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I. INTRODUCTION

In July 2004, a member of a Massachusetts hospital's nursing staff found Dr. Julie Colby, an anesthesiologist, unconscious on a hospital table.[1] Dr. Colby had served as a partner in a Merrimack anesthesiology practice for sixteen years when she became addicted to Fentanyl, an opioid commonly used in the practice.[2] She took a leave of absence to enter an inpatient substance treatment facility, where she was diagnosed with an opioid dependence, depression, and obsessive-compulsive personality traits.[3] Pursuant to her employer's group employee benefit plan, her insurer provided long-term disability (LTD) benefits during inpatient treatment.[4] She remained at the treatment facility until November 2004 when she left to begin outpatient treatment, during which she was under regular medical supervision and did not resume her use of Fentanyl.[5] Nevertheless, the Massachusetts Board of Registration in Medicine revoked her license and her

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[1] Brief of Plaintiff–Appellee at 3, Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013) (No. 11-2270).

[2] Colby v. Union Sec. Ins. Co., 705 F.3d 58, 60 (1st Cir. 2013).

[3] *Id.*

[4] *Id.* See *infra* Part II for more background on LTD benefits.

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

insurer refused to provide benefits for any of her outpatient treatment because it did not consider her risk of relapse a "current disability" under her employee benefit plan.[6]

Unfortunately, Dr. Colby's experience is not particularly rare among anesthesiologists. A 2005 study surveying anesthesiology residency programs from 1991 to 2001 determined that eighty percent of programs reported opioid abuse among residents and nineteen percent reported pretreatment fatalities from opioid abuse.[7] While most residents attempted to reenter anesthesiology after treatment, only forty-six percent who attempted reentry had completed an anesthesiology residency at the time of the survey. The substance-related death rate for those who remained in anesthesiology was nine percent.[8] Forty percent of those who were treated and returned to medicine ultimately entered another specialty.[9] Long-term follow-up for treated residents indicated that fifty-six percent were successful in medicine, though often in a different specialty.[10]

Possible factors contributing to high rates of drug abuse among anesthesiologists include: ease of access to highly addictive drugs, the ease of diverting small quantities for personal use, a high-stress work environment, and the increased sensitivity

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[6] *Id.*; *see also* Plaintiff Julie Colby's Combined Opposition to Defendant's Motion for Summary Judgment and Reply Brief at 9, Colby v. Assurant Emp. Benefits, 818 F. Supp. 2d 365 (D. Mass. 2011) (No. 07-11488-RCL). The plan at issue defined "total disability" as "an injury, sickness, or pregnancy [that] requires that you be under the regular care and attendance of a doctor, and prevents you from performing at least one of the material duties of your regular occupation." Complaint at 4, Colby v. Assurant Emp. Benefits, 818 F. Supp. 2d 365 (D. Mass. 2011) (No. 07CV11488). Disabilities must be "current" in order for individuals to receive benefits. *Id.*

[7] Ethan O. Bryson & Jeffrey H. Silverstein, *Addiction and Substance Abuse in Anesthesiology*, 109 ANESTHESIOLOGY 905, 905 (2008).

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

[9] *Id.* at 1459.

[10] *Id.* at 1460. Long-term follow-up data was available for ninety-three percent (185/199) of the study residents. *Id.*

of the brain's reward pathways[11] resulting from workplace exposure to the drug.[12] Unsurprisingly then, anesthesiologists and others in the field are common plaintiffs in Employee Retirement Income Security Act (ERISA)[13] actions against insurers that deny LTD benefits to individuals recovering from substance abuse disorders.[14]

Because of the prevalence of anesthesiologist plaintiffs in cases determining whether recovering addicts should be entitled to LTD benefits, the cases discussed in this Note focus on the anesthesiology context. However, whether insurers should be required to provide LTD benefits to recovering addicts is an important question in any field, particularly those in which the public health and safety are at risk. Additionally, this Note focuses on ERISA-governed LTD plans. As the following discussion will demonstrate, it is in this context that the case for treating the risk of relapse as a "current disability" is particularly strong. However, many of the arguments that follow will be equally applicable outside of the ERISA context.

