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LEGAL DIVISION  
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6 Attorneys for the Insurance Commissioner

7 **BEFORE THE INSURANCE COMMISSIONER**  
8 **OF THE STATE OF CALIFORNIA**

10 In the Matter of the  
11 Certificates of Authority of

12 UNUM LIFE INSURANCE COMPANY  
13 OF AMERICA,

14 PROVIDENT LIFE AND ACCIDENT  
INSURANCE COMPANY, and

15 THE PAUL REVERE LIFE INSURANCE  
16 COMPANY,

17  
18 Respondents.

ACCUSATION

(Cal. Ins. Code, §§700, 704)

File No. DISP05045984

File No. DISP05045985

File No. DISP05045986

19  
20 WHEREAS, the Insurance Commissioner of the State of California (hereafter, “the  
21 Commissioner”) has reason to believe that the above Respondents have engaged in or are  
22 engaging in this State in the practices set forth below, each falling within Sections 700 and 704  
23 of the California Insurance Code;

24 WHEREAS, the Insurance Commissioner has reason to believe that a proceeding with  
25 respect to the alleged acts of Respondents would be in the public interest;

26 NOW, THEREFORE, and pursuant to the provisions of Sections 700 and 704 of the  
27 California Insurance Code, it is alleged as follows:  
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1 **I.**

2 **JURISDICTION AND BACKGROUND**

3 Respondents UNUM LIFE INSURANCE COMPANY OF AMERICA (“Unum”),  
4 PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY (“Provident”), and PAUL  
5 REVERE LIFE INSURANCE COMPANY (“Paul Revere”) (all three collectively,  
6 “Respondents”), are, and at all relevant times have been, holders of Certificates of Authority  
7 issued by the Commissioner and are authorized to transact insurance business in California.

8 Unum is a Maine corporation licensed in the State of California to transact disability  
9 insurance, which includes disability income insurance as defined in Section 10147(a) of the  
10 California Insurance Code.

11 Provident is a Tennessee corporation licensed in the State of California to transact  
12 disability insurance, which includes disability income insurance as defined in Section 10147(a)  
13 of the California Insurance Code.

14 Paul Revere is a Massachusetts corporation licensed in the State of California to transact  
15 disability insurance, which includes disability income insurance as defined in Section 10147(a) of  
16 the California Insurance Code.

17 In the 1980s, Provident and its competitors were enjoying a growth-oriented market  
18 environment, earning high interest rates on their surpluses. They became highly competitive  
19 with each other by liberalizing policy provisions and underwriting. The primary product offered  
20 in the marketplace during that period was a disability income policy with quite liberal terms.  
21 Specifically, the policies sold could not be canceled, their premiums could not be raised, and  
22 their coverage applied to disability from performing the individual insured’s *own occupation* for  
23 life or some shorter period, at the insured’s option, in the event of total disability (with  
24 alternative coverages available for partial disability).

25 According to the law in California, “total disability” is defined as a disability that renders  
26 one unable to perform with reasonable continuity the substantial and material acts necessary to  
27 pursue his or her usual occupation in the usual or customary way or to engage with reasonable  
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1 continuity in another occupation in which he or she could reasonably be expected to perform  
2 satisfactorily in light of his or her age, education, training, experience, station in life, physical  
3 and mental capacity. *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 632;  
4 *Hangarter v. Provident Life & Accident Ins. Co.*, (2004) 373 F.3d 998, 1006. As the industry  
5 evolved in the 1980s and 1990s, the first part of the above-definition was applied as the total  
6 disability definition under an ‘own occupation’ (hereafter, “own-occ”) policy and both parts  
7 together were applied under a general or “any occupation” (“any-occ”) policy.

8 The target market for the own-occ policies was the upper income professional – 35% of  
9 the sales were made to physicians – thus the benefits offered were high.

10 In the early 1990s, interest rates fell and claims started coming in on those liberal  
11 policies. In 1993, Provident hired banking and investment executives to run the company, and  
12 retained consultants to evaluate the disability income side of its business in an effort to rectify  
13 the increasingly unprofitable situation.

