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Disabling the Disability Carrier: The Insurers: Top 10 Defenses and How to Defeat Them

So your client wants to bring a claim under his disability policy? Be forewarned: Taking on a disability insurer - especially in California - is not for the timid or faint of heart.

Your client will be bombarded with a seemingly endless barrage of anti-coverage grenades that share a single target - preventing your client from collecting disability benefits.

If your client's benefits would pay him more money than he was making at his job, the insurer will argue that he is pursuing his claim out of choice or for financial gain - not because he is truly disabled. If your client's injury or sickness bears the slightest resemblance to, or shares even one symptom with, a condition he had before his policy incepted, the insurer will insist that his injury or sickness is a preexisting condition or first manifested before the policy incepted. If the insurer suspects that your client is feigning his disability (and, with alarming frequency, even if it doesn't), the insurer will trot out one of its well-paid "independent" physicians to conduct a medical examination that, inevitably, will find your client in perfect health. And if all else fails, the insurer will have its paparazzi conduct a week-long surveillance of your client that will produce - after careful editing - a 60-minute videotape which suggests that your client could easily qualify for the Olympics (or, at the very least, perform his job).

What can you - and your client - do? This syllabus, and the presentation that accompanies it, will provide you with powerful ammunition to combat the insurer's arsenal of coverage weapons and, in the process, fortify your bad faith action against the insurer.

1. Incontestability

Pursuant to Insurance Code § 10350.2, a disability policy is required to contain an incontestability clause in one of two forms. Under Form A, no misstatement on the insured's policy application can be used by the insurer to rescind the policy or deny a claim for a disability commencing more than two years after policy inception, unless the misstatement was fraudulent. Under Form B, if a disability commences after the policy has been in effect for two years, the insurer cannot rescind the policy or deny a claim on the ground that the disease or physical condition giving rise to the disability had existed before the policy began, even if the insured made a fraudulent misstatement on his application regarding the preexisting condition.

Form A generally is viewed as being more favorable to the insurer, since it enables the insurer to deny coverage or rescind the policy more than two years after policy inception, as long as the insured's misstatement on the policy application was "fraudulent". However, an insurer may encounter difficulty taking advantage of that perceived benefit. Fraud, of course, requires an intent to deceive. As stated by the California Supreme Court in Sun n Sand, Inc. v. United California Bank (1978) 21 Cal.3d 671, 703, 148 Cal.Rptr. 329, 351, "an action for fraudulent misrepresentation lies only when the defendant is charged with knowledge of falsity and an intent to deceive" (emphasis added1). It may prove problematic, if not impossible, for an insurer to demonstrate that its insured intended to deceive the insurer at the time of the policy application, especially if the insured testifies that he had no such intent or the alleged misstatement was arguably correct.

The incontestability clause can come into conflict with the policy's "preexisting condition" and "first manifest" provisions. As discussed below, the California Supreme Court recently resolved that conflict, in a manner

favorable to insureds, in Galanty v. Paul Revere Life Ins. Co. (2000) 23 Cal.4th 368, 97 Cal.Rptr.2d 67.

2. Preexisting condition

Disability policies typically include a clause that excludes coverage for preexisting conditions that were not disclosed on the policy application. Obviously, should an insurer rely upon this clause, your first line of attack will be to argue that the insured's current injury or sickness is unrelated to the condition that was not disclosed on the application.

But what if the insured's present disability is related to a pre-policy condition and the insured told the insurer's agent about it, but the agent failed to record it on the application? Or what if the agent, during the meeting where he took the application, failed to ask the insured the question that would have disclosed the preexisting condition, or told the insured that the insurer wouldn't care about the non-disclosed condition and the insured relied on that statement?

Fortunately, if the agent is a licensed and appointed agent of the insurer, his knowledge, acts and omissions are imputed to the insurer. Loehr v. Great Republic Ins. Co. (1990) 226 Cal.App.3d 727, 734, 276 Cal.Rptr. 667, 671. Thus, the insurer is deemed to have made whatever representations were made by the agent, and to be aware of whatever conditions were disclosed by the insured to the agent.

Moreover, if the insurer rescinds the insured's policy notwithstanding its knowledge, through its agent, of the preexisting condition it claims was not disclosed, it can be liable for bad faith. A disability insurer's unreasonable attempt or threat to rescind a policy based on a claimed misrepresentation by the insured on the policy application may constitute bad faith. Fletcher v. Western National Life Ins. Co. (1970) 10 Cal.App.3d 376, 401-402, 89 Cal.Rptr. 78, 93-94; Imperial Casualty and Indemnity Co. v. Sogomonian (1988) 198 Cal.App.3d 169, 185, 243 Cal.Rptr. 639.

