Blurred Lines:
The Convergence of Mental/Physical Disability, Partial/Total Disability, and Legal/Factual Disability

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I. Introduction

Disability insurance cases are far from black and white. Gray areas exist, particularly when it comes to mixed questions of fact and law. Dichotomies are created due to the courts’ varying interpretations of policy provisions and factual scenarios that do not lend themselves to neatly defined categories. Questions that seem simple on the surface can become complex. This is particularly the case in following areas of disability law: (1) mental/physical disabilities; (2) total/partial disabilities; and (3) legal/factual disabilities. These three issues are prime examples of the blurred lines that exist in disability claims.

First, in mental versus physical disability cases, insureds claim that the policy’s mental illness limitation does not apply as a bar or limit to coverage because they are purportedly disabled from a physical condition or cause. The analysis may turn on the policy language or the claimant’s inability to establish a physical disability. The line between mental and physical disabilities becomes blurred when both conditions are implicated.

Second, in total versus partial disability cases, courts evaluate whether insureds who can still perform some, or even most of the essential duties of their occupations are totally disabled under the policies. Insureds may claim that they cannot perform the core duties of their occupation, thus are totally disabled. On the other hand, insurers may point to the presence of partial disability provisions in comparison to the definition of total disability in the policies to require that an insured show an inability to perform all essential duties to be totally disabled. Courts have ruled both ways, at times tailoring their decisions to the specific facts at issue.

Third, in legal versus factual disability cases, an insured who is precluded from working by operation of law (e.g. a professional license is revoked or suspended) may claim to be otherwise disabled from a factual (i.e. medical) disability. Courts evaluate the timing of the onset of the factual disability as well as the strength of the factual disability claim. Due to the context in which these cases arise, courts often favor the insurer.

In “blurred line” cases, it is important to know where the lines are drawn and what arguments can be made on both sides of the boundaries. This paper will discuss the varying approaches to these three issues as well as provide strategies for litigating these cases.

II. Mental Versus Physical Disabilities—The Debate Continues

Mental illness limitations provide fertile ground for the ongoing debate between “physical” versus “mental” disabilities. These limitations generally serve to bar or limit coverage for disabilities due to or contributed by “mental illness,” as defined by the policy. Typical cases can include depression arising from back pain or a disability allegedly resulting from a combination of both mental and physical factors.

Claimants often assert that the limitations are ambiguous and must be construed in their favor. They are quick to point out the physical nature of their symptoms or the physical origin of their disability. On the other hand, insurers stress the strength of the policy language and the nuances of the claimant’s disability, which may fall squarely within the limitation. Bright lines are difficult to draw because the analysis is often dependent on the policy provisions and the specific facts at hand. Over the years, guidelines have emerged that focus on the policy language and rules of contractual interpretation.
After touching on the application of ERISA cases to the state law analysis, the following provides a discussion of the two most prominent issues for mental/physical disabilities – the causation versus symptoms debate and approaches to dealing with combination mental/physical disability cases.

A. State Law Approaches to Mental/Physical Claims

In recent years, ERISA cases have been leading the way in developing the law on mental/physical disability claim issues. The majority of reported decisions on the subject are ERISA cases, rather than individual disability claims. (From a practical standpoint, this may happen because mental illness limitations may be more prevalent in group ERISA-governed policies, the decisions of state lower courts adjudicating non-ERISA cases are not reported, or ERISA cases are more likely to proceed to the motion briefing stage where these issues are addressed.)

Nonetheless, non-ERISA cases often draw on the holdings and concepts in ERISA cases and vice versa. For example, in Bosetti v. U.S. Life Ins. Co. in City of N.Y., 175 Cal.App.4th 1208, 96 Cal.Rptr. 3d 744, 762 (2009), a non-ERISA action, the California Court of Appeal discussed Ninth Circuit ERISA cases, such as Patterson v. Hughes Aircraft Co., 11 F.3d 948 (9th Cir. 1993) and Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794 (9th Cir. 1997), without making a distinction between ERISA and non-ERISA cases. In turn, ERISA cases, such as Johnson v. Gen. Am. Life Ins. Co., 178 F.Supp.2d 644 (W.D.Va. 2001), acknowledge the parties' citation to non-ERISA authorities, including Elam v. First Unum Life Ins. Co., 72 Ark.App. 54, 32 S.W.3d 486, 490 (2000) (reversed by Elam v. First Unum Life Ins. Co., 346 Ark. 291, 298, 57 S.W.3d 165, 170 (2001)) and Akins v. Washington Metro. Area Transit Authority, 729 F.Supp. 903, 906 (D.D.C.1990). Note that plaintiffs may point out that ERISA cases adjudicated under the de novo standard of review, rather than those adjudicated under the abuse of discretion standard, are more appropriate for comparison because de novo cases do not give deference to the insurer’s claim decision. Also, the doctrine of contra proferentum (ambiguities are construed against the drafter) may not apply in abuse of discretion cases. See e.g., Johnson v. Am. United Life Ins. Co., 716 F.3d 813, 820 (4th Cir. 2013) (if plan language remains ambiguous after application of the primary principles of contract construction, then courts are “compelled to apply the rule of contra proferentum and construe the terms strictly in favor of the insured).

Insurers in non-ERISA cases can also use discovery to their advantage. One of the primary differences in ERISA cases versus non-ERISA cases is the ability to conduct merits discovery. Thus, the additional factual development in non-ERISA cases in litigation may aid the insurer in fleshing out the underlying issues between a mental versus physical disability.

B. The Causation Versus Symptoms Debate

There is a split amongst the courts regarding how to interpret mental illness limitations that do not specify whether a condition is classified as a “mental illness” based on its symptoms versus its manifestations. For example, does the limitation apply to a claimant who suffers from depression due to chronic fatigue syndrome? The claimant has symptoms of a mental illness (depression), which manifested from a physical disability (chronic fatigue syndrome). Plaintiffs often claim that if the mental illness limitation does not specify which approach should be used, it should be deemed ambiguous and therefore construed against the insurer under the doctrine of contra proferentem. Insurers respond that there is no ambiguity – the limitation applies to symptoms, not causes. Courts have ruled both ways.
1. Courts that Employ a Symptoms-Based Analysis

The Fifth and Eighth Circuits in the ERISA context have applied a “plain meaning” analysis in finding that an illness is considered “mental” under the policy by its symptoms, not its cause. See *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979, 983–84 (5th Cir. 1996) (depression is a mental disorder, irrespective of its physical causes or symptoms); *Brewer v. Lincoln Nat’l Life Ins. Co.*, 921 F.2d 150, 153–54 (8th Cir. 1990) (affective mood disorder was a “mental illness” regardless of cause of the disorder).

