Aggrieved Disability Policyholders In New York Are Not Limited To Past Benefits as Remedy

By Michael S. Hiller

As litigation between disabled persons and their insurance carriers becomes more widespread, it is important to understand the remedies available to policyholders before commencing an action.

One of the prevailing myths is that, in New York, recovery of past disability benefits is the sole remedy that may be granted to insured individuals aggrieved by an insurance carrier's breach of an individual[1] disability policy.[2] This myth is often based upon a misreading of several frequently cited, although largely misunderstood, state and federal court decisions. Although seemingly contradictory, the cases present a clear line of authority confirming an insured's right to seek damages, not only for past disability benefits, but also for repudiation and bad faith, even in the absence of insurer misconduct directed at the general public. And, this clear line was strengthened last year by decisions of the state Supreme Court in *Wurm v. Commercial Ins. Co. of Newark, N.J.*[3] and the Appellate Division in *Acquista v. New York Life Ins. Co.*[4] Indeed, as described below, the availability of these remedies is not only supported by existing precedent, it is also sustained by considerations of public policy.[5]

Availability of Damages for Repudiation

In the context of disability insurance, the courts have consistently held that, under the theory of repudiation, "special circumstances" may warrant imposition of damages for immediate lump-sum payment of future benefits otherwise due under a disability policy.[6] One such "special circumstance" identified by the courts exists when the insurance carrier "calls off the whole arrangement."[7] In *Bell v. Mutual Benefit Health & Accident Ass'n of Omaha*, the court held that an insured may recover the present-day value of future benefits in lump sum in cases in which an insurer informs an insured that the former will not further perform under the policy (*i.e.*, not pay any further claims or benefits), declines future premiums, or otherwise cancels its insurance contract.[8] The court in *Bell* concluded that, under such circumstances, an insured "with legitimate claims should not be forced to resort to repeated lawsuits" to recover the benefits due.[9] The *Bell* decision has been cited with approval by the First and Second Departments on this particular issue and remains good law.[10]

Most recently, in *Wurm*, the court declined to set aside a jury verdict granting the plaintiff-insured the present-day value of future benefits for the defendants' repudiation of a disability policy.[11] The plaintiff had established that she had been informed by her carrier that she would never again receive any benefits under her policy, thereby terminating the relationship and abrogating the insurance contract.[12] This testimony was confirmed at trial by (1) one of the defendant-carrier's former employees and (2) the insurer's refusal to send the plaintiff any further premium statements after terminating her benefits.[13] Following the *Bell* decision, the court in *Wurm* concluded that "where the insurance company 'calls off' the whole arrangement, the plaintiff-insured should not be required to resort to repeated lawsuits" to recover benefits owed for repudiation of the policy.[14]

The decision in *Wurm* was cited with approval by the U.S. District Court for the Southern District of New York in *Scherer v. Equitable Life Assurance Society of U.S.*[15] The multiplicity of decisions affirming the right of an insured to recover damages for repudiation, coupled with the recent jury verdict in *Wurm*, confirm the continuing vitality of claims for the present-day value of future benefits in disability cases.[16]

Availability of Attorneys' Fees When a Carrier Acts in Bad Faith

The concept of bad faith has several different meanings in insurance litigation. The most frequent use of the

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term refers to circumstances in which an insured, after being sued by a third party for a covered liability, is subjected to a damage award in excess of policy limits as a result of the carrier's wrongful refusal to settle.[17] In such circumstances, the insured is entitled not only to compensatory damages to reimburse the cost of satisfying the ultimate judgment, but also to punitive damages in many instances.[18]

In the context of disability insurance litigation, there is no third party; instead, the focus is on the carrier's conduct in investigating, assessing and ultimately determining the insured's entitlement to benefits. And, in such first-party cases, the remedy for bad faith is not punitive damages (which are rarely recoverable in New York), but rather reimbursement of the insured's legal fees and expenses in prosecuting the claim against the insurance carrier.

