DEFEATING THE DISABILITY CARRIER'S TOP TEN DEFENSES

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So your client wants to bring a claim under his disability policy? Be forewarned: Taking on a disability insurer – especially in California – is not for the timid or faint of heart. Your client will be bombarded with a seemingly endless barrage of anti-coverage grenades that share a single target – preventing your client from collecting disability benefits.

If your client's benefits would pay him more money than he was making at his occupation, the insurer will argue that he is pursuing his claim out of choice or for financial gain – not because he is truly disabled. If your client's injury or sickness bears the slightest resemblance to, or shares even one symptom with, a condition he had before his policy incepted, the insurer will insist that his injury or sickness is a preexisting condition or first manifested before the policy incepted. If the insurer suspects that your client is feigning his disability (and, with alarming frequency, even if it doesn't), the insurer will trot out one of its well-paid "independent" physicians to conduct a medical examination that, inevitably, will find your client in perfect health. And if all else fails, the insurer will have its paparazzi conduct a week-long surveillance of your client that will produce – after careful editing – a 60-minute videotape which suggests that your client could easily qualify for the Olympics (or, at the very least, perform his occupation).

What can you – and your client – do? Following are ways to defeat the insurer's top ten defenses and, in the process, fortify your bad faith action against the insurer.

1. Incontestability

Pursuant to California Insurance Code § 10350.2, a disability policy is required to contain an incontestability clause in one of two forms. Under Form A, no misstatement on the insured's policy application can be used by the insurer to rescind the policy or deny a claim for a disability commencing more than two years after policy inception, unless the misstatement was fraudulent. Under Form B, if a disability commences after the policy has been in effect for two years, the insurer cannot rescind the policy or deny a claim on the ground that the disabling condition had existed before the policy began, even if the insured made a fraudulent misstatement on his application regarding the preexisting condition.

Form A generally is viewed as being more favorable to the insurer, since it enables the insurer to deny coverage or rescind the policy more than two years after policy inception, as long as the insured's misstatement on the policy application was "fraudulent". However, an insurer may encounter difficulty taking advantage of that perceived benefit. Fraud, of course, requires an

intent to deceive.[1] It may prove problematic, if not impossible, for an insurer to demonstrate that its insured intended to deceive the insurer at the time of the policy application, especially if the insured testifies that he had no such intent or the alleged misstatement was arguably correct.

The incontestability clause can come into conflict with the policy's "preexisting condition" and "first manifest" provisions. However, as discussed below, this conflict has been resolved in a manner favorable to insureds.

2. Preexisting Condition

Disability policies typically include a clause that excludes coverage for preexisting conditions that were not disclosed on the policy application. Obviously, should an insurer rely upon this clause, your first line of attack will be to argue that the insured's current injury or sickness is unrelated to the condition that was not disclosed on the application.

But what if the insured's present disability *is* related to a pre-policy condition and the insured told the insurer's agent about it, but the agent failed to record it on the application? Or what if the agent, during the meeting where he took the application, failed to ask the insured the question that would have disclosed the preexisting condition, or told the insured that the insurer wouldn't care about the non-disclosed condition and the insured relied on that statement?

Fortunately, if the agent is a licensed and appointed agent of the insurer, his knowledge, acts and omissions are imputed to the insurer.[2] Thus, the insurer is deemed to have made whatever representations were made by the agent, and to be aware of whatever conditions were disclosed by the insured to the agent.

Moreover, if the insurer rescinds the insured's policy notwithstanding its knowledge, through its agent, of the preexisting condition it claims was not disclosed, it can be liable for bad faith. A disability insurer's unreasonable attempt or threat to rescind a policy based on a claimed misrepresentation by the insured on the policy application may constitute bad faith.[3]

And if more than two years have passed since the insured's application, the insurer cannot rescind the policy based on the insured's non-disclosure of the preexisting condition even if that condition is related to the insured's current disability. That is because the California Supreme Court determined that the statutorily-required incontestability clause (Insurance Code § 10350.2) trumps the policy's preexisting condition clause, such that that an insurer which utilizes a Form B incontestability provision cannot rescind the policy or deny coverage based on the preexisting condition clause (or, as discussed below, the first manifest provision) after the policy has been in

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[1] *Sun 'n Sand, Inc. v. United Calif. Bank*, 21 Cal. 3d 671, 703, 148 Cal. Rptr. 329, 351 (1978) ["an action for fraudulent misrepresentation lies only when the defendant is charged with knowledge of falsity and an ***intent to deceive***"].
[2] *Loehr v. Great Republic Ins. Co.*, 226 Cal. App. 3d 727, 734, 276 Cal. Rptr. 667, 671 (1990).
[3] *Fletcher v. Western Nat'l Life Ins. Co.*, 10 Cal. App. 3d 376, 401-02, 89 Cal. Rptr. 78, 93-94 (1970); *Imperial Cas. and Indem. Co. v. Sogomonian*, 198 Cal. App. 3d 169, 185, 243 Cal. Rptr. 639 (1988).

effect for two years.[4]

3. First Manifest

Disability policies afford coverage for disability due to sickness or injury. "Sickness" is typically defined as a "sickness or disease which first manifests itself after the date of issue".

