GROUP COVERAGE IS NOT THE SAME AS INDIVIDUAL COVERAGE

Millions of Americans are grateful to their employers for the employee benefits they provide in connection with their jobs. Many of them are a bit less grateful in light of the cuts over recent years and the increasing expense of these benefits. But to anyone who is uninsurable under individual medical and disability insurance policies, the coverage is a godsend. And by and large, the cost of such plans is subsidized to a greater or lesser extent by the employer, using pre-tax dollars.

However, there are some serious differences between group and individual policies that you should be aware of.

Governance of Insurance Claims.

All insurance companies are regulated by state law. The federal government has the right to regulate insurance companies, but has declined to do so. So policy language and claims practices are regulated by the state in which the insured resides at the time the policy is purchased. The states and the National Association of Insurance Commissioners (NAIC) have developed an extensive framework of regulations that have been designed with the primary purpose of protecting consumers against insurance companies. These include, among others, a set of unfair claims practices, including requirements that claims be promptly and fairly investigated, that valid claims be paid, that denials be based on valid reasons, etc. Typically, a state will have a specific statute such as California Insurance Code §790.03(h), which provides that:

State courts have complemented these protections through decisions and legal doctrines that have, by and large, followed the same philosophy. As a result, there have been many cases where insurance companies have been forced to pay substantial judgments for failing to pay promptly, failing to investigate, denying claims without a valid reason, or other practices deemed unfair by laws of the state where the action is brought.

Prior to 1974, the federal government and courts have had little experience with insurance claims, except in cases of diversity, where the laws of one state or another would be applied by the federal court. There was no body of common law relating to the interpretation of insurance contracts in the federal courts.

The Employee Retirement Income Security Act (ERISA), which became law on September 2, 1974 (labor day), was to change all that. ERISA was enacted to protect the interests of employee benefit plan participants and their beneficiaries by requiring the disclosure to them of financial and other information concerning the plan; by establishing standards of conduct for plan fiduciaries; and by providing for appropriate remedies and access to the federal courts. The law grew out of a series of pension failures that left millions of Americans without promised benefits when their employers went out of business or mismanaged pension fund assets.

ERISA governed not only pension plans, but all employee benefit plans. That included health insurance plans, disability plans, long term care plans, and dental insurance plans.

Because the law was enforceable only in federal courts, it had the effect of preempting almost all state law claims that could previously have been made under any group insurance policy. These types of claims, such as the failure to pay disability benefits, refusal to pay for health care, refusal to pay accidental death claims, which had previously been brought in consumer-friendly state courts with powerful laws to protect against unfair claims practices, would now be brought in federal courts under ERISA.

The state claims practices laws were preempted by ERISA, which contained no specific unfair claims practices limitations, but only a general admonition:

§ 1104. Fiduciary duties

> (a) Prudent man standard of care
> (1) Subject to sections 1103 (c) and (d), 1342, and 1344 of this title, **a fiduciary shall discharge his duties with respect to a plan**
>
> (A) **for the exclusive purpose of:**
> **(i) providing benefits to participants and their beneficiaries**; and
> (ii) defraying reasonable expenses of administering the plan;"

There are no punitive damage claims for outrageous conduct by the insurance company. Attorneys' fee recovery is discretionary and rarely granted. The standards of review of the denial are entirely different than in state court. And you can't get a jury trial.

These laws were written to encourage employers to provide employee benefits and to protect them from undesirable consequences. The employee protections they provided were secondary.

Thus, the group insurance policy is interpreted under an entirely different set of rules, though it may be identical in form and language to an individual policy issued by the same company in the same state.

Pursuant to 29 U.S.C. § 1002 there are two types of "employee benefit plans". They are "employee welfare benefit plans" and "employee pension benefit plans". "Employee welfare benefit plans" are defined as ". . . any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . ." 29 U.S.C. § 1002(1). (Pension benefit plans are beyond the scope of this article.)

Under modern ERISA plans, the plan fiduciary almost always has discretion to determine benefits under the plan. The applicable standard of review of the denial of a claim is the "reasonableness standard". In other words, if there was any "reasonable" basis for denying your claim, whether or not it was correct or in accordance with the ordinary rules for interpretation of insurance contracts, it will usually be upheld. Federal district courts confine their inquiries to whether or not there was a reasonable basis for the denial of coverage. They do not consider whether the denial was correct under state law.

