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Disability Insurance: Combatting Insurers' Tactics and Making Them Pay

The 1980's were the halcyon days for disability insurers. Summoning all their considerable resources, the carriers were aggressively marketing long-term disability policies to doctors, lawyers and other high-earning professionals -- and the professionals were taking the bait.

And why not? The premiums were reasonable, the coverage was generous, and the sales pitch -- significant protection from the financial devastation that can result from a loss of income in the event of disability -- was irresistible.

But as the 20th Century ends and the 21st begins, the high stress and physical demands of professional careers are causing a surge of claims under disability policies. And the insurers -- having happily banked years of premiums -- are responding just the way you might expect: denying more claims

This syllabus is designed to supplement the basic background provided in the oral presentation and to highlight some of the case law that will help you deal with this new era in disability insurance. Hopefully, the syllabus will help you identify insurers bad faith tactics and leave you better prepared to combat them. It is not, however, intended to be a comprehensive analysis of this area of practice.

I. What is total disability ?

In *Erreca v. Western States Life Ins. Co.* (1942) 19 Cal.2d 388, 396, 121 P.2d 689, 695, the California Supreme Court specifically addressed the issue of how disabled an insured must be in order to qualify for benefits:

According to overwhelming authority, the term 'total disability' does not signify an absolute state of helplessness but means such a disability as renders the insured unable to perform the substantial and material acts necessary to the prosecution of a business or occupation in the usual or customary way. (emphasis added(1))

The *Erreca* court added that an insured is totally disabled where his condition prevents his working with reasonable continuity in his customary occupation [19 Cal.2d at 394-395; 121 P.2d at 694], and thus that recovery is not precluded under a total disability provision because the insured is able to perform sporadic tasks. [19 Cal.2d at 396; 121 P.2d at 695].

These rules were reaffirmed in *Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892, which defined total disability as:

[A] disability that renders one unable to perform with reasonable continuity the substantial and material duties necessary to pursue his usual occupation in the usual or customary way (2)

Thus, an insured is totally disabled as long as he cannot perform the essential duties of his profession in the customary way and with reasonable continuity -- even if he can perform some of those duties to some extent and/or on some occasions. Accordingly, in *Erreca* the Court found that an injured farm supervisor was totally disabled from his occupation even though he could still buy livestock and supplies, sell farm products, arrange crop financing, negotiate leases, and determine what crops to plant and the time and price for selling them. Similarly, in *Austero v. Nat. Cas. Co. of Detroit, Mich.* (1978) 84 Cal.App.3d 20, 148 Cal.Rptr. 653, the

Court held that an attorney was totally disabled despite the fact that he appeared at 251 court hearings (an average of 20.9 per month), had 689 scheduled office appointments with clients (57.3 per month), and took 16 depositions -- and thus was obviously able to perform at least some of the functions of his profession . 84 Cal.App.3d at 23, 148 Cal.Rptr. at 668.

And an insured who attempts to return to work is still disabled if he cannot perform his duties as he did before his injury. In *McMackin v. Great American Reserve Ins. Co.* (1971) 22 Cal.App.3d 428, 99 Cal.Rptr. 227, the Court found that an injured C.H.P. officer remained totally disabled even though he returned to work for 8 months and received his regular compensation, because he was unable to perform his duties fully and worked slowly as compared to his efficiency before his injury. 22 Cal.App.3d at 434-435, 99 Cal.Rptr. at 231. As stated by the Court, an insured should not be penalized for a desire to resume his job, and a futile effort to return to work, notwithstanding the existence of disability, will not preclude recovery of benefits . *Id.*, 22 Cal.App.3d at 438, 99 Cal.Rptr. at 233.

Moreover, the type of disability policy purchased by the insured can significantly impact whether he will be considered totally disabled. Disability policies fall into two general classes -- the general disability' policy, which insures against disability of the insured to engage in any occupation for which he is suited; and the occupational disability' policy, which insures against disability to engage in the insured's specific usual occupation. *Weum v. Mutual Benefit Health & Accident Assoc.* (1952) 237 Minn. 89, 99, 54 N.W.2d 20, 27.(3) An occupational disability policy, commonly called an Own Occupation or Regular Occupation policy, provides coverage for the insured's real occupation [*Dixon v. Pacific Mutual Life Ins. Co.* (2nd Cir. 1959) 268 F.2d 812, 815; *Continental Cas. Co. v. Novy* (1982) 437 N.E.2d 1338, 1349], chosen profession [*Continental*, 437 N.E.2d at 1350], or regular job [*Vanderklok v. Provident Life and Accident Ins. Co.* (6th Cir. 1992) 956 F.2d 610, 614] -- i.e., his particular occupation for which he seeks protection by insurance [*Dixon*, 268 F.2d at 815; *Continental*, 437 N.E.2d at 1351]. And the fact that the insured, although unable to perform the duties of his particular occupation, might be able to perform those of some other occupation, is immaterial [*Pistorious v. Prudential Ins. Co. of America* (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, 663, n. 4] and beside the point [*Warren v. Commercial Travelers Mutual Accident Assoc. of America* (1951) 199 Misc. 864, 865, 107 N.Y.S.2d 325, 326] when he is insured under an own occupation or regular occupation policy.

II. Rescission for Misrepresentation in the Application

There are two primary areas of potential non-disclosure or misrepresentation upon which disability insurers typically rely when seeking to rescind a policy: The failure to disclose all relevant medical information and the failure to accurately state the insured's income.

In that regard, it is a well settled that an applicant for a disability insurance policy, when asked, must disclose information the insurer considers material in deciding whether to accept the risk and issue a policy. *Thompson v. Occidental Life Ins. Co.* (1973) 9 Cal.3d 904, 915-916, 109 Cal.Rptr. 473, 480, 513 P.2d 353; *Ransom v. Penn Mutual Life Ins. Co.* (1954) 43 Cal.2d 420, 427, 274 P.2d 633. The non-disclosure of such material information entitles the insurer to rescind the policy. *Id.*

The corollary, however, is equally true: The failure to disclose information which is not material does not permit the insurer to rescind the policy. *Rutherford v. Prudential Ins. Co.* (1965) 234 Cal.App.2d 719, 725-726, 44 Cal.Rptr. 697, 701. In considering the materiality issue, courts look to the practice of the insurance company when confronted with an application containing a truthful disclosure to determine whether it would . . . have been influenced by full and truthful answers . *Id.*

And if an insurer is on notice that answers in the application are inconsistent or inaccurate but fails to further inquire as to those statements, it waives the right to assert that the information was material. *Anaheim*

Builders Supply, Inc. v. Lincoln Nat. Life Ins. Co. (1965) 234 Cal.App.2d 719, 43 Cal.Rptr. 494.