Courts are divided as to whether the risk of relapse into drug addiction constitutes a "current disability."[15] Under LTD benefit plans, a disability is generally defined for the first year or two as

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[11] Reward pathways are the parts of the brain that are "responsible for driving our feelings of motivation, reward and behavior." *See The Reward Pathway Reinforces Behavior*, GENETIC SCI. LEARNING CTR., http://learn.genetics.utah.edu/content/addiction/rewardbehavior/ (last visited Mar. 5, 2014).

[12] Bryson & Silverstein, *supra* note 7, at 905.

[13] 29 U.S.C. § 1001 (2012).

[14] *See, e.g.*, Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013); Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F. Supp. 2d 785 (W.D. Mich. 2009). For more information on ERISA, see *infra* Part I.

[15] *Compare Colby*, 705 F.3d 58 (upholding reversal of LTD benefit denial), *with* Stanford v. Continental Cas. Co., 514 F.3d 354 (4th Cir. 2008) (upholding LTD benefit denial). The disability plan at issue in *Stanford* defined disability as "injury or Sickness [that] causes physical or mental impairment to such a degree of severity that You are . . . continuously unable to perform the Material and Substantial Duties of Your Regular Occupation." Brief of Appellant at 10, *Stanford*, 514 F.3d 354 (No. 06-2006). For a claimant to be entitled to benefits, his disability must therefore be "current." *Id.*

a condition that prevents one from engaging in his regular occupation.[16] Afterward, the definition changes: it requires that the individual be unable to perform *any* gainful occupation.[17]

If a court determines that the risk of relapse is a "current disability," then it will require the insurer to provide benefits under standard LTD benefit plans.[18] The First and Fourth Circuits have come to opposite conclusions on this issue.[19] The First Circuit in *Colby v. Union Security Insurance Co.*[20] determined that the risk of relapse into drug abuse is akin to the risk of relapse into cardiac distress or orthopedic complications, and can therefore be so severe as to constitute a current disability for which LTD benefits must be provided. The court explained that a current disability could exist even when an individual is physically capable of performing his job.[21]

By contrast, the Fourth Circuit in *Stanford v. Continental Casualty Co.*[22] came to a different conclusion. In *Stanford*, the insurer had determined that the "potential risk of relapse" is not a current disability for which LTD benefits must be provided, and the court held that the insurer did not abuse its discretion in

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[16] Diane B. Hill, *Employer-Sponsored Long-Term Disability Insurance*, BUREAU OF LABOR STATISTICS 16, 17 (1987), http://bls.gov/opub/mlr/1987/07/art2full.pdf.

[17] *Id.*

[18] For more traditional types of conditions for which courts have upheld LTD benefits, see generally Rothman v. Office Env'ts of New England Health & Welfare Benefit Plan, 794 F. Supp. 2d 276 (D.Ma. 2011) (awarding LTD benefits to a salesperson who suffered from post-concussion syndrome); Adams v. Hartford Life & Acc. Ins. Co., 694 F. Supp. 2d 1342 (M.D. Ga. 2010) (holding that a plan participant who experienced cognitive problems following a stroke was entitled to LTD benefits); Alexander v. Winthrop, Simpson, Putnam & Roberts Long Term Disability Coverage, 497 F. Supp. 2d 429 (E.D.N.Y. 2007) (upholding LTD benefits to a legal secretary who suffered from persistent and severe lower back pain).

[19] *Compare Colby*, 705 F.3d 58 (upholding reversal of LTD benefit denial), *with Stanford*, 514 F.3d 354 (upholding LTD benefit denial).

[20] *Colby*, 705 F.3d at 59–60.

