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Recommended Citation
Andrew Cassady, Can the Risk of Relapse, in an Addiction Context, Constitute a Current Disability for Purposes of Long-Term Disability Plans?, 82 U. Cin. L. Rev. 927 (2014)
Available at: https://scholarship.law.uc.edu/uclr/vol82/iss3/7

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CAN THE RISK OF RELAPSE, IN AN ADDICTION CONTEXT, CONSTITUTE A CURRENT DISABILITY FOR PURPOSES OF LONG-TERM DISABILITY PLANS?

Andrew Cassady*

I. INTRODUCTION

Ninety-hour weeks, high stress environments, and abuse of the drug Fentanyl had become the norm for Dr. Julie Colby, until 2004, when a colleague found her unconscious on a table in the hospital where she worked. Dr. Colby was an anesthesiologist in Newburyport, Massachusetts, and she became addicted to the same drug that she used to treat patients in her practice. After this episode, Dr. Colby took a leave of absence and entered inpatient substance-abuse treatment in Atlanta, where she was diagnosed with, among other things, opioid dependence. She remained at the treatment center for about four months, after which time she remained under regular medical supervision on an outpatient basis. Although she stopped using the drug, her medical license was revoked.

When Dr. Colby’s dependence on Fentanyl initially came to light, her employer offered a group employee benefit plan underwritten and administered by Union Security Insurance Company & Management Company (USIC). This plan was governed by the Employee Retirement Income Security Act of 1974 (ERISA or Act), and it included long-term disability (LTD) benefits.USIC paid Dr. Colby these benefits while she was at the treatment center, but it refused to pay them once she left. USIC reasoned that although she remained under a doctor’s care and feared a relapse, a “risk of relapse” did not amount to a current disability, and thus, she was not entitled to any LTD benefits.

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2. Id. Fentanyl is an opioid commonly used in the practice of anesthesiology. It is a very potent morphine-like analgesic, and is typically administered to treat severe pain in patients before and after surgery. Fentanyl, NATIONAL INSTITUTE ON DRUG ABUSE: THE SCIENCE OF DRUG ABUSE AND ADDICTION, http://www.drugabuse.gov/drugs-abuse/fentanyl (last visited Jan. 8, 2014).
3. Colby, 705 F.3d at 60. She was also diagnosed with a dysthymic disorder, obsessive-compulsive disorder, and degenerative disc disease.
4. Id.
5. Id.
6. Id.
8. Colby, 705 F.3d at 60.
9. Id.
10. Id.
Dr. Colby exhausted her administrative appeals under ERISA\textsuperscript{11} and eventually brought suit against USIC in federal court.\textsuperscript{12} The district court deemed USIC’s termination of benefits unreasonable,\textsuperscript{13} but after the case was remanded,\textsuperscript{14} USIC continued to resist paying any benefits beyond the date that Dr. Colby left the treatment center.\textsuperscript{15} Once again, Dr. Colby exhausted her administrative appeals, after which point the district court reopened her case and awarded her LTD benefits for the remainder of the time period available under the plan.\textsuperscript{16} USIC appealed to the First Circuit, arguing that the categorical exclusion of risk of drug abuse relapse was a reasonable interpretation of the plan.\textsuperscript{17}

This Comment will address the issue of whether, in an addiction context, a risk of relapse can constitute a current disability under ERISA. The First Circuit in \textit{Colby}\textsuperscript{18} was only the second United States appellate court to analyze this question, and its affirmative answer created a split with the Fourth Circuit.\textsuperscript{19} Part II provides a brief introduction into ERISA and then traces two competing lines of cases dealing with the risk of relapse in both substance abuse and nonsubstance abuse contexts. Part III details the opinions of the Fourth\textsuperscript{20} and First\textsuperscript{21} Circuits. Part IV addresses the merits of both of those decisions. Finally, Part V concludes that the risk of relapse of a drug addiction can amount to a current disability and hypothesizes the normative and positive effects of the First Circuit’s decision in \textit{Colby}.\textsuperscript{22}

\section*{II. BACKGROUND}

\subsection*{A. ERISA}

ERISA is a federal statute that sets minimum standards for private-sector employee-benefit plans.\textsuperscript{23} ERISA was enacted to promote the

\begin{thebibliography}{99}
\item[12.] The Complaint actually named an array of defendants, but according to the First Circuit, USIC was the real party in interest. \textit{Colby}, 705 F.3d 58.
\item[14.] USIC had categorically excluded the risk of relapse as a basis for disability, and thus, the district court instructed USIC to determine the likelihood of Dr. Colby’s relapse before denying her benefits. \textit{Colby}, 705 F.3d at 61.
\item[15.] \textit{Id}.
\item[16.] \textit{Id.} The time period was 36 months.
\item[17.] \textit{Id}.
\item[18.] \textit{Colby}, 705 F.3d 58.
\item[19.] \textit{Stanford} v. \textit{Cont’l Cas. Co.}, 514 F.3d 354 (4th Cir. 2008).
\item[20.] \textit{Stanford}, 514 F.3d 354.
\item[21.] \textit{Colby}, 705 F.3d 58.
\item[22.] \textit{Id}.
\item[23.] \textit{Frequently asked Questions about Pension Plans and ERISA, United States Department}
\end{thebibliography}
interests of employees and their beneficiaries in employee-benefit plans, and to protect contractually defined benefits.24 Before the enactment of ERISA in 1974, employees were forced to use state contract law in order to recover their benefits, and they faced many jurisdictional and procedural barriers in doing so.25 Thus, by passing ERISA, Congress attempted to change this “unfavorable legal climate” for participants.26 The Act regulates the manner in which plans process benefit claims, and most importantly, ensures that the plans afford a reasonable opportunity for a full and fair review of rulings adverse to the claimant.27 ERISA imposes “higher-than-marketplace quality standards on insurers,” mandating that plan administrators discharge their duties “solely in the interests of the participants and the beneficiaries of the plan.”28 When an ERISA plan grants the administrator discretionary authority to determine eligibility, a denial decision will be reviewed by the courts under an abuse of discretion standard.29

B. The Circuit Split

While ERISA provides the statutory framework for the manner in which insurance companies are supposed to process claims, it does not set forth any requirements for what actually must be included in disability plans; instead, the parties to the plan may contract as they see fit. Whether a certain disability is covered thus often turns on the language of the policy at issue, but the discussion by no means should end there. This Part will briefly discuss several cases that have addressed the question of whether a risk of relapse can constitute a

OF LABOR, http://www.dol.gov/ebsa/faqs/faq_compliance_pension.html (last visited Jan. 8, 2014). The Act does not specify how much money a participant must be paid as a benefit. Id. ERISA requires plans to regularly provide participants with information about the plan including, inter alia, plan features and funding; sets minimum standards for participation, vesting, benefit accrual and funding; requires accountability of plan fiduciaries; and allows participants to sue for benefits and breaches of fiduciary duty. Id. The term “employee-benefit plan” can mean an employee benefit welfare plan, an employee pension benefit plan, or both. Peter Schmidt, Part I. The Basics of ERISA as it Relates to Health Plans, in EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF NO. 167, at 3 (1995).

25. George Lee Flint, Jr., ERISA: Reformulating the Federal Common Law for Plan Interpretation, 32 SAN DIEGO L. REV. 955, 955 (1995); but cf. Andrew Morrison Stumpff, Darkness at Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants Under ERISA than had the Statute Never Been Enacted, 23 ST. THOMAS LAW REV. 101 (2011) (arguing that judicial decisions under ERISA have been so anti-employee that it could now be said that participants in employer-sponsored pension and health insurance plans would have been better off if the statute had never been enacted).
current disability in the nonsubstance abuse context. Some of these cases, and the reasoning employed therein, were cited by both the Fourth and First Circuits. This Part will then progress to a discussion of the same issue in the addiction context—the true focus of this Comment—and will conclude by detailing the opinions of the only two federal appellate courts to address the issue.

