

July 01, 2001

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Disabling the Disability Carrier: How to Overcome Unfavorable Evidence in a Bad Faith Case 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 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 the insurer suspects that your client is feigning his disability, 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. If your client is wealthy, the insurer will dredge up his financial statements and insist that he stopped working out of choice - not because he is truly disabled. Or conversely, if your client's business is struggling and his policy benefits are substantial, the insurer will obtain his tax returns and assert that he is filing a disability claim for financial gain - not because he is unable to work. 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? This syllabus will help you combat the insurer's arsenal of coverage weapons and, in the process, fortify your bad faith action against the insurer.

The second job

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 an "owner-manager". 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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However, disability policies provide coverage for the insured's "real occupation" [Dixon v. Pacific Mutual Life Ins. Co. (2nd Cir. 1959) 268 F.2d 812, 815; Continental Cas. Co. v. Novy (1982) 437 N.E.2d 1338, 1349], "chosen profession"[Continental, supra, 437 N.E.2d at 1350], or "regular job" [Vanderklok v. Provident Life and Accident Ins. Co., Inc. (6th Cir. 1992) 956 F.2d 610, 614] - i.e., "his particular occupation for which he seeks protection by insurance" [Dixon, supra, 268 F.2d at 815; Continental, supra, 437 N.E.2d at 1351]. And the fact that the insured, although unable to perform his particular occupation, might be able to perform some

other occupation, is "immaterial" [Pistorious v. Prudential Ins. Co. of America (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, 663, n. 4] and "beside the point" [Warren v. Commercial Travelers Mutual Accident Assoc. of America (1951) 199 Misc. 864, 865, 107 N.Y.S.2d 325, 326].

Based thereon, an insured physician (to continue the example) can argue that (1) he has a single "real occupation" or "chosen profession"; (2) that occupation or profession is physician; (3) the insurer knew, based on the insured's policy application, that the "particular occupation for which he [sought] protection by insurance" was physician, and it insured him as such; (4) the substantial and material duties of that occupation are performing surgeries (or whatever the case may be) - not being an administrator or otherwise running a business; and (5) his inability to perform those duties renders him disabled.

Significantly, the California Supreme Court rejected an insurer's "dual occupations at onset" argument (although it was not stated as such) in *Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 121 P.2d 689. In *Erreca*, the Court found that an injured owner of multiple ranches was totally disabled from his occupation 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 - i.e., administer the farming business. The Court reasoned that before his injury, the insured's duties had included manual labor (including plowing, driving tractors, and repairing fences and machinery) and personally supervising his employees' farm work (via walking, horseback and automobile), and that he could not perform those tasks - i.e., the tasks of an active farmer - as he had before his injury.

The 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 is genuinely disabled. For example, the insurer may argue that the insured has chosen to leave his job because he has grown weary of long hours and declining pay, or because he is tired of dealing with clients or patients, or because he is going through a mid-life crisis, or because he is wealthy and doesn't need the income from his occupation (or, as discussed below, because his tax-free disability benefits provide him with more money than working full-time at his occupation).

At the risk of stating the obvious, the best way to counter the "choice" argument is to deny it. For example, the insured can testify that he is not suffering from burnout or some kind of mid-life crisis, that he loves his work, that he derives great fulfillment from his profession (helping clients, saving lives, working with the public, etc.), that he takes enormous pride in providing for his family, that he hates being a burden to his wife and children, and that he would work if he were able.

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

Finally, 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 himself for an occupation which he would be physically able to pursue. And 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. *Pistorious v. Prudential Ins. Co. of America* (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, n. 4.

The impoverished insured

As a variation on the "choice" theme, a disability carrier may argue that the insured has filed its disability claim for financial gain - not because he is truly disabled. 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, this argument should be countered in the same fashion as the insurer's "choice" argument. For example, the insured - again, supported by friends, family and co-workers - can testify that he finds his occupation highly fulfilling, that he garners great satisfaction out of providing for his family, and that he would much rather be working than collecting disability benefits. And of course, if the insured made, or had the potential to make, more money working than he receives in disability benefits, that fact needs to be emphasized - and, if possible, verified by balance sheets, financial projections, or similar documents.

The surprise guest

Many disability insurers are cynical by nature. They believe that most claimants (especially those with long-standing claims or particularly high benefits) are not truly disabled - or, at the very least, are not as disabled as they contend. And 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.