The New York State Court of Appeals initially established an insured's right to recover legal fees for bad faith in first-party cases, in *Sukup v. State*.[19] The Court explained that, where a carrier "evinces gross disregard for its policy obligation," an insured may recover legal fees and expenses.[20] Over the years, the courts have interpreted *Sukup* to permit recovery of attorneys' fees for bad faith in situations where an insurance carrier commences an investigation to find a "bogus basis" for denying benefits or otherwise engages in a "disingenuous or dishonest failure to carry out" the policy.[21]

For example, in *New England Mutual Ins. Co. v. Johnson*,[22] the insured, a homosexual, purchased a life insurance policy and listed as his beneficiary his business partner, a man with whom he also had a romantic relationship. When the insured died of AIDS, the carrier, upon learning the cause of death, "searched through its files in an effort to determine a way to escape its obligation" and avoid paying benefits to the beneficiary of the policy.[23] The court held that, under the circumstances, an award of attorneys' fees was necessary to deter the insurance carrier and others similarly situated from engaging in such misconduct.[24]

In *Wurm*, the court also granted the plaintiff-insured attorneys' fees for bad faith;[25] the jury determined, and the court, in refusing to set the verdict aside, subsequently affirmed, that the carrier had *actually determined* the plaintiff to be permanently and totally disabled, and yet, despite this knowledge and understanding, engaged in a relentless and purposeful investigation designed to create the knowingly false impression that she had recovered sufficiently from her injuries to return to her occupation as a dentist.[26] The court concluded that, under the circumstances, an award of attorneys' fees for bad faith was factually supported by the jury's verdict and consistent with precedent. The *Wurm* decision reinforces the continuing vitality of the attorneys' fees remedy in first-party cases for an insurer's bad faith.

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Expansion of Remedies for Bad Faith

For more than 30 years, an insured's sole remedy available in New York for a carrier's bad faith in the context of first-party coverage (in the absence of evidence of a public-wide injury) was attorneys' fees. However, in *Acquista*, the Appellate Division, First Department, expanded the remedies for an insurer's bad faith to include recovery of consequential damages.[27] In *Acquista*, a disability case, the court reversed dismissal of the plaintiff-insured's allegations of bad faith, stating that "there is no reason to limit damages recoverable for breach of a duty to investigate, bargain, and settle claims in good faith to the amount specified in the insurance policy."[28]

The court in *Acquista* stated that its expansion of remedies was made necessary by reason of certain financial and other real-world considerations that regularly influence carriers' decisions regarding coverage. For example, the court explained that "if statutory interest is lower than that which the insurer can earn on the sums payable [*i.e.*, benefits due to the insured], the insurer has a financial incentive to decline to cover or pay on a claim."[29] Thereafter, in surprisingly sweeping language, the court described wrongful denials and terminations of first-party disability insurance coverage as a national problem, explaining in part: "The problem of dilatory tactics by insurance companies seeking to delay and avoid payment of proper claims has apparently become widespread enough to prompt most states to respond with some sort of remedy for aggrieved policyholders."[30] The court concluded that, "[i]n view of the inadequacy of contract remedies where an insurer purposefully declines or avoids a claim without a reasonable basis for doing so," an insured should have the right to obtain consequential damages for bad faith.[31]

Notably absent from the *Acquista* decision was any language relating to an award of attorneys' fees for bad faith. However, a review of the briefs submitted on appeal in *Acquista* confirms that the plaintiff-insured in that case never sought, and thus did not appear to argue

entitlement to, attorneys' fees for bad faith.[32] The plaintiff-insured in *Acquista* did not cite the decisions in *Sukup*, *New England Mutual*, and *FDIC v. National Surety Corp.* in support of the claim for bad faith.[33] Accordingly, the First Department did not address the issue.[34]

The advent of the decisions in *Acquista* and *Wurm* reflect a growing recognition that mere payment of past benefits plus reinstatement are insufficiently remedial to compensate policyholders for insurer misconduct. With the addition of a consequential damages remedy, insured individuals will receive enhanced protections against bad-faith practices taken by carriers.