1. Nonsubstance Abuse Cases

Some courts have held that the risk of recurrence of a physical condition is not sufficient to constitute a current disability. For instance, in James v. Kansas City Chiefs Football Club, Inc., Long Term Disability Ins. Plan, the plaintiff was employed as an assistant coach for the Kansas City Chiefs football team and was provided with a LTD benefits plan. Following a bout with abdominal pain and nausea, the plaintiff went to the emergency room, where he was diagnosed with acute necrotizing pancreatitis. After he was released from the hospital nearly a month later, his rehabilitation consisted of occupational and speech therapy. The defendant initially approved the plaintiff’s claim for LTD benefits, but it later discovered that he had been coaching two other football teams even though he maintained that he was not fit to return to work. After obtaining several medical opinions, the defendant retroactively denied the plaintiff’s benefits, and although he appealed, the plaintiff made no attempt to introduce additional medical evidence to support his claim that he was disabled. While the plaintiff argued that the potential for episodes of pancreatitis would cause him to miss work, the court noted, “[t]he Plan’s definition of disability is in the present tense; thus, benefits are only available for currently existing

30. Id.
33. Id. at *2.
34. Id. at *3.
35. Id. at *4–5. The plaintiff had previously indicated a number of times that he had not yet returned to work since becoming disabled. Id. at *3–4. The two other teams he was coaching were an XFL team and an Arena Football 2 Team, both based out of Birmingham. Id. at *4.
36. Id. at *5. One doctor opined that the plaintiff was “physically capable of functioning in at least a medium work level with accommodations during exacerbations of his chronic pancreatitis,” id. at *6, while another proffered, “[t]here is no reason or time frame during which Mr. James would not be able to work in his occupation.” Id. at *6–7. This latter opinion was given by a doctor who also indicated that even though the plaintiff may have suffered from a few outbreaks, he was “fully functional between acute attacks.” Id. at *12.
disabilities." 37 Because the plaintiff was not "presently and continuously unable to perform the material duties" of his job, the mere potential for future disability did not oblige the defendant to provide the plaintiff with LTD benefits. 38

Conversely, other courts have found that the risk of recurrence of a physical illness could amount to a current disability. In Hannagan v. Piedmont Airlines, Inc., the plaintiff was a pilot who stopped working when he was diagnosed with an allergy to unknown substances, which caused him to have anaphylactic reactions. 39 After months of treatment, the doctor indicated that medication had controlled the plaintiff's conditions reasonably well but still advised him to carry an EpiPen at all times in case of an anaphylactic reaction. 40 The defendant denied the plaintiff's application for LTD benefits, claiming that he was not "disabled" under his plan because it was merely the revocation of the plaintiff's license that precluded him from flying, not the underlying disability. 41 While first noting that the mere existence of a legal disability "does not negate a health-related disability on which such legal detriment is based," 42 the court asserted that plan administrators may not deny benefits for future risk "when such a denial would put claimants and/or others at risk unless the policy at issue expressly denied coverage for such future risks." 43 Thus, in assessing whether a future risk of harm is in fact a disability, the plan administrator must focus on the probability of its future occurrence. 44 As the plan at issue did not expressly exclude risk of future harm from coverage, the defendant should not have denied the plaintiff's LTD benefits. 45

Likewise, in Saliamonas v. CNA, Inc., the court determined that the plaintiff was disabled according to the terms of his employer's LTD policy because work-related stress had the potential to aggravate his

37. Id. at *13.
38. Id.
39. Hannagan v. Piedmont Airlines, Inc., 2010 U.S. Dist. LEXIS 31472, at *2 (N.D.N.Y. Mar. 31, 2010). He was also diagnosed with obsessive-compulsive disorder and was treated with an antidepressant. Id. Due to these diagnoses and treatment, the plaintiff failed his medical exam and had his pilot's license suspended. Id. at *2–3.
40. Id. at *9–10.
41. Id. at *3–4. Thus, the plaintiff filed suit pursuant to ERISA. Id.
42. Id. at *12. By legal disability, the court was simply referring to the revocation of the plaintiff's license. Id.
43. Id. at *13; accord Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 391 (3d Cir. 2003) (finding that the plaintiff's return to his stressful occupation would pose a substantial and increased risk of heart attack and could thereby constitute a disability).
44. Id.
45. Id. at *14. Distinguishing its case from Stanford, the Hannagan court proffered that the important consideration was not whether "a return to work would necessarily further aggravate his condition; the disability arises from the grave risk that Plaintiff would pose to himself and those aboard his plane if he did not take the prescribed medication." Id.
permanent heart condition. The plaintiff in *Saliamonas* worked as a programmer analyst for a hospital, from which he took medical leave, citing that he could not work as a result of his coronary artery disease and severe aortic insufficiency. The defendant denied the plaintiff’s application for LTD benefits because the policy did not insure against “future risks or possible loss.” Observing that the defendant’s interpretation suggested “that heart and artery disease can only rise to the level of a disability if they are sure to cause a heart attack,” the court disagreed, asserting that this was “not a future condition, but rather a present risk.” The court concluded that to hold that “a permanent heart condition that may be aggravated by stress can only rise to the level of a disability when and if the insured suffers a heart attack” would be unreasonable, and thus, the plaintiff should have received LTD benefits.

2. Substance Abuse Cases

More pertinent to this Comment are the cases that analyze the risk of relapse question in a substance abuse context; although they arise in a factually distinguishable context, many of the following cases draw on the reasoning employed by the above opinions. Notably, all of these courts, and even the insurance companies, acknowledge that the actual drug addictions are covered under the plans as current disabilities. The only dispute is whether the risk of relapse into that addiction is covered. In a case that was factually similar to *Colby*, a Georgia district court held that the risk of a drug addiction relapse did not constitute a current disability. The plaintiff in that case was an anesthesiologist,

47. Id. at 998.
48. Id. at 1000. The defendant cited other reasons for the denial, such as the fact that the plaintiff could still perform some sedentary work and there was a lack of objective medical evidence of a disability. Id. The only relevant issue for this Comment, however, deals with the “future risk” argument. After his application was denied, the plaintiff brought suit pursuant to ERISA. Id. at 998.
49. Id. at 1001.
50. Id; but cf. New York Life Ins. Co. v. Harvey, 1998 U.S. App. LEXIS 13703 (4th Cir. 1998) (where the plaintiff was justifiably denied benefits because he only suffered a mild hard attack, his own doctor said there was no physical condition preventing him from going back to work, and his heart was recovered and functioning normally).
51. See, e.g., Colby v. Union Sec. Ins. Co., 705 F.3d 58, 62 (1st Cir. 2013) (“the definitions contained in the plan make clear that substance abuse, dependence, and addiction . . . are conditions that may give rise to ‘sickness’ within purview of the plan”); Stanford v. Cont’l Cas. Co., 514 F.3d 354, 358 (4th Cir. 2008) (“Continental did not contest Stanford’s characterization of his addiction as a sickness . . . .”).
52. Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1383 (N.D. Ga. 2001). This is one of the few cases discussed in this Comment where the underlying benefits plan did not fall within the scope of ERISA.
and after becoming addicted to Fentanyl, was admitted to a rehabilitation facility where he was diagnosed with opiate dependence. The defendant approved his application and paid him disability benefits for the next three years, during which time the plaintiff commenced a full-time practice as an internal medicine physician. Although the plaintiff still received outpatient treatment, had individual doctor appointments, attended Alcoholics Anonymous meetings, and was subjected to random drug screenings, the defendant eventually stopped paying benefits, reasoning that he had not practiced, or attempted to practice, anesthesiology in four years. Studying the language of the plan, the court concluded that the plaintiff did not show an uninterrupted inability to pursue anesthesiology. The court was not persuaded by the plaintiff's doctor's testimony that plaintiff's own fear of relapse and his previous history of relapse behavior raised the potential for relapse if he were to return to anesthesiology. Instead, the court noted that "future potentialities" did not amount to a present impediment to the plaintiff's return. The court stressed the fact that the plaintiff had not used drugs in six years, and there was no evidence that he would regress to such dependence by returning to the practice of anesthesiology.

