

*Legal Disability Update:*

# **A Potpourri of Interesting Disability Cases**

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I have reviewed and summarized a number of recent disability cases that I found of interest. In content they span a dozen or so issues that typically arise in the handling of disability income claims. I have limited the review to cases that were issued from near the end of 2007 through the first quarter of 2009.

I focused primarily on individual disability cases (as opposed to ERISA cases), because they are not “infected” with the issue of the standard of review. However, when an interesting topic was reflected best in an ERISA case, I included and discussed that case.

Note that this list is *not* intended to be exhaustive review of the law over the past one to two years. Instead, as the title of the paper is meant to imply, it is (hopefully) a helpful review of recent cases for one who wants to obtain a “flavor” of recent disability insurance case law.

## 1. PROOF OF LOSS

***Kniespeck v. Unum Life Ins. Co. of America***, 2009 WL 118090 (9<sup>th</sup> Cir. [Cal] 2009)

*Facts and holding*: Plaintiff was an insured under a long term disability policy, but refused to provide continuing proof of loss of his partial disability. The trial court found that the policy language was ambiguous, and that such continuing proof was not needed. On appeal the Ninth Circuit reversed. It found that “it was incumbent on [the insured] to provide proof that he had a continuing disability in order to collect benefits for partial disability.”

*Lessons learned*: This opinion doesn’t really provide new law, but emphasizes that an insured’s lack of cooperation can, in appropriate cases, be fatal to his claim.

## 2. DAMAGES

***Leavey v. UnumProvident Corp.***, 2008 WL 4472937 (9<sup>th</sup> Cir. [Ariz] 2008)

*Facts and holding:* A jury awarded the insured \$4 million in compensatory damages and \$15 million in punitive damages. The trial judge reduced the compensatory award to \$1.2 million and the punitive damages award to \$3 million. Each side appealed. The Ninth Circuit upheld the trial court's decisions.

Although \$1 million of the \$1.2 million compensatory award was for emotional distress, the court noted that Leavey “felt a great deal of anxiety,” was “devastated,” “confused” and depressed, felt compelled to move into a cheaper apartment, and was subjected to “real discouraging” and “degrading” experiences trying to find and keep a job. The Ninth Circuit held that “the \$1 million award for Leavey’s emotional distress, while generous, is supported by evidence in the record and does not ‘shock the conscience’ of the court.”

The Ninth Circuit also felt the reduction in the punitive damages award was justified by the trial court because (i) the compensatory award was substantial and constituted complete compensation, (ii) the emotional harm “arose from a transaction in the economic realm, not from physical assault or trauma [and] there were physical injuries,” (iii) the insured presented “scant evidence of repeated misconduct of the sort that injured [him],” (iv) the ratio of punitive damages to compensatory damages was large, and (v) there was a large disparity between the punitive damages award and the civil penalties authorized in comparable cases.

*Lessons learned:* What an insurer perceives to be a small amount of emotional distress can still lead to a large emotional distress award, and appellate courts are not likely to reduce those awards, instead giving deference to the trial court.

### 3. TOTAL DISABILITY

#### A. Unable to Perform “All” of One’s Duties

***Fountain v. Unum Life Ins. Co.***, 2009 WL 619458 (Ga. App. 2009)

Facts and holding: Walter Fountain, a corrections officer, suffered a slip and fall which precluded him from performing some, but not all, of the duties of his occupation. The definition of total disability in the policy at issue required that the insured be unable “to perform all of the material duties of his/her occupation. . . .” At issue was whether the reference to “all” meant: (i) that if the insured could not perform some of his duties, then he could not perform “all” of them (as urged by Fountain); or (ii) that if the insured could perform some of his duties, then he was not precluded from performing “all” of them (as urged by Unum Life). The court found the definition to be unambiguous and Unum’s construction to be correct. Nonetheless, the court found that there was still an issue for the jury as to whether Klein’s impairment so limited him from performing the material duties that he should be considered totally disabled. “Total disability, irrespective of the technical variations in the language employed, should be given a rational and practical construction. The phrase is a relative term, depending upon the circumstances and peculiar facts of each particular case. . . .”

Lessons learned: First, although this court interpreted the term “all” in the manner in which most insurers would interpret the term, not all courts have come to the same conclusion. Some have found a definition of total disability such as that described above to be ambiguous, and thus to be interpreted in favor of the insured. See, e.g., *Giddens v. Equitable Life Assur. Soc. of the U.S.*, 445 3d 1286 (11<sup>th</sup> Cir. 2006). Second, note how even though this court ruled that Unum Life’s interpretation was correct, it *still* did not grant Unum Life summary judgment, but instead found that the particular application of the definition was one for the jury. Insurers should act with caution if they conclude that an insured is not totally disabled based on a strict and literal construction of the total disability provision, to the effect that the insured must be completely precluded from engaging in each and every material duty before being considered totally disabled.

