Journal of Health Care Law and Policy

Volume 17 | Issue 2 Article 5

# *Colby v. Union Sec. Ins. Co*: Defining the Risk of Relapse into Substance Abuse as a Current Disability

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# *COLBY v. UNION SEC. INS. CO.*: DEFINING THE RISK OF RELAPSE INTO SUBSTANCE ABUSE AS A CURRENT DISABILITY

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In *Colby v. Union Sec. Ins. Co.*,[1] the United States Court of Appeals for the First Circuit considered whether the risk of relapse into substance abuse constitutes a current disability under the Employee Retirement Income Security Act (ERISA).[2] The Court held that the risk of relapse into substance dependence is the same as a current disability.[3] Based on this determination, the Court correctly concluded that the plaintiff was eligible for long-term benefits under an ERISA long-term disability plan.[4] In addition, the Court aptly relied on expert testimony to determine the significance of a risk of relapse into substance dependence, finding the risk to be a current disability under the terms of the ERISA disability plan.[5] However, the Court's narrow holding failed to address whether the risk of relapse constitutes a current disability under any circumstance.[6] The First Circuit's holding provides guidance on how other reviewing courts should analyze a plan administrator's decisions,[7] yet the majority fails to state whether reviewing courts should view the risk of relapse into substance dependence as equivalent to actual dependence. [8]

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1. (*Colby III*), 705 F.3d 58 (1st Cir. 2013).
2. *Id.* at 59–60.
3. *Id.*
4. *See id.* at 60 (holding that the plaintiff's risk into substance abuse was a current disability deserving of long-term disability benefits). *See also infra* Part IV.A (explaining why the *Colby* Court's holding was correct).
5. *See Colby III*, 705 F.3d at 63–64 (discussing testimony from medical experts that strongly indicated that Dr. Colby was at a high risk of relapse and was "disabled for at least some period of time").
6. *See infra* Part IV.B.
7. *See infra* Part IV.A.
8. *See infra* Part IV.C.

## I. THE CASE

Beginning in the summer of 2000, Dr. Julie Colby, an anesthesiologist, experienced lower back pain and left leg numbness.[9] Dr. Colby was diagnosed with a herniated disc.[10] In 2001, Dr. Colby underwent a discectomy, the surgical removal of a herniated disc, to relieve the pain.[11] The discectomy failed to relieve Dr. Colby of her pain, which led her to regularly self-medicate with Fentanyl, a Schedule II prescription drug Dr. Colby used to treat patients with severe back pain.[12] Dr. Colby became "addicted to and dependent on Fentanyl."[13]

While on duty in July 2004, Dr. Colby was found sleeping or unconscious on a staff table in a hallway at Anna Jacques Hospital.[14] At this time, Dr. Colby agreed to a requested urine drug screen, which tested positive for Fentanyl.[15] Shortly thereafter, Dr. Colby volunteered to give up her license to practice medicine.[16]

On August 16, 2004, Dr. Colby enrolled in Talbott Recovery Campus (Talbott Recovery) in Atlanta, Georgia, an inpatient substance abuse treatment facility known for treating physicians.[17] Dr. Colby also enrolled in a long-term disability plan with Union Security Insurance Company (USIC) around this time.[18] At Talbott Recovery, Dr. Colby was diagnosed with dysthymic disorder (also known as chronic depression), a history of major depressive disorder, and compulsive and avoidant personality traits in addition to her opioid dependency.[19]

When Dr. Colby was discharged from Talbott Recovery on November 20, 2004, USIC discontinued her long-term disability benefits.[20] USIC claimed that Dr. Colby could not be afforded benefits for substance abuse where there was only

9. Colby v. Assurant Emp. Benefits (*Colby I*), 603 F.Supp.2d 223, 226 (D. Mass. 2009).

10. *Id.*

11. *See id.* (explaining that the discectomy enabled Dr. Colby to use her calf muscle, but it did not fully relieve Dr. Colby's back and leg pain).

12. *See id. See also* MERRIAM WEBSTER, http://www.merriam-webster.com/dictionary/fentanyl (defining Fentanyl as a "synthetic opioid narcotic analgesic", similar to morphine, that is used in combination with other drugs in anesthesia); NAT'L INSTIT. ON DRUG ABUSE, http://www.drugabuse.gov/drugs-abuse/fentanyl (describing Fentanyl as a schedule II prescription drug used to treat patients that experience chronic pain).

13. *Colby I*, 603 F.Supp.2d at 226.

14. *Id.*

15. *See id.*

16. *See* Colby v. Assurant Emp. Benefits *(Colby II)*, 818 F.Supp.2d 365, 370 (D. Mass. 2011), *aff'd sub nom Colby III*, 705 F.3d 58 (1st Cir. 2013).

17. *Colby I*, 603 F.Supp.2d at 226.

18. *See Colby II*, 818 F.Supp.2d at 370. The plan with USIC provided disability benefits where Dr. Colby was "unable to perform a material duty of her profession, including the ability to work full time." *Colby I*, 603 F.Supp.2d at 227.

19. *See Colby I*, 603 F.Supp.2d at 227. (discussing how Dr. Colby's "physical and psychological intake exams" revealed various health problems, but Dr. Colby's attendance at exercise programs and group meetings resulted in mental and physical health improvements).

20. *Id.* at 227–28.

a risk of relapse and not a current disability of active opioid dependency and abuse.[21] Dr. Colby submitted two administrative appeals to USIC's claim.[22] Both of these administrative appeals were denied by USIC, exhausting Dr. Colby's right to appeal under the terms of the disability plan.[23]

After the denials, Dr. Colby filed suit in the United States District for the District of Massachusetts.[24] USIC and Dr. Colby filed cross-motions for a "judgment based on the administrative record . . . and . . . agreed to permit the court to resolve their dispute."[25] The District Court ruled on the parties cross-motions, finding USIC's termination of Dr. Colby's long-term disability benefits to be unreasonable.[26] Yet the court remanded the matter, asking USIC to "consider Dr. Colby's risk of drug abuse relapse as a long-term disability if the risk is found to be sufficiently high."[27]

After considering the issue on remand, USIC denied Dr. Colby long-term disability benefits, finding that the risk of relapse was not [sufficiently high to constitute] a current disability under the insurance plan.[28] Dr. Colby again appealed twice to the USIC board and was denied both times.[29] In 2009, Dr. Colby "reopened the administratively closed case," by suing in the United States District Court for the District of Massachusetts.[30] At this time, both USIC and Dr. Colby filed motions for summary judgment.[31] The District Court granted Dr. Colby's motion for summary judgment, awarding her long-term disability benefits.[32]

USIC appealed to the United States Court of Appeals for the First Circuit, arguing that the risk of relapse was not a present disability that could afford benefits under the long-term plan.[33] USIC contended that when Dr. Colby was released from Talbott Recovery, she "no longer had symptoms of active substance

21. *Id.* at 229.

22. *See Colby I*, 603 F.Supp.2d at 229–35 (discussing Dr. Colby's two appeals, the information that Dr. Colby provided in support of the appeals, and the outcomes of the appeals).

23. *See id.* at 234.

24. *See id.* at 235.

25. *Id.*

26. *See id.* at 245–46 (finding USIC's interpretation of the disability plan's benefits to be arbitrary and capricious because USIC categorically excluded the risk of relapse as a current disability).

27. *Colby II*, 818 F.Supp.2d 365, 369 (D. Mass. 2011), *aff'd sub nom Colby III*, 705 F.3d 58 (1st Cir. 2013).

28. *Id.* After USIC denied Dr. Colby's claims, "USIC also concluded that Dr. Colby's condition could be mitigated by a reasonable accommodation, precluding the need for LTD benefits." *Id.*

29. *Id. See supra* note 22 and accompanying text.

30. *See Colby II*, 818 F.Supp.2d at 369.

31. *Id.*

32. *Id.* at 385.