53. See supra note 2.
54. Allen, 216 F. Supp. 2d at 1379. He was also diagnosed with alcohol dependence and depressive disorder. Id. The Virginia Board of Medicine suspended his medical license. Id.
55. Id. The doctor at the rehabilitation center noted that the plaintiff was unable to perform his regular work due to his opiate dependence, but also indicated that he had no limitations of functional capacity, was capable of heavy work, and was able to function under stress and engage in personal relations; the doctor also expected the plaintiff to improve in the future. Id. at 1380. When he was released a few months later, his prognosis for recovery was considered good, provided that he strictly adhere to a relapse prevention plan and a continuing care plan. Id. at 1379. While the plaintiff did not use Fentanyl or alcohol after he was released, his urine showed the possible presence of blocking samples, and thus he was admitted to another recovery center. Id. The doctor at this second facility made the same observations that the doctor at the first facility made. Id.
56. Id. at 1381. His license to practice had since been reinstated. Id. at 1380–81.
57. Id. at 1380. The second rehabilitation facility doctor believed that the plaintiff was disabled to practice anesthesiology. Id.
58. Which, among other things, required that the disability be a "continuing" one. Id. at 1382.
59. Id. at 1384. The court highlighted that it was undisputed that the plaintiff did not suffer any physical or mechanical limitations. Id. at 1383.
60. Id. at 1383–84. The doctor believed that remaining away from anesthesiology was part of the plaintiff's recovery. Id. at 1384.
Other courts have held that the risk of a relapse in an addiction setting can amount to a current disability. In a Michigan district court case, *Kufner v. Jefferson Pilot Fin. Ins. Co.*, the plaintiff was also an anesthesiologist who became addicted to opioids. After being released from a treatment center, the plaintiff entered a residential treatment program, and a few months later, returned to work under doctor-imposed restrictions. The defendant denied the plaintiff’s LTD claim, noting that his doctor had granted his request to increase his work hours and he had not experienced any relapses. The court observed that the defendant’s “denial of LTD benefits is based on the rather amorphous determination that the plaintiff can and should work 70-80 hours a week as... an anesthesiologist unless and until he has an actual relapse of his narcotics addiction.” The court characterized this position as “untenable” due to the serious risks it posed to public health and safety: “[d]efendant essentially engaged in a form of ‘benefits Russian roulette’ with plaintiff’s career and his patients’ lives at risk.” Thus, because there was extensive medical evidence regarding the threat of his relapse, the plaintiff was entitled to LTD benefits.

In *Royal Maccabees Life Ins. Co. v. Parker*, the Northern District of Illinois similarly found that the risk of a drug relapse could constitute a current disability, but it focused its attention on countering the characterization of an addiction as a “temporary indisposition.”


64. *Id.* at 789. These restrictions included a maximum 40-hour week (his normal was 80 hours), no on call duties, and he could not dispense narcotics. *Id.*

65. *Id.* Pursuant to ERISA, the plaintiff appealed the denial of his benefits. *Id.* After an exhaustive review, the defendant upheld the denial of benefits, despite the fact that there were conflicting medical opinions on whether or not the plaintiff should, or could, return to work. *Id.* at 790-92. The court engaged in a lengthy discussion about the appropriate weight to accord to each of the doctor’s opinions and determined that the plaintiff had presented better medical evidence than the defendant, quantitatively and qualitatively. *Id.* at 792-96.

66. *Id.* at 796.

67. *Id.* The court felt strongly about this, as it added: “Given that anesthesiology is an enormously complex and crucial, if not perilous, component of the surgical process, necessarily entrusted to the judgment and oversight of the healthcare system rather than the individual patient, defendant’s position with regard to disability benefits is tantamount to a breach of the public trust. Defendant would force plaintiff to work to the brink of failure to justify disability benefits, thereby imposing an unacceptable risk on patients, hospitals and the public generally...” *Id.*

68. *Id.* at 797. The court also noted that administrators of plans under ERISA must abide by a higher standard of care in discharging their duties, which made the defendant’s position all the more egregious. *Id.*

69. *Royal Maccabees Life Ins. Co. v. Parker*, No. 98 C 50422, 2001 U.S. Dist. LEXIS 20563, at *17 (N.D. Ill. Sept. 20, 2001). The plaintiff there was the insurance company, and it filed a declaratory judgment against the defendant employee, claiming that it did not owe the latter any disability benefits. *Id.* at *1-2. As a side note, this case was vacated by settlement, but that does not render its reasoning inapplicable. No. 98 C 50422, 2003 U.S. Dist. LEXIS 25965 (N.D. Ill. 2003).
employee there worked as an emergency room physician until he became addicted to Vicodin. He subsequently underwent inpatient addiction treatment, where he was diagnosed with chemical dependency; after being released, he continued outpatient treatment programs. His employer refused to reinstate him, and he eventually found other employment. Nearly a year after entering rehab, the employee submitted a disability claim to the plaintiff insurance company, which the latter denied, characterizing his sickness as merely an “addiction in remission.” Looking to the dictionary for guidance, the court asserted that the employee’s addiction was not a temporary indisposition; instead, it was a chronic illness that required long-term follow-up care, for “the risk of relapse is always present.” Highlighting the fact that five medical professionals recommended that the employee not return to his former occupation, the court rejected the insurance company’s argument that the risk of relapse did not prevent the employee from performing the substantial duties of an emergency room physician at the present time.

C. The Federal Appellate Split

Like the plaintiffs in Colby, Allen, and Kufner, Robert Stanford succumbed to heavy use of the drug Fentanyl. And like the anesthesiologists in those cases, he entered, and completed, an addiction

71. Id.
72. Id. at *7-8.
73. Id. at *8, *15. Since he had entered rehab, the employee had not relapsed on Vicodin, had fully complied with his after-care program, and was stable in recovery. Id.
74. It defined “sickness” as “illness; disease. An ailment of such a character as to affect the general soundness and health; not a mere temporary indisposition, which does not tend to undermine and weaken the constitution.” BLACK'S LAW DICTIONARY 1380 (6th ed. 1990).
75. Royal Maccabees Life Ins. Co., 2001 U.S. Dist. LEXIS 20563, at *17. This was essentially the position taken by the recovering drug addict plaintiff in Berry v. Paul Revere Life Ins. Co., 21 So. 3d 385, 392 (La. App. 2009), where he claimed that the risk of relapse is ever-present, thus disabling him from ever returning to his former occupation. The defendant disagreed, asserting that it would take “affirmative action on [the plaintiff’s] part . . . for him to become disabled and unable to perform the duties of his occupation.” Id. at 389. In noting that the policy did not categorically exclude the risk of relapse for drug addiction as a basis for disability, the court held that summary judgment for the defendant would have been improper. Id. at 394. Notably, in also applying the language of the plan, the dissent commented that the majority’s observation that the policy did not include a “risk of relapse” provision compelled the exact opposite result: because it was not in the plain language of the plan, it warranted no coverage. Id. at 399.
77. Colby v. Union Sec. Ins. Co., 705 F.3d 58, 60 (1st Cir. 2013).
treatment and rehabilitation program. Unlike those anesthesiologists, however, he relapsed less than a month later and entered treatment for a second time. While attending this second program, Stanford applied to Continental Casualty Company (Continental) for LTD benefits, which were approved. Apparently the treatment did not work; shortly after returning to work nearly a month after being released from his second program, Stanford began taking Fentanyl again, causing him to once again leave work, undergo treatment, and petition for benefits. While Continental approved the benefits for his duration at the clinic, it notified him that his claim remained under review. After Stanford's physician told Continental that he no longer suffered any impairment that would prevent him from returning to work, Continental terminated his benefits. Continental denied his appeal, opining that "the policy does not cover potential risk . . . ."