[21] *Id.* at 66.

[22] *Stanford*, 514 F.3d at 358–59.

making this determination.[23] The court ruled that while the risk of relapse into cardiac arrest is a likely result of a stressful work environment, the risk of relapse into substance abuse is a choice.[24] Also in contrast to the First Circuit, the Fourth Circuit distinguished heart conditions from drug addiction on the ground that one who is heart attack-prone has a current physical impairment, while one who risks relapse into substance dependence does not.[25] The court agreed with the insurer that the mere risk of relapse is not a current disability for which the insurer must provide LTD benefits.[26]

This Note examines whether the Fourth Circuit's decision in *Stanford* was justified and asserts that *Stanford* contravenes both Supreme Court precedent and the congressional intent that motivated ERISA's passage. Furthermore, *Stanford* is at odds with current psychology literature, which views addiction as a disease rather than a choice, and there is no compelling reason why ERISA plan administrators should treat the risk of relapse differently from other chronic medical conditions. Finally, the Fourth Circuit failed to properly take into account the potentially disastrous public policy consequences of *Stanford*. The First Circuit's decision in *Colby* is more firmly grounded in law and psychology, and it makes for better public policy. *Colby* therefore provides better guidance for future courts confronted with the issue of whether to construe the risk of relapse as a disability for which LTD benefits should be provided.

Part II provides a brief historical background of ERISA and LTD benefits. Part III details the differences between *Colby* and *Stanford*, and discusses related decisions by other courts.[27] Part

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[23] *Id.*

[24] *Id.* at 358.

[25] *Id.* at 359.

[26] *Id.* at 361.

[27] John Utz questions whether *Colby* and *Stanford* truly created a circuit split because the two courts were interpreting different plans. John L. Utz, *Addict's Risk of Relapse as Disability*, 21 ERISA LITIG. REP., no. 2, 2013, at 6. However, a true split is apparent given the courts' completely divergent attitudes regarding the nature of addiction. Utz's skepticism also ignores Judge Wilkinson's dissenting opinion in *Stanford*, which was echoed in *Colby*, and

IV examines recent psychology literature on addiction and how scholars in the field have come to regard addiction as a disease rather than a choice. Finally, Part V examines why *Stanford* is flawed and argues that courts should therefore follow the First Circuit in treating the risk of relapse into substance abuse as a "current disability."

II. HISTORICAL BACKGROUND OF ERISA AND LTD BENEFITS

During the Second World War, several economic factors contributed to an older workforce in the years that followed.[28] One factor was wartime inflation, which discouraged retirement by reducing the value of Social Security Old-Age and Survivors Insurance.[29] Another was the policy of many firms to directly discourage retirement.[30] Due to the resulting older workforce, Congress of Industrial Organizations (CIO) unions began to prioritize the interests of older workers by emphasizing retirement benefits in their collective bargaining agreements.[31] However, increased retirement benefits for older workers typically came at the expense of liberal vesting requirements and other policies that would have benefited younger workers.[32] Additionally, CIO unions often bargained for systems requiring employers to lay off workers in reverse order of seniority.[33]

Events at Studebaker-Packard[34] highlighted the vulnerability

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demonstrates how judges' differing attitudes toward addiction can result in sharply different interpretations of a benefit plan. *See Stanford*, 514 F.3d at 361–65 (Wilkinson, J., dissenting).

[28] James A. Wooten, *"The Most Glorious Story of Failure in the Business": the Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683, 687 (2001).

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *Id.* at 688. When funds are "vested," an employee has an absolute right to them. Employers cannot reclaim vested funds.

