

TRIAL

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## **Disabling the Disability Carrier: How to overcome unfavorable evidence in a bad faith case**

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So your client wants to bring a claim under his or her disability policy. Be warned: Taking on a disability insurer is not for the faint of heart. The insurer will respond with a seemingly endless barrage of anti-coverage grenades in an assault that has a single objective—preventing your client from collecting disability benefits.

If the insurer suspects that your client is feigning a disability, the company will trot out one of its well-paid “independent” physicians to conduct a medical examination that, inevitably, will find your client in perfect health. If your client is wealthy, the insurer will dredge up his or her financial statements and insist that the client stopped working out of choice—not because of a disability. Or conversely, if your client’s business is struggling and his or her policy benefits are substantial, the insurer will obtain the client’s tax returns and assert that he or she filed a disability claim for financial gain—not because of an inability to work. And if all else fails, the insurer will have it paparazzi conduct a weeklong surveillance of your client that will produce—after careful editing—a 60-minute video-tape suggesting that your client could easily qualify for the Olympics (or, at the very least, perform his or her occupation).

What can you—and your client—do? There are effective ways to combat the insurer’s arsenal of coverage weapons and, in the process, fortify your bad-faith action against the insurer.

#### Disputing denials

Insurers seeking ways to disqualify an insured from coverage make several common arguments for denial of benefits.

The second job. Disability policies generally provide that an insured is totally disabled (and thus entitled to benefits) if he or she is unable to perform the substantial and material duties of his or her occupation due to an injury or sickness. The insured’s occupation is usually defined as the occupation in which he or she was regularly engaged at the time the insured became disabled. More and more, 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 might argue that a self-employed physician is not only a physician but also an “owner-manager.” The insurer would then argue that even if the insured cannot carry out medical duties (for example, perform surgeries or deliver babies,) he or she still can run the medical business and thus is not totally disabled.

However, disability policies provide coverage for the insured’s “real occupation,” “chosen profession” , or “regular job” —that is, “his particular occupation for which he seeks protection by insurance.” The fact that the insured, although unable to perform a particular occupation, might be able to perform some other occupation, is “immaterial” and “beside the point.”

So an insured physician (to continue the example) can argue that

- he or she has a single “real occupation” or “chosen profession”
- his or her occupation or profession is physician
- the insurer knew, based on the policy application, that the “particular occupation” for which the insured sought coverage was physician, and it insured him or her as such
- the substantial and material duties of that occupation are performing surgeries (or delivering babies, or whatever the case may be)—not being an administrator or otherwise running a business
- the insured’s inability to perform those duties renders him or her disabled.

Significantly, the California Supreme Court long ago rejected an insurer’s “dual occupations” argument (although it was not stated as such) in *Erreca v. Western States Life Insurance Co.* The court found that an injured ranch owner was totally disabled even though he could still buy livestock and supplies, sell farm products, arrange crop financing, negotiate leases, and determine what crops to plant and the time and price for selling them—that is, he could still administer the farming business.

The court reasoned that before his injury, the insured’s duties had included manual labor (such as plowing, driving tractors, and repairing fences and machinery) and personally supervising his employees’ farm work (by walking, horseback riding, and driving). The court concluded that because he could not perform those aspects of his occupation—the tasks of an active farmer—the way he had before his injury, he was entitled to disability benefits under his policy.

Career burnout. Disability insurers frequently argue that an insured has stopped working—and made a claim for disability benefits—out of choice, not because he or she is genuinely disabled. For example, the insurer 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 or she derives great fulfillment from working (helping clients, saving lives, working with the public, and so forth), takes enormous pride in providing for his or her family, hates being a burden to his or her spouse and children, and would work if able.

The insured’s work ethic and occupational satisfaction must be corroborated by third-party witnesses, including a 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 client. If he or she 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 retrain for an occupation that he or she 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 or she is totally disabled.

The impoverished insured. As a variation on the “choice” theme, a disability carrier might 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 more money than he or she was making at work.

Generally, you should counter this argument in the same way that you counter the “choice” argument. The insured—again, supported by friends, family, and coworkers—can testify that he or she finds work highly

fulfilling, garners great satisfaction out of providing for family, and would much rather be on the job than collecting disability benefits. Of course, if the insured made or had the potential to make more money by working than by receiving disability benefits, that fact needs to be emphasized—and, if possible, verified by balance sheets, financial projections, or similar documents.

### Keeping watch

Even if they suspect that their claimants may in fact be disabled, insurers—who want to hold on to premiums, earn interest on them, and turn their claim departments into profit centers—are constantly looking for ways to avoid paying benefits. To that end, some disability carriers make field visits or conduct surveillance of their insureds to look for evidence of alleged fraud.

The surprise guest. 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 or her into making a devastating admission that will support the choice defense (“Yeah, I’m tired; yeah, I’m burned out”), the financial gain 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 or she 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 company or, ultimately, a jury. Also instruct your client to speak with no one affiliated with the insurer (especially if the conversation is being recorded) unless you are present.