33. *See Colby III*, 705 F.3d 58, 64 (1st Cir. 2013) (discussing USIC's argument that a risk of relapse is not a current disability, "no matter how grave").

abuse," and thus the risk of relapse was not the same as a current disability.[34] On appeal, the First Circuit reviewed the USIC plan administrator's decision to deny long-term disability benefits and addressed whether the risk of relapse into substance abuse is significant enough to constitute a current disability.[35]

## II. LEGAL BACKGROUND

In recent years, the United States District Courts have differed on whether the risk of relapse constitutes a current disability under ERISA long-term disability plans.[36] In 2013, the United States Court of Appeals for the First Circuit created a circuit split as it sought to determine whether a plan administrator used reasonable discretion in declining long-term disability benefits for a risk of relapse into substance abuse.[37] Part II.A of this Note discusses the deferential standard of review for ERISA cases, how the standard has evolved, and what courts must take into consideration when applying the standard. Part II.B explains how, notwithstanding the standard of review, state and lower federal courts have adopted varying interpretations of what constitutes a current disability under ERISA long-term disability plans.

### *A. The Arbitrary and Capricious Standard*

Courts operate more like appellate tribunals rather than trial courts when deciding ERISA cases.[38] In an ERISA context, courts must "evaluate the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary."[39] Courts are to apply a deferential standard of review, under which the plan administrator's denial of benefits for the risk of relapse is assessed under an "arbitrary, capricious, or an abuse of discretion" standard.[40] In evaluating whether the plan administrator's determination is permissible under the arbitrary and capricious standard, courts should consider the plan administrator's interpretation and application of the plan.[41]

34. *Colby I*, 603 F.Supp.2d 223, 226 (D. Mass 2009).

35. *See Colby III*, 705 F.3d at 59.

36. *See infra* Part II.B.

37. *Colby III*, 705 F.3d at 59–60.

38. *See* Leahy v. Raytheon Co., 315 F.3d 11, 17–18 (1st Cir. 2002) (discussing the standard of review for ERISA cases, indicating that the district court "does not take evidence, but, rather, evaluates the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary.").

39. *Id.* at 18.

40. Wright v. R.R. Donnelley & Sons. Co. Grp. Benefits Plan, 402 F.3d 67, 74 (1st Cir. 2005) (citing Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 183 (1st Cir. 1998)).

41. *See* Conkright v. Frommert, 559 U.S. 506, 521 (2010) (acknowledging that where there is an unreasonable determination of plan benefits, courts applying the deferential standard of review consider the plan administrator's interpretation of the plan).

*1. The Evolution of the Arbitrary and Capricious Standard*

In 1989, the Supreme Court of the United States in *Firestone Tire & Rubber Co. v. Bruch*,[42] determined the appropriate standard that reviewing courts must apply when evaluating a plan administrator's benefit determination under ERISA.[43] The majority noted that ERISA did not establish a standard for courts reviewing "benefit eligibility determinations."[44] In order to fill this gap, the Court noted that most federal courts have applied the arbitrary and capricious standard.[45] "[I]n light of Congress' general intent to incorporate much of LMRA [Labor Management Relations Act] fiduciary law into ERISA, . . . and because ERISA, like the LMRA, imposes a duty of loyalty on fiduciaries and plan administrators, . . . LMRA arbitrary and capricious standard should apply to ERISA actions."[46] Yet, LMRA principles could not be adopted by ERISA, because unlike ERISA, LMRA does not authorize suits against fiduciaries and plan administrators to remedy violations.[47] Instead, the Court found that "a denial of benefits challenged under [an ERISA plan] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[48] Thus, under *Firestone*, courts must provide a deferential standard of review where an ERISA plan administrator has discretionary authority.[49]

In 1996, the Fourth Circuit in *Haley v. Paul Revere Life Ins. Co.*,[50] agreed that a plan administrator could be given "discretionary power."[51] "[W]hen the administrator's exercise of a discretionary power forms the basis of a dispute between the parties, courts . . . decide only the contractual questions of whether the administrator exceeded its power or abused its discretion . . ."[52] The Fourth Circuit

42. 489 U.S. 101 (1989). In this case, Firestone refused to pay severance benefits to former employees with termination pay plans, under ERISA. *Id.* at 106. The District Court and the Court of Appeals applied different standards of review and issued different rulings on the interpretation of the plan. *Id.* at 106–08. The Supreme Court granted certiorari to determine the appropriate standard of review. *Id.* at 108.

43. *Id.* at 104–05.

44. *Id.* at 108–09.

45. *See id*. at 109 (explaining that the arbitrary and capricious standard was a "provision of the Labor Management Relations Act, 1947 (LMRA)"). *See, e.g.*, Struble v. N. J. Brewery Emps.' Welfare Trust Fund, 732 F.2d 325, 333 (3d Cir. 1984) (finding that the arbitrary and capricious standard comes from LMRA); Bayles v. Cent. States, Se. & Sw. Areas Pension Fund, 602 F. 2d 97, 99–100 (5th Cir. 1979) (discussing the Court's decision to apply the arbitrary and capricious standard, in the absence of a set ERISA standard of review).

46. *Firestone*, 489 U.S. at 109. *See* NLRB v. Amax Coal Co., 453 U.S. 322, 331–32 (1981) (discussing Congressional intent to incorporate LMRA law into ERISA).

47. *See Firestone*, 489 U.S. at 109–10.

48. *Id.* at 115.

49. *Id.*

50. 77 F.3d 84 (4th Cir. 1996).

51. *See id.* at 88.

52. *Id.*

explained that "reviewing court[s] must also consider, to the extent relevant, (1) the scope of discretion conferred; (2) the purpose of the plan provision in which discretion is granted; (3) any external standard relevant to the exercise of that discretion; (4) the administrator's motives; and (5) any conflict of interest under which the administrator operates in making its decision."[53] Thus, *Haley* provides reviewing courts with factors to consider when evaluating the plan administrator's discretionary power.[54]

In 2008, the Supreme Court in *Metro. Life Ins. Co. v. Glenn*,[55] recognized an additional factor to be considered in the arbitrary and capricious calculus under ERISA.[56] The Court noted the conflict of interest inherent in the fact that the entity administering the long-term disability plan often "determines whether an employee is eligible for benefits and pays benefits out of its own pocket."[57] The Court determined that "this dual role creates a conflict of interest" given that the plan administrator stands to save itself money by finding the plan holder ineligible for long-term disability benefits.[58] Consequently, in reviewing the reasonableness of an administrative determination, courts must consider the conflict of interest to be a factor in the arbitrary and capricious calculus.[59] Additionally, the Court found that the significance of the conflict would depend on the circumstances of each case.[60] The Court reasoned that if a conflict of interest is present, "any one factor [including the conflict of interest] will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance."[61] Thus, under *Glenn*, courts determine whether a plan administrator's decision is arbitrary and capricious on a case-by-case basis, incorporating conflict of interest as one factor.[62]

53. *Id.* at 89.

54. *See id.*

55. 554 U.S. 105 (2008).

56. *See id.* at 108. In using the deferential standard of review, the Court found a conflict of interest existed where the entity administering the long-term disability plan determined the eligibility for benefits and paid the benefits. *Id.* at 108; *see also id.* at 112 (discussing how *Firestone's* fourth principle refers to the conflict of interest that is created by a plan administrator's dual role).

57. *Id.*

58. *See id.*

59. *See id.*

60. *See id.* at 117 (discussing how circumstances of the conflict of interest may suggest a higher or lesser likelihood of affecting the benefits determination such as "where an insurance company administrator has a history of biased claims administration").

61. *Id.*

62. *See id.* ("Benefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts – which themselves vary in kind and in degree of seriousness – for us to come up with a one-size-fits-all procedural system that is likely to promote fair and accurate review.").