## **B. Working in the “Usual and Customary” Manner**

***Klein v. Northwestern Mutual Life Ins. Co.***, 562 F.Supp.2d 251 (D. Conn. 2008)

*Facts and holding:* Eric Klein, a dentist suffered a left hand injury that reduced his ability to practice dentistry and required him to make various accommodations to his practice. Although Klein returned to dentistry, his injury required him to contort his body in unusual ways, he had to work with an assistant, he worked more slowly, and he could not always work on children. He also could not perform about half of the kinds of dental procedures he used to perform. He thus asserted he was “unable to perform any of his duties in the customary and usual manner in which a dentist performs them.”

Northwestern Mutual eventually accepted Klein’s claim, but only as one for partial disability. Klein maintained he was totally disabled. The policies at issue contained fairly traditional TD and PD definitions. Total disability meant the insured is “unable to perform the principal duties of the regular occupation.” Partial disability was defined to apply if the insured is, among other things, “unable to perform one or more but not all of the principal duties of the regular occupation.” Reading the two definitions together, the court found that “it is unambiguous that Klein is not totally disabled if he can perform at least one principal duty.”

With respect to Klein’s argument that he could not perform any of his duties in the “usual and customary manner,” the court found Klein’s position unpersuasive. The court stated that the underlying cases using such language were actually concerned with insureds being denied total disability benefits when they could only perform trivial aspects of their occupation. Here, the court found that the definition of total disability in the policies at issue would not cause such an insured to be denied total disability benefits. The court explicitly rejected reading the terms “in the usual and customary manner” into the definition of total disability.

*Lessons learned:* There are very few cases that discuss the oft-quoted but seldom applied “usual and customary manner” language. This court interpreted the policy in a common sense manner: “[T]his result accords with what one might expect from a disability policy. The premise behind a total disability policy is that, when the insured is completely unable to perform his occupation (and thus cannot earn money from doing so), he is fully reliant on the supplemental income provided by a total disability policy. When an insured can instead partially perform his job, and can thus earn some money

from his occupation (albeit less than was the case earlier), it make sense that such an individual would be classified as ‘partially’ disabled.”

Not all courts may be as generous as was this federal district court. First, the court took a very literal (although also common sense) view of the policy’s definitions, ignoring the traditionally quoted (although admittedly rarely explained) “usual and customary” language. Also, the court ignored the impact of the insured being required to make accommodations in the performance of his duties. (Although in an ERISA context, *Klein* is one of the few cases that has specifically ruled that additional injuries or different claims of disability suffered after the complaint was filed should not be resolved at the same trial.)

***Hecht v. The Paul Revere Life Ins. Co.***, 168 Cal.App.4<sup>th</sup> 30 (2008)

*Facts and holding:* Michael Hecht, the insured under a disability policy issued by Paul Revere, claimed total disability in his occupation as the owner of a retail clothing business with several branch locations. Hecht was a “hands on” owner who suffered injuries in an automobile accident. After the accident he claimed that although he could perform all of his pre-disability duties, he could no longer do so in the usual and customary way he had previously performed them. Paul Revere moved for summary judgment with respect to Hecht’s claim of total disability, and the trial court granted its motion.

The Court of Appeal affirmed. Although it noted that Hecht “is limited in his physical activities and cannot perform each and every physical task that he did prior the accident,” it found those limitations not to be dispositive. That is because under controlling law, “he is physically and mentally capable of performing a substantial portion of the work connected with his employment.”

*Lessons learned:* Most practitioners in the DI field recognize the “*Erreca*” case as the “granddaddy” of all total disability cases. Lawyers and claims people alike quote *Erreca*’s definition of total disability as one’s inability to perform the substantial and material duties of one’s occupation in the usual and customary way. The *Hecht* case makes clear that the *second sentence* in the *Erreca* definition (one is not totally disabled if he can still perform a substantial portion of his work) is equally important, and may be used to ascertain that an insured is not entitled to total disability benefits.

### **C. Dual Occupation**

***Forrest v. Provident Life & Accident Ins. Co.***, 2008 WL 4814437 (Cal. App. 2008)

*Facts and holding:* Alfred Forrest, who had been working 40 hours per week as an ob/gyn and 40 hours per week as the medical director of a medical center, was injured in an automobile accident. He had a disability policy with Provident which provided, in part: “Your occupation means the occupation (or occupations, if more than one) in which you are regularly engaged at the time you become disabled.”

As a result of his accident, Forrest could no longer perform his duties as an ob/gyn. However, Forrest continued to work in his job as a medical director of the medical center, earning over \$200,000 per year in that position. Provident denied Forrest’s claim for total disability benefits, reasoning that Forrest could still perform one of his two occupations. After Forrest sued, the trial court granted Provident summary judgment on Forrest’s breach of contract claim.

The California Court of Appeal reversed. It found the term “your occupation” to be ambiguous, because, notwithstanding the above definition, it did not specify what work activities constitute an insured’s “occupation.”

*Lessons learned:* Sometimes there is nothing an insurer can realistically do to “bullet proof” its policies. The Court of Appeal’s seems wrong. It implicitly assumes that every term in an insurance policy can be defined *ad nauseam*, when both practical considerations and common sense must play a role in policy interpretation. Even if the court’s critique might be applicable in some factual situations, it seems especially inappropriate in a case in which the insured was working 40 hours per week in his second occupation, and also earning a substantial wage in that second occupation.

