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THE DISABILITY INSURANCE INDUSTRY'S ATTACK ON CALIFORNIA'S CONSUMER PROTECTION INITIATIVE

by Mark D. DeBofsky

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Recent developments in California involving disability insurance have created great turmoil in that state. On October 3, 2005, the California Department of Insurance ("CDI") distributed an industry-wide notice concerning seven provisions applicable to all disability insurance policies sold in the state. The CDI also said it was taking steps to withdraw approval of existing policies that are unacceptable. Although the provisions are viewed by the disability insurance industry as substantial changes, the provisions merely restate longstanding interpretations of disability insurance policies. The provisions are discussed below.

The Discretionary Clause

Perhaps the greatest paradigm shift in disability insurance was the introduction of a standard of court review triggered by the passage in 1974 of the Employee Retirement Income Security Act ("ERISA") and its applicability to group disability insurance. ERISA has been interpreted by the U.S. Supreme Court to apply broadly to such insurance, and the Court has given approval to insurers to incorporate language in their policies reserving discretion to determine benefit eligibility and to interpret policy provisions. In the presence of such language, courts review group disability insurance claims under what is known as the "arbitrary and capricious" or "abuse of discretion" standard of review, meaning the insurer's decision is presumed correct and will be upheld so long as there is any rational support for the conclusion reached by the insurer. Even in a case where the greater weight of the evidence favors a contrary result, the insurer still wins when the policy contains a discretionary clause.

Although the reach of ERISA preemption is extremely broad, Congress reserved within the statute the right of the states to regulate insurance. Acting under that authority, the National Association of Insurance Commissioners promulgated a model law in 2004 prohibiting the inclusion of discretionary clauses in disability insurance policies. Several states, including California, have enacted the model law or utilized regulatory authority to implement the prohibition. Without discretionary clauses, courts review claims on a *de novo* basis, weighing all the evidence and allowing broader pretrial discovery.

Implementing a prohibition against discretionary clauses appears to be within the states' regulatory authority reserved by Congress. However, on November 30, 2005, four industry associations—the Association of California Life & Health Insurance Companies, America's Health Insurance Plans, the American Council of Life Insurers, and the California Chamber of Commerce—brought a lawsuit in California Superior Court challenging the commissioner's authority to prohibit discretionary clauses. On December 15, the California affiliate of the National Association of Insurance and Financial Advisors joined the lawsuit. On December 20, the court denied their application for a temporary restraining order.

A report prepared by Milliman, Inc., commissioned by America's Health Insurance Plans and issued on November 14, 2005, analyzes the effect of a prohibition against discretionary clauses. The report estimates that the prohibition will lead to a 3 to 4 percent increase in group disability insurance premiums due to an anticipated higher incidence of litigation, a higher cost per litigated claim, and lower claim recovery costs. Nonetheless, as a leading federal jurist, Richard Posner of the U.S. Court of Appeals for the Seventh Circuit, pointed out in a 2000 case (*Herzberger v. Standard Ins. Co.*), ERISA was enacted to protect employee benefits and

> **the very existence of "rights" under [employee benefit] plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has . . . .**

Thus the prohibition against discretionary clauses leads to greater protection of insureds. It also restores the *status quo* prior to the passage of ERISA.

The Definition of Total Disability

The CDI said it will apply a definition of "total disability" drawn from a 1942 California Supreme Court case (*Erreca v. Western States Life Ins. Co.*) and restated in a 1984 California appellate ruling (*Moore v. American United Life Ins. Co.*). The definition, as stated in CDI documents, says a total disability is a

> **disability that renders one unable to perform with reasonable continuity the substantial and material**

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acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

The first part of the definition applies to "own occupation" clauses, and the second part applies to "any occupation" clauses. The associations' lawsuit challenges the insurance commissioner's authority to mandate a disability definition without undergoing rule making proceedings. The Milliman report estimates that adoption of the *Moore* definition will increase disability insurance premiums by 10 to 15 percent.