In 2010, the Supreme Court in *Conkright v. Frommert*,[63] reaffirmed the deferential standard of review for administrative decisions.[64] Finding that the "one-strike-and-you're-out" approach to deferential review did not apply to courts reviewing ERISA cases,[65] the Court determined that the plan administrator's decision must be given deference whether or not the decision was the plan administrator's "first efforts to construe the Plan."[66] The Court held that "[a]pplying a deferential standard of review does not mean that the plan administrator will prevail on the merits. It means only that the plan administrator's interpretation of the plan 'will not be disturbed if reasonable.'"[67] Thus, under *Conkright*, courts must solely use the deferential standard of review in ERISA cases where plan administrator's use discretion.[68]

In *Hinkle ex. rel. Estate of Hinkle v. Assurant, Inc.*,[69] the Third Circuit Court of Appeals explained that "where the courts of appeals are in disagreement on an issue, a decision one way or another cannot be regarded as arbitrary and capricious."[70] The Third Circuit reasoned that where there is a circuit split over the reasonableness of a plan administrator's interpretation of the language of a specific insurance plan, district courts are only permitted to find the plan administrator's interpretation to be reasonable,[71] and may not conduct a review of the administrator's decision.[72] Thus, under *Hinkle*, a plan administrator's decision should be reviewed with deference, as it cannot be regarded as arbitrary or capricious during a circuit split.[73]

63. 559 U.S. 506 (2010).

64. *See id.* at 512.

65. *Id.* at 513.

66. *Id.*

67. *Id.* at 521 (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989)).

68. *See id.* at 521–22 (agreeing with the established standard in *Firestone* and *Glenn* that lower courts should defer to plan administrators except where a plan administrator abused her discretion).

69. 390 F. App'x 105 (3d Cir. 2010). This is an unpublished opinion that was printed in the Federal Appendix, and pertained to courts experiencing a circuit split. *Id. at* 108.

70. *See id.* (discussing how the Third Circuit permitted the plan administrator's interpretation of accidental death where the courts of appeals were in disagreement on the issue of accidental death).

71. *Id.*; *Colby II*, 818 F.Supp.2d 365, 380 (D. Mass. 2011) *aff'd sub nom Colby III*, 705 F.3d 58 (1st Cir. 2013).

72. *See Hinkle*, 390 F. App'x at 108 (discussing how courts are precluded from finding a plan administrator's decision to be arbitrary or capricious).

73. *See id.* (explaining that when courts of appeals do not agree on an issue, decisions made by a plan one way or the other cannot be found arbitrary or capricious). In applying *Hinkle's* rationale, courts must use a very deferential standard of review that assumes the plan administrator's decision is valid where a circuit split exists on the particular issue to be decided. Courts are not prone to adhere to *Hinkle's* rationale, as it is an unpublished opinion.

### *B. Interpretation and Application of ERISA Long-Term Disability Plans*

Under the arbitrary and capricious standard, courts must look to the plan administrator's interpretation and application of the plan's provisions to evaluate whether the plan administrator's determinations are permissible.[74] Three cases illustrate factors courts must consider when reviewing the interpretation and application of language found in an ERISA plan. The first case, *Harris v. Harvard Pilgrim Health Care, Inc.*,[75] explains the importance of understanding and administering the plain meaning of words used in the plan.[76] *Rodrigues-Abrue v. Chase Manhattan Bank*[77] and *Stanford v. Cont'l Cas. Co.*[78] discuss how to interpret ambiguous plan language that cannot be plainly interpreted or applied.[79]

In *Harris*, the First Circuit explained that ERISA's main purpose is to "ensure the integrity and primacy of the written plans."[80] Hence, the Court reasoned, "the plain language of an ERISA plan must be enforced in accordance with 'its literal and natural meaning.'"[81] Similarly, in *Rodrigues-Abrue*, the First Circuit found that language in an ERISA plan must be given its plain meaning.[82] Like the *Harris* and *Rodrigues-Abrue* Courts, courts traditionally refer to the plain meaning of language used in insurance plans.[83]

The *Rodrigues-Abrue* Court recognized that there are instances where the plain meaning of a plan's provisions cannot be interpreted or applied.[84] The Court explained that a plan's terms may be ambiguous when "the terms are inconsistent on their face, [and] . . . allow reasonable but differing interpretations of their meaning."[85] According, the First Circuit found that where the plan's provisions are ambiguous, courts must turn to "surrounding circumstances [and] undisputed extrinsic evidence."[86] Thus, under *Rodrigues-Abrue*, courts must determine

74. *See supra* note 43 and accompanying text (explaining that courts must evaluate the reasonableness of the plan administrator's determination).

75. 208 F.3d 274 (1st Cir. 2010).

76. *See id.* at 277–78 (1st Cir. 2010) (citing United McGill Corp. v. Stinnett, 154 F.3d 168, 172 (4th Cir. 1998)) (discussing how the plain language of a plan must be enforced in accordance with the "literal and natural meaning" of the plan's language).

77. 986 F.2d 580 (1st Cir. 1993).

78. 514 F.3d 354 (4th Cir. 2008).

79. *See Stanford*, 514 F.3d at 357 (finding that courts must consider the plain language of the plan and whether the plan contains ambiguous language); *Rodrigues-Abrue*, 986 F.2d at 586.

80. *See Harris*, 208 F.3d at 277–78.

81. *Id.* (quoting United McGill Corp. v. Stinnett, 154 F. 3d 168, 172 (4th Cir. 1998).

82. *Rodrigues-Abrue*, 986 F.2d at 586 (citing Burnham v. Guardian Life Ins. Co. of Am., 873 F.2d 486, 489 (1st Cir. 1989)).

83. *See id.*; *Harris*, 208 F.3d at 277–78 (finding that contract language in ERISA plans must be given plain meaning). *See, e.g.*, Brazas Sporting Arms, Inc. v. Am. Empire Surplus Lines Ins. Co., 220 F.3d 1, 4 (1st Cir. 2000) (explaining that traditional rules of contract interpretation are used for ERISA plans).

84. *Rodrigues-Abrue*, 986 F.2d at 586.

85. *Id.*

86. *Id.*

whether the language can be construed plainly or if it is ambiguous.[87] If the language is ambiguous, courts must consider the surrounding circumstances and undisputed extrinsic evidence to interpret and apply the language of the ERISA plan.[88]

In addressing ambiguous language, the Fourth Circuit in *Stanford* affirmed the holding in *Rodrigues-Abrue*.[89] The Fourth Circuit asserted that reviewing courts must find substantial evidence to support an ambiguity in the plan's provisions.[90] The Court explained that there must be 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."[91] Yet, in *Stanford*, the Court held that every ambiguity cannot be found in the plan holder's favor.[92] The Court reasoned that reviewing courts must remember to give the plan administrator discretion when interpreting and applying ambiguous language.[93] Thus, under *Stanford*, courts must continue to apply the arbitrary and capricious standard when there is ambiguity in a plan's provision.[94]

### *C. Additional Considerations for Reviewing Courts*

Following review of the plan administrator's interpretation and application of an ERISA plan, courts are to consider whether the plan administrator's denial of benefits was "reasoned and supported by substantial evidence"[95] that is "sufficient to support a conclusion."[96] For example, in *Gannon v. Metro. Life Ins. Co.*, the First Circuit explained that the existence of contrary evidence does not mean that a plan administrator's decision is automatically arbitrary and will not be upheld.[97] Even when there is contrary evidence, substantial evidence may nonetheless

87. *See id.* (citing Federal Deposit Ins. Corp. v. Singh, 977 F.2d 18, 22 (1st Cir. 1992)).

88. *See id.* (citing Lumpkin v. Envirodyne Indus., Inc., 933 F.2d 449, 456 (7th Cir. 1990)).

89. *See* Stanford v. Cont'l Cas. Co., 514 F.3d 354, 357 (4th Cir. 2008) (finding that where there is a contact ambiguity, the court must determine the plan administrator's decision to be supported by more substantial evidence that shows there was no abuse of discretion).

90. *See id.* at 357.

91. *Id.*

92. *See id*. ("[T]the reduced deference standard does not require the reviewing court to construe every contract ambiguity in favor of the claimant.").

93. *See id.* (noting that if the court was required to construe every contract ambiguity in favor of the claimant, then the provision granting the plan administrator discretion would be erased).

