Burden of Proof: The "What Changed?" Argument from "A Smorgasbord of Interesting Disability Cases"

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Muniz v. Amec Construction Mgmt., 623 F.3d 1290 (9th Cir. 2010)

Facts and holding: Due to his HIV diagnosis, in 1992, Dierro Muniz ("Muniz") began receiving long term disability benefits under his ERISA-governed long-term disability insurance plan issued by Connecticut General Life Insurance Company ("CGLIC").

Under the terms of the plan, Muniz was entitled to continue to receive benefits after 24 months if he was "totally disabled," which was defined by the plan as being "unable to perform all the essential duties of any occupation."

In April 2005, Muniz's claim came up for periodic review. During the review process, CGLIC's nurse case manager determined that Muniz's current medical records did not support the severity of the symptoms he reported. In addition, CGLIC determined in its vocational assessment that Muniz could perform sedentary work, thus rendering him qualified for clerical positions.

Muniz's treating physician advised CGLIC that he disagreed with its findings and that it was his opinion that Muniz could not work in any field, sedentary or otherwise. However, he did not provide any objective medical evidence in support of this opinion. As a result, CGLIC requested that Muniz undergo a Functional Capacity Evaluation ("FCE").

Although Muniz was willing to have an FCE, his treating physician refused to authorize the exam, given Muniz's fatigue and overall condition. CGLIC then requested updated medical records from Muniz's treating physician. Upon review of those records, CGLIC terminated Muniz's benefits. Muniz's appeals were denied and Muniz filed an ERISA suit.

Applying a *de novo* standard of review, the District Court ruled that the administrative record was insufficient to determine whether Muniz was totally disabled under the terms of the plan and ordered Muniz to submit to an FCE. Thereafter, the court ruled that the results of the FCE did not support Muniz's position that he was totally disabled, and Muniz appealed.

The Ninth Circuit affirmed, rejecting Muniz's argument that the burden of proof should shift to the claim administrator when the claim administrator terminates benefits without providing evidence of how the claimant's condition changed or improved since the initial benefits award.

The Court held that although the fact that a claimant is initially found disabled under the terms of a plan may be considered as evidence of the claimant's disability, paying

benefits does not “operate forever as an estoppel so that the insurer can never change its mind.”

The Court held that under the applicable *de novo* standard of review, the burden of proof remained with the claimant. Here, Muniz did not provide sufficient evidence to demonstrate that the district court’s holding was “clearly erroneous.”

The Ninth Circuit also rejected Muniz’s assertion that the district court improperly rejected the medical opinion of his treating physician, holding that courts are not required to give special weight to the opinions of a claimant’s treating physician. (That position has been well-established since the U.S. Supreme Court so ruled in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003).)

Finally, the Ninth Circuit rejected Muniz’s argument that the results of the court-ordered 2009 FCE were irrelevant to the issue of whether he was disabled when his benefits were terminated in 2006.

Although the results were not conclusive, they potentially provided insight as to Muniz’s previous condition because Muniz had many of the same symptoms and activity levels in 2009 as he did in 2006. Moreover, the district court did not rely solely on the FCE results; rather, it considered them in combination with the other evidence.

Lessons Learned: This case highlights the “What changed?” argument often advanced by insureds. (“If you found me disabled before, then you should have to show that something changed if you are not going to continue to find me disabled.”)

The Ninth Circuit rejected this argument; just because an insurer commences disability payments to an insured does not render the insured presumptively disabled until the insurer can demonstrate otherwise.

Note, however, that the argument *has* found favor with certain courts. For example, last year a Florida district court adopted the contrary view. In *Kafie v. Northwestern Mutual Life Ins. Co*., 2010 U.S. Dist. LEXIS 24184 (S.D. Fla. 2010), the court suggested that once an insurer makes disability payments, it has the burden of proof in demonstrating that the insured is no longer disabled. (The *Kafie* case was included in last year’s *Cornucopia*.)

From A Smorgasbord of Interesting Disability Cases.