

# Find the catch in the contract

*As a trial attorney, you don't claim to be an expert in contract law, but you surely have to know how to read and interpret an insurance policy. Even boilerplate language can trip you up. Here, several lawyers tell you what phrases to watch for in the fine print.*

## 'Actual charges'

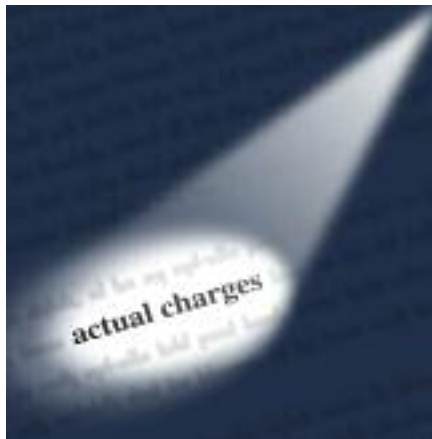
ELLEN M. DOYLE  
AND JOEL R. HURT

When a health insurance policy does not offer all the coverage a policyholder wants, he or she may purchase supplemental insurance to bridge the gap. Sometimes, the policyholder learns later that the additional insurance may not cover what it seemed to. The problem is often rooted in the policy's language about "actual charges."

That term has been used in hundreds of thousands of supplemental insurance policies since the 1970s. For several decades, insurers interpreted "actual charges" to mean the amount a medical provider charged before giving discounts to third-party payers like Medicare.

In recent years, however, insurers have attempted to limit their liability to the discounted amounts paid by third parties. They have changed how they interpret their policies, orchestrated judicial review in the forums they perceive to be friendly, and sought new legislation to define "actual charges" by state statute.

After a few early decisions in their favor, the tide has turned against the insurers. The federal government defines and uses "actual charges" in a manner that is favorable to policyholders,<sup>1</sup> and



several courts have now held that "actual charges" is ambiguous when undefined.<sup>2</sup>

For example, in *Ward v. Dixie National Life Insurance Co.*, the Fourth Circuit found that "actual charges" was a term of art and that numerous health care dictionaries defined it as the amount billed.<sup>3</sup> The court held that the policy did not indicate whether "actual charges" meant the amount actually billed or the amount actually owed.

In *Guidry v. American Public Life Insurance Co.*, the Fifth Circuit held that the purpose of supplemental insurance was not only to indemnify against loss from illness or disease, but also to provide supplemental income.<sup>4</sup> The court found the insurer's revised interpretation of "actual charges" to be "suspect" because negotiated discounts were

"nothing new."<sup>5</sup>

This holding suggests that policyholders should argue that the insurer's prior practice should be given great weight.<sup>6</sup> They should also determine whether the insurer's other policies define "actual charges" and whether its instructions to claims examiners and statements to state insurance departments support its arguments about the meaning of the phrase.

At least two juries have reached verdicts in favor of policyholders in cases focusing on a policy's "actual charges" language. In one case, the mother and beneficiary of a policyholder who died of cancer in 2005 claimed the insurer had changed its "actual charges" policy. When her son purchased his policy in 1992, the insurer paid whatever the patient was billed; after 1994, it paid only the discounted amounts.<sup>7</sup> The jury awarded punitive damages.

Now insurers have taken a different tack—lobbying state legislatures—and those efforts have begun to pay off. At least four state legislatures have acted to define the term in the insurers' favor.<sup>8</sup> ■

### Notes

1. "Actual charges" is "the amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves." Ctrs. Medicare & Medicaid Servs., *Glossary*, www.

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cms.hhs.gov/apps/glossary.

2. See e.g. *Conner v. Am. Public Life Ins. Co.*, 448 F. Supp. 2d 762 (N.D. Miss. 2006); *Hodges v. Am. Fid. Assurance Co.*, 2008 WL 723994 (S.D. Miss. Mar. 17, 2008); but see *Claybrook v. C. United Life Ins. Co.*, 387 F. Supp. 2d 1199 (M.D. Ala. 2005).

3. 257 Fed. Appx. 620, 626-27 (4th Cir. 2007).

4. 512 F.3d 177, 182 n. 6 (5th Cir. 2007).

5. *Id.* at 184.