94. *See id.* (finding that even where there is a contract ambiguity, and a conflict of interest such as "when a benefit plan is administered and funded by the same party," the plan administrator is entitled to some deference).

95. Gannon v. Metro. Life Ins. Co., 360 F.3d 211, 213 (1st Cir. 2004) (citing Vlass v. Raytheon Employees Disability Trust, 244 F.3d 27, 30 (1st Cir. 2001)).

96. *Id.* at 213.

97. 360 F.3d 211, 213 (1st Cir. 2004).

support a conclusion that the Court held.[98] In this case, the First Circuit considered medical records, medical opinions, surveillance reports, and other expert evaluations to be substantial evidence.[99] In the aggregate, the First Circuit found this evidence was substantial enough to support a conclusion in this instant case.[100]

Adopting the reasoning set forth in *Gannon*, the United States District Court for the Western District of Michigan in *Kufner v. Jefferson Pilot Fin. Ins. Co.*,[101] agreed that "extensive medical evidence, treatment records, and the opinions of plaintiff's physicians" is substantial evidence that supports a conclusion.[102] The *Kufner* Court found that the reviewing court and the plan administrator must take this evidence into account when applying the plan's provisions.[103] The Court reasoned that where the plan administrator ignored substantial evidence, the administrator's decision can be deemed arbitrary and capricious for abuse of discretion.[104] In the case at issue here, the First Circuit found that the plan administrator's decision "lack[ed] a credible basis for denying benefits."[105] Thus, under *Kufner*, reviewing courts must locate any substantial evidence and ensure that the plan administrator has taken this evidence into account.[106]

### *D. State and Lower Federal Courts Adopted Varying Interpretations of a Current Disability*

Various state and lower federal courts have issued differing opinions on whether ERISA plan administrators have reasonably determined if the risk of relapse into substance abuse is equal to a current disability that is deserving of long-term disability benefits.[107] When evaluating a plan administrator's decision for denial of benefits, reviewing courts must not only apply the arbitrary and capricious standard, courts must also consider the meaning of a risk of relapse into

98. *Id.*

99. *Id.* at 213–14.

100. *See id.* at 213–16. Here, the Court found that "in the presence of conflicting evidence, it is entirely appropriate for a reviewing court to uphold the decision of the entity entitled to exercise its discretion." *Id.* at 216.

101. 595 F.Supp.2d 785 (W.D. Mich. 2009).

102. *See id.* at 797 (identifying substantial evidence that supported the conclusion that the plaintiff's probability of relapsing was high enough to justify a disability, under the insurance plan).

103. *See id.* (determining that the plan administrator's decision did not result from a "deliberate principled reasoning process," and was not "supported by substantial evidence") (internal quotations omitted).

104. *See id.*

105. *See id.* (finding the plan administrator's decision to deny the plaintiff benefits was unreasonable because the plan administrator failed to conduct a proper review of the plan and substantial extrinsic evidence provided by the plaintiff).

106. *See id.* (noting that where the plan administrator fails to take substantial evidence into account, the administrator's decision may constitute an abuse of discretion).

107. *See infra* Part II.B.1–2 (discussing courts that defined the risk of relapse as a current disability and courts that declined to define the risk of relapse as a current disability).

substance abuse.[108] Hence, the consideration of the risk of relapse is contingent on a court's interpretation of the language found in a long-term disability plan.[109] State and lower federal courts adopted varying interpretations of whether a risk of relapse into substance abuse constitutes a current disability based on the plan administrator's interpretation, disability claims, and medical evidence of the disability.[110] As a result, the courts are split.[111] Some state and lower federal courts find a risk of relapse into substance abuse to constitute a current disability,[112] while others do not.[113]

*1. Courts Defining the Risk of Relapse as a Current Disability*

Some state and lower federal courts reasoned that a risk of relapse into substance abuse constitutes a current disability under an ERISA long-term disability plan.[114] For example, in *Price v. Disability, RMS*,[115] the United States District Court for the District of Massachusetts explained, "that the risk that a recovering substance abuser may relapse would be sufficient to support a finding of total disability as defined in the Policy."[116] Yet, in *Price*, the District Court held that there was no substantial evidence that supported a finding of a current disability.[117] Thus, the Court merely recognized that a risk of relapse into substance abuse could constitute a current disability where there is evidence to support this conclusion.[118]

Similarly, in *Kufner v. Jefferson Pilot Fin. Ins. Co.*, the United States District Court for the Western District of Michigan explained that extensive evidence indicated that the risk of relapse constituted a current disability under an ERISA long-term disability plan.[119] The District Court found that a plan administrator's

108. *See Colby I*, 603 F.Supp.2d 223, 241–42 (D. Mass. 2009) (stating that courts should take into consideration any evidence that indicates whether an individual's risk of relapse is a "disabling sickness" under a long-term disability plan).

109. *See infra* Part II.B.1 (showing that courts adopted varying interpretations of whether a risk of relapse constituted a current disability).

110. *See infra* Part II.B.1

111. *Colby III,* 705 F.3d 58, 59–60 (1st Cir. 2013).

112. *See infra* notes 116–20 and accompanying text.

113. *See infra* Part II.B.2.

114. *See* Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F.Supp.2d 785, 797 (W.D. Mich. 2009) (awarding the plaintiff disability benefits where a plan administrator's denial of benefits was arbitrary and capricious); Price v. Disability RMS, No. 06-10251-GAO, 2008 WL 763255, at *21 (D. Mass. 2008) (recognizing that the risk of relapse constitutes a current disability, even though the plaintiff's claim did not meet the standard for a current disability).

115. 2008 WL 763255.

116. *Id.* at *21.

117. *See id.* (explaining that the plaintiff's risk of relapse was only identified in general terms, without specific data that supported the plaintiff's circumstances).

118. *See id.* (showing that if the plaintiff's record supported his claim for risk of relapse, then the risk could constitute a current disability).

119. *Kufner*, 595 F.Supp.2d 785, 795–97 (W.D. Mich. 2009).

denial of continuing long-term disability benefits to Ronald Kufner, an opioid and alcohol-dependent anesthesiologist, was an abuse of discretion.[120] The *Kufner* Court reasoned that there was extensive evidence presented to support the disability claim, as well as case-specific factors such as "the nature of the evidence, conflict of interest, and public health and safety."[121] The plan administrator received extensive evidence showing the risk of relapse "remained a lifelong issue" for Ronald Kufner.[122] Yet, the plan administrator did not take this extensive evidence into consideration when making a disability benefits determination.[123] Therefore, the *Kufner* Court concluded that the plan administrator's decision did not result "from a 'deliberate principled reasoning process,'" or was "'supported by substantial evidence.'"[124]

*2. Courts Declining to Define the Risk of Relapse as a Current Disability*

The United States Court of Appeals for the Fourth Circuit, in *Stanford v. Cont'l Cas. Co*., reasoned that a risk of relapse into substance abuse does not constitute a current disability under an ERISA long-term disability plan.[125] Thus, individuals that have a potential risk of relapse into substance abuse are excluded from receiving the benefits of a long-term disability plan.[126] The Fourth Circuit explained that a plan administrator's denial of long-term disability benefits was reasonable where a nurse practitioner, who was addicted to Fentanyl, risked relapsing into substance abuse.[127] Robert Stanford, the nurse practitioner, enrolled

120. *See id.* at 788, 792.

121. *See id.* at 792. The court used the evidence that was presented to determine whether the plan administrator interpreted the disability plan and the plaintiff's disability claim reasonably. *See id.* at 797. "Weighing the record and the factors involved in the benefits determination, the Court concludes that defendant abused its discretion in disregarding plaintiff's evidence and opinions in favor of the "independent" opinions secured by defendant, from physicians who are less qualified on addiction issues and less familiar with plaintiff's medical treatment." *Id.*

122. *See id.* at 794–95. The plan administrator reviewed extensive evidence provided by medical experts, before the denial of benefits occurred. *See id.* at 794. "Defendant's initial denial was based on a review of medical records and opinions submitted by plaintiff. Defendant subsequently secured opinions from Dr. Gratzer and Dr. Goldman, which defendant ultimately relied on in denying plaintiff's claim for LTD." *Id.*

123. *See id.* at 792.