[33] *Id.*

[34] Studebaker was an American automobile manufacturer. It merged with the Packard Motor Car Company in 1954 to form Studebaker-Packard. Due to poor sales, Packard ceased operations in 1958. Studebaker continued to

of younger workers under these systems.[35] During the 1950s, adverse economic events, such as the loss of wartime defense contracts and a recession, made it more difficult for independent automobile manufacturers to compete with larger firms.[36] As a result of these events, in December 1963 Studebaker-Packard closed its plant in South Bend, Indiana.[37] To make matters worse for the employees, Studebaker-Packard's pension plan lacked adequate funds and the company defaulted on its obligations to workers under sixty, with some workers receiving nothing at all.[38] This was the result of a 1961 collective bargaining agreement, which favored older workers by prioritizing retirees and retirement-eligible employees over younger workers.[39] The plant's shutdown gained national attention when advocates of pension reform repeatedly invoked the default as a symbol of the need for regulation and reform.[40] While the closing of Studebaker-Packard became a rallying cry for pension reform advocates, pension reform remained controversial and it took more than a decade for substantial reform to occur.[41]

The reform effort culminated on Labor Day in 1974, when President Gerald Ford signed into law the Employee Retirement Income Security Act (ERISA).[42] Congress enacted ERISA in order to ensure that employees actually receive promised benefits in accordance with a benefit plan's terms.[43] To this end, ERISA imposes minimum standards for private industry pension plan

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manufacture cars until 1966. *History*, STUDEBAKER NAT'L MUSEUM, http://www.studebakermuseum.org/p/about/history/ (last visited Apr. 25, 2014).

[35] Wooten, *supra* note 28, at 684.

[36] *Id.* at 693.

[37] *Id.* at 683–84.

[38] *Id.* at 684.

[39] *Id.* at 731.

[40] *Id.* at 684.

[41] *Id.* at 739.

[42] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

[43] LEE T. POLK, 1 ERISA PRACTICE AND LITIGATION § 1:1 (2013). *See also* 29 U.S.C. § 1001 (2012).

administrators and creates causes of action for plan participants and their beneficiaries.[44] ERISA-imposed duties are derived from the common law of trusts.[45] Fiduciaries are therefore required to discharge their duties with the prudence of a reasonable man under like circumstances.[46] They must also "act solely in the interests of participants and beneficiaries and for the exclusive purposes of providing benefits and defraying reasonable expenses of the plan."[47] The statute creates a private cause of action against plan administrators who fail to meet their obligations.[48] While ERISA sets a benefit floor, employers can choose to provide greater benefits.[49] Courts may therefore enforce a contractual obligation to provide benefits beyond what the statute requires.[50]

ERISA's "standards of fiduciary responsibility" govern both "pension plans" and "welfare plans."[51] "Pension plans" include an array of deferred compensation plans, while "welfare plans" include a variety of benefits, such as disability insurance.[52] LTD insurance is designed to provide income to employees who are unable to work for extended periods due to prolonged disability.[53]

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[44] *ERISA*, LEGAL INFO. INST., http://www.law.cornell.edu/wex/erisa (last visited Mar. 5, 2014). ERISA also regulates the impact of federal income taxes on the management of benefit plans. *Id.*

[45] POLK, *supra* note 43, § 1:6. Trust law establishes principles by which one holds property for another's benefit.

[46] H.R. REP. NO. 93-533, at 4659 (2007). ERISA defines a "fiduciary" as the entity that manages the benefit plan and its assets. Often, both an employer and a hired administrator will serve as benefit plan fiduciaries. *ERISA Fiduciary Advisor*, DEPT. OF LAB., http://www.dol.gov/elaws/ebsa/fiduciary/q4a.htm (last visited Apr. 25, 2014).

[47] 2 AM. JUR. PROOF OF FACTS 3D *ERISA – Arbitrary Denial of Benefits Under Disability Income Plan* § 1 (1988).

[48] *See* 29 U.S.C. § 1132(a)(1)(B).

[49] PAUL J. ROUTH, WELFARE BENEFITS GUIDE § 2:27 (1973).

[50] *Id.*

[51] POLK, *supra* note 43, § 1:3.