Moreover, the insured's failure to disclose information in response to questions on an application will not justify rescission where he did not know about the non-disclosed medical condition or appreciate its significance, or where that condition related to minor indispositions rather than serious ailments which undermine the general health. Thompson, 9 Cal.3d at 915-916, 109 Cal.Rptr. at 480, 513 P.2d 353

Additionally, where the insured did disclose the condition to the insurer's agent but the agent failed to include it in the application or told the insured it was not relevant, the insurer may not rescind the policy. Boggio v. California-Western States Life Ins. Co. (1952) 108 Cal.App.2d 597, 599-600, 239 P.2d 144, 146-147; Byrd v. Mutual Benefit Health & Acc. Ass'n (1946) 73 Cal.App.2d 457, 463, 166 P.2d 901, 904. And an agent is deemed to be the insurer's agent where the insurer has filed a notice of agency appointment with the Department of Insurance, even if the insured believes the agent to be the insured's own agent. Loehr v. Great Republic Ins. Co. (1990) 226 Cal.App.3d 727, 732--734, 276 Cal.Rptr. 667, 670-672.

Finally, a disability insurer's attempt or threat to rescind the policy because of claimed material misrepresentations or concealments by the insured, if found to be unreasonable, may subject the insurer to extracontractual liability. [Fletcher v. Western Nat'l Life Ins. Co. (1970) 10 Cal.App.3d 376, 89 Cal.Rptr. 78].

III. Interplay of Incontestability Clauses, Pre-Existing Condition Provisions and First Manifest Restrictions

Even if an insured fails to disclose information on an application, the potential for having the policy rescinded is not open-ended. Disability policies typically contain "incontestability" clauses which provide that once a certain time period (commonly two years) following issuance of the policy has expired, the insurer can no longer "contest" the policy on the grounds that the insured did not fully disclose some bit of medical history or financial information during the application process.

In a recent life insurance case, the California Supreme Court reiterated the enforceability of such incontestability provisions, even where the insured knew he had AIDS at the time of his application and actually had an impostor appear for the medical exam. Amex Life Assurance Co. v. Superior Court (1997) 14 Cal.4th 1231, 60 Cal.Rptr.2d 898. The Amex court emphasized that incontestability clauses operate as a statute of limitations (4) that requires the insurer to investigate and act with reasonable promptness if it wishes to deny liability on the ground of false representation or warranty by the insured and, in the process, prevents an insurer from lulling the insured, by inaction, into fancied security during the time when the facts could best be ascertained and proved. Id., 14 Cal.4th at 1236, 60 Cal.Rptr.2d 898. And if an insurer fails to challenge an application within the incontestability period, the insurer may be said to have taken the [insured] as it found him [McMackin v. Great American Reserve Ins. Co. (1971) 22 Cal. App. 3d 428, 440, 99 Cal.Rptr. 227, 234].(5)

In addition to (or, in California, as part of(6)) the incontestability clause, a disability policy usually contains a provision that limits an insurer's ability to deny coverage on the ground that the disability arose from a pre-existing condition. The provision typically states that no claim for disability which begins more than two years after the Date of Issue will be reduced or denied on the grounds that a disease or physical condition not specifically excluded from coverage existed before the Date of Issue.

The simple, straightforward application of the incontestability and pre-existing condition clauses mandates that a pre-existing condition, whether disclosed or not, cannot preclude coverage so long as the disability arising from that condition does not incept within the first two years after issuance of the policy. But disability insurers have tried to side-step the protection offered by such provisions by defining a sickness causing disability as a sickness . . . that . . . first manifests itself while this Policy is in force and defines manifest as becomes known to you by the presence of symptoms that would cause an ordinarily prudent person to seek

medical attention

It is in the interplay between these provisions that the insurer tries to trap the unwary into a denial of benefits. Specifically, where a condition was not disclosed on the application and caused a disability more than two years after the policy went into effect, the insurer argues that even though the disability cannot be challenged on the basis that the condition was not disclosed on the application, the condition still first manifested prior to inception of the policy and the later-occurring disability is excluded.

Unfortunately, two California appellate courts recently fell into this trap and concluded that the first manifest clause controls over the incontestability and pre-existing condition provisions. In *Callahan v. Mutual Life Ins. Co. of New York* (1999) 71 Cal.App.4th 1089, 84 Cal.Rptr.2d 342, the Court of Appeal held that the incontestability clause does not trump or expand the first manifest provision, and thus does not bar an insurer from denying coverage on the ground that a condition first manifested before the policy inception. Similarly, in *Galanty v. Paul Revere Life Ins. Co.* (1998) 66 Cal.App.4th 15, 77 Cal.Rptr.2d 589, the Court of Appeal concluded that the incontestability clause cannot create coverage where coverage does not otherwise apply. The court posited that the first manifest clause was the coverage provision and that coverage did not exist unless the illness which ultimately resulted in disability first manifested during the policy period. Fortunately, however, the California Supreme Court has granted review in both *Galanty* and *Callahan*.

The Supreme Court should find at least two fundamental flaws in the Court of Appeal's analysis. First, it is unreasonable to permit an insurer to draft around state-mandated coverage for pre-existing conditions. Second, the assumption that existence and manifestation are one and the same is insupportable. To exist means to have being or actuality [American Heritage Dictionary, 2nd. Coll. Ed., 1982, p. 475]. To manifest means clearly apparent to the sight or understanding; obvious [Id., p. 763]. Thus, something may exist (i.e., be actual), yet not be manifest (i.e., not apparent). But something cannot manifest (be apparent) unless it first exists (is actual).

Thus, to exist is broader than to manifest. That being the case, if a condition exists before policy inception, the incontestability provision applies irrespective of whether the condition was manifest before the policy commenced. And the incontestability clause requires that the disability be covered so long as the condition existed prior to policy inception and did not result in disability until at least two years after the policy began. Since a disease may exist whether it is manifest or not, but a disease cannot manifest if it does not exist, the statutory provision mandates coverage for every disease which existed irrespective of whether it manifested prior to coverage.

Indeed, to rule otherwise would violate the plain meaning rule that is well established in California⁽⁷⁾ and most other states. When the entire policy, and the relevant clauses, are given their plain meaning, the result is that any condition which pre-existed the issuance of the policy, whether manifest or not, cannot be a basis for denial of a claim after the policy has been in effect for the incontestability period. *Insurance Commissioner of Maryland v. Mutual Life Ins. Co. of New York* (1996) 680 A.2d 584; *Oglesby v. Penn Mutual Life Ins. Co.* (D. Del. 1995) 889 F.Supp. 770. And to reach a contrary result would allow coverage provisions of a policy to prevail over the statutorily required clauses and thereby thwart the mandate of the legislature [Wischmeyer v. Paul Revere Life Ins. Co. (S.D. Ind.1989) 725 F.Supp. 995, 1004].