124. *Id.* at 797.

125. *See* Stanford v. Cont'l Cas. Co., 514 F.3d 354, 361 (4th Cir. 2008). *But see id.* (Wilkinson, J., dissenting) (arguing that the majority's holding was based on two abstractions that are not grounded in the law: (1) the disability plan does not have to cover a risk of relapse, and (2) the risk of relapse is different than physical illnesses like a heart attack).

126. *See id.* at 361 (majority opinion) (explaining that the risk of relapse is "not a form of disability under the benefit plan").

127. *See id.* at 361; *see also id.* at 355 (explaining how "Stanford [who was] a trained nurse anesthetist, a health care professional responsible for administering anesthesia to patients undergoing surgical and obstetric procedures," began to self-administer Fentanyl, and became addicted to the drug by September 2003).

into treatment programs three times and relapsed twice.[128] When Stanford completed the third treatment program, the plan administrator terminated Stanford's disability benefits.[129] The Fourth Circuit contended that the plan administrator's denial of benefits was not arbitrary or capricious.[130] Reasoning that substance abuse is a choice and not a disability, the *Stanford* Court concluded that "whether [the nurse practitioner] succumbs to that temptation [of relapsing in substance abuse] remains his choice; the heart-attack prone doctor has no such choice."[131]

In *Stanford*, the Fourth Circuit determined that the risk of relapse into substance abuse was unlike the risk of recurrence of a heart attack.[132] This conclusion relied on the distinction between the origins of the risks of these two conditions.[133] The Fourth Circuit reasoned that:

> [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.[134]

Consistent with this reasoning, the Court asserted that the individual facing a risk of relapse into substance abuse has a choice to make, where the individual facing a risk of another heart attack has no choice.[135] Hence, the Fourth Circuit held that a risk of relapse into substance abuse is not a current disability. In holding that the risk of relapse into substance abuse was not a current disability under ERISA,[136] the Fourth Circuit established a categorical exclusion.[137] The Court recognized "that this creates a somewhat troubling – some might say perverse – incentive structure: an addict who continues to abuse drugs will be entitled to long-term benefits, but upon achieving sobriety will lose those benefits unless he again begins to abuse drugs."[138] Yet, the Fourth Circuit found that where there is a risk of relapse into

128. *See id.* at 356.
129. *See id.*
130. *Id.* at 361.
131. *Id.* at 358.
132. *Id.* at 358.
133. *See id.*
134. *Id.* (internal quotation marks omitted).
135. *See id.* (discussing how the risk of relapse into substance abuse is not the same as the risk of a reoccurring heart attack, because the risk of relapse involves the choice to avoid temptation).
136. *Id.* at 361.
137. *See id.* (finding that where the disability plan contains no language concerning the risk of relapse, the Fourth Circuit has permitted a plan administrator's decision to exclude the potential risk).
138. *Id.* at 359.

substance abuse, there is no current disability.[139] Thus, the individual prone to relapse into substance abuse does not qualify for long-term disability benefits.[140]

## III. THE COURT'S REASONING

In *Colby v. Union Sec. Ins. Co.*, the United States Court of Appeals for the First Circuit affirmed the judgment of the United States District Court for the District of Massachusetts, holding that the risk of relapse into substance abuse is significant enough to be a current disability.[141] In so holding, the First Circuit concluded that Dr. Colby had a current disability that qualified for disability benefits, and therefore USIC acted unreasonably in terminating Dr. Colby's long-term disability benefits.[142]

According to the majority, in order to determine whether Dr. Colby had a current disability that qualified for disability benefits, the court had to assess the reasonableness of USIC's termination of Dr. Colby's benefits based on the arbitrary and capricious standard.[143] The *Colby* Court acknowledged that the main issue on appeal was whether USIC exercised reasonable discretion when it terminated Dr. Colby's benefits, finding that the risk of relapse was not a current disability.[144]

In deciding the case, the First Circuit examined Dr. Colby's claim for long-term disability benefits with regard to her risk of relapse into substance abuse.[145] First, the Court assessed Dr. Colby's long-term disability benefits plan to determine whether Dr. Colby's claim for disability benefits was supported by the plan.[146] Upon completing this assessment, the Court found that Dr. Colby's plan included an occupation test.[147] This test covered injury and sickness, and "require[d] a claimant to 'be under the regular care and attendance of a doctor, and [have a condition that] prevents [her] from performing at least one of the material duties of [her] regular occupation.'"[148] According to this test, the Court must evaluate Dr. Colby's ability to perform at least one of the material duties of her job as a physician.[149] This evaluation of whether Dr. Colby could complete her job as a

139. *Id.* at 360.

140. *See id.* at 358.

141. *Colby III*, 705 F.3d 58, 59–60 (1st Cir. 2013).

142. *See id.* at 68.

143. *See id.* at 59–60.

144. *See id.* at 61 (explaining that the court must show deference when reviewing whether the USIC plan administrator appropriately used her discretion in the interpretation and application of the plan).

145. *See id.* at 62.

146. *See id.*

147. *Id.*

148. *See id.* (indicating that coverage under the occupational test applies to the "first 36 months of a period of disability, subsequent to a 90-day waiting period").

149. *See id.*

physician consisted of a number of factors, including Dr. Colby's ability to work full-time, Dr. Colby's medical records and reports, and a medical expert's opinion and diagnosis of Dr. Colby's conditions.[150]

The First Circuit considered Dr. Colby's risk of relapse in light of the plan's occupation test.[151] The Court recognized that substance abuse, substance dependence, and substance addiction are like mental illnesses and constitute sickness under the plan's terms.[152] Dr. Colby "suffered from opioid dependence and addiction, . . . and faced such a significant risk of relapse that she could not perform one or more of the material duties of her customary occupation."[153] The Court explained that Dr. Colby's risk of substance abuse was likely to become a "sickness" because of Dr. Colby's occupation and her access to the drug of her choice.[154] Dr. Colby was a physician that worked with opioids and was exposed to other substances that attributed to a higher risk of substance abuse.[155] Additionally, the *Colby* Court noted that there were other conditions that could trigger Dr. Colby's tendency to use opioids, such as her continual back pain, various mental disorders, and stressors from her personal life.[156] Thus, under the occupation test, the First Circuit contended that Dr. Colby would be unable to perform one or more of her material duties as a physician because her occupation attributed to a heightened risk of relapse into substance abuse.[157]

In determining whether Dr. Colby's high risk of relapsing into opioid dependency constituted a sickness under the plan's occupation test, the First Circuit further considered Dr. Colby's medical records and reports, and any medical expert's opinion on Dr. Colby's condition.[158] The Court explained "[Dr. Colby's] record reflects that, due largely to risk of relapse, a number of medical experts agreed that [Dr. Colby] remained disabled[159] for at least some period of time . . . ."[160] The *Colby* Court also stated that "a number of allied professionals

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.* at 62–63.

154. *Id.*

155. *See id.* at 63 (explaining that even though there was conflicting evidence, "the record generally suggests that the plaintiff was at a high risk of relapse into opioid dependence following her discharge from inpatient care").

156. *Id.*

157. *See id.*

158. *See id.* at 62–63 (explaining that Dr. Colby's therapist, Dell-Ross, predicted that if Dr. Colby returned to work, her "access to opiates, . . . combined with the usual and unusual stressors of everyday life and work would make her relapse almost inevitable").

159. *See id.* (stating that experts found to the term "disabled" to mean that Dr. Colby faced a high risk of relapse where she "could not perform one or more of the material duties of her customary occupation").