[52] *Id.*

[53] ROUTH, *supra* note 49, § 2:27 ("It is not uncommon for a plan to provide that disability means the inability to perform one's regular duties for two years. After that, the definition often changes requiring the person to demonstrate an inability to perform any occupation for which the employee is reasonably qualified."). This ongoing inability is what renders a disability

The income amount is generally a predetermined percentage of the employee's pre-disability earnings.[54] Employees typically must have worked for an employer for a period of five months to a year before becoming eligible for LTD benefits.[55] In addition, employees must be disabled for an extended period, usually three to five months, before LTD benefits begin.[56] Thus, the LTD benefit period typically begins when the short-term disability period ends.[57] LTD benefit payments are generally payable until recovery, a specific age, or retirement.[58] Additionally, LTD payments may be reduced if an employee is only partially disabled, meaning the employee can either perform some duties of his original occupation or can perform another occupation in which his earnings are reduced.[59]

In an action for benefits, the court's standard of review will depend on whether the plan gives the administrator discretion to construe the plan's terms.[60] If the administrator is given no such discretion, the court will review the denial of benefits de novo.[61] If the administrator is given such discretion, the court will apply the arbitrary and capricious standard of review,[62] a deferential standard in which reversal is only appropriate if the lower court has failed to exercise sound and reasonable judgment.[63] However, if an administrator with discretion is operating under a conflict of interest, the reviewing court will consider this as a factor in

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"current."

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] Diane B. Hill, *Employer-Sponsored Long-Term Disability Insurance*, BUREAU OF LABOR STATISTICS 16, 16 (1987), *available at* http://bls.gov/opub/mlr/1987/07/art2full.pdf.

[59] *Id.* at 17.

[60] RONALD J. COOKE, 3 ERISA PRACTICE AND LITIGATION § 8:46 (2013).

[61] *Id.*

[62] *Id.*

[63] *Abuse of Discretion*, LEGAL INFO. INST., http://www.law.cornell.edu/wex/abuse_of_discretion (last visited Mar. 29, 2014).

determining whether the administrator has abused its discretion.[64]

III. RISK OF RELAPSE AS A CURRENT DISABILITY

Courts are conflicted as to whether the risk of relapse into substance abuse constitutes a "current" disability under LTD plans.[65] As noted earlier, the First and Fourth Circuits disagree on this issue. The Fourth Circuit contends that the risk of relapse involves a choice component and is not a continuous disability,[66] while the First Circuit asserts that the risk may be so severe as to render an individual "currently" disabled.[67] However, such disagreement is not confined to the First and Fourth Circuits.[68] Below is an overview of cases addressing this important question.

A. Cases Upholding the Denial of Benefits

1. Stanford v. Continental Casualty Co.[69]

Robert Stanford worked as a nurse anesthetist at Beaufort Memorial Hospital in South Carolina when he became addicted to Fentanyl, an anesthetic used in his practice.[70] After completing a twenty-eight-day inpatient treatment program, he returned to work only to relapse two months later.[71] He then began a ninety-day inpatient treatment program and filed for LTD benefits

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[64] COOKE, *supra* note 60, § 8:46.

[65] *Compare, e.g.*, Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013) (requiring LTD benefits), *with* Stanford v. Continental Cas. Co., 514 F.3d 354 (4th Cir. 2008) (upholding LTD benefit denial).

[66] *Stanford*, 514 F.3d at 358 ("Whether [an addict] succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice.").

[67] *Colby*, 705 F.3d at 60 ("[A] risk of relapse into substance dependence . . . can swell to so significant a level so as to constitute a current disability.").

[68] However, the First and Fourth Circuits are the only federal appeals courts to have addressed this question.

[69] *Id.* at 354; Stanford v. Continental Cas. Co., 455 F. Supp. 2d 438 (E.D.N.C. 2006).

[70] *Stanford*, 455 F. Supp. 2d at 439.

