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FUTURE HARM AS A CURRENT DISABILITY: INSURANCE COVERAGE FOR A RISK OF SUBSTANCE ABUSE RELAPSE UNDER ERISA

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ABSTRACT—Disability insurance policies generally provide benefits to workers who are unable to work because they become addicted to drugs or alcohol. But what happens when the addict stops the substance abuse? Addiction is considered to be a lifelong disease with no real cure. Many addicts fear that a return to the workplace will trigger a relapse into substance abuse, for example when an anesthesiologist returns to work after becoming addicted to an anesthetic drug. This Note examines whether the risk of relapsing into substance abuse can ever qualify as a disability under conventional own-occupation group disability policies, which are subject to ERISA. Although courts have readily held that risks of physical harm, such as a heart attack, can constitute a disability because they render a policyholder unable to work, courts have thus far split when it comes to a risk of relapse into substance abuse. This Note argues that a risk of relapse into substance abuse can sometimes constitute a disability because there is no meaningful legal distinction between that and a risk of physical injury. To determine when these risks of future harm constitute a current disability, courts and ERISA plan administrators should assess whether the risk faced by the policyholder would prevent a reasonable person without disability insurance—and thus no reason to falsely claim an inability to work—from returning to employment.

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INTRODUCTION

For sixteen years, Dr. Julie Colby was a successful anesthesiologist in Massachusetts and a partner in her medical practice.[1] But in July 2004, Colby was found unconscious in the hospital by a coworker.[2] This was the first sign that she had become addicted to Fentanyl, an extremely strong—approximately 100 times more potent than morphine[3]—and very addictive opioid that Colby administered as an anesthesiologist. She had been diverting Fentanyl from patients for her own use for quite some time.[4]

Colby left her job and enrolled in a substance abuse treatment facility in Georgia in August 2004.[5] There, Colby was diagnosed not only with Fentanyl dependence, but also with chronic depression, mild obsessive-compulsive disorder, and a degenerative disc disease that caused her severe back pain.[6] She remained in treatment at the facility in Georgia until November 2004 and remained under supervision on an outpatient basis

[1] Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan (*Colby II*), 705 F.3d 58, 60 (1st Cir. 2013).

[2] *Id.*

[3] DRUG & CHEM. EVALUATION SECTION, DRUG ENFORCEMENT ADMIN., FENTANYL (2013), *available at* http://www.deadiversion.usdoj.gov/drug_chem_info/fentanyl.pdf.

[4] *Colby II*, 705 F.3d at 60.

[5] *Id.*

[6] *Id.*

thereafter.[7] In 2005, her medical license was revoked.[8] Soon after that, Colby experienced a series of distressing life events, including the deaths of her mother and mother-in-law and the death of her abusive ex-husband from a heroin overdose. Unsurprisingly, these events only worsened her depression.[9] Nevertheless, all accounts suggest that Colby has not relapsed in her use of Fentanyl since her addiction was first revealed.[10]

Though Colby's addiction ended her ability to practice her profession, she was fortunate to have disability insurance. Like many Americans, Colby received disability coverage through her employer.[11] Her policy was own-occupation long-term disability insurance, which is quite common.[12] Basically, the policy required the insurance company to pay her benefits if an injury or illness prevented her from performing the material duties of her regular occupation as a physician.[13] After thirty-six months of paying benefits, the insurance company could cease payment under the terms of the contract unless Colby's injury or sickness prevented her from performing any "gainful occupation for which [her] education, training, and experience qualifie[d her]."[14]

Colby's insurance company agreed to pay benefits during Colby's stay in the treatment facility, as the policy's definition of disability clearly included addiction.[15] But when Colby left the treatment program, the insurer ceased payment of benefits.[16] Though she was no longer using Fentanyl, Colby argued that she was disabled under the terms of the policy because a return to work as a physician, specifically in her field of anesthesiology, would lead to a significant risk of relapse.[17] In short, she claimed that her history of addiction constituted a disability that prevented her from returning to an occupation where she would be surrounded by

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[7] *Id.*

[8] Brief of Appellant Union Security Insurance Co. at 5, *Colby II*, 705 F.3d 58 (1st Cir. 2013) (No. 11-2270), 2012 WL 605506, at *5.

[9] *Colby II*, 705 F.3d at 63 & n.8.

[10] *Id.* at 60.

[11] Michelle Andrews, *Employers Increasingly Trimming or Cutting Disability Benefits*, KAISER HEALTH NEWS (Sept. 20, 2011), http://www.kaiserhealthnews.org/features/insuring-your-health/michelle-andrews-on-disability-coverage.aspx.

[12] *See* 3 INSURANCE CLAIMS AND DISPUTES § 11:34 (6th ed. 2013).

[13] *Colby II*, 705 F.3d at 62. A second condition required Colby to "be under the *regular care and attendance* of a *doctor*." *Id.*

[14] *See* Colby v. Assurant Emp. Benefits, 818 F. Supp. 2d 365, 384 (D. Mass. 2011).

[15] *Colby II*, 705 F.3d at 60–62.

[16] *Id.* at 60.

[17] *Id.* at 62–63. Even if Colby wanted to return to practice, she would not have been allowed to because her license had been revoked. This is called a "legal disability," which is not covered under most disability insurance policies. *See* Colby v. Assurant Emp. Benefits, 603 F. Supp. 2d 223, 245 (D. Mass. 2009). The existence of a "legal disability, however, does not negate a health-related disability on which such legal detriment is based." Hannagan v. Piedmont Airlines, Inc., No. 3:07-CV-795 (FJS/DEP), 2010 WL 1235395, at *4 (N.D.N.Y. Mar. 31, 2010).

Fentanyl. The insurer disagreed, stating that a "risk for relapse is not the same as a current disability."[18]

After unsuccessfully pursuing administrative remedies, Colby filed suit in federal district court in Massachusetts, arguing that the denial of benefits was arbitrary and capricious.[19] Colby faced an uphill battle; most of the courts that had addressed the question of whether a risk of relapse into substance abuse could constitute a current disability had ruled that it could not,[20] including the only circuit court that had ruled on the matter at that point—the Fourth Circuit, in *Stanford v. Continental Casualty Co.*[21] Luckily for Colby, the First Circuit disagreed with those other courts, holding that her risk of relapse into substance abuse upon a return to work was so high that it constituted a current disability under her policy.[22]

In so ruling, the First Circuit created a circuit split significant not only to those that struggle with substance abuse but also to any person who is on the margin of qualifying for disability benefits. This Note will examine whether the risk of relapsing into substance abuse can ever qualify as a disability under a conventional own-occupation group disability policy and, if it can, what type of evidence should be required to show a current disability. Employers provide own-occupation group disability policies, so they are regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA).[23] Because these plans are regulated on a national scale, there must be a single national answer to this question.

Though this question is narrow, it requires a much broader analysis of what the term "disability" means in such a policy. The policies themselves define disability as an injury or sickness that leaves the insured unable to perform the material duties of her own occupation.[24] This definition leaves many questions unanswered, chief among them: when is a sick or injured person truly "unable to perform the material duties" of a job? Does the definition require physical inability—a broken arm that leaves a firefighter unable to carry a hose? Such a narrow definition would deny coverage to a worker who could physically perform the tasks of a job but would face a dire threat of a heart attack from performing them; it would also exclude the mentally ill. In contrast, an overly broad definition that provided coverage for anyone remotely afraid that his job could cause him injury

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[18] *Colby II*, 705 F.3d at 60.

[19] *See id.* at 60–61.

[20] *See, e.g.*, Forste v. Paul Revere Life & Accident Ins. Co., No. 1:02-CV-1584 RLY TAB, 2004 WL 3315386, at *12 (S.D. Ind. Sept. 22, 2004); Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1383–84 (N.D. Ga. 2001) (state law non-ERISA case); Laucks v. Provident Cos., No. 1CV971507, 1999 WL 33320463, at *4–6 (M.D. Pa. Oct. 29, 1999).

[21] 514 F.3d 354, 358–60 (4th Cir. 2008).

[22] *Colby II*, 705 F.3d at 66.

[23] Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5, 18, 26, 29, and 42 U.S.C.).

[24] *See, e.g.*, *Colby II*, 705 F.3d at 62.

could lead people to take advantage of the system by applying for benefits instead of working.

To date, courts have not established a coherent test to determine whether or not a particular risk of future injury constitutes a current disability. Although courts have readily found that a significant risk of future physical injury—such as a heart attack—may constitute a current disability,[25] most courts have refused to so characterize a risk of relapse into substance abuse. Yet, these same courts have done little to distinguish between the risks of future physical injury and substance abuse relapse.

This Note lays out a framework that courts—and ERISA plan administrators—can use to determine whether a risk of future injury constitutes a current disability. Courts should ask whether the risk faced would prevent a reasonable person without disability insurance from returning to work. Starting from the notion that some risks, such as a very high risk of a heart attack, clearly rise to the level of current disability, while others, such as the risk of contracting the common cold from a coworker, do not, this framework will draw a line between these two extremes of potential future injury. This test will focus on the quantitative likelihood that a relapse will occur upon a return to work, as well as the qualitative severity of the possible harm. Additionally, this Note analyzes the possibly perverse incentives facing someone with a risk of relapse into substance abuse, as well as concerns such as moral hazard, adverse selection, and the goals of disability insurance. Finally, this Note examines the most convincing distinction that has been made between physical relapse and relapse into substance abuse: that a person can relapse into substance abuse only if they "choose" to resume abuse.

Using this framework, this Note argues that the risk of relapsing into substance abuse can rise to the level of current disability because there is no meaningful legal distinction between it and a risk of physical injury. This Note focuses on a specific type of relapse risk in order to demonstrate the way in which the framework functions: the risk that an anesthesiologist will relapse into an opioid[26] addiction. This example is chosen both because such abuse is shockingly common[27] and because it has been the context of

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[25] *See, e.g.*, Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 383 (3d Cir. 2003).

[26] The term "opioid" is distinct from the more common "opiate." An opiate is a substance derived from the opium poppy plant, such as heroin, morphine, and codeine. The term opioid includes all opiates, as well as synthetic and semisynthetic substances that affect the brain in the same manner as opiates. Synthetic and semisynthetic opioids include fentanyl and oxycodone. *See* MICHAEL G. BISSEL & MICHAEL A. PEAT, *Opioids 1: Opiates*, *in* CLINICAL TOXICOLOGY TESTING: A GUIDE FOR LABORATORY PROFESSIONALS 140, 140 (Barbarajean Magnani et al. eds., 2012).

