

# Longtime Problems with Long-Term Disability Insurance

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**A proponent of reform shares how ERISA laws concerning private disability insurance are failing people with CFS.**

## FAST FACTS ▶

- Private long-term disability (LTD) insurance falls under ERISA, the Employee Retirement Income Security Act.
- Weaknesses in ERISA law contribute to insurance company practices that are making it difficult for people with a chronic illness to receive long-term disability benefits.
- People with CFS are at particular risk for certain insurance company tactics of benefit denial and limitation.

People with chronic fatigue syndrome (CFS) not only must cope with a debilitating chronic illness, but they frequently face an assault on their financial security as well. However, unlike CFS itself, this potential slide into poverty has a known cause and cure. We know that when an adult wage earner is rendered disabled and unemployed, the loss of earned income diminishes the ability to provide life necessities and access to medical care that can ameliorate the illness. The economic loss also increases the stresses of living, further exacerbating conditions like CFS.

For many, the cure for this financial harm resides in a disability insurance safety net woven by a private sector system of long-term disability (LTD) benefits offered through employer-provided plans, coupled with the Social Security system's Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI).

The LTD system covers over 50 million employees and is overseen by the U.S. Department of Labor under a 1974 federal law known as ERISA (the Employee Retirement Income Security Act). ERISA provides for group coverage aimed at replacing 50-70 percent of base annual income up to a maximum limitation. This private insurance contractual guarantee provides more meaningful financial security than either Social Security benefits like SSDI or SSI—neither of which offer enough to keep a recipient far from the poverty level.

This article focuses on the LTD benefit under ERISA not only because of its significant potential to help the disabled, but because current practices by insurance companies are making it difficult for those with chronic illnesses to receive these benefits. Many people close to the issue feel this situation is compounded by federal courts that have stepped away from vigorous judicial review of denials and a Congress that has largely overlooked the issue. This leaves CFS claimants and others with chronic illness with a sizable hole in the safety net meant to keep them from poverty.

Although CFS claimants still have some problems accessing SSDI and SSI disability benefits, in 1999 the Social Security Administration issued its Social Security ruling 99-2p that officially acknowledged CFS as a qualifying disability for SSDI or SSI—greatly facilitating the award of claims that meet the Centers for Disease Control and Prevention's (CDC) diagnostic criteria. In addition, the Social Security Administration remains an impartial, adjudicatory agency where a denied claimant can receive an independent, personal hearing, and thereafter gain access to a federal court that will scrutinize a denial.

But in the ERISA system the process is stacked against claimants—especially those with chronic illnesses like CFS.

In fact, in a *Los Angeles Times* article last summer on LTD insurance practices (“The Safety Net She Believed in Was Pulled Away When She Fell,” August 21, 2005), U.S. District Judge William M. Aker Jr., of Alabama described LTD claimants as worse off than they were two or three decades ago, before ERISA. Judge Aker went on to say, “The law that was supposed to protect [LTD claimants] has been turned on its head. The chief beneficiaries are now the insurance companies.” The late Judge Edward Becker of the U.S. Court of Appeals for the Third Circuit once described ERISA insurers as having an “active incentive to deny close claims in order to keep costs down.” (*Pinto v. Reliance Standard Life Insurance Company*, 2000)

This pattern of LTD abuses is not new among CFS claimants. Close to a decade ago, a *CFIDS Chronicle* article (“Delays, Denials & Deception,” Fall 1996) reported on an informal survey of over 100 LTD claimants with CFS, showing a “disproportionate number of claims for long-term disability denied.” Only 12 percent of those who responded to this voluntary survey were currently receiving LTD for their CFS, and these, the survey reported, were subjected to repeated evaluations.

CFS claimants also appeared among victims of LTD abuses in the recent scandal involving the nation’s largest private disability insurer, UnumProvident, whose practices—exposed via state insurance commissioner investigations—revealed patterns of improperly denying LTD claims.

Fast forward to the present, and we find Dr. Charles Lapp and others reporting last year to the Chronic Fatigue Syndrome Advisory Committee of the U.S. Department of Health and Human Services about a pattern of unfair and arbitrary delays, denials and terminations of CFS claims.

