

# THINK YOU'RE INSURED?

**Why do insurance companies play rough with legitimate claims? And, more important, what can you do if it happens to you?**

BY WALTER UPDEGRAVE  
AND KATE ASHFORD

»»When Jacqueline Epcar of Valley Glen, Calif. turned 19 last year, she no longer qualified for coverage on her parents' health plan. So her mother, Ellyn, signed her up for a new individual policy with Blue Shield of California. The insurer cashed the Epcars' check, and their broker gave Ellyn a policy number and told her coverage would start July 1. Shortly after, Jacqueline went to the doctor with a sore throat—she'd been getting them for months. The doctor in turn sent her to a specialist, who ordered a white-blood-cell scan. The scan indicated an auto-immune disease.

That's when Blue Shield decided that it hadn't really meant to cover Jacqueline after all. The insurer sent a letter explaining she was not eligible for a policy because she had, among other conditions, inflammatory acne. But she didn't. So the Epcars refuted the information. Blue Shield then sent a new rejection letter saying Jacqueline's policy hadn't been in effect when she was diagnosed,

and it wouldn't cover someone with an auto-immune disease—even though it had already taken Ellyn's money and given Jacqueline a policy number. The rejection left the Epcars with \$8,000 in medical bills, an uninsured daughter (later diagnosed with lupus) and bitter feelings toward their insurer. "They just didn't want to cover somebody who had a problem," says Ellyn. (Luckily, the family did find other coverage. Blue Shield declined to comment.)

Most of the time, when insurers don't pay, the reason is obvious. Maybe you missed a premium payment or forgot to mention last year's quadruple-bypass surgery on your application. Or maybe your policy's fine print excludes the kind of damage you incurred. But sometimes, as in the Epcars' case, an insurer's reason for not paying is...well, hard to fathom.

Are insurers more hard-nosed with claims than they used to be? Since the industry is regulated by the states, there are no national data to draw on. But the

# MAYBE NOT.

scattered state-level evidence suggests that insurers may be taking a harder line. In Michigan, for instance, complaints against insurers are up 16% over 2001, while in Connecticut, justified complaints against health insurers (those considered to have validity by regulators) have risen more than 60% since 2000. Enforcement action is up too: In Texas last year the number of cases against insurers increased 21% compared with 1999.

Current headlines, meanwhile, leave a strong impression. For starters, there's the ongoing Hurricane Katrina saga, in which companies like Nationwide, State Farm and USAA debate thousands of plaintiffs on such existential issues as whether the damage to the Gulf Coast was due to flooding, which typically isn't covered, or wind, which is. In California, meanwhile, Blue Cross recently settled more than 60 cases in which policyholders claimed their coverage had been unfairly voided, and regulators slapped both Blue Cross and Kaiser Foundation Health Plan with six-figure fines for wrongful rescissions. (The carriers say they're working with state regulators to improve their practices.)

Against this contentious backdrop, it's ironic that insurers are thriving. Big public health carriers have been posting 20%-plus gains in earnings, and property/casualty companies (which cover, for example, autos and homes) are more profitable than ever.

Or maybe it's not so ironic. A study this January by Robert Hunter, a former insurance commissioner of Texas, now the insurance director of the Consumer Federation of America,

shows that property/casualty insurers are paying out less in claims relative to the premiums they collect than at any time in the past 20 years. (See below.) That's partly due to smart underwriting and higher premiums, which have jumped 100% or more in some coastal markets over the past few years. But lower claims payouts also play a role. Hunter, along with a chorus of consumer advocates, attributes some of that to increasingly aggressive claims management across the industry. More bare knuckles in the claims department, more battles with consumers.