[71] *Id.* at 440; *Stanford*, 514 F.3d at 364.

pursuant to his employer's disability plan, administered by insurer Continental Casualty Company.[72]

The insurer initially granted Mr. Stanford's request for LTD benefits.[73] However, after Mr. Stanford spent several months in recovery, the insurer terminated his benefits, citing a lack of medical evidence that he was functionally unable to perform "the material and substantial duties of [his] regular occupation."[74] Mr. Stanford appealed the insurer's decision to terminate his benefits.[75] Along with the appeal, he submitted a letter from his treating physician, which stated that he could not return to work as a nurse anesthetist because he should not be subjected to controlled substances and because the effects of his treatment medication could put patients at risk.[76] After the insurer denied the appeal, Mr. Stanford filed suit in the United States District Court for the Eastern District of North Carolina alleging wrongful termination of benefits.[77] The court granted summary judgment in favor of the insurer, stating that the risk of relapse did not render Mr. Stanford disabled because he was not "continuously unable" to perform his duties.[78]

The Fourth Circuit affirmed the district court.[79] It took a narrow view of what constituted a "mental impairment" under the insurer's ERISA-governed plan and stated that while Mr. Stanford could not return to his old job, he was nevertheless "physically and mentally capable of performing that job and countless other jobs."[80] It further argued that addiction is a choice: "[w]hether [an addict] succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice."[81] The court therefore upheld the insurer's determination

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[72] *Stanford*, 455 F. Supp. 2d at 440.

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] *Id.* at 440–41.

[77] *Id.* at 441.

[78] *Id.* at 443.

[79] Stanford v. Continental Cas. Co., 514 F.3d 354, 361 (4th Cir. 2008).

[80] *Id.* at 359.

[81] *Id.* at 358.

that "Stanford no longer suffered from physical or mental impairments as a result of his drug use or his recovery, [and] the fact that he remained an addict did not [prevent him from performing] the material and substantial duties of [his] regular occupation."[82]

However, the *Stanford* court was sharply divided. Judge J. Harvie Wilkinson wrote an impassioned dissent, describing the majority's conclusion as "an uncommonly harsh result."[83] He argued that the majority's holding rested on two "abstractions" not grounded in law.[84] The majority's first "abstraction" was that a disability plan was not required to cover "potential risk of relapse."[85] According to Judge Wilkinson, the majority's rejection of "potential risk of relapse" as a current impairment appeared to exclude all serious medical conditions that could make performing one's job "unreasonably dangerous" because an individual could technically perform a job function at grave medical risk.[86] According to Judge Wilkinson, such an exclusion contravened "a basic tenet of insurance law that an insured is disabled when the activity in question would aggravate a serious condition affecting the insured's health."[87] The second "abstraction" was the majority's assertion "that for disability purposes, 'a physical condition such as a heart attack . . . is different from the risk of relapse into drug use.'"[88] Judge Wilkinson stated that the majority's attempt to distinguish these conditions was insufficient, as it rested on "moral considerations" that were not the court's to make.[89]

Judge Wilkinson also argued that the majority's position was

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[82] *Id.* (internal quotation marks omitted).

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

[84] *Id.*

[85] *Id.* at 361.

[86] *Id.* at 362.

[87] *Id.* at 362–63 (citation omitted).