In *Lynd v. Reliance Standard Life Insurance Company*, the Fifth Circuit found that permitting a cause-based interpretation would eliminate the distinction between mental and physical disorders. 94 F.3d at 983. It noted that it would be inappropriate to collapse the term ‘mental disorder’ to include only those illnesses, if any exist, which have no ‘physical” manifestations. The Court reasoned, “If the exclusion of disability, lasting more than twenty-four months, due to ‘mental or nervous disorders’ is to mean anything—and we think it must—then there is no principled basis on which to exclude Lynd’s ‘major depressive disorders’ from the reach of that exclusion.” *Id.* at 984. Likewise, *Brewer v. Lincoln National Life Insurance Company* involved ERISA-governed health policies wherein the plaintiff claimed that his son’s mood disorder derived from an organic basis and thus the mental illness limitation did not apply. The Court held that the district court erred by failing to examine the term “mental illness” as a layperson would have, which meant focusing on symptoms, not on the disease’s etiology. It held that the terms of the policies should be given their ordinary, and not specialized, meanings. 921 F.2d at 154. See also *Stauch v. Unisys Corp.*, 24 F.3d 1054, 1056 (8th Cir. 1994) (district court correctly focused on the symptoms of plaintiff’s illness; the cause was immaterial).

Other cases utilizing a symptoms-based analysis include *In re Campbell*, 116 F.Supp.2d 937, 948 (M.D.Tenn. 2000) (surveying Circuit split, concluding that definition of mental illness was not ambiguous); and *Johnson v. Gen. Am. Life Ins. Co.*, 178 F.Supp.2d 644, 657 (W.D. Va. 2001) (mental illness coverage limitation applied to exclude coverage after 24 months for insured’s depression, which was allegedly caused by his coronary disease).

2. Courts Upholding the Finding of an Ambiguity

Claimants attempting to find an ambiguity may find support from the Seventh, Ninth, and Eleventh Circuits, which have held that a mental illness limitation can be ambiguous if it fails to contain language clarifying whether an illness is categorized as mental based on its symptoms or manifestation. See *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 950 (9th Cir. 1993) (term “mental disorder” construed in plaintiff’s favor); *Billings v. UNUM Life Ins. Co. of Am.*, 459 F.3d 1088 (11th Cir. 2006) (obsessive compulsive disorder was organic in nature, thus negating limitation); *Phillips v. Lincoln Nat’l Life Ins. Co.*, 978 F.2d 302, 311 (7th Cir. 1992) (congenital encephalopathy, an organic brain disorder, is not subject to mental illness limitation).

These Courts in specific cases held that the limitation does not apply to mental illnesses that result from physical causes. See *Patterson*, 11 F.3d at 950; *Billings*, 459 F.3d at 1094; *Phillips*, 978 F.2d at 311. In *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794 (9th Cir. 1997), for example, the Ninth Circuit held that the plaintiff’s depression, which was caused by fibromyalgia, fell outside the mental illness limitation. The Court applied *contra proferentem* to find that the phrase “mental disorder” does not include mental conditions resulting from physical disorders.

However, insurers maintain that these cases are distinguishable because the mental illness provisions in those policies were undefined. As noted in *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 541 (9th Cir. 1990), the term “mental illness” was ambiguous when “[t]he policy contains no definition or explanation of the term ‘mental illness,’ and offers no illustration of the conditions that are included or excluded.” See also *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948 (plan did not define “mental disorder,” or offer illustrations.
of conditions that are excluded or included); *Phillips v. Lincoln Nat’l Life Ins. Co.*, 978 F.2d at 310–11 (holding that “the Plan term ‘mental illness’ is ambiguous as applied to individuals like [the plaintiff] who have mental disorders caused by organic illnesses” when “the Plan contains no definition or explanation of the term ‘mental illness,’ and offers no illustration of the conditions that are included or excluded”); *Billings v. UNUM Life Ins. Co. of Am.*, 459 F.3d at 1093 (policy ambiguous where it defined “mental illness” as “mental, nervous or emotional diseases or disorders of any type” and did not identify specific examples).


Many policies now identify specific mental disorders, which provide examples of the types of mental illnesses subject to the limitation. See, e.g., *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 378 F.App’x 725 (9th Cir. 2010) (unpublished) (limitation applied where plan defined mental disorder as a disorder found in Diagnostic Standards Manual (DSM), and depressive disorders were found in that manual); *Randles v. Galichia Med. Grp., P.A.*, No. 05-1374 WEB, 2006 WL 3760251, at *2 (D.Kan. Dec. 18, 2006) (evidence showed that disability was caused or contributed by a mental disorder, which was defined as “Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorder, anxiety and anxiety disorders.”) Even if the subject policy does not identify the specific mental disorder at issue, insurers can use these examples to serve as guideposts.

Insurers also distinguish decisions that rely on the organic nature of a mental illness. As noted in *Johnson v. Gen. Am. Life Ins. Co.*, 178 F.Supp.2d 644, 657 (W.D.Va.2001), “a great many ‘mental illnesses’ are now traceable, at least in part, to chemical imbalances and other underlying physiological conditions. . . To say that an illness is not ‘mental’ because it has an identifiable physical cause would narrow the term ‘mental illness’ to an absurdly low number of conditions about which scientists do not currently have any physiological understanding.” Id. at 656. *Johnson* provides a thorough discussion of relevant case law and contractual interpretation. It held that the alleged cause of the claimant’s depression from cardiac issues did not defeat application of the mental illness limitation.

Since policies in recent years are more likely to cite specific examples of mental illnesses, such as depression or anxiety disorders, or reference the Diagnostic and Statistical Manual of Mental Disorders (DSM) in their definition of mental illnesses, insurers can benefit from distinguishing the insured’s cited cases based on the policy language and/or factual situation.