Public Policy Considerations In Bad Faith Cases

As noted in *Standards for Limiting the Tort of Bad Faith Breach of Contract*:

> The adhesionary aspects of the insurance contract, including the lack of bargaining strength of the insured, the contracts' standardized terms, the motivation of the insured for entering into the transaction and the nature of the service for which the contract is executed, distinguish this contract [an insurance contract] from most other non-insurance commercial contracts. These features characteristic of the insurance contract make it particularly susceptible to public policy considerations.[35]

As a matter of public policy, the First Department in *Acquista* recognized that the dynamic relationship between policyholders and their carriers required the expansion of remedies available in cases of bad faith. As explained in *Acquista*, one aspect of this dynamic is that, in the absence of an adequate remedy for bad faith, insurers are not threatened with any adverse consequences for a baseless denial or termination of benefits. As discussed above, the insurer would be permitted to retain the disability benefits otherwise payable to the insured during the pendency of the action by the insured to enforce the policy. If the carrier can earn a greater return on the withheld benefit moneys than the rate of statutory interest (and, at 9%, this threshold is not difficult to transcend), it makes a profit on its denial even if it ultimately loses the case. In enhancing the remedies available for an insurer's bad faith, the court in *Acquista* identified this skewed dynamic. However, the financial incentive to insurers to deny or terminate benefits transcends what was addressed in *Acquista*.

Most individual disability policies suspend an insured's obligation to pay premiums during the period of disability. In the event of a permanent disability, an insurance carrier will never receive future premiums under the policy. Thus, the carrier has effectively received all of the consideration that it would be entitled to receive under the insurance contract, but will nonetheless have a continuing legal obligation to make benefit payments for the remainder of the insured's life (or until age 65, depending on the policy). At that point, the insurer has absolutely no financial incentive, *vis à vis* its relationship with its policyholder, to pay the insured's claim unless threatened with larger liability, *i.e.*, attorneys' fees and other damages.

Moreover, it is not as if the insured can threaten to violate the insurance contract as a means of retaliating against the carrier for wrongful denial or termination of benefits. Because the insured's obligation to make premium payments is extinguished at the time of disability, a threat of retaliatory breach by the policyholder would be an empty one. The carrier has nothing at stake other than its own obligation to pay benefits. Without adequate remedies for bad faith, insurers would have nothing to lose financially by knowingly denying or terminating benefits in situations in which they are aware of the policyholder's disability.

Aside from the skewed financial incentives to deny benefits, there are additional considerations when evaluating the public-policy implications of allowing enhanced remedies for "bad faith" claims against an insurer which were not addressed by the court in *Acquista*. For example, most insureds who are disabled cannot afford to hire and pay attorneys on an hourly basis to prosecute disability claims. Unable to work, the policyholders generally lack an income and are thus resigned to seek lawyers on a contingency-fee basis. If the sole remedy available to insureds were mere past benefits, most lawyers would be reluctant to accept disability cases on contingency, unless the policyholder waited a sufficiently long period of time (two years or more depending on the monthly benefit in the policy) to accumulate enough past benefits to make the case worthwhile financially (to the attorney). After all, one-third of a year's benefits at $5,000 per month is still just $20,000. Few competent practitioners would assume the obligation to litigate a disability case from inception to verdict on a contingency-fee basis under such circumstances; it simply would not make economic sense. This would impress upon the insured the Hobbesian choice of either (1) attempting to return to work, despite a disability; (2) not working and waiting years before commencing an action (to make the case economically advantageous for lawyers working on a contingency fee), only to receive a smaller percentage of benefits later (after the fee and costs of litigation are deducted); or (3) endeavoring to pay a lawyer on an hourly basis and risking insolvency in the process.

This choice would be made even more difficult by the economic realities confronting any potential claimant. The insured bringing the disability claim has purchased the policy to protect against the inability to work in a chosen occupation, usually a profession or executive po-

sition. These individuals typically have higher salaries, with correspondingly increased financial obligations (*i.e.*, mortgages, school tuition for children, cars and other items of significant expense). Confronted with the inability to work and catastrophic loss of income, many policyholders with looming financial difficulty would simply capitulate and either withdraw or compromise their claims (for pennies on the dollar) after considering the prospect of a lawsuit against a well-financed insurance company with a battery of lawyers. Indeed, the Kentucky Supreme Court, in establishing an insured's right to obtain punitive damages for bad faith, has observed that insurers, in obvious recognition of these circumstances, often "attempt unfair compromise [*i.e.*, offering far less than the actual value of the benefits in lump sum] by exploiting the policyholder's economic circumstance[s]."[36] Certainly, the prospect of paying an attorney on an hourly basis is sufficiently daunting for any individual, not to mention one without an income. The availability of enhanced remedies for insurer misconduct was essential to reducing the economic disparities in the dynamic between policyholder and carrier.

