Accidental Death Becomes Suicide When Insurers Dodge Payouts

Bloomberg

Jane Pierce spent nine years struggling alongside her husband, Todd, as he fought cancer in his sinus cavity. The treatments were working. Then, in July 2009, Todd died in a fiery car crash. He was 46. That was the beginning of a whole new battle for Jane Pierce, this time with Todd's life insurance company, MetLife Inc. A state medical examiner and a sheriff in Rosebud County, Montana, concluded that Pierce's death was an accident, caused when he lost control of his silver GMC pickup after passing a car on a two-lane road. Their findings meant Jane was eligible to collect $224,000 on the accidental death insurance policy that Todd had through his employer, power producer PPL Corp. MetLife, however, refused to pay. The nation's largest life insurer told Pierce on Dec. 8, 2009, that her husband had killed himself. The policy didn't cover suicide, the insurer said, Bloomberg Markets magazine reports in its April issue. "How dare they suggest such a thing," says Pierce, 44, a physician assistant in Colstrip, a Montana mining and power production city of 2,346 people. She says she's insulted that the man who courageously battled his disease for a decade was accused by an insurance company of abandoning his wife and two sons — one a U.S. Marine, the other a National Guardsman — and giving up on his fight to live. Pierce Sues Pierce argued with MetLife for months. She supplied the insurer with the autopsy report, medical records and a letter from the medical examiner saying the death was accidental. MetLife still said no. Finally, in May 2010, she sued. In July, a year after Todd's death, MetLife settled and paid Pierce the full $224,000 due on the policy. The New York- based insurer, as part of the agreement, denied wrongdoing and paid Pierce no interest or penalties for the year during which it held her money. Life insurers have found myriad ways to delay and deny paying death benefits to families, civil court cases across the U.S. show. Since 2008, federal judges have concluded that some insurers cheated survivors by twisting facts, fabricating excuses and ignoring autopsy findings in withholding death benefits. Insurers can make erroneous arguments with near impunity when it comes to the 112.8 million life and accidental death policies provided by companies and associations to their employees and members. That's because of loopholes in a federal law intended to protect worker benefits. ERISA Loopholes Under that law — the

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Employee Retirement Income Security Act, or ERISA — insurers can win even when they lose in court because they can keep and invest survivors' money while cases are pending. Congress enacted ERISA in 1974, after bankruptcies and union scandals caused thousands of employees to lose benefits. The law requires employers to disclose insurance and pension plan finances, and it holds company and union officials personally accountable for sufficient funding. In order to achieve ERISA's goals, federal courts have ruled that employees must surrender their rights to jury trials and compensatory and punitive damages if they sue an insurer for wrongfully denying coverage. Judges have reasoned that companies and insurers should have these protections to encourage them to continue providing benefits. ERISA puts these issues under federal jurisdiction, so state regulators sometimes say they can't help consumers. 'Law Backfired' "The most important federal insurance regulation of the past generation is ERISA," says Tom Baker, deputy dean of the University of Pennsylvania Law School in Philadelphia. "If ever a law backfired for the public, ERISA is the perfect example." Life insurers do pay most claims in full — more than 99 percent of the time, according to data from the American Council of Life Insurers, a Washington-based trade group. Nobody keeps track of how often companies delay making those payments or how often they use spurious reasons. As of 2009, the latest year for which figures are available, insurers in the U.S. were disputing an accumulated total of $1.3 billion in claims, the ACLI reports. Included in that amount was $396 million in death benefits turned down in 2009. In the same year, insurers paid out $59 billion, the ACLI reports. What those numbers don't measure is the trauma survivors like Jane Pierce face when wrongfully denied, says Aaron Doyle, a professor of sociology and criminology at Carleton University in Ottawa. Most Don't Sue Most survivors don't have the stamina and knowledge to file a lawsuit, says Doyle, who has spent a decade interviewing life insurance customers, employees and regulators in the U.S. and Canada. Often, survivors are dissuaded by their insurers from taking their grievances to state regulators or to court, Doyle says. "The company tells the customer, 'Oh no, that's not an unusual practice, so you don't really have a complaint,'" he says. Insurers have an obligation to policyholders and shareholders to challenge death claims they consider fraudulent, says John Langbein, a professor at Yale Law School who co- authored Pension and Employee Benefit Law (Foundation Press, 2010). Insurers maintain a reserve of money to cover benefits. 'Conflict of Interest' "It's their job to protect the insurance pool by blocking undeserved payouts," Langbein says. That doesn't give them the right to wrongly deny claims, he adds. "There's a profound structural conflict of interest," he says. "The insurer benefits if it rejects the claim. Insurers like to take in premiums. They don't like to pay out claims." MetLife and Newark, New Jersey-based Prudential Financial Inc. declined to answer all questions on cases cited in this story, as well as all queries about ERISA and accidental death policies. "We pride ourselves on delivering on our promises, paying claims in accordance with the terms of the policy and