And if more than two years have passed since the insured's application, the insurer cannot rescind the policy based on the insured's non-disclosure of the preexisting condition even if that condition is related to the insured's current disability. That is because the California Supreme Court determined in Galanty, supra, that the statutorily-required incontestability clause (Insurance Code § 10350.2) trumps the policy's preexisting condition clause, such that that an insurer which utilizes a Form B incontestability provision cannot rescind the policy or deny coverage based on the preexisting condition clause (or, as discussed below, the first manifest provision) after the policy has been in effect for two years.

3. First manifest

Disability policies afford coverage for disability due to sickness or injury. "Sickness" is typically defined as a "sickness or disease which first manifests itself after the date of issue".

As indicated above, the "first manifest" provision can come into conflict with the statutorily-mandated incontestability clause. For example, what happens if the insured's sickness first manifested before the policy incepted but the insured does not file his claim for benefits until more than two years after policy inception? Does the incontestability clause (which bars an insurer from contesting statements on the insured's application after the policy has been in place for two years, unless the insured has a Form A policy and the insurer can demonstrate a fraudulent misstatement on the application) protect the insured, or can the insurer seize upon the "first manifest" clause to deny coverage or rescind the policy?

The California Supreme Court resolved the issue favorably to insureds in Galanty v. Paul Revere Life Ins. Co. (2000) 23 Cal.4th 368, 97 Cal.Rptr.2d 67. As indicated above, the Court held that even if the sickness

causing the insured's disability first manifested before policy inception, the incontestability clause bars the insurer from denying coverage based on the "first manifest" or "preexisting condition" provision after the policy has been in effect for two years (at least where, as in Galanty, the insurer utilized a Form B incontestability clause). The Court reasoned that a statutorily-required incontestability clause takes precedence over policy language, such as a "first manifest" provision, that has been drafted by an insurer.

4. ERISA

If the insured's policy was provided by his employer, the insurer will argue that his civil suit is preempted by the Employee Retirement Income Security Act (ERISA). Remedies in connection with an ERISA-preempted insurance policy 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 in an ERISA action.2
Here are a few ways to attempt to circumvent ERISA:

An independent contractor is not an "employee" and is therefore not subject to ERISA preemption,3 unless he obtains insurance benefits through the same group plan that covers employees of the company.4
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 [29 C.F.R. sections 2510.3-3(b) and (c).5

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.6 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 plan.7 Still others have found that the "established or maintained" requirement may not be met even if the employer was significantly involved in the administration of the plan.8 Certain others have indicated that an ERISA plan has not been "established" where the insurer failed to comply with ERISA's reporting and disclosure requirements and failed to mention ERISA in policy documents, brochures and letters.9 And a few others have held that the "is maintained" requirement implies that the plan must be in current operation,10 and thus that ERISA does not apply where the former employer has sold his business and stopped contributing to the plan11 or has gone bankrupt and ceased any involvement in the plan.12

Plans that fall under the Department of Labor's "safe harbor" regulations [29 C.F.R. section 2510.3-1(j)] are exempt from ERISA. The regulations generally state that ERISA is inapplicable where (1) the employer does not "endorse" the program;13 (2) employee participation is completely voluntary; (3) premiums are paid entirely by the employee;14 (4) the employer's sole functions are to permit the insurer to publicize the program, collect the premiums through payroll deductions, and remit the premiums to the insurer; and (5) the employer receives no consideration, except reasonable compensation for collecting and remitting the premiums. Significantly, however, some courts have found the "safe harbor" regulations applicable despite employer activities far beyond those permitted by the regulations.15

An insurer sometimes concedes that the insured is a partner or other non-employee and that the disability policy covers only him, but argues that his claims are nevertheless subject to ERISA because his policy is part of an overall company benefit plan that included other policies which did cover employees. This

argument has been made - and soundly rejected - in several recent opinions.16

In addition to the cases discussed above, there is a recent indication by the United States Supreme Court that it will be receptive to arguments against ERISA preemption. In UNUM Life Ins. Co. of America v. Ward (1999) 526 U.S. 358, 119 S.Ct. 1380, 1390, n. 7, the Court noted that the Solicitor General of the United States - on whose brief the Court had based its ruling in Pilot Life17 that ERISA is the exclusive remedy for state law causes of action for bad faith - had changed its position on that issue. Although the Court concluded in Ward that it "need not address the Solicitor General's current argument" because Ward was suing under ERISA (for benefits due) rather than trying to circumvent it, the case at least suggests that the Court may be open to reconsidering its decision in Pilot Life.