IV. Legal Disability

Another fertile area being plowed by disability insurers is the concept of legal disability. This denial of benefits occurs where the insured is unable to engage in his profession due to legal impediments (e.g., revocation of a license necessary to practice), irrespective of whether the insured also happens to be physically disabled.

The primary published decision on this issue is *Massachusetts Mutual Life Ins. Co. v. Ouellette* (1992) 159 Vt. 187, 617 A.2d 132. In *Ouellette*, an optometrist was found guilty of lewd and lascivious conduct, resulting in the revocation of his license to practice optometry and his imprisonment. As a result, he applied for benefits under his disability policy. The Court held that the insured's pedophilia, while causing his license revocation and incarceration, was not a sickness which rendered him physically unable to practice his profession. In other words, but for the license revocation and the incarceration, he was physically able to practice and thus was not factually disabled.(8)

In a similar context, some courts have held that a person afflicted with a disease but not otherwise disabled is not entitled to benefits where he is precluded from engaging in his profession because he is a carrier of the disease [*Dang v. Northwestern Mutual Life Ins. (D. Neb. 1997)* 960 F.Supp. 215; *Gates v. Prudential Ins. Co. (1934)* 270 N.Y.S. 282].

Those holdings, of course, should have no application where the insured's physical or mental illness or disability occurred first, even if the condition subsequently led to the revocation of his license or legal disability. And, indeed, that is the conclusion reached in at least two published opinions. In *Ohio National Life Assurance Corp. v. Crampton (E.D. Va 1993)* 822 F.Supp. 1230, *aff'd*, 53 F.3d 328 (4th Cir. 1995) and *Paul Revere Life Ins. Co. v. Bavaro (S.D.N.Y. 1997)* 957 F.Supp. 444, the courts reasoned that if the insured was, in fact, disabled, a later legal disability did not preclude recovery of benefits.

Thus, the key to addressing these cases is clarifying for the court the fact that the disability -- whether it be mental or physical -- existed first and that even if the legal disability vanished, the factual disability would preclude the insured from engaging in his occupation in any event.

V. Disparity in Case Law Between Physical-Based Disabilities and Mental-Based Disabilities

There seems to be an unjustifiable distinction in the case law between the validity of disability claims based on physical injuries or standard medically-based diseases (e.g., cancer) and disability claims based on injuries derived from mental-based conditions. This unwarranted distinction is best exemplified by the cases dealing with whether the fear of relapse of a disabling condition itself constitutes a disability for purposes of disability insurance claims.

For example, there is a body of case law that provides that where an insured has suffered a disabling condition, received treatment and recovered, but there is a risk of relapse if the insured returns to work, the insured remains disabled and entitled to recover disability insurance benefits. (*Forman v. New York Life Ins. Co., (1934)* 267 Mich. 426, 255 N.W. 222 [phlebitis]; *Cato v. Aetna Life Ins. Co. (1927)* 164 Ga. 392, 399, 138 S.E. 787, 794; *Metropolitan Life Ins. Co. v. Johnson (1942)* 194 Ga. 138, 20 S.E.2d 761 [tuberculosis]; *Wright v. Prudential Ins. Co. of American (1938)* 27 Cal.App.2d 195, 205, 80 P.2d 752, 757 [degenerative spinal condition].)

In contrast, where the condition relates to a chronic stress syndrome, chronic pain or self-induced condition such as drug use, or a socially distasteful disease such as hepatitis, the courts take a notably less tolerant view. [*Dang v. Northwestern Mutual Life Ins. Co. (D. Neb.1997)* 960 F.Supp. 215; *Damascus v. Provident Life Ins. Co. (N.D. Cal. 1996)* 933 F.Supp. 885; *Allmerica Financial Life Ins. & Annuity Co. v. Llewellyn (D. Ore. 1996)* 943 F.Supp. 1258; *Gaines v. Sun Life Assur. Co. of Canada (1944)* 306 Mich. 192, 196, 10 N.W.2d 823, 825]. (D. Del. 1995). Similarly, where insureds have mental illnesses which cause them to act inappropriately in the context of their professions (e.g., sexual molestation, sexual harassment), the courts have been loathe to approve disability benefits. [See *Goomar v. Centennial Life Ins. Co. (S.D. Cal. 1994)* 855 F.Supp. 319; *Grayboyes v. General American Life Ins. Co. (E.D. Pa 1995)* 1995 U.S. Dist. LEXIS 4233; *Hammond v. Fidelity and Guaranty Life Ins. Co. (7th Cir. 1992)* 965 F.2d 428; *Hunter v. Dept. of Health, Education & Welfare (E.D. Pa. 1971)* 329 F.Supp. 43].

Practical experience in unreported decisions confirms the sense that courts have a fundamental hostility to and/or misunderstanding of mentally-related conditions and the disabling effect of stress-induced physical ailments which subside once the insured ceases working in the stressful environment. For example, where the insured has a stress-induced anxiety disorder or stress-related physical ailments such as high blood pressure, exacerbation of a diabetic condition, heart palpitations or angina, the insurer will often obtain a medical examination of the insured after the insured has stopped working and has received treatment for several months for the disabling condition.

At that point, the stress-induced anxiety and/or physical condition is controlled and the medical examiner invariably concludes that the insured is no longer disabled. But, of course, that analysis ignores the fact that if the professional is returned to the same high-stress profession, the disabling symptoms will simply recur -- and may, perhaps, even threaten the insured's life.

In large part, the judicial resistance to stress-related disability claims seems to be predicated on the assumption that such claims can be easily faked since they often deal with subjective symptoms. But medical studies conducted over the past decade and more confirm the reality of these stressed-based medical concerns.

For instance, one study of stress in women concluded that work stress more commonly resulted in illnesses whereas family stresses tended to result in depression. [Steward, Salt, Life Stress, Life-Styles, Depression and Illness in Adult Women, *Journal of Personal Social Psychology*, June 1981, p. 1063].

In another study, the researchers concluded that work conflicts notably affected the health of workers, and that workers who were already affected with disease were the most severely impacted by workplace stress. [Tuomi, Eskelinen, Toikkanaen, Jarvinen, Ilmarinen & Klockars, Work Load and Individual Factors Affecting Work Ability Among Aging Municipal Employees, *Scandinavian Journal of Work Environment Health*, 1991, 17 Supple 1:128-34].

