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Care provision language is key in disability insurance policies

Does an insured have to undergo surgery in order to receive disability insurance benefits?

The issues that arise in disability insurance litigation are varied. Sometimes they are routine – such as whether the claimant is disabled from his or her own occupation or whether the “IME” doctor is biased and failed to consider all of the medical evidence. Sometimes they are more technical, such as whether the policy is contestable based on fraudulent misstatements on the application, or whether the claimant is residually disabled due to a monthly earnings loss that is greater than 80 percent of pre-disability earnings.

One of the issues that I have found myself fighting more times than I care to in my disability bad-faith practice is whether the insured is satisfying the care provisions in the policy.

By way of background, disability insurance policies typically condition benefits on the policyholder satisfying two conditions. One condition relates to the nature of the disability – it must be severe enough to prevent the insured from working. The severity will depend on whether the policy promises coverage if the insured is unable to perform the material duties of his or her own occupation, or whether the disability must be so severe that the insured cannot perform the duties required for *any* occupation. Some policies are a hybrid, providing “own occupation” benefits for a period, and then requiring satisfaction of the “any occupation” condition for benefits to continue. The second condition is that the insured be under the care of a physician.

The care provision often appears in the insurance policy in the following forms: “under the care of physician other than yourself” or “the appropriate care for the condition causing the disability”

or “under the regular care of a physician” or “under the care and attendance of a physician.”

The necessity of surgery

The disability-insurance companies have in the last decade or so aggressively interpreted these care provisions to require the insured to undergo reasonably curative surgery in order to remain eligible to receive benefits. They argue that, if the insured unreasonably refuses to undergo a simple, safe and effective surgery, the company can rightfully deny the disability claim. This issue often arises in claims involving carpal-tunnel syndrome cases where a claimant such as a surgeon or dentist or other medical professional requires both fine and gross-motor movements of the hands and fingers in order to perform their occupation.

The claim scenario goes as follows: Insured makes a disability claim and asserts that he or she cannot perform the substantial and material duties of the occupation of, say, a dentist, with reasonable continuity in the usual and customary way because of bilateral carpal-tunnel syndrome. Insurance company approves the claim. After time and efforts at conservative therapy have failed, insured is advised by his or her physician that carpal-tunnel release surgery is indicated. Insured does not want to accept risks of the surgery and refuses to have the surgery. Insurance company then denies the claim and asserts that insured has unreasonably failed to seek out and accept “appropriate care” for the disability, and therefore is no longer eligible to receive benefits.

The battle lines are then drawn. Is an insured required to undergo surgery

as a condition to receiving disability-insurance benefits?

There are only three reported cases on the issue in California: *Provident Life & Accident Insurance Co. v. Henry* (C.D.Cal.2000) 106 F.Supp.2d 1002; *Provident Life and Accident Ins. Co. v. Van Gemert* (C.D.Cal. 2003) 262 F.Supp.2d 1047; and *Buck v. UNUM Life Insurance Company of America* (N.D.Cal.2010) 2010 WL 887379. Fortunately or unfortunately, I have been involved in all three.

Provident v. Henry

In *Henry*, a case involving a podiatric surgeon with carpal-tunnel syndrome, the Court found that the language of “appropriate care for the condition causing the disability” created a duty on the part of the insured to submit to appropriate medical treatment which, in some circumstances, may include a surgical procedure.

Provident v. Van Gemert

In *Van Gemert*, in a case involving a dentist refusing to undergo cataract surgery, and faced with distinctly different language in two insurance policies, the Court adopted the reasoning of the decision in *Henry*. However, the Court found that the language of “under the care and attendance of a physician” may consist of surgery, where surgery represented the only course of medical care a reasonably prudent person would pursue.

Buck v. UNUM

And finally, in *Buck*, when the Court was confronted with two different insurance policies and two different sets of language for the care provisions, it made a finding that “under the care of physi-

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cian other than yourself” does not condition eligibility for benefits on the insured’s submitting to surgery to treat the disability. However, the Court refused to make a similar finding that “appropriate care for the condition causing the disability” did not require surgery.

The favorable finding in *Buck* that surgery was *not* required by the “under the care of physician other than yourself” language was largely based on the Seventh Circuit’s decision in *Heller v. Equitable Life Assurance Soc.* (7th Cir.1987) 833 F.2d 1253, which held that a “care and attendance” provision did not require an insured to submit to surgery as a condition of receiving benefits.