As indicated above, the "first manifest" provision can come into conflict with the statutorily-mandated incontestability clause. For example, what happens if the insured's sickness first manifested before the policy incepted but the insured does not file his claim for benefits until more than two years after policy inception? Does the incontestability clause (which bars an insurer from contesting statements on the insured's application after the policy has been in place for two years, unless the insured has a Form A policy and the insurer can demonstrate a fraudulent misstatement on the application) protect the insured, or can the insurer seize upon the "first manifest" clause to deny coverage or rescind the policy?

The California Supreme Court resolved the issue favorably to insureds in *Galanty v. Paul Revere Life Ins. Co.*[5]. The Court held that even if the sickness causing the insured's disability first manifested before policy inception, the incontestability clause bars the insurer from denying coverage based on the "first manifest" or "preexisting condition" provision after the policy has been in effect for two years (at least where, as in *Galanty*, the insurer utilized a Form B incontestability clause). The Court reasoned that a statutorily-required incontestability clause takes precedence over policy language, such as a "first manifest" provision, that has been drafted by an insurer.

4. ERISA

If the insured's policy was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). Remedies in connection with an ERISA-preempted insurance policy are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered in an ERISA action.[6]

Here are a few ways to circumvent ERISA:

- An **independent contractor** is not an "employee" and is therefore not subject to ERISA preemption,[7] unless he obtains insurance benefits through the same group plan that covers employees of the company.[8]

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[4] *Galanty v, Paul Revere Life Ins. Co.*, 23 Cal. 4th 368, 97 Cal. Rptr. 2d 67 (2000).
[5] *Galanty v. Paul Revere Life Ins. Co.*, 23 Cal. 4th 368, 97 Cal. Rptr. 2d 67 (2000).
[6] *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142-44, 105 S. Ct. 3085, 3090 (1985).
[7] *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 319, 327, 112 S. Ct. 1344, 1350 (1992).
[8] *Harper v. American Chambers Life Ins. Co.*, 89 F.2d 1432, 1434 (9th Cir. 1990).

- A **government employee** or the employee of a public agency is exempt from ERISA.[9]

- **Employees of churches** or church-operated businesses are exempt from ERISA.[10]

- **Sole proprietors, partners, and their spouses** are exempt, so long as the business does not provide benefits under the policy to a common-law employee.[11]

- Some courts have suggested that a plan is not "established or maintained" by an employer[12] unless the employer **intended** to create an ERISA plan.[13] Other courts have indicated that an employer has "established or maintained" an ERISA plan only if it actively **participated** in the design and operation of the plan, directly **controlled** the day-to-day operation of the plan, exercised substantial **discretion** over the plan, and/or established a **separate administrative scheme** to manage the plan.[14] Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.[15] Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.[16] And a few others have held that the "is maintained" requirement implies that the plan must be in **current operation**,[17] and thus that ERISA does not apply where the former employer has **sold his business** and stopped contributing to the plan[18] or has gone **bankrupt** and ceased any involvement in the plan.[19]

- Plans that fall under the Department of Labor's "**safe harbor**" regulations are exempt from ERISA.[20] The regulations generally state that ERISA is inapplicable where (1) the

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[9] 29 U.S.C. § 1003(b)(1).
[10] 29 U.S.C. § 1003(b)(2).
[11] 29 C.F.R. §§ 2510.3-3(b), (c). See also *Robertson v. Alexander Grant & Co.*, 798 F.2d 868, 872 (5th Cir. 1986); *Meredith v. Time Ins. Co.* 980 F.2d 352, 353, 357 (5th Cir. 1993); *Fugarino v. Hartford Life & Acc. Ins. Co.*, 969 F.2d 178, 185 (6th Cir. 1992); *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1104 (11th Cir. 1999).
[12] 29 U.S.C. § 1002(1).
[13] See *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 493 (9th Cir. 1988); *Stanton v. Paul Revere Life Ins. Co.*, 37 F. Supp.2d 1159 (S.D. Cal. 1999); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991).
[14] See *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1134 (1st Cir. 1995).
[15] See *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118, 1121 (9th Cir. 1998); *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1130 (1st Cir. 1995).
[16] See *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1132-33 (1st Cir. 1995).
[17] See *Stanton v. Paul Revere Life Ins. Co.*, 37 F. Supp.2d 1159, 1166 (S.D. Cal. 1999).
[18] *Loudermilch v. The New England Mutual Life Ins. Co.*, 942 F. Supp. 1434, 1437.
[19] *Mizrahi v. Provident Life and Accident Ins. Co.*, 994 F. Supp. 1452, 1453-54 (S.D. Fla. 1998).
[20] 29 C.F.R. § 2510.3-1(j).

employer does not "endorse" the program;[21] (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;[22] (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; **and** (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.[23]

An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which *did* cover employees. This argument has been made – and soundly rejected – by several courts.[24]

And ERISA preemption does not extend to state-law claims arising under an individual insurance policy – even though the policy was converted from an earlier group policy subject to ERISA.[25]

5. Legal Disability

Another fertile area being plowed by disability insurers is the concept of "legal disability". This denial of benefits occurs where the insured is unable to engage in his profession due to legal impediments (e.g., revocation of a license necessary to practice), irrespective of whether he also happens to be physically disabled.