And the federal district courts concur. In recent months, district court judges in Colorado18 and Oklahoma19 have relied on Ward in ruling that ERISA does not preempt a bad faith cause of action by an insured under a group insurance policy. In so holding, those courts distinguished Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549, wherein the U.S. Supreme Court had held that Mississippi's bad faith law was preempted by ERISA because it imposed liability against both insurance and non-insurance entities (and therefore did not "regulate insurance" within the meaning of ERISA's "savings clause" [29 U.S.C § 1144(B)(2)(A)] so as to avoid preemption). Conversely, Colorado and Oklahoma limit the cause of action to the insurance industry20 - and so does California.

More specifically, the California Supreme Court has repeatedly held that claims for tortious breach of the implied covenant of good faith and fair dealing (i.e., bad faith) can only be brought in cases involving insurance contracts. For example, the Court held in Foley v. Interactive Data Corp. (1988) 47 Cal.3d 654, 684, 254 Cal.Rptr. 211, 228 that it is only "in the context of insurance contracts where . . . breach of the implied covenant will provide the basis for an action in tort". And just last year, the Court reiterated that "compensation for [breach of the implied covenant] has almost always been limited to contract rather than tort remedies" and that "at present, this court recognizes only one exception to that general rule: tort remedies are available for a breach of the covenant in cases involving insurance policies [Cates Construction Inc. v. Talbot Partners (1999) 21 Cal.4th 28, 43, 86 Cal.Rptr.2d 855].

Thus, unlike the Mississippi law construed in Pilot Life (which allowed tortious bad faith claims in a variety of contexts and therefore did not "regulate insurance"), California's bad faith tort is only available in the insurance arena. For that reason, California's bad faith law should be found to "regulate insurance" and therefore be "saved" from ERISA preemption.

5. 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 he 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 6. Dual occupations at onset

Disability policies generally provide that an insured is totally disabled (and thus entitled to benefits) if he is unable to perform the substantial and material duties of his occupation due to an injury or sickness. The

insured's occupation is usually defined as the occupation in which he was regularly engaged at the time he became disabled.

With increasing frequency, disability insurers are trying to argue that their insureds have dual occupations, and that even if they are unable to perform one of those occupations they are not totally disabled under the policy because they can perform the other. For example, an insurer may argue that a self-employed physician is not only a physician but also an "owner-manager". The insurer goes on to argue that even if the insured cannot perform his medical duties (e.g., perform surgeries), he still can run his medical business and thus is not totally disabled.

However, disability policies provide 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, supra, 437 N.E.2d at 1350], or "regular job" [Vanderklok v. Provident Life and Accident Ins. Co., Inc. (6th Cir. 1992) 956 F.2d 610, 614] - i.e., "his particular occupation for which he seeks protection by insurance" [Dixon, supra, 268 F.2d at 815; Continental, supra, 437 N.E.2d at 1351]. And the fact that the insured, although unable to perform his particular occupation, might be able to perform 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].

Based thereon, an insured physician (to continue the example) can argue that (1) he has a single "real occupation" or "chosen profession"; (2) that occupation or profession is physician; (3) the insurer knew, based on the insured's policy application, that the "particular occupation for which he [sought] protection by insurance" was physician, and it insured him as such; (4) the substantial and material duties of that occupation are performing surgeries (or whatever the case may be) - not being an administrator or otherwise running a business; and (5) his inability to perform those duties renders him disabled.

Significantly, the California Supreme Court rejected an insurer's "dual occupations at onset" argument (although it was not stated as such) in Erreca v. Western States Life Ins. Co. (1942) 19 Cal.2d 388, 121 P.2d 689. In Erreca, the Court found that an injured owner of multiple ranches 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 - i.e., administer the farming business. The Court reasoned that before his injury, the insured's duties had included manual labor (including plowing, driving tractors, and repairing fences and machinery) and personally supervising his employees' farm work (via walking, horseback and automobile), and that he could not perform those tasks - i.e., the tasks of an active farmer - as he had before his injury.