Toward that end, some disability carriers conduct field visits. These visits are usually unannounced, and are designed to catch the insured performing activities that are inconsistent with his claimed disability. Additionally, the field representative often will try to take a recorded statement from the insured, hoping to lure the insured 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 importantly, you need to tell your client to assume that he is being watched by a representative of the insurer (either a field visitor or, as discussed below, a videotaper) at all times and to refrain from engaging in activities that could be misinterpreted by the insurer or, ultimately, a jury. In addition, you must instruct your client to speak with no one affiliated with the insurer (especially if the conversation is being recorded) unless you are present as well.

The paparazzi

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

So what can you do if the insurer's paparazzi videotapes your client performing activities that, at least arguably, are inconsistent with his disability claim? The key is to remember that "'total disability'; does not signify an absolute state of helplessness" [Erreca v. Western States Life Ins. Co. (1942) 19 Cal.2d 388, 396, 121 P.2d 689, 685]. 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" [Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892].¹ 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 some of those duties to some extent and/or on some occasions (on a videotape or otherwise).

Accordingly, in Erreca, supra, 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 financing, determine what crops to plant, and set the price of crops and the time for selling them. Similarly, in *Austero v. Nat. Cas. Co. of Detroit, Mich.* (1978) 84 Cal.App.3d 20, 148 Cal.Rptr. 653, the Court held that 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". 84 Cal.App.3d at 23, 148 Cal.Rptr. at 668. Based thereon, you must argue that the videotape merely suggests that that your client can sporadically perform certain non-work activities for a few minutes over the course of a week of surveillance, and does not show that he 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 include the following:

The videotape is tainted, slanted and otherwise biased. The tape reflects the insurer's carefully calculated effort to "investigate" the claim with an eye toward denying benefits rather than an eye toward paying them - in flagrant violation of its duty of good faith.² For example, the insurer's investigator - who was recommended by the insured's lawyer and paid by the insurer's adjuster - stalked plaintiff for 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 from the tape. Predictably, all of the videotaping that was done (or at least all of the videotaping that was included in the selectively spliced video) was of activities deemed by the investigator to be inconsistent with plaintiff's disability, and the investigator failed to videotape any activities (or inactivity) to the contrary. In fact, the videotape never shows plaintiff doing nothing.

The surveillance tape is distorted. The tape was deceptively created through the use of telephoto lenses, misleading camera angles, and careful omission of footage favorable to the insured.

The videotape was obtained through deceptive means. The videographer set up the activities the insured unwittingly performed, induced the insured to perform those activities, or otherwise manipulated events to entrap the insured.

The insurer offered plaintiff no opportunity to explain his activities on the surveillance tape. The insurer never wrote to plaintiff to ask if he had any explanation for his taped activities. Thus, plaintiff never had the chance to tell the insurer that he had no choice but to perform the activities on the videotape because groceries had to be bought and children had to be lifted, and there was nobody else to do it. Also, plaintiff had no opportunity to explain that he was only able to perform the tasks depicted on the tape because he was having an usually good day or was wearing a back support and was under heavy medication (a medication that, if taken at work, would prevent him from performing his job). Moreover, plaintiff had no chance to tell the insurer how many rest periods (all untaped) he had to take during the depicted activities or how infrequently he performed them because of the pain they produced. Further, plaintiff had no opportunity to explain that performing the activities on the tape caused him to suffer excruciating pain for many hours after the activities shown on the tape, and so exhausted him that he had had to rest in bed for several days. And plaintiff never had the chance to have his treating physician explain that the depicted activities were not inconsistent with plaintiff's complaints or the physician's own findings, or that the videotape showed that plaintiff had to guard himself in his movements to avoid extremes of motion that produce pain or was otherwise restricted in ways that insurers - and jurors - might not observe.

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, in violation of the insurer's duty to evaluate the insured's claim objectively, and to consider the totality of the evidence produced.³

And what if the insurer's paparazzi filmed the insured at his office or other place of work? Significantly, an insured who attempts to return to work is still disabled if he cannot perform his duties as he did before his injury. In *McMackin v. Great American Reserve Ins. Co.* (1971) 22 Cal.App.3d 428, 99 Cal.Rptr.227, the Court found that an injured C.H.P. 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" as compared to his efficiency before his injury. *Id.* at 434-435. As stated by the Court, "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." *Id.* at 438.

Thus, you must demonstrate that although the insured tried to return to work, his effort was unsuccessful. Perhaps the insured could not "work . . . with reasonable continuity" [*Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 394-395; 121 P.2d 689, 694] or was only "able to perform sporadic tasks" [*Id.*, 19 Cal.2d at 396, 121 P.2d at 695]. Or maybe he was unable to perform his work tasks in his "usual or customary way" [*Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892]. One or more of these arguments should be aggressively advanced.