[27] Substance abuse has been called an "occupational hazard of being a physician, especially for anesthesiologists." TASK FORCE ON CHEM. DEPENDENCE, AM. SOC'Y OF ANESTHESIOLOGISTS, MODEL CURRICULUM ON DRUG ABUSE AND ADDICTION FOR RESIDENTS IN ANESTHESIOLOGY, *available at* http://www.asahq.org/For-Members/Quality-and-Regulatory-Affairs/Practice-Management-Publications/~/media/E64BA6191C474DD5946981FDF8DF501D.ashx. For example, in a 1987 study,

many cases dealing with the risk of relapse into substance abuse.[28] The statistical likelihood of such a relapse and the consequences of relapse are often so severe as to truly bar a person from performing the material duties of her occupation. Furthermore, there are no convincing policy reasons that the risk of relapse into substance abuse should be barred as a disability. Finally, the idea that a person can only relapse into substance abuse after a choice to do so is overly simplistic and should not be a bar to benefit payments.

This Note begins in Part I by reviewing the structure of insurance law, the language and typology of disability insurance policies, and the case law concerning risks of relapse for both physical illness and substance abuse. Part II develops a framework for analyzing whether a risk of future injury should constitute a current disability. In Part III, this framework is applied to risks of relapse into substance abuse, with a special focus on opioid addiction among anesthesiologists. This Note concludes that risk of substance abuse relapse can in some circumstances be considered a current disability for purposes of own-occupation group disability insurance plans.

I. DISABILITY INSURANCE LAW AND THE RISK OF RELAPSE

Insurance law in America is governed by a convoluted regulatory structure. Largely through historical accident,[29] insurance is primarily regulated by the states; though state insurance regulation is quite similar from state to state, the existence of fifty different regulatory regimes makes it difficult to generalize in the realm of insurance law.[30] Insurance provided through an employer, however, is also governed by ERISA, a federal statute that sometimes preempts state insurance laws.[31] This Note avoids disparities in state laws by focusing mainly on ERISA-covered disability policies. Thus, a single legal standard can apply. Another problem with

anesthesiologists made up 12% of physician admissions into drug treatment programs, though they constituted only 4% of physicians in the United States. E. Laura Wright et al., *Opioid Abuse Among Nurse Anesthetists and Anesthesiologists*, 80 AM. ASS'N NURSE ANESTHETISTS J. 120, 120 (2012). Opioids, especially Fentanyl and Sufentanil, are the "drug[s] of choice" for anesthesiologist addicts. Ethan O. Bryson & Jeffrey H. Silverstein, *Addiction and Substance Abuse in Anesthesiology*, 109 ANESTHESIOLOGY 905, 905 (2008). The possible reasons for this high rate of opioid abuse are discussed in Bryson & Silverstein, *supra*.

[28] *See, e.g.*, *Colby II*, 705 F.3d at 60; Stanford v. Cont'l Cas. Co., 514 F.3d 354, 355 (4th Cir. 2008); Hellman v. Union Cent. Life Ins. Co., 175 F. Supp. 2d 1044, 1045–46 (M.D. Tenn. 2001); Brosnan v. Provident Life and Accident Ins. Co., 31 F. Supp. 2d 460, 461 (E.D. Pa. 1998); Holzer v. MBL Life Assurance Corp., No. 97 Civ. 5834(TPG), 1999 WL 649004, at *1, *5 (S.D.N.Y. Aug. 25, 1999).

[29] David A. Skeel, Jr., *The Law and Finance of Bank and Insurance Insolvency Regulation*, 76 TEX. L. REV. 723, 731 n.27 (1998).

[30] Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 629 (1999).

[31] Donald T. Bogan, *ERISA: State Regulation of Insured Plans After* Davila, 38 J. MARSHALL L. REV. 693, 695–96 (2005).

generalizing in this realm is that insurance law is at its core based on contract interpretation, making the precise language of a policy vitally important. Thankfully, the policies involved in risk-of-relapse cases contain language that is functionally identical, allowing for generalization across many policies.[32]

A. The Basic Structure of Insurance Law and ERISA

Insurance in the United States is primarily regulated through the states, mostly because insurance was considered to be legally beyond the reach of congressional action for many years. In *Paul v. Virginia*, an 1869 case, the Supreme Court ruled that Congress could not regulate insurance via its Commerce Clause power because "[i]ssuing a policy of insurance is not a transaction of commerce."[33] This decision prompted the states to develop their own legal regimes for the regulation of insurance law.[34] However, in 1944 the Court reversed itself, coming to the logical conclusion in *United States v. South-Eastern Underwriters Ass'n* that insurance is indeed commerce.[35] Though this opened the door for Congress to displace the states in insurance regulation, Congress largely declined to exercise this option, mostly because insurance companies by this point favored state regulation.[36] Instead, Congress passed the McCarran–Ferguson Act in 1945, which mandated that insurance would be regulated by the states and that no act of Congress would be construed to preempt a state insurance law unless the federal statute specifically related to insurance.[37]

Although Congress has continued to allow states to be the primary regulators of most types of insurance, a huge change occurred in health and disability insurance regulation with the passage of ERISA in 1974. ERISA federalized the regulation of employee benefits, with the initial primary target being employee pension plans.[38] At the last minute, however, Congress expanded the law to include insurance benefits provided by employers.[39] This inclusion constituted a major shift in the insurance

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[32] *See infra* Part I.B.

[33] 75 U.S. (8 Wall.) 168, 183 (1869).

[34] *See* TOM BAKER, INSURANCE LAW AND POLICY 24 (2d ed. 2008).

[35] 322 U.S. 533, 553 (1944).

[36] *See* Alan M. Anderson, *Insurance and Antitrust Law: The McCarran–Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81, 85–86 (1983).

[37] 15 U.S.C. §§ 1011–1015 (2012).

[38] Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 105–06 & n.3 (2001).

[39] *See ERISA: A Quarter Century of Providing Workers Health Insurance: Hearing Before the Subcomm. on Emp't–Emp. Relations of the H. Comm. on Educ. and the Workforce*, 106th Cong. 13 (1999) (statement of Rand Rosenblatt, Professor of Law and Associate Dean of Academic Affairs, Rutgers University Law School) (arguing that ERISA's application to insurance was added as a last-minute change in the conference committee and passed without reasonable scrutiny by the democratic

industry, as most health[40] and disability insurance[41] in the United States for those under sixty-five is provided by employers.

The application of ERISA to insurance is quite complex and generally has created many problems for those employees whom ERISA was created to help. While ERISA in general must not "be construed to [preempt] any law of any State which regulates insurance,"[42] ERISA also declares, "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company."[43] In essence, this means that ERISA *does* preempt *all* state insurance laws when the employer creates a trust into which it deposits money to pay employee insurance claims.[44] Many employee benefit plans follow this route.[45]

For the purposes of this Note, this preemption has two profound effects on a group disability insurance claimant.[46] First, benefit denials are usually reviewed in federal rather than state court.[47] Second, benefit denials are often judged according to a deferential standard of review.[48] In *Firestone Tire & Rubber Co. v. Bruch*,[49] the Supreme Court ruled that judicial review of benefit denials under ERISA should use the abuse of discretion standard if "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[50] This is because ERISA imposes a fiduciary duty derived from trust law on administrators of all employee benefit plans,[51] and review of the decisions of trustees is governed by the abuse of

process, as the conference bill was passed without serious discussion of the significance of this addition).

[40] Elise Gould, *2010 Marks Another Year of Decline for Employer-Sponsored Health Insurance Coverage*, ECON. POL'Y INST. (Sept. 13, 2011), http://www.epi.org/publication/2010-marks-year-decline-employer-sponsored.

[41] Andrews, *supra* note 11.

[42] 29 U.S.C. § 1144(b)(2)(A) (2012).

[43] *Id.* § 1144(b)(2)(B).

[44] BAKER, *supra* note 34, at 131.

[45] *Id.* at 132.

[46] It also has one profound effect not explored herein: members of any employer-sponsored health or disability benefit plan, whether or not in trust form, are unable to collect punitive damages or tort damages for wrongful death or personal injury. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52–57 (1987); *see also* Aetna Health Inc. v. Davila, 542 U.S. 200, 214–15 (2004) (invalidating Texas law that sought to avoid this aspect of ERISA by providing a breach of contract remedy); Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 55–56 (D. Mass. 1997) (criticizing this aspect of ERISA).

[47] Sandra J. Weiland, *ERISA's Silence: Standards of Review in Deemed Denial Employment Benefit Claims*, 82 DENV. U. L. REV. 613–15 (2005).

[48] *See, e.g.*, *Colby II*, 705 F.3d 58, 61 (1st Cir. 2013). Benefit approvals, of course, are never challenged in court because the insurer itself is the party approving payment.

[49] 489 U.S. 101 (1989).

[50] *Id.* at 115.

[51] *Id.* at 110.

discretion standard.[52] In ERISA cases, this standard is equivalent to the familiar arbitrary and capricious standard.[53]

However, "trust law presupposes that the trustee . . . will be disinterested, in the sense of having no personal stake in the trust assets."[54] Yet, in most instances, the administrator of an ERISA insurance plan is an employee of the insurance company providing the benefits or is otherwise aligned with the employer.[55] The administrator therefore has a conflict of interest created by a clear incentive to deny benefits: "[E]very dollar saved by the administrator on behalf of his employer is a dollar in [the employer]'s pocket."[56] Not only is the person evaluating claims the same person that would have to pay approved benefits, but his decisions also receive significant deference from courts.[57] To counteract this conflict of interests, courts have adopted "a sliding scale according to which the plan administrator's decision must be more objectively reasonable and supported by more substantial evidence as the incentive for abuse of discretion is shown to increase."[58] ERISA claimants, however, still face a difficult battle in court, because "the existence of a conflict of interest is only one factor to be considered in reviewing a denial of benefits for abuse of discretion."[59]

Finally, insurance law is, at its core, contract law.[60] While ERISA slightly modifies this arrangement for employment-based insurance, contract law still provides the general guidelines for insurance policy interpretation.[61] One key doctrine of contract law that courts typically apply to insurance contracts is *contra proferentem* ("against the drafter"), under which a court will "interpret ambiguous insurance policies in favor of policyholders."[62]

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[52] RESTATEMENT (SECOND) OF TRUSTS § 187 (1959).

[53] *Colby II*, 705 F.3d at 61.

[54] John H. Langbein, Essay, *Trust Law as Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1326 (2007).

[55] *Id.* at 1326–27.

[56] Bruch v. Firestone Tire & Rubber Co., 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part*, 489 U.S. 101 (1989).

[57] For a thorough criticism of this arrangement, see Langbein, *supra* note 54, at 1327.

[58] Stanford v. Cont'l Cas. Co., 514 F.3d 354, 357 (4th Cir. 2008); *see, e.g.*, Fought v. UNUM Life Ins. Co. of Am., 379 F.3d 997, 1004 (10th Cir. 2004) (per curium) (discussing the sliding scale approach).