In *Massachusetts Mutual Life Ins. Co. v. Ouellette*,[26] an optometrist was found guilty of lewd and lascivious conduct, resulting in the revocation of his license to practice optometry and his imprisonment. As a result, he applied for benefits under his disability policy. The Court held that the insured's pedophilia, while causing his license revocation and incarceration, was not a

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[21] "Endorsement of a program requires more than merely recommending it." *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1136 (1st Cir. 1995).

[22] The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See *Hrabe v. Paul Revere Life Ins. Co.*, 951 F. Supp. 997, 1001 (M.D. Ala. 1996).

[23] *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1135-38 (1st Cir. 1995).1135-1138.

[24] *LaVenture v. Prudential Ins. Co.*, 237 F.3d 1042, 1044-45 (9th Cir. 2001) ["A disability policy, not originally covered by ERISA, is (not) converted into an ERISA plan merely because a company offers its employees unrelated health insurance coverage."]; *Slamen v. Paul Revere Life Ins. Co.*, 166 F.3d 1102, 1105 (11th Cir. 1999) ["Non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits"]; *Rand v. The Equitable Life Assur. Society*, 49 F. Supp. 2d 111, 118 (E.D.N.Y. 1999) ["The plaintiff's disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance."].

[25] *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 877 (9th Cir. 2001).

[26] *Massachusetts Mutual Life Ins. Co. v. Ouellette*, 159 Vt. 187, 617 A.2d 132 (1992).

sickness that rendered him ***physically*** unable to practice his profession. In other words, but for the license revocation and the incarceration, he was physically able to practice and thus was not "factually" disabled.[27]

In a similar context, some courts have held that a person afflicted with a disease but not otherwise disabled is not entitled to benefits where he is precluded from engaging in his profession because he is a carrier of the disease.[28]

Those holdings, of course, should have no application where the insured's physical or mental illness occurred ***first***, even if the condition subsequently led to the revocation of his license or other "legal" disability.[29]

Thus, the key to addressing these cases is clarifying for the court the fact that the disability – be it mental or physical – existed first and that even if the legal disability vanished, the factual disability would preclude the insured from engaging in his occupation in any event.

6. Dual Occupations at Onset

Disability policies generally provide that an insured is totally disabled (and thus entitled to benefits) if he is unable to perform the substantial and material duties of his occupation due to an injury or sickness. The insured's occupation is usually defined as the occupation in which he was regularly engaged at the time he became disabled.

With increasing frequency, disability insurers are trying to argue that their insureds have *dual* occupations, and that even if they are unable to perform one of those occupations they are not totally disabled under the policy because they can perform the other. For example, an insurer may argue that a self-employed physician is not only a physician, but also a "business owner". The insurer goes on to argue that even if the insured cannot perform his medical duties (e.g., perform surgeries), he still can run his medical business and thus is not totally disabled.

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[27] There are a number of reported and unreported decisions which follow the *Ouellette* analysis. See *Damascus v. Provident Life and Accident Ins. Co.*, 933 F. Supp. 885 (N.D. Cal. 1996); *Grayboyes v. General American Life Ins. Co.*, 1995 U.S. Dist. LEXIS 4233; *Goomar v. Centennial Life Ins. Co.*, 855 F. Supp. 319 (S.D. Cal 1994), aff'd 76 F.3d 1059 (9th Cir. 1995); *Allmerica Fin. Life Ins. & Annuity Co. v. Llewellyn*, 943 F. Supp. 1258 (D. Ore. 1996); *Hammond v. Fidelity and Guaranty Life Ins. Co.*, 965 F.2d 428 (7th Cir. 1992); *Brumer v. Nat'l Life of Vermont*, 874 F. Supp. 60 (E.D.N.Y. 1995).

[28] *Dang v. Northwestern Mutual Life Ins.*, 960 F. Supp. 215 (D. Neb. 1997); *Gates v. Prudential Ins. Co.*, 270 N.Y.S. 282 (1934).

[29] Indeed, that is the conclusion reached in at least two published opinions. In *Ohio National Life Assurance Corp. v. Crampton*, 822 F. Supp. 1230 (E.D. Va. 1993), aff'd, 53 F.3d 328 (4th Cir. 1995) and *Paul Revere Life Ins. Co. v. Bavaro*, 957 F. Supp. 444 (S.D.N.Y. 1997), the courts reasoned that if the insured was in fact disabled, a later legal disability did not preclude recovery of benefits.