Heller is helpful for several reasons on the issue and more specifically on why non-surgical care for the treatment of carpal-tunnel syndrome can be considered “appropriate care.” There, the Court stated, “Equitable ignores the fact that many insureds like the plaintiff-appellee, choose not to undergo surgery because of the accompanying risks of infection, transfusion (hepatitis), bleeding, motor enervation of the median nerve, adhesions, scar tissue, possible anesthetic shock, trauma, anxiety, and even reoccurrence of the carpal tunnel syndrome condition.” (*Id.*, at p. 1259.) These risks are discussed in detail in the *Heller* opinion at footnote 11.

Based on the risks for carpal-tunnel release surgery, the *Heller* court concluded that, “even if the Equitable policy contained an express term requiring the insured to undergo ‘reasonably essential’ surgery, we seriously doubt that Dr. Heller’s refusal to undergo surgery would be unreasonable. This is especially the case because the carpal-tunnel syndrome condition can and does frequently reoccur even after the patient undergoes surgery.” (*Id.* at p. 1263, n. 11.)

Language must be clear

There are several ways to argue that surgery should never be required as a condition of the insured’s eligibility to receive disability-insurance benefits. To start, the policy is silent on the issue and absent an express requirement that surgery could be

required, it would be unfair to force an insured to accept risks of surgery.

We have argued that the care language is ambiguous and cannot require surgery. The Courts first look to the plain language contained in the contract and any unfair or unusual language (i.e. restrictions and limitations) *must* be brought to the attention of the party and explained before the insured is bound by it. (*Fields v. Blue Shield of California* (1985) 163 Cal.App.3d 570, 578-579 [209 Cal.Rptr. 781] (emphasis added).

Exclusions in coverage must be called to the insured’s attention, clearly and plainly before the exclusion will be interpreted to relieve the insurer of liability or performance. (*Id.*, See Also *Logan v. John Hancock Mutual Life Ins. Co.* (1974) 41 Cal.App.3d 988, 994-995 [116 Cal.Rptr. 528].)

In the absence of plain, clear, and conspicuous language, the term(s) are ambiguous. Ambiguities in insurance contracts are to be construed against the insurer and exceptions to coverage should be strictly construed and in accordance with the intent of the parties. (See Couch on Insurance 3d §§ 22.14 et. seq. and 22.30 et. seq.)

“Under statutory rules of contract interpretation, the *mutual intention of the parties* at the time the contract is formed governs interpretation.” (*AIU Ins. Co. v. Sup.Ct.* (1990) 51 Cal.3d 807, 821-822 [274 Cal.Rptr. 820] (emphasis added).) If possible, such intent is to be inferred first from the written provisions of the contract. (*Ibid.*) Words used in an insurance policy should be interpreted in their “ordinary and popular sense” (Civ. Code, § 1644) and the Court shall not be construed a contract or term to reach a result that is unconscionable. (Couch, § 22.11 page 22-33). Civil Code section 1636 provides that, “A contract must be so interpreted as to give effect to the *mutual intention* of the parties as it existed at the time of contracting, so far as the same is ascertainable and lawful.” (emphasis added).

If the terms have no “plain meaning” and are ambiguous or uncertain, they must be interpreted in the sense the insurance company reasonably believed the insured understood them *when the*

policy was issued; i.e., in accordance with the insured’s “objectively reasonable expectations.” (*AIU*, 51 Cal.3d at p. 822 (emphasis added). For example, a word or phrase may be ambiguous if it can be interpreted to have more than one meaning, both of which are reasonable. (*Cyler v. Mission Ins. Co.* (1973) 10 Cal.3d 216, 219 [110 Cal.Rptr. 139]). For example, in *Safeco Ins. Co. of America v. Robert S.* (2001) 26 Cal.4th 758, 765-766 [110 Cal.Rptr.2d 844], the California Supreme Court held that an “illegal acts” exclusion was ambiguous because it was susceptible to two reasonable meanings: acts violating criminal laws or acts violating any law, criminal or civil.

In challenging an insurer’s insistence that the insured undergo surgery as a condition of receiving benefits, we have pointed out that no insured has ever been advised that surgery is required at the point of sale. In addition, the surgical requirement is not disclosed in any of the sales and promotional materials.

We have argued that the care language was never intended to require surgery when it was drafted. The policies issued in the ‘80s and ‘90s did not contain “appropriate care” language that required surgical intervention, and none of the claims-staff training manuals indicated that an insured must submit to surgical intervention in order to be eligible for benefits.

Monitoring an insured’s recovery

Disability policies issued in the ‘70s and early ‘80s simply required that an insured’s physician certify to disability on a monthly basis. Typically, the insurance claims staff was instructed to obtain monthly Attending Physician Statements and to submit the information for medical review if there were any questions relative to the nature and extent of impairment, the restrictions and limitations, and the prognosis for recovery. Usually all that was required as proof of loss, was a monthly supplemental form completed by any physician.