[59] *Stanford*, 514 F.3d at 357.

[60] BAKER, *supra* note 34, at 29.

[61] *Id.* at 30.

[62] *Id.*; *see also* Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599, 601–03 (2d. Cir. 1947) (Hand, J.) (applying the doctrine of *contra proferentem*).

B. Disability Insurance Policies

The main goal of disability insurance is to protect the income of the insured in the event that physical or mental illness interferes with the insured's ability to work.[63] Another goal of disability insurance is the rehabilitation of disabled claimants.[64] Despite the importance of these goals, and the fact that people are quite likely to become disabled in their lifetime,[65] "[d]isability insurance tends to be one of the more overlooked forms of insurance," with just under half of young American workers covered by short-term disability insurance (coverage for less than two years), and even fewer with long-term disability insurance.[66]

The main reasons for disability insurance's relative unpopularity are the twin concerns of moral hazard and adverse selection, which make the price of an individual disability insurance policy quite high.[67] Insurance companies are willing to sell policies only at high prices because of the concern that insured people will act in a way likely to lead to injury or will fake an injury (moral hazard), or that only people who know they face a high risk of injury will purchase disability insurance (adverse selection). Another reason for low enrollment is that most Americans are entitled to public disability benefits through Social Security, leading people to discount the value of individual coverage.[68] However, Social Security provides benefits only to those who have an "inability to engage in any substantial gainful activity."[69] Because most disabilities are not covered by this strict definition, most workers who sustain an injury that prevents them from continuing in their job will suffer a substantial income loss unless they have personal coverage.[70]

The majority of disability insurance coverage is for "total disability."[71] Such coverage provides benefits when an illness or injury makes the

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[63] Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 81 (1993).

[64] *See Stanford*, 514 F.3d at 362 (Wilkinson, J., dissenting); David M. Richards, *Understanding Today's Disability Insurance Contracts*, COLO. LAW., Mar. 2011, at 69, 71.

[65] *Policy Basics: Top Ten Facts About Social Security*, CENTER ON BUDGET & POL'Y PRIORITIES (Nov. 6, 2012), http://www.cbpp.org/cms/index.cfm?fa=view&id=3261 ("Of recent entrants to the labor force, almost four in ten men (37 percent) and three in ten women (31 percent) will become disabled or die before reaching the full retirement age.").

[66] Kimberly Palmer, *Why You Probably Need More Disability Insurance*, U.S. NEWS (Oct. 9, 2013), http://money.usnews.com/money/personal-finance/articles/2013/10/09/why-you-probably-need-more-disability-insurance.

[67] BAKER, *supra* note 34, at 177.

[68] *Social Security Basic Facts*, SOC. SECURITY ADMIN. (July 26, 2013), http://www.ssa.gov/pressoffice/basicfact.htm (noting that approximately 91% of workers between twenty-one and sixty-four years old that are in employment covered by Social Security are eligible for benefits if long-term disability occurs).

[69] 42 U.S.C. § 416(i)(1) (2006).

[70] *See* Abraham & Liebman, *supra* note 63, at 84.

[71] *Id.* at 81.

policyholder unable to perform the major duties of either her own occupation or any reasonable alternative occupation, depending on the type of policy purchased.[72] Some disability insurance plans also cover "partial disability," which provides benefits if the insured is unable to perform one or more of the essential tasks of his or her (or any) occupation.[73] Disability plans can also be differentiated between individual plans and group plans—those provided through an employer.

Roughly speaking, there are three different types of private total disability insurance policies. First, and most common, is "own-occupation"[74] coverage, which provides benefits if the insured is unable to perform the material duties of her specific occupation due to illness or injury.[75] The second type is "general disability" coverage, which pays benefits only if injury or illness leaves the insured unable to perform the material duties of *any* occupation.[76] Some general disability policies are more lenient, requiring an inability to work in any occupation for "which [the insured's] education, training, and experience qualifies [the insured]."[77] The third type is a "hybrid" policy, in which a period of own-occupation coverage is followed by a longer period of general disability coverage.[78]

Own-occupation coverage is the most expensive of the three because it is the broadest; any injury that causes inability to perform the insured's own work will constitute a disability, even if the insured is able to do countless other jobs. Additionally, it is very prone to moral hazard because claimants have no incentive to return to the workforce in an otherwise equal or lesser paying occupation. That is the reason for hybrid policies.

This Note is primarily concerned with group total own-occupation disability policies for several reasons. First, group policies are covered by ERISA,[79] making it easier to compare cases and develop a legal standard. Group policies are also much more common than individual ones.[80]

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[72] *See* 10A COUCH ON INSURANCE § 147:2 (3d ed. 2012).

[73] *Id.* § 147:7; *see also* AM. COUNCIL ON LIFE INSURERS, DISABILITY INCOME INSURANCE: FINANCIAL PROTECTION FOR YOU AND YOUR FAMILY 4 (2007). Partial disability coverage is rare and quite expensive due to the significant moral hazard implications of allowing an insured to continue working, yet also apply for benefits based on a supposed inability to perform certain work-related tasks. *See* Abraham & Liebman, *supra* note 63, at 110–11.

[74] *See, e.g.*, 17 FLORIDA INSURANCE LAW AND PRACTICE § 38:4 (2013–2014 ed. 2013).

[75] COUCH ON INSURANCE, *supra* note 72, § 147:107.

[76] *See id.* § 147:40.

[77] Colby v. Assurant Emp. Benefits, 818 F. Supp. 2d 365, 384 (D. Mass. 2011).

[78] COUCH ON INSURANCE, *supra* note 72, § 147:107.

[79] *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 43, 57 (1987).

[80] *See* David J. Christianson, *Disability Income Insurance: The Private Market and the Impact of Genetic Testing*, 35 J.L. MED. & ETHICS 40, 41–42 (Supp. 2007). Group policies are less expensive because they alleviate adverse selection problems. *See* Karl Kronebusch, *Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making*, 22 J. HEALTH POL. POL'Y & L. 839, 856 (1997). Similar to an insurance mandate, group insurance that covers all workers broadens the risk pool by

Second, total disability coverage is more common than partial disability insurance,[81] is implicated in more of the case law considered herein, and is a much more clear-cut issue in terms of coverage: the insured is either entitled to benefits or is not—there is no added difficulty of determining the amount of benefits to which the insured is entitled. Finally, only own-occupation policies are considered because former addicts will almost always be able to perform the material duties of *some* occupation, even if a risk of relapse does not allow them to return to their former occupation.[82]

Though the definition of "disability" in insurance policies can differ in many ways, the substance of coverage is materially the same among almost all group total own-occupation disability policies. Disagreements in the case law regarding the risk of relapse do not seem to stem from differences in policy language but rather from more fundamental notions of what this type of policy is meant to cover. Thus, it is possible for the purposes of this Note to generalize across the policies at issue in the case law and define a "disability" as "injury or sickness caus[ing] physical or mental impairment to such a degree of severity that [the insured is] . . . continuously unable to perform the material and substantial duties of [the insured's] regular occupation."[83] Basically, this definition requires the insurer to pay benefits when the insured is unable to return to work because of injury or sickness.

C. Judicial Decisions Regarding the Risk of Relapse

Courts have a mixed record when considering cases in which there is a risk of physical or mental illness associated with return to work. When analyzing these cases it is important to remember the more lenient standard of review that applies to benefit denials made by ERISA plan administrators.[84] In most ERISA cases, the reviewing court may overturn a benefit denial only if it is deemed to be arbitrary and capricious, meaning that there was no reasonable basis for the decision.

It is settled law that the risk of relapse of a physical disease can constitute a disability.[85] The leading case for this proposition, which the *Stanford*[86] and *Colby*[87] courts both cited approvingly, is the Third Circuit

including those with both a high and low risk of loss purchase insurance. *See* Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733, 1770–74 (2011).

[81] *See* Abraham & Liebman, *supra* note 63.

[82] *See Colby II*, 705 F.3d 58, 62–63 (1st Cir. 2013).

[83] Stanford v. Cont'l Cas. Co., 514 F.3d 354, 358 (4th Cir. 2008) (some alterations in original).

[84] *See supra* note 48 and accompanying text.

[85] *See* 31 JOHN ALAN APPLEMAN, APPLEMAN ON INSURANCE § 187.05[A], at 214 (2d ed. 2007) ("The insured is considered to be permanently and totally disabled when it is impossible to work without hazarding his or her health or risking his or her life.").

[86] 514 F.3d at 358.

[87] 705 F.3d. at 66.

case *Lasser v. Reliance Standard Life Insurance Co.*[88] The plaintiff in *Lasser* was a surgeon with an ERISA-regulated, own-occupation disability group policy which not only covered complete inability to work but also provided benefits if a disability allowed the policyholder to perform only some of the material duties of his occupation.[89] After suffering a heart attack, the plaintiff followed his doctor's orders to decrease his stress level by reducing his patient load by half, and ceasing to perform emergency surgery and being "on-call" at night and on weekends.[90] Though the insurer initially provided disability benefits, it then terminated his benefits on the ground that he was not disabled.[91]

The Third Circuit held that the benefit denial was arbitrary and capricious.[92] The majority quickly dispensed with the idea that the risk of future injury is insufficient to constitute a current disability, stating, "[W]hether risk of future effects creates a present disability depends on the probability of the future risk's occurrence."[93] The dissent conceded the possibility that a risk of relapse could be a current disability, but argued that a policyholder should have to quantify this risk in order to be granted benefits.[94] The majority disagreed, stating that it would be too difficult for a plaintiff to provide evidence of statistical risk. Thus, the majority accepted numerous doctors' qualitative reports stating that the plaintiff's risk of future injury was high—claims not convincingly refuted by the insurer—as sufficient and awarded the plaintiff benefits.[95] Other courts have similarly held that a risk of a heart attack can constitute a current disability.[96]

While risk of relapse of a physical disease is accepted as a disability, courts differ sharply on whether risk of relapse into substance abuse can be a disability. Although only two circuits have considered the issue, many federal district courts have analyzed these claims. About half of these courts held that risk of substance abuse relapse can never constitute a current disability.[97] The other half held that risk of relapse can constitute a

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[88] 344 F.3d 381 (3d Cir. 2003).

[89] *Id.* at 383–84.

[90] *Id.* at 383.

[91] *Id.* at 384.

[92] *Id.* at 383.

[93] *Id.* at 391 n.12.

[94] *Id.* at 397 (Garth, J., dissenting).

[95] *Id.* at 391 (majority opinion).