[88] *Id.*

[89] *Id.* at 363. As an example, he explained that a laborer who could literally lift heavy objects, but only at the risk of partial paralysis, would likely prevail in an action for benefits. *Id.*

unsupported by the plan's plain language.[90] He noted that the plan covered "mental impairments" severe enough that one is "unable to perform the material and substantial duties of [his] regular occupation."[91] He defined "mental impairments" more broadly than the majority and pointed out that the plan defined "mental impairments" according to the American Psychiatric Association's diagnostic manual, which devotes an entire section to substance-related disorders, including addiction.[92]

Judge Wilkinson also made strong public policy arguments against the majority's holding.[93] He pointed out that the insurer's requirement that Mr. Stanford relapse in order to obtain disability benefits would not only create, as the majority acknowledged, a "perverse-incentive structure" by only paying benefits upon relapse, but would "thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise to cope with it."[94] Because he did not believe that the risk of relapse could be categorically excluded from coverage, he argued that the proper inquiry as to whether a condition constitutes a current disability is "fact-intensive" and should focus on the likelihood and severity of the risk.[95] Judge Wilkinson concluded that Mr. Stanford's prior relapses and the extensive medical evidence indicating that his risk of relapse was severe rendered him "currently" disabled.[96]

2. Allen v. Minnesota Life Insurance Co.[97]

Allen v. Minnesota Life Insurance Co, while not based on an ERISA claim, involves facts similar to *Stanford*.[98] In *Allen*, Dr.

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[90] *Id.* at 362.

[91] *Id.* at 361.

[92] *Id.*

[93] *Id.* at 362–63.

[94] *Id.* at 362.

[95] *Id.* at 364.

[96] *Id.* at 364–65.

[97] Allen v. Minn. Life Ins. Co., 216 F. Supp. 2d 1377 (N.D. Ga. 2001).

[98] *Id.* at 1378–81. Allen's plan was not ERISA-governed because he purchased it individually, not through his employer.

Robert Lee Allen, an anesthesiologist who practiced in Virginia, brought a breach of contract claim against his disability insurer claiming wrongful termination of his benefits.[99] Dr. Allen had been employed at Anesthesia Associates of Hampton for only a month when he began abusing Fentanyl.[100] However, less than three months after entering an inpatient treatment program, he was discharged with a favorable prognosis for recovery provided that he adhere to a prescribed treatment plan.[101]

Nevertheless, the Virginia Board of Medicine suspended Dr. Allen's license.[102] However, it stayed the suspension provided that Dr. Allen confine his medical practice to a Board-approved residency or fellowship.[103] Dr. Allen eventually completed a residency in internal medicine and the Board reinstated his license to practice medicine on unrestricted status.[104] Two months into his subsequent employment as an internist at Fayette Medical, his insurer notified him that it would discontinue his benefit payments.[105] Although Dr. Allen was successfully reemployed, he was not engaged in his "regular occupation," so he argued that he was entitled to continued benefits.[106] However, the court ruled that he was not "*unable* to engage in [his] regular occupation."[107] The court therefore upheld the insurer's denial because Dr. Allen

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[99] *Id.* at 1378.

[100] *Id.* at 1379.

[101] *Id.*

[102] *Id.* at 1380.

[103] *Id.* Dr. Allen commenced a residency in internal medicine shortly thereafter, although he returned to inpatient treatment due to concerns that he was violating Board-imposed restrictions on his practice. However, undisputed evidence indicated that he had not abused Fentanyl or alcohol since his initial treatment. *Id.*

[104] *Id.* at 1380–81.

[105] *Id.* at 1381.

[106] *Id.* at 1383.

[107] *Id.* (emphasis added). The plan defined "disability" as follows: "You have a disability if, because of continuing sickness or injury, you (1) are under the regular, reasonable, and customary care of a physician; and (2) are unable to engage in your regular occupation," provided that "you are not earning more than 30% of your prior average earned income from your regular occupation." *Id.* at 1378–79.