## **D. Ob/Gyn Duties**

***Simon v. Unum Group***, 2009 WL 857635 (S.D.N.Y. 2009)

*Facts and holding:* An ob/gyn insured with a \$14,000 per month DI policy could no longer deliver babies or perform gynecological surgeries, due to an injury in his left hand, but was still able to engage in his own private general gynecological practice, and still had admitting privileges at hospitals. The insured's policy provided that "totally disabled" means that the insured is "not able to perform the substantial and material duties of your own occupation," and "residual disability" means "you are not able to do one or more of your substantial and material daily business duties or you are not able to do your usual daily business duties for as much time as it would normally take you to do them." Unum reviewed the insured's EOBs, and determined that prior to injury, his practice was primarily focused on gynecology, rather than obstetrics.

The court granted Unum's motion for summary judgment. It found that under the terms of the policy, the insured had to be unable to perform all of the substantial and material duties of his occupation. Otherwise, the residual disability provision could not be given any real meaning. As such, the court found the policy's total disability provision to be unambiguous and applied.

*Lessons learned:* This fact situation is fairly common in the realm of litigated TD disputes, and cases go both ways. (Indeed, the court cited to other ob/gyn cases that have analyzed the same issue, with different judges reaching different results.) It seems to this presenter that the more "solid" the insured's pre-disability gyn practice, the more likely the carrier will prevail on the residual disability argument.

## **E. “Any Occupation”**

### ***McElgunn v. CUNA Mutual Group.***, 2009 WL 632935 (D. S.D. 2009)

***Facts and holding:*** An insured was covered under a disability policy whose definition of total disability changed from “own occ” to “any occ” after twelve months. The court had to determine the practical application of an “any occ” definition (which it called a “general disability” definition). The court found that under South Dakota law, the term “total disability” in an “any occ” definition “does not mean absolute helplessness or entire physical disability rendering the insured unable to perform any work, but rather means the insured is unable to perform the substantial and material acts of any occupation which he insured is reasonably qualified by education, training or experience, in the usual and customary way.”

The holding above is not significant. It is typical of how courts interpret “any occ” total disability provisions. But the Court also had to determine whether *income* was a factor for the fact-finder to consider in determining whether the insured was totally disabled. To do so, the court reviewed other South Dakota and North Dakota cases, and held that income *is* a factor to be considered in determining whether another occupation is a suitable alternative occupation in which the insured might engage.

***Lessons learned:*** *McElgunn* is one of the few cases that specifically considers whether income should be implicitly considered in the traditional “education, training or experience” portion of an “any occ” definition. As a practical matter, it is this presenter’s experience that disability insurers routinely factor income into the “any occ” equation, whether on an explicit or implicit basis.

### ***White v. Continental Casualty Co.***, 9 N.Y.3d 264 (N.Y. 2007)

***Facts and holding:*** An orthopedic surgeon purchased a DI policy that added typical “any occ” language (to be disabled the insured had to be unable to “[perform] the duties of any gainful occupation for which [he is] reasonably fitted by education, training, or experience”) to an “own occ” definition. The insured complained that the language was ambiguous, or if not, provided for only illusory benefits. The trial court granted the insurer’s motion for summary judgment. The New York Court of Appeals affirmed, holding that the language was unambiguous and should be enforced as written.

Lessons learned: The result in *White* should not be surprising, but occasionally practitioners argue for ambiguity. This is one of the few cases to address the issue head on.

***Tate v. Long Term Dis. Plan for Champion Int'l Corp.***, 2008 WL 4276593 (7<sup>th</sup> Cir. 2008)

Facts and holding: Jo Ann Tate was a sales representative for a paper company who went on disability due to severe anxiety and depression. After Tate had been on disability for two years during her “any occ” period, the ERISA plan denied further benefits. She sued in district court, and the court found in her favor.

On appeal, the Seventh Circuit Court of Appeals found that the plan’s decision to deny benefits was arbitrary and capricious. It found that two doctors who performed paper reviews did not set forth their reasoning as to how or why Tate could engage in another occupation. Although the court stated it was *not* issuing a blanket rule that vocational analyses always had to be performed, “[u]nless the Plan provides a reasonable explanation for its conclusion that Tate was capable of performing another job for which she was qualified, we have no basis to uphold the Plan’s decision.” The court concluded that “[f]or the Plan to make a reasonable determination that Tate was able to work in an occupation for which she was qualified despite her impairments, the Plan was required, at minimum, to assess her qualifications and how they comport with jobs that Tate might be able to perform in spite of her impairments.”

Lessons learned: “Any occ” cases, with their lower standard for total disability, have the potential for luring an insurer into being less thorough than it should be. While vocational analyses are not necessarily required prior to claim denials, they should be considered. Certainly, as the *Tate* court points out, the insurer should tie together the insured’s functional capabilities and the availability of occupations whose duties “mesh” with those abilities.