[96] *See, e.g.*, Kent v. Provident Life & Cas. Ins. Co., 146 F. App'x 862, 864 (9th Cir. 2005); Napoli v. First UNUM Life Ins. Co., 78 F. App'x 787, 789 (2d Cir. 2003); Saliamonas v. CNA, Inc., 127 F. Supp. 2d 997, 1001 (N.D. Ill. 2001); Buffaloe v. Reliance Standard Life Ins. Co., No. 5:99-CV-710-BR(3), 2000 WL 33951195, at *7 (E.D.N.C. Nov. 8, 2000).

[97] *See, e.g.*, Forste v. Paul Revere Life & Accident Ins. Co., No. 1:02-CV-1584 RLY TAB, 2004 WL 3315386, at *12 (S.D. Ind. Sept. 22, 2004); Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377, 1383–84 (N.D. Ga. 2001) (state law non-ERISA case); Laucks v. Provident Cos., No. 1CV971507, 1999 WL 33320463, at *4–6 (M.D. Pa. Oct. 29, 1999).

present disability, though one of these courts held that the plaintiff at bar had not shown sufficient evidence that he was in fact likely to relapse to survive a motion for judgment on the administrative record.[98] The others found either that there was a triable issue of fact as to whether the risk was high enough,[99] that the denial was arbitrary and capricious in light of the evidence,[100] or, under de novo review, that the policy covered risk of relapse.[101]

A circuit court took up this issue for the first time in *Stanford v. Continental Casualty Co.*[102] The plaintiff, a nurse anesthetist, became addicted to Fentanyl.[103] After successfully completing an addiction treatment program, he quickly relapsed.[104] The plaintiff returned to his job the following year after completing another addiction treatment program but again relapsed when he began taking Fentanyl at work.[105] Yet again, he completed an addiction rehabilitation program and this time did not relapse. His insurer, which had paid him benefits during treatment, terminated those benefits in January 2005 after he had completed his treatment program, after being informed by a registered nurse consultant that the plaintiff "no longer suffered any impairment that would prevent him from performing the duties of his occupation."[106] The plaintiff sought administrative review of the denial, claiming that he remained at risk for a relapse if he returned to work. The insurer denied his appeal, stating that, "the policy does not cover potential risk."[107]

The Fourth Circuit agreed with the insurance company's claim that a risk of relapse into addiction could never constitute a present disability.[108]

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[98] *See* Price v. Disability RMS, No. 06-10251-GAO, 2008 WL 763255, at *21–22 (D. Mass. Mar. 21, 2008). "A motion for a judgment on the record in an ERISA case, although similar to an ordinary summary judgment motion, differs in that the non-moving party is not entitled to the usual inferences in its favor." *Id.* at *1 (quoting Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 517 (1st Cir. 2005)) (internal quotation marks omitted).

[99] *See, e.g.*, Hamilton v. Prudential Ins. Co. of Am., No. 2:07-cv-00944-MCE-DAD, 2010 WL 315025, at *3 (E.D. Cal. Jan. 19, 2010); Hellman v. Union Cent. Life Ins. Co., 175 F. Supp. 2d 1044, 1049–50 (M.D. Tenn. 2001); Holzer v. MBL Life Assurance Corp., No. 97 Civ. 5834(TPG), 1999 WL 649004, at *6 (S.D.N.Y. Aug. 25, 1999); Brosnan v. Provident Life and Accident Ins. Co., 31 F. Supp. 2d 460, 464–65 (E.D. Pa. 1998); *see also* Berry v. Paul Revere Life Ins. Co., 21 So. 3d 385, 395–96 (La. Ct. App. 2009) (holding under state law that whether risk of relapse into substance abuse constituted a current disability is a genuine issue of material fact).

[100] *See, e.g.*, Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F. Supp. 2d 785, 797 (W.D. Mich. 2009).

[101] Royal Maccabees Life Ins. Co. v. Parker, No. 98 C 50422, 2001 WL 1110489, at *4, *7 (N.D. Ill. Sept. 20, 2001).

[102] 514 F.3d 354 (4th Cir. 2008).

[103] *Id.* at 355.

[104] *Id.* at 356.

[105] *Id.*

[106] *Id.*

[107] *Id.*

[108] *Id.* at 358, 360.

The court held that the plaintiff was "not physically disabled or mentally impaired . . . [and] is physically and mentally capable of performing [the] job [of a nurse anesthetist]."[109] The court's analysis focused on differentiating this type of risk from the risk of future physical illness:

> [T]he 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 anesthetist 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.[110]

Though asserting that it "[did] not mean to suggest that it is easy to overcome an addict's temptation," the court found that "the availability of this choice . . . distinguishes" these types of risks of relapse from completely choiceless relapses like heart attacks.[111]

The court further stated that the split among lower court decisions regarding the risk of relapse into addiction was proof that reasonable minds can disagree over whether this risk constitutes a current disability. Therefore, the insurer's conclusion could not be considered unreasonable.[112] Finally, the court addressed the contention that its decision created a perverse incentive structure in which an addict who continues to abuse drugs would continue to receive benefits but would lose those benefits upon becoming sober. The court dismissed this argument because it "operates on a false assumption, namely that disability benefits are a sort of reward for sobriety. In fact, sobriety's reward is the creation of innumerable opportunities that were closed to [the plaintiff] as long as he continued to use drugs," even if these new opportunities do not include returning to his previous job.[113]

Judge Wilkinson wrote a vigorous dissenting opinion. He argued that coverage for risk of relapse was plainly called for under the terms of the policy and that the majority had created an unwritten exception to the coverage. Interpreting the contractual language, "[a]ll agree that [the plaintiff] cannot presently return to work in safety, and if we ask why not, the answer must be some *existing*, not future, impairment."[114] Wilkinson pointed out that "potential risk," which the insurer claimed the policy did not cover, is redundant: "'potential risk' is just risk."[115] The insurer may

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[109] *Id.* at 359.
[110] *Id.* at 358.
[111] *Id.* at 358 n.4.
[112] *Id.* at 359.
[113] *Id.*
[114] *Id.* at 362 (Wilkinson, J., dissenting).
[115] *Id.* at 361.

have meant that the policy does not cover risks of relapse, but such an interpretation would not allow coverage for an increased risk of a heart attack. Because that type of risk is undisputedly covered by the policy, so must a risk of relapse into addiction, as mental and physical disorders are treated equally under the plan.[116] The dissent also noted the perverse incentive inherent to the majority's holding, arguing that requiring the claimant "to relapse into addiction or lose his benefits would also thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise to cope with it."[117] Finally, Wilkinson took issue with the majority's contention that the presence of a choice differentiated risks of physical and addictive relapse, arguing that this was "legally ungrounded" and "appears to rest on moral considerations of choice and temptation on the one hand, and medical considerations of physical inability on the other, neither of which are to be found in the language of a Plan that puts addiction squarely on all fours with other impairments."[118]

The only other circuit court to address this question was the First Circuit in *Colby v. Union Security Insurance Co. & Management Co. for Merrimack Anesthesia Associates Long Term Disability Plan*.[119] The First Circuit overturned Union Security's denial of benefits to Dr. Colby as arbitrary and capricious, explicitly agreeing with Judge Wilkinson's reasoning.[120] Not only did the First Circuit rule that the risk of relapse into addiction *could* constitute a current disability, it also held that the overwhelming evidence in this instance could not support a denial of benefits.[121] The court found, "[G]iven the language of the plan, categorically excluding risk of relapse as a source of disability is simply unreasonable."[122] Given her history of abuse and physician testimony that she was likely to relapse upon a return to anesthesiology, Colby was clearly unable to perform the duties of her occupation, and there was no exclusion in the policy that exempted such a disability from coverage.[123] Moreover, the majority stated, there is no way to create a principled distinction between a risk of physical relapse and a risk of relapse into addiction. In either circumstance, the insured may be physically able to perform the

[116] *Id.* at 363.

[117] *Id.* at 362.

[118] *Id.* at 363.

[119] *Colby II*, 705 F.3d 58 (1st Cir. 2013).

[120] *Id.* at 66–67. For the factual background of this case, see *supra* Part I.

[121] *Id.* at 65–66, 68. The district court had previously remanded this case to the insurance administrator, ordering it to consider the factual basis of Colby's claim. Union Security then hardened its position, maintaining that risk of relapse could never constitute a disability. *Id.* at 61. Without this prior history of remand, it is likely that the circuit court would have simply remanded the case to the administrator instead of ruling itself that the denial was arbitrary and capricious. *See id.* at 68.

[122] *Id.* at 65.

[123] *Id.*

functions of his or her occupation; nevertheless the "risk of relapse is prohibitively impairing and thus becomes, for all practical purposes, a current disability."[124] The court did not discuss the possible distinction caused by one's "choice" to relapse into addiction.

II. RISK OF FUTURE INJURY AS A CURRENT DISABILITY

Currently, the courts lack a coherent way of analyzing whether a risk of future injury from employment constitutes a current disability. This leads to outcomes that are inconsistent across courts and also to arbitrary and illogical line drawing between different factual circumstances. In part, this is caused by the contractual nature of disability insurance as well as the deference given to ERISA plan administrators.[125] Courts are understandably reluctant to define the meaning of terms or phrases across all contractual agreements because context is key in deciding the meaning that parties wish to attach to specific language. Furthermore, the deferential nature of ERISA review requires judges to uphold reasonable interpretations of policy language.

Yet there are several good reasons for courts to develop a more coherent way of analyzing these types of claims. Although courts generally do not define specific words across contracts, they sometimes develop doctrines giving certain phrases a specified legal effect, and as a general rule try to construe contracts that are similar in the same way.[126] In the disability insurance context, the definition of disability is substantially identical across almost every policy.[127] This fact, combined with the large number of these cases that courts review, makes the development of a framework of analysis a feasible and necessary task in order to avoid inequitable inconsistency. Moreover, deference to administrative decisions does not require courts to completely relinquish any role in determining what should be covered under a given insurance policy. The framework developed here is not intended to help judges determine whether a benefit denial was correct; rather, it will guide judges in their proper role of analyzing whether an administrator's decision was reasonable.

A. Should a Risk of Future Injury Ever Be a Current Disability?

As with any question of insurance coverage, analysis must begin with the policy language. In an occupational disability policy, the insured is considered disabled if an injury or illness prevents her from performing the

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[124] *Id.* at 66.

[125] *See supra* note 50 and accompanying text.

[126] *See, e.g.*, Jacobsen v. Katzer, 535 F.3d 1373, 1381 (Fed. Cir. 2008) ("Under California contract law, the phrase 'provided that' typically denotes a condition.").

[127] *See supra* note 83 and accompanying text.

material duties of her occupation.[128] Thus, a risk of future injury is a disability only if the risk functionally prevents the insured from working.