### HARDBALL WITH HOMEOWNERS

Don't ask Geoff Still about claims management. In October 2005, a hurricane nearly lifted the roof off his home in Coral Springs, Fla., drenching the interior with torrents of rain. Still, now 38 and the director of finance and operations at a local

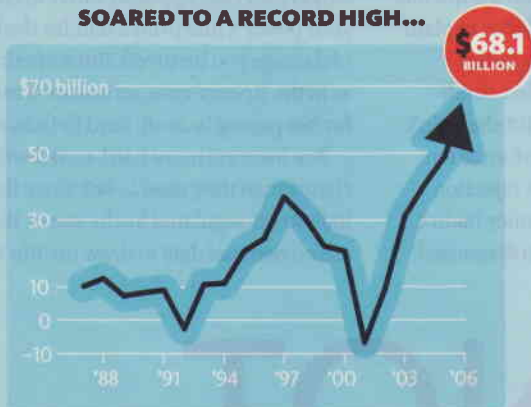
**"I believe 100% that they're purposely lowballing my claim."**

university, says he called his insurer, Universal Property & Casualty, the next day to report his loss. But it took four months, plus numerous follow-up calls and faxes with "Please Help Us" in 36-point type, to get an initial estimate. Meanwhile, mold spread through the house, and Still, his eight-year-old son, his five-year-old daughter and his wife Stacy, 34, then pregnant with their third child, had to move out.

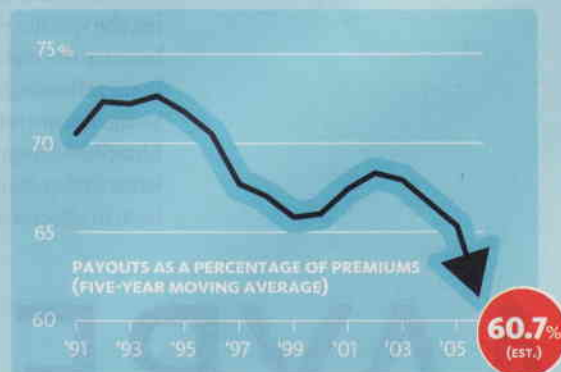
## FEWER OF YOUR PREMIUM DOLLARS ARE COMING BACK TO YOU

The less insurers pay out in claims, the more your premium dollars turn into profits. As the charts below show, payouts relative to premiums have been dropping and insurers' bottom lines have been rising.

**INSURERS' PROFITS HAVE SOARED TO A RECORD HIGH...**



**...HELPED BY A 20-YEAR LOW IN PAYOUTS TO POLICYHOLDERS.**



NOTE: Payouts are claims paid as percentage of premium dollars for the top 10 property/casualty insurers. SOURCE: Consumer Federation of America, based on A.M. Best figures.

## LOWBALLED

GEOFF AND STACY STILL  
—Coral Springs, Fla.

After a hurricane made their house unlivable, the Stills were offered \$64,000 for repairs from their insurer. Estimated cost of the fix-up: \$175,000.

The insurer's first offer came in at \$64,000, later upped to \$94,000—far less than the \$175,000 in estimates Still had gotten for fixing the roof, replacing drywall and installing new floors. He turned down the offer and hired a lawyer. Shortly after, Universal sent his lawyer a check for \$94,000, even though Still had rejected that amount as too low. At that point he had his lawyer file suit against Universal. As of late January, 15 months after the storm, Still and his family (including his new baby boy) are still living with his parents. "I believe 100% that they're purposely lowballing my claim," says Still. "They figure you have to take their offer because you need to move on."

Universal's response to his theory is unknown, since the insurer did not return MONEY's calls. But it sounds right to Santa Fe plaintiffs attorney David Berardinelli. Berardinelli is the author of *From Good Hands to Boxing Gloves*, a book based on some 12,500 PowerPoint slides that fell into his hands during a lawsuit against Allstate Insurance Co. The slides had been presented to Allstate between 1992 and 1997 by management consultant McKinsey & Co. as part of an overhaul (the Claim Core Process Redesign) of the insurer's claims handling process.

Much of the presentation encourages Allstate to adopt a hard-nosed approach to claims. One typical slide picked from the book refers to taking a stricter stance on settlements: "Stand firm on final offer with no real negotiation." Another—and the inspiration for the book's title—distinguishes between the treatment to be accorded to customers who hire a lawyer to press for a higher payout and those who don't: The unrepresented get the "good hands" approach (settlements within 200 days or so); the lawyered get "boxing gloves" (resolution that could take three years or longer). Think of it as the Oliver Twist strategy: Accept the company's initial offer (which may seem more fair to Allstate than it seems to you) and you'll get your money quickly. Ask for more and you may be in for a battle. And



while the slides specifically deal with Allstate's auto division, Berardinelli and others familiar with the project contend the concept was applied to homeowners as well.