**C. Combination Physical + Mental Disabilities**

Additional questions are posed when a disability results from both physical and mental conditions, which together result in disability. For example, a claimant may claim to be disabled from both fibromyalgia and depression. Insureds may contend that the mental limitation does not apply because the physical component is the disabling factor while the insurers may maintain the opposite – the mental condition commands the application of the limitation. This is a mixed factual and legal question. The nature of the disability must be examined (e.g. the physical component may actually play no part in the disability) against the backdrop of the legal interpretation of the policy.
1. Decisions Favoring Insurers

Courts generally uphold mental illness limitations in mixed causation cases that apply to disabilities that are “contributed to” or result “in part” by mental disorders. For example, in *Gunn v. Reliance Standard Life Ins. Co.*, 399 F.App’x 147 (9th Cir. 2010) (unpublished), the Ninth Circuit affirmed the denial of long-term disability benefits following the 24-month mental illness limitation period for a claimant who claimed to be disabled by both depression and multiple sclerosis. The policy’s limitation stated that “Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable” beyond the 24-month period unless the claimant is in a hospital or institution at the end of the 24-month period. The plaintiff argued that multiple sclerosis was the sole cause of his disability, and alternatively, his depression was due to the multiple sclerosis. The court held that the plaintiff could not prevail if his disability resulted from a combination of depression and multiple sclerosis. It stated: “The opinion that multiple sclerosis and severe depression, considered together, resulted in total disability is not sufficient to avoid the policy limitation precluding benefits where mental or nervous disorders caused “or contributed to” the applicant’s disability.” *Id.* at 152. Plus, the court found that the records did not indicate that his depression was solely caused by multiple sclerosis. See also *Eastin v. Reliance Standard Life Ins. Co.*, No. 13-6247, 2014 WL 3397141, at *3 (6th Cir. July 10, 2014) (no additional benefits where medical records supported insurer’s determination that depression contributed to plaintiff’s disability and the plain language of the plan provided for a lifetime maximum benefit of twenty-four months when a mental disorder contributed to a disability).

Similarly, in *Schwob v. Standard Ins. Co.*, 248 F.App’x 22, 29 (10th Cir. 2007), where the policy limited benefits for “Disability caused or contributed to by a Mental Disorder,” the Sixth Circuit found that the limitation applied where there was substantial evidence that a mental disorder caused or contributed to her disability. The plaintiff tried to tie her depression and cognitive problems to her Lyme disease. The court determined that “As long as Dr. Schwob’s mental disorder contributed to her disability, the limitation would apply even if the mental disorder resulted from Lyme disease or another physical disease.” *Id.* at *29. See also *Madrigal v. CNA Grp. Life Assur. Co.*, No. 03-74817, 2006 WL 2796189, at *8 (E.D. Mich. Sept. 27, 2006) (where plan excludes coverage for “any loss caused by, contributed to, or resulting from ... Disability beyond 24 months after the Elimination Period if it is due to a Mental Disorder of any type,” it is reasonable to construe this provision as terminating benefits after 24 months where the continued entitlement to benefits rests, in whole or in part, upon a mentally disabling condition that spanned the entire 24-month period).

Courts have also upheld mental illness limitations that contain “in whole or in part” language. In *Ringwald v. Prudential Ins. Co. of Am.*, 754 F.Supp.2d 1047, 1055 (E.D.Mo. 2010), the policy provided that “Disabilities, which, as determined by [the insurer], are due in whole or part to mental illness have a limited pay period during your lifetime.” *Id.* at 1047. Under a *de novo* standard, the court held that under this policy language, “If a mental illness, in whole or part, causes a participant to be unable to perform any gainful employment, then he will not receive any further benefits beyond the 24 months of benefits he has already received. Thus, if a mental illness, in combination with a physical illness, causes a participant to be unable to perform any gainful employment, then benefits are limited to 24 months.” *Id.* at 1055.

2. Insurer Strategies to Overcome Decisions Favoring Claimants

Some courts are inclined to permit recovery for mixed causation claims if they find the mental illness limitations are ambiguous in not addressing causation. In *Gemmel v. Systemhouse, Inc.*, No. CIV 04-198-TUC-CKJ, 2009 WL 3157263 (D. Ariz. Sept. 28, 2009), the court found that benefits beyond the 24-month period were warranted because the plaintiff’s disability was not solely attributable to a mental disorder. The policy provided that monthly benefits for “Total Disability due to mental or nervous disorders will not be payable...
beyond twenty-four (24) months . . . “ The insurer’s reviewing doctors concluded any disability was psychiatric in nature, but the court noted her long history of physical complaints - degenerative disc disease, fibromyalgia, connective tissue disorder, etc. Under de novo review, the court determined that if there was a physical component to the disability, the mental illness limitation could not be invoked.

In addition, if the “mental illness” is not defined, courts may hold that co-morbid mental/physical conditions that combine to result in a disability are exempt from the limitation. In Patterson v. Hughes Aircraft Co., 11 F.3d 948 (9th Cir.1993), the plan limited benefits for any disability “caused by or resulting from ... [m]ental, nervous or emotional disorders of any type,” but did not define “mental disorder.” The Ninth Circuit found the limitation ambiguous and interpreted it in the plaintiff’s favor, explaining that if his physical condition of headaches contributed to his total disability, the disability did not fall within the limitation.

Insureds often raise contractual interpretation disputes challenging the limitations. However, if the insureds lack proof on their disability – whether mental or physical – the legal interpretation of the policy and questions of ambiguity should be moot. In Coleman v. Am. Int’l Grp., Inc. Group Benefit Plan, 87 F.Supp.3d 1250, 1262-63 (N.D. Cal. 2015), the court found that the insurer reasonably invoked the 24–month mental illness limitation. The plaintiff’s medical records identified a host of diagnoses, many of them for physical ailments, but the court recognized that diagnosis of a physical ailment is not alone sufficient to establish disability. See also, Reid v. Aetna Life Ins. Co., 393 F.Supp.2d 256, 264-65 (S.D.N.Y. 2005) (plaintiff suffered from multiple physical problems, but the record does not support a finding that his mental health issues did not contribute to his disability); Massengill v. Shenandoah Life Ins. Co., 459 F.Supp.2d 656 (W.D. Tenn. 2006) (participant was not totally disabled by her claimed physical diagnoses of chronic pain syndrome, fibromyalgia, and systemic lupus erythematosus at expiration of maximum benefits period for mental disability).