Insurance policies are structured to provide benefits only if a certain *event* happens.[129] But it is clear that insurers do not provide benefits simply because there is a risk that something will happen. Insurance companies have used this latter point as an argument against providing benefits for risk of relapse, stating that their policies do not cover "potential risk."[130] In his *Stanford* dissent, Judge Wilkinson pointed out that this phrase is redundant.[131] Although he is literally correct, he is conceptually mistaken. Insurance is all about risk. A policy pays out if a specified event happens; the risk is simply the probability that this event happens.[132] Insurance companies are correct to point out that they do not have to pay for a "potential risk" and do not have to pay even if the likelihood of an event rises substantially. However, this does not necessarily foreclose coverage for risk of future injury under a disability policy, because an increase in the likelihood of future injury *can itself* constitute an event—a disability—that prevents the policyholder from returning to work. The difficulty comes in distinguishing an increase in risk that simply makes a future disability more likely from one that is in and of itself a disability.

A framework for analyzing this question must start with the somewhat controversial assumption that a risk of future injury can *ever* constitute a current disability. Insurers have argued that it cannot because this risk does not prevent someone from physically performing the duties of her occupation, but courts that have considered the question have correctly rejected such a narrow conception of disability.[133]

The primary support for this assumption is the fact that multiple courts have explicitly held that risk of future injury can constitute a current disability, usually in the context of a risk of heart attack.[134] These courts seem intuitively correct—few would argue that someone is able to perform the material duties of her profession if a return to work would entail a large chance of death. It is blackletter law that disability coverage applies where a person is able to perform the physical tasks of a job, but doing so would put them at unacceptable risk because of their physical condition.[135]

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[128] *See supra* note 75 and accompanying text.

[129] *See* BAKER, *supra* note 34, at 2.

[130] *See, e.g.*, Stanford v. Cont'l Cas. Co., 514 F.3d 354, 356 (4th Cir. 2008).

[131] *Id.* at 361 (Wilkinson, J., dissenting).

[132] *See* BAKER, *supra* note 34, at 2.

[133] *See supra* notes 85–88.

[134] *See supra* notes 85–96 and accompanying text.

[135] *See* 31 JOHN ALAN APPLEMAN, *supra* note 85; Lasser v. Reliance Standard Life Ins. Co., 146 F. Supp. 2d 619, 628 (D.N.J. 2001), *aff'd*, 344 F.3d 381 (3d Cir. 2003).

Because mental illness is covered under disability policies just as much as physical illness,[136] a risk of relapse should be similarly covered.

Coverage for risk of future injury is also supported by the fact that a risk of future harm is often accepted as a form of current injury in another area of the law—tort law. Three tort causes of action all use the idea of "probabilistic injuries" as a basis for recovery.[137] "Loss of chance" is a cause of action that allows recovery for medical malpractice that affects a patient's likelihood of survival.[138] "Increased risk of disease" is a tort that allows recovery for exposure to toxic substances that causes an increased risk of future disease—even if no symptoms are currently present and injury is not certain.[139] A similar cause of action exists for fear of future disease from exposure to toxic substances.[140] Although a majority of courts require the risk of future injury to rise above 50% before it is compensable, some have allowed for partial recovery where the risk is still below 50%.[141] These causes of action and courts' treatment of them show that courts are willing to accept future risks as current injuries in the context of tort law.

B. Reasonable Non-insured Person Test

Although some risks of future injury can constitute a current disability, most cannot. Everyone is at some risk for every kind of disability. Just by going into work every day, people expose themselves to the possibility of countless injuries: car crashes during the commute, exposure to communicable diseases from coworkers, and physical injuries inherent to job duties. Yet few people would argue that these risks, which could be avoided by staying at home in bed, constitute a disability; they do not prevent a person from performing the duties of her occupation. These risks are the reason that people purchase disability insurance, not the basis for benefits. On the other hand, most people would concede that a person truly is unable to perform the duties of his occupation if his risk of a severe heart

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[136] *See* Abraham & Liebman, *supra* note 63; *see also, e.g.*, Colby v. Assurant Emp. Benefits, 603 F. Supp. 2d 223, 245 (D. Mass. 2009). ("[T]he explicit terms of Dr. Colby's Plan do not distinguish between physical and mental disabilities. In other words, an individual who becomes disabled because of a mental illness is equally entitled to benefits as an individual who becomes disabled as a result of a physical illness.").

[137] Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 154–55 (1992).

[138] *Id.* at 155.

[139] *Id.* at 156–57.

[140] *Id.* at 154, 157.

[141] *See generally* Judith M. Dworkin & Janet E. Kornblatt, *Plaintiffs' Expanding Concepts of Compensation and the Courts' Responses*, 30 GONZ. L. REV. 487, 504 (1994) (surveying a liberalizing trend of reduced burdens on tort plaintiffs in establishing liability, causation, and damages). The 50% requirement stems from civil litigation's requirement that causation be proved by a preponderance of the evidence, or in other words that there is more than a 50% chance that the defendant's negligent conduct will result in future injury in the plaintiff. *See* Shelly Brinker, Comment, *Opening the Door to the Indeterminate Plaintiff: An Analysis of the Causation Barriers Facing Environmental Toxic Tort Plaintiffs*, 46 UCLA L. REV. 1289, 1304 (1999).

attack would rise from 40% to 90% upon returning to work after recovering from a first heart attack.

The best way to understand the difference between these situations is that in the case of minor job-associated risks, a reasonable person would, absent the availability of disability payments, decide to continue working. In contrast, a reasonable person would not continue working if the work would likely lead to a heart attack, even if the person had no disability insurance. This inquiry into reasonableness is what insurers, as well as reviewing judges, should use to determine whether a risk of future injury constitutes a current disability.

There are three main reasons that insurers and courts should use this reasonable insured test. First, it is the best way to faithfully implement the language in disability policies. Assessing coverage under these policies requires a determination of whether the claimant is able to perform the material duties of her occupation. How better to answer this question than by inquiring whether a reasonable person could perform those duties? A subjective test would be unworkable because it is impossible to know what the claimant would choose to do without the availability of benefits. A subjective test would unfairly punish or reward individuals with higher and lower risk tolerances, respectively, even though they signed the same standard contract as everyone else. Moreover, only a reasonable person test would allow coverage decisions to apply generally. In interpreting contracts, courts generally look to the reasonable meaning of terms. When more than one reasonable interpretation is possible, insurance law abides by the doctrine of *contra proferentem*, meaning that the reasonable interpretation of the insured will be accepted.[142] Using a test other than the reasonable person test would allow insurers to defeat the reasonable expectations of insureds.

Second, this test maintains the goals of disability insurance while avoiding the perverse incentives that insurance coverage can sometimes create. Disability insurance is meant to supply income to people when they are unable to work without giving them an incentive not to work—that is, minimizing moral hazard. In the disability context, the main source of moral hazard is obvious: insureds have an incentive to stop working if they can convince the insurer that they are disabled.

Thus, it is important that the definition of disability in a policy is broad enough to cover situations in which people have a legitimate inability to work, while simultaneously minimizing opportunities for people to fake disability. It is for this reason that the reasonable person test considers the actions of a reasonable person *without* disability insurance. By considering this question, it is possible to determine if a reasonable person would be

[142] *See supra* note 62 and accompanying text.

unable to work without the inquiry being tainted by the perverse incentives caused by the availability of insurance benefits.[143]

Third, the reasonable person standard is widely used in tort and criminal law, making the test relatively easy to apply. Though determining the actions of a reasonable person is far from straightforward, courts should be comfortable with the standard. The main inherent problem of a reasonable person standard is inconsistency of application.[144] Although it is true that administrators and courts may sometimes disagree about what a reasonable person would do in a given situation, this test provides the best possible framework in an area of law that currently has no guiding principle and in which a more precise standard is unworkable.

C. Qualitative–Quantitative Analysis of Future Risk

The next question is the way in which a judge or administrator should determine whether or not a reasonable person would decide to work in the absence of disability coverage. The crucial factor to analyze in considering whether a risk of relapse can be a current disability is the gravity of the risk—how likely is it that a former addict will actually relapse after returning to work, and what are the consequences of a relapse? If a person is unlikely to relapse and the health effects of a relapse are minor, it is safe to say that a reasonable person would not forgo a return to work absent the receipt of benefits. In such a case, the insured should not be considered disabled, because it can be inferred that the person is actually able to perform the material duties of her occupation. If the insured is claiming benefits, it is likely that the availability of disability benefits, not a fear of relapse, is preventing the insured from returning to work.

Conversely, when the risk of relapse is high and the possible health effects of relapse severe, it can be convincingly argued that the risk constitutes a current disability because it effectively prevents any reasonable person from performing the material duties of his profession. Courts use this type of reasoning to hold that a heightened risk of a heart attack can constitute a current disability.[145] Heart attacks can cause severe health effects and may lead to death.[146] Thus, one may assume that a person

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[143] A decision to return to work caused by financial hardship does not necessarily mean that a person is not disabled. Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 392 (3d Cir. 2003). "A desperate person might force himself to work despite an illness that everyone agreed was totally disabling." Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 918 (7th Cir. 2003).

[144] *See, e.g.*, Thomas K. Clancy, *The Supreme Court's Search for a Definition of a Seizure: What Is a "Seizure" of a Person Within the Meaning of the Fourth Amendment*, 27 AM. CRIM. L. REV. 619, 642–45 (1990).

[145] *See supra* notes 85–96 and accompanying text.

[146] Approximately 4.7% of heart attacks are fatal. *Heart Attack Victims Get Treated Faster, but Death Rate Stays the Same*, CBS NEWS (Sept. 5, 2013, 6:25 PM), http://www.cbsnews.com/news/heart-attack-victims-get-treated-faster-but-death-rate-stays-the-same/.

who faces a high risk of heart attack from a return to work would choose not to return to work because of the health risks, regardless of the availability of disability benefits.

This type of inquiry into the gravity of the risk of relapse is therefore both qualitative and quantitative, including both the harm and the likelihood of relapse. Thus far, however, courts considering coverage for a risk of relapse have generally not considered this type of specific evidence. Instead, they have focused on vague physician statements such as the claim the insured "could not [return to his work as an orthopedic surgeon full-time] without exposing himself to a high degree of risk,"[147] or "is at high risk of relapse should she return to the practice of anesthesia,"[148] and an assumption that a relapse into addiction or a heart attack would be harmful. No court has considered quantitative evidence of the risk of relapse, which can vary significantly among different types of addictions.[149] The court in *Lasser*, over a dissent, specifically found that requiring this type of evidence would raise the bar too high for the claimant.[150] Instead, the claimant could merely provide physicians' reports "suggest[ing] that the risk is high,"[151] ignoring the dissent's convincing argument that "stress, while it may affect cardiac patients, does not necessarily incapacitate them, or prevent them from successfully returning to, and performing, stressful jobs, i.e., Vice President Dick Cheney."[152] As the dissent correctly argues, only if the claimant "quantif[ies] that risk [can] the ERISA decision maker . . . determine if it constitutes a present disability."[153] Courts have also failed to examine how harmful a relapse would actually be. While a second heart attack could obviously be extremely harmful, the consequences of other relapses are less clear. The negative effects of a second paper cut or bout of the common cold are miniscule; even among addictions, there are likely to be widely diverse consequences between a relapse into different substances.

