Flaws can cancel life insurance — after death

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American General Life Insurance Co. markets its policies as protection for "the hopes and dreams of American families" — a promise Ian Weissberger took to heart during his losing battle with Lou Gehrig's disease. But after the Cathedral City mortgage broker died in 2005, American General cancelled his life insurance policy and refused to pay his widow the $250,000 benefit.

The Weissbergers' premiums were paid up. There was no foul play suspected. There was no question Sheila Weissberger was the widow and sole beneficiary. And Ian's illness was diagnosed months after he took out the policy.

The problem, the insurer told Sheila Weissberger, was that Ian's application for coverage was incomplete. American General concluded that he had failed to disclose conditions, including bipolar disorder and pulmonary disease, that, according to his doctors, he did not have.

For the company, which collected $2.3 billion in premiums last year, the amount at issue was minute. But it was no small matter for Sheila, 62, who reached a confidential financial settlement with American General earlier this year.

"I lost my house. I lost everything," she said in an interview. "It was very, very devastating."

More often than not, life insurers make good on policies, paying $38 billion in death benefits on individual policies last year.

But what happened to Sheila Weissberger was not unusual. The claims of thousands of beneficiaries are denied or disputed every year — more than 5,000 last year alone — many for allegedly flawed applications, a Times review found.

Overall, the amount of money life insurers withheld from beneficiaries has more than doubled over the last decade, to $372 million last year,

even as policy sales went down, according to a Times' analysis of data compiled by the National Assn. of Insurance Commissioners.

Insurers can dispute claims for a number of legitimate reasons — unpaid premiums, suicide, foul play by the beneficiary. But the No. 1 reason, accounting for about two thirds of disputes last year, is "material misrepresentation." That's failing to disclose information that insurers deem important in assessing risk, and it allows insurers to rescind coverage altogether.

To stop abuses by insurers, most states long ago banned limitless rescissions, but in California and elsewhere, they are allowed during the two years immediately after a policy is signed.

Experts and consumer advocates say some insurers have turned that into a "gotcha period," seizing on flaws after claims are made that they could have looked for before issuing coverage.

"Regulators need to come down hard on companies that are rushing applications through in order to gain premium income without taking time to screen the risks, then using rescission to control payouts and increase profits," said Amy Bach, an advisor to National Assn. of Insurance Commissioners and executive director of United Policyholders, a nonprofit consumer group.

Industry representatives say the power to rescind policies and withhold benefits is essential and fair. Accurate information is "crucial to the agreement and to the actuarially sound pricing of the product," said Steven Brostoff, a spokesman for the trade group the American Council of Life Insurers.

Yet some companies deny benefits far more than others.

American General, which ranks 11th in national market share, withheld more money than any other life insurer — $36 million — in disputes of 79 individual death claims in 2009, including several rescissions.

The company, a Houston-based subsidiary of American International Group Inc., declined to comment on the Weissberger case. In a statement, the insurer said that its record should be considered in light of its size and that it follows "the standard that has been California law for more

than 100 years.”

In contrast, Minnesota Life Insurance Co., another large insurer with $2 billion in annual sales, reported no disputes last year and no rescissions for three years on individual death claims.

“A life insurance policy is a promise to pay, and we at Minnesota Life are focused on keeping our promises,” said Craig Frisvold, a vice president at parent company Securian Financial Group.

The company takes an average of more than two months to vet applications and, in about a third of cases, gathers medical records to corroborate or clarify the applicants’ medical histories.

“The more information you get,” Frisvold said, “the less surprises there are and the less rescissions there are.”

Sheila Weissberger’s attorney, William Shernoff, said it is a matter of acting in good faith.

“You don’t wait until a guy dies to determine insurability,” he said. “That’s not fair.”

‘Nothing was hidden’

When American General sent a medical technician to examine him 2003, Ian Weissberger did not paint a rosy picture of his health.

Then 62, Weissberger reported that he had smoked 20 to 30 cigarettes a day for 40 years; that he was taking Zocor for high cholesterol and that both of his parents had died of heart attacks, according to his application. In signing the form, he authorized the company to contact his physicians and review his medical records.

“Nothing was hidden from them,” Sheila Weissberger said.

American General issued Weissberger a $250,000 policy with a monthly premium of $512.53, the “standard tobacco rate” for a man his age. A year later, Weissberger was diagnosed with amyotrophic lateral sclerosis, a nervous system disorder. Six months after that he was dead.

After her husband’s death, Sheila Weissberger said, the company sent a private investigator to her door, seeking permission to pull years of medical records.

An American General claims investigator in Houston deduced from the records that Weissberger had bipolar disorder, chronic obstructive pulmonary disease, also known as COPD, and depression but had failed to disclose these conditions on his application.

Seven months after Sheila Weissberger submitted her claim, American

General denied it, sending her a $10,452 check, a refund of the couple's premiums. On the back was some fine print that would have waived her right to challenge the denial in court. She did not sign.

Ian Weissberger's primary physician, Dr. Robert McPeake, sent a letter to the company vouching for the accuracy of his patient's application.