160. *Id.* at 63–64. Dr. Alan A. Wartenberg wrote: "to a reasonable degree of medical certainty, Dr. Colby is at high risk of relapse should she return to the practice of anesthesia, or to any situation where she could access anesthetic opioids." *Id.* at 64. Dr. Marcus J. Goldman wrote:

agreed with these assessments."[161] This extensive evidence indicated that Dr. Colby was indeed at a "very significant risk of relapse" and that she lacked the "functional capacity for returning to work," the Court concluded.[162]

After reviewing whether Dr. Colby's condition met the plan's occupation test, the Court evaluated USIC's termination of Dr. Colby's benefits.[163] The First Circuit noted that USIC "took a categorical approach, steadfastly maintaining that risk of relapse, whatever the degree, could not constitute a current disability under the plan."[164] Yet, the Court explained that "the defense is not viable in this case: given the language of the plan, categorically excluding risk of relapse as a source of disability is simply unreasonable."[165] The plain language of the plan "admits . . . no such categorical bar", the Court stated.[166] Recognizing that the plan made no mention of the risk of relapse, the Court determined that there was no per se exclusion of risk of relapse within the terms of the plan.[167] The First Circuit determined that there was no basis for reading an exclusion for risk of relapse into the plan.[168]

Following this, the Court mentioned Judge Wilkinson's dissenting opinion in *Stanford v. Cont'l Cas. Co.*,[169] where it previously held that a risk of relapse into substance abuse does not constitute a current disability under an ERISA long-term disability plan.[170] The Court agreed with the dissenting opinion, finding that "to relapse into addiction or lose . . . benefits would thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise to cope with it."[171] Furthermore, the First Circuit reasoned that USIC's

"the plaintiff had psychiatric functional incapacity from July 2004 through the end of 2005 and that her "risk of relapse . . . was significant." *Id.* Dr. William B. Land wrote: "the combination of psychiatric and physical conditions [including opioid dependence] rendered her unable to perform duties not only of an anesthesiologist, but also for a physician generally given the access to opioids." *Id.* Dr. Land also stated that Dr. Colby "appeared to have numerous psychosocial stressors which would have precipitated a relapse." *Id.*

161. *See id.* at 64 (discussing additional views of experts who agree that Dr. Colby's risk of relapse is significant). For example, Dr. Milton Jay, Ed. D., wrote: "[Dr. Colby had a] moderate severity relapse profile." *Id.*

162. *Id.*

163. *See id.* (discussing how USIC's initial motion for judgment suggested that "a mere risk of relapse into a prior, self-controlled condition is not . . . [a] condition that would preclude [Dr. Colby] from working in her occupation").

164. *Id.* at 64.

165. *Id.* at 65.

166. *Id.*

167. *Id.*

168. *See id.* (discussing how USIC determined a risk of relapse to be "a speculative future possibility" and not a present risk, refusing to consider whether Dr. Colby's risk of relapse was a present disability).

169. *See id.* at 66 (agreeing with Judge Wilkinson's dissenting opinion in *Stanford* that "there is no basis for importing an unwritten textual exclusion for risk of relapse into the plan").

170. *See* Stanford v. Cont'l Cas. Co., 514 F.3d 354, 360–61 (4th Cir. 2008).

171. *Colby III*, 705 F.3d at 66 (quoting *Stanford*, 514 F.3d at 362) (Wilkinson, J., dissenting).

termination of Dr. Colby's long-term disability benefits created a "perverse incentive" where Dr. Colby was permitted to receive benefits if she relapsed into substance abuse.[172]

The First Circuit in *Colby* concluded that "without such a written exclusion in place, we believe USIC acted arbitrarily and capriciously in refusing to consider whether [Dr. Colby's] risk of relapse swelled to the level of a disability."[173] The Court noted that its holding was based on the arbitrary and capricious standard, granting discretion to USIC's denial of long-term disability benefits.[174] Thus, the First Circuit narrowly held that Dr. Colby's risk of relapse into substance abuse is significant enough to be a current disability, in light of the particular facts of the case and the terms of her benefit plan.[175] Finding USIC's categorical approach inapplicable to this case, the First Circuit affirmed the judgment of the United States District Court for the District of Massachusetts by applying a case-by-case approach, permitting long-term disability benefits for the risk of relapse given the specific facts of Dr. Colby's case.[176]

## IV. ANALYSIS

In *Colby v. Union Sec. Ins. Co.*, the United States Court of Appeals for the First Circuit accurately held that the risk of relapse into substance abuse constituted a current disability under the Employee Retirement Income Security Act (ERISA).[177] The First Circuit's holding provided a clear standard of review for reviewing courts to employ when determining whether the risk of relapse is a condition that may constitute a long-term disability.[178] In its opinion, the Court adhered to the arbitrary and capricious standard in reviewing the plan administrator's decision, finding that a categorical exclusion cannot be written into the plan's provisions where that language is absent.[179] The First Circuit correctly relied on expert testimony to determine the significance of a risk of relapse into

172. *Id.* The court in *Kufner v. Jefferson Pilot Fin. Ins. Co.* agreed with this statement, finding that "unless and until …an actual relapse of narcotics addiction [occurs] . . . is untenable given the serious risk this poses to public health and safety." 595 F.Supp.2d 785, 796 (W.D. Mich. 2009).

173. *Colby III*, 705 F.3d at 67.

174. *See id.*

175. *See id.*

176. *Id.* at 67. The First Circuit recognized that its holding permits long-term disability benefits for the risk of relapse, where the Fourth Circuit has denied these benefits. *See id.* "We are keenly aware that the only court of appeals to have considered this precise issue has – albeit in a two-to-one decision – reached a contrary conclusion." *See id.*; Stanford v. Cont'l Cas. Co., 514 F.3d 354, 360–61 (4th Cir. 2008).

177. *See Colby III*, 705 F.3d at 59–60.

178. *See id.* at 65–66.

179. *See id.* at 65.

substance dependence, finding the risk sufficiently acute to constitute a current disability under the terms of the ERISA disability plan.[180]

Unlike the Fourth Circuit, the First Circuit's decision was accurate, as it was grounded in the traditional arbitrary and capricious calculus that included the consideration of evidence from medical experts.[181] Even so, the First Circuit failed to address whether the risk of relapse constitutes a current disability under any circumstance.[182] While the Court's decision to define the risk of relapse as a current disability furthers the argument that the risk of relapse is the same as a risk of mental illness,[183] the Court did not address how other reviewing courts should view the nature of the risk of relapse when determining if the risk is a current disability.[184] Furthermore, the *Colby* opinion did not clearly state what bridged the gap between risk of relapse and actual substance abuse.[185] The First Circuit should have adopted a bright-line rule to address instances where a certain disability, like a risk of relapse into substance abuse, is not included in a disability plan's plain language.

### *A. The Court's Ruling was Grounded in the Traditional Arbitrary and Capricious Calculus*

In *Colby*, the First Circuit properly adhered to the arbitrary and capricious standard when it assessed the reasonableness of the plan administrator's termination of the plaintiff's disability benefits under her ERISA plan.[186] First the Court examined the plaintiff's claim for long-term disability benefits by assessing the extent of her risk of relapse into substance abuse. [187] Next, the Court analyzed whether the claim for disability benefits was supported by the plan.[188] It found that the plaintiff's plan included an occupation test that consisted of a number of

180. *See id.* at 63–64 (discussing how the court considered Dr. Colby's therapist's opinion and diagnosis, as well as the view of medical experts, when evaluating the plan administrator's decision). *See supra* notes 160–64 and accompanying text.

181. *See infra* Part IV.A (discussing how the First Circuit's decision was grounded in the traditional arbitrary and capricious calculus).

182. *See infra* Part IV.B.

183. *See Colby III*, 705 F.3d at 62 (recognizing that if the risk of relapse constituted a current disability under the plan's occupation test, it would give rise to sickness like a mental illness).

184. *See infra* Part IV.C (discussing how the First Circuit did not provide guidance to other reviewing courts that will determine whether the risk of relapse is the same as an actual substance dependence, which is a current disability that can be afforded benefits under an ERISA plan's occupation test).