6. See *Eggleston v. Dudley*, 257 F.2d 398, 400-01 (3d Cir. 1958).

7. *Metzger v. Am. Fid. Assurance Co.*, 2006 WL 2792435 (W.D. Okla. Sept. 26, 2006); see also *Dykes v. C. United Life Ins. Co.*, No. CV-06-J-2264-S (N.D. Ala. Aug. 27, 2007).

8. See Ga. Code Ann. §33-24-16.1 (2009); Okla. Stat. Ann. §3651 (2009); S.C. Ann. §38-71-242 (2008); Tex. Ins. Code §1201.0601 (Vernon 2009).

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## 'Illegal acts' exclusions

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The primary function of exclusions in insurance policies is to *clarify* the coverage granted by the insurer, not to *take away* coverage from the insured.<sup>1</sup> Unfortunately, insurers often seek to include arguably covered conduct in their exclusions. A classic example of such overreaching can be found in the insurance industry's effort to exclude illegal acts from homeowners' policies.

Illegal-acts exclusions commonly provide no coverage for bodily injury "arising out of any illegal act committed by or at the direction of an insured." The exclusion's terms immediately raise important questions, particularly: What is an illegal act? The California Supreme Court addressed this question in *Safeco Insurance Co. of America v. Robert S.*<sup>2</sup>

The facts in *Safeco* were tragically simple: The insured's teenage son accidentally discharged a pistol, killing another teen. When the parents of the dead boy filed suit against the insured, Safeco denied coverage based on an illegal-acts exclusion in the homeowners policy. Safe-



co contended that the exclusion was intended to apply to criminal acts, and because the insured's son had committed involuntary manslaughter, the policy did not cover the claim.

The California Supreme Court found that the exclusion was susceptible of two different interpretations: The interpretation favored by Safeco, and a broader interpretation adopted by the appeals court that the exclusion would apply to "any act prohibited by law."<sup>3</sup> The court noted that if the broader interpretation were accepted, any negligent act committed by the insured would not be covered. This would clearly undermine the insured's reasonable expectation of coverage and make the coverage illusory.

Safeco's interpretation of the illegal-acts exclusion was also incorrect, the court said, observing that the exclusion did not contain the term "criminal." It noted that "had Safeco wanted to exclude criminal acts from coverage, it could have easily done so."<sup>4</sup>

The court concluded that because neither interpretation of the policy's illegal-acts exclusion could be "given meaning under established rules of construction of a contract, it must be rejected as invalid."<sup>5</sup>

In contrast, courts have upheld exclusions that are limited to criminal acts.<sup>6</sup> Unlike the illegal-acts exclusion, the criminal-acts exclusion makes clear exactly what risks the policy will not cover.

In evaluating policy exclusions, first determine whether one effect of the exclusion is to exclude otherwise covered risks. If that is the case, and the jurisdiction has adopted the efficient proximate

cause doctrine, then coverage may still be afforded if the covered cause is also the efficient proximate cause of the loss.<sup>7</sup> In addition, when opposing an insurer's attempt to apply an exclusion improperly, draw the court's attention to other insurers who have drafted exclusions that would avoid such a result. ■

### Notes

1. Eric C. Weining, *Insurance Contract Analysis* 65 (Chartered Prop. Cas. Underwriters 1992).

2. 28 P.3d 889 (Cal. 2001).

3. *Id.* at 893.

4. *Id.*

5. *Id.* at 895.

6. See e.g. *20th Cent. Ins. Co. v. Stewart*, 74 Cal. Rptr. 2d 492 (App. 1998).

7. See e.g. *Sabella v. Wisler*, 377 P.2d 889 (Cal. 1963).

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## 'Loss payment'

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No matter what type of case an attorney is handling, most insurance policies share a common trait: They contain numerous terms and conditions the policyholder must comply with to obtain benefits. The "loss payment" provision is one of the few such terms favoring the policyholder.

It requires the insurer to perform and



expressly sets out the time period within which it must tender undisputed insurance benefits to the policyholder.

A typical provision reads as follows:

Loss Payment. We will adjust all losses with you. . . . Loss will be payable:

a. 20 days after we receive your proof of loss and reach agreement with you; or

b. 60 days after we receive your proof of loss and

(1) there is an entry of a final judgment; or

(2) there is a filing of an appraisal award with us.

The loss payment provision must be interpreted to mean that once an insured has submitted a properly executed sworn proof of loss (POL) statement, the insurer has a certain number of days to tender the undisputed amount of benefits. Insurers argue that the provision implies an obligation to pay benefits only after there is an “agreement” between it and the policyholder.