A Swedish study also found a strong correlation between mental work stress and the occurrence of headaches, especially in men. [Antonio, Isacson, Headache in Sweden: The Importance of Working Conditions, *Headache*, April, 1997, 37(4): 228-34].

Further, a study of Type A personalities confirmed a strong correlation between declining emotional and physical health and Type A behavior, especially in men older than 45. [Burke, Weir, The Type A Experience: Occupational and Life Demands, Satisfaction and Well-Being, *Journal of Human Stress*, Dec. 1980, 6(4):28-38.]

Similarly, a 1993 study found that occupational stress has a notable effect on blood pressure in men. [James, Pickering, The Influence of Behavioral Factors on the Daily Variations of Blood Pressure, *American Journal of Hypertension*, June 1993, 6 (6 pt 2)170S-173S].

Finally, an interesting study from 1985 explains the fundamental physiological systems which link the mental stress response to the physical system, and includes a flow diagram which demonstrates the stress response in terms of the autonomic nervous system, hormonal system and immune response system. [Milsum, *Behavioral Science*, Oct., 1985, 30(4): 179-86].

These studies confirm the underlying predicate that physical disability can arise from stress-related factors. And it is this type of empirical, medical data linking occupational stress to physical disability which needs to be delivered to the courts in order to overcome the current prejudice against stress-based disabilities. Once that mental stress-physical effect link is made, there is no longer any reasoned basis for distinguishing between fear of relapse of a standard physical injury or illness and a physical or mental condition which is triggered by occupational stress.

VI. Mental/Nervous Disorders Versus Physical Disabilities With Mental/Nervous Components

Most disability policies limit recovery for disabilities which are "'caused or contributed to' by a mental disorder' . A recent Ninth Circuit decision has clarified the application of this limitation. [Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc. (9th Cir. 1997) 125 F.3d 794].

In Lang, the insured's inability to work was triggered by job stress; her symptoms included uncontrollable crying, throwing up before work and inability to concentrate. Based on Lang's claim form, the carrier notified her that it intended to limit payment under the 24-month mental/nervous disorder provision in the policy.

During the two-year period, Lang was diagnosed with fibromyalgia -- a soft-tissue rheumatism that principally affects muscles and their attachment to bones, but is also commonly accompanied by fatigue, sleep disturbances, lack of concentration, changes in mood or thinking, anxiety and depression. Additionally, there is a biologic link between fibromyalgia and some forms of depression and chronic anxiety.

When she received the diagnosis of fibromyalgia, Lang asked the insurer to reconsider its conclusion that her stress claim was solely mental/nervous and that she be provided benefits for her physical disability. The insurer declined her request. The Ninth Circuit explained why it was wrong to do so.

The Court noted that the mental/nervous disorder provision of the policy was silent as to whether the administrator should look to causes or symptoms when determining whether the claimant had a 'mental disorder' . That, the court held, rendered the provision ambiguous:

The Plan language presents an almost classic ambiguity. See Kunin v, Benefit Trust Life Ins. Co., 910 F.2d 534 (9th Cir.1990); Phillips v. Lincoln Nat. Life Ins. Co., 978 F.2d 302 (7th Cir.1992). Both Kunin and Phillips considered a similar phrase, 'mental illness,' and held that it was ambiguous in that it could reasonably refer either to illnesses with non-physical causes, or to illnesses with physical causes, but exhibiting both physical and non-physical symptoms.

The Lang court applied the standard rules regarding construction of ambiguous provisions (i.e., [a]mbiguities in ordinary insurance contracts are construed against the insurance company), and held that the phrase 'mental disorder' does not include 'mental' conditions resulting from 'physical' disorders [125 F.3d at 799].

Similarly, in Kunin v. Benefit Trust Life Ins. Co. (9th Cir. 1990) 910 F.2d 534, 541, the Ninth Circuit found a 'mental illness' policy limitation ambiguous in part because it did not contain . . . any language suggesting whether the cause or the manifestation determines whether an illness is covered and because the policy offered no illustration of the conditions that are included or excluded within the term. And in Phillips v. Lincoln Nat. Life Ins. Co. (7th Cir.1992) 978 F.2d 302, the Court concurred with Kunin that 'mental illness' is ambiguous. The Court emphasized that the 'mental illness' limitation did not state whether the cause or the manifestation of an illness determines whether an illness is covered by the limitation [Id. at 310-311], and concluded that [I]nsurers should not be permitted to exploit policy term ambiguities [Id. at 314]. Significantly, the court reached this conclusion even though the 'mental illness' limitation restricted benefits for 'mental illness' of any type or cause.

These cases help enormously in rationally applying the physical/mental dichotomy. The fact that there are stress-related or mental components to a disability does not -- in and of itself -- justify the conclusion that the person is not disabled or that the disability is not physically-based as opposed to mentally-caused.

VII. Statute of Limitations Issues

In determining the applicable statute of limitations, it is important to distinguish between the limitations period applicable to the claim for policy benefits and the limitations period for a claim for bad faith arising out of the wrongful denial of policy benefits.

A. Limitation Period Applicable To Policy Benefits.

In California, the Legislature has set forth policy provisions which are required in every disability policy which is either delivered or issued for delivery to any person in this State. [Insurance Code section 10350]. And those provisions apply even as to group policies which are issued out-of-state but provide disability insurance coverage to persons within the state. [Insurance Code section 10270.9]. Thus, an insurer that delivers a certificate of insurance in this state must comply with the statutory provisions set forth in Insurance Code sections 10350.1 through 10350.12.

California Insurance Code section 10350.7 requires that a disability policy covering a California citizen include the following provision:

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Moreover, California Insurance Code section 10350.11 mandates the following policy provision:

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Thus, under the proof of loss provision of section 10350.7, an insured has 90 days within which to provide the proof of loss.⁽⁹⁾ Then, pursuant to Insurance Code section 10350.11, the insured has three years from the date proof of loss is required within which to bring an action.

But the interplay between the statutory provisions actually creates an installment contract. An insured is not unconditionally entitled to disability benefits for the rest of his or her life. On the contrary, disability policies provide that the insured is entitled to each independent monthly benefit only so long as the insured remains totally disabled. Thus, the proof of loss requirement of section 10350.7 is actually triggered every month, and so is a new limitations period.

That was precisely the holding in *Nikaido v. Centennial Life Insurance Company* (9th Cir. 1994) 42 F.3d 557. In *Nikaido*, the court addressed this issue in the context of a claim for disability benefits under a policy issued to an employee benefit plan. Although *Nikaido* involved a policy subject to ERISA, the *Nikaido* court analyzed the statute of limitations issue on the basis of California's disability insurance statutes and its holding is therefore more universal than one solely restricted to ERISA issues.