A variation to the "dual occupations at onset" argument is that the insured is not totally disabled if he can perform *any* of the duties of his occupation. And this is especially true if the policy at issue includes a residual disability provision. These arguments, however, does not withstand judicial scrutiny.

It is well established under California law that one is "totally disabled" if he is ***unable to perform the substantial and material duties of his occupation in the usual and customary way with reasonable continuity***.[30]

Accordingly, in *Erreca v. Western States Life Ins. Co*, the California Supreme Court found that a farm owner who could not perform manual labor or supervise farm operations as he had before his injury was totally disabled even though he could still buy livestock and supplies, sell farm products, negotiate leases, arrange crop financing, and determine what crops to plant and the time and price for selling them.[31]

Similarly, in *Austero v. National Casualty Co.*, the court held that an attorney may be "totally disabled" under an own occupation disability policy even though he is able to return a client's telephone call or Shepardize a case, as such limited functions are not the "substantial and material" duties of an attorney's occupation.[32] The court adopted the *Erreca* definition of total disability and held than an attorney suffering from memory loss and impaired judgment was totally disabled despite the fact that he appeared at 251 court hearings (an average of 20.9 per month) had 689 scheduled office appointments with clients (57.3 per month), and took 16 depositions – and thus was "obviously able to perform at least some of the functions of his profession."[33]

And in *Hangarter v. Provident Life and Accident Ins. Co.*,[34] the Ninth Circuit applied California's long-standing definition of disability to an own occupation disability policy (which contained a residual disability provision) and ruled that a disabled chiropractor was entitled to ***total disability benefits*** even though she continued to do the clerical duties associated with her chiropractic business.

As such, there can be no doubt California's long-standing definition, as defined in *Erreca* and its progeny, continues to control over the policy definition, even when the policy contains both total and residual disability provisions.

7. Choice / Financial Gain

Disability insurers frequently argue that an insured has stopped working – and made a claim for disability benefits – out of *choice*, not because he is genuinely disabled. For example, the insurer

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[30] *Erreca v. Western States Life Ins. Co.*, 19 Cal. 2d 388, 394-96, 121 P.2d 689 (1942); *Moore v. American United Life Ins. Co.*, 150 Cal. App. 3d 610, 632, 197 Cal. Rptr. 878 (1984).
[31] *Erreca v. Western States Life Ins. Co*, 19 Cal. 2d 388, 392, 397 (1942).
[32] *Austero v. National Cas. Co.*, 84 Cal. App. 3d 1, 22, 148 Cal. Rtpr. 653 (1978).
[33] *Austero v. National Cas. Co.*, 84 Cal. App. 3d 1, 23 (1978).
[34] *Hangarter v. Provident Life and Accident Inc. Co.*, 373 F.3d 998 (9th Cir. 2004).

may argue that the insured has grown weary of long hours and declining pay, or is tired of dealing with clients or patients, or is going through a midlife crisis.

At the risk of stating the obvious, the best way to counter the "choice" argument is to *deny* it. The insured can testify that he derives great fulfillment from his profession (helping clients, saving lives, working with the public, and so forth), takes enormous pride in providing for his family, hates being a burden to his wife and children, and would work if able.

The insured's work ethic and occupational satisfaction be corroborated by third-party witnesses, including his spouse, children, friends, employees, supervisors, coworkers, neighbors, patients and clients. They must confirm that the insured is *unable*, not *unwilling*, to work.

Beware of the insurer that attempts to manufacture a "choice" argument by offering to retrain or rehabilitate the insured. If the insured declines the offer, the insurer will argue that the insured has chosen to remain disabled and therefore is not entitled to benefits. However, an insured is not required to make any attempt to retrain for an occupation he would be physically able to pursue. The fact that through rehabilitation or retraining the insured might be able to perform a job is not relevant to the issue of whether he is totally disabled.[35]

As a variation on the "choice" theme, a disability carrier may argue that the insured has filed a disability claim for *financial gain*. This argument is especially likely if the insured's benefits (which typically are tax-free) would provide him with more money than he was making at his occupation.

Generally, you should counter this argument in the same way that you counter the "choice" argument. The insured – again, supported by friends, family and co-workers – can testify that he finds his occupation highly fulfilling, garners great satisfaction out of providing for his family, and would much rather be working than collecting disability benefits. Of course, if the insured made or had the potential to make more money working than receiving disability benefits, that fact needs to be emphasized – and, if possible, verified by balance sheets, financial projections, or similar documents.

8. Activities Inconsistent with Disability

Many disability insurers are cynical by nature. Even if they suspect that their claimants may in fact be disabled, the insurers – who want to hold onto premiums, earn interest on those premiums, and turn their claim departments into profit centers – are constantly looking for ways to avoid paying claims. To that end, some disability carriers make field visits or conduct surveillance of their insureds.