The hired gun

Disability insurers frequently require their claimants to undergo independent medical examinations. In reality, though, they should be called "defense medical examinations", as the doctor is retained and paid by the insurer with one goal in mind: finding the insured not disabled. Indeed, it is virtually a foregone conclusion that the carrier's "independent" medical examiner will conclude that your client is not disabled. When the inevitable happens, there are numerous arguments you can make to attack the doctor and his findings. Here are a few examples:

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

The doctor is biased in favor of this particular insurer. Your client's insurer paid the doctor thousands of dollars to perform the "independent" medical examination, with the obvious expectation that he would come back with a finding of non-disability. And the doctor has performed many "independent" medical examinations for this insurer in the past (to his considerable profit), and certainly hopes that the insurer will continue to retain him in the future. The easiest way to ensure referrals in the future is to give the insurer an opinion that will save it money now.

The doctor performs "independent" medical examinations, including your client's, for his financial gain. Due to the restrictions of managed care, the doctor is earning far less money in his practice than he once did. It is much more lucrative for him to perform IMEs, at about \$5,000 per exam, than to actually practice medicine, especially if he has a volume 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.)

It isn't the insured who has made a choice to stop working and collect disability benefits. Rather, it's the doctor who has made a choice - the choice to sell out to high-paying insurance companies (by discrediting claimants with genuine disabilities) instead of helping patients. (This can be a particularly effective counterattack if the insurer is asserting that the insured made the choice to abandon his career.)

The doctor isn't qualified to render an opinion regarding the insured's condition. He is hardly seeing patients anymore, and does not keep current on the practice of medicine. Instead, the bulk of his time is devoted to performing "independent" medical examinations for insurance companies. And on those occasions 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.

In fact, you may want to hire your own investigator to help you neutralize the insurer's "independent" doctor and his findings. 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, during depositions and/or trial, and thereby 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're attacking the doctor, don't forget the insurer that retained him. For example, if your client's treating doctors found him disabled but the "independent" medical examiner did not, you should emphasize that an insurer has the duty to give more weight to treating physicians' opinions than those of non-treating physicians [Lester v. Chater (9th Cir. 1996) 81 F.3d 821, 830; Pitzer v. Sullivan (9th Cir. 1990) 908 F.2d 502, 506, n. 4; Gallant v. Heckler (9th Cir. 1984) 753 F.2d 1450, 1454; Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan (C.D. CA 1997) 971 F.Supp. 1310, 1315]. Further, if the insurer breached its duty to provide the policy definition of "disability" to the independent medical examiner it utilized to review the insured's claim [Moore, supra, 150 Cal.App.3d at 618 and 637-638, 197 Cal.Rptr. at 882-883 and 895-896], that failure should be highlighted as well. And if the insurer denied your client's claim without even having him undergo an independent medical examination, you should argue that an insurer has a duty to conduct such an examination before deciding whether its insured is entitled to disability benefits [Monroe, supra, 971 F.Supp. at 1316; Russell v. UNUM Life Insurance Co. of America (D.C. S.C. 1999) 40 F.Supp.2d 747, 751].

Conclusion

Armed with everything from deceptive field visits to one-sided videotapes to biased medical examiners, disability insurers are primed to wage battle with you and your client. We hope that the tips discussed in this syllabus will help you overcome the insurer's arsenal - and add zeroes to your bad faith verdict in the process.

1. This definition of "total disability" applies to both "own occupation" and "any occupation" policies [Austero v. National Cas. Co., (1978) 84 CA3d 1, 20, 148 Cal.Rptr. 653], and is read into the policy if the insurer attempts to impose a more stringent definition [Moore, 150 Cal.App.3d at 618, 637-638].
2. An insurance company must "fully inquire into all possible bases that might support the insured's claim" [Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 169 Cal.Rptr. 691 (1979); Mariscal v. Old Republic Life Ins. Co., 42 Cal.App.4th 1617, 1620, 50 Cal.Rptr.2d 224, 225 (1996)] and "must give at least as much consideration to [the insured's] interests as it does to its own" [Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 575, 108 Cal.Rptr. 480].
3. "An insurance company may not ignore evidence which supports coverage" or "just focus on those facts which justify denial of the claim". Mariscal v. Old Republic Ins. Co. (1996) 42 Cal.4th 1617, 50 Cal.Rptr.2d 224; see also Hughes v. Blue Cross of Northern California (1989) 215 Cal.App.3d 832, 845-846, 263 Cal.Rptr. 850 and Blake v. Aetna Life Insurance Company (1979) 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528.