## **F. Specialty Letters**

***Dekel v. UnumProvident Corp.***, 593 F.Supp.2d 516 (E.D. N.Y. 2009)

*Facts and holding:* The insured was an ob/gyn who claimed total disability. Unum wished to argue at trial that the insured had a second occupation that involved the sale of holistic medical products. The court was called upon to decide Unum's *motion in limine* (a motion made at time of trial, usually to exclude evidence) that requested that evidence of a "specialty letter" it had provided to the insured shortly after the policy's issuance should not be permitted to be introduced into evidence at trial. The specialty letter stated that the insured's occupation was that of the specialty of ob/gyn, and that if the insured could not perform the substantial and material duties of that specialty, he would be considered totally disabled.

The Court granted Unum's motion. It found that the policy (like almost all policies) contained an "integration clause," that is, a clause that provides that the policy itself contains the entire agreement between the parties. The Court ruled that the integration clause precluded the agreement between the parties from being anything other than the policy itself and any attachments to it (the specialty letter had not been attached).

*Lessons learned:* Not all courts are as generous to insurers as was the court in *Dekel*. Claims personnel reviewing a claim in which a specialty letter was issued would do well to consult their in-house counsel for advice as to the likely effect a court would give to that letter. The outcome could well depend upon the particular jurisdiction in which the action is pending, and even the particular judge.

#### 4. MENTAL ILLNESS LIMITATION

***Fitts v. Unum Life Ins. Co. of America***, 520 F.3d 499 (D.C. Cir. 2008)

*Facts and holding:* Jane Fitts was an attorney employed by Fannie Mae, when bi-polar disorder prevented her from working. She made a claim under her ERISA plan, which was administered by Unum. Unum accepted her claim, but limited her to two years of benefits pursuant to a provision in the plan that so limited benefits “for disability due to mental illness.” The plan defined “mental illness” as “mental, nervous or emotional diseases or disorders of any type.” Fitts complained that bi-polar disorder was a physical illness. When Unum disagreed, she sued under ERISA. At the district court, Fitts argued that because bi-polar disorder has a physical cause, it is not a mental disorder. Unum argued that because the condition was listed in the DSM, it qualified as a mental disorder. The district court noted that there were several bases on which to decide whether a particular condition should be classified as a mental illness, and since the policy did not specify how the decision was to be made, it was ambiguous, and the court ruled in favor of Fitts.

The D.C. Circuit Court of Appeals noted disagreements between the federal circuits as to how to classify what had traditionally been referred to as mental illnesses. (The Fifth and Eighth Circuits believe it is inappropriate to base the distinction on the “cause” of the condition; the Seventh, Ninth and Eleventh Circuits believe a cause-based rationale is permissible.) The D.C. Court of Appeals side-stepped the issue, finding that a triable issue of fact existed concerning the cause of Fitts’ condition, and therefore remanded the case back to the district court for further findings.

*Lessons learned:* Disputes over whether “traditional” mental illnesses should be so classified have existed since at least the 1990s. Since that time, many carriers have revised their definitions of mental illness to retreat from a “cause-based” analysis. Some define a mental illness in terms of its classification in the DSM, others name specific conditions that are to be included as mental illnesses, and some define the condition as one that is traditionally treated by psychiatrists or psychologists. The lesson to be learned, however, is that particular attention must be paid to the policy language, and that debate still occurs over what conditions should be classified as mental conditions subject to a benefits limitation.

## 5. RISK OF RELAPSE

***Stanford v. Continental Casualty Co.***, 514 F.3d 354 (4<sup>th</sup> Cir. 2008)

*Facts and holding:* Robert Stanford, a nurse anesthetist, became addicted to Fentanyl, a powerful pain killer and narcotic that he used in his occupation. Although he attended a drug rehab program, he relapsed, and had to attend a second program. After he returned to work, he relapsed again. Although Continental approved Stanford's ERISA claim while he was an inpatient during rehab, it denied his claim thereafter. Stanford appealed, arguing that his addiction rendered him unable to perform his duties because of the high risk that he would relapse into drug use if exposed to Fentanyl in the workplace. Continental rejected his argument, concluding that "[t]he policy does not cover potential risk" of relapse. The district court affirmed Continental's decision, and Stanford appealed to the Fourth Circuit Court of Appeals.

The Court of Appeals utilized a modified abuse of discretion standard, and concluded that "We cannot say that Continental's conclusion is unreasonable." Of note, however, the court distinguished cases in which the risk of relapse involved what it considered to be in part a matter of choice: "A doctor with a heart condition who enters a high-stress environment like an operating room 'risks relapse' in the sense that the performance of his job duties may *cause* a heart attack. But an anesthetist with a drug addiction who enters an environment where drugs are readily available 'risks relapse' only in the sense that the ready availability of drugs increases his temptation to resume his drug use. Whether he succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice." The court noted that other courts facing this issue – including cases concerning doctors with drug addictions – come to opposite conclusions. As a result, it reasoned that "Given this widespread, thoughtful, and reasonable disagreement, Continental's decision cannot plausibly be termed unreasonable."