Based on the deposition and expert testimony developed in *Buck v. UNUM*,
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we learned that in the early '80s, there was concern about the ability to monitor an insured's recovery due to the lack of regular medical care. Changes were made to the policy language on a going-forward basis and the policy language (for newly-issued policies) was modified to require the "regular care and attendance" of a physician.

Most insurers adopted this concept and incorporated "regular care" language into the policies. Once approved for new policies to be sold, "appropriate care" did not refer to the type of treatment being rendered, but rather to the care being provided by the appropriate medical expert. In fact, sales staff was resistant to the appropriate-care language in the policies for fear that it meant the company had the right to dictate or direct an insured's care. Legal staff was resistant to the language for fear that the company might be perceived as offering medical advice without a license.

In addition, these disability insurance policies were purchased and sold as *non-cancellable* and *guaranteed renewable*. Non-cancellable and guaranteed renewable means that as long as an insured paid his or her insurance premiums, the insurance company could not change the terms of the contract. Nor could it cancel the contract. Moreover, the companies had to permit the policies to be renewed year after year regardless of health or financial condition of the insured, as long as the premiums were paid. As a result, with those policies of insurance, the insurers were stuck with policy language that was far too restrictive to allow them to argue that surgery can be required under certain circumstances. Yet, the insurance companies are still arguing that surgery may be required despite the lack of an express condition in the policy but more importantly, contrary to the intent of the language as it was drafted.

And finally, we have argued that in order to protect consumers and to give fair warnings to the insured, it is the policy of the California Department of Insurance that any exclusions and limitations in an individual disability income policy are spelled out as clearly

as possible based on the testimony of a former attorney with the DOI. Thus, even if the Court were to find that the provisions require surgery, this is a limit on coverage which must be appropriately called to the insured's attention and in these cases, it was not.

How to make sure fair warning is given

If you are handling a disability claim and this issue comes up, here are the steps you can take to make the most compelling arguments to defeat the carrier's position:

Be sure to request all the marketing materials used to sell the policy. The companies usually created elaborate brochures that tout all the protection offered by the policies they were trying so hard to sell. You can ascertain that the materials make no mention of a requirement that undergoing surgery was a condition of coverage;

Request all the claims manuals, policy-and-procedure manuals, and training manuals for the policies when they were sold. You'll likely see that there is no mention of any kind of requirement for surgery. To the extent that this requirement is mentioned, it will likely be in only the most recent materials. This shows that when the policy was issued, the insurer did not understand the policy to require surgery. If the insurer did not hold this view, it cannot plausibly argue that the insured should have reasonably expected such a condition.

Take the deposition of the person most knowledgeable in the company about when the surgical requirement was adopted, and whether there was any discussion about the issue before it was adopted.

Track down former employees who may have knowledge of the drafting history of the relevant clauses. Using the company's own records, we have found employees who were involved in drafting the very language in dispute, who testified that the appropriate-care language was not considered to include a surgical requirement, and that the company's marketing and sales staff resisted such a requirement because they were concerned

that it would put their company at a competitive disadvantage in the marketplace.

Take discovery on whether the company has ever sought to market a policy that expressly contained a surgical requirement in California. If so, that effort itself supports the view that the more general "appropriate care" language in the policy did not contain such a requirement. In addition, find out how the proposal was treated by the Department of Insurance. Our experience is that if such requirements were proposed, the DOI rejected them.

Make sure you obtain the "informed consent" release that the surgeon would have the policyholder sign before doing the surgery. That form will list a range of risks and complications that wholly undercut the carrier's claim that the surgery is "simple" and "safe."

In deposition, ask company claims personnel to explain how risky a surgery must be before the company will not insist on the insured having it as a condition of benefits. It's unlikely that they will be able to answer this, and the absence of an answer will show that the company makes the decision about what surgery to require on an ad-hoc basis. This kind of standardless approach to claims handling is the hallmark of bad faith. (*Amadeo v. Principal Mut. Life Ins. Co.* (9th Cir. 2002) 290 F.3d 1152, 1163-1164.)

In summary, the care provisions in California were created and implemented to make certain that an insured was being treated and certified as disabled by a psychiatrist for a depression claim. But the insurance companies have now seized on an opportunity to expand this restrictive policy term and develop a hidden hurdle to trip unsuspecting disability claimants by imposing a requirement that a claimant submit to surgery and all of its attendant risks. Armed with an understanding of the legal issues and the cases, you will be well-positioned to overcome this hurdle.

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