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applicable law," says Joseph Madden, a MetLife spokesman. "Our insurance businesses' primary focus is on paying claims," says Simon Locke, a Prudential spokesman. "Contested claims represent a small fraction of the overall number of claims that are paid. Prudential's claims professionals are trained to conduct an appropriate review and follow applicable laws, regulations and the terms of the policy." Locke says Prudential denied 33 claims for misrepresentation in 2010, while paying out on about 255,000 policies. He declined to say how many claims Prudential denied for other reasons. $7.7 Trillion Company-provided life insurance is a big business. Employers can offer either accidental death policies — which cover just fatalities an insurer deems to be an accident — or term life insurance, or both. Group policies in the U.S. have a total face value of $7.7 trillion, or about 40 percent of all life insurance in the nation, according to ACLI data. ERISA contracts bring the industry about $25 billion in annual revenue. MetLife says it has 20 percent of the ERISA market. So eager are the largest insurers to get these ERISA contracts that they sometimes cross a line, according to prosecutors in California and New York. MetLife and Prudential have made improper undisclosed payments to brokers to win business with companies, according to settlements. The Settlements MetLife and Prudential each paid $19 million to settle accusations by the New York Attorney General's Office in 2006 that they had illegally paid brokers to get new corporate clients. In a similar case, MetLife paid $500,000 and Prudential spent $350,000 to settle with three California counties in 2008. In those cases, the insurers didn't admit wrongdoing. On April 15, 2010, in a San Diego case, MetLife admitted that it broke the law by paying a dealmaker to win insurance contracts, and it agreed with the U.S. Department of Justice to pay $13.5 million to avoid criminal prosecution. "MetLife made illegal payments that should have been fully disclosed," says Karen Hewitt, who was then the U.S. attorney in San Diego and is now a partner at Jones Day. "Because they were not, the transactions were criminal." MetLife's Madden says the company improved its broker compensation reporting starting in 2004. Prudential says it cooperated with investigators and enhanced disclosure. The money life insurers refuse to pay to people like Jane Pierce is emblematic of how the industry is increasingly making efforts to delay paying out benefits. In the past two decades, insurers have made a common practice of keeping money owed to survivors in their own investment accounts, even after claims are approved. Withholding Benefits Instead of sending lump-sum checks to survivors, companies send them "checkbooks." More than 130 insurers held $28 billion, as of July 2010, owed to families in these so-called retained-asset accounts. Prudential, which has a contract with the U.S. government to provide life insurance to 6 million soldiers and their families, has sent such "checkbooks" to survivors requesting lump sums since 1999. MetLife uses the same system for payments to survivors of the 4 million federal employees it covers. In September, seven weeks after Bloomberg Markets magazine reported that Prudential was sending "checkbooks" to families of those killed in combat, the U.S.