14 Out of the consultants’ reports came recommendations for “reengineering” the entire  
15 disability income book of business on the claims end. Among the recommendations were both  
16 revisions of policy provisions and “claims initiatives” that would lead to a fundamental change in  
17 corporate culture, with an emphasis on “claims management” instead of “claims payment.”

18 Regarding changes in policy language or its interpretation, for example, the consultants  
19 noted, “When combined with minimal defenses and exclusions, changing societal norms and  
20 inadequate pricing, overly generous terms resulted in the diminished profitability of Provident’s  
21 IDI [individual disability income] book of business.” Among other things, the consultants  
22 recommended that Provident:

- 23 • discontinue provisions offering guaranteed life-long renewal benefits, limiting guaranteed  
24 renewal or premium benefits to age 65;
- 25 • institute a mandatory rehabilitation clause in all general (i.e., any-occ as opposed to own-  
26 occ) IDI products;

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1 • where the policy states that a rehabilitation program paid for by Provident “must be  
2 designed to help you return to work,” the word “work” should not be construed to mean  
3 ‘any work’ but should be tied to the ‘own-occ’ coverages in the policy (i.e., it should be  
4 construed very narrowly, to mean the insured’s own occupation only), thus rendering a  
5 decision to deny payment for the rehab program reasonable.

6 Regarding mental and nervous condition claims, the consultants recommended, among  
7 other things, that Provident

8 • continue to vigorously change “corporate culture,” i.e., “[m]ake the adjuster – not the  
9 attending physician – the expert on the claimant’s condition, the proper treatment and  
10 how those aspects of a claim are connected to the insurance policy at issue. Build upon  
11 these changes to use the ‘subjective’ nature of mental and nervous claims to the  
12 Company’s advantage . . .”

- 13 • have insureds under ‘own-occ’ policies sign side agreements that would “effectively  
14 convert the voluntary provisions [of the policy] to a mandatory provision;
- 15 • utilize in-house lawyers to protect claims-handling functions from disclosure in the event  
16 of a denial;
- 17 • earmark high value claims for reevaluation.

18 Internally, a task force was established to, among other things, “initiate active measures  
19 to get new and existing policies covered by ERISA” (Employee Retirement Income Security Act  
20 of 1974, 29 U.S.C. §1134) where, it was noted, “state law is preempted by federal law, there are  
21 no jury trials, there are no compensatory or punitive damages, relief is usually limited to the  
22 amount of benefit in question, and claims administrators may receive a deferential standard of  
23 review. . . .” – where, in short, the “economic impact on Provident . . . could be significant.”

24 One of the measures planned and implemented was the inclusion of “endorsement” language in  
25 the payroll deduction agreements used at the point of policy sale. Payment of premium by  
26 payroll deduction or salary allotment is not enough in itself to subject a policy to ERISA  
27 jurisdiction; the policy must be employer-endorsed or -sponsored.  
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1 *America*, Superior Ct., County of San Mateo (Tried to the Court - Statement of Decision filed  
2 June 22, 1999, and Corrected Judgment on Statement of Decision filed August 10, 1999); and  
3 *Guirsch v. UnumProvident Corp.*, USDC Case No. EDCV 02-00360-VAP (SGLx).

4 The Department initially had conducted a routine on-site examination of the companies at  
5 their collective claims administration office in Glendale, California. This examination included  
6 closed claims for the period February 1, 2001 through January 31, 2002, under policies of group  
7 and individual life insurance, group life and special risk accident death & dismemberment  
8 insurance, long term care insurance, and group and individual disability income insurance (GDI  
9 and IDI).

10 When the Commissioner ordered that an investigation be conducted, a targeted review of  
11 open and closed IDI and GDI claim files was added to the on-site examination of the companies,  
12 with a window period of January 1, 2000 through June 30, 2003. Files then were added relating  
13 to Independent Medical Examination (IME) and vocational rehabilitation assessments.

14 Additionally, the examination included a review of (1) the guidelines, procedures,  
15 training plans and forms adopted by the companies for use in California, including any  
16 documentation maintained by the companies in support of positions or interpretations of the  
17 California Unfair Practices Act (the "Act") (Cal. Ins. Code, §790 et seq.) and the Fair Claims  
18 Settlement Practices Regulations (the "Regulations") (10 Cal. Code Reg., §2695.1 et seq.), and  
19 (2) the application of those guidelines, procedures, forms and interpretations, by means of an  
20 examination of claims files and related records.