In *Nikaido*, the court adopted the "installment contract" theory of entitlement to disability benefits pursuant to the statutory language in California Insurance Code section 10350.7. Under *Nikaido*, the "installment contract" doctrine applies to the accrual of the statute of limitations in a case involving claims for monthly disability benefits.

Accordingly, each month that a disability insurer fails to pay benefits constitutes a separate breach which establishes new legal liability on the insurer's part. Thus, the statute of limitations commences anew with each month's failure to pay. Therefore, even assuming the action was not filed within three years after the original denial, the insured is entitled to recover contract benefits for at least the three years preceding the filing of the action as long as the insurer has continued to deny benefits.(10)

The Ninth Circuit recently confirmed this rule (albeit in a somewhat confusing opinion) in *Wetzel v. Lou Ehlers Cadillac Group LTD Ins. Program* (1999) 189 F.3d 1160. The *Wetzel* majority held that as long as the disability policy contains the proof-of-loss language required by Insurance Code section 10350.7(11) (which is quoted above), a separate cause of action accrues for each month the insured is disabled and the insurer fails to make a payment. As crystallized by the *Wetzel* dissent, the majority opinion essentially eliminates the statute of limitation for ERISA claims [Id. at 1172].

Disability insurers in California typically rely on *Neff v. New York Life Ins. Co.* (1947) 30 Cal.2d 165, 180 P.2d 900, arguing that it overrides the application of sections 10350.7 or 10350.11. *Neff*, however, was a 1947 decision. Insurance Code sections 10350, et seq., were enacted four years later, in 1951. Thus, the statutes override any contrary holding in *Neff*. (See *Baer v. Associated Life Ins. Co.* (1988) 202 Cal.App.3d 117, 124, 248 Cal.Rptr. 236, 239 [where statute and common law conflict, statute will govern as latest expression of law].)

B. Limitation Period Applicable To Bad Faith Claims.

In California, an insured may seek to impose tort liability and recover punitive damages against an insurer for breach of the duty of good faith and fair dealing. That bad faith action, sounding in tort, must be brought within two years of the denial of the claim. [*Richardson v. Allstate Ins. Co.* (1981) 117 Cal.App.3d 8, 13, 172 Cal.Rptr. 423, 426; *Smyth v. USAA Prop. & Cas. Ins. Co.* (1992) 5 Cal.App.4th 1470, 1477, 7 Cal.Rptr.2d 694, 698].

An insured may, however, seek to impose liability on an insurer for its breach of the covenant of good faith and fair dealing sounding in contract. In that context, the limitations period is four years from the denial of benefits. [*Frazier v. Metropolitan Life Ins. Co.* (1985) 169 Cal.App.3d 90, 102, 214 Cal.Rptr. 883, 889-890]. And in the contractual bad faith action, it may even be possible for the insured to recover emotional distress damages, despite the absence of a tort cause of action. [Id.].

For both the two-year and four-year statutes of limitations, it is critical to determine when the limitations period begins to run. In *Frazier*, the court emphasized that as long as the insurer is considering the claim and seeking further information, the statute of limitation does not accrue:

Mrs. Frazier's action does not commence until Metropolitan denies her claim on the ground of suicide. Prior to such time Mrs. Frazier has a right . . . to sit back and wait until denial of claim before urging bad faith. . . .

So long as Metropolitan continues to tell Mrs. Frazier they are trying to uncover new evidence, they have not committed an ultimate act of bad faith, and Mrs. Frazier has a right to rely upon their assurances. (Id, 169 Cal.App.3d at pp. 103-104, 214 Cal.Rptr. at 890.)

VIII. The ADA

A newly evolving area of litigation regarding disability insurance is whether disability policies (as well as other insurance policies) are subject to regulation under the Americans with Disabilities Act. [42 U.S.C. section 12182, et seq.]. The possibility of applying the ADA to insurance policies is important for two reasons: First, it provides an additional basis for attacking discriminatory distinctions in coverage provisions. Second, because

the ADA is a federal law, its remedies are not preempted by ERISA.

The problem with using the ADA is the fact that it is very confusing and the case law to date is literally all over the map. For example, on the single issue of whether a disability insurer can issue a policy that provides differing coverage terms for disabilities resulting from mental/nervous disorders than for disabilities resulting from physical causes,⁽¹²⁾ compare *Esfahani v. Medical College of Pennsylvania* (E.D. Pa. 1996) 919 F.Supp. 832 and *Lewis v. Aetna Life Ins.* (E.D. Va. 1998) 7 F.Supp.2d 743 [holding that the disparity in coverage violates the ADA] with *Parker v. Metropolitan Life Ins. Co.* (6th Cir. 1997) 121 F.3d 1006, *EEOC v. CNA Ins. Co.* (7th Cir. 1996) 96 F.3d 1039 and *Weyer v. Twentieth Century Fox Film Corp.* (9th Cir. 2000) 2000 WL 1643 [holding that reduced coverage for mental/nervous disorders does not violate the ADA].

If you are interested in exploring this area, you can obtain some guidance from two recent articles: Martin and Bolduan, *The Impact of the ADA on Life, Health, and Disability Insurance*, *The Brief*, American Bar Association, Tort & Insurance Practice Section, Summer 1998, Vol. 27, No. 4 and DiMugno, *The Americans with Disabilities Act and Insurance*, *Insurance Litigation Reporter*, West Co., August 15, 1988, p. 641.

IX. ERISA Fundamentals

A. What is ERISA?

ERISA is a federal regulatory scheme enacted in 1974 in an effort to control fiduciary looting of company or union pension plans which left thousands of retired Americans stripped of the pension benefits they had accumulated after decades of work. [29 U.S.C. section 1001; *Massachusetts v. Morash* (1989) 490 U.S. 107, 115, 109 S.Ct. 1668, 1673]. Although originally enacted to prevent pension plan abuses, ERISA also applies to all employee benefit "plans", including health care coverage benefits, even when there is no formal "plan" established and even when the health care benefits are provided through the purchase of a group insurance policy [*Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 107 S.Ct. 1549].

B. What Court Has Jurisdiction If ERISA Applies?

ERISA provides concurrent jurisdiction in both state and federal court. However, ERISA's jurisdictional statute does not include the magic words required under 28 U.S.C. section 1441(a) [federal question cases may be removed to federal court except as otherwise expressly provided by Congress] to prevent removal if an action is filed in state court. Thus, an action seeking benefits under ERISA will most likely be removed by the defendant; see, e.g., *Emrich v. Touche Ross & Co.* (9th Cir. 1988) 846 F.2d 1190.