Field visits are usually unannounced and are designed to catch the insured performing activities that are inconsistent with the claimed disability. The field representative often will try to take a recorded statement from the insured, hoping to lure him into making a devastating admission that will support the choice defense ("Yeah, I'm tired; yeah, I'm burned out"), the financial gain

[35] *Pistorious v. Prudential Ins. Co.*, 123 Cal. App. 3d 541, 546, 176 Cal. Rptr. 660, 663 (1981).

defense ("Yeah, my industry has dried up; yeah, managed care has made it impossible for me to make a decent living"), or some other coverage shield.

So how can you keep your client's claim from being sabotaged by a field visit? Most important, tell your client to assume that he is being watched by a representative of the insurer at all times and to refrain from engaging in activities that could be misinterpreted by the insurer or, ultimately, a jury. Also instruct6 your client to speak with no one affiliated with the insurer (especially if the conversation is being recorded) unless you are present as well.

Disability insurers often use outside investigator to conduct covert surveillance of claimants. The surveillance will be videotaped, span a week or more, and follow the insured virtually wherever he goes. The goal, of course, is to obtain videotape that shows the insured engaging in activities (such as bending, twisting or lifting) that are inconsistent with the restrictions and limitations the insured claims and the treating physicians corroborate.

What can you do if the insurer's investigator videotapes your client performing activities that arguably are inconsistent with his disability claim? The key is to remember that "'total disability' does not signify an absolute state of helplessness"[36] Rather, it is "a disability that renders one unable to perform **with reasonable continuity** the substantial and material duties necessary to pursue his usual occupation **in the usual or customary way**."[37] Thus, an insured is totally disabled as long as he cannot perform the essential duties of his profession in the customary way and with reasonable continuity – even if he can perform <u>*some*</u> of those duties to <u>*some*</u> extent and/or on <u>*some*</u> occasions (on a videotape or otherwise).

You must argue that the videotape merely suggests that your client can sporadically perform certain nonwork activities for a few minutes over the course of a week of surveillance. It does not show that the client can perform his occupational duties in the manner he did before his injury or sickness, or that he can do so on a continuous basis – 8 to 10 hours a day, 5 to 6 days a week.

Other arguments to consider:

- The videotape is **biased**. It reflects the insurer's carefully calculated effort to "investigate" the claim with an eye toward *denying* benefits – in flagrant violation of its duty of good faith. For example, the insurer's investigator – who was recommended by the insurer's lawyer and paid by the insurer's adjuster – stalked plaintiff for <u>*12 hours a day*</u> for <u>*7 days*</u>, yet reduced its surveillance to a mere <u>*1-hour*</u> tape. The other <u>*83 hours*</u> of surveillance are conspicuously omitted. Predictably, ***all*** of the activities that were videotaped (or at least all of the activities that appear on the edited video) were deemed by the investigator to be inconsistent with plaintiff's disability. The investigator failed to videotape ***any*** activities (or *inactivity*) to the contrary. In fact, the videotape never shows plaintiff doing nothing.

[36] *Erreca v. Western States Life Ins. Co.*, 19 Cal. 2d 388, 396, 121 P.2d 689 (1942).
[37] *Moore v. American United Life Ins. Co.*, 150 Cal. App. 3d 610, 632, 197 Cal. Rptr. 878 (1984).

- The videotape was obtained through **deceptive** means. The videographer set up activities and induced the insured to perform them, or otherwise manipulated events to entrap the insured.

- The insurer offered plaintiff **no opportunity to explain** his activities on the surveillance tape. In many situations, a plaintiff has no choice but to perform the activities because, for example, groceries had to be bought and children had to be lifted, and nobody else is available to do it. Also, a plaintiff sometimes is able to perform certain tasks on an unusually good day or when he is wearing a back support, or taking medication that, if taken on the job, would prevent him from working.

- Reliance upon the videotape to deny coverage meant that the insurer had to ignore MRIs, X-rays, physical capacity evaluations, monthly progress statements, treating physicians' notes, and other objective evidence confirming his disability – all in violation of the insurer's duty to evaluate the insured's claim objectively, and to consider all the evidence produced.

In some cases, a plaintiff may have had to take several breaks during the taped activities, but the rest periods typically are not taped. While performing the tasks, he may have suffered excruciating pain that lasted for many hours afterward. The insurer should have given the plaintiff an opportunity to explain all of these factors.

Also, the plaintiff's treating physician should have been given an opportunity to explain that the activities captured on videotape were not inconsistent with the plaintiff's complaints or the physician's own findings. The physician might also be able to point out how the videotape showed that the plaintiff was restricted in his movements in ways that insurers – and jurors – might not observe.

What if the insurer filmed the insured at his place of work? Significantly, an insured who attempts to return to work is still disabled if he cannot perform his duties as before. In *McMackin v. Great American Reserve Ins. Co.*, the court found that an injured CHP officer remained totally disabled – even though he returned to work for eight months and received his regular compensation – because was "unable to perform his duties fully" and "worked slowly" compared to his efficiency before his injury.[38] As the court stated, "an insured should not be penalized for a desire to resume his job, and a futile effort to return to work, notwithstanding the existence of disability, will not preclude recovery of benefits."[39] You must demonstrate that although the insured *tried* to return to work, his effort was unsuccessful.