185. *See infra* Part IV.C (discussing how the risk of relapse into substance dependence was not included in the plan's language as a disability that could constitute benefits, yet the First Circuit found that the risk of relapse was a current disability, like actual substance dependence).

186. *See Colby III*, 705 F.3d at 61 (noting that the standard of review was deferential).

187. *See id.* at 62.

188. *Id.*

factors, including the plaintiff's ability to work full-time,[189] the plaintiff's ability to assess patient's medical records and reports, and a medical expert's opinion and diagnosis of the plaintiff's conditions.[190]

After reviewing the plaintiff's claim under the plan's occupation test, the First Circuit evaluated the plan administrator's termination of the plaintiff's benefits.[191] It found that the plan administrator "took a categorical approach, steadfastly maintaining that risk of relapse, whatever the degree, could not constitute a current disability under the plan."[192] Additionally, the Court determined that it was unreasonable for the plan administrator to categorically exclude the risk of relapse where the plain language of the plaintiff's plan "admits . . . no such categorical bar."[193] Since the plaintiff's plan made no mention of the risk of relapse, there could be no exclusion for the risk within the terms of the plan.[194] Thus, the First Circuit concluded that there was no basis for implying a categorical exclusion for the risk of relapse into substance abuse.[195]

Conversely, in *Stanford*, the Fourth Circuit held that the plan administrator could categorically exclude the plaintiff's risk of relapse from coverage where the plaintiff's disability plan made no mention of the risk.[196] In evaluating the plaintiff's claim for disability benefits, the Fourth Circuit determined whether the claim was supported by the plan's occupation test.[197] Following application of the plan's occupation test, the plaintiff's ability to perform at least one of the material duties of the plaintiff's occupation, in light of the plaintiff's risk of relapse into substance abuse was considered.[198] Yet, the Fourth Circuit did not consider a medical expert's opinion and diagnosis of the plaintiff's conditions.[199]

In *Stanford* the Fourth Circuit contended that the plan administrator's decision that a "risk of relapse was not a form of disability under the benefit plan was reasonable, even if strong arguments exist to the contrary; its failure to consult with a health care professional in making that determination was not improper

189. *See id.* (explaining that working full-time meant Dr. Colby worked at least forty-five hours per week).

190. *Id.*

191. *Id.* at 64–65.

192. *Id.* at 64.

193. *Id.* at 65.

194. *Id.*

195. *Id.* at 66.

196. Stanford v. Cont'l Cas. Co., 514 F.3d 354, 361 (4th Cir. 2008).

197. *Id.* at 357–58.

198. *See id.* at 358–59 (explaining that the plaintiff was capable of performing his former occupation because he was not physically or mentally disabled, but his license dictated that he could not return).

199. *Id.* at 360 (noting that the "determination that such a risk of relapse did not fall within the benefit plan's definition of 'disability'" was based on an analysis that was "purely contractual, not medical.").

since the decision was contractual rather than medical."[200] Unlike the First Circuit, the Fourth Circuit in *Stanford* incorrectly permitted the plan administrator to write in an exclusion for the risk of relapse when the plan itself did not include such an exclusion.[201] The Fourth Circuit also failed to examine evidence provided by medical experts about the plaintiff's condition, and his ability to perform the duties of his occupation.[202] In making its determination, the Fourth Circuit did not follow the arbitrary and capricious calculus for the plan's occupation test, which indicates that Courts should consider "aggregate evidence" when reviewing a plan administrator's decision.[203] Additionally, the Court permitted the plan administrator to write in a categorical exclusion and glossed over the fact that there was no plan provision addressing risk of relapse.[204] Thus, the Fourth Circuit based its decision on a faulty premise, as it was not grounded in the traditional standard of review like the First Circuit's decision.[205]

### *B. While the Court's Ruling Was Accurate, it Failed to Address Whether a Risk of Relapse into Substance Abuse is a Current Disability Under Any Circumstance*

In *Colby,* the First Circuit correctly concluded that the risk of relapse into substance abuse was the same as a current disability under the standard supplied by the plaintiff's ERISA long-term disability benefits plan.[206] Rather than addressing the issue of whether a risk of relapse constitutes a current disability, the court focused on whether the risk of relapse constituted a current disability under the narrowly-tailored provisions of the plaintiff's long-term disability plan.[207]

The First Circuit narrowly focused on the provisions of the plaintiff's ERISA long-term disability plan.[208] The plan's provisions included an occupation test, which covered injury and sickness, and "require[d] a claimant to 'be under the regular care and attendance of a doctor, and prevents [the claimant] from

200. *Id.* at 361.

201. *Colby III*, 705 F.3d 58, 66 (1st Cir. 2013). *See Stanford*, 514 F.3d at 361 (discussing the Fourth Circuit's holding that the risk of relapse into substance abuse does not constitute a current disability under an ERISA long-term disability plan).

202. *See Stanford*, 514 F.3d at 361 (holding that "continental did not abuse its discretion in denying Stanford's long term disability benefits," and that "failure to consult with a health care professional . . . was not improper.").

203. *See Colby I*, 603 F.Supp.2d 223, 226 (D. Mass. 2009) (quoting Wright v. R.R. Donnelley & Sons. Co. Group Benefits Plan, 402 F.3d 67, 74 (1st Cir.2005)) (finding that "The operative inquiry under arbitrary, capricious or abuse of discretion review is 'whether the aggregate evidence . . . could support a rational determination that the plan administrator acted arbitrarily in denying the claim for benefits.'''')). *See also Stanford*, 514 F.3d at 361 (showing that the court did not consult medical experts when evaluating the plan administrator's decision).

204. *See supra* note 204 and accompanying text.

205. *Id.* at 361 (Wilkinson, J., dissenting).

206. *Colby III*, 705 F.3d at 59–60.

207. *See id.* at 67 (acknowledging that the court's holding is narrow).

208. *Id.* at 62.

performing at least one of the material duties of [her] regular occupation.'"[209] The occupation test required the court to evaluate Dr. Colby's ability to perform at least one of the material duties of her job as a physician.[210] The Court referred to the plan's occupation test to determine whether Dr. Colby's claim for disability benefits was supported by the plan.[211]

In making its decision, the Court's evaluation consisted of a number of factors, including Dr. Colby's ability to work full-time, Dr. Colby's ability to review her patient's medical records and reports, and a medical expert's opinion and diagnosis of Dr. Colby's conditions.[212] All of these factors pertained solely to the plaintiff, Dr. Colby.[213] The holding specifically addressed Dr. Colby's disability benefits claim, and Dr. Colby's risk of relapse.[214] However, the First Circuit failed to address whether a risk of relapse into substance abuse can constitute a current disability under any circumstance.[215] The Court should have gone further and addressed the central issue that is before the Courts of Appeals, to determine whether a risk of relapse may constitute a current disability regardless of the terms of an individual's specific disability plan.

### *C. While the Court's Ruling Was Accurate, it Failed to Provide a Remedy for the Major Issue at Hand*

The First Circuit's holding provides guidance on how other reviewing courts should review plan administrator's decisions. [216] However, the opinion fails to provide clear guidance on how reviewing courts should view the nature of the risk of relapse into substance dependence when deciding if the risk is the same as an actual dependence.[217] Only one other United States Court of Appeals has ruled on whether the risk of relapse into substance abuse constitutes a current disability: the Court of Appeals for the Fourth Circuit in *Stanford*, holding a contrary ruling to the First Circuit.[218] Hence, the First Circuit's decision in *Colby* creates a circuit split.[219] The First Circuit, the most recent court to rule on this issue, has not made it easy on its fellow courts reviewing whether a risk of relapse constitutes a current

209. *Id.* (alteration in original) (emphasis omitted).
210. *Id.*
211. *Id.*
212. *Id.*
213. *Id.* at 62.
214. *See id.* at 67.
215. *See id.* (explaining that the Court's holding was narrow).
216. *See id.* at 65–66 (explaining that the court evaluated the plan administrator's decision to terminate benefits by following the arbitrary and capricious calculus, assessing the plain language of the disability plan, interpreting the plan's occupation test, and considering the evidence provided by medical experts).
217. *See id.* at 67 (noting that the majority's holding is narrowly focused).
218. *Id.*
219. *Id.* at 59–60.

disability[220] because it did not clearly address how courts should view the risk of relapse into substance abuse.[221] Although the Court considered the occupation test under the plaintiff's disability plan, it failed to clearly state what bridged the gap between risk of relapse and actual dependence—making both conditions equal to a current disability under an ERISA long-term disability benefits plan.[222] The First Circuit should not have explicitly stated that the risk of relapse was not a sickness included in the disability plan. Instead the Court should have discussed how the risk of relapse constituted a current disability like substance dependence, even though it was not written in the disability plan.

