

What Every Physician Needs to Know about Disability Insurance

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Physicians and their patients rely on disability insurance to provide economic protection against unforeseen illness or injury. This article discusses various types of disability coverage and issues that arise in disability claims both from the perspective of the physician as treater as well as consumer.

Key words: Disability; occupation; specialty; social security; tax; pain; fatigue; ERISA.

Just as physicians focus on protecting their patients' physical and mental well-being, it is important to keep in mind that economic security is also at risk when illness or injury strikes. To protect against such misfortune, insurers offer disability income insurance; and the Social Security system in the United States also affords some degree of protection, but only against a catastrophic loss of all work capability. Determining whether someone is disabled, though, is extremely complex. It involves not only medical expertise, but also requires a legal analysis of how the contract of insurance or the Social Security statute defines the term "disability," as well as a vocational judgment as to employability.

Even without legal and vocational training, some basic understanding of the fundamental differences among different disability insurance policies, a brief introduction to some of the more frequently raised issues in contested disability claims, and an overview as to how claims are adjudicated will assist the physician in circumstances where the doctor is asked to document a patient's disability for an insurer or the Social Security Administration. Of equal importance, such understanding will help the physician be a more informed consumer when purchasing his or her own disability coverage.

OVERVIEW OF DISABILITY INSURANCE

There are many different types of disability insurance. In addition to Social Security disability, which is

secured automatically through FICA deductions, consumers obtain disability income coverage through policies purchased individually from insurers and professional associations, as well as through group policies made available as an employee benefit. In addition, it is possible to insure fixed business overhead costs to obtain reimbursement of actual expenses in the event of disability. However, regardless of the source of coverage, all disability insurance can be divided into two types—"general" and "occupational." To qualify for benefits under a general disability policy or Social Security disability insurance, the insured must establish incapacity to perform the duties of any occupation.

The Social Security Administration oversees the largest disability insurance program in the world, which has two components: Social Security Disability Insurance (SSDI), and Supplemental Security Income (SSI). With some minor exceptions, the SSDI program is for workers who have paid into Social Security for at least five years through FICA deductions and who become disabled within five years of last paying into Social Security. SSI, on the other hand, is a public welfare program providing basic financial assistance to disabled individuals who lack insured status to qualify for SSDI, as well as disabled children. Both programs, however, use the same criterion for determining eligibility for receipt of disability benefits—the inability to engage in "any substantial gainful activity" [42 U.S.C. §423(d)(1)(A)]. In other words, to qualify for Social Security disability, a claimant must be unable to perform any gainful work at all; there is no partial or percentage disability under the Social Security Act. SSDI pays benefits at the same rate as if the wage earner were already of retirement age at the onset of disability;

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and an award of SSDI also triggers Medicare eligibility 29 months after the onset of disability.

In determining whether an adult claimant qualifies for either SSDI or SSI, the claimant is first assessed medically. If the claimant is not working and has a medical condition affecting that person's ability to work, Social Security compares the claimant's impairment or comorbid medical conditions in combination with one another against specific criteria known as the Listing of Impairments, which are found in Chapter 20 of the *Code of Federal Regulations*, Subpart P, Appendix 1. Those criteria are divided into categories such as orthopaedic impairments, neurologic impairments, pulmonary impairments, impairments of the senses, genitourinary impairments, cardiac impairments, and the like. By either meeting the criteria for a specific listing or having an impairment of equivalent severity, the claimant automatically qualifies for benefits. However, if the claimant fails to meet a listing, the inquiry continues. At that point, Social Security performs a vocational evaluation, first looking at whether the individual can perform the duties of any occupation held within the 15 years before the onset of disability, and then examining whether there are any jobs the individual can perform. Only if the claimant is unable to perform any jobs are benefits awarded.

In performing the vocational assessment, Social Security does not merely assess the severity of the medical impairments in question; instead, various vocational factors that would impact on an individual's ability to return to work are taken into consideration. Those factors primarily include the individual's age, the skill level of past work, and the claimant's education.

Qualifying for private disability benefits is not as demanding as meeting Social Security's requirements. For example, the availability of occupational disability insurance is highly desirable because it insures against the inability to perform the material or significant duties of one's *own occupation* even if there is capability to work in another occupation. In some cases, occupational disability insurance is further defined to insure against the inability to perform one's particularly specialty (e.g., "neurosurgeon"). Even if such a definition is not contained in the policy, many courts will imply it. Moreover, most courts will uphold coverage in cases in which the insured may be capable of working in a partial capacity or working under a significantly reduced workload. An example is a recent ruling from the Eighth Circuit United States Court of Appeals, *Dowdle v. National Life Insurance Company* (2005), which held that a surgeon who injured his back in a plane crash and could no longer perform surgery but who could still conduct office examinations was nonetheless entitled to benefits.