There are many cases where the fiduciary is also the claims payer, such as where the plan fiduciary is the insurance company itself or where the plan fiduciary delegates its authority to the insurance company to administer the plan. In those cases, the decision is subject to a higher level of scrutiny.

Under ERISA, the claimant is required to exhaust the administrative appeal process before resorting to court procedures, even where the policy itself contains no such restrictions. And make no mistake. The administrative claims process is critical to the ultimate success of your claim.

The denial letter and the plan do not necessarily advise you of the mandatory nature of this process. They also do not advise you of the fact that the information you submit during the appeals process may be the only information that you will ever be able to use, even if you file suit after going through that process.

This effectively means that you must present your entire case, including witness testimony and expert witness opinion testimony. You will not be permitted to take depositions, because you cannot file suit until the administrative remedy is exhausted. So there may be critical evidence that you are unable to present to the administrative appeal body. The entire process is fraught with problems with limited or inadequate solutions.

The court has discretion to allow evidence that was not submitted in the administrative claims process *only if such evidence is required* in order to make a proper determination. Otherwise, the court may not even consider that evidence. That means you have to prepare your case as if you were going to trial, before you ever file the court action, or risk your evidence being disallowed. It means witness statements, expert witness opinions, and medical records evidence must be compiled within the short time frame within which the appeal of the denial has to be submitted – usually only sixty days. This obviously places an extraordinary burden on the claimant and his or her attorney.

Many attorneys familiar with insurance claims and bad faith issues may be partially or wholly ignorant of the ERISA requirements in group policies – they do not appear anywhere in the policy language. The filing of a court action without first exhausting the administrative remedies provided in the plan will almost certainly obviate any claim, even a completely legitimate claim where the administrative appeal would

have been granted. You will in almost all cases be too late to institute an appeal after you find out in the course of litigation that it was required as a prerequisite. Of course, the denial letter must inform the plan participant of these requirements.

ERISA litigation is conducted only in federal court. There is no preemptive challenge to a judge you don't happen to like. As previously pointed out, you are not entitled to a jury trial on ERISA claims. The common law on which the outcome of the case turns will be federal common law, not state common law. Although in many cases these may overlap, the state cases generally provide much greater protections to policyholders than do the federal cases.

Even in cases where the denial is clearly contrary to federal decisional law and/or ERISA rules, the usual remedy is to remand the claim to the claims administrator for reconsideration. This simply gives the insurance company another bite at the apple, and more often than not, the company will find another (more acceptable) way to re-deny the claim. Thus, you can win the war, but lose your case anyway.

Advantages of Individual Plans.

In individual plans, by contrast, there are a number of statutory and common law rules that favor the insured. These include:

1. the insurance policy is considered to be a contract of adhesion, and all ambiguous terms are interpreted in favor of the insured, or at least in a manner in which the insured would reasonably have understood them.

2. the insurance company's violation of the statutory provisions of the insurance claims practices law is presumptively an act of bad faith. This fact is a powerful motivating force for the company to settle claims.

3. Denial of a claim for an invalid reason cannot be cured by a later denial based on a valid reason.

4. Upon denial, the insured has an immediate right of court action.

5. The court will interpret the policy, not send it back to the claims administration department.

6. The insurance company cannot change its reason for denying the claim, even if it later learns facts that would have justified the denial

7. You can take the insurance with you when you leave your job.

8. If the claim was denied in bad faith, you can recover attorneys' fees and punitive damages.

9. Courts interpret ambiguous clauses in the contract in the manner most favorable to the insured.

One caveat: group health policies have some major advantages over most individual policies in that: 1. They cannot be rescinded; 2. They usually provide better coverage, and 3. The employer pays part of the premium. Even if you leave your job, you are afforded important protections under COBRA. For example, if you are uninsurable, you can exhaust your COBRA benefits and then get a HIPPA policy that cannot be rescinded.

However, group accident and disability insurance plans, although much cheaper than individual policies, are manifestly inferior to individual plans. On these plans, it may be worthwhile to check out whether the employer would be willing to contribute to an individual plan instead of the group plan. Or, if you can afford it, pay for it yourself. You may be avoiding the biggest headache of your life.