The strategy outlined in the slides sounds much like the marching orders Shannon Brady Kmatz says she got when she was an Allstate claims adjuster. Kmatz, who left Allstate in 2000, says she felt under constant pressure to "fast-track" claims—that is, settle quickly for as little as possible. "We called it throwing them a bone," she said. "You offer \$500 and hope they go away." She said she was also evaluated on how successful she was at convincing people to accept the company's offer rather than try to get more money by hiring an attorney. Adjusters who excelled at these goals, Kmatz says, were rewarded with free dinners and bonuses that could add up to a few thousand dollars a year. Kmatz provided evidence of such bonuses in a 2003 affidavit that is part

of a class-action suit Berardinelli has filed against Allstate, and MONEY has reviewed those documents.

Allstate wasn't the only insurer to ask management consultants to help revamp claims processing, say several former claims adjusters. McKinsey helped State Farm with the program known as ACE, or Advancing Claims Excellence, and Accenture advised Farmers Insurance, which had a claims program called ACME, short for Achieving Claims Management Excellence. (McKinsey and Accenture would not comment on their role, citing confidentiality.)

All three insurers confirm the projects took place but deny that they were intended to help them short-change policyholders in any way. "Ridiculous and completely false," says Allstate spokesman Michael Trevino. He points out that Berardinelli has an obvious interest in exaggerating the import of the slides to try to promote his book. And he says the company does try to settle claims quickly, but not at the expense of policyholders. State Farm and Farmers also reaffirm their commitment to paying what they owe promptly and fairly and point out that the projects in question ended several years ago, implying that whatever effect the consultants may have had on claims handling, it isn't relevant today.

That may be, but it would be unusual for a business to hire a consulting firm with the intention of tossing out their work as soon as the M.B.A.s went home. Gary Fye, a claims consultant familiar with all three companies, agrees. "These practices continue today," he says.

One thing is not in dispute: All three insurers have made startling progress in lowering their claims payout ratios since they engaged the consultants. At Allstate, claims paid fell from 87.2% of premiums charged in 1992 to 43.5% last year, according to the CFA's Hunter. At State Farm the ratio dropped from 77.5% in 1994 to 66.6% in 2005 (the most recent figure available),

**"This just isn't right. They didn't even bother to do due diligence."**

while at Farmers it fell from 74.7% in 2001 to 56.9%. Claims management certainly didn't account for all of the drop. But whatever the insurers are doing in that regard, it's working.

➤➤ **An insurance company that wants** to hold down payout costs has several ways to do that apart from "throwing you a bone." One involves the software designed to help assess financial damages. The program most widely used in homeowners coverage, called *Xactimate*, comes preloaded with



**DENIED**

BARBARA AND DON SAXBY  
—San Rafael, Calif.

After Don Saxby had an expensive operation, his insurer rescinded his policy. Now he and wife Barbara owe more than \$400,000 in medical bills.

typical repair and replacement prices for more than 15,000 items, broken down by zip code. Thus armed, an adjuster can walk through a house, plug in information such as the number of windows that must be installed and the area of carpeting to be replaced and quickly deliver an impressively precise itemized assessment of what it will all cost.

The adjuster might not mention, however, that it's possible to override the prices in *Xactimate*. An insurer might instead insert fees charged by "preferred" vendors who agree to work at discounted rates to get regular referrals from insurers. Farmers spokesman Jerry Davies

confirms that Farmers occasionally does this in markets where its vendors can beat the going *Xactimate* rate, but he adds that its vendors do "top-quality work." Even so, you may prefer to have your home rebuilt by a contractor beholden to you, not your insurer—but if you do, you may have to pay the difference yourself.

If you have replacement-cost coverage on your house—and you should—be alert to another potential pitfall. (Replacement cost is a type of policy that promises you'll be paid the full amount needed to repair or replace your damaged property.)