Unfortunately, "own occupation" coverage that insures against the ability to perform one's own occupation to retirement age or for life is currently almost impossible

to obtain. The best alternative is to purchase insurance that will pay benefits for as many years as possible so long as the insured cannot work at his or her own occupation before reverting to "any occupation" coverage. However, based on a ruling issued in 2005 by the California Department of Insurance, even a general any-occupation policy will still require consideration of whether the insured is capable of generating earnings commensurate with pre-disability income. That ruling only applies in California, though other states are expected to follow suit.

Note how the policy treats residual disability or partial disability.

Another important consideration in analyzing disability insurance policies is how the policy treats *residual disability* or partial disability. If residual disability coverage is included, benefits may be reduced if the insured is working but earning significantly less than before the onset of disability. Even if the insured has capacity to work on a part-time basis but chooses not to because of the practical difficulties of maintaining a part-time medical practice, historically, full benefits remain payable. However, new policies have been developed that afford significant discretion to insurers to assess whether the insured is working to the maximum extent possible. Such policies penalize insureds who are found to be working at less than maximum capacity.

Hence, partial or residual disability claims can be exceedingly complex. Such claims also require the insured to produce volumes of billing and time records. The same is true with business overhead expense policies, which require production of records of expense payments before the insurer is willing to reimburse those payments up to the maximum amount of indemnity provided under the policy.

Other important issues relate to the amount of premiums and the indemnity payable each month as well as the duration of payments. Individual disability income insurance policies should provide that premium payments are guaranteed to remain level throughout the policy period. In addition, because individually purchased insurance usually pays a fixed monthly indemnity, the effect of earnings increases and inflation needs to be considered in purchasing coverage. Many policies provide an optional benefit allowing for automatic increases in the amount of insurance without the necessity of medical proof of underwriting qualification. However, once benefits commence, the amount of indemnity almost always remains at a set amount and is unadjusted for cost of living increases (COLA), even though Social Security benefits are adjusted by an annual COLA factor.

The duration of benefits is also an important consideration. In today's insurance market, it is very difficult

to obtain a policy that will pay benefits for the insured's lifetime; most policies cease payment at age 65 or at Social Security retirement age. Moreover, as the insured approaches an age when benefits would end, keeping the policy in force needs to be reassessed because there may be little value in retaining coverage that would be payable only for a short duration.

DIFFERENCES BETWEEN INDIVIDUAL AND GROUP COVERAGE

Most people who have disability insurance coverage have received it as an employee benefit; such coverage is purchased by an employer on a group basis for the benefit of the entire workforce. Group disability insurance differs markedly from individual disability income insurance. An individual policy of insurance insures one's *ability to earn a living*. Group coverage, on the other hand, insures *income*. Benefits are paid as a percentage of earnings, usually between 50 and 70 percent of the insured's base annual salary, which, depending on how income is classified under the policy, could potentially penalize workers who receive bonus compensation as a substantial component of overall earnings. Also, because such policies usually limit benefits to a maximum amount, such as \$10,000 per month, very highly compensated individuals may not be able to use employer-sponsored group coverage to adequately insure against a catastrophic loss of income.

An individual policy of insurance insures one's ability to earn a living. Group coverage insures income.

Another feature of group coverage that differs from individual coverage is that it coordinates with benefits from other sources. Most group policies contain provisions reducing benefits by the amount the insured recovers from other sources such as Social Security disability benefits paid both to the insured and his or her dependents. Offsets may also be made for workers' compensation payments, retirement plan payments, or other group disability insurance. Other group insurance benefits that may be offset against employer-sponsored group disability coverage include disability benefits purchased through a professional association, which are sometimes classified as franchise insurance. Consequently, paying premiums to maintain both group and association disability coverage may not be warranted if one benefit cancels out the other. In addition, some policies also offset recovery of damages from third parties for injuries they cause that result in disability claims. However, group disability payments are not offset by benefits received under a policy of individual disability income coverage. Because offsets can significantly reduce the value of the group coverage,

it is important to keep the potential offsets in mind when figuring the value of the benefits. Group coverage may also need to be supplemented with additional individual coverage in order to meet potential financial needs in the event of disability.