There are two important caveats to the qualitative–quantitative analysis. First, the relevant measure is not the *absolute* risk of relapse after returning to work. Rather, it is the relative difference in risks between a

147 *Lasser*, 344 F.3d at 390.

148 *Colby II*, 705 F.3d 58, 64 (1st Cir. 2013).

149 For example, approximately 90% of smokers who attempted to quit in one study eventually relapsed, with almost 80% resuming smoking within four months. Xiaolei Zhou et al., *Attempts to Quit Smoking and Relapse: Factors Associated with Success or Failure from the ATTEMPT Cohort Study*, 34 ADDICTIVE BEHAV. 365, 371 (2009). In contrast, only about 60% of those quitting heroin eventually relapse. *See infra* note 174 and accompanying text.

150 *Lasser*, 344 F.3d at 391 ("[T]o require [the insured] to provide statistics detailing the harm that working in his regular occupation might precipitate—as the dissent would require—raises the bar too high.").

151 *See id.* at n.12.

152 *Id.* at 398 (Garth, J., dissenting).

153 *Id.* at 397.

return to work and a decision not to work: a person who has the same 60% chance of relapse with or without a return to work cannot claim benefits because working does not create any added risk to their health. Second, there are some jobs for which a high risk of injury is inherent to the job, such as a firefighter or coal miner. This risk of future injury cannot be considered a disability because it is compensated for through increased wages: a compensating wage differential.[154] What is relevant is the differential risk of a claimant relative to her coworkers, because that is not compensated through wages.

The reasonable person test advocated here is, in a way, both objective and subjective. Like the reasonable person standard common in tort law, it is objective in that it is "based on externally verifiable phenomena, as opposed to an individual's perceptions, feelings, or intentions."[155] It asks, in short, what a reasonable person would do in the insured's situation. The tort standard also takes into account specific characteristics of a defendant, such as intelligence and superior skills.[156] The test advocated herein goes slightly beyond this to account for personal characteristics of the defendant, such as history of prior relapse and a family history of addiction; this level of subjectivity is more akin to tort law's reasonable child standard.[157] The reasonable uninsured person test takes these individual risk factors into account because they can significantly impact the likelihood of future injury. Failing to account for these differences would allow coverage for individuals with a low personal risk of future injury, and vice versa. While considering these factors will increase administration costs somewhat, the costs will not be large because many risk factors are easily discernible and data about them is widely available. Moreover, the test requires consideration of these individual factors only when they are readily available. By accounting for these individual characteristics, the test is somewhat subjective in that it is "based on an individual's perceptions, feelings, or intentions."[158] In essence, however, the test is objective because it considers the hypothetical decision of a reasonable person, without taking into account the insured's own feelings regarding a return to work.

A final concern is the way in which quantitative and qualitative evidence will be admitted into the record for an administrative decision. To prove a disability, a claimant will need to present three types of evidence to the extent that they are available: evidence regarding the overall likelihood

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[154] *See* Peter Dorman & Paul Hagstrom, *Wage Compensation for Dangerous Work Revisited*, 52 INDUS. & LAB. REL. REV. 116, 117–19 (1998).

[155] BLACK'S LAW DICTIONARY 1178 (9th ed. 2009).

[156] Gail D. Hollister, *Using Comparative Fault to Replace the All-or-Nothing Lottery Imposed in Intentional Tort Suits in Which Both Plaintiff and Defendant Are at Fault*, 46 VAND. L. REV. 121, 140 (1993).

[157] *Id.*

[158] BLACK'S LAW DICTIONARY 1561 (9th ed. 2009).

of future injury in her occupation given her health status, individual and family medical data, and evidence regarding the link between this data and the risk of relapse stemming from a return to her occupation. In general, claimants will simply be able to present their medical histories to the administrator along with data regarding the risk of injury; the insurer will likely present competing evidence.

In some circumstances, expert testimony may be required to interpret complex or contradictory studies, as well as to detail the physical condition of the claimant. This type of expert testimony would not be radically new to insurance administrative decisions because currently a claimant's and insurer's doctors frequently testify regarding the claimant's health.[159] These doctors will now have to present widely available data—such as research published in academic journals—to support their claims, rather than simply a gut instinct about an insured's chance of relapse. Although this could create a "battle of the experts," which could sometimes cause a stalemate that a trier of fact has no reasoned way to solve,[160] this problem will not be great when there is scientific data that the administrator can use to make a decision. Though research results can sometimes conflict, an administrator considering conflicting studies could simply weigh them to determine what a reasonable person would do. The flexibility of this test, which does not set a rigid percentage cutoff for coverage, allows the administrator to refrain from choosing between studies.

D. Policy Considerations and Categorical Bars to Coverage

To summarize thus far, a court or insurance administrator should determine coverage for risk of future disease by analyzing whether a reasonable person facing the risk without disability insurance would return to work. To determine this, it is necessary to consider the quantitative risk of relapse and the qualitative harms associated with relapse, including individual risk factors. However, the inquiry should not end there, because there could be other considerations that function as a categorical bar to coverage, meaning that an entire category of claims—such as claims for risk of substance abuse relapse—could be ineligible for coverage because of policy concerns. As a final step, the administrator should consider whether there are any important policy concerns that bar coverage for a particular category of risk.

Courts often take policy considerations into account when interpreting insurance contracts, and are especially wary of interpretations that will create perverse incentives or lead to results that are detrimental to society. In particular, insurance policy interpretation often takes into account the

[159] *See, e.g.*, Lasser v. Reliance Standard Life Ins. Co., 344 F.3d 381, 389–91 (3d Cir. 2003).

[160] Andrew B. Gagen, *What Is an Environmental Expert? The Impact of* Daubert*,* Joiner*, and* Kumho Tire *on the Admissibility of Scientific Expert Evidence*, 19 UCLA J. ENVTL. L. & POL'Y 401, 431 (2001).

concerns of moral hazard and adverse selection.[161] In the context of risks of future injury, the primary moral hazard concern, identified in Part I.B, is that a claimant will untruthfully claim an inability to work. This concern is alleviated by analyzing the reasonable decision of someone without insurance. Although it is also possible that the claimant could be "faking" the risk in itself—claiming to have a 70% chance of relapse when it is really only 30%—this problem is solved by the use of scientific data and doctors' testimony as evidence.

Adverse selection—the tendency for those most at risk for a disability to purchase disability insurance[162]—is another concern in insurance coverage. Adverse selection arises when there is an information asymmetry between the parties that leads the insurer to underestimate the insured's risk of future disability.[163] The key moment for adverse selection is when the insurance agreement is entered. Adverse selection can occur when the insured is aware that she has a high likelihood of qualifying for benefits, but the insurer is unaware of this fact.

It is unlikely that adverse selection could serve as a categorical bar to coverage for the risk of future injury. In general, adverse selection problems in health and disability are dealt with through underwriting—the process by which insurers evaluate the risk of potential clients, usually by requiring applicants to answer questions about their medical status and history.[164] If materially false statements are made in response to these questions, benefits can be denied based on that misrepresentation.[165] A categorical bar is necessary only where information is unobtainable through underwriting or where misrepresentation would not apply.

Other policy concerns could impact categorical bars in various ways. Factors such as public health, the personal health of the claimant, and coverage consistency can either make a categorical exclusion more or less warranted. Finally, in the case of a risk of substance abuse relapse, some courts have held that the presence of a choice in relapsing can serve as a bar to coverage.[166] This validity argument will be considered in Part III.C.[167]

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[161] *See, e.g.*, A.M.I. Diamonds Co. v. Hanover Ins. Co., 397 F.3d 528, 530–31 (7th Cir. 2005); August Entm't, Inc. v. Philadelphia Indem. Ins. Co., 52 Cal. Rptr. 3d 908, 919–20 (Ct. App. 2007); U.S. Fire Ins. Co. v. J.S.U.B., Inc., 979 So. 2d 871, 890–91 (Fla. 2007).

[162] BAKER, *supra* note 34, at 6.

[163] *See id.*

[164] Peter Siegelman, Essay, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1248 (2004).

[165] *See generally* Thomas R. Foley, Note, *Insurers' Misrepresentation Defense: The Need for a Knowledge Element*, 67 S. CAL. L. REV. 659, 659 (1994) (describing the defense of misrepresentation).

[166] *See supra* note 110 and accompanying text.

[167] *See infra* Part III.C.

E. Possible Criticisms of the Reasonable Uninsured Person Test

There are two important counterarguments that could be made against the reasonable uninsured person test. First, under ERISA, a reviewing court must uphold a benefit denial unless it is arbitrary and capricious, or, equivalently, unreasonable.[168] Therefore, this test creates a sort of double-reasonableness problem, in which the reviewing judge must decide the reasonableness of an administrator's determination of a reasonable person's decision (regarding a return to work). How, then, is a judge to implement the test?

Although this conjunction of reasonableness tests seems to present a linguistic maze, the job of the judge is actually quite straightforward. Application of the reasonable uninsured person test will proceed in the same manner as any arbitrary and capricious review with the judge determining whether the administrator's decision was reasonable.[169] In this case, however, the administrator herself will also have determined how a reasonable person would have acted in a situation. These two types of reasonableness are slightly different. In the initial benefit decision, the administrator will use evidence to determine what a reasonable person would do in the claimant's situation. The judge, on the other hand, will look at the evidence to determine whether the administrator had a reasonable basis for denying benefits. Even if the judge does not agree with the administrator's determination of the behavior of a reasonable person, he will uphold the administrator's determination unless the decision itself was unreasonable. The judge's job will be to assure that the administrator adhered to the test, weighed the evidence in a reasonable manner, and did not employ a categorical bar unreasonably. Although the judge's job is slightly complicated by the need to apply reasonableness at two levels, federal judges are likely qualified to engage in these minor mental gymnastics.

Second, this reasonable uninsured person test could impose large information costs on administrators, litigants, and courts due to its focus on scientific evidence and individual risk factors. But the evidentiary costs of the test need not be high. Claimants would need to present only widely available evidence regarding relapse rates and physician testimony. The specific risk implications of an individual's circumstances would only be considered if there is evidence available; a lack of specialized evidence should neither help nor hurt a claimant's case.[170] On the other hand, a person claiming benefits for a risk of future injury would have to present

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[168] *See supra* notes 48–53 and accompanying text.