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Department of Veterans Affairs changed its policy and required that Prudential pay a lump sum when survivors make such a request. Jane Pierce's Battle Jane Pierce's battle with MetLife began two months after her husband died. Todd Pierce, a power plant mechanic for Allentown, Pennsylvania-based PPL, was diagnosed in 1999 with a skin cancer called squamous cell carcinoma, in his nasal cavity. The treatment of the disease itself was a success. Within two years, he was cancer-free. During the next eight years, Todd had more than 40 surgeries to rebuild his jaw and palate following his medical therapies. "He was a fighter," Jane says. On July 5, 2009, Todd was at a family reunion in Bismarck, North Dakota, 350 miles (560 kilometers) east of Colstrip. While there, he made plans to go pheasant hunting three months later with his father, Donald, and elk hunting with an old friend after that. "He had a lot planned," Jane says. It was sunny and hot that day as Todd drove home. He had been on the road for more than four hours when, at 5:25 p.m., 18 miles north of Colstrip, he lost control of his pickup on Highway 39, according to state police records. The vehicle rolled down an embankment and burst into flames. Letters and Calls He died of smoke inhalation, according to the autopsy report. No one else was hurt in the accident. A month later, MetLife sent Jane Pierce a "checkbook" for her to tap the $224,000 from Todd's term life insurance policy through PPL. She didn't receive any form of payment on Todd's accidental death policy. Instead, for four months, MetLife officials flooded Jane with letters and phone calls. They asked her to send them the state's accident report, the death certificate, toxicology reports, medical records from 20 doctors and Todd's drug prescription files. Jane, who lives in a three-bedroom ranch house filled with framed photos of Todd and her sons, says she did everything she could to get MetLife all the facts. She didn't know what the company was after and says she felt the insurer was trying to wear her down. 'Misconstruing Information' "I was just so frustrated," she says. "MetLife was taking and misconstruing information to see if I would give up." At one point, a MetLife employee told her by telephone that Todd's medical files showed he had toxic levels of Tramadol, a pain reliever, in his body when he died. Jane told him that a doctor had prescribed the drug for Todd. At Jane's request, Thomas Bennett, Montana's associate medical examiner, explained the high readings of the pain medicine to MetLife. "This Tramadol elevation is an artifact of the severe damage Mr. Pierce's body received following the crash and is not a result of taking sky-high levels of the drug," Bennett wrote. He said the drug wasn't the cause of death. Jane recounts the ordeal as she sits at her kitchen table with Debra Terrett, a family friend. Laid out before them are stacks of neatly organized health and insurance file folders. "She not only lost Todd," Terrett says. "Every time she had to go through the paperwork, she had to walk through losing him again." The Denial The toughest day turned out to be Dec. 8, 2009. That's when MetLife sent her an unsigned letter containing this sentence: "We will not pay benefits for any loss caused or contributed to by intentionally self-inflicted injury." MetLife concluded that Todd had killed himself taking an overdose of Tramadol. Jane

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says she was dumbfounded. She cried for days. “It’s bogus,” she recalls thinking. “How can a responsible company possibly lie in such a terrifying way?” Not only was Todd an upbeat man who had defeated a dreadful disease, he also opposed suicide as a matter of faith, Jane says. Todd and Jane attended St. Margaret Mary Catholic Church every Sunday, and they were members of a Bible study group. “After a suicide in our town, Todd and I used to talk about it,” Jane says. “As Catholics, we agreed that was no way to heaven.” A co-worker referred Jane to a lawyer, Don Harris, in Billings, Montana. Under ERISA, Harris had to first file an appeal directly with MetLife, which the insurer ignored, Harris says. Pierce sued the company in federal court in Billings for breach of contract in May 2010. ‘Very Quickly’ The insurer hired a local Montana lawyer who rebuffed Jane again, six weeks later. Harris says he had a rational telephone call with the lawyer about the facts. “Very quickly, he realized that they didn’t have a leg to stand on,” Harris says. After that, MetLife agreed to pay out the full policy amount. The case never went to trial. Because ERISA prevents compensatory and punitive damages, Pierce wasn’t entitled to receive anything more. Harris — who was paid a fee of $4,500 for his seven months — estimates that a jury not bound by ERISA would have awarded punitive damages of more than $1 million, or 5 to 10 times the death benefit. “They accused her husband of committing suicide, which is outrageous,” he says. “They had no facts to support it. They just literally made it up.” ‘Nothing We Can Do’ Pierce never requested help from Montana’s insurance department. If she had, she would have been turned away, says Amanda Roccabruna Eby, a spokeswoman. She says the agency can’t assist people like Pierce because of ERISA’s federal preemption. “There’s nothing we can do,” she says. “We don’t have any authority.” The department doesn’t even track ERISA complaints. Prudential used the ERISA shield when it denied payment to the widower of a middle school teacher in Rochester, New York. Lois Brondon died of a heart attack at age 49 while refereeing a soccer game in May 2007. The company refused to pay her husband, Christian, the $50,000 death benefit, saying the educator had failed to disclose her “heart trouble” when she applied for insurance. Christian, who knew his wife had no history of a heart condition, sued Prudential in U.S. district court in Rochester. “Mrs. Brondon had absolutely no symptoms referable to cardiac disease or heart trouble,” Judge Michael Telesca ruled on Nov. 9, 2010. He said her records showed common and mild thickening of the aorta that required no medical treatment and didn’t limit her activities in any way. False Grounds The judge said she’d been truthful on her application for insurance and ordered Prudential to pay the full $50,000. The judge said Prudential’s reasoning created false grounds the company could use to wrongfully deny death benefits to others. “Indeed, under such a scenario, only Prudential would be allowed to define what constitutes ‘heart trouble,’” the judge wrote. Three weeks later, a judge in Lexington, Kentucky, ruled on a case that shows how inventive insurers can be in their denials — even to the point of invoking drunk-driving laws when the person who died wasn’t in