The Fourth Circuit's majority opinion, written by Judge Ellis, began with a brief look at the mechanics of ERISA. Stanford's primary argument was that Continental abused its discretion by applying an unreasonably restrictive interpretation of the benefit plan when it concluded that the plan did not apply to the potential risk of relapse. Continental acknowledged that Stanford's addiction was a sickness, but it argued that because he no longer suffered from any physical or mental impairment as a result of it, the fact that he remained an addict did not render him unable to perform the duties of an anesthesiologist. The court agreed, making a notable distinction between cases in which the risk of recurrence of a physical condition did amount to a current disability and the situation at hand:

81. Id. at 356.
82. Id.
83. Id.
84. Id.
85. Id.
86. Id. Meanwhile, the South Carolina Board of Nursing restricted his license, thus prohibiting him from having access to narcotics. Id.
87. Id. Stanford then brought suit pursuant to ERISA. Id.
88. Id. The court also noted that a conflict of interest can exist when a benefit plan is administered and funded by the same party. Id. at 357.
89. Id. He also argued that Continental violated ERISA regulations by not consulting with a health care professional before denying benefits, but as this is irrelevant to the specific focus of this Comment, it will not be discussed. Id. at 358. The court first turned its analysis to the actual language of the plan, which defined a "disability" as an "injury or sickness caus[ing] physical or mental impairment to such a degree of severity that you are . . . continuously unable to perform the material and substantial duties of your regular occupation." Id.
90. Id.
But the risk of a heart attack is different from the risk of relapse into drug use. A doctor with a heart condition who enters a high-stress environment like an operating room "risks relapse" in the sense that the performance of his job duties may cause a heart attack. But an anesthesiologist with a drug addiction who enters an environment where drugs are readily available "risks relapse" only in the sense that the ready availability of drugs increases his temptation to resume his drug use. Whether he succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice.92

While the Fourth Circuit did acknowledge that some courts have found that the risk of relapse in an addiction context can constitute a current disability,93 it observed that because there are cases directly to the contrary, Continental’s decision was not unreasonable.94

The court then conceded that its holding would require Stanford to return to work and suffer a relapse in order to qualify for LTD benefits: "We recognize that this creates a somewhat troubling—some might say perverse—incentive structure: an addict who continues to abuse drugs will be entitled to long-term benefits, but upon achieving sobriety will lose those benefits unless he again begins to use drugs."95 The court reasoned its way around this startling realization by asserting that such an argument operates on the false assumption that disability benefits act as a reward for sobriety.96 Countering this “assumption,” Judge Ellis wrote, “sobriety’s reward is the creation of innumerable opportunities that were closed to Stanford as long as he continued to use drugs.”97 While these opportunities did not include returning to work as an anesthesiologist, because “no prudent addict would place himself in such a position,”98 the court proclaimed that “[s]uch prudence is a part of recovery, and it can have significant costs—but these costs are greatly outweighed by the opportunities sobriety provides.”99 The court noted that Stanford was not physically disabled or mentally impaired, and it concluded by observing, "[i]t would be truly perverse if Stanford were to go on to great success in another occupation but was still able to

92. Stanford, 514 F.3d at 358.
95. Stanford, 514 F.3d at 359.
96. Id.
97. Id.
98. Id. The court also noted that Stanford could not return to work as an anesthesiologist as his license was limited. Id.
99. Id.
collect insurance checks on the basis of ‘disability.’”

In a scathing dissent, Judge Wilkinson criticized the majority, commenting that it seemed driven by “moral opprobrium” rather than sound legal analysis. Judge Wilkinson began his dissent by simply interpreting the language of the insurance policy at hand, affirming what neither party denied: addiction qualifies as a sickness that causes mental impairment. Regarding Continental’s position that the policy did not cover “potential risk,” the dissent emphasized that “potential risk” is redundant because “potential risk’ is just risk.” Judge Wilkinson was equally perplexed by Continental’s assertion that “a risk of relapse is not evidence of current impairment; instead, it is a future, potential concern.” Noting that addicts are not the only medical patients who relapse, the dissent asserted, “all agree that Stanford cannot presently return to work in safety, and if we ask why not, the answer must be some existing, not future, impairment—namely, [his] fentanyl addiction.” Judge Wilkinson solidified this point by remarking that the plan contained an “Exclusions and Limitations” section that notably said nothing about “potential risk,” and thus, the majority permitted Continental to carve out an unwritten exception.

The dissent also emphasized the “perverse incentive” that the majority’s decision would create and did not find persuasive the fact that Stanford would be able to work “countless other jobs,” because the plan defined disability as the inability to perform the duties of one’s regular occupation. Further, “[forcing Stanford to relapse into addiction or lose his benefits would . . . thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise cope with it.” Judge Wilkinson observed

100. Id. at 359–60.
101. Id. at 365 (Wilkinson, J., dissenting). The dissent said, “[t]he moral and medical choices are not this court’s to make. They belong to those who bargained for the Plan—and who have something at stake in it.” Id. at 363 (Wilkinson, J., dissenting).
102. Id. at 361 (Wilkinson, J., dissenting). Wilkinson noted that the plan defined “mental impairment” as all disorders found in the current diagnostic standards manual of the American Psychiatric Association, which devotes a full section to substance-related disorders, “addiction notably among them.” Id. (Wilkinson, J., dissenting). That is why Continental paid Stanford benefits for as long as it did. Id. (Wilkinson, J., dissenting). He stressed that not even Continental denied that Stanford could not, “with any safety,” perform his duties as an anesthesia nurse, and “not a shred of contrary evidence was every presented . . .” Id. (Wilkinson, J., dissenting).
103. Id. (Wilkinson, J., dissenting).
104. Id. at 362 (Wilkinson, J., dissenting).
105. Id. (Wilkinson, J., dissenting).
106. Id. (Wilkinson, J., dissenting).
107. Id. at 359.
108. Id. at 362 (Wilkinson, J., dissenting).
109. Id. (Wilkinson, J., dissenting).
that Continental’s unwritten exception would seem to exclude all medical conditions whose “effect is to create grave medical risk, conditions that make doing one’s job, though not literally impossible, unreasonably dangerous.”110 Solidifying this argument, the dissent highlighted the treatise definition of “disability,” which holds that “the insured is considered to be permanently and totally disabled when it is impossible to work without hazarding his or her health or risk his or her life.”111 Thus, the dissent turned its inquiry to determining the likelihood and gravity of the risk of Stanford’s relapse.112 In observing that every medical opinion in the record indicated that Stanford should not have returned to work as an anesthesia nurse due to his risk of relapse, Judge Wilkinson concluded that because Stanford had presented substantial evidence of disability, he should have been awarded his LTD benefits.113

The Colby opinion reached the same conclusion that Judge Wilkinson did in Stanford by holding that the risk of relapse can constitute a current disability.114 After briefly noting the deference that an ERISA plan gives to its administrators,115 Judge Selya, writing for a unanimous First Circuit, addressed the literal language of the plan.116 The court emphasized that substance abuse, dependence, and addiction are considered sicknesses under the plan, and the risk of relapse in Dr. Colby’s case was “particularly acute because returning to