7. Choice

Disability insurers frequently argue that an insured has stopped working - and made a claim for disability benefits - out of choice, not because he is genuinely disabled. For example, the insurer may argue that the insured has chosen to leave his job because he has grown weary of the long hours and stress of his work, or because he is tired of dealing with clients or patients, or because he is going through a mid-life crisis, or because he is wealthy and doesn't need the income from his occupation (or, as discussed below, because his tax-free disability benefits will provide him with more money than his job).

At the risk of stating the obvious, the best way to counter the "choice" argument is to deny it. For example, the insured can testify that he is not suffering from burnout or some kind of mid-life crisis, that he loves his job, that he derives great fulfillment from his profession (helping clients, saving lives, working with the public, etc.), that he takes enormous pride in providing for his family, that he hates being a burden to his wife and

children, and that he would much rather continue his career and support his family than be out on disability.

And it is imperative that the insured's work ethic and job satisfaction be corroborated by third-party witnesses, including his spouse, children, friends, employees, supervisors, co-workers, neighbors, patients and clients. They must confirm that the insured is unable, not unwilling, to work.

Finally, beware of the insurer that attempts to manufacture a "choice" argument by offering to retrain or rehabilitate the insured. If the insured declines the offer, the insurer will argue that the insured has chosen to remain disabled and therefore is not entitled to benefits. However, an insured is not required to make any attempt to retrain himself for an occupation which he would be physically able to pursue. And the fact that through rehabilitation or retraining the insured might be able to perform a job is not relevant to the issue of whether he is totally disabled. Pistorious v. Prudential Ins. Co. of America (1981) 123 Cal.App.3d 541, 546, 176 Cal.Rptr. 660, n. 4.

8. Financial gain

As a variation on the "choice" theme, a disability carrier may argue that the insured has filed its disability claim for financial gain - not because he is truly disabled. This argument is especially likely if the insured's benefits (which typically are tax-free) would provide him with more money than he was making at his job.

Generally, this argument should be countered in the same fashion as the insurer's "choice" argument. For example, the insured - again, supported by friends, family and co-workers - can testify that he finds his job highly fulfilling, that he garners great satisfaction out of providing for his family, and that he would much rather be working than collecting disability benefits. And of course, if the insured made, or had the potential to make, more money working than he receives in disability benefits, that fact needs to be emphasized - and, if possible, verified by balance sheets, financial projections, or similar documents.

9. Activities inconsistent with disability

Many disability insurers are cynical by nature. They believe that most claimants (especially those with long-standing claims or particularly high benefits) are not truly disabled - or, at the very least, are not as disabled as they contend. And even if they suspect that their claimants may in fact be disabled, the insurers are constantly looking for ways to avoid paying claims.

Toward that end, some disability carriers have their claim adjusters conduct field visits. These visits are usually unannounced, and are designed to catch the insured performing activities that are inconsistent with his claimed disability. Additionally, the field representative often will try to take a recorded statement from the insured, hoping to lure the insured into saying something that will support the choice defense ("yeah, I'm tired; yeah, I'm burned out"), the financial gain defense ("yeah, my industry has dried up; yeah, managed care has made it impossible for me to make a decent living"), or some other coverage defense.

Even more frequently, disability insurers use outside or in-house investigators to conduct covert surveillance of their claimants. The surveillance will be videotaped, will span a week or more, and will follow the insured virtually wherever he goes. The goal, of course, is to obtain videotape that shows the insured engaging in activities (e.g., bending, twisting, lifting) that are inconsistent with the restrictions and limitations claimed by the insured and corroborated by his treating physicians.

So what can you do if the insurer's paparazzi videotapes your client performing activities that, at least arguably, are inconsistent with his disability claim? The key is to remember that, in California, "'total disability' does not signify an absolute state of helplessness" [Erreca v. Western States Life Ins. Co. (1942) 19 Cal.2d

388, 396, 121 P.2d 689, 685]. Rather, it is "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" [Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892].22 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 (on a videotape or otherwise).