21 Incorporated by reference in its entirety herein is the *Public Report of the Market*  
22 *Conduct Examination of the Claims Practices of the Unum Life Insurance Company of America,*  
23 *Provident Life and Accident Insurance Company, and The Paul Revere Life Insurance Company*  
24 *as of June 30, 2003.*

25 In the initial review, the examiners cited 151 violations of the Act and the Regulations in  
26 the non-GDI and non-IDI files. In the total number of IDI and GDI claim files reviewed in both  
27 exams, the examiners cited 150 violations of the Act and/or Regulations.

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1 Violations cited were of Section 790.03(h)(1), (3) and (5) of the Act, and, of the  
2 Regulations, the following:

- 3 • §§2695.3(a) and (b)(2);
- 4 • §§2695.4(a) and (c);
- 5 • §§2695.5(b), (e)(1) and (e)(3);
- 6 • §2695.6(a);
- 7 • §§2695.7(b)(1) and (3), (d), (f) and (g); and
- 8 • §2695.11(b).

9 Concurrently with the targeted Field Claims examination, CDI staff counsel conducted an  
10 off-site examination of 68 of Respondents' litigated disability income claim files, finding  
11 potential violations of Insurance Code section 790.03(h)(3), (6) and (7), in many of the files.

12 The Claims Services Bureau (CSB) of the Department of Insurance reviewed 454  
13 Requests for Assistance ("complaints") submitted to the Department concerning claims disputes  
14 with Unum, of which 421 concerned disability income benefits. Of these, 254 complaints  
15 alleged improper denial or termination of benefits. The complaint files reviewed were closed by  
16 CSB between January 1, 2000, and December 31, 2002.

17 CSB reviewed 47 complaints against Paul Revere, of which 38 concerned disability  
18 income benefits. Of these, 31 complaints – 17 insured under individual policies and 14 under  
19 group – alleged improper denial or termination of benefits. The complaint files reviewed were  
20 closed by CSB between January 1, 2000, and December 31, 2002.

21 CSB reviewed 113 complaints against Provident, of which 63 concerned disability  
22 income benefits. Of these, 35 complaints alleged improper denial or termination of benefits.  
23 The complaint files reviewed were closed by CSB between January 1, 2000, and December 31,  
24 2002.

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**III.**  
**ALLEGATIONS**

It is alleged that Respondents have knowingly engaged in the following conduct, in violation of Sections 700 and 704 of the California Insurance Code:

A. “Disability” Definition and Proof Issues

- Defining “total disability” in claims handling in a manner inconsistent with the definition of “total disability” set forth in California case law;
- Failing to inform the IME of the legal definition of “total disability” or of the specific job duties of the claimant’s occupation;
- Pressuring attending physicians for a finding of partial disability on meritorious total disability claims.
- Failing to train claims personnel adequately or correctly on California’s legal definition of “total disability,” on how properly to conduct an evaluation of a claimant’s occupational duties, and on other policy provisions;
- Defining a person’s regular occupation as that which is “normally performed in the national economy” (using the Dictionary of Occupational Titles (DOT) from the U.S. Dept. of Labor or deciding for itself how the occupation is performed in the national economy) instead of as how the substantial and material duties of the job are performed for a specific employer or at a specific location (as the policy was sold), thus rendering coverage potentially illusory or, at best, treating an “own-occ” policy as if it were an “any-occ” policy;
- Ignoring “national economy” descriptions of an occupation when it is advantageous to the company (e.g., in nursing occupations);
- Targeting nurses’ claims for termination or denial, mischaracterizing their nonsedentary jobs as sedentary, and requiring them to find work in sedentary nursing occupations (e.g., as a utilization review nurse) even during the “own occupation” period;
- Targeting medical specialists’ claims for termination or denial, then determining predominantly through a ‘billing analysis’ that the medical specialist could continue in his or her