9. "Independent" Medical Examination

[38] *McMackin v. Great American Reserve Ins. Co.*, 22 Cal. App. 3d 428, 434-35, 99 Cal. Rptr. 227 (1971).
[39] *McMackin v. Great American Reserve Ins. Co.*, 22 Cal. App. 3d 428, 438, 99 Cal. Rptr. 227 (1971).

Disability insurers frequently require their claimants to undergo independent medical examinations (IMEs). In reality, these should be called "defense medical examinations," as the doctor is retained and paid by the insurer with only one goal in mind: finding the insured is *not* disabled. When the physician inevitably reaches that conclusion, you can make numerous arguments to attack the doctor and his findings.

Here are a few examples:

- The doctor has a bias in favor of insurers. The vast majority of his practice is devoted to performing "independent" medical examinations for which he is paid by insurance companies. And, unsurprisingly, those insurers typically get what they paid for – the doctor finds that the claimant is not disabled virtually every time.

- The doctor performs "independent" medical examinations, including your client's, for financial gain. Due to the restrictions of managed care, the doctor earns far less money in practice than he once did. It is much more lucrative to perform IMEs, at about $5,000 per exam, than to practice medicine, especially if the doctor has a large IME practice. (This can be a particularly effective counterattack if the insurer has taken the position that your client is pursuing his claim for *his* financial gain.)

- The doctor is not qualified to render an opinion regarding the insured's condition. He devotes large amounts of time to performing IMEs for insurance companies. The doctor rarely sees patients and does not keep current on the practice of medicine. When he does practice medicine, it is outside the medical area relevant to the insured's condition.

- The doctor ignored objective evidence of the insured's disability, including X-rays, MRIs, CT scans, discograms, and attending physicians' statements.

You may want to hire your own investigator to neutralize the findings of the insurer's "independent" doctor. Your investigator can look for prior malpractice actions against the doctor, medical board or license problems, or even disability claims filed by the doctor. The investigator can also search for other cases in which the doctor has testified. This will help you establish that the doctor is biased in favor of insurance companies or has taken a position in other cases that is inconsistent with the one he is advocating in your client's suit.

And while you are challenging the doctor, do not forget to take on the insurer. If the insurer breached its duty to provide the policy definition of "disability" to the independent medical examiner, that failure should be highlighted.[40] And if the insurer denied your client's claim without even ordering an IME, you should argue that an insurer has a duty to conduct such an examination before deciding whether its insured is entitled to disability benefits.[41]

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[40] *Moore v. American United Life Ins. Co.*, 150 Cal. App. 3d 610, 618, 637-38, 197 Cal. Rptr. 878 (1984).

[41] *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan*, 971 F. Supp. 1310, 1316 (C.D. Cal. 1997); *Russell v. UNUM Life Ins. Co.*, 40 F. Supp. 2d 747, 751 (D.C. S.C. 1999).

10. "Regular" vs. "Appropriate" Care

Your client has made a claim under his "own occupation" disability policy, and the insurer has been paying benefits for a few months. But now, the insurer is taking the position that the treatment your client is receiving is inappropriate for his condition. Perhaps the insurer is arguing that your client has to undergo carpal tunnel surgery (instead of cortisone injections, night splints and anti-inflammatory medication), even though the policy contains no duty or requirement to undergo surgery. Or maybe the insurer is asserting that your client should have back surgery, even though conservative treatment (pain injections, physical therapy and chiropractic manipulations) is providing your client with some relief. And to make matters worse, the insurer is threatening to cut-off your client's benefits – or even sue him for declaratory relief and reimbursement of the benefits previously paid – if he doesn't undergo the surgery.

But your client doesn't want to undergo surgery. Perhaps he feels that the conservative treatment he is receiving will eventually correct the problem. Perhaps he feels that the risks of the supposed safe, simple and routine surgery outweigh the benefits. Perhaps he has peripheral neuropathy or some other condition that lessens the likelihood that the operation would be a success. Maybe his religious convictions preclude him from receiving medical treatment of any kind. Or perhaps, like many people, he is simply afraid of surgery.

What should your client do? Does the law support his right to decide whether he will undergo invasive medical treatment? What about the constitutional right to privacy? Does the insured's duty to mitigate and/or duty to act in good faith include a duty to submit to treatment dictated by his insurance company? And even if the insurer can condition benefits on whether its insured undergoes appropriate care, who determines what care is "appropriate" – is it the insured, the treating physician, the insurance company, or the jury?

Actually, it's rather remarkable that disability insurers are even arguing that policyholders have a duty to undergo surgery or other corrective treatment. That is because if your client shelled out big bucks for "special" coverage in the 70's, 80's or early 90's, his individual policy contains *no written duty to undergo any surgery of any kind in any circumstance.*

But that has not stopped disability carriers from combing their policies for other language that they hope will require an insured to undergo surgery or other curative treatment. Sometimes, insurers rely on – without success – the policy provision that requires an insured to "cooperate" with the insurer. More often, however, carriers focus on the policy's definition of "total disability." In addition to requiring that the insured be unable to perform the substantial and material duties of his occupation, that definition either requires (depending on which version the insurer is using) that the insured be in the regular care and attendance of a physician (Type 1) or that the insured be receiving care by a physician which is appropriate for the condition causing his disability (Type 2).