*Lessons learned:* If anything, the *Stanford* court's citation to other cases "going both ways" demonstrates that the "risk of relapse" issue is still one open to debate, and that there are no hard and fast rules to be applied in such cases.

Of additional interest to me was the court's further discussion that even if the potential for addiction would cause potential future employers to refuse to hire Stanford, that fact would not serve to tip the scales in his favor:

“No prudent employer would hire Stanford into a job in which he administered the drug to which he is addicted, just as no prudent employer would hire a recovering alcoholic as a bartender. More importantly, no prudent addict would place himself in such a position. Such prudence is a part of recovery, and it can have significant costs-but these costs are greatly outweighed by the opportunities sobriety provides. It is important to remember that Stanford is not physically disabled or mentally impaired; though prudence and his license dictate that he cannot return to his old job administering Fentanyl, he is physically and mentally capable of performing that job-and countless other jobs.”

Not all courts are likely to take such an insurer-friendly view.

## 6. SUBJECTIVE VERSUS OBJECTIVE EVIDENCE OF DISABILITY

***Salomaa v. Honda Long Term Dis. Plan***, 542 F.Supp.2d 1068 (C.D. Cal. 2008)

Facts and holding: Samuel Salomaa was employed as a project manager for Honda. He filed a claim for disability benefits under the ERISA plan administered by Life Insurance Company of North America (LINA), asserting that his Chronic Fatigue Syndrome (CFS) disabled him. LINA denied Salomaa's claim, asserting that there were no objective findings that would support his claim. Salomaa's physician responded by noting that CFS does not show itself through objective testing.

The district court found that an abuse of discretion standard applied to its review of LINA's decision and that "benefits may rightfully be denied in this case solely on the basis that Plaintiff has not shown that he is totally disabled, even if he has established that he suffers from CFS." The court explained the distinction between requiring medical evidence of a *medical condition* (which may not be possible with CFS), and requiring medical evidence of the *impact* of that medical condition on the claimant's occupational functionality: "The Court does not rule here on whether, as a general rule, it is an abuse of discretion for a plan administrator to deny benefits when an employee cannot establish CFS with a showing of objective medical evidence. ...But the Court does affirm a plan administrator's right to require objective evidence that employees are totally disabled by the medical condition which afflicts them, regardless the condition at issue." The court then reviewed the law of various circuits in handling the above issue. Eventually the court sided with LINA.

Lessons learned: First, caution must be exercised anytime one relies on an ERISA case as instructive in a traditional DI dispute, because, as was the case here, courts often apply an abuse of discretion standard in resolving such cases, and that standard is not used in traditional judicial disputes. However, insurers should also take away the lesson that if objective evidence is being requested, it is not simply to ascertain the medical condition about which the insured complains, but the *impact* that the medical condition is having on the insured's ability to perform his occupational duties. (The court also included nice language concerning an insurer's right not to accept blindly the conclusions of treating physicians that are based solely on their patients' self-report.)

For other recent cases that also note either that it is not unreasonable for an ERISA claims administrator to require objective evidence, or that there is a difference between requiring objective evidence of a medical condition versus an impairment, see *Jackson*

*v. Prudential Ins. Co. of America*, 530 F.3d 696 (8<sup>th</sup> Cir. 2008), *Speciale v. Blue Cross and Blue Shield Ass'n*, 538 F.3d 615 (7<sup>th</sup> Cir. 2008), *Desrosiers v. Hartford Life & Acc. Ins. Co.*, 515 F.3d 87 (1<sup>st</sup> Cir. 2008) and *Williams v. Aetna Life Ins. Co.*, 509 F.3d 317 (7<sup>th</sup> Cir. 2007).

Social Security Administration decision side-bar: The *Salomaa* court also discussed the fact that the claims administrator's decision was at odds with that of the Social Security Administration, and why such a disagreement was hardly fatal to the plan's decision. For additional recent cases that touch on that subject, see *Bennett v. Kemper National Services, Inc.*, 514 F.3d 547 (6<sup>th</sup> Cir. 2008) and *Speciale v. Blue Cross and Blue Shield Ass'n*, 538 F.3d 615 (7<sup>th</sup> Cir. 2008).

## 7. BAD FAITH

### A. Delay in Payment

***Barnes v. Stonebridge Life Ins. Co.***, 2009 WL 736190 (S.D. Miss. 2009)

Facts and holding: Stonebridge issued an accident only policy to an association, of which Barnes was a member. Barnes suffered an automobile accident in January 2007, and Barnes notified Stonebridge of the accident at that time. The policy effectively required that Barnes satisfy a 180 day elimination period (he had to survive 180 days to start receiving benefits). Barnes submitted a claim in July 2007 (after he had satisfied the elimination period). Stonebridge investigated the claim, but several delays ensued, none of which were Stonebridge's fault. In late January, 2008, within days after receiving its IME report, Stonebridge approved Barnes' claim. However, Barnes had just filed suit, asserting that "the delay in paying the claim is patently unreasonable." Barnes conceded that the delay after July 2007 was reasonable, but insisted that Stonebridge should have begun examining his claim in January 2007, after he had notified the company of his accident.