One purpose of the CDI's definition of total disability is to prevent insurers from rewriting their contracts expressly or arguing in litigation something other than the *Moore* interpretation, which has been adopted by the courts of most states. Another purpose is to prevent insurers from denying benefits to insureds who retain the capability of performing some but not all pre-disability job duties, and to mandate that even under an any occupation standard of disability the insured's earning capability be considered, so that a high-earning professional will not be denied benefits when capable of working at a menial job.

The CDI's proposal is not new. The California court interpretation cited by the CDI is generally accepted across the nation as the proper interpretation of both own occupation and any occupation disability coverage. Moreover, the CDI proposal fulfills the reasonable expectations of insureds with respect to how disability insurance ought to work and prevents insurers from defeating those expectations with interpretations that render the coverage virtually illusory.

Additional Benefit Criteria

The CDI also said it will prohibit additional criteria or preconditions to qualify for or continue receiving benefits beyond the total disability definition described above, such as requirements of "appropriate" medical care or mandatory rehabilitation. The Milliman report suggests that this prohibition will cause an increase in independent medical examinations and lower recovery rates, and therefore increase disability insurance premiums.

This prohibition also makes clear that a national economy standard to define the insured's occupation, rather than evaluating disability from the standpoint of the job the insured is actually performing, is unlawful. It also appears that this provision will prohibit "loss of income" disability insurance policies, which allow an insured to continue working and have the disability benefits make up for the earnings loss. The associations' lawsuit challenges the commissioner's authority to impose such a provision.

The apparent reason for this provision is a history of abuse of these requirements by insurers who have imposed their own beliefs about appropriate care or whether insureds are working to the maximum extent of their ability regardless of the contrary opinions of treating physicians or vocational rehabilitation consultants with whom insureds are already working. Traditionally, residual disability clauses have given insureds control over whether to work and collect residual disability benefits or to collect total disability benefits. This reflects the difficulty many insureds have in securing and maintaining fulfilling and remunerative employment when they may be incapable of performing their principal job duties. An example is a surgeon who may be limited to seeing patients in the office due to a spinal impairment that precludes extensive standing. Again, the issue comes down to the reasonable expectations of the insured and the superior knowledge possessed by the treating physician versus a reviewing physician regarding the claimant's medical conditions, restrictions, and limitations.

Offsets in Group Disability Insurance

Historically, group insurers have offset Social Security disability benefits, workers' compensation benefits, and other benefits that make up for the insured's loss of earnings. The purpose is to prevent overinsurance. The CDI will still allow such offsets, but will permit insurers to offset only benefits actually received by the insured. Also, the benefit being offset must relate to the same condition for which the insured is seeking disability benefits. The associations' lawsuit challenges the commissioner's authority as not supported by law and as beyond the state's authority without the issuance of a regulation. The Milliman report suggests the CDI's requirement will increase costs because the insured will lack the incentive to apply for Social Security disability benefits.

Even though the insured may recognize that an award of Social Security benefits would be offset, a properly informed claimant will recognize the value of applying for Social Security benefits so long as the disabling impairment is sufficiently severe to establish the insured's inability to perform the duties of *any* occupation. Failure to apply for Social Security disability benefits could lead to a substantial reduction in Social Security retirement benefits, the loss of Medicare benefits, and the loss of Social Security cost-of-living increases, which are not offset. The well-informed claimant will also recognize the value of having additional corroborative evidentiary support of the disability claim produced during the course of a successful Social Security appeal. Thus the concerns raised in the Milliman report appear unwarranted.

However, the most important argument supporting the CDI's proposal is that if the insurer is able to offset estimated (as contrasted with received) benefits for which the insured may be eligible, the insured may

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never qualify for Social Security or workers' compensation benefits. Even if the insured qualifies, claimants may be deprived of valuable financial resources during the length of time it takes before a Social Security disability claim is fully adjudicated. In this author's experience, it can take more than 18 months between the initial application for benefits and the disposition of a Social Security claim by an administrative law judge. Consequently, the insured may have to relinquish necessary medical treatment or medications due to lack of financial support from the disability insurer. The result may be an adverse effect on the insured's recovery.

