pain, limited range of motion, weakness), then accepting only objective test results to support disability resulting from these conditions even though no policy provision requires objective test results."

Encouraging claim denials in order to improve bottom-line results. The California Settlement Agreement particularly noted Unum's practice of "Targeting certain types of claims for 'resolution' (i.e., denial or termination of benefits) in the interest of improving 'net termination ratios.'" The paper trail documenting Unum's efforts to pressure claims adjusters to meet financial projections on the amount of claims that would be denied on a monthly and quarterly basis was clear. Indeed, in one particular e-mail from 2002, a Unum claim manager advised his team of adjusters, "We are projected to have 1,800,000.00 in recoveries this month but are coming up short at 1,772,000.00…*Are there any other claims that are possible recoveries this week????*" (Emphasis in original.)

So, a decade ago, Unum had suffered trial losses of over $136 million, had to pay an additional $23 million in penalties to government regulators, and agreed to transform its claims handling practices to ensure the fair and objective adjudication of benefit claims.

The "new" Unum

Based on the manner in which Unum continues to evaluate California insureds' claims, it seems that Unum has simply paid lip service to the promises it made in the multistate and California settlement agreements to change its claims handling protocols.

(1.) Unum still denies claims for lack of "objective" medical evidence.

Take, for example, the regulators' condemnation of Unum's practice of denying claims on the grounds that disability was not supported by so-called "objective" medical evidence.

In a 2015 denial letter Unum sent to a California insured claiming disability due to Thoracic Outlet Syndrome and Cubital Tunnel Syndrome, Unum engaged in semantic somersaults to express the conclusion that her claim was rejected for lack of objective medical evidence without using the words "objective medical evidence": "Our physician advised us that the physical findings not subject to patient input were essentially negative for thoracic outlet syndrome and cubital tunnel syndrome."

Stunning deposition by in-house physician

In a stunning deposition, the in-house physician Unum relied upon to deny benefits, John Groves, M.D., admitted that, following issuance of the multistate market conduct examination report, he was instructed to review claims in the same manner but without using the words "objective" and "subjective."

Question: You endeavored to not use the word objective or subjective in your reviews; is that right?
Answer: That is correct.

Question: And you did that on instruction from the insurance company; is that right?
Answer: That is correct.

Question: So instead you used phrases "subject to patient input" or "independent from patient input;" is that right?
Answer: That is correct. We have been instructed at Unum not to use the word objective and subjective, so we use other phrases which varies from individual doctor. That's just my way of saying it. When I'm talking about objective and subjective findings, that's how I phrase it, just like you said.

In other testimony, Groves admitted that *all* Unum physicians were instructed simply to change their terminology but to keep performing their reviews in the exact same way:

Question: How did you learn about the fact that the company wanted you to just use different words to mean the same thing?
Answer: I think it was [Unum's Medical Director] Dr. Alvino who said we shouldn't use subjective and objective. He didn't tell us what to use in place of that, but he said we shouldn't use those terms.

Question: Did he tell you individually, or was there some sort of meeting, or how did he convey it?
Answer: I think it was probably at a group meeting.

Question: So there's group meetings where the medical consultants are participating?
Answer: Correct, medical employees and the medical consultants.

Question: And he told you that, you and the other physicians?
Answer: That's correct, as a group.

Question: So did he just tell you it's not a change regarding what you're supposed to do, we just want you to use different phrases?
Answer: Yeah, right.

Question: All right. So he told you that what you were doing was fine, it's just we want different phrases seen in the reports?
Answer: That's the impression I got from what Dr. Alvino told us.

(2.) Unum still relies on in-house physicians to review claims, with no IME

In another case recently filed against Unum after it denied benefits to a southern California attorney, the insured wrote to Unum complaining that it denied benefits based on the opinions of its in-house physicians who disagreed with her treating specialists without bothering to obtain a medical examination of her.

Ten years ago, this was the exact same conduct that deeply disturbed the multistate regulators: *"Where there is conflicting medical evidence or conflicting medical opinions with respect to a claimant's eligibility for benefits, the Companies have the ability to invoke the policy provision and obtain an IME,* ***and should do so****."* (Emphasis added.)

Unum's response was to essentially say, "We don't care." What they actually wrote was, "You state we failed to obtain an honest medical evaluation. The physicians involved in the review of file documentation are dedicated professionals. We are entitled to rely on their input in the evaluation of the medical evidence that has been presented to us."

Unum's conduct completely ignores the finding by the California Department of Insurance that it was mishandling claims, in part, by "Overruling the opinion of the attending physician after [its] in-house medical personnel have conducted a 'paper review' of the medical file." According to Unum, it is free to do so once again so long as its in-house physicians are "dedicated professionals."

(3.) Unum still encourages claims directors to deny claims

Finally, damning evidence against Unum came to light last year during the trial of *Broffman v. Provident Life and Accident Ins. Co.*, N.D. Cal., Case No. 3:13-CV-04922. Admitted into evidence during that case were "Weekly Tracking Reports" that compared, among things, a claim team's "actual" monthly and quarterly "LAR" against the company's "plan." LAR refers to "Liability Acceptance Rate," which is the percentage of claims submitted that are approved for an initial payment of benefits. The lower the LAR, the more claims that are being denied.

Although all disability insurers maintain statistics as to their LAR for review by executive management, Unum's Weekly Tracking Reports are disseminated to its Claim Directors – the individuals responsible for approving or denying payment of benefits – and disclose existence of a "plan" to maintain acceptance rates at a specified level.

Also admitted into evidence during the *Broffman* trial were color-coded "Director Scorecards" that track individual directors' performance with respect to, among other things, their own LAR. These publicly available trial exhibits are available from the author upon request from plaintiffs' attorneys. Many thanks to Dr. Broffman's attorneys, Rick Friedman and Jeff Rubin, for getting this evidence admitted at trial and into the public record.

It is no wonder that immediately after the *Broffman* trial (the jury hung and the matter settled confidentially), Unum unsuccessfully attempted to have the exhibits retroactively sealed and to prevent other attorneys from using them. As the Court stated in *Hepp v. Paul Revere Life Ins. Co.*, 2015 WL 4072101, (M.D. Fla., July 2, 2015), "Sealing so-called confidential documents that are already in the hands of third-parties serves no useful purpose, and Defendants fail to present any argument to the contrary."

The Unum of tomorrow

It remains to be seen what the Unum of tomorrow will look like. We expect that a new wave of verdicts will soon be reported as a new generation of insureds stand up against the company. Stay tuned.


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