1 'occupation' even though unable to practice the specialty itself (e.g., surgery; delivering babies;  
2 chiropractic);

- 3 • Applying an incorrect description of the claimant's occupation in determining that the  
4 claimant is not disabled from performing the occupation's substantial and material duties;
- 5 • Selectively using portions of the medical history and IME findings to the company's own  
6 advantage, at the claimant's expense;
- 7 • Using pressure tactics on the attending physician to, among other things, get the doctor to  
8 agree to an estimated return-to-work date or to state that the insured could return to work in some  
9 capacity;
- 10 • Misapplying the partial and/or residual disability provisions in the policy;
- 11 • Inappropriately using aggressive surveillance on a claimant and misusing the results;

12 B. Discretionary Authority

- 13 • Including a clause that confers unlimited discretion on the company in interpreting policy  
14 language, requiring an "abuse of discretion" standard of review if a lawsuit ensues;

15 C. Self-Reported Conditions

- 16 • Characterizing certain disabling conditions as "self-reported" (e.g., pain, limited range of  
17 motion, weakness), accepting only objective test results to support disability, and sometimes  
18 using the concept to invalidate objective medical evidence in the file, thus limiting payment of  
19 benefits under the "self-reported conditions" policy provision;
- 20 • Not having the IME perform objective testing that might support the symptoms, or  
21 ignoring objective test results that support disability;
- 22 • Discounting both Functional Capacity Evaluation (FCE) results and IMEs that support  
23 disability, with little or nothing in the record to support the decision;
- 24 • Discounting objective test results by stating the results cannot predict disability or by  
25 imputing the disabling condition to a "psychological component" (thus triggering the "mental or  
26 nervous condition" limitation);

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1 D. Mental and Nervous Conditions

- 2 • Utilizing a policy provision limiting the “mental and nervous conditions” benefit to 24-  
3 months to unreasonably limit the time benefits are paid for physiologically-based disabilities that  
4 may or may not have a psychological component;
- 5 • Categorizing a disability as being limited by the “mental or nervous conditions” benefits  
6 24-month limitation period when the disability is physiologically based and/or had its inception in  
7 a physical disability, and terminating benefits that were being paid for a physical disability;
- 8 • Discounting objective test results by stating the results cannot predict disability or by  
9 imputing the disabling condition to a “psychologically component” (thus triggering the “mental  
10 or nervous condition” limitation);

11 E. Pre-Existing Conditions

- 12 • Including language in group policies that excludes coverage for pre-existing conditions  
13 “caused by, contributed to [by], or related to the disabling condition” and for “symptoms for  
14 which diagnostic treatment was performed or symptoms for which a prudent person would have  
15 sought treatment,” so that a disabling condition would not have to have been diagnosed, treated or  
16 even in existence during the policy’s pre-existing condition period for it to be excluded from  
17 coverage, the policies therefore providing potentially illusory coverage;
- 18 • Misapplying the pre-existing condition clause to deny meritorious claims; e.g.,  
19 characterizing obesity as the pre-existing condition for a previously asymptomatic, undiagnosed  
20 and untreated musculoskeletal, cardiovascular, peripheral vascular, pulmonary or orthopedic  
21 disability;

22 F. Offsets

- 23 • Offsetting for benefits that it is estimated the claimant might receive, instead of only for  
24 those benefits actually received by the claimant and appropriately offset under the law;
- 25 • Stating in correspondence to the claimant that the claimant must apply for Social Security  
26 Disability Income (SSDI) benefits in order to receive an unreduced benefit, when no such duty  
27 exists in the policy;
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1 G. Mandatory Vocational Rehabilitation

- 2 • Imposing a duty to participate in vocational rehabilitation on a claimant where no such
- 3 duty exists in the policy;
- 4 • Developing a vocational rehabilitation program consisting of no more than looking for a
- 5 job in a different occupation, then terminating benefits when the claimant cannot look for another
- 6 job because the claimant is unable to work at all;

7 H. Survivor Benefits

- 8 • Including a more restrictive policy definition of “eligible survivor” than exists in statutory
- 9 language, such that no benefits are payable if there are no surviving spouse, no surviving child
- 10 under 25, and no estate is formed;