For example, in Gent v. CUNA Mut. Ins. Soc’y, 611 F.3d 79, 86 (1st Cir. 2010), the First Circuit reviewed the evidence and found that the plaintiff’s disability was caused by depression (which was subject to the mental illness limitation), not Lyme disease. The plaintiff’s argument that the mental illness limitation was ambiguous made no difference because she still could not show her disability resulted from a physical or organic cause. See also Pace v. Liberty Life Assur. of Boston, No. CIV.A. 05-152-KD-C, 2006 WL 287863, at *18 (S.D. Ala. Feb. 3, 2006) (judgment in favor of insurer where plaintiff could not provide documentation of a physical or mental impairment consistently during the six month elimination period); Harrison v. Catholic Healthcare W. Grp. Long Term Disability Plan, 612 F. Supp. 2d 1099 (C.D. Cal. 2009), amended (Jan. 28, 2009) (administrator did not abuse its discretion in determining that beneficiary was not suffering from physical ailment).

At bottom, if the plaintiff does not have the evidence to support his or her physical disability, the plaintiff’s legal arguments on the mental/physical dichotomy should be irrelevant.

III. Total Disability vs. Partial Disability

The distinction between total disability and partial disability often falls into a gray area. The line between the two becomes particularly blurred when claimants continue to work in their occupation while claiming to be totally disabled. Typical cases include doctors/dentists who continue to own and manage their practices and physicians who claim to be restricted from performing certain procedures, such as surgery, which they characterize as defining features of their occupation. Claimants in these situations maintain that their disabilities are “total” disabilities, not “partial” disabilities because they are unable to perform a core aspect of their occupation, even if they are still able to perform other essential duties that allow them to keep practicing.
Claimants rely on the definition of total disability in the policies, which often do not specify that an insured must be disabled from “all” essentially duties. On the other hand, insurers will point to the presence of a residual disability clause in the policy, maintaining that the definition of residual disability, which typically provides coverage if an insured is unable to perform “one or more” of his or her essential duties, results in a finding that total disability means what it implies – total.

This debate is an open question in most jurisdictions. Courts that have confronted the issue have taken one of two approaches. In the first approach, courts hold that in order to recover total disability benefits, an insured must show that his disability prevented him from performing all of those duties, not just some of them. See, e.g., Conway v. Paul Revere Life Ins. Co., No: 5:99CV150–T, 2002 WL 31770489, *9 (W.D.N.C.2002), aff’d, 70 F. App’x. 117, 2003 WL 21730096 (4th Cir.2003); Yahiro v. Nw. Mut. Life Ins. Co., 168 F.Supp.2d 511 (D.Md.2001); Dym v. Provident Life & Accident Ins. Co., 19 F.Supp.2d 1147 (S.D.Cal.1998). In the second approach, courts have concluded that the definitions of “total disability” and “residual disability” are ambiguous and hold that an insured can be totally disabled despite being able to perform one or more substantial and material duties. See, e.g., Giddens v. The Equitable Life Assurance Soc’y of the United States, 445 F.3d 1286 (11th Cir.2006) (rejecting “all” substantial and material duties interpretation); Dowdle v. Nat. Life Ins. Co., 407 F.3d 967 (8th Cir. 2005) (discussing the two lines of cases and holding that where the insured’s disability prevented him from performing the most important part of his occupation as an orthopedic surgeon, he was entitled to total disability benefits under Minnesota law).


A. Cases Supporting the Insurer’s Position—An Insured Who Can Still Perform “Some” Material Duties Is Not Totally Disabled

Courts that uphold the insurer’s interpretation of total disability as the inability to perform all of the insured’s essential duties recognize the interplay of the residual disability clause. In Duda v. Standard Ins. Co., 649 F. App’x 230, the Third Circuit upheld the District Court’s grant of summary judgment in favor of the insurer, holding that under Pennsylvania law, the claimant’s inability to perform open surgeries did not constitute total disability. Dr. Duda was an orthopedic surgeon who claimed he could no longer perform open surgery (invasive procedures including total joint replacement surgery), which he claimed was the cornerstone of his practice because it served as the “magnet” that drew the full array of surgical procedures performed at the practice. Dr. Duda’s other occupational duties included non-open procedures, in-office visits with patients, which involved patient consultations and non-surgical procedures such as joint aspirations, orthopedic injections, fracture treatments, and castings. According to Dr. Duda’s billing codes, total knee replacements and other open surgery procedures accounted for approximately 1.8% and 6.5%, of all procedures, while non-open procedures accounted for over 91% of his procedures. Under the policies, “total disability” was defined to mean that “the insured, due to injury or sickness, cannot perform the main duties of his or her regular occupation.” Id. at 236.

The Third Circuit upheld the grant of summary judgment on the breach of contract claim in favor of the insurer, holding that in reading the total and residual disability definitions together, “it is clear that an insured who can still perform some of the main duties of his occupation is not eligible for ‘total disability’
benefits.” *Id.* at 235. Even assuming open surgeries were the driver of Dr. Duda’s practice, he could not prevail on the theory that open surgery was the exclusive “main duty” of his regular occupation. The Court stated, “Because Duda’s inability to perform open surgeries did not preclude him from performing some of the main duties of his occupation at the time of his total disability claims, Lincoln did not breach the policies by denying those claims.” *Id.* at 237. The Court similarly upheld the grant of summary judgment on the bad faith claim, since no reasonable jury would find that the insurer lacked a reasonable basis for denying total disability benefits.

In *Hansen v. Nw. Mut. Life Ins. Co.*, No. A14-1703, 2015 WL 4611950 (Minn. Ct. App. Aug. 3, 2015) (unpublished), the Minnesota Court of Appeals held that an insured is not totally disabled when she may still perform at least one of her principal duties. The policy defined total disability as the inability to perform the principal duties of the insured’s occupation and required that he or she not be gainfully employed in any occupation. The policy also contained a partial disability provision which provided that an insured is partially disabled when she is unable to perform one or more principal duties which accounted for at least 20% of the time she spent at her occupation before the disability started or has at least a 20% loss of time spent at her occupation. The plaintiff, an obstetrician/gynecologist who has epilepsy, asserted that her inability to perform surgeries, deliver babies, cover call, and perform obstetrics-related work rendered her totally disabled as defined by the policy. The insurer determined that Dr. Hansen was still able to perform her non-surgical gynecologic duties, which accounted for 42% of her pre-disability duties and 23% of the related charges.