Taking this argument to its extreme, the insurer would never be obligated to pay benefits as long as it disagreed with the POL’s claimed amount, in part or whole. Under such a contract, the insurer could collect premiums from the policyholder but never have a contractual obligation to perform any duties, unless it expressly agreed to them.

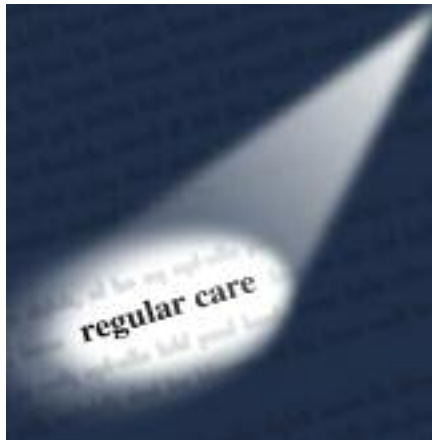
A more reasonable interpretation of the loss payment provision is that on submission of the POL, if the claimed amount exceeds the insurer’s damage estimate, the insurer is obligated to tender undisputed benefits in agreement with the policyholder, leaving the balance as disputed.

Sometimes insurers claim that the POL is a “hostile” filing and reject it. This is not only a breach of the policy but also clear evidence of the insurer’s bad-faith claims handling. How can the POL be considered hostile when it is the only way an insured can demand payment within a certain time period? If the POL form has not been properly completed, the insurer may argue that it is improper in form only and needs to be revised and resubmitted.

Once the POL is filed, the clock starts ticking for payment. That is why insurers concoct a coverage defense by rejecting

the POL, arguing that their obligation to tender benefits is not ripe. However, when a POL is properly completed, whether or not the insurer disagrees with the claimed amount, it is inherently bad faith for the insurer to reject the POL on that basis alone. ■

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## ‘Care’

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The same noun in two different contracts can mean completely different things depending on how it’s modified—and who parses the phrase.

Disability insurance policies typically have a “care” requirement written into the policy’s definition of disability, and this requirement is usually qualified by the word “regular” or “appropriate.” The insurer promises to pay benefits to the policyholder if, for example, “you are under the regular and personal care of a physician” or “you are receiving care by a physician that is appropriate for the condition causing the disability.”

“Regular” care is largely quantitative, while “appropriate” care is largely qualitative. Often, however, the insurance company will read “appropriate” into a “regular” care policy requirement or interpose an “optimal” or “aggressive” care requirement into an “appropriate” care policy standard.

**Regular care.** Stanley Heller, a board-

certified cardiologist who specialized in invasive cardiology, was insured under an Equitable Life disability policy that would not pay benefits “for any period during which the insured [was] not under the *regular care and attendance* of a physician.”<sup>1</sup> When Heller concluded that he could no longer safely practice invasive cardiology because of carpal tunnel syndrome, he submitted a disability claim.

Equitable paid the claim for about a year but then denied it, concluding that Heller had failed to satisfy the “regular care” requirement by declining to have corrective surgery, which two of his doctors recommended. The company conceded that Heller still could not practice invasive cardiology.

Heller sued and prevailed at trial, where the judge determined that the insurance policy did not require Heller to undergo elective surgery because Equitable failed to include a surgery requirement in the policy language. Equitable appealed to the Seventh Circuit, which resoundingly rejected its construction of the “regular care” requirement.

“[T]he clause ‘under the regular care and attendance’ means just what it says, namely, that the insured is obligated to periodically consult and be examined by his or her treating physician at intervals to be determined by the physician,” wrote the court.<sup>2</sup> It further held that the “regular care” clause “was not intended to allow the insurer to scrutinize, determine, and direct the method of treatment the claimant receives.”<sup>3</sup>

When the word “care” is qualified by “regular” in a disability insurance policy, the qualification is one of quantity (requiring periodic visits, for example) as opposed to one of quality (assessing the appropriateness or desirability of the care rendered).