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Public Policy Considerations Affecting Remedies for Repudiation

Although currently available only in circumstances demonstrative of repudiation, damages for future benefits may well be in the offing even in the absence of such proof. As pointed out in *Robbins v. Travelers' Ins. Co.*, a disability insurance policy is a single contract; "the fact that [the] defendant [insurer] is required to perform in part at stated intervals does not change its unitary character into a multiplicity of contracts, each relating to but one installment."[37] The court in *Robbins* explained that once the disability benefits are terminated, there is nothing left to the insurance contract from the insured's perspective; such circumstances dictate that the dispute ought to be resolved as a single claim, in a single lawsuit.[38]

The rationale underlying the decision in *Robbins* is consistent with that relied upon in other contexts involving contracts to pay money in installments. For example, in cases to enforce the terms of promissory notes, lenders are entitled to declare a default when any one payment remains unpaid and then immediately demand the entire sum due. The lender need not rely on the theory of repudiation; once the borrower defaults in making payments, the lender can accelerate the loan and collect the entire balance. Cases arising from breach of disability contracts should be treated no differently. One can only imagine the uproar from financial institutions if banks and other institutional lenders, in cases arising from breached installment contracts, were limited in their recovery to only those sums due as of the date of the lawsuit, with all future payments deferred pending the remainder of the payout.

Moreover, where an insurer purposely denies or terminates benefits, despite the fact that its employees believe (or, in good conscience, should believe) that the insured was disabled, the carrier should not be permitted to cling to the policy's installment provisions under the false notion that a contract of sorts still exists. Public policy dictates that, where an insurer denies a claim that its employees know (or have good reason to know) is valid, or otherwise engages in bad faith, there is a repudiation of the policy, even in the absence of the "special circumstances" identified in *Bell*, entitling the insured to future benefits rather than subjecting the policyholder to further acts of misconduct by the carrier.[39] As the law develops in this area, an expansion of remedies for breach of a disability policy by the insurance carrier, particularly in circumstances suggesting bad faith, will likely continue.[40]

Conclusion

As implied by the First Department in *Acquista*, denial of first-party benefits, particularly in disability insurance cases, has become common on a nationwide basis. If the sole remedy recoverable against a disability insurance carrier were what would be payable to the policyholder in the first instance, the financial incentives to deny benefits, however unreasonable such denial may be, would be too economically enticing for insurers to ignore. The decisions in *Wurm* and *Acquista* represent important steps in the ongoing evolution of the law in this area. Given considerations of public policy, the evolution is likely to continue in the future.

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1. This article does not address an insured's rights pursuant to group policies under ERISA, which raises an entirely different set of issues.
2. Indeed, two partners from a highly regarded insurance-defense firm recently argued in an Outside Counsel submission to the *New York Law Journal* that the Court of Appeals had all but eliminated bad faith as a substantive allegation and claim in first-party insurance litigation. E. Krinik & N. Tolle, *Appellate Ruling Roils Bad Faith Waters*, N.Y.L.J., Oct. 18, 2001, p. 1, col. 1. The Court of Appeals's decisions to which Messrs. Krinik and Tolle referred, and

the propositions upon which these writers relied, pertained only to *punitive damages* awards arising from bad faith claims, not attorneys' fees which, as discussed in this article, continue to be recoverable under New York law.