The Court granted summary judgment in favor of the insurer, holding that the total disability definition was unambiguous. It reasoned, “Read together, these provisions clearly state that an insured may have more than one principal duty, and that an insured is not totally disabled when he may still perform at least one of his principal duties.” *Id.* at *1. An insured is not totally disabled when he may still perform at least one of his principal duties. The Court found no genuine factual issues to defeat summary judgment. Although Dr. Hansen’s experts declared that OB/GYN is a fundamentally surgical practice and that office work is secondary to the principal duties of an OB/GYN, the Court held that because Dr. Hansen was still able to “perform some of her most important duties, she is not entitled to receive total-disability benefits.” *Id.* at *4. The Court rejected Dr. Hansen’s argument that she could not sustain a practice with her limited duties. Rather, “[t]he undisputed fact that Dr. Hansen can still provide services that comprised 42% of her production before the onset of her disability establishes that she is not totally disabled.” *Id.* at *3. The Court cited *Socas v. Nw. Mut. Life. Ins. Co.*, 829 F.Supp.2d 1262 (S.D.Fla.2011); *Hershman v. Unumprovident Corp.*, 660 F. Supp. 2d 527 (S.D.N.Y. 2009); and *Provident Life & Acc. Ins. Co. v. Knott*, 128 S.W.3d 211 (Tex.2003) in support of its decision.

Other courts are in accord. See, e.g. *Karlin v. Paul Revere Life Ins. Co.*, 742 F.Supp.2d 1253 (D. Kan. 2010) (language of disability insurance policy, construed as a whole, was not ambiguous; a person who could perform some but not all important duties of his occupation had a “residual disability” not a “total disability” under the policy); *Bowery v. Berkshire Life Ins. Co. of Am.*, No. 3:11-CV-03, 2013 WL 1497339, at *5 (E.D. Tenn. Apr. 11, 2013); *Bond v. Cerner Corp.*, 309 F.3d 1064 (8th Cir. 2002); *McOsker v. Paul Revere Life Ins. Co.*, 279 F.3d 586 (8th Cir. 2002); *Conway v. Paul Revere Life Ins. Co.*, No. Civ. 5:99CV150–T, 2002 WL 31770489, at *9 (W.D.N.C. Dec. 5, 2002); *Yahiro v. Nw. Mut. Life Ins. Co.*, 168 F.Supp.2d at, 517–518; *Dym v. Provident Life & Accident Ins. Co.*, 19 F.Supp.2d at 1149–50; *Phelps v. Unum Provident Corp.*, 245 F.App’x 482 (6th Cir. 2007) (dismissing insured’s bad faith claim, holding that it was reasonable for the insurer to maintain that “total disability” required Dr. Phelps to show something more than an inability to perform certain material duties of a dentist).
B. Decisions in Favor of Claimants—“Important Duties” Means Most, Not All Important Duties

Under the second approach, courts find that an insured does not have to establish an inability to perform “all material duties” in order to be totally disabled under the policy. See, e.g., Dowdle v. Nat. Life Ins. Co., 407 F.3d 967 (8th Cir. 2005) (insured was totally disabled by reason of his inability to perform orthopedic surgery, notwithstanding his continuing ability to manage non-surgical patients); Stoneman v. Paul Revere Life Ins. Co., No. 12-15334, 2013 WL 6768616 (E.D. Mich. Dec. 20, 2013). Courts may emphasize the inequities that may result if the test were taken to the extreme – i.e., a claimant who could not perform most of her material duties would not be entitled to benefits simply because she could perform one material duty. See Gross v. Unum Provident Life Ins. Co., 319 F.3d 1129, 1141 (C.D. Cal. 2004) (“a literal interpretation of the total disability clause would defeat the very purpose of insurance against total disability, because it rarely happens that an insured is so completely disabled that he can transact no business duty whatsoever.”) From a practical standpoint, this scenario does not play out because the battles over total disability occur when insureds demonstrate far greater work capacity, nonetheless insureds still rely on this hypothetical. Courts rejecting the “all material duties” approach attempt to find a middle ground, recognizing that a claimant still has to prove he is unable to perform the vast majority or most of his material duties. This still leaves room for insurers to maintain that the claimant is unable to satisfy the definition of total disability even under the standard of the second approach.

For example, in Giddens v. Equitable Life Assur. Soc. of U.S., 445 F.3d 1286 (11th Cir. 2006), the Eleventh Circuit, interpreting Georgia law, declined to adopt an “all material duties” standard and instead described residual versus total disability as existing along a “continuum” of disability. The Court reasoned that “[a]t some point, a line must be drawn where the disability becomes so severe, and affects such a large percentage of the insured’s material and substantial duties, that the disability is total rather than residual.” Id. at 1301. The presence of the residual disability provision did not compel any particular conclusion about where the line should be drawn. The insured in Giddens, a former dentist, was able to establish that he was unable to perform the vast majority of his substantial duties of his new occupation as a real estate developer due to cognitive impairment, fatigue, and side effects from his medications. The Court held that he was not required to prove he was unable to perform all of his material duties under its interpretation of Georgia law.

The context of Giddens is important. Giddens is not a case where the insured continued to work or was only slightly limited in his job duties. Rather, Giddens was unable to perform the “vast majority” of his substantial duties of his occupation. Courts have distinguished Giddens on this ground. See, e.g. Berenguer v. Lincoln Nat. Life Ins. Co., No. 2:06CV190, 2006 WL 3327643, at *17 (E.D. Va. Nov. 15, 2006) (even under the standard in Giddens, the plaintiff would still not be totally disabled because he was capable of engaging in the duties of an office-based gynecological practitioner); Repass v. Nw. Mut. Life Ins. Co., 684 F. Supp.2d 779, 783 (S.D.W. Va. 2009) (court was not required to choose among the different approaches because even under the more favorable Giddens standard, the plaintiff still could not show he was totally disabled under the terms of the policy at the critical time). The facts that compelled the Court’s discussion of total disability in Giddens are also instructive. The insured in Giddens submitted evidence during the claim that his real estate development activities were only a passive investment carried on by his wife, but later characterized his occupation as involving entrepreneurial, financial, planning, coordinating, and administrative duties. This explains how the “all” material duties question materialized as one of the main issues in the case whereas it may not have been an issue in other similar cases where the insured is not working in any capacity.

