

TYPES NOT MAPPED YET August 30, 2018 | TTR not mapped yet | Richard J. Pautler

Bifurcated trials: A road map for better results for insurers facing non-ERISA disability claims

A version of this article originally appeared in the August 2018 issue of DRI's "For the Defense."

The typical scenario in a lawsuit for non-ERISA disability benefits is as follows: (1) A plaintiff purchases a disability policy; (2) the plaintiff experiences an accident or sickness that he or she claims causes him or her to become disabled (e.g., on October 1, 2013); (3) the plaintiff files his or her disability claim with the insurer (e.g., January 2, 2014); (4) the insurer denies the claim (e.g., December 1, 2014); (5) the plaintiff files his or her lawsuit asserting that the insurer breached its contract by refusing to pay disability benefits (e.g., June 1, 2015); (6) the parties for 18 months engage in discovery, including taking the depositions of both treating doctors and expert physicians who first examined the plaintiff after the advent of the suit; and (7) the parties go to trial (e.g., May 1, 2017).

During the trial, is the issue whether the insured was disabled on 1. October 1, 2013, when he or she experienced the accident or sickness; 2. January 2, 2014, when he or she submitted his claim; 3. December 1, 2014, when the insurer denied the claim; 4. June 1, 2015, when the insured filed his or her lawsuit; or 5. May 1, 2017, when trial began?

Are the parties trying a combination of these issues? Can the insurer do anything to assure that it tries the correct issue?

Most disability trials encompass two distinct time periods, although frequently the distinctiveness of these two periods is not acknowledged or recognized during the trial. The first time period ends on the day that an insurer denies a claim. The first issue that a jury should decide is whether an insured presented a proof of loss to an insurer sufficient to establish that the insured was disabled on the day that the insurer denied his or her claim. If yes, the insurer breached its contract by denying the claim.

The second time period concerns the period of time between an insurer's denial of a claim and a trial. This second time period is relevant only if a jury first determines that an insurer breached its contract by denying a claim. If an insurer correctly denied a claim, this second time period never becomes ripe for determination.

But even if an insurer incorrectly denied an insured's claim, it does not necessarily follow that the insured has continued to be disabled through the date of trial. Thus, a jury must determine not only if an insured was disabled when an insurer denied his or her claim, but also whether the insured remained continuously disabled from the date of that denial through the date of trial.

The evidence relevant and material to these two time periods is different, indeed significantly different. The only evidence that a jury should consider when deciding whether an insured was disabled on the date that an insurer denied a claim is the evidence included in the insured's proof of loss (and other information that the insurer may have gathered). But for the second time period, a jury may consider all the evidence developed, created, or discovered after an insurer denied a claim. Insurance counsel, however, frequently allow these two time periods to conflate so that when deciding whether an insurer erroneously denied a claim, jurors are allowed to consider evidence that did not even exist at the time of the claim denial. This is a mistake. It behooves counsel for insurers not to allow the conflation of those two periods during trials.

To prove that he or she is disabled at the time of a trial, an insured need only present sufficient evidence to persuade a jury that he or she is disabled. But to prove his or her entitlement to benefits at the time of the claim denial (i.e., that the insurer improperly denied the insured's claim), the insured must prove not only that he or she was disabled when the insurer denied the claim. The insured also must prove that he or she submitted sufficient evidence to the insurer before the claim was denied to prove that he or she was disabled.

The distinction between an insured's burden of proving that he or she is disabled at the time of a trial and that an insurer breached its contract by denying his or her claim is critical. Unless counsel for an insurer keeps these two issues distinct, a jury frequently loses sight of which evidence the insurer possessed when it denied a claim and assumes, erroneously, that the insurer possessed all the evidence presented at trial. There lies the avoidable risk for an insurer.

This article advocates that an insurer can and should take steps to limit the issue at trial to those concerning the first period: did an insured submit a proof of loss to an insurer that established the insured's disability? If successful in so limiting the issue tried, the only evidence admitted at trial should be the evidence that an insurer had when it denied a claim. Framing the issue as such, and limiting the evidence in this manner, should substantially enhance an insurer's likelihood of success at trial. Allowing a jury to decide simultaneously both the issue of liability for the first period and the issue of liability for the second period most always will reduce an insurer's probability of success.