And even if the ERISA action remains in state court, the substantive issues will be controlled by the federal ERISA statutes.

C. What State Laws Are Preempted When ERISA Applies?

The preemption clause under ERISA provides that all state laws which relate to an employee benefit plan are preempted [29 U.S.C. section 1144]. The Supreme Court has traditionally interpreted that relate to language very broadly [see *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133, 139, 111 S.Ct. 478, 483], although more recent cases suggest that the Court is pulling back from that broad preemption [See *New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 218, 115 U.S. 1671 (concluding that '[i]f relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course)]. Under 29 U.S.C. section 1144, all state laws are preempted, except those regulating insurance. And, incredibly, even California Insurance Code section 790.03 (dealing with unfair insurance practices) has been found to not be a law regulating insurance under ERISA's savings clause. [*Marshall v. Bankers Life & Cas.* (1992) 2 Cal.4th 1045, 10 Cal.Rptr.2d 72].

However, the United States Supreme Court's recent decision in *UNUM Life Insurance Co. v. Ward* (1999) 119 S.Ct. 1380, 143 L.Ed.2d 462 is highly encouraging. In *Ward*, the Supreme Court considered California's notice-prejudice rule, which generally bars an insurer from denying coverage based on the insured's delay in submitting notice of claim (or violation of any general cooperation requirement in the policy) unless the insurer was prejudiced thereby. The Court held that the notice-prejudice rule is a law . . . which regulates insurance and is therefore saved from preemption by ERISA.

D. What Remedies Are Available If ERISA Applies?

Determination of whether an action is subject to ERISA preemption is critical because of the limited remedies available under ERISA [29 U.S.C. 1132]. The courts almost universally conclude that remedies in connection with an ERISA-preempted insurance policy, healthcare plan or self-insured benefit plan are limited to the benefits owed and, in the court's discretion, reasonable attorney's fees. Thus, most courts hold that no consequential damages, emotional distress damages or punitive damages can be recovered [*Mass. Mut. Life Ins. Co. v. Russell* (1985) 473 U.S. 134, 142-144, 105 S.Ct. 3085, 3090; *Mertens v. Hewitt Assoc.* (1983) 508 U.S. 248, 113 S.Ct. 2063, 2069].

However, one line of cases has held that damages are properly recoverable under ERISA based on language in the U.S. Supreme Court's opinion in *Ingersoll-Rand*. In that case, an employee sought compensatory and punitive damages for his employer's tortious termination of his employment just before his plan benefits would have vested [498 U.S. at 136, 111 S.Ct. at 481]. The Supreme Court stated that "[I]t is clear that the relief requested here is well within the power of federal courts to provide" 498 U.S. at 145, 111 S.Ct. at 486].

This language was authored by Justice O'Connor, the same Justice who only three years earlier penned the landmark case of *Pilot Life*. Based on *Ingersoll-Rand*, some courts have concluded that consequential and punitive damages are meant to be recoverable under ERISA.(13) At present, however, that is far from the majority view.

E. What is the Standard of Review Where ERISA Applies?

As if ERISA's restrictions on remedies weren't onerous enough, insurers in ERISA cases are also arguing that their decisions to deny benefits are entitled to deference from the court, and thus that an insured can't even recover policy benefits unless he can somehow prove that the insurer's decision to deny those benefits was arbitrary and capricious.

In that regard, any court evaluating a claim subject to ERISA must first decide what standard of review should be applied to the benefit determination by the ERISA administrator. [*Snow v. Standard Life Ins. Co.* (9th Cir 1996) 87 F.3d 327, 330]. The choice of the standard of review often determines the outcome of the litigation. If the court adopts the *de novo* standard of review, it will reevaluate and reweigh the evidence available to the administrator and independently determine whether the insured is disabled.br/>

But if the court applies the highly deferential *abuse of discretion* standard of review, the only issue before the court is whether the insurer's decision to deny benefits was arbitrary and capricious. Under that standard, the court will typically uphold the insurer's denial as long as the insurer can point to some rational justification for its decision, even if the overwhelming weight of the evidence favors the insured. Where a deferential standard of review is applied, the insurer's determination will be overturned only if it was clearly erroneous or conflicts with the plain language of the plan [*Saffle v. Sierra Pacific Power Co.* (9th Cir. 1996) 85 F.3d 455, 458; *Williamson v. UNUM Life Insurance Co. of America* (C.D. CA 1996) 943 F.Supp. 1226].(14)

Fortunately, under the Supreme Court's mandate in *Firestone Tire & Rubber Co. v. Bruch* 1989) 489 U.S. 101, 115, 109 S.Ct. 948, 956-957, 103 L.Ed.2d 80, a court reviewing the determinations of an ERISA

administrator must conduct a de novo review unless the plan explicitly grants the administrator discretionary authority to interpret plan language or make benefit determinations. Whether a plan administrator has discretionary authority, and is thus entitled to deferential judicial review, must be determined from the plan language. *Id.* That discretion cannot be implied from the language of the plan; it must be express. [*Orozco v. United Airlines, Inc.* (9th Cir. 1989) 887 F.2d 949, 952; *Cathey v. Dow Chemical Co. Medical Care Program* (5th Cir. 1990) 907 F.2d 554, 559; *Moon v. American Home Assur. Co.* (11th Cir. 1989) 888 F.2d 86, 88].

The express language that warrants deferential review typically is either a general grant of discretionary authority or a grant of specific authority as to particular determinations. Examples of grants of general authority include the following:

(a) "Full and exclusive authority to determine all questions of coverage and eligibility." [*Guy v. Southeastern Iron Workers' Welfare Fund* (11th Cir. 1989) 877 F.2d 37, 38-39];

(b) "Full power to construe the provisions of the Trust." [*Id.*];

(c) "Full and exclusive authority to determine all questions of coverage and eligibility . . . [and] full power to construe the provisions" of the plan. [*Batchelor v. Int'l Broth. of Elec. Workers Local 861 Pension and Retirement Fund* (5th Cir. 1989) 877 F.2d 441, 443];

(d) "Full and final determination as to all issues concerning eligibility for benefits" and "authoriz[ation] to promulgate rules and regulations to implement th[e] Plan." [*Lowery v. Bankers Life & Cas. Retirement Plan* (5th Cir. 1989) 871 F.2d 522, 524];

(e) Authority to "interpret and construe" the plan and "to determine all questions of eligibility and status under the Plan" [*Bali v. Blue Cross & Blue Shield Ass'n* (7th Cir. 1989) 873 F.2d 1043, 1047];

(f) Authority "to determine eligibility for benefits or to construe the terms of the plan." [*Dytrt v. Mountain State Tel. & Telegraph Co.* (9th Cir. 1990) 921 F.2d 889, 894]; and

(g) "Power . . . to construe the provisions of this Trust Agreement and the Plan, and any such construction adopted by the Board in good faith shall be binding." [*Jones v. Laborers Health & Welfare Trust Fund* (9th Cir. 1990) 906 F.2d 480, 481].