Plaintiffs may also cite to Leonor v. Provident Life & Acc. Co., 790 F.3d 682 (6th Cir. 2015), a recent Sixth Circuit decision which held that under Michigan law, the policy’s requirement of an inability to perform
“important duties” of the insured’s occupation did not mean “all important duties.” However, in Leonor, the Court also acknowledged that there is a threshold to be met (i.e. the inability to perform most material duties) before an insured can be declared totally disabled. The plaintiff in Leonore was a dentist, who also owned and managed a number of dental practices and other businesses. Prior to his disability, he worked 35-40 hours per week performing dental procedures and spent 15-25 hours a week managing his dental practices and other businesses. These investments brought in over half of his income. After his injury, he “more aggressively” sought out “investment opportunities in terms of purchasing dental practices.” As a result, his overall income increased after his disability.

The policies in Leonor provided “total disability benefits” in the event that the insured became unable to perform “the important duties of [his] Occupation.” The appeal turned on the question of whether the words “the important duties” necessarily meant “all the important duties.” The insurers maintained that the policies’ residual disability clauses, which recognized the insured’s inability to perform “one or more” important duty, suggested that “total disability” must refer exclusively to the inability to perform all important duties. The Sixth Circuit disagreed, holding that the separate definition of “residual disability” did not eliminate the ambiguity of the policies’ definition of total disability. Citing Giddens, the court held that the presence of the residual-disability category only means that a totally disabled individual must be unable to perform most, as opposed to some, of the important duties of her profession. Dr. Leonor met this standard because he was unable to perform the important duties of his occupation that had occupied approximately two-thirds of his time. Even if Dr. Leonor's business management activities were a significant source of income, they were not the “core” of his occupation as a dentist. The Court characterized his business management as only a “side-operation,” speculating that Dr. Leonor spent the majority of his time performing dental procedures either due to subjective preference (he could have found dentistry more rewarding) or due to financial considerations (performing dental procedures is likely a more stable source of income than owning and managing businesses).

These cases demonstrate that a literal interpretation of the definition of total disability can be downplayed by the courts, but the context of the claimant’s disability and the facts matter.

C. Strategies for Litigating Disability Cases Under the Second Approach

As Leonor and Giddens demonstrate, it is particularly important for insurers to focus on the insured's occupation and abilities when litigating cases in jurisdictions adopting the second approach. For example, in Socas v. Nw. Mut. Life Ins. Co., 829 F.Supp.2d 1262 (S.D. Fla. 2011), the court held that even if the policy’s definition of total disability was ambiguous as to whether it required inability to perform any of the principal duties, or just inability to perform the majority of the principal duties, the insured was not totally disabled under either scenario. The insured was a general dentist both before and after the automobile accident that she claimed left her totally disabled. Although she could no longer perform complex surgical procedures, she could perform majority of her previous duties, including crown and bridge work, simple oral surgery, and non-surgical endodontics and periodontics.

Likewise, it may be important to explore if there is a dual occupation at issue. Klein v. Nat'l Life of Vermont, 7 F.Supp.2d 223, 228 (E.D.N.Y. 1998) (“[M]anagement of a health care facility by a health care professional may well constitute an occupation separate and apart from that of the health care practitioner.”). In Klein, the court held that a podiatrist was not totally disabled despite his inability to perform surgery because he could still perform his occupation of managing clinics. It found that Dr. Klein's pre-disability ownership of numerous podiatry clinics was not just a passive investment. He was principally engaged in the management and operation of a chain of his podiatric clinics—an activity he continued to engage in for at least the next two years following the onset of his disability. His podiatric surgical practice, from which he claimed to
be disabled, was, at most, a minor and insubstantial part of his work and income. See also Brotman v. Nat’l Life Ins. Co., No. 94 CV 3468 (S), 1997 WL 442173, at *2 (E.D.N.Y. Aug. 5, 1997) (“A reasonable inference can be drawn that Dr. Brotman’s ownership of these clinics constituted an occupation separate and apart from his occupation of surgeon. If the Plaintiff had more than one occupation and was still qualified to perform any one, the Plaintiff did not have a total disability, and is not entitled to payments from Defendant.”)

Courts may also utilize a “continuity” approach to the disability analysis, which focuses on the continuity of work both before and after disability to determine if the insured is performing work that involves the same general characteristics. If the work is too similar, total disability is defeated. As the court in Hershman v. Unumprovident Corp., 660 F.Supp.2d 527, 534 (S.D.N.Y. 2009) explained:

“In Hershman’s case, there is far too much continuity between his work before and after the onset of his back condition to sustain a ‘total disability’ finding. Hershman prospered as a cardiologist then and he prospers as a cardiologist now. He works from the same office, sees many of the same patients, supervises the same multi-million dollar laboratory business, and earns roughly the same income. Like before the back injury, he makes daily hospital rounds and is frequently on call. His inability to perform invasive procedures in the catheterization lab is the only professional consequence of his disability.” Id. at 533.

Hershman's invasive procedures accounted for less than 50% of his work. The court held that at best, Dr. Hershman was a cardiologist with two sets of duties, consultative and invasive. His undisputed ability to perform consultative cardiology rendered a finding that he was not totally disabled.

Similarly, in a recent case, Nefsky v. Unum Life Ins. Co. of Am., No. 1:15-CV-2119-WSD, 2017 WL 621269, at *4 (N.D. Ga. Feb. 15, 2017), the court compared the insured’s pre-disability and post-disability duties. The insured in Nefsky was a watch and jewelry broker, who suffered from a retinal vein occlusion. He claimed he was limited from performing certain eye-intensive tasks, such as product inspection, which he could not do for as long as he did before. The court granted summary judgment in favor of the insurer, finding that the plaintiff was only residually disabled, not totally disabled. His eye condition restricted him from performing certain tasks for as long as or as effectively as he performed them before his injury/sickness, but it did not prevent him from engaging in his regular occupation. He still continued to buy and sell items at trade shows, over the telephone, and over the internet, working ten to twenty hours per week.