This article proposes that counsel for insurers should seriously consider demanding a bifurcated trial so that the first trial only addresses the question whether an insured submitted a sufficient proof of loss to establish his or her disability at the time that an insurer denied the insured's claim. In such a bifurcation, the second trial would occur only if the insured succeeded in the first trial; this second trial would address only whether the insured had remained disabled at all times between the insurer's denial and the trial. Alternatively, if a court will not allow such a bifurcation, an insurer should consider stipulating prior to trial that in the event that a jury finds for an insured on the sufficiency of the proof of loss, the insurer will agree to pay benefits through the date of trial.

Analysis

An insurance policy is a contract. In simplest terms, that contract provides that an insurer will pay benefits (1) if a plaintiff pays premium; (2) becomes "disabled" within the meaning of the policy; and (3) submits sufficient evidence of that disability to the insurer (i.e., proof of loss). If the plaintiff satisfies all three conditions, and the insurer refuses to pay benefits, the insurer has breached its contract, and the insured is entitled to recovery. These are the narrow issues that a jury should first decide before ever addressing whether the insured is disabled at the time of trial.

Significantly, an insurer does not have any duty to pay benefits until an insured both becomes disabled and submits proof of loss of that disability. An insured who becomes disabled does not have any right to collect policy benefits unless and until he or she submits sufficient proof of loss. Sometimes plaintiffs mistakenly plead, "the plaintiff became unable to perform his occupation on June 1, 2016, as a result of automobile accident and thereby became entitled to benefits under the Policy." Such an allegation is incorrect. Becoming disabled, by itself, does not entitle an insured to policy benefits. To be entitled to benefits, that disabled insured must also submit a satisfactory proof of loss.

Courts and hornbooks repeatedly have explained that a submission of a sufficient proof of loss is a condition precedent to the insurer's obligation to pay benefits.

Often the [insurance] policy will provide that no claims will be paid unless proof of loss is filed with the insurer within sixty days of the loss. Such provision is usually interpreted as a condition precedent. The insurer's duty of payment does not become absolute unless this condition is complied with. Calamari and Perillo on Contracts, Second Edition 385-86 (1977).

In *Bergholm v. Peoria Life Ins. Co. of Peoria, Ill.*, 284 U.S. 489 (1932), the insured died on April 18, 1929. The petitioners sought disability benefits for the period December 1, 1927, to April 1, 1929. Premium had last been paid in May 1927. The policy allowed that the insurer would pay premium upon receipt of proof that the insured was disabled. The insurer denied the disability claim on the grounds that the policy had lapsed due to failure to pay premium after May 1927.

The petitioners asserted that because the insured had become disabled in January 1927, premium was waived from that point forward so that the failure to pay premium after May 1927 could not have caused the policy to lapse. The Supreme Court readily rejected the petitioners' argument.

Here the obligation of the company does not rest upon the existence of the disability; but it is the receipt by the company of proof of the disability which is definitely made a condition precedent to an assumption by it of payment of the premiums becoming due after the receipt of such proof. 284 U.S. at 491-92.

Because the insured had failed to submit a proof of loss before the policy lapsed, the insurer properly denied the claim. See also *Robbert v. Equitable Life Assur. Soc. of U. S.*, 46 So.2d 286, 292 (La. Sup. Ct. 1949) ("There are many other cases involving provisions in insurance policies similar to those in the instant case which follow the doctrine of the *Bergholm* case, to the effect that the submission of proof of disability is a condition precedent to liability on the part of the insurance company for total and permanent disability benefits, as well as to its obligation to waive premiums.").

In *Swartz v. Berkshire Life Ins. Co.*, 2000 WL 1448627 (S.D.N.Y. Sept. 28, 2000), Swartz notified Berkshire in April 1991 that he wished to make a claim for disability benefits. But Swartz never submitted completed claim forms, and Berkshire closed its file in July 1991. Swartz's four disability policies lapsed in January 1992, for non-payment of premium. Swartz finally submitted claim forms in October 1996, but Berkshire refused to pay benefits, and the court affirmed its determination.

However, the defendant did not breach any obligation to the plaintiff in 1991 because the plaintiff never submitted any proof of loss in 1991, which was a condition precedent to the defendant's obligation to pay any benefits. The disability policies lapsed in January 1992, because premiums on the policies had not been paid. Because the policies are unambiguous as to the conditional nature of Berkshire's obligations, and Mr. Swartz did not submit proof of his disability within the specified period, Berkshire was not obligated in 1991, or at any later date, to pay Mr. Swartz any benefits under the policies. 2000 WL 1448627, at *8.