In order to obtain deferential review where general discretion has not been granted, an insurer must demonstrate the grant of specific discretionary authority as to the issue of whether the insured is totally disabled and therefore entitled to benefits. Thus, an insurer that has discretionary authority as to some determination under the plan which is not at issue in the case is not entitled to deferential review concerning the determination of total disability if no express discretionary authority has been granted as to that specific determination.

For example, in *Reinking v. Philadelphia American Life Ins. Co.* (4th Cir. 1990) 910 F.2d 1210, the plan document gave the administrator authority to (1) determine what information is necessary for calculation of premium rates and the efficient administration of the policy and (2) deal with payments concerning overlapping coverage with other plans, but contained no general grant of discretionary authority. The court concluded that "[i]f anything, the grant of specific limited authority with no mention of a general power to interpret policy terms suggests an intention not to delegate such responsibility." [*Id.* at 1214].

And the grant of discretionary authority cannot be qualified or ambiguous. Deferential review is appropriate only where discretion was unambiguously retained by the administrator. *Bogue v. Ampex Corp.* (9th Cir. 1992) 976 F.2d 1319, 1325. Based thereon, in *Kearney v. Standard Insurance Company* (9th Cir. 1999) 175

F.3d 1084, the Ninth Circuit found that an insurer was not entitled to deferential review where a group disability policy provided that:

Subject to all the terms of the group policy, Standard will pay the LTD benefit described in Part 8 upon receipt of satisfactory written proof that you have become disabled while insured under the group policy.

In *Kearney*, the insurer argued that the term 'satisfactory written proof' was sufficient to trigger the abuse of discretion standard of review. But the Ninth Circuit concluded that there were at least three fair readings of the phrase with quite different consequences. [*Id.* at 1090],⁽¹⁵⁾ and thus that the carrier had not 'unambiguously retained' discretion [*Id.*]. Accordingly, the Court held that the plaintiff's claim should be reviewed de novo. [*Id.*].

But even if, in fact, discretionary authority is granted and the administrator is entitled to an arbitrary and capricious standard of review, the analysis does not stop there. In determining whether the administrator's determination was arbitrary and capricious, that deferential standard must be exercised in favor of the ERISA beneficiary where there is a conflict of interest between the insured and the administrator.

For example, that modification of the arbitrary and capricious standard is required where the employer purchased a group policy and the policy benefits are paid out of the insurer's own general fund. As determined in *Snow v. Standard Ins. Co.* (9th Cir. 1996) 87 F.3d 327, 331, where an insurer underwrites a policy issued to an ERISA plan, a true conflict of interest exists because the insurer has the power to affect its own financial interests depending on the outcome of the claim.

The next step in the analysis required by *Snow* is whether there is probative evidence of bad faith -- or improper motivation inferable from the evidence -- which would demonstrate that the true conflict led to an actual conflict and that the administrator's self interest led to a breach of its fiduciary obligations. If such evidence does exist, the abuse of discretion standard should be modified and the court is required to act very skeptically in deferring to the discretion of [such] an administrator. [*Id.*, quoting *Atwood v. Newmont Gold Co., Inc.* (9th Cir. 1995) 45 F.3d 1317, 1321 and n. 1]. And the Ninth Circuit Court's discussion in *Snow* implies that evidence outside the administrative record is admissible to prove the conflict of interest. [*Snow*, 87 F.3d at 331 (evidence of how an administrator handled other claims is a proper basis for determining whether the administrator's conduct constituted bad faith or improper motive)].

In *Snow*, the court did not articulate any bright line rule for determining whether an actual conflict exists. Rather, the court merely indicated that because the district court in that case made a specific finding that there was no bad faith on the part of the insurer in its handling of the claim at issue in that case, the evidence did not support a finding of actual conflict. Additionally, the court stated that the statistical information regarding the insurer's general handling of other similar claims did not support a finding of actual conflict. Thus, the *Snow* court, without limiting the means by which such an actual conflict may be proven, did at least delineate two means by which it can be proven: evidence of the insurer's bad faith in the handling of the specific claim or statistical history demonstrating that such claims are frequently denied.

But more recent Ninth Circuit authority has expanded on those elements. In *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Technology, Inc.* (9th Cir. 1997) 125 F.2d 794, the court delineated the requirements for determining whether a conflict of interest actually exists, relying on *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, (11th Cir. 1990) 898 F.2d 1556. The *Lang* court held that where an insured comes forward with evidence that the insurer may have acted in its own self-interest (such as evidence that the insurer changed its basis for denying coverage after its initial ground was challenged by the insured), the burden shifts back to the insurer to prove that its determinations were motivated by its interest in protecting the plan or the other beneficiaries. If the insurer fails to show that it acted for the benefit of the plan as a whole and not for its own interests, the standard of review becomes de novo.

And the Ninth Circuit recently decided the scope of evidence that an insured may offer in attempting to show that the insurer acted in its own interests and -- if the insured satisfies that initial burden -- what evidence the insurer can put forth to demonstrate that it acted to protect the plan and its beneficiaries. In *Tremain v. Bell Industries, Inc.* (1999) 196 F.3d 970, the Court expressly held (as it had implicitly done in *Snow*, supra) that evidence outside the administrative record may be considered in determining whether the insurer's conflict of interest affected its decisions to deny benefits.

F. What Evidence Can Be Considered at a De novo ERISA Trial?

Even where a court applies a de novo standard of review to an ERISA administrator's benefit determination, there is no guarantee that the court will consider evidence outside the administrative record compiled by the administrator. For example, although the Second Circuit typically accept[s] without discussion a district court's consideration on de novo review of evidence not presented to the plan administrator [*Masella v. Blue Cross & Blue Shield of Connecticut* (2nd Cir. 1991) 936 F.2d 98, 104], the Ninth Circuit generally accepts evidence beyond the administrative record only when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review [*Kearney v. Standard Insurance Company* (9th Cir. 1999) 175 F.3d 1084, 1090]. The Ninth Circuit is especially reluctant to consider extrinsic evidence that could as easily have been submitted to the administrator [*Id.* at 1091](16) before it made its claim decision.