[169] *See supra* notes 48–53 and accompanying text.

[170] It is possible that this test would have the collateral effect of increasing the output of scientific research into injury and relapse risk, as claimants or, especially, insurers seek evidence for uses in these claims.

some evidence of a heightened risk—more than the unsupported physician's testimony used today.

III. THE REASONABLE PERSON TEST AND THE RISK OF SUBSTANCE ABUSE RELAPSE

A. The Science of Relapse

The risk of relapse into substance abuse is different for every substance and for every person, hence the need for evidence that is as individualized as possible. As an example, this Note focuses on the risk of relapse into opioid abuse by anesthesiologists. Aside from the probability of a relapse, the physical consequences of relapse are also a crucial variable in determining reasonableness of not returning to work. It is also important to look at any risk factors that may increase the likelihood of relapse; the presence or absence of these factors may impact the reasonableness of a claimant's decision not to return to his occupation.

Scientific evidence shows that, in many cases, the danger of a relapse can rise to a level that would prevent a reasonable person from returning to work. Addictions are associated with very high relapse rates; this is the reason that many consider addiction to be a lifelong disease that can only be managed, not cured.[171] Relapse rates are highly variable, depending on factors such as the substance involved, physical and mental characteristics of the abuser, and environmental factors.[172] In general, relapse rates range from 40%–60%, rates that lead many to characterize addiction as a chronic medical illness similar to diabetes or hypertension.[173]

Although there are not reliable statistics regarding the general relapse rates for users of especially potent opioids such as Fentanyl (perhaps because abuse is relatively rare due to the difficulty in obtaining these drugs), multiple studies demonstrate that the relapse rates for users of more common opioids, such as heroin, are very high. One study found that relapse rates for heroin users after release from a treatment facility were approximately 60%, with most relapses occurring within thirty days of

[171] *See, e.g.*, *Stairway to Recovery*, U. PA. HEALTH SYS., http://www.uphs.upenn.edu/addiction/berman/treatment/ (last visited Mar. 17, 2014).

[172] *See, e.g.*, Karen B. Domino et al., *Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders*, 293 JAMA 1453, 1456–57 (2005).

[173] A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1689 (2000).

release.[174] Another study of long-term outcomes found that, years after treatment, abstinence rates were quite low.[175]

Many studies examine the relapse rates of anesthesiologists upon a return to work because it is such a common problem. Of course, this will not often be the case with other professions—there are probably no studies examining the risk of relapse into opioid abuse by a return to work as a plumber. A claimant would not be automatically denied benefits in such a case—instead, the claimant would use more general evidence regarding risk of relapse into abuse of their particular substance, the effects that a return to full-time work may have on that risk, and any job-specific factors that may change this risk.

One sign that a return to anesthesiology may create a high risk of relapse is the mere fact that so many anesthesiologists become addicted in the first place—an environment that spawns an initial addiction seems likely to be a fertile ground for relapse as well.[176] There are multiple theories as to why anesthesiologists frequently become addicts. Factors leading to anesthesiologist addiction are "proximity to large quantities of highly addictive drugs, the relative ease of diverting particularly small quantities . . . for personal use," and a high-stress work environment.[177] A separate theory argues that small amounts of these substances can be found in the air in an operating room, causing sensitization to the substance.[178] Even if this theory does not in fact lead to initial substance abuse, it seems logical that physical exposure to small amounts of opioids could lead to relapse.

Studies of relapse rates among anesthesiologists returning to work show that a return can be quite dangerous. Research findings vary, but generally paint a pessimistic picture, making the question of "[w]hether

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[174] Michael Gossop et al., *Factors Associated with Abstinence, Lapse or Relapse to Heroin Use After Residential Treatment: Protective Effect of Coping Responses*, 97 ADDICTION 1259, 1262 (2002). "The sample [for this study] was drawn from clients from . . . residential [treatment] programmes who reported using heroin during the 3 months prior to treatment and who completed the post-treatment follow-up interview during the first 12 months of the study." *Id.* at 1261.

[175] John Marsden, *Long-Term Outcome of Treatment for Drug Dependence*, 3 PSYCHIATRY 47, 48 (2004).

[176] There is mixed evidence about whether anesthesiologists returning from an opioid addiction are more likely to relapse than physicians in other specialties. *Compare* Chet Pelton & Richard M. Ikeda, *The California Physicians Diversion Program's Experience with Recovering Anesthesiologists*, 23 J. PSYCHOACTIVE DRUGS 427, 430 (1991) (finding that anesthesiologists and other types of physicians were equally likely to relapse into opioid addiction upon return to work), *with* Emil J. Menk et al., *Success of Reentry into Anesthesiology Training Programs by Residents with a History of Substance Abuse*, 263 JAMA 3060, 3061 (1990) (finding a higher risk of relapse for anesthesiologists returning from an opioid addiction than anesthesiologists returning from other addictions). Both anesthesiologists and other types of physicians, however, face a very high risk of relapse.

[177] *See* Bryson & Silverstein, *supra* note 27.

[178] Mark S. Gold et al., *Fentanyl Abuse and Dependence: Further Evidence for Second Hand Exposure Hypothesis*, 25 J. ADDICTIVE DISEASES 15, 17, 20 (2006).

anesthesia personnel should be allowed to return to the operating room after successful treatment . . . highly controversial."[179] One study found that 66% of those opioid addicts reentering anesthesiology relapsed,[180] and another showed a relapse rate of 40%.[181] A separate study of residents who became addicted to opioids during their training in anesthesiology found that only 46% of those that returned successfully reentered and completed training in the field.[182] These different results can be explained primarily by methodological differences. Yet all of these studies suffer from the common shortcoming of measuring only the relapse rates of those anesthesiologists willing to return to work. It is probable that these people only returned because they thought themselves unlikely to relapse; those choosing not to return, conversely, probably thought that a return would lead them to relapse. Because these studies likely considered only those least likely to relapse, the risk of relapse of a random anesthesiologist addict is likely to be much higher. It is probably impossible to know the true rate of relapse; administrators will simply need to take this methodological concern into account when interpreting study results.

Importantly, there is also evidence that the risk of relapse for those anesthesiologists who return to work is much larger than for those who choose not to and instead change their specialty or simply do not return to the medical profession.[183] It is this relative risk of relapse that is relevant for the reasonableness analysis. One study showed that those returning to anesthesiology faced a risk of relapse approximately eight times higher than those who did not.[184] Although this may in part reflect an endogeneity problem[185] caused by the fact that those most likely to relapse are less likely to return to anesthesiology, it likely also shows a real danger in returning to anesthesiology.

These studies also show that the qualitative physical risks of relapsing into abuse of potent opioids are extremely high. Any relapse into addiction, of course, leads to significant health problems. However, relapse into potent opioid abuse is especially harmful. In one study, death was the first

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[179] Bryson & Silverstein, *supra* note 27, at 912.

[180] Menk et al., *supra* note 176.

[181] Richard T. Paris & David I. Canavan, *Physician Substance Abuse Impairment: Anesthesiologists vs. Other Specialties*, 18 J. ADDICTIVE DISEASES 1, 3 (1999).

[182] Gregory B. Collins et al., *Chemical Dependency Treatment Outcomes of Residents in Anesthesiology: Results of a Survey*, 101 ANESTHESIA & ANALGESIA 1457, 1459 (2005).

[183] *See* Domino et al., *supra* note 172, at 1456.

[184] *Id.*

[185] An endogeneity problem occurs when the independent variable is correlated with the error term in a regression. *See* JEFFREY M. WOOLDRIDGE, INTRODUCTORY ECONOMETRICS: A MODERN APPROACH 848 (5th ed. 2013). Here, the independent variable (whether or not the anesthesiologist returns to work) is likely correlated to the error term (the difference between the measured effect on relapse of returning to work and the true effect) because a heightened risk of relapse may lead an anesthesiologist not to return.

sign of relapse for 16% of a large group of anesthesiologists returning from opioid addiction;[186] in another study 9% of those reentering anesthesiology died due in part to relapse.[187] Obviously, even a 9% mortality rate among returnees is extremely high, perhaps high enough to dissuade a reasonable anesthesiologist from returning to work. Because of the high likelihood and harm of relapse, many in the field argue that reentry should be allowed only on a case-by-case basis after closely considering an individual's risk of relapse;[188] others have even argued for a "one strike, you're out" policy, meaning that a substance abuser should never be allowed to return.[189]

Although the general danger of relapse is a good starting point for analyzing whether a reasonable person would return to work, it is important to also consider individual risk factors for relapse. Two people that worked in the same occupation and abused the same substance may have very different risks of relapse, depending on personal factors. The harm of a relapse could also differ between individuals if, for example, people with a certain gene or level of physical health are more likely to die from an overdose. A study of anesthesiologists has shown that the major factors that raise the risk of relapse include a family history of substance abuse and the presence of a coexisting psychiatric disorder; the presence of these factors together makes an opioid abuser thirteen times more likely to relapse.[190] This disparity shows that individual factors are as important as general relapse rates in determining reasonableness.

Multiple studies show that relapse rates are significantly lower when returning anesthesiologists take part in a strict monitoring program in the workplace that includes procedures such as random urine testing, frequent behavioral assessment, and workplace surveillance.[191] The presence or absence of such a program at the claimant's place of work should be taken into account in analyzing the reasonableness of a nonreturn to work.

This scientific evidence clearly shows that the danger of a return to anesthesiology can rise to a level that would lead a reasonable person to refuse to return to work, even without the prospect of benefit payments. It seems safe to say that a reasonable recovering addict would choose to avoid a situation in which the general risk of relapse is around 50%, where the claimant has risk factors that make her especially likely to relapse, and where approximately 10% of those who relapse die. For those with a lesser

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[186] Menk et al., *supra* note 176.

[187] Collins et al., *supra* note 182.

[188] *See, e.g.*, Bryson & Silverstein, *supra* note 27, at 912.

[189] *See* Wright et al., *supra* note 27, at 125.

[190] *See* Domino et al., *supra* note 172, at 1457.

[191] *See id.* at 1453; Michael R. Oreskovich & Ryan M. Caldeiro, Editorial, *Anesthesiologists Recovering from Chemical Dependency: Can They Safely Return to the Operating Room?*, 84 MAYO CLINIC PROC. 576, 579 (2009); TASK FORCE ON CHEM. DEPENDENCE, *supra* note 27.

risk, it will be up to first the administrator and then a judge to decide what is reasonable in a given situation.

B. Public Policy and Substance Abuse Addiction Relapse

The final step in the reasonable uninsured person test is whether there are policy concerns that require a categorical bar against coverage. Among the policy issues to consider are moral hazard, adverse selection, public health, and individual health of the claimant. This section analyzes the category of risk of substance abuse relapse claims in light of these concerns.

