ERIC BUCHANAN AND ASSOCIATES

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ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

For more Information about Eric Buchanan & Associates, PLLC, visit our website at www.buchanandisability.com.

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PRE-EXISTING CONDITION EXCLUSIONS IN ERISA LONG TERM DISABILITY CASES BY: R. SCOTT WILSON

One of the most common "non-disability" issues we confront in long term disability cases is the pre-existing condition exclusion. As I explain it to my clients, a pre-existing condition exclusion is nothing more than the disability equivalent of the principle that you can't get car insurance after the accident has already taken place. However, an automobile accident is a discrete event, whose time is easily ascertained. Disability, on the other hand, particularly when it results from a degenerative condition or a disease rather than a traumatic injury, is much more of a process than a single event. An individual might "hold on" for weeks or even months before concluding that he can't keep going in the face of the pain or other symptoms he is experiencing. The insurers' natural concern is that an individual might not obtain coverage—and, more importantly, not pay premiums—until he starts experiencing symptoms, and then claim benefits under the policy after just a short time of paying those premiums.

Insurance companies have utilized a variety of different policy terms to combat the possibility of someone not paying for coverage until just before he is going to need it. By far the most common definition of a preexisting condition in ERISA LTD plans defines a pre-existing condition as one for which the claimant "receives treatment"—usually defined broadly to include receiving "advice or treatment . . . takes prescribed drugs; or . . . receives other medical care . . ."—during a "look-back period"—most often 90 days, though other lengths may be used—immediately prior to the effective date of coverage. The policy then excludes coverage for disabilities "caused or contributed to by" a pre-existing condition that occurs within a certain period of time—usually one year, but other periods are sometimes used—after the effective date of coverage. To put it another way, "you can't be disabled in the first year of coverage for something you were treated for during the 90 days before you became covered."

Application of the Exclusion Turns on "Treatment," Not "Existence." The first thing that should be noted about the typical pre-existing condition exclusion, is that, despite its name, its application does not actually turn on whether the condition existed prior to coverage. At least one court has suggested that such a provision "might be described more accurately as a 'recent treatment' exclusion" as its application actually depends upon treatment for the condition during the relevant period, not existence of the condition during the relevant period. *See Hughes v. Boston Mutual Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir. 1994). The *Hughes* court noted:

> an insured who was disabled within the probationary period and did not receive medical treatment for a condition contributing to the disability during the pre-probationary period would be entitled to coverage even if she (1) received treatment for such a condition *before* (but not during) the pre-probationary period, [or] (2) knowingly suffered from symptoms of the condition during the pre-probationary period without seeking

> medical attention

Id.

"Treatment for" a condition requires some knowledge on the part of the physician that a particular condition existed; symptomatic treatment of vague symptoms that could be caused by a number of different medical conditions is insufficient. When both diagnosis of and disability due to a given medical condition occur shortly after the coverage effective date, there often arises an issue of whether medical care directed at symptoms prior to the coverage effective date constitute "treatment for" the later diagnosed condition sufficient to invoke the pre-existing condition exclusion. Two separate though overlapping lines of case law address what it means to be treated "for" a condition during the "look-back period" sufficient to trigger a pre-existing condition exclusion.

Firstly, a line of case-law holds that the word "for" implies intent, and a doctor cannot treat a patient "for" a condition unless he knows what the condition is. As such, a doctor cannot be said to have treated a patient for a condition during the look-back period, sufficient to trigger a pre-existing condition exclusion, unless that condition was diagnosed, or at the very least reasonably suspected:

> The word "for" connotes intent. Webster's Dictionary states that "for" is "used as a function word to indicate a purpose" . . . In short, it is hard to see how a doctor can provide treatment "for" a condition without knowing what that condition is or that it even exists.

Lawson v. Fortis Ins. Co., 301 F.3d 159, 165 (3rd Cir. 2002). As the Sixth Circuit reasoned:

> Because none of Mitzel's physicians even considered the possibility that she had [Wegner's Granulomatosis] before her effective date of coverage, none of them treated her *for* WG, notwithstanding the fact that she displayed some of the symptoms of that disease. It was unreasonable for Anthem to deny Mitzel's claim simply because she presented symptoms associated with a later-diagnosed disease and consulted with a doctor during the look-back period in connection with those symptoms, where the doctor did not suspect, diagnose or treat the specific disability for which she eventually applied for benefits.

Mitzel v. Anthem Life Ins. Co., 351 Fed.Appx. 74, 83-84 (6th Cir. 2009). *See also Pitcher v. Principal Mutual Life Ins. Co.*, 93 F.3d 407, 412 (7th Cir. 1996); *Hughes v. Boston Mutual Life Ins. Co.*, 26 F.3d 264 (1st Cir. 1994); *Ross v. Western Fidelity Ins. Co.*, 881 F.2d 142 (5th Cir. 1989) (Even though policy language did not require specific diagnosis to exclude pre-existing conditions, "treatment *for a specific condition* cannot be received unless the specific condition is known").

Secondly, the presence of vague or non-specific symptoms during the look-back period, that could be caused by the medical condition for which the claimant ultimately claims benefits but could also be caused by other medical conditions, is insufficient to render the medical condition for which the claimant ultimately claims benefits pre-existing:

> that Monica had some symptoms which later proved consistent with cancer is insufficient to support a denial [of coverage for that cancer] on preexisting grounds. Monica's symptoms were also consistent with a variety of other ailments she did not ultimately suffer, such as the peptic ulcer her doctor suspected. To permit such backward-looking reinterpration of symptoms to support claims denials would so greatly expand the definition of preexisting condition as to make that term meaningless: any prior symptom not inconsistent with the ultimate diagnosis would provide a basis for denial.

