Unum Group: Is everything old, new again?

The company's litigated claims handling practices for disability claims continue to haunt it

By Eric Buchanan, David Lilienstein, and Katie Spielman

If a good story is at the heart of a successful trial, then every plaintiff's attorney deserves at least one Unum Group case. Unum, the largest disability insurer in the country, has a villainous history of multimillion-dollar punitive damages awards, regulatory investigations, millions of dollars in fines.

With all this sordid history the question for the insurance bad-faith practitioner is whether the company's misconduct *is* or *is not* a thing of the past, and if it isn't, how can evidence of past conduct be used to support "pattern and practice" allegations?

A cautionary tale

First, the cautionary tale[1]: In the late 1980's, Unum saw an opportunity in the disability insurance marketplace, and tried to corner the market by offering great products – occupation-specific, noncancellable, guaranteed renewable individual disability policies – to high-income earners such as doctors and lawyers. Other companies, and particularly Provident Life and Accident Insurance Company, followed suit.

By the early 1990's insureds began making claims on the policies. Many claims. So many claims, in fact, that Provident reported a $400+ million loss in its disability line of business. Heads rolled, executives were replaced, and new claims handling practices became the rule of the day for this block of business. Perhaps the most egregious of the company's new so-called initiatives was that it could not approve too many claims unless it denied an equivalent number of claims. This is famously known as the "net-terminations ratio." No longer were insurance claims evaluated on their merits, as is required under California law.

The new initiatives worked. Profitability reigned and consolidation followed. In 1999, Unum and Provident merged into a disability insurance behemoth, UnumProvident.

Then the documents came out, and UnumProvident's unlawful claims handling practices were laid out for all to see, in 2002, in the form of a unanimous insurance bad-faith jury verdict and a $5 million punitive damages award (*Hangarter v. Paul Revere Life Ins. Co.*, 236 F.Supp.2d 1069 (N.D.Cal. 2002).[2] That action concerned the denial of a chiropractor's disability claim, not because she could no longer practice chiropractics, but instead on the basis that she was not disabled from running a small business – her chiropractic practice.

For anyone interested in how to establish institutional bad faith against an insurer, the *Hangarter* opinions are a must read. For example, the court highlighted evidence that the insurer "had developed and applied to [plaintiff's] casefile a comprehensive system for targeting and terminating expensive claims. . . ."[3]

Medical evidence is paramount in proving many types of insurance cases. In *Hangarter*, the court called out the company for using a so-called independent doctor who rejected the insureds' position "in thirteen out of thirteen cases."[4] Practitioners take note: do not refer to insurance medical examinations as "independent." The proper term is "defense medical examination."

Hangarter v. Paul Revere Life Ins. Co.

Hangarter was only the tip of the iceberg for UnumProvident. After years of complaints piling up, insurance commissioners nationwide took note. The ensuing multistate investigation and settlement resulted in millions of dollars in fines, promises of claims handling reforms, and an agreement to "reassess" previously denied claims.

California, under the leadership of then-insurance commissioner John Garamendi, opted out of the multistate settlement, and entered into its own settlement with the disability giant. In addition to the tens of millions of dollars of fines levied nationwide, the California fine alone was $8 million.

Included among the findings of the California Department of Insurance ("DOI") were that UnumProvident:

- Failed to train claims personnel adequately or correctly on how to properly conduct an evaluation of a claim;[5]
- Targeted claims for termination or denial based on company economics aimed at improving "net-termination ratios" instead of the claim's merits;
- Selectively used portions of a claim file (such as medical history and IME findings) to the company's own advantage, at the insured's expense;
- Misapplied policy provisions in order to limit or deny benefits;
- Failed to document claim files regarding in-person meetings at which substantive claims decisions were made; and
- Continued to seek additional information where claimants provided adequate proof of loss.

There were additional allegations in the DOI's accusation against Unum that were not included in the specific final findings, including offering adjusters incentives or rewards for closing files, and placing the burden of investigating the claim on the claimant while failing to fulfill its own duty to adequately investigate.[6]

More important for practitioners were the many claims handling reforms UnumProvident agreed to institute.

This included:

• Engaging experienced claim personnel at the earliest possible stage of claim reviews;[7]
• Increasing emphasis on claim staff accountability for compliance with the terms of insurance policies and applicable law;
• Increasing involvement of higher levels of claim management staff in each claim denial or termination decision; and
• Giving proper weight to the opinions of an insured's treating physician.

Imagine that! A disability insurer must credit the medical opinions of its insureds' treating physicians.

It would be nice to think Unum learned it lessons and reformed its claims handling procedures as promised. The facts – and punitive damages verdicts – speak otherwise. If the $5 million award in *Hangarter* wasn't sufficient, shortly after the multistate and California settlement agreement, the company was hit with a $36 million punitive damages award.[8]

Merrick v. Paul Revere Life Ins. Co.

The multiple opinions in *Merrick* are also required reading for understanding just how pervasive, and damaging, institutional bad faith can be. The court's findings here are like headlines in an insured's nightmare. A "Scheme Engaged In To Augment . . . Profits at the Expense Of . . . Insureds"[9]; Unfair and Unlawful Claims Handling Practices "Handled In Accordance With Defendants' Corporate Scheme"[10]; "Unrepentant . . . Conduct[11]; and "Document Destruction."[12]

Unum Group: A change of name

What is a company to do when its name is, at least to some, mud? When it feels it is reformed and prior bad acts are drowning out all the good it is doing for insureds nationwide? When multiple legal opinions set forth a continuing scheme to defraud insured?