TAXATION OF BENEFITS

The value of disability income payments can be maximized if the payments are tax-free. So long as premiums for the insurance are paid with after-tax dollars, the benefits are tax-free. However, if an employer pays for its employees' disability coverage, the benefits are taxable. Therefore, disability insurance premium payments should be structured in such a way that they are made with after-tax dollars in order to maximize the value of the disability insurance payments.

Another reason to have all disability insurance premiums paid for by the employee with after-tax dollars is that if the employer pays premiums it may have the effect of creating an employee benefit plan and triggering the applicability of the Employee Retirement Income Security Act (ERISA) to any resulting claim.

ERISA

Although the ERISA law was enacted in 1974 to protect employee benefits, the courts have interpreted the law to make it much more difficult to obtain benefits in circumstances in which ERISA applies. ERISA encompasses any benefit provided by private-sector employers; it excludes government employees and employees of religious organizations in some circumstances. Although the ERISA law is primarily focused on retirement benefits, its scope was expanded by Congress to include employer-sponsored health, life, and disability insurance, although individually purchased insurance falls outside of ERISA's purview.

The ERISA law changes insurance claims in many respects. First of all, it takes away remedies afforded by state law, such as the right to sue for damages in the event of wrongful denial of benefits. Most courts have also interpreted the ERISA law to preclude jury trials of claims; and the evidence admitted in court is also, in most cases, drastically limited to only the claim record made prior to suit being filed. Indeed, a federal judge in Michigan was so frustrated by ERISA's effect on disability claims, that he began his opinion in the case of *Loucks v. Liberty Life Assurance Company* (2004) by writing:

Caveat Emptor! This case attests to a promise bought and a promise broken. The vendor of disability insurance now tells us, with some legal support furnished by the United States Supreme Court, that a woman determined disabled by the Social Security Administration because of multiple disabilities which prevent any kind of work cannot be paid on the disability insurance she

purchased through her employment. The plan and insurance language did not say, but the world should take notice, that when you buy insurance like this you are purchasing an invitation to a legal ritual in which you will be perfunctorily examined by expert physicians whose objective it is to find you not disabled, you will be determined not disabled by the insurance company principally because of the opinions of the unfriendly experts, and you will be denied benefits.

Part of the reason for the judge's frustration is that in addition to all of the other detriments of ERISA set forth above, the courts have permitted insurance companies, without any regulatory oversight, to write language into their policies granting themselves the discretion to decide whether claimants are entitled to benefits. The legal effect of the insurer having such discretion is that it requires claimants to do more than prove the insurer wrongfully denied benefits; he or she must show the decision was so arbitrary and capricious that no rational fact finder could have rendered such a decision. In 2004, the National Association of Insurance Commissioners found such a standard has the effect of rendering coverage illusory and recommended a model law prohibiting such provisions. Yet other than California and Illinois, few other states have adopted the law.

ERISA preemption is triggered by an employer's establishment of an employee benefit plan, which can be accomplished simply by purchasing an insurance policy. Thus, if a doctor's office buys group disability coverage for the physicians and other professional and clerical staff, it has established an employee benefit plan; and any claim made under that policy will likely be governed by the ERISA law. Even if a doctor has only one employee, the purchase of insurance covering that employee is sufficient for the ERISA law to apply even to claims made by the doctor according to the Supreme Court's ruling in *Yates v. Hendon* (2004).

The import of all this is that it can be assumed benefits under ERISA plans will be harder to secure, and obtaining separate individual coverage to supplement group coverage is a wise idea.

HOW DISABILITY CLAIMS ARE ADJUDICATED

Determining whether someone is disabled is an exceptionally difficult process. Because the word "disability" can be subject to many interpretations, proving disability involves not only a legal construction of the term as it is used either in the Social Security Act or in a disability insurance policy, but also requires both a medical and vocational judgment. Doctors lack the training to assess someone's ability to work either at a particular job or class of jobs. Nor are vocational specialists trained in making medical diagnoses and judgments. Attorneys,

while qualified to interpret insurance terminology, lack competence to render either medical or vocational judgments. Consequently, litigation over disability insurance claims is prevalent.

The following discussion focuses on some of the issues that arise with frequency in lawsuits involving disability benefits and suggests ways of approaching the problems.