# WHO IS IN DENIAL?

According to America's Health Insurance Plans, an industry trade association, **insurers initially deny about 4% of health claims, and some of those denials are eventually overturned on appeal.** But a study of 8,000 physicians in 33 states by Athenahealth, a medical-billing management company, suggests that **denial rates by several leading health insurers may be considerably higher.**

## DENIAL RATES (BY COMPANY)

UnitedHealth Group	14.4%
Aetna	10.3%
Wellpoint	9.0%
Humana	8.6%
Medicare B	8.5%
CHAMPUS/Tricare	7.1%
Cigna	7.1%

## INDUSTRY ESTIMATE

4.2%

NOTE: Company data is from the second quarter of 2006.

Most companies initially reimburse you only for the "actual cash value" of your loss, or replacement cost minus depreciation. To get the additional benefit, you have to provide receipts showing how much you actually paid.

If you can't pay up front, you may be out of luck, says Steve Strzelec, a Seattle claims consultant. Meanwhile, many policyholders who do pay out of pocket never get the extra money to cover their replacement costs because they don't know they're entitled to it. How much is left on the table? Hard to tell. But an internal study made public during a lawsuit this year estimated that in 1999 alone State Farm customers failed to claim as much as \$135 million in replacement-cost benefits. The insurer told MONEY it began paying replacement costs up front in 2000, but saw an "unexpected spike" in claims, so it returned to paying only actual cash value up front in 2003.

**»» So how do you protect yourself when you make a claim?** It should be clear by now that the prudent course is not to assume that your insurance company will automatically offer you all you're entitled to. Even before

the insurance adjuster arrives, contact a few contractors in your area to get estimates of what it will cost to restore your home to its original condition. If the insurer matches those estimates, great. If not, you'll have a better sense of how much more you need to push for. If your carrier won't budge from an offer you feel is too low, invoke the appraisal clause that's part of most homeowner policies. You and the insurer both hire appraisers, and they try to agree on a binding settlement. If they can't, an umpire selected by the appraisers or a judge will arrive at a figure.

If you feel the adjuster you've been dealing with is stalling or delaying your claim, explain your view of the situation in a letter to the claims manager who oversees the adjuster and request that the manager intercede to expedite the claim. If that doesn't bring satisfaction, move up to the regional claims manager and, if necessary, the executive in charge of the claims department.

And if you have replacement-value coverage and receive only the actual cash-value portion of your claim initially, keep meticulous receipts of what you shell out for materials and labor. You'll need them to claim the share that was held back once the job is done. Also be aware that many insurers may be willing to advance the full replacement cost up front once you sign a contract with a builder to do repairs—if you ask. So ask.

## YOU'RE COVERED...THEN YOU'RE NOT

Waiting for an overdue reimbursement check is a hassle. Finding that your health insurance has been nullified after you've incurred serious medical costs can be an outright catastrophe. Called "rescissions," such ex-post policy denials are rare—insurers say they affect only about 1% of individual policyholders (they don't occur in employer-sponsored group plans)—but the practice appears to be growing. Last year, for example, California regulators launched investigations into the rescission practices of Blue Shield, Health Net, PacifiCare and other providers. Meanwhile, the Connecticut Department of Insurance is also investigating Assurant Health after 15 of 20 complaints to the state attorney general involved its use of

**“They just didn't want to cover someone who had a problem.”**

retroactive denials of coverage. (Assurant asserts that it enacts rescissions only when policyholders don't provide truthful or complete information during enrollment.)

Rescission is, in effect, the neutron bomb of health insurance. If you're hit by one, you're not only left without insurance to cover the illness at hand, but you're also liable for your previously paid claims. In some states, insurers can't void your policy unless they can show you meant to deceive them; in others, including Michigan and Ohio, they can drop the bomb over any

inaccuracy, even an innocent mistake. "This is a very serious concern," says Cindy Ehnes, director of California's Department of Managed Health Care. "The consequences of failing to list something as simple as headaches can be profound."