11 I. Miscellaneous Claims Handling Issues

- 12 • Targeting claims for “resolution” (i.e., for denial or termination of benefits) based on
- 13 company economics instead of the claim’s merits, e.g., high benefit, noncancellable long term
- 14 disability income policies previously heavily marketed, which had become costly for the
- 15 company through claims;
- 16 • Failing to document claim files regarding the so-called “roundtable” sessions at which
- 17 substantive claims decisions were made;
- 18 • Placing claimants in the position of either having to sign an overly broad authorization
- 19 form – thus giving up the right to privacy in financial and credit scoring records in claims in
- 20 which such records may be neither necessary nor material to resolution of the claims – or having
- 21 to alter the form/refuse to execute the form and risk claim denial;
- 22 • Failing to refer the claimant to CDI in the event the claimant believes his or her claim has
- 23 been denied or benefits terminated unfairly;
- 24 • Placing the burden of investigating the claim on the claimant (e.g., imposing unreasonable
- 25 documentation obligations on the claimant) and failing to fulfill its duty to adequately investigate;
- 26 • Misrepresenting to claimants under individual or government employer-sponsored group
- 27 policies that ERISA preemption applies and thereby limits a claimant’s rights on appeal;
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- 1 • Offering a payroll deduction/salary allotment option for payment for individual insureds,  
2 then asserting that the policy is employer-sponsored or employer-endorsed, thus governed by  
3 ERISA;
- 4 • Overruling the opinion of attending physicians after the company's in-house physician or  
5 nurse has conducted only a "paper review" of the medical file;
- 6 • Overruling the opinion of in-house medical personnel that supported disability or the need  
7 for specific objective testing;
- 8 • Continuing to seek additional information where claimants provided adequate proof of  
9 disability;
- 10 • Offering adjusters "incentives" or "rewards" for closing files;
- 11 • Paying a claim under a reservation of rights (sometimes for many years), then terminating  
12 benefits and notifying the claimant of the company's intent to recover the benefits paid, thus  
13 creating undue stress on the claimant in order to compel settlement for less than the amount due  
14 under the policy;
- 15 • Failing to disclose to the claimant additional benefits that might be available under the  
16 policy, e.g., a waiver of premium, a cost of living endorsement, a seat belt benefit;
- 17 • Compelling a claimant to accept an unreasonably low settlement offer through the above  
18 means and others, or resort to litigation;

#### 19 20 **IV.**

#### 21 **CONCLUSION**

##### 22 A. California Insurance Code, section 704(a)

23 The facts alleged above show that Respondents have conducted their business  
24 fraudulently, constituting grounds for the Insurance Commissioner to suspend the Certificates of  
25 Authority of Respondents for a period not to exceed one year, pursuant to Section 704(a) of the  
26 Insurance Code.

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1 B. California Insurance Code, section 704(b)

2 The facts alleged above show that Respondents have failed to carry out their contracts in  
3 good faith, constituting grounds for the Insurance Commissioner to suspend the Certificates of  
4 Authority of Respondents for a period not to exceed one year, pursuant to Section 704(b) of the  
5 Insurance Code.

6 C. California Insurance Code, section 704(c)

7 The facts alleged above show that Respondents have habitually and as a matter of  
8 ordinary practice and custom compelled claimants under policies to either accept less than the  
9 amount due under the terms of the policies or resort to litigation against Respondents to secure  
10 the payment of the amount due, constituting grounds for the Insurance Commissioner to suspend  
11 the Certificates of Authority of Respondents for a period not to exceed one year, pursuant to  
12 Section 704(c) of the Insurance Code.

13 D. California Insurance Code, section 700(c)

14 The facts alleged above show that Respondents have failed to comply with the  
15 requirements as to their business set forth in the California Insurance Code, constituting grounds  
16 for the Insurance Commissioner to revoke the Certificates of Authority of Respondents, pursuant  
17 to Section 700(c) of the Insurance Code.

18 Dated: October 1, 2005

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JOHN GARAMENDI  
Insurance Commissioner

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By

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/s/  
CINDY A. OSSIAS  
Senior Staff Counsel

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