As argued in Part II.D, concerns of moral hazard and adverse selection will rarely lead to a categorical bar in risk-of-future-injury cases.[192] This is generally true within the category of substance abuse relapse as well. On the moral hazard side, there is a slight concern that the claimant could fabricate a risk factor such as a family history of addiction or a psychiatric disorder. Although the insurer will often be able to disprove such a fabrication, the possibility of this source of moral hazard weighs slightly in favor of a categorical bar. In terms of adverse selection, the claimant could have failed to disclose a heightened risk of initial addiction when the insurance policy was purchased. This creates an adverse selection problem in regard to coverage for an initial addiction. But insurers concede that this adverse selection issue does not create a categorical bar to coverage for addiction, which is clearly covered under these policies.[193] It is therefore hard to argue that it should create a bar for the more remote risk of a future relapse.

One argument against giving benefits for the risk of substance abuse relapse is that it creates bad incentives and rewards people for their mistakes. First, the availability of benefits for risk of substance abuse relapse eliminates a disincentive to engage in the behavior that can lead to an initial addiction. This is a moral hazard once removed from the disability at issue. But again, this is primarily an argument against coverage for addiction itself. It is unlikely that an anesthesiologist will be induced to begin using Fentanyl because of the availability of disability benefits for addiction; it strains credulity to believe that the availability of benefits for a risk of relapse will impact this decision whatsoever.[194]

Second, some may balk at the prospect of providing benefits to former addicts who "got themselves into this mess." Under this argument, coverage is unconscionable because it is "rewarding" people for their destructive decisions. But insurance is not meant to reward anything, and

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[192] *See supra* Part II.D.

[193] *See, e.g.*, *Colby II*, 705 F.3d 58, 60 (1st Cir. 2013) (an example of a policy where the insurance company covered treatment for initial addiction).

[194] Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOK. L. REV. 185, 216 (2002).

benefit payments are not prizes for good behavior. Insurance is simply meant to transfer risk so that insureds are made whole following an unforeseen event, whether caused in part by the insured (e.g., surgery after a car accident) or not (e.g., flood insurance). Additionally, it is nonsensical under this argument to provide benefits for addiction but not for risk of relapse. This argument seems to stem more from the widespread stigmatization of addiction than from any reasoned analysis.[195]

There is a third argument related to the health of individual claimants that counsels against a categorical bar. If benefits are granted to those addicts who continue abusing a substance, but not to those who have ceased abuse and yet are still unable to work, insureds that begin abusing drugs have a perverse incentive to *continue* the abuse. Although the *Stanford* court correctly pointed out that there are many other reasons for an addict to cease abuse,[196] the loss of income will still provide a marginal disincentive to recovery. A primary goal of disability insurance is to allow for recovery and rehabilitation; a categorical bar against coverage for risk of relapse would undermine this goal.[197]

Finally, there are public health reasons for providing benefits to anesthesiologists—and physicians in general—for a significant risk of relapse. If denied benefits, an anesthesiologist with a high risk of relapse may, due to financial constraints, be forced to return to practice.[198] An anesthesiologist that relapses is a significant threat to the health of patients because their lives are in his potentially-drug-impaired hands. A substance-abusing doctor could divert medications from patients and, if working while under the influence, could severely injure a patient or worse. One court has explicitly weighed this public safety concern against a benefit denial for risk of relapse.[199] The threat to public safety from an anesthesiologist's relapse should weigh heavily in favor of providing benefits for the risk of substance abuse relapse.

C. Does Choice Matter?

The policy considerations considered in the previous section do not require a categorical bar against coverage, but one important consideration remains: the idea that an addict has a choice whether or not to relapse. This

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[195] *See* Martha D. Burkett, *The Burden of Stigma: Barrier to Treatment, Bane of Recovery*, 87 MICH. B.J. 34, 35 (2008).

[196] *See* Stanford v. Cont'l Cas. Co., 514 F.3d 354, 359 (4th Cir. 2008).

[197] Another argument, made by the majority in *Stanford*, is that "[i]t would be truly perverse if [the plaintiff] were to go on to great success in another occupation but was still able to collect insurance checks on the basis of 'disability.'" *Id.* at 359–60. This argument completely ignores the nature of *own-occupation* disability insurance.

[198] *See supra* note 143. A risk of relapse should be covered if a reasonable person without insurance, who otherwise would choose not to return to work, would return only because of financial necessity.

[199] Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F. Supp. 2d 785, 796 (W.D. Mich. 2009).

is a somewhat tricky issue. Basically, the contention made by insurers is that the risk of relapse cannot prevent an addict from working because the addict controls her own relapse.[200] The issue comes down to causation: a return to work cannot cause a heightened risk of relapse if the cause of relapse is individual choice.

There are three central reasons that the choice problem should not create a categorical bar to coverage. First, many addicts do not have a meaningful "choice" whether or not to relapse. There are two main models of addiction, each of which provide different insights into the degree of choice or rational action involved in drug use by an addict.[201] The first is the disease model, which holds that addiction causes a "complete enslavement of the will," and that there is effectively no choice involved in relapsing.[202] This theory is supported by the fact that continuing in abuse is seemingly irrational and extremely self-destructive.[203] The model holds that choices to ingest substances are not made rationally, and thus that addictive behavior cannot be changed through incentives.

The other model is the economic model of addiction, which holds that addicts do, in fact, make rational decisions.[204] This model is supported by studies showing that addicts do respond—at least slightly—to market forces such as tax increases or criminalization.[205] Economic models of addiction are based on the assumption that as the addict begins to abuse a substance more and more, the effects of past consumption lead even a rational actor to enter a spiral of continued abuse;[206] some also argue that addicts are hyperbolic discounters that weigh present utility much more heavily than future utility.[207]

The disease model of addiction argues that addicts truly do not have a choice in relapsing. On the other hand, if the economic model is correct, the picture is much less clear. Although addicts under the economic model technically make rational choices, these choices are made under extreme pressures that push the addict into relapse—relapse is often the rational option.[208] Furthermore, short-run incentive changes are very unlikely to

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[200] Brief for Appellee at 19, Stanford v. Cont'l Cas. Co., 514 F.3d 354, 359 (4th Cir. 2008) (No. 06-2006), 2006 WL 3739273.

[201] Stevenson, *supra* note 194, at 203.

[202] *See id.* at 203–04.

[203] *See* A. David Redish, *Addiction as a Computational Process Gone Awry*, 306 SCIENCE 1944, 1946 (2004).

[204] Stevenson, *supra* note 194, at 203, 204–05.

[205] *See id.* at 204; Jonathan Gruber & Botond Köszegi, *Is Addiction "Rational"? Theory and Evidence*, 116 Q.J. ECON. 1261, 1264–65 (2001).

[206] *See* Gary S. Becker & Kevin M. Murphy, *A Theory of Rational Addiction*, 96 J. POL. ECON. 675, 694 (1988).

[207] *See id.*; Gruber & Köszegi, *supra* note 205, at 1263.

[208] *See* A.L. Bretteville-Jensen, *Addiction and Discounting*, 18 J. HEALTH ECON. 393, 397 (1999).

change the rationality of a relapse,[209] and moral hazard through insurance benefits is almost nonexistent.[210]

Second, voluntary choice affects many illnesses—both in initiation and maintenance—that are readily covered by disability insurance. Drug addiction disease is not set apart from other medical illnesses by the presence of choice.[211] For example, hypertension can be caused by a combination of salt sensitivity—a genetic factor—and individual salt use patterns.[212] Other chronic diseases such as heart disease and diabetes are intimately related to individual choices regarding diet, exercise, and monitoring.[213] Disability policies cover these sorts of illnesses despite their choice component;[214] the (limited) choice component involved in a relapse should not set it apart. The idea that addiction is a choice rather than a disease similar to hypertension probably stems largely from the widespread stigmatization of addiction in this country.[215]

Third, the incentive structure of insurance means that even the presence of a true choice of future injury should not bar coverage. The economic fear of paying benefits for risk of "chosen" future injuries comes from the *possibility* that a claimant can claim to have a high risk of relapse, which is actually much lower because the claimant can control this risk. Yet the use of scientific data can show the *actual* risk; a high rate of relapse demonstrates that the claimant is not making a false threat. Moreover, the fact that a return to work can increase the chance of a claimant making a harmful choice can clearly be a disability. For example, consider a schizophrenic who, if exposed to the work environment, will engage in self-destructive behavior. There is a choice here, yet few would argue that schizophrenia is not a disability. Even if an anesthesiologist were able to truly choose whether or not to relapse, the mere fact that a return to employment would make the destructive choice much more likely should constitute a disability.

CONCLUSION

A fall into drug addiction and dependence is a life-threatening experience for any individual. On top of the health consequences of

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[209] *See* Gary S. Becker et al., *An Empirical Analysis of Cigarette Addiction*, 84 AM. ECON. REV. 396, 407 (1994).

[210] *See* Stevenson, *supra* note 194, at 218–19.

[211] McLellan et al., *supra* note 173, at 1690.

[212] *Id.*

[213] *See Causes and Consequences: What Causes Overweight and Obesity?*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/adult/causes/index.html (last updated Apr. 27, 2012).

[214] COUCH ON INSURANCE, *supra* note 72, § 147:97. ("It is possible for an individual to be totally disabled from performing the essential tasks of his or her, or any other, occupation by diabetes.").

[215] Burkett, *supra* note 195.

addiction lie equally significant financial consequences—drug addiction often leads to a loss of employment. Thankfully for addicts, disability insurance provides benefits to those unable to work due to addiction. However, many insurance companies attempt to stop these payments once the addiction has been "treated" and the active abuse has ceased, regardless of whether the addict is able to return to work. Many courts have gone along with this, creating a circuit split.

This Note provides a way for policy administrators and courts to analyze insurance coverage for risk of relapse into substance abuse and for all other risks of future injury: the reasonable uninsured person test. By considering the likelihood of relapse and the harm associated with a relapse, courts will be able to make coverage decisions based upon whether a reasonable person without disability insurance would return to work in the insured's situation. The process is not easy on claimants because they will have to provide scientific data (if it is available) that sheds light on their personal risk of relapse. This test's focus on individual risk factors may make the test harder to administer, and may make it more difficult for an insured to prove her case. Yet consideration of these factors will make the test much more accurate, and claimants will not be denied benefits simply because there is no data available. Although many claimants will be denied coverage under this standard, those who face grave danger from a return to employment will receive coverage.

This analysis avoids the artificial line drawing and moral judgments that courts are currently employing in these cases. It also protects the central goals of insurance by supplying income to those who truly cannot work, preventing false claims by those who can, and encouraging the rehabilitation of those with serious illnesses.