The Definition of a Pre-Existing Condition

The CDI also said it will prohibit pre-existing conditions limitations from being drafted to exclude claims where the insured has had a "consultation" or undergone "diagnostic measures" unless the disease or condition was actually diagnosed or existed before the effective date of the insurance. The Milliman report estimates that this provision will increase the cost of group disability insurance by 1 to 2 percent, and the associations' lawsuit asserts that the CDI's action exceeds its regulatory authority.

A 2004 U.S. Court of Appeals ruling (*Glista v. Unum Life Ins. Co. of America*) rejected an insurer's efforts to expand the applicability of the pre-existing conditions clause to a situation where the insured had complained of some pain and possible neurological abnormalities prior to the effective date of the insurance. Some months later, the insured was diagnosed with primary lateral sclerosis, and the insurer tried to exclude the ensuing disability. Because the symptoms for which the insured sought consultation were general in nature, and because no diagnosis was made until after the insurance went into effect, the court ruled that the insurer improperly excluded coverage. The ruling states the majority view of the courts on this issue: where an insured is treated for general symptoms not attributable to any particular condition, the pre-existing conditions clause is inapplicable. The CDI proposal merely clarifies that benefits may not be denied in such circumstances.

Compulsory Uniform Provisions

The CDI has clarified that certain compulsory provisions specified in California statutes must be included in every disability insurance policy. The Milliman report says that "since these statutory provisions are not new, there should be no issues from the insurers' or consumers' perspective." The associations' lawsuit, however, challenges the commissioner's authority to take such action.

All Benefits Must Be Paid to the Insured

The CDI says all benefits must be paid directly to the insured. The requirement prohibits workplace modification benefits where an insurer may pay money directly to an employer to modify a workplace to accommodate an insured's disability. Likewise, the requirement prohibits insurers from making pension or 401(k) contributions on behalf of an insured to help fund retirement benefits when the insured lacks resources. The Milliman report suggests that the requirement also might prohibit disability buy-out policies, which provide funds to buy out a disabled insured's share in a business, or products that pay a business based on the disability of a key employee.

The requirement also may prohibit the payment of rehabilitation benefits to a third party. The Milliman report suggests that the requirement also could apply to a survivor benefit that pays benefits to an insured's survivor for a short period after the insured's death.

The Milliman report correctly points out that these benefits could have significant value to consumers. This author questions the CDI's authority and reasons for this requirement.

Summary and Conclusions

The Milliman report estimates that the combined impact of the seven provisions will be an increase of 28 to 46 percent in the cost of group disability insurance and an increase of 21 to 33 percent in the cost of individual disability insurance. However, it is unclear what methodology supports those findings, particularly the finding that the California definition of total disability will increase the cost of disability insurance across the board by 10 to 15 percent. The Milliman report also suggests that the provisions will disproportionately benefit those who choose not to return to work or who elect not to receive appropriate medical care, but provides no supportable rationale for a conclusion that seems to blame victims of disabilities rather than insurers whose conduct triggered the CDI's initiative.

On October 3, 2005, the CDI issued a stinging indictment of the world's largest disability insurer, UnumProvident Corporation, and laid bare systemic and pervasive unfair and improper business practices in the administration of disability insurance claims. The CDI action followed by about a year a multistate market conduct investigation of UnumProvident; all states (except California and Montana) and the U.S. Department of Labor agreed to the settlement. In addition to the CDI, numerous court decisions have pointed to pervasive misconduct in the administration of disability insurance claims. Yet none of the regulators' reports or court rulings has pointed the finger at the root of the problem: the U.S. Supreme Court's rulings that transformed insured group health, life, and disability benefits into federalized ERISA claims that are exempt from state court proceedings and remedies. Perversely, a law enacted by Congress for the protection of plan participants has been manipulated

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into a mechanism for aggressive claims denial tactics by insurers.