### What makes CFS claimants more susceptible to improper ERISA practices?

First, it’s important to note that all disability claimants under ERISA are at risk of improper denials of benefits because of inherent problems in the law. Unlike other forms of insurance—like property and auto insurance—ERISA insurance lacks many of the consumer protections provided by state insurance laws. Essentially, the Supreme Court has said that ERISA law trumps these state law protections. So ERISA insurers are shielded from aggrieved claimants

seeking to recover punitive damages for bad faith delays or denials, or compensatory damages for harm caused by the denial of benefits. An aggrieved claimant can only sue in federal court for the amount of benefits available under the contract of insurance, with the possibility of recovering only prejudgment interest and attorney’s fees in addition.

And the federal courts have said that claimants have no right to a jury trial in these cases and no right to obtain discovery when in court. Claimants are also limited to the claims records established with the insurance company, even when there is additional or new medical evidence to provide a court reviewing the company’s denial of benefits.

What’s perhaps even worse, the Supreme Court has allowed employers and insurance companies to write

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## Unlike other forms of insurance, ERISA-governed long-term disability insurance lacks the scope of consumer protections provided by state insurance laws.

ERISA policies giving themselves the discretion to determine whether someone is entitled to benefits. In 2004 the National Association of Insurance Commissioners (NAIC) found that such policies made ERISA insurance coverage illusory and unfairly shielded insurers. Though the NAIC recommended abolishing these policies, they live on.

What’s more, when a denial is appealed in federal court, the court can’t overturn it simply by finding that the insurer made the wrong decision. It may only reverse the denial when the decision is deemed “arbitrary and capricious”—meaning that the denial is so outrageously wrong that it is without rational basis. It’s no wonder the Supreme Court described this deferential standard of judicial review as “highly prized by benefit plans.” (*Rush Prudential HMO v. Moran*, 2002)

Beyond the major failings in ERISA law, certain aspects of CFS itself make the CFS claimant an easy mark for insurance companies bent upon protecting their bottom line. The most expensive LTD claims tend to be for chronic illnesses striking workers who were previously earning substantial

“*I had been declared totally disabled by the government, while my employer and ERISA were still insisting I left work for no reason . . . that there was no medical justification.* - Rebecca Haskell”

salaries. Many with CFS fit that profile, having been high achievers in their careers before falling ill. Therefore, people with CFS are stuck with the “double whammy” of falling into a category that insurers would like to avoid and suffering from an illness with characteristics that insurers can exploit in denying a claim.

For example, insurance companies have capitalized on the current state of medicine, which to date lacks clear markers or diagnostic tests for CFS. They deny or limit claims by pejoratively categorizing CFS as a “self-reported” illness, proffering psychological explanations for symptoms.

It’s not surprising that in an NBC *Dateline* expose of LTD abuses (*Dateline*, October 13, 2002), insurance company employees disclosed that claims for “so-called subjective illnesses . . . that don’t show up on X-rays or MRIs” were most vulnerable to bad-faith denials.

In addition, because the stresses of CFS can lead to the presence of secondary emotional or psychological challenges—even though these may be controlled by medications or therapy which don’t adversely affect employment—companies readily seize on these as the cause of disability. This occurs because most LTD policies have a convenient 24-month cap on benefits caused “at least in part” by mental illness.

### What tactics have insurance companies employed to delay or deny CFS claims?

Insurance companies utilize a wide array of practices that exploit both the feeble ERISA law and the characteristics of CFS. Three of the worst are described here, with others briefly noted:

**1** Some insurance companies have expressed their bias against CFS claims by writing new or revised policies that establish 24-month limitations for “chronic fatigue conditions” or “self-reported” symptoms. If a claimant is under a contract without this limitation, insurers often make demands for test results to substantiate the claim, despite the fact that there is no current diagnostic test for CFS. They commonly do not acknowledge the official diagnostic criteria for CFS adopted by the CDC, nor developments in CFS research that establish objective evidence for the illness.

Fortunately, at least one respected federal appellate court has held that a CFS claim cannot be denied for lack of objective medical evidence. The court ruled that, with the current absence of definitive tests for CFS, such a require-

ment would defeat the legitimate expectations of the insured. (*Mitchell v. Eastman Kodak*, 113 F.3d 433, 3d Cir. 1997)

**2** Insurance companies will sometimes cut their costs in CFS cases by misusing the 24-month benefits cap on claims where mental illness is a cause of the disability. In this way, a claim may be initially granted but then later terminated when the company seizes on any evidence of mental illness or psychological treatment before or after the claim award, whether or not it’s causing the disability rendering the person unable to work.

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## You have a right to see the entire claims file and a right to add new evidence and counter reports.