Stonebridge moved for summary judgment. The court evaluated several Mississippi cases involving only delay of payment – not denial of a claim – and held that the insurer had no duty to investigate until the 180 day period had run: "The plaintiff's right to benefits did not arise until he survived 180 days beyond the date of his injury. There was no obligation on the part of Stonebridge to begin its investigation until the expiration of this time period."

Lessons learned: Delay in payment cases are always tricky, and the law varies from state to state. Here, the federal Mississippi district court opined that the duty to investigate does not run until the elimination period expires. As a practical matter, few carriers adopt this practice. It is possible the case can be distinguished on the fact that the 180-day period was not technically an "elimination" or "waiting" period, but rather a condition of coverage (the insured had to *survive* 180 days to obtain benefits). One of the factors that may have heavily influenced the court was that the insurer was very diligent in its investigation once the 180-day period started.

## **B. The “Genuine Issue” and “Fairly Debatable” Standards**

***Knoepfler v. The Guardian Life Ins. Co. of Amer.***, 2008 WL 4371767 (D. N.J. 2008)

*Facts and holding:* The insured filed suit against Guardian, and later amended his claim to assert bad faith causes of action. Guardian moved for summary judgment. The court ruled that New Jersey substantive law applied, and that under New Jersey law, “if a claim is ‘fairly debatable,’ no liability in tort will arise.” The court equated the “fairly debatable” standard as whether the insured would be able to prevail on summary judgment in the underlying claim. The court found that there were triable issues of fact as to whether the insured was, in fact, totally disabled; therefore, his bad faith claim failed.

*Lessons learned:* Different states apply different standards in assessing whether an insured’s bad faith claim can survive. California’s overall standard is whether the insurer acted reasonably, and in many cases, courts have found that if there is a “genuine dispute” as to liability, that will serve as a defense to a bad faith claim. New Jersey’s “fairly debatable” standard would seem to be the rough equivalent. However, how that standard is applied in *practice* – here, the court ruled that the insurer should prevail on the bad faith claim if the insured cannot prevail as a matter of law on the underlying claim – is highly favorable to the insurer.

***Origel v. The Northwestern Mut. Life Ins. Co.***, 2008 WL 4914839 (N.D. Cal. 2008)

*Facts and holding:* The insured, a chiropractor, claimed total disability in his occupation, due to various orthopedic ailments. There were numerous medical conditions and Northwestern Mutual conducted a significant medical and occupational investigation. Eventually it denied the insured’s claim. In moving for summary judgment, Northwestern Mutual asserted, among other things, that the insured had not provided sufficient proof of loss. The court denied this portion of Northwestern Mutual’s motion. It noted that although the insured had certainly not provided all of the information that Northwestern Mutual had requested, he had provided information sufficient to constitute proof of loss, and sufficient information from which a jury could conclude he was disabled.

With respect to the insured’s claim of bad faith, Northwestern Mutual noted that there was a disagreement among the medical experts as to the level of the insured’s medical

impairment. Courts have in the past viewed such a “battle of the experts” as a “genuine dispute” between the parties sufficient to defeat a bad faith claim. However, in this case the Court noted that there were deficiencies in Northwestern Mutual’s expert’s reports that “could provide a weak inference of bias.” The Court found this sufficient to preclude application of the “genuine dispute doctrine” defense to the bad faith claim.

Lessons learned: Here, Northwestern Mutual’s investigation appears quite thorough. One would have thought that the “genuine issue” doctrine would have precluded the claim for bad faith. Perhaps the only conclusion that can be reached is that a judge has extremely wide latitude in deciding whether to grant or deny a motion for partial summary judgment on a bad faith claim. Before some judges, and with the benefit of hindsight, an insured might only need to present skimpy evidence to be permitted to advance his or her bad faith claim to a jury.

### **C. Real World Prospects**

***Hood v. Hartford Life and Accident Ins. Co.***, 2008 WL 5101584 (E.D. Cal. 2008)

*Facts and holding:* The insured was an office services supervisor who claimed total disability due to back pain and Crohn's disease. Her policy with Hartford provided "own occ" total disability benefits for the first 30 months, and thereafter "any occ" benefits. Hartford eventually denied the insured's claim and the plaintiff sued for breach of contract and bad faith. In taking the deposition of one of the insured's doctors, Hartford believed that the doctor retreated somewhat from his prior position that the insured could do full-time work. Hartford thus re-opened the insured's claim, elected to accept the claim, and paid her all back benefits due, plus interest.

After paying the above benefits, Hartford moved for summary judgment on both the breach of contract and bad faith claims. As for the breach of contract claim, the court noted that with the payment of all back benefits plus interest, the insured had been made whole. Since the insured was unable to demonstrate any other economic damages that flowed from the delayed benefits, the Court held that there was no breach of contract to sue over. The Court so ruled even though the insured argued that at the time *she had sued*, her benefits were unpaid.

With respect to the bad faith claim, however, the Court found that there was a triable issue of fact as to whether Hartford had conducted a thorough investigation. In addition, the Court found that there was a triable issue of fact as to whether Hartford had considered the insured's "real world prospects," given her need for frequent bathroom breaks, and the lack of suitable jobs within a 50 mile distance.