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a car. U.S. District Court Judge Joseph Hood ruled that Prudential had wrongly denied a $300,000 accidental death benefit to the family of Ernest Loan. Loan, a medical sales representative for Bayer AG, fell down a staircase in his house after drinking three glasses of wine on June 29, 2006, according to court records. Prudential told his wife, Mimi, in a Nov. 7, 2006, letter that 53-year-old Ernest was drunk by state driving intoxication standards. Court Reversal The Loan family sued Prudential in January 2008. Hood initially dismissed the case, saying Prudential's argument was sufficient under ERISA guidelines. The judge was reversed by the Sixth Circuit Court of Appeals, which said drunk-driving law doesn't outlaw conducting chores around the house. "A legal definition specifically intended to apply to someone who is driving a motor vehicle is not rational as applied to someone who is in his home and is not operating machinery," the court wrote. On Nov. 30, 2010, Hood ordered Prudential to pay the family $300,000. The threshold for what judges will accept as evidence in an ERISA case can be so low that an insurer can use Internet searches and not interview witnesses. Pfizer Employee Brad Kellogg, an employee of Pfizer Inc., died in September 2004 when he drove his Dodge Caravan into a tree in Merced, California. MetLife paid his wife, Cherilyn, $443,184 under Kellogg's term life policy. The insurer then received a letter from Stephen Morris, Merced County's deputy coroner. "Mr. Kellogg died as a result of traumatic injuries sustained in a motor vehicle accident," Morris wrote. "His death is considered to be accidental." MetLife refused in November 2005 to cover his $438,000 accidental death policy, saying Kellogg's death was caused by a seizure while driving. The insurer referred to a police report citing an eyewitness to the crash. "It appears that Mr. Kellogg may have possibly had a seizure," police wrote. Cherilyn wrote to MetLife, disputing its conclusion, on Jan. 13, 2006. MetLife again refused to pay. She sued in U.S. District Court in Salt Lake City on July 26, 2006, for breach of contract. MetLife didn't provide medical evidence and didn't specify what kind of seizure, court records show. 'The Low End' Judge Dale Kimball found that MetLife's medical research was limited to Internet searches. The company failed to interview witnesses, the coroner, the police or responding paramedics and didn't obtain Kellogg's medical records, the judge wrote. Even with those findings, Kimball dismissed the case. He said the insurer met the standard of proof under ERISA. "The court need only assure that the administrator's decision falls somewhere on the continuum of reasonableness — even if on the low end," the judge wrote. The U.S. Court of Appeals for the 10th Circuit reversed that decision in December 2008. "MetLife wholly ignored Kellogg's counsel's request for documentation," the court wrote. "The car crash — not the seizure — caused the loss at issue, i.e. Brad Kellogg's death." Kimball then ordered the insurer to pay the full face value of the accidental death policy, as well as $75,377 in legal fees and 10 percent interest. Medical Errors Under ERISA, insurers have also been able to dispute the nature of deaths that involve medical errors. In February 2007, Trudy Barnes, a 31-year-old housewife in Wills Point, Texas, had elective surgery for