These cases demonstrate that the claimant’s occupation and the ability to continue working can be determinative. Unlike in ERISA cases, discovery can be undertaken to investigate the full range of the claimant’s pre-disability and post-disability occupations and finances that stretch beyond the claimant’s rough estimates or recollection of the amount of time spent on their specific job duties. This includes discovery to obtain calendars (including those kept electronically), appointment books, emails, billing codes, financial/corporate/tax documents (i.e. showing how was the corporation formed and how is it structured), documents pertaining to other disability claims, malpractice insurance documents, and other discovery for statements concerning the claimant’s representations about his occupation and income.

IV. Factual Versus Legal Disabilities

Examples of legal disabilities include the inability to work due to incarceration, the loss or suspension of a professional license, or restrictions imposed by a licensing board. See, e.g., *Massachusetts Mut. Life Ins. Co. v. Ouellette*, 159 Vt. 187, 617 A.2d 132 (1992) (incarcerated optometrist not entitled to disability benefits); *Massachusetts Mut. Life Ins. Co. v. Millstein*, 129 F.3d 688, 691 (2d Cir. 1997) (lawyer prevented from practicing because of the loss of his license, not his alleged medical conditions); *Zenk v. Paul Revere Life Ins. Co.*, 171 F.Supp. 2d 929, 935 (D. Minn. 2000) (ability to practice medicine only ceased when plaintiff decided voluntarily surrender his medical license).

Disability insurance comes into play when insureds who are precluded from working due to their legal disabilities, seek benefits based on their medical conditions, claiming that but for their factual disabilities, they would still be working. As discussed below, courts evaluate the nature and timing of the disability, in keeping with the general principle that legal disabilities are not compensable.

**A. The General Rule—Coverage is Provided for Factual Disabilities, Not Legal Disabilities**


The distinction between factual disabilities and legal disabilities is typically rather clear. Conflicts arise, however, when an insured has both a legal disability and factual disability concurrently. For example, a disbarred attorney may claim that his depression which led to his negligent handling of cases is first and foremost a factual disability. A legal disability will not automatically serve as a bar to benefits. See, e.g., *Berry v. Paul Revere Life Ins. Co.*, 2008-0945 (La. App. 1 Cir. 7/9/09), 21 So.3d 385, 390. “There is no rule that legal impediments per se can never be a basis for disability.” *Id.* If a claimant suffers from both a factual and a legal disability and the factual disability is medically bona fide and genuinely arose before the legal disability, the fact that the legal disability arose later will not necessarily terminate a claimant’s right to disability benefits. *See Ohio Nat’l Life Assurance Corp. v. Crampton*, 822 F.Supp. 1230, 1233 (E.D.Va., 1993). In those situations, the claimant must demonstrate that his factual disability was the cause of the claimant’s inability to work. *Paul Revere Life Ins. Co. v. Bavaro*, 957 F.Supp. 444, 449 (S.D.N.Y. 1997). Accordingly, courts have fashioned several guidelines to aid in the analysis.

**B. Guidelines for the Legal Versus Factual Disability Analysis**

1. **Did the Factual Disability Follow the Legal Disability?**

As an initial matter, courts examine which of the two disabilities occurred first. “If the legal disability preceded the onset of the factual disability, the courts uniformly hold that the claimant is not entitled to disability benefits.” *Massachusetts Mut. Life Ins. Co. v. Jefferson*, 104 S.W.3d 13, 26–27 (Tenn. Ct. App. 2002) citing *Allmerica Financial Life Ins. and Annuity Co. v. Llewellyn*, 139 F.3d 664 (9th Cir. 1997) (denying disability benefits because chiropractic license had been revoked the day before disability began and finding, therefore, that chiropractic medicine was not regular occupation at time of disability); *Provident Life & Acc. Ins. Co. v. Fleischer*, 26 F. Supp. 2d 1220, 1224 (C.D. Cal. 1998), *aff’d sub nom. Provident Life & Accident Ins. Co. v. Fleischer*, 18 F.App’x 554 (9th Cir. 2001) (financial advisor’s depression was brought on by his legal difficulties and incarceration); *Brumer v. National Life of Vt.*, 874 F.Supp. 60, 64 (E.D.N.Y. 1995) (if the onset of plaintiff’s disability occurred during the period that his medical license was suspended, he would not be entitled to receive disability payments).
This rule makes sense because if the claimant was previously barred from his practice, his subsequent (factual) disability is not the true reason he cannot work in his occupation.

Note that claimants may try to claim that their legal disabilities did not technically start until after their medical disabilities because their licenses were not officially suspended or revoked. However, courts employ a “constructive notice” standard, due to the fact that claimants are on notice of the potential loss of their professional licenses. See, e.g. Allmerica Financial Life Ins. and Annuity Co. v. Llewellyn, 139 F.3d at 666 (even if insured chiropractor did not learn of his license revocation until after he closed his practice, he had sufficient constructive notice such that the revocation became effective the day Board’s final order was issued, and therefore insured was not “disabled” within meaning of his disability policy).

2. Assessing the Strength of the Factual Disability

The fact that a factual disability predates the legal disability does not ensure the receipt of benefits. Courts in these situations examine whether the insured’s medical condition, on its own, precludes the return to work. As explained by Paul Revere Life Ins. Co. v. Bavaro, 957 F. Supp. 444, 449 (S.D.N.Y. 1997):

“If [the claimant] demonstrates to the trier of fact that he is unable to work because of his mental and emotional problems then he is entitled to disability payments, despite the existence of his subsequent legal disability. If, however, the trier of fact believes that but for his legal disability he would be able to perform his occupation, then he is not entitled to disability payments.” Id. at 449.

In Massachusetts Mut. Life Ins. Co. v. Jefferson, 104 S.W.3d at 26–27, the court identified three factors to consider:

“First, the courts address whether the claimed factual disability is medically bona fide. Second, if the claimed factual disability is medically bona fide, the courts address whether its onset actually occurred before the legal disability. Third, if the factual disability is medically bona fide and actually arose before the legal disability, the courts address whether the factual disability actually prevented or hindered the person seeking disability benefits from engaging in his or her profession or occupation.” Id. at 27.