3. N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
4. 285 A.D.2d 73, 730 N.Y.S.2d 272 (1st Dep't 2001). The *Acquista* decision was not appealed.
5. This article does not address any of the practical aspects relating to an effort to obtain past disability benefits or other contractual remedies which, of course, involve a different set of issues and considerations.
6. *Romar v. Alli*, 120 A.D.2d 420, 501 N.Y.S.2d 877, 878 (1st Dep't 1986); *Apostolou v. Mutual of Omaha Ins. Co.*, 72 A.D.2d 781, 421 N.Y.S.2d 600, 601 (2d Dep't 1979); *Robbins v. Travelers' Ins. Co.*, 151 Misc. 151, 269 N.Y.S. 841, 842–43 (Sup. Ct., N.Y. Co.), *aff'd*, 241 A.D. 350, 272 N.Y.S. 551 (1st Dep't 1934) (breach of the obligation to make installment payments under a disability insurance policy entitles the insured to collect the entire unpaid balance in lump sum). Though the courts in *Romar* and *Apostolou*, based upon the particular facts of those cases, denied future damages to the plaintiff-insureds therein, both courts took pains to emphasize the availability of a future-damage remedy under circumstances evincing repudiation.
7. *Bell v. Mutual Benefit Health & Accident Ass'n*, 19 Misc. 2d 754, 192 N.Y.S.2d 854, 855 (Sup. Ct., Bronx Co. 1959); *see Robbins*, 151 Misc. at 152; *Brauner v. Provident Life & Cas. Ins. Co.*, 97-CV-3556, 1998 U.S. Dist. LEXIS 23042 (E.D.N.Y. Mar. 24, 1998) ("The rule against anticipatory breach is not absolute. A plaintiff can recover a judgment regarding future benefits if, for example, the plaintiff is able to show that the insurer completely repudiated the contract.").
8. *Bell*, 19 Misc. 2d at 755–56.
9. *Id*.
10. *See Romar*, 120 A.D.2d at 421 (1st Dep't); *Apostolou*, 72 A.D.2d at 781 (2d Dep't).
11. N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
12. *Id*.
13. *Id*.
14. *Id*.
15. 190 F. Supp. 2d 629, 633 (S.D.N.Y. 2002).
16. Notably, New York is not the only jurisdiction to award future damages in lump-sum under the theory of repudiation. *See, e.g.*, *Novick v. UnumProvident Corp.*, Civil Action No. 01-CV-258, 2001 U.S. Dist. LEXIS 9735 (E.D. Pa. July 10, 2001) (future benefits permissible under circumstances evincing a repudiation by the carrier; motion to dismiss anticipatory breach claim, denied); *Dunlap v. New York Life Ins. Co.*, 958 F. Supp. 589, 591 (M.D. Fla. 1997) (applying Florida law, motion to remand case to state court based upon alleged failure to meet the statutory damages threshold for subject-matter jurisdiction, denied owing to the lump-sum benefit demanded in the complaint; "Defendant repudiated the entire contract when it refused to continue making any payments whatsoever to Plaintiff"). *Smith v. Union Mut. Life Ins. Co.*, 726 F.2d 437, 440 (8th Cir.), *cert. denied*, 469 U.S. 981 (1984), *reh'g denied*, 469 U.S. 1143 (1985) (applying Arkansas law, appellate court reversed order granting judgment notwithstanding the verdict and awarded insured full benefits, past and future, under the policy); *National Cas. Co. v. Brundage*, 148 F.2d 687 (D.C. Cir. 1945) (insured entitled to receive present-day value of policy upon proof of repudiation); *Metropolitan Life Ins. Co. v. Harper*, 189 Ark. 170, 70 S.W.2d 1042 (Ark. 1934) (where an insurer repudiates its contractual obligation, as by denying the existence or validity of the contract, an insured entitled to disability payments is not limited in recovery to installments which have accrued up to time of suit, but may also recover the present value of future benefits); *Prudential Ins. Co. v. Ferguson*, 51 Ga. App. 341, 180 S.E. 503 (Ga. Ct. App. 1935) (remedy for repudiation of a disability insurance contract is the present-day value of future benefits); *Prudence Life Ins. Co. v. Morgan*, 138 Ind. App. 287, 306, 213 N.E.2d 900 (Ind. Ct. App. 1966) (citing Indiana and Kentucky law, the court held that the insurance carrier's effort to establish its affirmative defense of fraud in the inducement for rescission of the policy constitutes repudiation, entitling the insured to obtain the present-day value of future benefits in lump-sum); *Group Life & Health Ins. Co. v. Turner*, 620 S.W.2d 670 (Tex. Ct. App. 1981) (denial of benefits, coupled with an instruction by adjuster to stop calling for reconsideration because the carrier was not going to reconsider, constituted repudiation, entitling the insured to recover not only past benefits but future benefits in lump sum, plus attorneys' fees and a 12% penalty against the carrier).
17. *See, e.g.*, *Pavia v. State Farm Mut. Auto. Ins. Co.*, 82 N.Y.2d 445, 605 N.Y.S.2d 208 (1993).
18. *Id*.
19. 19 N.Y.2d 519, 281 N.Y.S.2d 28 (1967).
20. *Id*. at 522.
21. *New York Marine & Gen. Ins. Co. v. Tradeline LLC*, 98 Civ. 7840, 1999 U.S. Dist. LEXIS 20022 (S.D.N.Y. Dec. 27, 1999) (in the context of first-party claim, "attorneys' fees may be awarded where there has been an unreasonable, bad faith denial of coverage"); *FDIC v. National Sur. Corp.*, 425 F. Supp. 200, 204 (E.D.N.Y. 1977) (motion to dismiss claim for attorneys' fees in first-party claim for bad faith, denied); *Pavia*, 82 N.Y.2d 445; *New England Mut. Life Ins. Co. v. Johnson*, 155 Misc. 2d 680, 589 N.Y.S.2d 736 (Sup. Ct., N.Y. Co. 1992) (damages for bad faith, granted).
22. 155 Misc. 2d 680.
23. *Id*. at 684.
24. *Id*. at 685.
25. *Wurm v. Commercial Ins. Co. of Newark, NJ*, N.Y.L.J., Oct. 15, 2001, p. 21, col. 1 (Sup. Ct., N.Y. Co.).
26. According to the decision in *Wurm*, the defendant-insurers "originally determined that [the plaintiff] was entitled to benefits under the policy" and confirmed that determination after retaining an orthopedist who similarly concluded that her injuries were totally and permanently debilitating. Nonetheless, the defendants placed her under surveillance repeatedly, attempted to convince the plaintiff to perform services in her occupation by posing as a patient, provided the insured's doctors with misleading and incomplete medical records in an effort to convince them to change their diagnoses, and otherwise pursued additional investigations to provide a "bogus basis" to deny her claims. *Id*.
27. *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 80–81, 730 N.Y.S.2d 272 (1st Dep't 2001).
28. *Id*. (quoting *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 801 (Utah 1985)).
29. *Acquista*, 285 A.D.2d at 79.
30. *Id*. at 81 (citations omitted).