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scoliosis, an abnormal curvature of the spine. During the procedure at Baylor Regional Medical Center in Plano, an anesthesiologist incorrectly inserted a catheter into her chest causing massive internal bleeding, a medical examiner found. She died two days later. Barnes's husband, Clint, an aircraft mechanic, had purchased an American International Group Inc. accidental death insurance policy for Trudy in 2004. The coverage came through a group plan from his employer, L-3 Communications Holdings Inc., a New York-based company that maintains Air Force planes. It was Trudy's only life insurance policy. AIG sent a letter to Clint on Sept. 6, 2007, saying it wouldn't pay out on the policy. 'We Regret' "This is an accident-only policy and does not cover sickness or disease," AIG, then the world's largest insurer, told Clint in a letter. "We regret that our decision could not be favorable." Clint Barnes says he couldn't believe an insurer could make up such an excuse. "How could they say that when the death certificate says it's an accident?" he asks. He needed $16,000 for his wife's funeral, he says, and he expected to get the money from her insurance. Barnes sued AIG for breach of contract in July 2008 in New York. His lawyer, Michael Quiat, says insurers face no risk when denying claims under ERISA. "From a business standpoint, it makes perfect sense for them," he says. On Feb. 4, 2010, U.S. District Court Judge Denny Chin granted Barnes's motion for summary judgment, meaning he found the facts against AIG so overwhelming that there was no need for a trial. 'Arbitrary and Capricious' "This was an unintentional, unexpected, unusual and unforeseen event — an accident," the judge ruled. "AIG's determination to the contrary must be set aside as arbitrary and capricious." AIG paid Barnes the $148,000 death benefit, along with unspecified interest and attorney fees of $50,533. New York- based AIG spokesman Mark Herr declined to comment on the case. "It is AIG's practice to conduct a good faith review of all claims submitted to determine whether a particular claim is covered," Herr says. "If a claim is not covered by the policy in question, we do not pay it." Barnes says he can see why life insurers would routinely deny legitimate claims. "They know the average person doesn't know what to do," he says. "They figure you're the little guy. Just pay us your money, and we'll keep it." One of the highest-profile cases of an insurer refusing to pay a death benefit claim involved television correspondent David Bloom. He reported live from Iraq for NBC News for 18 days in 2003. 'Trauma Plates' He spent up to 20 hours a day sitting with his knees bent, jamming his 6-foot (1.8-meter) frame into a 2-foot-by-3½-foot space inside an M88 tank recovery vehicle, says his cameraman, Craig White. "We were unable to straighten our legs, and we weren't able to stand," White says. "Added to this, we were required to wear chemical gear, flak jackets with trauma plates and helmets." On April 2, 2003, Bloom hurt his left foot leaping down from the vehicle to the sand, White says. Four days later, the journalist collapsed and died. He was 39. A blood clot from his leg, called a deep vein thrombosis, had traveled through his bloodstream to his lungs, causing a fatal pulmonary embolism, his autopsy report says. MetLife, which

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provided insurance for General Electric Co., then the parent company of NBC, paid Bloom's wife, Melanie, $2.9 million on his term life policy. The insurer refused to pay on Bloom's $1.2 million accidental death policy. MetLife's Doctor In a denial letter dated July 23, 2003, MetLife said Bloom had died because his genetic background had put him at three to six times greater risk for a deep vein thrombosis than the average person. MetLife relied on Clayton Hauser, a St. Petersburg, Florida, family physician. Hauser is the same doctor who in 1994 performed a drug test that resulted in a new employee at Bankers Insurance Group losing her job because of what she ate for breakfast. The insurer dismissed Julie Carter after Hauser determined she had tested positive for morphine. Actually, Carter was clean; she'd just eaten two poppy seed bagels. Carter sued Bankers under a federal law protecting workers wrongly accused of drug use. She won $859,000 from the insurer. "That's not my fault," Hauser says. "That's what the lab reported. I collected a urine sample." Bloom's Experts In the Bloom case, Abraham Jaros, Melanie's attorney, asked three medical experts to examine Bloom's death, and each determined it was accidental. Kenneth Hymes, a professor at New York University School of Medicine, concluded that MetLife was wrong to blame Bloom's genes for his death. "That would be like saying the cause of a fire was oxygen rather than gasoline or a match," Hymes wrote on Nov. 18, 2003. "Almost every person has some genetic mutation. Mr. Bloom had this gene mutation for 39 years, traveled extensively on airplanes with cramped conditions and experienced no problems." Melanie Bloom sued MetLife in federal court in New York in July 2004. The company settled for an undisclosed amount in October 2005. Melanie declined to comment in detail. "Given the painful and deeply personal nature of this matter, I am not able to participate," she says. In Colstrip, Jane Pierce says the odds are stacked against families when insurers wrongfully deny benefits. "I think it's just a racket," she says. Sitting at her kitchen table, she recalls how her husband's health had been improving just before his death and how she and Todd were looking forward to skiing in the winter. Two years after Todd died, his voice is still on their home answering machine. Jane says she got the strength to fight a life insurance company from Todd, who would never give up. "He'd amaze me," she says.

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