During the arbitrary and capricious calculus, the First Circuit explained that the occupation test considered substance dependence to be a sickness, which could afford benefits.[223] However, the Court did not state that within the plan's occupation test, a risk of relapse into substance dependence was defined as a sickness that could afford benefits.[224] The opinion merely discussed what factors were to be considered to meet the standard for the plan's occupation test.[225] Then, the Court held that the plaintiff's risk of relapse met the standard for the plan's occupation test.[226] In light of the occupation test, the plaintiff's risk of relapse was so high that the plaintiff was unable to complete one or more of the material duties of her occupation, as a physician.[227]

In relying on medical expertise, the First Circuit explained that Dr. Colby experienced a significantly high risk of relapse into substance dependence.[228] Therefore it acknowledged that the level of risk was important.[229] Yet, in its opinion the Court did not explicitly state whether there was an actual range of risk level, and if this range could have an effect on the disability benefits determination.[230] The First Circuit should have specifically explained how courts

220. *See supra* note 37 and accompanying text.

221. *See infra* note 222 and accompanying text.

222. *Colby III*, 705 F.3d at 62 (showing the court's analysis did not address how the risk of relapse, which is not included in the plan's language as a disability, can be seen as an actual addiction to substance abuse, which is included in the plan's language as a disability deserving of long-term disability benefits).

223. *Id.*

224. *See id.* (noting that under the definition of "sickness" contained in the plan, substance abuse, dependence, and addiction may be covered).

225. *See id.* (discussing the factors of the occupation test, which relate to the plaintiff's ability to work full-time).

226. *Id.* at 60.

227. *See id.* at 64 (explaining that the material duties of the plaintiff's occupation include: working full-time as an anesthesiologist with access to the drug of her choice, Fentanyl).

228. *Id.*

229. *See id.* (noting that Dr. Colby's risk of relapse was significantly high).

230. *See id.* (discussing various expert's opinions on the level of Dr. Colby's risk of relapse into substance abuse).

should use the evidence from medical experts to determine whether a plaintiff is likely to risk relapse into substance abuse, and if there is a range of risk level.

The First Circuit could have referred to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for guidance on this issue.[231] The DSM-5 features the "standard classification of mental disorders used by mental health professionals in the United States."[232] The purpose of the DSM-5 is to "be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors."[233]

The First Circuit could have searched for "Opioid Use Disorders"[234] to get a better understanding of whether the risk of relapse into substance use dependence could be defined as an active substance use dependence, for purposes of receiving disability benefits under and ERISA plan.[235] Realistically, a risk and an active disorder are not the same thing, but in the context of a disability plan, the definition of these two conditions may be the same.[236] Yet, the DSM-5 finds that "individuals with opioid use disorder often develop conditioned responses to drug-related stimuli," and that "these responses probably contribute to relapse, are difficult to distinguish, and typically persist long after detoxification is completed."[237] Since the DSM-5 reveals that a risk of relapse is a condition that persists, it can be clearly argued that the risk is active and thus, a current disability.[238]

Second, the First Circuit did not indicate whether reviewing courts should find that the risk of relapse into substance abuse is the same as a risk of relapse into a mental illness or physical illness.[239] The Court should have addressed the Fourth Circuit's comparison between a risk of relapse into substance use and the likelihood of a reoccurring heart attack.[240] The Fourth Circuit stated that "whether [the plaintiff] succumbs to that temptation [of relapsing into substance abuse] remains his choice; the heart-attack prone doctor has no such choice."[241] The Fourth Circuit determined that the risk of relapse into substance abuse was not the

231. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, DSM-5, (5th ed. 2013).

232. *DSM*, AM. PSYCHIATRIC ASS'N, http://www.psych.org/practice/dsm (last visited Mar. 24, 2013).

233. *Id.*

234. *See supra* note 13 and accompanying text (indicating that Dr. Colby had dependence issues with Fentanyl, an opioid).

235. AM. PSYCHIATRIC ASS'N, *supra* note 234, at 541..

236. *See Colby III*, 705 F.3d 58, 62 (1st Cir. 2013) (explaining that the disability plan's occupation test covers injury and sickness, which pertain to current disabilities not future risks).

237. AM. PSYCHIATRIC ASS'N, *supra* note 234, at 542.

238. *Id.*

239. *See infra* notes 240–44 and accompanying text.

240. Stanford v. Cont'l Cas. Co., 514 F.3d 354, 358 (4th Cir. 2008).

241. *Id.* at 358.

same as the risk of recurrence of a heart attack.[242] In its holding, the Fourth Circuit asserted that the individual facing a risk of relapse into substance abuse has a choice to make, where the individual facing a risk of another heart attack has no choice.[243] In *Stanford,* the Fourth Circuit's comparison was not grounded in expert medical evidence.[244]

Reviewing courts should refer to expert medical testimony in making determinations that concern medical conditions. Medical research shows that individuals facing a risk of relapse into substance abuse do not have a choice in succumbing to temptation, as the Fourth Circuit states.[245] Research on addiction shows that substance abuse "alter[s] brain regions that control decision-making and judgment."[246] Dr. Nora D. Volkow, a physician who specializes in treating addiction, explains that repeated substance use affects the brain's functioning, control, and choice.[247] Dr. Volkow states that, "[d]rug addiction is insidious because it affects the very brain areas that people need to 'think straight,' apply good judgment and make good decisions for their lives."[248] Since this medical research reveals that individuals that risk relapse into substance dependence do not have a choice, it can be contended that the risk of relapse is like the risk of recurrence of a heart attack.[249] Thus, courts can contend that the risk of relapse into substance abuse is the same as a risk of relapse into a physical illness, and is deserving of disability benefits under any circumstance.[250]

## V. CONCLUSION

In *Colby v. Union Sec. Ins. Co.*, the United States Court of Appeals for the First Circuit determined that the risk of relapse into substance abuse was the same as a current disability under this ERISA long-term disability benefits plan.[251] Yet, the Court did not address how reviewing courts should view the nature of the risk of relapse when determining if the risk is a current disability.[252] The First Circuit should have clearly stated what bridged the gap between risk of relapse and actual

242. *Id.*

243. *Id.*

244. *Id.* at 361.

245. *See* Nora D. Volkow, *Addiction and the Brain's Pleasure Pathway: Beyond Willpower*, HBO, https://www.hbo.com/addiction/understanding_addiction/12_pleasure_pathway.html (last visited Apr. 6, 2014) (discussing how addiction causes a surge in levels of dopamine in the brain, which results in the repeated desire for pleasure). *See also* AM. PSYCHIATRIC ASS'N, *supra* note 234, at 542 (showing that the risk of relapse can be a "conditioned response").

246. Volkow, *supra* note 248.

247. *Id.*

248. *Id.*

249. Volkow, *supra* note 248; AM. PSYCHIATRIC ASS'N, *supra* note 234, at 542.

250. *See supra* notes 241–52 and accompanying text.

251. *Colby III*, 705 F.3d 58, 59–60 (1st Cir. 2013).

252. *See supra* Part IV.C.

substance abuse.[253] The Court should have specifically explained how courts should use the evidence from medical experts to determine whether a plaintiff is likely to risk relapse into substance abuse, and if there is a range of risk level.

253. *Supra* Part IV.C.