"At no time did I feel he was bipolar," the letter said.

McPeake's letter said he had prescribed an anti-depressant for routine work-related stress. The application, which was reviewed by The Times, had not asked about depression.

Another of his physicians later testified that he had mentioned COPD as a potential concern in the records, because of Weissberger's smoking, but never had diagnosed it.

American General stood by its decision, and Sheila Weissberger sued, contending American General had acted in bad faith.

Unable to afford payments on the couple's home, she moved into a $400-a-month room. Distraught, she quit her sales job and began caring for elderly people to make ends meet.

"My husband loved me very much, and he always wanted to make sure that if anything happened to him, I would be covered," she said. "Everything he thought was covered fell apart."

Shernoff and other industry critics contend that life insurance rescissions are very similar to those long employed by health insurers, a practice that ignited bipartisan outrage last year and was prohibited under the federal healthcare reform law except in cases of fraud.

Earlier this year, days before testimony was set to begin in the Weissberger case, Riverside County Superior Court Judge Gary Tranbarger also made that link, citing a 2007 appellate court ruling in a case against health insurer Blue Shield. That court ruled that it was "patently unfair" to offer insurance, then pull coverage after a claim was submitted. "If the insured is not an acceptable risk, the application should be denied upfront, not after a policy is issued," the appellate court said.

American General, Tranbarger ruled, should be held to a similar standard: A jury should decide whether the company conducted a

“reasonable” investigation of Weissberger’s application before issuing coverage and, if it did not, the company would have to prove Weissberger intentionally omitted information.

The case was settled the next day.

Security for his family

A repairman in his mid-50s, Hugh Devlin wanted to make sure his daughters could get through college if anything happened to him.

An insurance agent said she could more than double his $200,000 policy with AXA Equitable Life Insurance Co. without raising his premium, recalled his wife, Ivy. The couple met with the agent, who asked questions and filled out the application herself. According to a copy reviewed by The Times, Devlin reported an operation six months earlier, in December 2007, for a work-related back injury.

Equitable issued the $450,000 policy. But when Devlin died of a heart attack 18 months later, at 57, the company refused to pay the claim. Ivy Devlin said she was visiting her husband’s Hugh’s grave when an Equitable representative called her cellphone with the news.

“I just felt like I was abandoned,” she said. “It was a hit against the family, Hughey’s integrity, my integrity.”

In a letter to Ivy Devlin, Equitable said Devlin had failed to disclose a follow-up hospital visit for a fever that developed the day he was discharged after his back surgery. “Had we known this information, this policy would not have been issued,” it said.

The company offered to pay the amount on Devlin’s original $200,000 policy. But his widow refused and sued. She argued that the second hospitalization was not hidden from the insurer; it had been part of the back surgery treatment episode. The couple had assumed that the fever was related to the surgery, but the cause was not diagnosed as far as they knew, she said.

“We signed a release for his medical records,” Ivy said in an interview, “so why would we hold anything back?”

The case is pending.

Equitable collected more than $2.2 billion in premiums last year and reported withholding $12 million related to 10 disputed claims.

Without discussing the case, spokesman Chris Winans said that it’s

routine to examine a policy in effect for less than two years “to make sure everything’s in order.” The company, he said, has “a financial responsibility not to jeopardize our ability to pay claims by paying illegitimate claims based on misrepresentation or fraud.”

Nearly collected

Bang Lin, a 37-year-old Irvine business owner, died in 2006 of stomach cancer, leaving a wife and two school-age children.

Had Lin died three weeks later, the two-year “contestibility” period would have been over. His family would have collected $1 million. Instead, Metropolitan Life, the nation’s largest life insurance company with $8.6 billion in annual sales, rescinded the policy, alleging misrepresentation.

The issue was not the cancer; that had been diagnosed 15 months after he took out the policy. Rather, the company alleged Lin had failed to mention in his application that he had been successfully treated years before for hepatitis B, a condition unrelated to his death.

Jean Lin sued. She said the agent had filled out the application, not her husband, and that she never asked about hepatitis. In any case, Jean Lin said the information was in her husband’s medical records and the firm could easily have ordered a hepatitis B test.

The agent said in a deposition that she had asked all the required questions. The application shows a check in the “No” box next to hepatitis B, according to court papers.

A federal judge in New York, where the company is based, ruled last year that it didn’t matter why the information was missing: The application submitted was false, so the company had a right to rescind. Lin’s lawyer, Eric Dinnocenzo, has filed an appeal.

Though it declined to discuss the case, Metropolitan Life issued a statement saying it had disputed about 0.05% of the total number of claims filed in the last five years because of misrepresentation. Last year, the Times found, the company withheld $13.3 million overall in 82 disputes.

“In order to accurately assess the degree of risk presented, and to be fair to all current insureds, the company depends on proposed insureds

to be truthful about their medical histories," the statement said.
The case could take years to resolve. In the meantime, Jean Lin has closed the family business, sold her home and moved her teen-age son and daughter into a condominium.
"I thought we had very good protection," she said. "I didn't expect that they would refuse to pay."