In *Rowan v. New York Life Ins. Co.*, 124 S.W.2d 577 (Mo. App. 1939), the insured had become disabled March 6, 1932, but had not submitted proof of disability to the insurer until April 21, 1933. Disability was not disputed. The issue was whether the insurer had to pay benefits for the period beginning March 1932 or April 1933. The court held that benefits only became payable in 1933 because the insured's submission of proof of disability was a condition precedent to any obligation to pay benefits. The court summarized:

Our conclusion is, therefore, that when all the provisions relating to disability benefits are read together and each is given its natural meaning and effect, there is no ambiguity in the contract to be resolved one way or another, and that while it was conceded the insured's total and permanent disability which was the contingency insured against, it was not the commencement of disability, but the receipt of proof of disability at defendant's home office, which rendered the disability benefits "effective", so as to mark the beginning of the period for which disability benefits were to be thereafter allowed. *Id.* at 580.

In summary, for the first time period at issue—the period resulting in a claim denial—the burden rests on an insured to prove not only that he or she was disabled, but that the proof of loss that the insured submitted to an insurer established his or her disability. The critical questions for a jury on this breach of contract action should be (1) what evidence of disability did the insured present (or did the insurer have) concerning the insured's alleged disability when the insurer denied the claim; and (2) was that evidence sufficient to establish the insured's disability?

When deciding whether an insurer breached its contract, a jury should consider only the evidence that was a part of an insured's proof of loss. Jurors should not be allowed to consider (1) evidence of an insured's disability that was never submitted to an insurer; (2) evidence of what the insured's medical condition may have become after the insurer denied the claim; or (3) evidence developed after the insurer's denial. A jury, when deciding whether an insurer breached its contract, should consider only that evidence that the insurer had at the time that it made its benefit determination. An insurer cannot have breached any contract by not acting on information that was not in its possession, or not even in existence, when it made its determination.

Issues May Be Conflated

In most disability trials, however, as mentioned, a jury will hear evidence that did not even exist when an insurer denied a claim. Why? Because for an insured to prove that he or she is entitled to disability benefits through the date of trial, the insured has to prove to a jury that he or she has remained continuously disabled from the date of the claim denial through the date of trial. An insured attempts to meet this burden by presenting post-claim-denial evidence from his or her treating physician and his or her expert witnesses to a jury, as well as such evidence from his or her own mouth. But this post-claim-denial evidence is evidence that a jury should not consider when determining whether the insurer breached its contract by denying the claim.

Many times a jury, and sometimes even a judge, will not appreciate that the two questions—whether an insured presented sufficient proof of loss at the time of claim denial and whether the insured is disabled at the time of the trial—are different and distinct. Frequently, jurors discern only that they are being asked to decide whether an insured who has sat before them during the week of trial is disabled.

Insurance counsel should do all that they can to prevent jurors from adopting such a mindset. When jurors are deciding whether an insurer breached its contract by denying a claim, counsel should do their best to limit evidence to that which was a part of the insured's proof of loss.

An insurer might benefit significantly from limiting evidence to that which existed at the time that the insurer denied a claim. An insured who is limited to submitting evidence that he or she provided to an insurer may base his or her entire claim on the opinion of his or her treating physician, who may not have the credentials, experience, or judicial temperament to be an effective witness at trial. The physician consultants relied on by an insurer to deny a claim may outshine the treating physician in all categories so that a jury would be inclined to credit the consultants' opinions and conclusions over those of the treating physician.

In addition, on filing suit, a plaintiff's attorney likely will solicit testimony from a hand-picked expert who may build a better case for the insured plaintiff than the treating physician was capable of building. That may be because the expert has more experience and expertise with the medical condition at issue, the insured's condition may have materially deteriorated by the time that the expert first examines the plaintiff, the expert may be a more experienced and compelling witness, and perhaps most importantly, the expert may be more amenable to suggestions from the plaintiff's attorney, who will pay that expert's fee.

Further, usually, though not always, an insured's medical condition will deteriorate over time. Frequently, the insured who shows up in the courtroom two years after filing suit looks much worse and is much less healthy than the insured who had his or her claim denied. The doctor describing the insured's medical condition six months prior to the filing of the claim may be describing a very different patient and menu of medical conditions and may impose

materially different restrictions and limitations than the expert who first saw the insured eight months after suit was filed.