110. Id. (Wilkinson, J., dissenting).
111. Id. at 363 (Wilkinson, J., dissenting) (citing JOHN ALAN APPLEMAN, 31 APPLEMAN ON INSURANCE § 187.05[A], at 214 (2d ed. 2007)). Judge Wilkinson proffered some examples to explain why potential risk can amount to current impairment. Id. at 363 (Wilkinson, J., dissenting). For instance, some back conditions would leave a patient literally able to lift heavy objects, but at risk of partial paralysis upon doing so. Id. (Wilkinson, J., dissenting).
112. Id. at 364 (Wilkinson, J., dissenting).
113. Id. at 365 (Wilkinson, J., dissenting). The medical evidence was clear to Judge Wilkinson. First, Stanford had relapsed twice before and when he was released to work after a third treatment program, the doctor restricted him from having access to narcotics. Id. at 364 (Wilkinson, J., dissenting). Second, Stanford submitted an article about the “apparently common problem of anesthesiologists becoming addicted to” Fentanyl. Id. (Wilkinson, J., dissenting); See Eric B. Hedberg, Anesthesiologists: Addicted to the Drugs They Administer, AM. SOC. ANESTHESIOLOGIST NEWSLETTER, May 2001 (stating that only about half of opiate-addicted anesthesia personnel can return to their profession even after substantial treatment); Ethan O. Bryson & Jeffrey Silverstein, Addiction and Substance Abuse in Anesthesiology, NATIONAL INSTITUTE OF HEALTH, NOV. 2008, at 905–917 (Between 1991–2001, 80% of U.S. anesthesiology residency programs reported experience with impaired residents). Finally, the dissent found persuasive the fact that Fentanyl has an analgesic potency of about 80 times that of morphine, which led to its rampant use among medical personnel. Stanford, 514 F.3d at 365 (Wilkinson, J., dissenting).
115. Id. at 61. The abuse of discretion standard in an ERISA context is equivalent to the arbitrary and capricious standard. Id. The court stressed that applying a deferential standard of review did not mean that the plan’s administrator would prevail on the merits. Id.
116. Id. at 62–63.
work...would afford her easy access to opioids and other addictive substances." The court found persuasive the abundance of evidence indicating that there was a high risk of relapse into opioid dependence if Dr. Colby had returned to work. Ultimately, the First Circuit's biggest concern was USIC's categorical exclusion of risk of relapse from coverage. Given the language of the plan, which did not mention risk of relapse, much less categorically exclude it, the denial of benefits on the ground that a risk of relapse cannot amount to a current disability was unreasonable, especially given the Act's mandate that plan administrators use their discretion to process claims solely in the interests of the participants and beneficiaries of the plan. The court found unavailing USIC's argument that the risk of relapse was a "speculative future possibility," while the plan's language was crafted in the present tense; again, it was the absolute exclusion of risk of relapse, without any further investigation into the likelihood of that risk, that proved fatal for USIC.

The First Circuit then turned its analysis to the risk of relapse in other contexts, asserting that "risk of relapse is not a concept peculiar to the realm of substance abuse and addiction." The court conceded Dr. Colby was not physically unable to perform the motions of her occupation; instead, it found that her risk of relapse was prohibitively impairing, thus amounting to a current disability. Judge Selya also expounded on the "perverse incentive" that such a denial of benefits would create, stressing that it would not only put Dr. Colby herself at risk, but it would also endanger her patients: "denying benefits to an

117. Id. at 63.

118. Id. For example, her physician recommended that she not return to the field of medicine for at least six months and Dr. Colby was arrested for driving under the influence of alcohol six months after being released from treatment. Id. Additionally, her therapist linked her opioid dependence to her back pain, her "turbulent" personal life, and the stresses of her job; thus, the therapist opined that returning to work and facing exposure to her drug of choice could exacerbate these other conditions. Id. at 63-64. Numerous other medical experts averred to Dr. Colby's high risk of relapse. Id. The court did note that it could have been possible for USIC to limit the period of disability by arguing that the risk progressively diminished over the 36-month period. Id. at 64.

119. Id. at 65. USIC's initial motion posited that "a mere risk of relapse into a prior, self-controlled condition is not...[a] condition that would preclude the plaintiff from working in her occupation." Id. at 64.

120. Id. at 66. The court stressed that this was all the more important in an ERISA case, where exclusions from coverage are not favored in an ERISA plan: "Plucking an exclusion for risk of relapse out of thin air would undermine the integrity of an ERISA plan." Id. at 65.

121. Id.

122. Id. at 66.

123. Id. The court analogized her situation to that of an air traffic controller with a seizure disorder, holding that the latter may be totally disabled with respect to her regular occupation because the runway's flickering lights put her at a grave risk of convulsive episodes. Id. The fact that she could was not literally unable to work as an air traffic controller did not mean that she was not prohibitively impaired from doing so due to her risk of relapse. Id.
anesthesiologist ‘unless and until... an actual relapse of a narcotics addiction [occurs]... is untenable given the serious risk this poses to public health and safety.’”124 Ultimately, the court’s holding was a narrow one that hinged on the plain language of the plan and “USIC’s all-or-nothing approach to its benefits determination.”125 Had USIC written an exclusion into the plan or conducted a more in-depth factual inquiry to assess the degree of the risk of relapse, the First Circuit may have decided the case differently.126

III. DISCUSSION

In his dissent in Stanford, Judge Wilkinson proposed that rather than being grounded in law or the language of the underlying plan, the special exclusion for drug addicts that was adopted by the majority was instead the product of “moral opprobrium.”127 While the other justices on the Fourth Circuit likely took exception to that accusation, it is hard to fathom any other explanation. The First Circuit’s recent decision in Colby128 was the first at the appellate level to accept the argument that a risk of relapse of a substance addiction could constitute a current disability. In so holding, the First Circuit reached the correct result, but missed a golden opportunity to set a stronger precedent. The risk of relapse in a substance abuse context can constitute a current disability under ERISA because simple policy interpretation so requires; to hold otherwise would incentivize drug use; and the debilitating nature of addiction compels that conclusion.

A. Policy Interpretation

Mere interpretation of the policies at issue in the above-mentioned cases dictates that the risk of relapse should constitute a current disability, but this conclusion could have an impact on the way such policies are drafted in the future.129 Insurance contracts are controlled

124. Id.
125. Id.
126. Id. The court also noted that USIC did suggest that it would have been a reasonable work accommodation for another healthcare professional to monitor and supervise Dr. Colby’s exposure to opioids, thus permitting her to return to work. Id. at 67. This suggestion, however, came too late as this possible accommodation was not mentioned until four years after USIC first denied LTD benefits to Dr. Colby. Id.
128. Colby, 705 F.3d 58.
129. In order to claim disability benefits, an employee’s plan must cover the alleged disability, and thus interpreting the provisions of the plans at issue is crucial. Filing a Claim for Your Health or Disability Benefits, UNITED STATES DEPARTMENT OF LABOR, http://www.dol.gov/ebsa/publications/filingbenefitsclaim.html (last visited Jan. 8, 2014).
by the same rules of construction as are other contracts, and thus, the goal of interpreting insurance policies is to ascertain the intent of the parties.\textsuperscript{130} Ambiguities in coverage are to be construed in favor of coverage, while exclusions will be narrowly construed against the insurer.\textsuperscript{131} The language of the contract itself is the "first and most important reference when interpreting a contract."\textsuperscript{132}

Engaging in this formulaic policy interpretation, courts should reach the conclusion that if a plan does not exclude the risk of relapse from coverage, then such risk should warrant coverage.\textsuperscript{133} The language in these plans does not even mention the risk of relapse, much less contain a categorical bar to providing coverage for it, but the Fourth Circuit in \textit{Stanford} nonetheless concluded that the risk of relapse should not be covered if the policy does not expressly provide for it.\textsuperscript{134} This runs counter to the aforementioned principles of policy interpretation for two reasons. First, the plans in both \textit{Stanford}\textsuperscript{135} and \textit{Colby}\textsuperscript{136} defined a disability as an injury or sickness that renders one unable to continuously perform the material duties of his regular occupation. Thus, to conclude that the risk of relapse does not warrant coverage if the plan does not specifically provide for it necessarily entails skipping a step. Insurance companies and courts should not focus on whether or not the plan specifically provides for certain coverage\textsuperscript{137} but should instead determine whether the alleged illness fits within the plan's definition of a disability. For instance, if an employee is hurt at work and breaks his back, surely an insurance company would not argue that