The paparazzi. Disability insurers often use outside investigators to conduct covert surveillance of claimants. The surveillance will be videotaped, span a week or more, and follow the insured virtually wherever he or she 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 the insured claims and the treating physicians corroborate.

What can you do if the insurer’s investigator videotapes you client performing activities that arguably are inconsistent with his or her disability claim? The key is to remember that “‘total disability’ does not signify an absolute state of helplessness.” 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.” Thus the insured is totally disabled if he or she cannot perform the essential duties of his or her profession in the customary way and with reasonable continuity—even if the insured can perform some of those duties to some extent on some occasions.

Accordingly, in *Erreca*, the California Supreme Court found that the ranch 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 manage the ranching business. Similarly, in *austere v. National Casualty Co.*, the California Court of Appeal held that an attorney suffering from memory loss and impaired judgment was totally disabled, although he appeared at 251 court hearings (an average of 21 per month), had 689 scheduled office appointments with clients (57 per month), and took 16 depositions—and thus was “obviously able to perform at least some of the functions of his profession.”

Applying New York law, the Second Circuit found that a dentist who spent the majority of his time performing chair dentistry, and no more than 4 of his 40 work hours each week on administrative duties, was “totally disabled” by progressive skeletal illness, even if the disability caused no change in his gross revenue.

Based on this line of cases, you should argue that the videotape merely suggests that your client can sporadically perform certain non-work activities for a few minutes over the course of a week of surveillance. It does not show that the client can perform his or her occupational duties in the manner he or she did before injury or sickness, or that the client 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 calculated effort to "investigate the claim with an eye toward denying benefits—in flagrant violation of its duty of good faith. For example, the investigator—who was recommended by the insurer's lawyer and paid by the insurer's adjuster—tracked the plaintiff 12 hours a day for 7 days, yet reduced its surveillance to a mere 1-hour tape. The other 83 hours of surveillance are conspicuously omitted. Predictably, all the activities that were videotaped (or at least all the activities that appear on the edited video) were deemed by the investigator to be inconsistent with the plaintiff's claimed disability. The investigator failed to videotape any activities (or inactivity) to the contrary. In fact, the videotape never shows the plaintiff doing nothing.
- 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 the plaintiff no opportunity to explain his or her activities on the surveillance tape. In many situations, a plaintiff has no choice but to perform certain activities because, for example, groceries have to be bought and children have 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 or she is wearing a back support, or taking medication that, if taken on the job, would prevent him or her from working.

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 or she 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 the 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 or her movements in ways that insurers—and jurors—might not observe.

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

What if the insurer filmed the insured at his or her place of work? An insured who tries to return to work is still disabled if he or she cannot perform his or her duties as before.

For example, in *McMackin v. Great American Reserve Insurance Co.*, the court found that an injured California Highway Patrol officer remained totally disabled—even though he returned to work for eight months and received his regular compensation—because he was "unable to perform his duties fully" and "worked slowly" compared to his efficiency before his injury. 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 recover of benefits.”

You must demonstrate that although the insured tried to return to work, his or her effort was unsuccessful. Perhaps the insured tried to return to work, his or her effort was unsuccessful. Perhaps the insured could perform only “temporary or intermittent work,” could not “work...with reasonable continuity,” or was only “able to perform sporadic tasks.” Or maybe he or she was unable to perform required work tasks in the “usual or customary way.”

The hired gun

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 that the insured is not disabled. When the physician inevitably reaches that conclusion, you can make numerous arguments to attack the doctor and his or her findings.

Here are a few examples:

- The doctor has a bias in favor of the insurers. The vast majority of the doctor’s practice is devoted to performing, “independent” medical examinations for which he or she 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 or she 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 the claim for his or her financial gain.)
- The doctor is not qualified to render an opinion regarding the insured’s condition. He or she devotes large amounts of time to performing IMEs for insurance companies. The doctor rarely sees other patients and does not keep current on the practice of medicine. When the doctor does practice medicine, he or she does not do so in the area that is relevant to the insured’s condition.
- The doctor ignored objective evidence of the insured’s disability, including X-rays, MRIs, CT scans, 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 negligence actions against the doctor, medical board or license problems, or even disability claims that the doctor has filed. The investigator can also search for other cases in which the doctor has testified during depositions or at trial. 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 or she is advocating in your client’s suit.

And while you are challenging the doctor, do not forget to take on the insurer. For example, if your client’s treating doctors found him or her disabled but the “independent” medical examiner did not, emphasize that an insurer has a duty to give more weight to treating physicians’ opinions than to those of other doctors.

Also if the insurance company breached its duty to provide the policy definition of “disability” to the independent medical examiner, highlight that failure as well. Finally, 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 was entitled to disability benefits.

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.