These tests put the focus on claimant’s medical condition on his or her ability to work. One of the prime questions is whether the loss of the license or the insured’s medical condition is the reason the insured is no longer working. Insurers often point to the fact that the claimants would have continued working but for the discovery of the alleged malpractice or negligence. On the other hand, claimants prefer to separate the two issues, solely focusing on their medical issues.

For example, in Berry v. The Paul Revere Life Ins. Co., 21 So.3d 385, an anesthesiologist claimed that his addiction to prescription medications rendered him disabled because resuming his practice would require him to handle a variety of narcotic and other controlled substances, increasing his risk of relapse. Dr. Berry’s medical licenses in multiple states were suspended due to his addiction (his negligence left a patient under his care in a permanent vegetative state). Dr. Berry became sober, but claimed that if he returned to anesthesiology, he may relapse. The trial court granted summary judgment for the insurer and the appeals court reversed holding that triable issues of fact remained as to whether Dr. Berry “is able to return to the important duties of his occupation without seriously risking his health and the health and well-being of the public he may serve.” Id. at 395. In addition to accepting Dr. Berry’s risk-of-relapse argument, the Court held that his legal disability was not necessarily a preclusive bar to benefits. It concluded that a genuine issue of material fact existed concerning “whether Dr. Berry’s claim for benefits arises from factual disability and not solely on his inability to practice medicine based on the revocation of his medical licenses.” Id. at 392.
Similarly, in *Paul Revere Life Ins. Co. v. Bavaro*, 957 F.Supp. at 449, the court denied the insurer’s summary judgment in a legal disability case involving an insurance broker who pled guilty to criminal charges of wire fraud which led to the revocation of his insurance brokerage license. The insured claimed that he was disabled from his occupation due to anxiety, post-traumatic stress disorder, and a personality disorder, which he claimed preceded his license revocation. The court acknowledged that the insured had the burden of establishing he was disabled from a sickness under the policy. The court found a triable issue of material fact remained regarding the insured’s disability: “If [Bavaro] demonstrates to the trier of fact that he is unable to work because of his mental and emotional problems then he is entitled to disability payments, despite the existence of his subsequent legal disability. If, however, the trier of fact believes that but for his legal disability he would be able to perform his occupation, then he is not entitled to disability payments.” *Id.* at 449.

An insured’s ability to keep practicing in his profession despite the alleged medical disability before the license revocation is highly relevant. In *Massachusetts Mutual Life Ins. Co. v. Ouellette*, 617 A.2d 132, the insured, an optometrist, was found guilty of lewd and lascivious conduct with a minor. As a result, he was imprisoned and surrendered his license to practice optometry. He filed a disability claim due to his alleged mental illness of pedophilia. The court found in favor of the insurer on summary judgment, noting that while the insured’s pedophilia had manifested in the 1970’s, he continued to practice optometry for nearly 10 years. Prior to the criminal proceedings, the insured felt physically and mentally able to assume the duties of his occupation. He stopped working due to the legal consequences of his behavior, not his alleged mental illness.

Further, a treating physician’s opinion that the insured can return to work despite the legal disability is persuasive evidence. In *Young v. Paul Revere Life Ins. Co.*, No. CIV.A. 11-1784, 2014 WL 1323391, at *6 (W.D. La. Mar. 31, 2014), a psychiatrist who had his medical license suspended due to his substance abuse, claimed entitlement to disability benefits. However, his treating physician agreed he was sober and opined that he would be qualified to return to the practice of psychiatry from an addiction standpoint by the next month (the two-year mark of his sobriety). The *Young* court framed the pertinent questions as follows: “Has Dr. Young demonstrated that he is unable to work because of his substance abuse issues despite his legal disability? [No.] Conversely, do the facts suggest that but for Dr. Young’s legal disability he would be able to perform his occupation? [Yes.]” *Id.* at *6. The court found Dr. Young’s treating physician’s opinions very compelling. It held that “[b]ut for his legal disability Dr. Young would be able to perform the duties of his occupation. Thus, he is not entitled to disability benefits.” *Id.*

While claimants may desire to focus on their alleged inability to work due to a medical condition, the claimants’ employment and legal disability puts decisions of choice and motivation to seek disability benefits into context.

**C. Public Policy Concerns**

Courts also invoke public policy to deny benefits to insureds who are precluded from working due to their own bad acts, even due to purported medical conditions. As noted by the Second Circuit in *Massachusetts Mut. Life Ins. Co. v. Millstein*, 129 F.3d 688 (2d Cir.1997), allowing an insured to benefit from his intentionally injurious conduct is against public policy.

In that case, Millstein’s license to practice law was suspended based on his misuse of client funds and fraudulent activities. He was subsequently convicted and imprisoned for the misuse of client funds. He sought disability benefits from his insurer based on the attention deficit disorder and chemical dependency he had since childhood, claiming that these disabilities impaired his judgment and caused him to commit his crimes. In addition to noting that Millstein’s chemical dependency did not prevent him from practicing law, the Court...
relied on a public policy argument to support the denial of benefits. It held, “We find that a rule which would allow a lawyer to steal from his clients, even when such theft occurs in the throes of a drug addiction, and then recover disability benefits for income lost due to the suspension resulting from such theft, would be against public policy.” Id. at 691.

The Vermont Supreme Court reached a similar result in Massachusetts Mut. Life Ins. Co. v. Ouellette, 159 Vt. at 617, where the insured filed a claim for disability benefits based on pedophilia. The Court upheld the denial of benefits, holding that “[i]mposing liability on disability insurance companies in cases like this would be contrary to the public interest in discouraging coverage for an insured’s own intentional criminal conduct.” Id. at 191. The Court noted the effect of higher premiums on other insureds, stating it would be inappropriate to transfer the responsibility for this defendant’s conduct onto the shoulders of disability insureds. Id. at 192.

These court decisions relying on public policy help bring the focus back to the insured’s own actions and the reasons why they are legally precluded from returning to their occupation.

V. Conclusion

Mental/physical, partial/total, and factual/legal disability claims are representative samples of “blurred line” cases that keep disability insurance practitioners on their toes. They help demonstrate the importance of understanding both the factual context of the claim at issue as well as the legal complexities arising from these cases.