Accordingly, in Erreca, supra, the California Supreme Court found that a farm owner who could not perform manual labor or supervise farm operations as he had before his injury was totally disabled even though he could still buy livestock and supplies, sell farm products, negotiate leases, arrange financing, determine what crops to plant, and set the price of crops and the time 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 suffering from memory loss and impaired judgment 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. Based thereon, you must argue that the videotape does not show that your client can perform his occupational duties in the manner he did before his injury or sickness, or that he can do so on a continuous basis.

bOther arguments to consider include the following:

The videotape is tainted, slanted and otherwise biased. The tape reflects the insurer's carefully calculated effort to "investigate" the claim with an eye toward denying benefits rather than an eye toward paying them - in flagrant violation of its duty of good faith.23 For example, the insurer's investigator stalked plaintiff for 12 hours a day for 7 days, yet reduced its surveillance to a mere 1 hour tape. The other 83 hours of surveillance are conspicuously omitted from the tape. Predictably, all of the videotaping that was done (or at least all of the videotaping that was included in the selectively spliced video) was of activities deemed by the investigator to be inconsistent with plaintiff's disability, and the investigator failed to videotape any activities (or inactivity) to the contrary. In fact, the videotape never shows plaintiff doing nothing.

The surveillance tape is irrelevant. The fact that plaintiff could sporadically perform certain non-work activities for a few minutes over the course of 7 days of surveillance bears absolutely no correlation to engaging in the substantial and material duties of his profession in his customary way and with reasonable continuity - 8 to 10 hours a day, 5 to 6 days a week. Occasionally picking up light groceries or a small child obviously does not equate with performing a physically taxing occupation on a daily and ongoing basis, and the insurer's attempt to do so is preposterous.

The insurer offered plaintiff no opportunity to explain his activities on the surveillance tape. The insurer never wrote to plaintiff to ask if he had any explanation for his taped activities. Thus, plaintiff never had the chance to tell the insurer that he had no choice but to perform the activities on the videotape because groceries had to be bought and children had to be lifted, and there was nobody else to do it. Further, plaintiff had no opportunity to explain that he was only able to perform the tasks depicted on the tape because he was having an usually good day or was under heavy medication (a medication that, if taken at work, would prevent him from performing his job). And plaintiff had no chance to tell the insurer that performing the activities on the tape caused him to suffer excruciating pain in the hours and days after the activities shown on the tape.

Reliance upon the videotape to deny coverage meant that the insurer had to ignore MRIs, X-rays, physical capacity evaluations, monthly progress statements, treating physicians' notes, and other objective evidence confirming his disability, in violation of the insurer's duty to evaluate the insured's claim objectively, and to consider the totality of the evidence produced.24

And what if the insurer's paparazzi films the insured at his office or other place of work? Significantly, 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 eight 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. Id. at 434-435. 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. at 438.

Thus, you must demonstrate that although the insured tried to return to work, his effort was unsuccessful. Perhaps the insured could not "work . . . with reasonable continuity" [Erreca v. Western States Life Ins. Co. (1942) 19 Cal.2d 388, 394-395; 121 P.2d 689, 694] or was only "able to perform sporadic tasks" [Id., 19 Cal.2d at 396, 121 P.2d at 695]. Or maybe he was unable to perform his work tasks in his "usual or customary way" [Moore v. American United Life Ins. Co. (1984) 150 Cal.App.3d 610, 632, 197 Cal.Rptr. 878, 892]. One or more of these arguments should be aggressively advanced.

10. "Independent" medical examination

Disability insurers frequently require their claimants to undergo independent medical examinations. In reality, though, they should be called "defense medical examinations", as the doctor is retained and paid by the insurer with one goal in mind: finding the insured not disabled. Indeed, it is virtually a foregone conclusion that the carrier's "independent" medical examiner will conclude that your client is not disabled. When the inevitable happens, there are numerous arguments you can make to attack the doctor and his findings. Here are a few examples:

The doctor has a bias in favor of insurers generally. The vast majority of his practice is devoted to performing "independent" medical examinations for which he is paid by insurers. And those insurers typically get what they paid for, as the doctor finds that the claimant is not disabled virtually every time.

The doctor is biased in favor of this particular insurer. Your client's insurer paid the doctor thousands of dollars to perform the "independent" medical examination, with the obvious expectation that he would come back with a finding of non-disability. And the doctor has performed many "independent" medical examinations for this insurer in the past (to his considerable profit), and certainly hopes that the insurer will continue to retain him in the future. The easiest way to ensure referrals in the future is to give the insurer an opinion that will save it money now.

The doctor performs "independent" medical examinations, including your client's, for his financial gain. Due to the restrictions of managed care, the doctor is earning far less money in his practice than he once did. It is much more lucrative for him to perform IMEs, at about $5,000 per exam, than to actually practice medicine, especially if he has a volume IME practice. (This can be a particularly effective counterattack if the insurer has taken the position that your client is pursuing his claim for his financial gain.)