Ermenc v. American Family Mutual Ins. Co., 221 Wis.2d 478, 484, 585 N.W.2d 679,682 (Wis. 1998). *See also Mitzel*, *supra*; *Hall v. Continental Cas. Co.*, 207 F.Supp.2d 903 (W.D. Wis. 2002); *McLeod v. Hartford*, 372 F.3d 618, 626 (3d Cir. 2004); *Ceccanecchio v. Continental Cas. Co.*, 50 Fed. App'x 66 (3d Cir. 2002); *App v. Aetna Life Ins. Co.*, 2009 WL 2475020 (M.D. Pa. 2009). This principle has a surprisingly broad reach. In *McLeod v. Hartford*, 372 F.3d 618 (3rd Cir. 2004), the claimant became disabled due to multiple sclerosis eight months after the policy effective date. During the look-back period, the claimant had consulted with a doctor for numbness in her left arm. There was no suggestion at that time from the doctor that the claimant had multiple sclerosis, and the claimant had a history of cervical disc disease as well as cardiac insufficiency, medical conditions that might also cause left arm numbness. Four months after the policy effective date, the claimant was diagnosed with MS; the claimant's own doctor testified that it was "likely" that her MS had begun several years earlier, and that the left arm numbness in the look-back period was a manifestation of MS. Nevertheless, the court ruled that MS was not a pre-existing condition, and that the insurer could not engage in a backward-looking reinterpretation on non-specific symptoms that could be caused by multiple different medical conditions.

"Causing or contributing" to disability. Even if a particular medical condition is pre-existing, benefits are only precluded if that medical condition "causes or contributes to" (typical policy language) disability. If an individual has other medical conditions that, independently of the pre-existing condition, are sufficient to render him disabled, benefits will not be precluded.

This is frequently a factual issue, that simply needs appropriate medical evidence. A recent case involved a client with

long-standing ankylosing spondylitis (an inflammatory rheumatological condition affecting the spine) that was plainly a pre-existing condition under her policy. However, both her rheumatologist and her orthopedic surgeon agreed that the herniated disc requiring lumbar fusion surgery, the reason she went out of work, was a new medical condition, arising after the policy effective date, and unrelated to the pre-existing ankylosing spondylitis. Appropriate medical evidence establishing that she was disabled due to something other than the pre-existing condition was all that was necessary to establish her entitlement to benefits.

In addition to factual development, there are also some key legal principles limiting what it means for disability to be "caused or contributed to by" a pre-existing condition. It is insufficient for the pre-existing condition to be a remote, but-for cause of disability; it must be the proximate cause of disability as well. "The exclusion cannot merely require that the pre-existing condition be one in a series of factors that contributes to the disabling condition; the disabling condition must be *substantially or directly attributable* to the pre-existing condition." *Fought v. Unum Life Insurance Company of America*, 379 F.3d 997, 1011 (10th Cir. 2004)(emphasis added). In *Fought*, the claimant became disabled as a result of surgical complications following a surgery to address an admittedly pre-existing condition. The insurer argued that Ms. Fought's disability was excluded due to pre-existing coronary artery disease, but for which she would not have had surgery, but for which she would not have had a surgical wound, but for which she wouldn't have contracted a staphylococcus aureus infection which was resistant to antibiotics and ultimately caused her disability. The Court found that the insurer "seems to suggest that it need not cover anything for which it can construct a but/for story. If we were to accept this contention, we would effectively render meaningless the notion of the pre-existing condition clause by distending the breadth of the exclusion." *Fought*, 379 F.3d at 1010.

Conclusion. In many instances, the insurance company will be right: it is a pre-existing condition, and there is nothing to be done about it. In other cases, it is easy to establish that the disability is not pre-existing, that the claimant is disabled by a different condition, one that is not pre-existing. In between, there will be a gray area, where a combination of precise evidence gathering and advocacy can establish that either there was no treatment "for" a specific condition during the look-back period, or that the pre-existing condition is too remotely related to the ultimate disability to establish that it was the cause of the disability.

UPCOMING SPEAKING ENGAGEMENTS

Eric Buchanan will be speaking at the Tennessee Bar Association Disability Forum on May 5, 2011 in Nashville. He will speaking on Attorney's Fees in Social Security Cases.

Jeremy Bordelon will be speaking at the Tennessee Bar Association Disability Forum on May 5, 2011 in Nashville. He will speaking on the Interplay of Social Security Disability, WC, Medicare, COBRA & Long Term Disability.

R. Scott Wilson will be speaking at the Tennessee Bar Association Disability Forum on May 5, 2011 in Nashville. He will speaking on Prima Facie Proof of Disability in Social Security cases.

Eric Buchanan will be speaking at the Spring NOSSCR Social Security Disability Law Conference on May 13, 2011 in Baltimore, MD. He will speaking on ERISA LTD Claims for Beginners Part I and ERISA Part II.

Eric Buchanan will be speaking at the Association for Justice Conference on July 10, 2011 in New York, NY. He will speaking on Is your Client's Insurance Claim Preempted by ERISA.

NEED A SPEAKER?

The attorneys at Eric Buchanan & Associates are available to speak to your organization regarding Social Security Disability, ERISA Long-term Disability, Group Long-term Disability, Private Disability Insurance, ERISA Benefits, Denied Health Insurance Claims and Life Insurance Claims. Contact Molina Haynes, Office Manager at (423) 634-2506 or via email at mhaynes@buchanandisability.com