*Lessons learned:* This is an interesting case. I believe other courts might not agree with this judge's opinion that because the insured was *eventually* made whole, her breach of contract claim necessarily fails. It is also important because it is one of the few cases that specifically discusses the need for an insurer to take into consideration an insured's "real world prospects." While the concept of "real world prospects" has been around for a long time (*see Moore v. American United Life Ins. Co.*, 150 Cal. App. 3d 610, 630 (1984)), it is far from clear what precisely this means. This Court took a somewhat expansive view: It not only considered the *work restrictions* that the insured's condition imposed, but also the availability of actual job prospects.

## 8. DICTIONARY OF OCCUPATIONAL TITLES

***Jones v. Mountaire Corp. Long Term Dis. Plan***, 542 F.3d 234 (8<sup>th</sup> Cir. 2008)

*Facts and holding:* Larry Jones, a sales representative who sold animal feed products, was covered under a disability policy administered by Prudential that was part of an ERISA plan. The plan defined regular occupation as the occupation the beneficiary routinely performed when his disability began. Further, Prudential was permitted to look at the occupation “as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.”

Jones had numerous heart and lung problems. He filed a claim for total disability, and his physician attested that stress and physical exertion, among other things, rendered him unable to work. Although Jones’ job was not sedentary – he regularly visited farms, handled animals and lifted large bags of feed – his job category under the Dictionary of Occupational Titles (DOT) was listed as sedentary. As a result, Prudential found that Jones could perform his occupation. Jones appealed. He asked that Prudential review his actual job duties to ensure that the company was using the correct DOT classification. After Prudential upheld its denial, Jones filed suit in federal district court. The district court found for Jones, criticizing Prudential for using the DOT, when the more up-to-date O\*Net could have been used.

The federal court of appeals found that the district court had not given the parties an opportunity to brief the issue of whether Prudential’s use of the DOT as opposed to the O\*Net was appropriate, and remanded the case to the district court, so it could do so.

*Lessons learned:* I included this ERISA case because it is under ERISA plans that the definition of total disability is often tied to occupations generally, as opposed to a claimant’s particular job. (The “job versus occupation” issue is worthy of an entire, separate legal discussion.) There are several cases that critique an insurer’s use of the DOT. This case is a cautionary tale that those carriers that do so perhaps note the reason for their use of the DOT as opposed to the O\*Net.

## 9. BUSINESS OVERHAD EXPENSE POLICIES

***Butler v. Unum Life Ins. Co. of America***, 2009 WL 604278 (W.D. La. 2009)

*Facts and holding:* Unum issued a business overhead expense policy to Butler, a former orthopedic surgeon who became disabled due to carpal tunnel syndrome. It paid up to approximately \$20,000 per month for up to twelve months. One of the requirements for a purported business expense to be covered is that it is “incur[red] on a regular basis and [is] essential to [the] established business operation.”

Butler closed his practice on January 1, 2006. Unum argued that expenses incurred after the closing or sale of a practice are not compensable, and the court noted other decisions which so held. Butler cited another BOE case in which such expenses *were* found compensable because the insured intended to continue with his practice after he recovered from his disability.

The court denied Unum’s motion for summary judgment. It found that that if the insured does not actually sell his business, the language of the BOE policy at issue should be interpreted to encompass the expenses involved in the winding down of the business, as long as those expenses are the usual and customary expenses in such a wind-down.

*Lessons learned:* The *Butler* case is helpful as a roadmap of the main decisions on the issue of whether expenses incurred after the closing of a business are compensable under a BOE policy. It is also instructive in showing that the outcome may be particularly dependent upon the specific language of the policy.

***Uno v. Provident Life and Accident Ins. Co.***, 221 Or. App. 661 (2008)

*Facts and holding:* John Uno, a disabled urologist, appealed the trial court’s determination that he was not entitled to business overhead expense benefits because he was not engaged in the practice of medicine. Although Uno had stopped practicing medicine, he continued to maintain his medical office, and employed a part-time employee for the limited purpose of collecting accounts receivable, copying and mailing patient charts, paying bills and storing financial and patient records. Uno and Provident disagreed as to whether the above expenses constituted “covered overhead expenses.” Those expenses were defined in the policy as expenses “incurred by you which are usual and customary *in the operation of your business or profession.*” The appellate

court held that “the plain meaning of ‘operation of a business or profession’ in the context of the insurance policy includes performing actions to continue plaintiff’s business, without regard to whether patients are still being treated.” In addition to basing its conclusion on the words themselves, the court noted that with an elimination period, the policy contemplated the payment of expenses over a long period of time, during which the insured must by definition already be disabled.

Lessons learned: The court in *Uno* noted that other decisions have come to the opposite conclusion, but noted the factual differences in those other decisions. Significantly, some of the other cases concerned a situation in which the insured had *sold* his practice. Obviously, expenses incurred after such a sale are not expenses incurred in the continuation of the operation of the practice.