In some cases, companies use in-house psychiatrists, psychologists or even medical professionals with no mental health qualifications to determine mental illnesses that have never previously been diagnosed or which are being managed and don’t contribute to the disability. In one such case, a major insurance company terminated a CFS claim based on several mental illness diagnoses, buttressed by the report of a rheumatologist who had no significant CFS experience and who had never personally examined the claimant.

In further pursuit of the 24-month limitation, an insurer can use the reported presence of CFS-related cognitive impairments to trigger their own full-blown neuropsychological assessment, where a CFS-skeptical assessor can then “find” somatoform and dependent personality disorder diagnoses to explain away the physical symptoms.

**3** Insurance companies also frequently rely solely upon their medical reviewers or independent medical examiners (IMEs)—both of which are paid by the insurer and often have no clinical or research background in CFS. Some of these reviewers don’t accept the CFS diagnosis criteria of the CDC.

Adding to the insurers’ ability to use their own reviewers toward their own ends, the Supreme Court has ruled that claims brought under the ERISA statute don’t have to follow the Social Security practice of giving special weight to “treating professionals.”

Other tactics appearing in CFS cases include:

- Unfairly seizing upon isolated case notes such as “doing well” or “doing better” and failing to evaluate the totality of the claimant’s medical condition.

- Exploiting the vulnerability of disabled claimants who may be too fatigued, ill or financially strapped to deal with the repeated stresses of improper denials, prolonged appeals and the like—opting instead for a quicker but perhaps less viable settlement.

### What can you do to protect your rights?

With LTD abuses and CFS denials so pervasive, people with CFS must be especially diligent in protecting their rights to ERISA disability benefits.

First, well before any claims decision, denial or termination, it's essential to obtain expert assistance, preferably from a lawyer with expertise in ERISA and CFS cases.

Second, work with treatment professionals from the beginning to obtain the medical evidence that will support the CDC case definition and diagnostic criteria, including documentation of all physical symptoms, lab tests and any other objective evidence of illness. Rule out other causes for the disability and clearly establish your inability to work. Make sure you understand the details of your LTD coverage so that your documentation will build the strongest case possible to your specific insurer.

Third, after an initial denial or termination decision, insist on your legal right under ERISA to a "full and fair review" by the insurance company (29 United States Code sec. 1133). You have a right to see the entire claims file, including all the reports the insurer used against you. You also have the right to add new medical evidence and counter reports from your doctors to explain why the company's assessments are wrong. These internal appeals are important because if you subsequently have to appeal to federal court, it's unlikely that you'll be able to add to the record already established with the insurer.

Finally, as part of your appeal, let the company know you are sending copies of your appeal and objections to people who potentially have the power to correct unfair ERISA practices. Send copies to: (1) your congressperson and senators; (2) the U.S. Department of Labor, Employee Benefits Security Administration; and (3) your state insurance commissioner.

The need for ERISA law and policy reform has never been greater, and the CFS community can take a national

lead, joined by allies in other disability communities, to create greater awareness and a more aggressive response to the industry wide pattern of LTD abuses. We need more critical reports in the media, such as those of NBC's *Dateline* and the *Los Angeles Times*. We need the creative engagement of lawyers to bring affirmative litigation and appeals, including consideration of class action litigation.

And we need an informed and conscientious Congress willing to take on the insurance industry and revisit the 30-year-old ERISA statute, which, as it states in its preamble, was intended "to protect. . . participants in benefit plans and their beneficiaries."

Among ERISA reforms being discussed by those looking to remedy abuses are:

- Empowering truly independent adjudicators to make benefits decisions and to judge denied claims upon appeal.
- Returning full powers to the federal courts to review the correctness of benefit decisions, ending the current standard of reversing denials only if found "arbitrary and capricious."
- Requiring that insurance companies use medical reviewers and IMEs who have expertise recognizing and treating the illness they are evaluating, and requiring special deference for the opinions of claimants' treating physicians.
- Providing for compensatory and punitive damages when insurance companies engage in bad-faith delays or denials of valid claims.
- Requiring that insurers pay the claimant's attorney's fees when claims are won, both for the litigation time and also for time expended in internal appeals.

As the CFS community struggles to find a remedy for the illness, we cannot forget that the financial security of those with CFS is important both to their quality of life and physical well-being. The struggle to find a cause and cure for CFS must be joined by a struggle to sew up the ERISA hole in the disability safety net. ■

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“**They try to wear me down and make it very expensive for me to keep my benefits because I have to keep paying an attorney and paying my doctors to write rebuttal letters** - Brenda McCree