But even in circuits where extrinsic evidence is admitted only if it is necessary for an adequate de novo review, the courts are finding such necessity with increasing frequency. For example, the circumstances under which the Fourth Circuit will consider evidence outside the administrative record include the following:

[C]laims that require consideration of complex medical questions or issues regarding the credibility of medical experts ;

[T]he availability of very limited administrative review procedures with little or no evidentiary record

[T]he necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts ;

[I]nstances where the payor and the administrator are the same entity and the court is concerned about impartiality ;

[C]laims which would have been insurance contract claims prior to ERISA ; and

{C}ircumstances in which there is additional evidence that the claimant could not have presented in the administrative process

Quesinberry v. Life Ins. Co. of North America (4th Cir. 1992) 987 F.2d 1017, 1027.(17) The *Quesinberry* court emphasized that [t]his list of factors is not exhaustive and is merely a guide for district courts faced with motions to introduce evidence not presented to the plan administrator [*Id.*].

And the types of extrinsic evidence being considered by the courts are expanding as well. For example, in *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan* (9th Cir. 1995) 46 F.3d 938, the Ninth Circuit reversed a district court that had excluded a doctor's affidavit and other medical evidence outside the administrative record which tended to show the insured under a disability policy was suffering from chronic fatigue syndrome. Moreover, in *Donatelli v. The Home Ins. Co.* (8th Cir. 1993) 992 F.2d 763, the Eighth Circuit held that the district court properly permitted testimony by experts at trial concerning the issue of

whether the insured under a life insurance policy was sane when he committed suicide. Similarly, in *Masella v. Blue Cross & Blue Shield of Connecticut* (2nd Cir. 1991) 936 F.2d 98, the Second Circuit held that the district court correctly allowed the insured to elicit expert testimony at trial from two dentists.⁽¹⁸⁾ And in *Quesinberry v. Life Ins. Co. of North America* (4th Cir. 1992) 987 F.2d 1017, 1027, the court allowed the plaintiff to introduce live expert medical testimony [Id.] at his ERISA trial. The court allowed this extrinsic evidence even though the plan administrator [had] reviewed [the decedent's] medical records and statements from several doctors, reasoning that:

[L]ive testimony by the doctors at trial would assist the court in its de novo review of the claim. Such testimony could facilitate the understanding of complex medical terminology and causation through an exchange of questions and answers between the experts, counsel, and the court. Id.

Most recently, in *Walker v. American Home Shield Long Term Disability Plan* (9th Cir.1999) 180 F.3d 1065, the district court had appointed an independent medical expert [b]ecause of the difficulty of reviewing the administrator's decision de novo where the medical evidence was not particularly clear' [Id. at 1068]. The Ninth Circuit condoned the district court's appointment of a medical expert to help evaluate medical evidence [Id. at 1070]. In so holding, the Ninth Circuit flatly rejected the insurer's attempt to characterize . . . the district court as viewing the evidence in equipoise in a de novo ERISA trial [Id. at 1071], concluding that the insurer was mistaken [Id.]. The Ninth Circuit also rejected the insurer's argument that additional evidence is not necessary' because the record was sufficiently developed [Id.]. The Court reasoned that the medical evidence in the administrative record was confusing and conflicting and an expert would assist the court in evaluating contradictory evidence about an elusive disease of unknown cause [Id.].

G. What Are Some of the Ways to Escape ERISA Preemption?

To assess whether a policy is subject to ERISA preemption, it must first be determined whether there is any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing . . . benefits in the event of sickness, accident, disability, death or unemployment . . . [29 U.S.C. section 1002(1)].

The insurer has the burden of proving the facts necessary to establish the existence of an ERISA plan. *Kanne v. Connecticut General Life Insurance Co.* (9th Cir. 1988) 867 F.2d 489, 492, n. 2, cert. denied, 492 U.S. 906 (1989); see also *Zavora v. Paul Revere Life Ins. Co.* (9th Cir. 1998) 145 F.3d 1118, 1120, n.2. As a practical matter, though, most courts will determine that a benefit is part of an ERISA plan if the benefit is provided through employment.

That does not mean, however, that there are no potential ways to circumvent ERISA. Here are a few: An independent contractor is not an employee and is therefore not subject to ERISA preemption [*Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 319, 327, 112 S.Ct. 1344, 1350 (1992); *Barnhart v. New York Life* (9th Cir. 1998) 141 F.3d 1310.⁽¹⁹⁾

A government employee or the employee of a public agency is exempt from ERISA [29 U.S.C. section 1003(b); 29 U.S.C. section 1002(32)].

Employees of churches or church-operated businesses are exempt from ERISA [29 U.S.C. section 1003(b)]. Sole proprietors, partners, and their spouses are exempt, so long as the business does not provide benefits under the policy to a common-law employee. See 29 C.F.R. sections 2510.3-3(b) and (c); *Kennedy v. Allied Mutual Ins. Co.* (9th Cir. 1991) 952 F.2d 262; *Meredith v. Time Insurance Co.* (5th Cir. 1993) 980 F.2d 352. In *Robertson v. Alexander Grant & Co.* (5th Cir. 1986) 798 F.2d 868, the Court relied on those regulations in [f]inding ERISA inapplicable to plans covering only partners. Similarly, in *Meredith v. Time Insurance Co.* (5th Cir. 1993) 980 F.2d 352, the court held that an insurance plan purchased by a sole proprietor, covering

only herself and her

spouse, [does not] constitute . . . an employee welfare benefit plan' as that term is defined in ERISA .(20) Further, in *Fugarino v. Hartford Life & Acc. Ins. Co.* (6th Cir. 1992) 969 F.2d 178, the Court held that a business owner is exempt from ERISA, stating that a plan whose sole beneficiaries are the company's owners cannot qualify as a plan under ERISA . And in *Slamen v. Paul Revere Life Insurance Co.* (11th Cir. 1999) 166 F.3d 1102, 1104, the Court stated that in order to establish an ERISA employee welfare benefit plan, the plan must provide benefits to at least one employee,(21) not including an employee who is also the owner of the business in question , and thus that ERISA does not apply where the disability insurance policies at issue were for the sole interest and benefit of the plaintiff, and not his employees .

Some courts have suggested that a plan is not established or maintained by an employer [29 U.S.C. section 1002(1)] unless the employer intended to create an ERISA plan.(22) Other courts have indicated that an employer has established or maintained an ERISA plan only if it actively participated in the design and operation of the plan, directly controlled the day-to-day operation of the plan, exercised substantial discretion over the plan, and/or established a separate administrative scheme to manage the pla