The solution: a name change. That's precisely what UnumProvident did, in 2007. It changed its name to Unum Group. Ostensibly made to shorten the company's name for ease of use. Observers can judge for themselves whether the multistate investigations, the millions of dollars in fines for unfair and unlawful claims handling practices, and some of the biggest punitive damages awards in the company's history played any role in this name change.

"Stale" documents do not reflect the new Unum

By now some of the documents used with such success in Unum's biggest defeats are almost two decades old. In the words of the insurer's attorneys, these damning documents are "stale." That was then, this is now, they claim – with a straight face, no less. No longer, they say, does the company engage in an ongoing, entrenched, and conscious corporate course of conduct aimed at identifying claims for termination or denial and relying on trumped up justifications to support the termination or denial, that the court in *Merrick* delineated.

Also discontinued, the company now proffers, were staff meetings called "roundtable reviews" where claims personnel, medical staff, vocational staff, legal counsel, and management discussed high value claims that could be denied, terminated or reduced. Indeed, the court in *Merrick* found that legal counsel were invited to these roundtables in order to cloak the meetings with the attorney-client privilege and further insulate the claims decisions and process from outside review and scrutiny.

Have things really changed?

But has this billion-dollar entity actually reformed its rogue ways? Based on recent depositions of current and former Unum executives, it appears that little of substance has changed in 2017. At best, the company has become more creative in re-packaging of the same toolbox of claims handling misdeeds that has served its bottom line so well for decades.

Some of the changes are simply linguistic. Today, the company no longer engages in "targeting" and "denying" claims. Now, Unum's directors and claims specialists engage in "forecasting" to identify potential claim "recoveries." But consider the use of the term "recovery." The company culture concerning a terminated claim is that it is "recovering" monies, as if these claims payouts should never have been made. This change in parlance suggests that while the techniques may be different, the outcomes are virtually unchanged from the company's pre-2004 playbook.

Unum's use of the term "forecasting" is also instructive. "Forecasting" among other things, involves tracking the number and dollar value of claims that leave a claims manager's desk when it appears the claim will continue to be paid for an extended duration. Since insurers are required to maintain certain levels of reserves to pay future claims, the "forecasting" is used to identify – and target – monies (claims) that can be "recovered" from reserves and that go right to the company's bottom line. Put differently, recovered claims are those that move dollars from Unum's untouchable reserves into its general fund, and therefore consist of denied initial claims and terminated or reduced ongoing claims. To be clear, targeting claims for termination or denial, simply to improve an insurer's bottom line, is unlawful.

Just as Unum previously used the net-termination ratio, now it forecasts recovery rates. If the ratio of recovered claims does not meet or exceed the forecasted recovery rate, you can be sure a

claims handler will hear about it from his or her direct supervisor.

"You want it in writing?"

Another new tactic appears to be a concerted effort to no longer put things in writing. Forecasts, potential recoveries, and internal Unum team performance metrics are discussed, but hard copies of this conduct can't be discovered through a standard document production request. Unum's executives now, it seems, disseminate performance metric directives in a hierarchical manner from the very top of the company down through the ranks via a series of one-on-one, in-person meetings. The oral discussions involve topics such as historical forecasts, targeted claims, recoveries and performance goals.

Of course, some information is committed to writing. To avoid e-discovery, however, claims personnel now use coded language, creative use of s p a c i n g and @lt3rn@tiv3 spelling conventions to obscure the already-misleading euphemisms for targeting and denying claims and other common search terms. One executive matter-of-factly admitted in a deposition that if he ever did record forecasting and recovery targets in writing, he would do so in a spreadsheet which he saved only locally on his own computer rather than on the company server. He would then print a hard copy of the spreadsheet for use in his one-on-ones with his direct reports, and shred the hard copy of the document following the in-person meeting.

So has the Unum leopard changed its spots? If the new nomenclature, coded claims language, and shredded spreadsheets are any indication, the answer is a resounding no!

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Endnotes

[1] What follows comes from allegations in numerous complaints, court decisions, and internal company documents.
[2] See *Hangarter v. Paul Revere Life Ins. Co*., 236 F.Supp.2d 1069 (N.D.Cal. 2002) (district court opinion with findings of fact and conclusions of law: and *Hangarter v. Provident*, 373 F.3d 998 (9th Cir. 2004) (Ninth Circuit Opinion upholding the district court).
[3] 373 F.3d at 1011.
[4] Id.
[5] Decision and Order of Insurance Commissioner Upon Settlement In the Matter of the Certificates of Authority of Unum Life Ins. Co. of America, Provident Life and Accident Ins. Co., and The Paul Revere Life Ins. Co. (Before the Insurance Commissioner of the State of California, 2005, File Nos. DISP05045984, DISP05045985, DISP05045986)
[6] Accusation In the Matter of the Certificates of Authority of Unum Life Ins. Co. of America, Provident Life and Accident Ins. Co., and The Paul Revere Life Ins. Co. (Before the Insurance Commissioner of the State of California, 2005, File Nos. DISP05045984, DISP05045985, DISP05045986)
[7] Report of the Targeted Multistate Market Conduct Examination, November 18, 2004.
[8] See *Merrick v. Paul Revere Life Ins. Co*. 594 f.Supp.3d 1168 (D.C. Nev. 2008) (lowering the punitive damages award to $26 million
[9] Id. at p. 1174.
[10] Id. at p. 1181.
[11] Id. at p. 1182.
[12] Id. at p. 1183.