Notes:

Dixon v. Pac. Mut. Life Ins. Co., 268 F.2d 812, 815 (2d Cir. 1959); Cont'l Cas. Co. v. Novy, 437 N.E.2d 1338, 1349 (Ind. Ct. App. 1982)

Cont'l Cas. Co., 437 N.E.2d 1338, 1350.

See VanderKlok v. Provident Life & Accident Ins. Co., 956 F.2d 610, 614 (6th Cir. 1992)

Dixon, 268 F.2d 812, 815; Cont'l Cas. Co., 437 N.E.2d 1338, 1351

Pistorious v. Prudential Ins. Co., 176 Cal. Rptr. 660, 663 n.4 (Ct. App. 1981)

Warren v. Commerical Travelers Mut. Accident Ass'n of Am., 107 N.Y.2d 325, 326 (N.Y. City Ct. 1951).

121 P.2d 689 (Cal.1942).

Pistorious, 176 Cal Rptr. 660, 663 n.4; John Hancock Mut. Life Ins. Co. v. Poss, 267 S.E.2d 877, 881-82 (Ga. Ct. App. 1980).

Erreca, 121 P.2d 689,695.

Moore b. Am. United Life Ins. Co., 197 Cal. Rptr. 878, 892 (Ct. App. 1984) (emphasis added); see also Kaufman v. Provident Life & Cas. Ins. Co., 828 F. Supp 275,284-85 (D.N.J. 1992), aff'd, 993 F.2d 877 (3d Cir. 1993); Russell v. Prudential Ins. Co. of Am., 437 F.2d 602, 605 (5th Cir. 1971); Kottle b. Provident Life & Accident Ins. Co., 775 So. 2d 64, 75 (La. Ct. App. 2000); Sova v. Wheaton Franciscan Servs., Inc. Health & Welfare Benefit Trust, 40 F.Supp. 2d 1031, 1040 (E.D. Wis. 1999); Sun Life Ins. Co. of Am. v. Evans, 340 So.2d 957, 958 (Fla. Dist. Ct. App. 1976). This definition of "total disability" applies to both "own occupation" and "any occupation" policies and is read into the policy if the insurer attempts to impose a more stringent definition. See Austero v. Nat'l Cas. Co., 148 Cal. Rptr. 653,666 (Ct. App. 1978); Moore, 197 Cal. Rptr. 878, 895-96.

148 Cal. Rptr. 653, 668.

Shapiro v. Berkshire Life Ins. Co., 212 F.3d 121, 124 (2d Cir. 2000); see also Mowers v. Paul Revere Life Ins. Co., 27 F. Supp. 2d 135, 141-42 (N.D.N.Y. 1998), aff'd in part, vacated in part, 204 F.3d 372 (2d Cir. 2000); Johnson v. Trustmark Ins. Co., 771 So. 2d 307, 309-10 (La. Ct. App. 2000), cert. denied, 786 So. 2d 101 (La. 2001)

An insurance company must "fully inquire into all possible bases that might support the insured's claim" Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141,145 (Cal.1979); see also Mariscal v. Old Republic Life Ins. Co., 50 Cal. Rptr. 2d 224,225 (Ct. App. 1996); State Farm Lloyds v. Nicolau, 951 S.W.2d 444,449 (Tex. 1997); Zoppo b. Homestead Ins. Co., 644 N.E.2d 397,400 (Ohio 1994); Gulf Atl. Life Ins. Co. v. Barnes, 405 So. 2d 916,924 (Ala. 1981); Anderson b. Cont'l Ins. Co., 271 N.W.2d 368,377 (Wis. 1978).

An insurance company may not ignore evidence that supports coverage or "just focus on those facts which justify denial of the claim." Mariscal, 50 Cal. Rptr.2d 224,227; see also In re Hannover Corp. of Am., 67 F.3d 70, 73-74 (5th Cir. 1995); Hughes v. Blue Cross of N. Cal., 263 Cal. Rptr. 850, 857-58 (Ct. App. 1989); Liberty Mut. Ins. Co. v. McKneely, No. 1999-CA-01857-CAO, 2001 WL 379996, at \*3-7 (Miss. Ct. App. 2001).

99 Cal. Rptr.227,231 (Ct. App. 1971).

Id. at 233.

Kauffman, 828 F.Supp.275,285.

Erreca, 121 P.2d 689, 694.

Id. at 695.

Moore, 197 Cal. Rptr. 878, 892; see also Kottle, 775 So.2d 64,75.

Lester v. Charter, 81 F.3d 821, 830 (9th Cir. 1995); Pitzer v. Sullivan, 908 F.2d 502,506 n.4 (9th Cir. 1990).

See Moore, 197 Cal. Rptr. 878,882-883,895-96.

Monroe v. Pac. Telesis Group Comprehensive Disability Benefits Plan, 971 F.Supp. 1310,1316 (C.D.Cal. 1997); Russell b. UNUM Life Ins. Co. of Am., 40 F.Supp.2d 747, 751 (D.S.C. 1999)