## 10. THE “CONTRACTUAL” STATUTE OF LIMITATIONS

***Wall v. The Northwestern Mutual Life Ins. Co.***, 2008 WL 4450283 (W.D. La. 2008)

*Facts and holding:* In 1998 and 1993, Northwestern Mutual issued two policies of DI insurance to Dr. Wall, a plastic surgeon. In 2005, Dr. Wall made a claim for partial disability under the policies, claiming that long-standing coronary artery disease (CAD) impaired him.

With respect to one of the policies, Northwestern Mutual asserted rescission was proper, because Dr. Wall had lied in his policy application about his CAD. Northwestern Mutual moved for summary judgment based on the rescission, but the court denied the motion. Although it found Dr. Wall's answers false, and material to the insurer, it ruled there was a triable issue of fact as to whether Dr. Wall intended to deceive the company.

Northwestern Mutual also correctly asserted that Dr. Wall's claim was significantly untimely. Although the court agreed, it nonetheless denied summary judgment on this basis, as Louisiana (like many states) requires that an insurer demonstrate actual prejudice from the lateness of the claim before it can assert such lateness a defense.

However, Northwestern Mutual further asserted that Dr. Wall failed to file suit within the three year period mandated by the policy, a sort of “contractual statute of limitations.” The court agreed, and granted Northwestern Mutual summary judgment on the contract claim.

*Lessons learned:* (1) Note well the standards for rescission, which can vary widely from state to state. For example, while Louisiana (the state in which this case was decided) requires that an insurer demonstrate an insured's actual intent to deceive, California does not. (2) Prior to denying a claim based on late notice, determine if the state in which the insured is making the claim adheres to the “notice prejudice rule.” (3) It may be wise to seek legal counsel as to the enforceability of “contractual statutes of limitation” contained in a policy, even if no actual prejudice from a very late claim can be demonstrated.

## 11. REGULAR CARE OF A PHYSICIAN

***Bakal v. The Paul Revere Life Ins. Co.***, 576 F.Supp.2d 889 (N.D. Ill. 2008)

Facts and holding: Bakal was a commodities trader in 2004. He started complaining of hearing loss in 2003, and sought medical treatment for the problem. He filed a claim for benefits in 2005. Paul Revere asserted that Bakal's notice of claim was untimely, and also that he was not under the regular care of a physician (a prerequisite for entitlement to disability benefits).

With respect to the obligation to file notice of claim within 30 days, or as soon as reasonably possible, the court agreed that Bakal did file notice of claim within 30 days. However, because Bakal asserted he had delayed giving notice because he was hoping his condition would improve, and because the court felt that a reasonable jury might conclude that a delay in giving notice for that reason was reasonable, it denied Paul Revere's motion for summary judgment based on untimely notice of loss.

With respect to the "regular care of a physician" requirement, the court found that the insured must satisfy that prong of the TD definition to be eligible for benefits. Under Illinois law, the court interpreted that requirement to mean that "the insured is obligated to periodically consult and be examined by his or her treating physician at intervals to be determined by the physician." The court found that a physician's directive that the insured come back for treatment if he continued to have medical problems, coupled with the insured's failure to seek further treatment, meant that the insured had not satisfied the "regular care" provision, even though the insured continued to take medications for his ailment. The court believed that "although 'regular care' does not require monthly visits with accompanying monthly reports, it does require some form of continuity in the insured's treatment by physicians." (The court did note, however, that if Bakal had demonstrated that regular care would have been futile for the treatment of his condition, the regular care requirement would have been waived.) Thus, the court granted Paul Revere summary judgment for the time periods during which Bakal was not under the regular care of his physician.

Lessons learned: It may be dangerous to rely on a "regular care" provision in denying disability benefits. Not all courts may agree that taking medication alone does not satisfy a regular care provision. Further, if the court does not grant summary judgment on such a defense for the insurer, juries may not be sympathetic to the defense if the insured is otherwise medically disabled.

## 12. LIABILITY OF REINSURERS & THIRD PARTY ADMINISTRATORS

***Brand v. AXA Equitable Life Ins. Co.***, 2008 WL 4279863 (E.D. Pa. 2008)

*Facts and holding:* Brand claimed that he became totally disabled after he suffered an automobile accident. He asserted that Equitable committed bad faith by, among other things, waiting too long to make a claims decision and then asserting that he was only entitled to residual (not total) disability benefits. He also sued Centre (Equitable's reinsurer) and DMS (Equitable's third party administrator), claiming that he was a "third party beneficiary" of the contracts that Centre and DMS had with Equitable. Centre and DMS moved to dismiss the claims against them. The court granted Centre's and DMS' motion. It found that to be third party beneficiary, there must have been an intent by both parties (e.g., between Equitable and Centre) to benefit the party asserting third party beneficiary status (the insured). Here, the court found no such intent, and no compelling reason to confer such a benefit upon Brand.

*Lessons learned:* Insureds are often creative in their attempts to hold persons other than the insurer liable for what they perceive to be the wrong committed against them. While claims of direct liability against reinsurers and third party administrators grounded on third party beneficiary theories are not all that common, similar claims based on "alter ego" theories are more frequently asserted.

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