Similarly, it isn't the insured who has made a choice to stop working and collect disability benefits. Rather, it's the doctor who has made a choice - the choice to sell out to high-paying insurance companies (by discrediting claimants with genuine disabilities) instead of helping patients. (This can be an especially potent counter-argument if the insurer is asserting that the insured made the choice to abandon his career.

The doctor isn't qualified to render an opinion regarding the insured's condition. He is hardly seeing patients anymore, and does not keep current on the practice of medicine. Instead, the bulk of his time is devoted to performing "independent" medical examinations for insurance companies. And on those occasions when he

does practice medicine, it is outside the medical area relevant to the insured's condition.

The doctor ignored objective evidence of the insured's disability, including X-rays, MRIs, CT scans, discograms, and attending physicians' statements.
In fact, you may want to hire your own investigator to help you neutralize the insurer's "independent" doctor and his findings. Your investigator can look for prior malpractice actions against the doctor, Medical Board or license problems, or even disability claims filed by the doctor. The investigator can also search for other cases in which the doctor has testified, during depositions and/or trial, and thereby help you establish that the doctor is biased in favor of insurance companies or has taken a position in other cases that is inconsistent with the one he is advocating in your client's suit.

And while you are attacking the doctor, be sure to impugn the insurer that retained him. For example, if your client's treating doctors found him disabled but the "independent" medical examiner did not, you should emphasize that an insurer has the duty to give more weight to treating physicians' opinions than those of non-treating physician [Lester v. Chater (9th Cir. 1996) 81 F.3d 821, 830; Pitzer v. Sullivan (9th Cir. 1990) 908 F.2d 502, 506, n. 4; Gallant v. Heckler (9th Cir. 1984) 753 F.2d 1450, 1454]. And if the insurer breached its duty to provide the policy definition of "disability" to the independent medical examiner it utilized to review the insured's claim [Moore, supra, 150 Cal.App.3d at 618 and 637-638, 197 Cal.Rptr. at 882-883 and 895-896], that failure should be highlighted as well.

Conclusion

Armed with everything from one-sided videotapes to biased medical examiners to manufactured "choice" defenses, disability insurers are primed to wage battle with you and your client. We hope that the strategies discussed in this syllabus will help you overcome the insurer's arsenal - and add zeroes to your bad faith verdict in the process.

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1. Unless otherwise noted, all emphases herein are added by the authors.

2. 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.

3. 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.

4. Harper v. American Chambers Life Ins. Co. (9th Cir. 1990) 89 F.2d 1432, 1434.

5. See also Robertson v. Alexander Grant & Co. (5th Cir. 1986) 798 F.2d 868; Meredith v. Time Insurance Co. (5th Cir. 1993) 980 F.2d 352; Fugarino v. Hartford Life & Acc. Ins. Co. (6th Cir. 1992) 969 F.2d 178; Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102, 1104.

6. See Kanne v. Connecticut General Life Ins. Co. (9th Cir. 1988) 867 F.2d 489, 493; Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159; Hansen v. Continental Ins. Co. (5th Cir. 1991) 940 F.2d 971, 978.

7. See Hansen, 940 F.2d at 978; Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1134; Elco Mechanical Contractors. Inc. v. Builders Supply Assoc. of West Virginia (S.D. W. Va. 1993) 832 F.Supp. 1054, 1057-1058; Taggart Corp. v. Life and Health Benefits Administration, Inc. (5th Cir. 1980) 617 F.2d 1208, 1210; and Sindelar v. Canada Transport, Inc. (Neb. 1994) 520 N.W.2d 203, 207.

8. See Zavora v. Paul Revere Life Ins. Co. (9th Cir. 1998) 145 F.3d 1118, 1121; du Mortier v. Massachusetts General Life Ins. Co., supra (C.D. Cal. 1992) 805 F.Supp. 816, 821; Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson, supra, 63 F.3d 1129.

9. See du Mortier and Johnson, supra.

10. See Stanton, supra, (S.D. Cal. 1999) 37 F.Supp.2d 1159.

11. Loudermilch v. The New England Mutual Life Ins. Co. (S.D. Ala. 1996) 942 F.Supp. 1434.

12. Mizrahi v. Provident Life and Accident Ins. Co. (S.D. Fla. 1998) 994 F.Supp. 1452.

13. "Endorsement of a program requires more than merely recommending it". Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129, 1136.