Consider Barbara and Don Saxby of San Rafael, Calif., a self-employed couple who applied for an individual health insurance policy with Nationwide in January 2006. When Barbara showed the application she'd submitted to Don, he pointed out a couple of gaps in his medical history. Barbara called Nationwide to correct the application, but was told not to worry, the insurer would catch omissions during underwriting. Shortly after the policy went into effect, Don, 41, tore most of the ligaments in his left knee in a skiing accident. The ensuing surgery was unusually expensive, partly due to a condition in which Don's blood doesn't clot normally. (The blood condition was on record with his doctors, who didn't consider it a problem. Nor had it stopped Don from qualifying for insurance in the past.) In December, Nationwide sent a letter rescinding Don's policy due to a "misrepresentation" on the application. The Saxbys now find themselves saddled with more than \$400,000 in medical bills and are pursuing litigation against Nationwide. "This just isn't right," says Barbara. "They don't even bother to do due dili-

gence." (Nationwide declined to comment on the case.)

For many applicants, the trouble starts when they sign a medical release giving insurers access to their medical records. Don't assume the insurer is going to examine those records before okaying coverage. It may not follow through, says Paul Roller, a former insurance commissioner of Alaska who's now a plaintiffs lawyer in California. "The company takes the position, 'We have a clean application so there's no need to get records,'" he says. "The insurer, in effect, says, 'If I know about a condition and you get sick, I'll have to pay. So don't tell me.'"

The period of convenient ignorance ends, of course, as soon as you file a claim. Many insurers use software that singles out claims for review by diagnostic code. The review then determines if you may have had a pre-existing condition or left anything off the initial application. While insurers need to protect themselves from people who misrepresent their health status to get coverage, the potential for abuse is obvious: An insurer looking to lower risk can use the review to find any excuse not to pay an expensive claim. Says Connecticut Attorney General Richard Blumenthal: "There is powerful evidence that 'look back' provisions are used systematically to exclude people with valid claims simply because those claims are expensive."

## WHAT MORE YOU CAN DO

You can improve the odds that you'll collect the policy benefits you expected, if and when you need them, if you take these steps.

### PREVENTIVE MEASURES

» **Keep good records.** Create an inventory of your possessions to make it easier to document any losses. You can download a home inven-

tory form at the Policyholders of America website ([Policyholdersofamerica.org](http://Policyholdersofamerica.org)) or create your own video inventory by walking through your home, recording each item and narrating pertinent details, such as the cost. Keep records of remodeling jobs as well as building plans that attest to your home's size and type of construction. Store copies of these records in a repository outside your home (like a safe-deposit box) so they're not lost in a fire or other disaster.

» **Be frank.** If you're applying for an individual health insurance policy, err on the side of providing more info. Spell out any condition for which you've seen a doctor or been treated. If you need more

space, attach an explanation. "Writing a letter about the knee problem that went away five years ago is appropriate," says Maureen Smith, director of consumer relations for Connecticut's Office of the Health Care Advocate. If the application has only four or five broad questions, offers instant approval or asks for your lifetime medical history (instead of a specific period like 10 years), consider going with a different company.

### » **Read the fine print.**

Renewing your homeowners policy or buying a new one? Make sure the policy doesn't include special deductibles for wind damage, onerous limits on replacement costs or other expensive restrictions on coverage, advises Robert

Hunter, director of insurance for the Consumer Federation of America. Switching employer health plans or buying an individual policy? Read the plan documents carefully, noting the policy's exclusions and limitations, as well as its appeals process (including deadlines). If the plan won't cover treatment you're likely to need, better to know that up front.

### » **Be a Boy (or Girl) Scout.**

Before you go in for an expensive health procedure, call your insurer to make sure that it's covered. Get pre-approvals and referrals, as required. Document your calls (jot down the name of the representative, date and time) and keep copies of referrals and other relevant paperwork.

## »» So what should you do if your health policy is rescinded?

File an appeal with your insurer right away. And if the company sends you a check refunding your premiums, don't cash it. That can be taken as tacit agreement, says Bryan Liang, executive director of the Institute of Health Law Studies at California Western School of Law in San Diego. If you lose the appeal, file a complaint with

your state. If all else fails, consider hiring an attorney.