In summary, many reasons exist why it is to an insurer's advantage to try a case based on an insured's medical condition and the proof of loss, rather than based on the insured's medical condition, supported by all the evidence generated after suit was filed.

It is impractical to think that a jury, when deciding whether an insurer breached its contract when it denied a claim, can limit its considerations to the proof of loss and disregard all the evidence generated by the insured's counsel after filing suit. The key is to keep from the jury, while it decides whether the insurer wrongly denied the claim, all that evidence that did not exist when the insurer denied the claim (e.g., the evidence created by experts who first examined the insured after suit was filed).

If an insured persuades a jury that his or her proof of loss submitted to an insurer proved that the insured was disabled when the insurer denied the insured's claim, then and only then should the case proceed to the second period: the period between the date that the insurer denied the claim and the jury enters its verdict. If an insured does not prevail in the first period, the parties need not move on to the second period.

An insured's burden is different and lesser for the second, post-claim-denial time period. To recover benefits for the period between a claim denial and a trial, an insured need only persuade a jury that he or she is disabled without submitting any evidence about the materials that the insured may or may not have submitted to an insurer after the insurer's claim denial. Those who litigate ERISA disability claims know that courts limit their considerations to the materials in the administrative record. In the same way, when deciding whether an insurer breached its contract by denying an insured's claim, a jury should limit its consideration to the insured's proof of loss (and other materials that the insurer may have obtained and considered). If a jury limits its considerations to the proof of loss and the materials that an insurer had and considered, and based on this evidence determines that insured breached its contract, only then should the door be opened to allow the jury to consider other materials.

Limiting the evidence this way has another significant advantage. It significantly reduces the cost of trial preparation. No longer does it make sense to retain or depose any experts except those who submitted documents and opinions to an insurer before an insurer made a decision about a claim. It does not make sense to conduct independent medical examinations, either, unless a jury first has determined that an insurer wrongly denied a claim.

Ways to Limit the Evidence

So how does insurance counsel limit the evidence to the proof of loss and the other evidence that an insurer considered when making its determination? There are three ways: (1) a motion in limine, (2) a bifurcated trial, or (3) a stipulation that in the event that a jury finds that an insurer breached its contract by denying a claim, the insurer will agree to pay benefits through the date of trial.

Motion in Limine

A motion in limine may succeed in limiting evidence to that which was before an insurer when it denied a claim. In *Millman v. Provident Life & Acc. Ins. Co.*, 2015 WL 5507901 (W.D. Mo. Sept. 17, 2015), the disability defendant insurer asserted in a motion in limine that the plaintiff should not be permitted at trial to submit evidence created after the insurer had issued its final denial. The insurer had denied the claim in October 2013, and at the September 2015 trial, the plaintiff had wanted to submit evidence developed between those two dates. The court granted the defendant's motion and held that evidence created after the insurer's denial was not admissible.

Evidence concerning Plaintiff's disability status that was submitted after October 22, 2013 is not relevant to whether Defendants breached the parties' contract on October 22, 2013 [footnote omitted] when it found Plaintiff not disabled for the period from December 2011 to October 22, 2013. Defendants made their final claim decision based on proof of loss that was provided to Defendants as of October 22, 2013. To the extent that Plaintiff wishes to provide additional evidence of proof of loss for the period from December 2011 to October 22, 2013 (e.g., retrospective diagnoses or other evidence not previously provided), Plaintiff is required under the policy to first submit that evidence to Defendants prior to filing suit; the insurance contract states "[y]ou may not start a legal action to recover on this policy within 60 days after you give us required proof of loss." Here, Plaintiff did not provide Defendants the post-denial evidence at issue in this motion until after Plaintiff filed suit. Therefore, the Court finds that such evidence is not relevant to whether Defendants breached the contract because Defendants had no ability at the time or later duty to consider such evidence. See Fed. R. Evid. 401- 402. Moreover, to the extent that Plaintiff seeks to provide post-denial evidence as proof of loss for the time period after October 22, 2013, that later time period is not related to the alleged breach in this case. 2015 WL 5507901, at *2.