14. The mere fact that the employer gave employees the option of using a portion of their pre-tax salary to purchase plan benefits does not mean that it contributed to the payment of plan premiums. See Hrabe v. Paul Revere Life Insurance Company (M.D. Ala. 1996) 951 F.Supp. 997, 1001.

15. Garrett v. Delta Air Lines, Inc. (N.D. Ind. 1978) 1978 U.S. Dist. LEXIS 16460 and Johnson v. Watts Regulator Co. (1st Cir. 1995) 63 F.3d 1129.

16. Slamen v. Paul Revere Life Insurance Co. (11th Cir. 1999) 166 F.3d 1102 ["Non-ERISA benefits do not fall within ERISA's reach merely because they are included in a multibenefit plan along with ERISA benefits"]; Rand v. The Equitable Life Assur. Society of the U.S. (E.D.N.Y. 1999) 49 F.Supp.2d 111 ["The plaintiff's

disability insurance policies, which are not covered by ERISA, are not converted into an ERISA plan merely because the plaintiff's employees received unrelated health insurance"]; In re Watson (9th Cir. 1998) 161 F.3d 593, 596, n. 4 ["Even if the plans were created simultaneously or shared other common characteristics, they are independent plans under ERISA"]; see also Agrawal v. Paul Revere Life Ins. Co. (2000) 205 F.3d 297; Robertson v. Alexander Grant & Co. (5th Cir. 1986) 798 F.2d 868, Fugarino v. Hartford Life & Acc. Ins. Co. (6th Cir. 1992) 969 F.2d 178, and Stanton v. Paul Revere Life Ins. Co. (S.D. Cal. 1999) 37 F.Supp.2d 1159.

17. Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41, 107 S.Ct. 1549.

18. Hall v. UNUM Life Ins. Co. of America, U.S. District Court for the District of Colorado, Case No. 97-M-1828, November 1, 1999 Order by Chief Judge Richard S. Matsch Granting Motion For Leave To File Amended And Supplemental Complaint Adding Third Claim For Relief. Note that although the unpublished order did not expressly reference the Supreme Court's decision in Ward, the order was issued in response to a motion (for leave to file an amended and supplemental complaint) that had been based solely on Ward.

19. Lewis v. Aetna U.S. Healthcare, Inc. (N.D. Ok. 1999), No. 99-CV-104-H(M).

20. For example, in Oklahoma the tort of bad faith is "specific to the insurance industry" [Lewis, 78 F.Supp.2d at 1215], "applie[s] exclusively to contracts between insurance companies and their insureds" [Id. at 1212] and "has never been extended beyond the insurance area" [Id. at 1208].

21. There are a number of reported and unreported decisions which follow the Ouellette analysis. [Damascus v. Provident Life and Accident Ins. Co. (N.D. Cal. 1996) 933 F.Supp. 885; Grayboyes v. General American Life Ins. Co. (E.D. Pa. 1995) 1995 U.S. Dist. LEXIS 4233; Goomar v. Centennial Life Ins. Co. (S.D. Cal 1994) 855 F.Supp. 319, aff'd 76 F.3d 1059 (9th Cir. 1995); Allmerica Fin. Life Ins. & Annuity Co. v. Llewellyn (D. Ore. 1996) 943 F.Supp. 1258; Hammond v. Fidelity and Guaranty Life Ins. Co. (7th Cir. 1992) 965 F.2d 428; Brumer v. Nat'l Life of Vermont (E.D.N.Y. 1995) 874 F.Supp. 60].

22. This definition of "total disability" applies to both "own occupation" and "any occupation" policies [Austero v. National Cas. Co., (1978) 84 CA3d 1, 20, 148 Cal.Rptr. 653], and is read into the policy if the insurer attempts to impose a more stringent definition [Moore, 150 Cal.App.3d at 618, 637-638].

23. An insurance company must "fully inquire into all possible bases that might support the insured's claim." [Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 169 Cal.Rptr. 691 (1979); Mariscal v. Old Republic Life Ins. Co., 42 Cal.App.4th 1617, 1620, 50 Cal.Rptr.2d 224, 225 (1996)].

24. Hughes v. Blue Cross of Northern California (1989) 215 Cal.App.3d 832, 845-846, 263 Cal.Rptr. 850; Blake v. Aetna Life Insurance Company (1979) 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528.