THE RISE AND FALL OF THE TREATING PHYSICIAN RULE

The Social Security disability program recognizes the value of the treating doctor's assessment of a patient's disability. Not only does the doctor possess first-hand knowledge of the patient, his or her training and experience enable the doctor to assess the patient's functionality. However, the treating doctor may also consider the patient a friend and may therefore want to assist the patient in obtaining benefits. To balance those issues, Social Security has promulgated a specific regulation requiring that deference be given to a treating doctor's opinion, but only if certain requirements are met. First, the doctor has to have a significant longitudinal treatment relationship with the patient to evaluate the course of the patient's condition. Second, the physician must be a specialist in the field of medicine involved in the patient's disability. Third, the opinion given must be consistent with any objective test results and with the record as a whole.

The federal courts began using the Social Security "treating physician rule" as a means of mitigating the harsh arbitrary and capricious standard of judicial review in ERISA cases. The issue eventually made its way to the Supreme Court, which ruled in *Black & Decker Disability Plan v. Nord* (2003) that there was no cause to give deference to the treating physician in cases governed by the ERISA law. The Court did, however, express skepticism about reports from consultants frequently retained by insurers, and the Court insisted that insurers must give consideration to the treating source opinions and weigh those opinions, particularly in light of the Congressional statement in the ERISA law that the statute was enacted to protect contractually promised benefits. In light of *Nord*, courts have been less willing to give deference to the treating doctor's opinion. Nonetheless, when the opinion of a treating physician is weighed against a non-examining doctor who simply reviews a medical file, the current trend is to reject the reviewing doctor's opinion.

However, even when an insurer conducts an examination, that does not automatically mean the insurer will win. A federal appellate ruling entitled *Hangarter v. Provident Life and Accident Insur. Co.* (2004) disregarded a so-called "independent" medical examination after finding the same doctor had been retained multiple times by the insurer and always found against the claimant. Other examiners' opinions have been rejected due to evidence

the examination was cursory and incomplete, or because the insurer's consultant failed to show expertise in understanding the diagnostic criteria for the condition under consideration.

Another factor to keep in mind is usage of the term "malingering" in medical reports. In the federal appeals case of *Nichols v. American National Insur.Co.* (1998), a court disregarded a psychiatrist's opinion that the claimant was malingering, due to concerns that the use of such a term infringed on the jury's province as trier of fact and evidentiary rules prohibiting one witness from testifying as to the credibility of another.

The key lesson here is that the treating doctor needs to be wary of how the courts accept and validate doctors' opinions. Conclusory opinions will never suffice. Neither the Social Security Administration nor any insurance company will accept a doctor's finding that the "patient is disabled" without an expressed rationale for that conclusion. To the extent applicable, the reporting doctor has to elaborate on the patient's specific restrictions and limitations that should be related to the relevant test results.

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Beware the ambush! Many insurers hire reviewing doctors who will call the treating doctor and prepare a summary of what was discussed. That summary must be reviewed, and misstatements and omissions need to be corrected. Obviously, the doctor's primary responsibility is patient care. However, the patient's financial health is integrally related to physical and mental health; and however onerous the task of preparing a report may be, it is a necessary part of caring for the patient. Of course, appropriate charges should be rendered for preparing reports, but time spent early in providing documentation may avoid more extensive time spent later in depositions and courtroom testimony.

An illustration of the importance of the treating doctor's response to the insurer's requests for documentation with a detailed rationale was shown in *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan* (2004), a ruling issued by a federal appeals court. There, the claimant's submission of conclusory opinions by the treating doctors was trumped by carefully reasoned opinions of the reviewing doctor that furnished a well-supported rationale for the conclusions reached and that also described unsuccessful efforts to contact the treating doctors to discuss their opinions and obtain their comments on the reviewing doctor's opinions.

Another caveat is the myth of the functional capacity evaluation. Although a number of organizations pur-

port to offer testing that can assess a patient's functionality, none of the test protocols have been scientifically validated. Thus numerous court cases have questioned the utility and validity of such tests, which are performed by physical therapists and attempt to extrapolate a patient's ability to maintain work over a normal work week, month, and year by test results from an evaluation lasting only a few hours.

Although doctors cannot make specific vocational findings, one does not need to be a certified rehabilitation counselor to know that patients who are in such severe pain that they need frequent narcotics are not able to perform a cognitively demanding occupation or a job requiring the operation of dangerous machinery. Thus it is important to gain an understanding of the type of job the patient is performing and to relate documentable medical findings to the patient's ability to perform the job.

Finally, the use of proper terminology is essential. The word "sedentary" has very specific meaning in disability assessment. That term is defined by the United States Department of Labor and Social Security Administration to mean the ability to perform a job that is done in the seated position and requires lifting no more than 10 pounds. However, the term "sedentary" to a cardiologist may mean the doctor wants the patient to avoid any strenuous activity. Moreover, just because someone may have the physical ability to sit for several hours a day does not mean that in the physician's judgment the person can remain on task for that period of time. Insurers frequently try to get physicians to pigeonhole their opinions, and doctors need to be wary so that their opinions are not misinterpreted in a manner that could do harm to the patient.