Meanwhile, shop for a new policy. If you live in a state like Massachusetts, where insurers are required to offer you coverage, you'll likely pay more, but at least you'll be insured. In states like California, which allows insurers to refuse to sell a policy to anyone with a previous medical condition, you may be relegated to your state's high-risk insurance pool.

Obviously it's better to try to avoid rescission from the get-go. When filling out an application for a policy, err on the side of telling too much, noting any condition you've ever been seen or treated for. And if you've been with a health plan for two years or more, be cautious about switching carriers. Rescissions are typically allowed only within the first two years of a policy.

Liang, for one, sees practices like rescission and lowballing as a sign that insurers—property and casualty companies as well as health carriers—sometimes forget the business they're in: buying risk. "Risk means you win some, you lose some—you can't eliminate it," he says. "That's not what insurance is about."

The best insurers know that. But to assume yours is one of them may be taking on more risk than you should. \$

FEEDBACK: [wupdegrave@moneyemail.com](mailto:wupdegrave@moneyemail.com); [kashford@moneyemail.com](mailto:kashford@moneyemail.com)

## WHERE TO GO FOR HELP

Preparing to file a claim? Concerned you're not getting the full benefit you're owed? Check out these online tools and tips.

Families USA  
[familiesusa.org](http://familiesusa.org)

Find state agencies that help with health insurance issues.

Georgetown University Health Policy Institute  
[healthinsuranceinfo.net](http://healthinsuranceinfo.net)

Go here for state-by-state guides

that spell out your rights as a policyholder.

National Association of Insurance Commissioners  
[naic.org](http://naic.org)

Get direct links to state insurance departments.

Policyholders of America  
[policyholdersofamerica.org](http://policyholdersofamerica.org)  
Download home inventory forms and get help crafting effective complaint letters.

United Policyholders  
[unitedpolicyholders.org](http://unitedpolicyholders.org)  
Go to Claims Tips for advice about the best techniques for filing claims and resolving disputes quickly and fairly.

## MAKING YOUR CLAIM

### »» Do your homework.

Don't automatically accept an insurer's damage estimate; instead, document the claim yourself. If, say, a storm has seriously damaged your home, get bids from three qualified local contractors and have them spell out exactly what repairs are needed and what that will cost. If the insurer's estimate comes in appreciably lower than your own, the estimates will provide you with evidence to help make the case for a higher payout. (For tools to help you file a more effective claim, see "Where to Go for Help," above.)

»» **Keep your cool.** Getting angry with an adjuster or other insurance rep rarely helps your case and could hurt it. "It might make you feel better, but if you get angry, more than likely your file is going to the bottom of the pile," says Susan Dressler, owner of Health Claim Assistance, who spent 17 years working in the claims department of several insurers. Instead, get the name and phone extension of anyone helping with your claim and make him your ally.

»» **Don't take no for an answer.** If you're turned down for a higher payout or

your claim is denied altogether, appeal. Relatively few policyholders challenge coverage decisions, but those who do are often successful. Studies show that nearly half of appeals are decided in favor of the consumer.

»» **Get help.** Still can't get any satisfaction? Ask your state regulator and department of insurance for help. Bear in mind, though, that insurance commissioners in some states are decidedly more useful than in others. Find other state health-care advocates at [familiesusa.org](http://familiesusa.org) (click on Consumer Assistance Program Locator). For problems with health coverage, a claims assistance professional can also fight on your behalf (find one at

[claims.org](http://claims.org)). Fees range from \$30 to \$160 an hour.

### »» Weigh your last resorts.

So you've exhausted your appeals to no avail. What to do? Sure, you could hire a lawyer and sue. But because of the cost involved, a lawsuit usually doesn't make sense unless you have a very large claim or the insurer's actions are so egregious you might get punitive damages. Lawsuits can also drag out for years. A better bet for homeowner claims: Invoke the appraisal clause that's part of most policies, allowing you and the insurer to both hire appraisers who try to agree on a binding settlement. If they can't come to terms, an umpire chosen by the appraisers or a judge will arrive at a figure.