For Type 1 policies, most courts have concluded that an insurer *cannot* require its insured to undergo surgery as a condition to receiving benefits. In fact, those courts have found that an

insured need not undergo surgery even where surgery is usually successful and the refusal to undergo surgery was arguably unreasonable.[42]

As for Type 2 policies, there is surprisingly little case law on the subject. Some courts have found that medical care can be "appropriate" even if it was not the ideal, perfect or best possible treatment for the disabling condition. Others have concluded that where the insured had two reasonable courses of treatment for his disability, the insurer has no right to complain that the insured chose one rather than the other. But, unfortunately, some courts have ruled otherwise.

In *Sebastian v. Provident Life and Accident Ins. Co.*,[43] the insurer filed a motion seeking summary adjudication that the insured had not received "care by a physician which is appropriate for the condition causing the disability." Although the court concluded that the insured did not receive appropriate care during the first three months of his disability "because he was not under the care of any physician," the court otherwise denied the insurer's motion.[44] Significantly, the court held that "a reasonable jury could find that [the insured] received 'appropriate care' for his disabling psychiatric disorder"[45] despite the fact that: (1) the insured had been treated by his primary care physician – not a psychiatrist or psychologist; (2) the insured's physician had waited five months before physically examining the insured and had prescribed anxiety and antidepressant medications before examining the insured; (3) it was undisputed that the insured's physician had misdiagnosed his condition; and (4) a psychiatrist had testified that had the insured been properly diagnosed, the treatment protocol would have been different.[46] In so holding, the court emphasized that treatment for a disability can be "appropriate" even if "it was not the ideal treatment," and that "[a]ppropriate means suitable under the circumstances . . . not . . . perfect care, or best possible care."[47]

In *Morinelli v. Provident Life and Accident Ins. Co.*,[48] the insurer presented evidence at trial regarding the poor quality of care rendered by the insured's physician along with the treatment that would have been successful in controlling the insured's diabetes. The Court of Appeal held that the trial court abused its discretion in allowing the insurer's testimony and argument regarding the quality of care received by the insured. In so holding, the appellate court determined that "'appropriate care' does not require a qualitative evaluation of the care provided" and that "whether the level of treatment met the standard of care is not pertinent to a

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[42] See *Heller v. Equitable Life Assur. Society*, 833 F.2d 1253, 1255, 1257, 1259-60 (7th Cir. 1987). But see *Provident Life and Accident Ins. Co. v. Van Gemert*, 262 F. Supp. 2d 1047, 1050-51 (C.D. Cal. 2003) [holding that a provision requiring the insured to be "under the care and attendance of a physician" should be "construed to both govern the care required, and that such care may consist of surgery where surgery represents the only course of medical care a reasonably prudent person would pursue"].

[43] *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp. 2d 521 (D. Md. 1999).

[44] *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp. 2d 521, 529 (D. Md. 1999).

[45] *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp. 2d 521, 531 (D. Md. 1999).

[46] *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp. 2d 521, 529-30 (D. Md. 1999).

[47] *Sebastian v. Provident Life and Acc. Ins. Co.*, 73 F. Supp. 2d 521, 529-30 (D. Md. 1999).

[48] *Morinelli v. Provident Life and Acc. Ins. Co.*, 617 N.W.2d 777, 782 (Mich. Ct. App. 2000).

determination of whether the care was appropriate."[49] Instead, the court concluded that "[t]he insurer's review of the nature of the care" received by the insured should be limited to "whether it is 'necessary and causally related' to the alleged disability."[50] Moreover, "the [insurer's] allegation that the care received by [the insured] was inappropriate in that it did not meet the standard of care was not a proper contractual defense to his claim for disability benefits."[51] Thus, the court determined that: "Care 'appropriate for the condition causing the disability' is care that is necessary and causally related to the condition forming the basis of the disability claim."[52]

More recently, in *Kottle v. Provident Life and Accident Insurance Co.*,[53] the insured physician became disabled due to "panic disorder" and treated with a psychiatrist, with many of the therapy sessions occurring by telephone due to the distance between the insured and his treating physician. The insurer denied the claim because, among other things, the insured had not received appropriate care for his psychological disorder. At trial, defense presented three medical experts, all of whom criticized the use of "telemedicine" and opined that the insured had not received appropriate care for his condition.[54] Following a bench trial, the court found that insured was "unable to perform the substantial and material duties of his occupation" and was "receiving care by a physician which was appropriate for the condition causing the disability."[55]

On appeal, the insurer argued (among other things) that the trial court erred in concluding as a matter of law that the insured was receiving appropriate care when, according to the insurer, "the plaintiff not only failed but steadfastly refused to seek appropriate care as is required by the contract."[56] The court of appeal acknowledged that there was "considerable disagreement regarding [the treating physician's] current treatment and whether additional treatment would have allowed [the insured] to return to his occupation."[57] Although the court considered "the opposing views raised by [the insurer's] experts to be significant," it agreed with the trial court that the medical treatment received by the insured was "sufficient and appropriate."[58]

Even if the court believes that your client has a duty to undergo "appropriate" care, it is clear that the issue of what constitutes such care is a factual question that must be determined by the jury – not the judge via summary adjudication.