31. *Id*. at 79.
32. *See* Brief for Plaintiff-Appellant at 27–30, *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 730 N.Y.S.2d 272 (1st Dep't 2001) (Plaintiff-Appellant argued entitlement to punitive damages and other relief for bad faith, but not attorneys' fees).
33. *Id*.
34. It is also possible that the First Department in *Acquista* intended to include attorneys' fees as an element of consequential damages, as other courts have done. *Canyon Country Store v. Bracey*, 781 P.2d 414, 420 (Utah 1989) (one-third contingency fee awarded to attorneys as an elemental of consequential damages); *Jordan v. National Grange Mut. Ins. Co.*, 183 W. Va. 9, 393 S.E.2d 647 (W. Va. 1990) (attorneys' fees awarded for bad faith in first-party disability case as element of compensatory damages).
35. *Standards for Limiting the Tort of Bad Faith Breach of Contract*, 16 U.S.F. L. Rev. 187, 200–201 (1982).
36. *Curry v. Fireman's Fund Ins. Co.*, 784 S.W.2d 176, 178 (Ky. 1989).
37. *Robbins v. Traveler's Ins. Co.*, 151 Misc. 151, 152, 269 N.Y.S. 841 (Sup. Ct., N.Y. Co.), *aff'd*, 241 A.D. 350, 272 N.Y.S. 551 (1st Dep't 1934).
38. *Id*. at 153.
39. *See, e.g.*, *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, n.7, 620 P.2d 141 (Cal. 1979) (in cases in which the insurer engages in bad faith, "the jury may include in the compensatory damage award[,] future policy benefits that they reasonably conclude, after examination of the policy's provisions and other evidence, the policy holder would have been entitled to receive had the contract been honored by the insurer").
40. Of course, this should not prevent a carrier from enforcing the terms of the policy when its employees *reasonably* believe an insured to be sufficiently recovered to resume employment.

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