\begin{itemize}
\item \textsuperscript{131} Swisher, supra note 130, at 566.
\item \textsuperscript{133} Some courts have taken this approach. \textit{See}, e.g., \textit{Colby}, 705 F.3d 58; Hannagan v. Piedmont Airlines, Inc., No. 3:07-CV-795, 2010 U.S. Dist. LEXIS 31472, at *13–14 (N.D.N.Y. Mar. 31, 2010) ("Defendant[s]' . . . policy does not expressly exclude risk of future harm or future manifestations of symptoms from coverage; and, therefore, its failure to consider such is arbitrary and capricious."); \textit{Stanford v. Cont’l Cas. Co.}, 514 F.3d 354, 362 (4th Cir. 2008) (Wilkinson, J., dissenting) ("The chief problem with excluding 'potential risk of relapse' from coverage is that the exclusion has no support whatsoever in the language of the Plan.").
\item \textsuperscript{134} \textit{Stanford}, 514 F.3d at 358.
\item \textsuperscript{135} \textit{Id.}
\item \textsuperscript{136} \textit{Colby}, 705 F.3d at 67.
\item \textsuperscript{137} As the insurance company in \textit{Stanford} did. The dissent in \textit{Berry v. Paul Revere Life Ins. Co.}, 21 So. 3d 385, 397 (La. Ct. App. 2009), incorrectly employed similar reasoning: "The issue is not whether [plaintiff’s] risk of relapse is so great that he is incapable of performing the material functions of his job, but whether risk of relapse is covered by the policy language in question.”
\end{itemize}
a broken back is not specifically provided in the plan; rather, it would ask whether or not that injury constituted a disability in conformity with the terms of the plan. Second, ambiguities in such policies are to be construed against the insurer; that is, they should be resolved in favor of coverage. This is even more telling in an ERISA case, where exclusions from coverage are not favored given the Act’s mandate that plan administrators process claims “solely in the interests of the participants and beneficiaries of the plan.”

Many insurance companies have argued that as the risk of relapse is a “future potentiality,” it is not covered when the language of the plan is phrased in the present tense. This is nonsensical because, as Judge Wilkinson notes in his dissent in Stanford, “the phrase ‘potential risk’ is a redundancy; ‘potential risk’ is just risk.” Likewise, the Saliamonas court correctly rejected the insurance company’s contention that the risk of relapse was a future possibility: “This is not a future condition, but rather, a present risk.” “Risk” is defined as “the possibility of loss or injury,” while “potential” is similarly defined as “existing in possibility.” Attempting to circumvent a plan written in the present tense by claiming that “future” or “potential” risk is not covered is redundant, and courts should find such an argument unavailing. Indeed, the risk of relapse is ever-present, as will be discussed below.

This conclusion could have some implications for the way such policies are drafted in the future, especially after Colby: “Our holding today is narrow. It pivots on the fusion of the plain language of the plan . . . USIC could have written into the plan an exclusion for risk of relapse, but it did not choose to do so.” Whether or not such exclusions will be included in policies in the future remains to be seen, but as the rest of this Comment will argue, the risk of relapse likely will

139. See, e.g., Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1383 (N.D. Ga. 2001) (where the court held that the doctor’s recommendation that the plaintiff not return to work was based on “future potentialities rather than any present impediment”); Saliamonas v. CNA, Inc., 127 F. Supp. 2d 997, 1002 (N.D. Ill. 2001) (insurance company claimed that the policy did not insure against “future risks or possible loss”); Stanford v. Cont’l Cas. Co., 514 F.3d 354, 361 (4th Cir. 2008) (insurance company argued that the policy did not cover “potential risk of relapse”).
140. Stanford, 514 F.3d at 362 (Wilkinson, J., dissenting).
144. See infra Part III.C.2.
145. Colby v. Union Sec. Ins. Co., 705 F.3d 58, 67 (1st Cir. 2013); accord Stanford, 514 F.3d at 363 (Wilkinson, J., dissenting) (“The moral and medical choices are not this court’s to make. They belong to those who bargained for the Plan . . . .”).
be, and should be, just as protected as the addiction itself.

**B. Not Providing Coverage for the Risk of Relapse Incentivizes Drug Use**

Denying a former or recovering addict's claim for LTD benefits is unreasonable at best and potentially deadly at worst because it creates a perverse incentive. Take for instance Robert Stanford, the trained nurse anesthetist who became addicted to a drug he was administering to his patients.146 After completing a third treatment program for his opiate dependence, Stanford was denied his benefits after his physician told the defendant insurance company that he was no longer addicted to the drug; the physician did, however, indicate that Stanford remained at risk for relapse if exposed to the drug again.147 Stanford then returned to the environment that prompted his addiction in the first place and was presented with two choices: lose his disability benefits while he tried to stay sober or indulge in his addiction for the fourth time and once again receive benefits. Undoubtedly the former is the much more difficult, and sometimes a nearly impossible, option to choose.148 This truly puts people like Stanford in a "cruel" position, for it incentivizes abusing a drug which many former addicts have spent months and sometimes years trying to stop using.149 This is not to say that refusing to use the drug is not a viable option; rather, it is a very difficult option to take, especially with addict's knowledge that she will receive disability benefits upon doing so.

Creating this incentive not only forces recovering addicts into relapse, but it also "thwart[s] the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and to cope with it."150 Denying benefits for the risk of relapse encourages former addicts to abandon whatever progress they have made in attempting to overcome their drug dependence.151 Despite expressly acknowledging this "perverse incentive structure," the Fourth Circuit in *Stanford* finessed itself around such a disturbing realization by claiming that it

147. *Id.* at 355–57.
148. As discussed *infra* Part III.C.
150. *Id.* at 362 (Wilkinson, J., dissenting). Indeed, these plans would not replace, partially or wholly, the income of employees who are disabled if their purpose was not to give them time to recover after a sickness or accident.
151. This applies in substance abuse and nonsubstance abuse cases alike. See, e.g., Saliamonas v. CNA, Inc., 127 F. Supp. 2d 997, 1001 (N.D. Ill. 2001) ("To suggest . . . that a permanent heart condition that may be aggravated by stress can only rise to the level of a disability when and if the insured suffers a heart attack is unreasonable.").
operates on the false assumption that "benefits are a sort of reward for sobriety." Instead, "sobriety’s reward," the court countered, is "the creation of innumerable opportunities that were closed to Stanford as long as he continued to use drugs," and thus it would be unreasonable to allow Stanford to start another job and continue to receive disability benefits. That Stanford could have applied to other jobs is irrelevant, for the language in the plan at issue, and nearly all of the plans mentioned in this Comment, defined disability as the inability to perform the duties of "your regular occupation." Surely a construction worker who injures his back could choose to apply for a job inputting data into a computer, but the purpose of providing such an employee with LTD benefits in the first place is to support him so that he can adequately recover and return to work as a construction worker. This coverage for the inability to work in one’s “normal occupation” is precisely the reason why none of these plans include a stipulation that the disabled employee will only receive benefits if she is unable to find another job.

Denying coverage unless and until a plaintiff actually suffers a relapse not only places the recovering drug addict in danger, but it can also put others in jeopardy. Specifically in the context of health care practitioners, the denial of benefits for the risk of relapse is tantamount to a form of “‘benefits Russian roulette’ with [the employee’s] career and his patients’ lives at risk.” Such a stand “would force plaintiff to work to the brink of failure to justify disability benefits, thereby imposing an unacceptable risk on patients, hospitals, and the public generally . . . .” Such a danger is particularly acute in the field of anesthesiology:

One of the most disabling problems for opiate dependent anesthesiologists is the tremendous distracting obsession about their drug of choice. During surgery and administration of anesthetics, many

152. Stanford, 514 F.3d at 359.
153. Id. The court added that “no prudent addict would place himself in such a position.” Id. Such a statement belies the true nature of addiction as will be discussed infra Part III.C.
154. Id. at 362.
156. Id. This is particularly egregious considering ERISA’s imposition of higher-than-marketplace quality standards on insurance plan administrators. Id. at 797.
anesthesiologists are fighting obsession and craving... due to their obsessions, the anesthetized patients are receiving their partial attention and are being placed at an unacceptable risk during surgery... [Thus,] the anesthesiologist is incapable of performing the substantive duties of their job.157

This risk is not merely a theoretical one. Take for instance a Louisiana doctor who attended a procedure while under the influence of drugs following a relapse.158 Due to his drug use, he made a mistake that rendered the patient under his care in a permanent vegetative state.159 While addiction in the medical profession undoubtedly entails a greater risk to others, similar perils could arise in a myriad of other occupations.160 This danger, in itself, mandates that the risk of relapse should be treated as a current disability.