In *Provident Life and Accident Ins. Co. v. Henry*,[59], the court held that "the policy's appropriate-care provision . . . create[s] a duty to submit to appropriate medical treatment, which, *in some*

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[49] *Morinelli v. Provident Life and Acc. Ins. Co.*, 617 N.W.2d 777, 782 (Mich. Ct. App. 2000).
[50] *Morinelli v. Provident Life and Acc. Ins. Co.*, 617 N.W.2d 777, 781 (Mich. Ct. App. 2000).
[51] *Morinelli v. Provident Life and Acc. Ins. Co.*, 617 N.W.2d 777, 781 (Mich. Ct. App. 2000).
[52] *Morinelli v. Provident Life and Acc. Ins. Co.*, 617 N.W.2d 777, 782 (Mich. Ct. App. 2000).
[53] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64 (La. App. 2d Cir. 2001).
[54] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64, 73 (La. App. 2d Cir. 2001).
[55] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64, 74 (La. App. 2d Cir. 2001).
[56] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64, 74 (La. App. 2d Cir. 2001).
[57] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64, 77 (La. App. 2d Cir. 2001).
[58] *Kottle v. Provident Life and Acc. Ins. Co.*, 775 So. 2d 64, 77 (La. App. 2d Cir. 2001).
[59] *Provident Life and Accident Ins. Co. v. Henry*, 106 F. Supp. 2d 1002 (C.D. Cal. 2000).

circumstances, *may* include a surgical procedure." In so holding, the court acknowledged that "there is substantial ground for difference of opinion" regarding whether a disability insurer can condition benefits on the insured's acceptance of appropriate treatment, and even authorized the insured to take "an immediate appeal from this order."[60] The court also emphasized that the insurer "does ***not*** have [the] power" to force the insured to "obey every doctor's recommendation" or "defer to [the insurer's] judgment about the appropriate care for his condition."[61] And most importantly, the court ***denied*** the insurer's motion for summary judgment on the issue of whether the insured's treatment for carpal tunnel syndrome (which did *not* include surgery) was "care . . . which is appropriate for the condition causing the disability" – and it did so even though carpal tunnel surgery is (at least according to the insurer) "a common, low-risk procedure with the potential to cure the insured's disability and enable him to return to his practice."[62] The court concluded that the question of "whether [the insured] has fulfilled his duty under the appropriate-care policy provision" was "a genuine issue of material fact" for the jury to resolve.[63]

Similarly, in *Provident Life and Accident Ins. Co. v. Van Gemert*,[64] an insured was disabled from performing his occupation as an oral surgeon due to the loss of vision in one eye. The insurer brought a declaratory relief action that it was not required to pay benefits during the period of time in which the insured refused to undergo curative surgery, and claiming that it was entitled to restitution for benefits it paid. The court adopted as its own the reasoning set forth in *Henry* and held there "remains a triable issue of fact whether the surgery urged by the insurer represents 'appropriate care,' i.e., whether such care 'would be determined objectively as the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals.'"[65]

Conclusion

Armed with everything from deceptive field visits to one-sided videotapes to biased medical examiners, disability insurers are well equipped to wage battle with you and your client. You can overcome the insurer's arsenal – and obtain a bad faith verdict in the process.

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[60] *Provident Life and Accident Ins. Co. v. Henry*, 106 F. Supp. 2d 1002, 1005 n.2 (C.D. Cal. 2000) [The case settled while an appeal was being prepared.].
[61] *Provident Life and Accident Ins. Co. v. Henry*, 106 F. Supp. 2d 1002, 1004 (C.D. Cal. 2000).
[62] *Provident Life and Accident Ins. Co. v. Henry*, 106 F. Supp. 2d 1002, 1003 (C.D. Cal. 2000).
[63] *Provident Life and Accident Ins. Co. v. Henry*, 106 F. Supp. 2d 1002, 1005 (C.D. Cal. 2000).
[64] *Provident Life and Accident Ins. Co. v. Van Gemert*, 262 F. Supp. 2d 1047 (C.D. Cal. 2003).
[65] *Provident Life and Accident Ins. Co. v. Van Gemert*, 262 F. Supp. 2d 1047, 1050 (C.D. Cal. 2003), quoting *Provident Life and Accident Ins. Co. v. Henry*, 106, F. Supp. 2d 1002, 1004 (C.D. Cal. 2000).