Insurers are well aware of the advantages of ERISA, including the manner in which it insulates insurers from facing punitive damages and "bad faith" awards that exist in a non-ERISA context. Also, it is well documented how insurers have sought to broaden the scope of ERISA preemption. However, the most important benefit to insurers has been through discretionary clauses that have resulted in courts deferring to the insurers' claims determinations and accepting without question insurers' interpretations of various policy provisions. In 1989 the U.S. Supreme Court admonished (*Firestone Tire & Rubber Co. v. Bruch*) that consumers should not fare worse under ERISA than before the law's enactment. The CDI notice in October is a significant step toward reaching that goal by reiterating well-established provisions that have long applied to disability insurance claims. It is within the CDI's authority to protect consumers against illusory coverage and to mandate benefit terms, irrespective of ERISA. The changes ordered by the CDI are merely the first step toward bringing increased consumer protection to the rest of the nation.

SPITZER, GREENBERG, AND THE STARR FOUNDATION

In December 2005, New York Attorney General Eliot Spitzer made the first move in what may be his next major legal action against Maurice R. Greenberg, former chairman and chief executive officer of American International Group, Inc. ("AIG"). After he resigned from AIG in March 2005, Mr. Greenberg continued to control The Starr Foundation, C. V. Starr & Co., Inc. ("CVSCO"), and Starr International Company, Inc. ("SICO"). Cornelius Vander Starr, who died in 1968, started AIG, CVSCO, and SICO, and established the foundation.

The recent move by Attorney General Spitzer is in the form of a letter to Florence A. Davis, president of The Starr Foundation. The letter and the accompanying report allege that Mr. Greenberg and the other executors of Mr. Starr's estate had "a fundamental conflict of interest" and engaged in three transactions that "enriched CVSCO, SICO, and the executors at the expense of the Estate and the Foundation." The letter and report, together with a memorandum from Mr. Greenberg's attorneys and a statement by the foundation, are discussed in this article.

Background

In May 2005, Attorney General Spitzer—together with New York Superintendent of Insurance Howard D. Mills, III—filed a civil complaint against AIG, Mr. Greenberg, and Howard I. Smith, former vice chairman and chief financial officer of AIG. Our August 2005 issue discusses the complaint, and the full text of the complaint is in an appendix in that issue.

As discussed in a follow-up article in our November 2005 issue, SICO for many years provided a major portion of the benefits of a deferred compensation program for AIG executives. The current senior management of AIG recently ended the arrangement; AIG now pays and treats as an expense all compensation of AIG executives. Also, AIG currently is engaged in litigation with SICO.

On November 25, 2005, *The Wall Street Journal* reported that Attorney General Spitzer decided in June 2005 not to file criminal charges against Mr. Greenberg. The *Journal* also reported that Attorney General Spitzer was expected to amend the civil complaint soon.

On December 14, 2005, instead of amending the civil complaint, Attorney General Spitzer sent a letter to Ms. Davis of The Starr Foundation. Accompanying the letter was a "Report on Breaches of Fiduciary Duty by the Executors of the Estate of Cornelius Vander Starr" consisting of 26 pages of text, a 3-page appendix, and 24 exhibits.

Also on December 14, Mr. Greenberg's attorneys issued a 34-page "Memorandum re: Probate of Estate of Cornelius Vander Starr" on behalf of the four living executors of the Estate—Houghton Freeman, Mr. Greenberg, John J. Roberts, and Ernest E. Stempel—and T. C. Hsu, who was president of The Starr Foundation from 1969 through 1999. Mr. Greenberg's attorneys also issued a "backgrounder," the four living executors of the estate issued a statement, and the foundation issued a statement. These recent developments, which are discussed in this follow-up article, represent a significant escalation in the legal struggle between Attorney General Spitzer and Mr. Greenberg.

The Spitzer Letter

The Spitzer letter to Ms. Davis says that in 1969 and 1970 three sales of assets of the Starr estate were "for the Foundation's ultimate benefit," and that the "transactions were designed and carried out by Mr. Greenberg and the other directors of CVSCO, all of whom had been appointed executors of the Estate." The letter alleges that "the executors had a fundamental conflict of interest because they controlled the seller (the Estate), the buyer (CVSCO or SICO) and the ultimate Estate beneficiary (the Foundation)." The letter also alleges that "the executors caused the Estate to sell its assets at low prices" and that the "process enriched CVSCO, SICO, and the executors at the expense of the Estate and the Foundation." The Spitzer letter is the first item in Appendix A.

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