Rulings on limine motions, however, are sometimes squishy. Sometimes trial counsel think that they have a reliable limine ruling from a court, only to discover mid-trial that the judge is all too willing to reconsider his or her order after he or she has gained a better appreciation of the issues.

A limine order may be particularly difficult to enforce in a trial in which a jury eventually will be asked to decide whether an insured is disabled at the time of the trial. If the jury will decide that issue, evidence created after the insurer's denial will eventually have to come before the jury. As noted, for a judge to instruct a jury that it may consider Dr. Jones' testimony when deciding whether a plaintiff is disabled today, but the jury may not consider Dr. Jones' testimony when deciding whether that plaintiff submitted a proof of loss establishing his or her disability two years before, is impractical.

Trial Bifurcation

A second and better option than a motion in limine is for an insurer to ask a court to bifurcate the trial. As mentioned, the first trial concerns only whether an insurer breached the contract by denying a claim, and the evidence is limited to an insured's proof of loss and the other evidence the insurer may have acquired before denying the claim. If the insured prevails in the first trial, the court can conduct a second trial to cover the period between the claim denial and the trial.

Stipulation

A third option, in the event that a court will not agree to a bifurcation, is for an insurer to stipulate that if an insured prevails on the claim, and the insurer incorrectly denied the claim, the insurer will stipulate that the insured is entitled to benefits through the date of trial. This stipulation makes irrelevant any evidence of an insured's medical condition after the insured's claim denial and ought to result in its exclusion at trial.

Circumstances could make such a stipulation difficult for an insurer to swallow. If a trial comes many years after the claim denial, for instance, an insurer may be unwilling to pay the hefty price that accompanies the stipulation should an insured win. It is one thing if an insured "continued to be disabled" during a one year interim period, but it is another thing altogether if that intervening period is five or six years.

On the other hand, if an insured's condition materially worsens after the claim was denied, perhaps because he or she developed Parkinson's six months before the trial, such a stipulation may be easy.

Dangers

If evidence in a bifurcated trial is not limited in the first part to the proof of loss, we all know what is likely to occur. A plaintiff's experts will testify about their examinations and state their conclusion that plaintiff was disabled at the time that they examined him (i.e., months after the insurer denied the claim and even after the plaintiff filed suit). The plaintiff's treating physician will testify about plaintiff's condition two weeks before the trial during an office visit. The plaintiff will testify about his or her life in the here and now, the aches and the pains that he or she feels, and the limitations and restrictions that he or she experiences. The plaintiff's spouse will testify, too, about the plaintiff's pain and agony and how little plaintiff does today to contribute around the house.

All of this testimony will distort the insured's true condition at the time that the insurer denied the plaintiff's claim, ignore that the insurer did not have any of this post-claim-created evidence, and most likely confuse the jury, which may easily lose sight of the issue in dispute: did the insured, before the insurer denied the claim, present evidence to the insurer sufficient to prove disability. The more the insurer can limit the evidence to the proof of loss, the better.

Another warning is merited. Often an insurer will have based its denial on the opinions of consulting doctors who reviewed a claimant's medical records but who never personally examined the claimant. Such a scenario would allow the claimant's attorney to emphasize that the claimant's treating physician examined and treated the claimant monthly, the related records were submitted as a part of the proof of loss, and the jury (and the insurer) ought to give greater weight to that treating physician's opinions than any other physician who the insurer may have consulted when denying the claim.

Trial counsel must weigh the threat that these arguments may present to a case. In some cases, the consulting physicians may have qualifications, compared to a treating physician, that minimize the risk. The opinion of a board-certified consulting cardiologist who works at the Mayo Clinic, but who never personally examined the claimant, may surpass the opinion of a treating physician who does not have cardiology certification. In other instances, such as when the disabling condition is chronic fatigue syndrome, the treating physician's opinions may outweigh a consulting physician's when the consultant did not examine the insured. An insurer's counsel must weigh these factors when deciding whether it is prudent to bifurcate.

Conclusion

The first issue in any trial seeking the recovery of disability benefits is whether an insurer breached its contract by denying a claim for benefits. An insurer could have committed such a breach only if an insured first submitted a proof of loss that established the insured's disability. This article advocates that trial counsel would do well to make certain that issue is the one that they try first: it is the correct issue for trial. Limiting the issue to that narrow question allows an insurer to limit the evidence to that which it had in its hands when it denied the claim and eliminates all the evidence that was created ever.

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