**Appropriate care.** Linda Pralutsky was insured by her employer’s group disability policy with Metropolitan Life. To qualify for benefits, Pralutsky was required to show that she was “receiving *appropriate care and treatment* from a doctor on a continuing basis.”<sup>4</sup> She stopped working because of a disability that evaded definitive diagnosis but, according to her neurologist, “fit in a chronic fatigue

or fibromyalgia category.”<sup>5</sup>

After a medical review, Met Life denied Pralutsky’s claim, citing a lack of medical documentation supporting the fibromyalgia diagnosis and noting that she had not shown she was “aggressively” treating the condition and under appropriate care for it. The denial was upheld during the ERISA appeal even though a clinician hired by Met Life noted that Pralutsky was “receiving appropriate and regular medical care at this time.”<sup>6</sup>

On further appeal, the *Pralutsky* court found the denial to be arbitrary and capricious, in part because the insurer ignored subjective evidence and grafted an “aggressive treatment” standard into the policy’s “appropriate care” requirement.<sup>7</sup>

Appropriate care need not be the most aggressive care, optimum care, or even the best care money can buy. It need only be appropriate with the aim of improving the patient’s condition.

Although *Pralutsky* and similar cases recognize that “appropriate care” is something more qualitative than “regular care,”<sup>8</sup> the distinction does not mean that the policyholder “must obey every doctor’s recommendation” or defer to the insurance company’s “judgment about the appropriate care for the condition.”<sup>9</sup> Appropriate medical care can be “determined objectively as the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals.”<sup>10</sup>

The word “care” has significance in the context of a disability policy. Be wary of the insurance company that tries to make it mean more than what the insurance policy suggests. ■

#### Notes

1. *Heller v. Eq. Life Assurance Socy. of the U.S.*, 833 F.2d 1253, 1255 (7th Cir. 1987) (emphasis added).

2. *Id.* at 1257.

3. *Id.*

4. See *Pralutsky v. Metro. Life Ins. Co.*, 316 F. Supp. 2d 840, 845 (D. Minn. 2004) (emphasis added), *rev’d on other grounds*, 435 F.3d 833 (8th Cir. 2006).

5. *Id.* at 843.

6. *Id.* at 844.

7. *Id.* at 852.

8. See e.g. *Gough v. Metro. Life Ins. Co.*, 2003 WL 23411993 \*3 (M.D. Tenn. Nov. 21, 2003) (plaintiff who claimed mental confusion but was

not undergoing regular treatment for depression, mood disorder, or any other psychological disorder was not “receiving appropriate care and treatment from a doctor on a continuing basis”).

9. *Provident Life & Accident v. Henry*, 106 F. Supp. 2d 1002, 1004 (C.D. Cal. 2000) (“appropriate” and “regular” care differ, and whether the insured is receiving “appropriate care” is a triable issue of fact).

10. *Id.*

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## ‘Special-events liability’

### JOSEPH L. VACCARO

Sometimes a policy’s language seems to exclude everyone from coverage. This may occur when facility owners and operators buy coverage for special events.

For example, say you have a client who attended a Mudfest event at a location that included more than 60 acres of mud holes and 210 acres of open pasture. The client was catastrophically injured when his ATV struck a camouflaged trench and he was thrown headfirst into the wheel well of a parked flatbed trailer.

You discover that the event owners and operators purchased special-events liability coverage. But the insurance company takes the position that there is no coverage under the policy since the client was a “participant” at the event.

The policy contains a “special-event participant exclusion,” which states:

This policy does not provide coverage for “bodily injury,” “property damage,” or “personal injury” to any “participant” arising out of

1. The practicing for or participation of any person in any athletic event, contest, game, demonstration, exhibition, race, or show covered by this policy; or

2. The use of any amusement device operated by or on your behalf.

The term “participant” shall include performers, stagehands, volunteers, drivers, set-up crew, pit crew and other persons located in the pit area, security personnel, mechanics, stewards, officials or attendants, or

any other person taking part in Paragraph 1 or 2 above.

Initial review of this exclusion suggests that the insurance company may be right that your client’s injury isn’t covered. But when you examine the exclusion closely, you may reach another conclusion.

Close review reveals that the policy would exclude virtually everyone present at the event under the language “any other person taking part in Paragraph 1 or 2 above.” Everyone attending the Mudfest for any reason is participating in some way, even if only as a spectator. Therefore, no one is covered, rendering the liability coverage under the policy illusory.

Selling and collecting a premium on coverage that does not exist is fraud. Clearly the insurance carrier intended to cover the event, or said so when it sold the policy. Broad, ambiguous, and vague exclusionary language that can be interpreted to exclude everyone renders the policy meaningless and may be ground for a fraud claim. ■

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