C. Addiction as a Chronic Illness

Drug addiction is a chronic illness,161 is classified as a mental disorder by the DSM-IV,162 and affects millions of people each year.163 Not surprisingly then, none of the insurance companies in any of the above cases disputed the fact that substance dependence itself warranted

159. Id. at 386.
160. For example, a truck driver who risks relapse of a heart attack; an airplane pilot who risks relapse of seizures; a lifeguard who risks relapse of fainting, etc. The unique problem posed by the medical profession is two-fold: first, that the doctors are using the drugs they are administering to patients; and second, that drug is causing them to harm others if they attempt to practice while abusing the drug.
162. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is published by the American Psychiatric Association and is the standard classification of mental disorders by mental health professionals in the United States. It recognizes both substance abuse and substance dependence as mental disorders. See AMERICAN PSYCHIATRIC ASSOCIATION, 1 DSM-IV SOURCEBOOK (Washington D.C. 1994).
coverage under the respective plans. \(^{164}\) Despite the recognition of the severity of drug addiction and thus the unanimous inclusion of it in the purview of a plan’s definition of “disability,” many insurance companies and courts have been hesitant to also include the risk of relapse into that definition, reasoning that addiction, as opposed to other chronic illnesses, is a voluntary choice. Such a conclusion is not only incongruous with the remainder of the plans at issue, but it is medically incorrect and runs afoul of the true nature of the disease, for the risk of relapse is part of the illness and is ever-present.

1. Addiction as a Voluntary Choice

The Stanford court distinguished the risk of relapse into drug use from the risk of relapse of purely physical ailments by asserting, “an anesthesiologist . . . ‘risks relapse’ only in the sense that the ready availability of drugs increases his temptation to resume his drug use. Whether he succumbs to that temptation remains his choice . . . .”\(^{165}\) Such a conclusion is illogical for three reasons.

First, it was undisputed that the plan at issue provided coverage for substance dependence. If the insurance company really wanted to advance the argument that drug addiction differs to such an extent from other disabilities due to the alleged voluntariness of it, why provide LTD benefits for the addiction itself in the first place? Obviously the parties thought the underlying illness debilitating to the point that it warranted protection under the plan; under the court’s reasoning, becoming addicted to the drug in the first place necessarily involved a voluntary choice as well, yet it was still defined as a disability in the policy.

Second, that drug addiction is a purely voluntary choice is a stereotype about substance abuse that has been debunked and holds no water in the medical community. \(^{166}\) While the public may continue to

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164. See, e.g., Colby v. Union Sec. Ins. Co., 705 F.3d 58, 62 (1st Cir. 2013) (“The definitions contained in the plan make clear that substance abuse, dependence, and addiction—like mental illness more generally—are conditions that may give rise to ‘sickness’ within the purview of the plan”); Stanford v. Cont'l Cas. Co., 514 F.3d 354, 356 (4th Cir. 2008) (insurance company approved plaintiff’s application for LTD benefits while he was in rehabilitation); Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1381 (N.D. Ga. 2001) (same).

165. Stanford, 514 F.3d at 358; accord Jeffrey A. Schaler, Drugs and Free Will, SOCIETY, Sept./Oct. 1991, at 42–44 (“Drug addicts simply have different values from the norm and often refuse to take responsibility for their actions. Public policy based on the disease model of addiction enables this avoidance to continue by sanctioning it in the name of helping people.”).

166. Sonja Starr, Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment, 111 YALE L.J. 2321, 2325–26 (2002) (“Alive as it may be in the public mind, the idea that people are addicts by choice has long since lost currency among medical experts. Medical descriptions of addiction as a disease date to the eighteenth century.”) (citing John N. Chappel, Attitudes Toward the Treatment of Substance Abusers, in SUBSTANCE ABUSE 983, 984 (Joyce H. Lowinson et al. eds., 2d ed. 1992)); Robinson v. California, 370 U.S. 660, 667 n.9 (1962) (noting that addiction may not
think of drug addiction as a failure of character, a moral flaw, or a mere surrender to temptation, drug addiction has a clear biological basis: “Addiction . . . is a disorder of the brain no different from other forms of mental illness.”\textsuperscript{167} Thus, while the Stanford majority asserted that “no prudent addict” would put herself in a drug-laden environment, it operated on the false assumption that such addicts can rationally and totally control their disability.\textsuperscript{168}

Third, it is true that “addiction undeniably has an underlying behavioral basis, and the initial behavior that triggers a cycle of addiction is generally voluntary.”\textsuperscript{169} There is an argument to be made that the purpose of health insurance is to protect people from harms inflicted by chance, not to spread the costs of self-inflicted injuries.\textsuperscript{170} While not without merit, such a claim “appears disingenuous . . . when applied solely to addiction as opposed to other diseases . . . [that] stem at least in part from behavioral choices.”\textsuperscript{171} Many illnesses, including lung cancer, high blood pressure, heart disease, and diabetes are influenced, if not caused, by voluntary choices and lifestyle decisions.\textsuperscript{172} Even many commonplace accidents that result in personal injury and subsequent insurance coverage are the fault of the insured.\textsuperscript{173} Thus, to base the denial of LTD benefits on the allegation that drug addiction is somehow more voluntary than other covered diseases is arbitrary and without empirical support.

\textsuperscript{167} Starr, supra note 166, at 2326 (quoting J. Madeleine Nash, \textit{Addicted: Why Do People Get Hooked? Mounting Evidence Points to a Powerful Brain Chemical Called Dopamine}, \textsc{Time}, May 5, 1997, at 68, 70; Drug, Brains, and Behavior: The Science of Addiction, \textsc{National Institute on Drug Abuse}, http://www.drugabuse.gov/publications/science-addiction/drug-abuse-addiction (last visited Jan. 8, 2014) (noting several factors that can increase the risk of addiction)).

\textsuperscript{168} Stanford, 514 F.3d at 359.

\textsuperscript{169} Starr, supra note 166. “An individual may be genetically predisposed toward alcoholism, but she cannot become an alcoholic without ever taking a drink.” \textit{Id}.

\textsuperscript{170} \textit{Id}. When a person chooses to use drugs for the first time then, they should not expect sympathy if “that risk is actualized.” \textit{Id}.

\textsuperscript{171} \textit{Id}. at 2336.

\textsuperscript{172} \textit{Id}. Expounding on this point, Starr continues, “[w]e drive too fast, or we smoke, or we do not exercise enough, or we eat too many carbohydrates. Why, then, single out addiction for the type of moral condemnation implied by the voluntariness argument?” \textit{Id}.

\textsuperscript{173} Take for instance car accidents. No insurer would deny LTD benefits to a day laborer who was injured in a car crash and could not work for six months, despite the fact that the insured may have caused the crash.
2. Risk of Relapse as Part of the Disease

Perhaps the gravest mistake that insurance companies and courts make regarding the denial of coverage for the risk of relapse is the assumption that such a risk is itself not part of the underlying addiction. Again, the inclusion of coverage for the addiction in the first place is telling because the insurance companies thought it warranted protection; not providing similar treatment for the risk of relapse overlooks the fact that such a risk is part of the disability.

The treatise definition of “disability” posits that “the insured is considered ... disabled when it is impossible to work without hazarding his or her health or risking his or her life.” Relapsing into a drug addiction certainly poses this risk. This risk itself makes the ability to work prohibitively impairing, and thus, while working may not be literally impossible, it would be unreasonably dangerous. For example, “we would not deny disability benefits to a laborer” whose back condition would not render him literally unable to lift heavy objects but who risks paralysis upon doing so. Similarly, an air traffic controller with a seizure disorder may be totally disabled with respect to her regular occupation because the runway’s flickering lights put her at a grave risk of convulsive episodes; the fact that she was not literally unable to work as an air traffic controller did not mean that she was not prohibitively impaired from doing so due to her risk of relapse. Such a risk is all the more prevalent in the anesthesiology setting where opiate-dependent doctors and nurses are fighting the “tremendous distraction about their drug of choice,” which just happens to be the same drug they are working with all day.