Likewise, insurers try to isolate remarks in patient chart notes of "patient doing well" or "seems better" to try to disprove disability. Fortunately for claimants, there are cases recognizing that a single isolated note in a medical chart cannot be the basis for ignoring the context of the physician's overriding opinions. Nonetheless, if the physician becomes aware of opinions being taken out of context, the mistake needs to be corrected immediately because there may never be a later opportunity to fix the problem, especially if the claim is governed by the ERISA law.

PSYCHIATRIC CONDITIONS, PAIN, AND FATIGUE

Psychiatric claims may often be problematic; and patients whose primary disabling symptom is pain or fatigue frequently have difficulty with their claims. First of all, almost all group disability insurance policies limit the duration of benefit payments due to psychiatric conditions; and the courts have accepted the legality of such distinctions. However, the distinction between mental and physical conditions is often blurred; and courts have,

in some cases, found the policy definitions of “mental and nervous” conditions ambiguous.

Other claims involving “subjective” impairments such as chronic pain or fatigue are also frequently challenged. Many policies limit the duration of payments for conditions involving pain or fatigue in addition to psychiatric claims. A recent federal appellate ruling, *Hawkins v. First Union Corp. Long-Term Disability Plan* (2003), found an insurer improperly rejected a claim based on fibromyalgia and ruled that subjective complaints may be just as disabling as claims that can be proved with objective evidence.

The way to remove a claim from the categorization of “self-reported” limitations is to provide clinical confirmation (e.g., electromyography or evoked-potential tests proving radiculopathy; positron emission tomography scans demonstrating brain activity during migraine headaches; or even positive trigger point findings for fibromyalgia or documentation of low-grade fevers and swollen glands for chronic fatigue syndrome). With respect to certain organic mental-impairment claims, neuropsychological testing can establish the presence of dementia or confirm other organic causes that may remove the duration limit for the payment of benefits.

In general, however, as long as the patient’s symptoms are consistent and the complaints are known to be associated with the medical condition at issue, courts have ruled that pain and fatigue complaints must be credited by the insurers. The reason is probably best summed up in a fibromyalgia case decided by a federal court in Washington entitled *Ellis v. Egghead Software Disability Plans* (1999), which ruled:

When they are read together with the earlier medical records and reports, the following picture emerges: a man who is continuously drowsy and fatigued, unable to concentrate, unable to perform the most simple physical tasks, unable to stand, sit, or walk for more than an hour at a time, unable to work more than 15 hours per week, and unable to predict which hours he will be available, if at all. This court cannot imagine any occupation that such a person could fill successfully, much less an employer who would be willing to hire him.

The court’s commonsense observations should be kept in mind by any doctor either considering submitting

a claim for disability or completing a report on behalf of a patient; and can be summed up with the question, “Would I hire this individual to work in my office?”

CONCLUSION

Disability insurance presents a number of very complex issues. Because of its unique character, it is easy to see how disputes can arise regarding even the most basic question: What is a disability? Thus it is not at all surprising that there has been an explosion in litigation regarding disability insurance. And because of the ERISA law, litigation has grown even more contentious. However, litigation is not the inevitable course that every claim follows. Indeed, most claims are paid without dispute. To maximize the likelihood of success, it is important to gain an understanding of disability insurance well before a claim is even contemplated. If insurance has already been purchased, it is time to review the policies currently in effect to make sure that it is the most appropriate coverage and in a sufficient amount. If not, or if purchasing insurance is contemplated, different potential policies should be reviewed with a qualified legal and/or financial professional to make sure that the desired financial protection is achieved.

However, that is only one side of the coin. Physicians are drawn into the disability-determination process on a daily basis and need to understand the information necessary to adequately document a claim and to anticipate issues that might become problematic. Patients should be encouraged to obtain legal representation early in the process. Waiting until the claim is denied is often too late.

Of course, not every claim is compensable. Again, the assistance of experienced legal counsel is essential in helping to make that determination. While someone may not appear to be disabled to a treating doctor, under the terms of the policy, the claim may be payable. The opposite is also true, and the patient who may appear to be disabled might not meet the terms and conditions set forth in the insurance policy. For all of these reasons, understanding disability insurance and the claims process is not only good business, but an essential part of a medical practice. ■