174. Stanford, 514 F.3d at 363 (Wilkinson, J., dissenting) (quoting JOHN APPLEMAN, 31 APPLEMAN ON INSURANCE § 187.05[A], at 214 (2d ed. 2007)). Not only is the drug addict’s life in danger here, but incentivizing drug use also poses risks to others in such a context, as discussed supra Part III.B.

175. Stanford, 514 F.3d at 363 (Wilkinson, J., dissenting). Likewise, “when busy professionals with cardiac troubles have brought ERISA suits because workplace stress caused a risk of heart attack, they have typically prevailed.” Id.

176. Colby v. Union Sec. Ins. Co., 705 F.3d 58, 66 (1st Cir. 2013). The same would be true of a football player who broke his leg. Once his leg is healed, if his doctors recommend that he stay away from practice for a while to avoid re-injuring it right away, surely no insurance company would claim that such a risk is not provided for.

177. Supra note 157. This apparently is a common problem amongst anesthesiologists. The plaintiff in Stanford submitted an article during his appeal regarding the opiate addiction problems in his field. Stanford, 514 F.3d at 364 (Wilkinson, J. dissenting). The article stated that only about half of opiate-addicted anesthesia personnel can return to their profession even after substantial treatment. Id. (citing Eric. B. Hedberg, Anesthesiologists: Addicted to the Drugs They Administer, AM. SOC. ANESTHESIOLOGIST NEWSLETTER, May 2001). This is very different from James v. Kansas City Chiefs Football Club, 2005 WL 1532945, at *12 (W.D. Mo. June 28, 2005), where the plaintiff’s risk of relapse of pancreatitis did not amount to a current disability because he was “fully functional between acute attacks,” and that “working or not working would not in any way aggravate” his condition.
is prohibitively impairing for many recovering drug addicts, this risk itself is a symptom of the underlying disease. An insurance company's definition of drug addiction as being characterized merely by active use therefore has no merit, especially considering that the DSM-IV expressly notes that relapse is part of the disability itself.\(^{178}\) Indeed, the risk of relapse is not merely a hypothetical one; it is prevalent, and it is ever-present.\(^{179}\) The plaintiffs in *Colby* and *Stanford* are living evidence that the risk is real and is very much intertwined with the drug dependence itself.\(^{180}\) Thus, to provide coverage for the addiction itself, but not the risk of relapse into addiction, runs counter to the true nature of the illness.

This is not to say that all former drug addicts should receive LTD benefits for the rest of their lives. This would be an undue burden on the insurance companies, and it would not be right to indefinitely provide benefits to addicts who are fully recovered and have only a minimal risk of relapse. Regarding these concerns, the answer seems simple: listen to the doctors. Insurance companies and courts are not trained in medicine, so they should not be in the habit of overruling a doctor's opinions. If a doctor concludes that an employee's risk of relapse is so severe as to constitute a current disability, any contrary claims that the risk of relapse is a future, rather than a current, impediment should be unavailing. Whether the risk of relapse of an addiction should be covered should turn on the severity of that risk. Inevitably then, these cases should amount to little more than the facts of each case and most importantly, a medical professional's assessment of the likelihood of relapse. Thus, the probability of a future relapse should drive the

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178. According to the DSM-IV, opioid dependence, or "addiction" as it is more generally and commonly known, is a chronic illness characterized by periods of active use (relapses) and periods of remission, where the probability of relapsing back into active use may remain high. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV 175–273 (Washington D.C., 1994).


180. For example, Colby relapsed twice and Stanford relapsed three times. Relapse itself does not amount to a treatment failure, as many believe: "The chronic nature of the disease means that relapsing to drug abuse is not only possible, but likely. Relapse rates . . . for drug addiction are similar to those for other well-characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply imbedded behaviors, and relapse does not mean treatment failure." *Drugs, Brains, and Behavior: The Science of Addiction*, NATIONAL INSTITUTE ON DRUG ABUSE, http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery (last visited Jan. 8, 2014).
outcome of these cases. Perhaps then Colby and Stanford can be reconciled; after all, there was far more medical evidence presented suggesting Dr. Colby's high risk of relapse than there was for Robert Stanford. By no means then should every former addict continue to receive LTD benefits; not every case will have facts as extreme as those presented in Colby and Stanford, where the former opiate addicts were actually working with those opiates on a daily basis.

IV. CONCLUSION

The question of whether the risk of relapse can amount to a current disability is not an easy one; to be sure, there are strong policy arguments against providing benefits to current or former drug addicts. After all, there is some substance to the argument that addiction at least begins with a voluntary choice (and in many of these cases, a voluntary choice to illegally use drugs). A doctor who is unable to work because she is battling the unlawful abuse of opiates is not as innocent as a doctor who gets into a car crash and is physically incapable of performing surgeries. And it would seem that providing coverage for the risk of relapse could be easily manipulated. For instance, how would we measure who is at risk for relapse? Does every former addict have the same risk of relapse? If not, what is stopping recovering addicts from falsely telling their doctors that their desire to re-abuse drugs is stronger than it actually is?

While not completely without merit, these concerns overlook some of the facts. First, while the initial use of drugs is many times the product of a voluntary choice, numerous illnesses are influenced, if not caused, by voluntary choices as well. Thus, singling out addiction for unfavorable treatment seems driven more by moral opprobrium and false assumptions than it does medical science. Second, and this point bears emphasizing, the plans at issue in Colby and Stanford explicitly provided LTD benefits for drug addiction. In other words, the employers in those cases felt that substance abuse was no different than the myriad other forms of illnesses that were being covered under the plans. The “voluntary choice” argument about drug abuse is thus nonsensical; why would the plans have included benefits for such a

181. Colby, 705 F.3d at 63–64.
182. Stanford, 514 F.3d at 356. Similarly, in both James v. Kansas City Chiefs Football Club, 2005 WL 1532945, at *6–7 (where the plaintiff's doctor said that he could return) and Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1380 (N.D. Ga. 2001) (where the doctor said that the plaintiff had no limitation of functional capacity, was able to function under stress, and was expected to improve), the relatively small risk of relapse factored into the courts' denials of coverage for that risk.
183. As discussed supra Part III.C.1.
184. See Starr, supra note 166.
disease in the first place if it was truly brought on by purely voluntary means? Focusing an analysis on this "voluntary choice" argument is distracting; it frames the issue as whether or not the addiction itself is covered while obfuscating the real question: whether, given that the underlying addiction is covered under the plan, the risk of relapse into that addiction is similarly covered. Finally, regarding any concerns that a former addict could merely claim that he has a grave risk of relapsing, the easy solution to this would be to merely listen to the doctors' opinions. The decision to provide, or not provide, coverage for the risk of relapse of an addiction should turn on the severity of that risk, the severity of which is unarguably a medical determination.

Ultimately the Colby ruling is unlikely to impact how benefit plans are drafted in the future. Drug addiction is an illness and is recognized as such by medical professionals. Coverage for such addiction in the benefit plans in Colby and Stanford is therefore not surprising; instead, it reflects the growing recognition of substance abuse as a disease. In many cases, the risk of relapse is part of that disease. Several medical professionals averred that Dr. Colby suffered a high risk of relapse into her opiate addiction and thus was currently disabled and incapable of returning to her occupation as an anesthesiologist. Her insurance company's denial of benefits for such risk was rightly overturned by the First Circuit. Future cases should simply be driven by a medical professional's assessment of the employee's risk of relapse. In so doing, all other arguments regarding the lack of explicit coverage in the benefit plans for such risk or the voluntariness of drug abuse should be rendered moot; after all, if a doctor concludes that a risk is so severe that it constitutes a current disability, it will necessarily satisfy the requirements of the plan and will thus warrant coverage under it.

185. Plus, the "voluntary choice" argument in the addiction context is a misguided assumption about the nature of addiction, as discussed supra Part III.C.