"suffer[ed] from no physical or mechanical limitations on his ability to practice anesthesiology."[108] It further determined that even though Dr. Allen's treating physician testified that he should not return to practicing anesthesiology, the physician based his opinion on "future potentialities" only, not on any present disability.[109]

The court also based its decision on its determination that Dr. Allen's disability was not "uninterrupted," as the plan required.[110] This conclusion was based partially on the testimony of Dr. Allen's treating physician, who provided testimony about his anesthesiologist patients generally, and stated that in most cases, he recommends a return to the field.[111] The physician also gave testimony specific to Dr. Allen, and opined that Dr. Allen should avoid returning to anesthesiology because of the likelihood of relapse.[112] The court evidently gave more weight to the general testimony than the testimony specific to Dr. Allen.[113] It interpreted the treating physician's claim—that he recommends most of his patients return to anesthesiology—as an indication "that drug addiction does not itself disable someone from practicing in that field."[114] It also noted Dr. Allen's sobriety period and a lack of evidence "that he would inevitably regress."[115] The court determined that Dr. Allen had no "existing impediment" to his ability to practice anesthesiology and upheld the denial of Dr. Allen's benefit payments.[116]

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[108] *Id.* at 1383. While the *Colby* court determined that the anesthesiologist's "current occupation" was that of a physician, the *Allen* court defined "current occupation" more specifically to mean anesthesiologist. *See generally* Utz, *supra* note 27 (discussing a possible circuit split over the definition of "own occupation" under ERISA-governed LTD benefit plans).

[109] *Allen*, 216 F. Supp. 2d at 1383.

[110] *Id.* at 1384. The plan required a "continuing disability," which the court interpreted to mean an "uninterrupted" disability. *Id.* at 1383.

[111] *Id.*

[112] *Id.* at 1383–84.

[113] *Id.*

[114] *Id.* at 1383.

[115] *Id.* at 1384.

[116] *Id.*

3. Price v. Disability RMS[117]

While anesthesiologists are more likely than other physicians to abuse drugs, a stressful work environment and easy access to potent drugs contribute to addiction among other physicians as well. Dr. Howard Price had worked as a urologist and surgeon at Milford-Whitinsville Regional Hospital in Massachusetts when he was forced to stop work because he began abusing opioids.[118] However, Dr. Price's insurer denied his claim for LTD benefits because he had not used opioids during the policy's two-year coverage period, which began when Dr. Price stopped working.[119] After the insurer denied his two subsequent appeals, Dr. Price brought an ERISA action, claiming his depression, anxiety, and risk of relapse prevented him from performing all of the material duties of his occupation.[120]

In upholding the insurer's denial of LTD benefits, the court placed significant emphasis on a lack of individualized evidence and Dr. Price's continued "functional capacity."[121] The court noted that the letters written by Dr. Price's substance abuse counselor spoke only in general terms and did not make specific references to Dr. Price's ability to function.[122] The court further noted that the counselor's delineation of the disability period included several weeks during which Dr. Price was still practicing, which further illustrated the generality of the counselor's testimony and its failure to illustrate a "functional

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[117] Price v. Disability RMS, No. 06-10251-GAO, 2008 WL 763255 (D. Mass. Mar. 21, 2008).

[118] *Id.* at *1.

[119] *Id.* at *17–18.

[120] *Id.* at *1.

[121] *Id.* at *18. As used in the opinion, "functional capacity" is simply the ability to practice medicine. *See id.* at *6.

[122] *Id.* at *19 ("[The doctor's letter] did not relate the described symptoms in any persuasive way to Dr. Price's functional capacity. How poor [was his concentration]? Did his poor concentration prevent him from performing his duties? [W]hat must be shown is that the illness caused a loss in functional capacity, and that is what was missing.").

impairment."[123]

Price is readily distinguishable from *Stanford* and *Allen*. Since the court found that Dr. Price did not have a severe risk of relapse, it never reached the question of whether a risk of relapse could be so severe as to constitute a current disability.[124] Also, unlike the *Allen* court, the *Price* court considered testimony specific to Dr. Price in making its determination that Dr. Price's risk of relapse did not constitute a current disability.[125] Because of these differences, it is unclear whether the court's conclusion would have been different had Dr. Price's risk of relapse been more severe.

As the above cases reveal, courts upholding denial of benefits generally place significant emphasis on an addict's lack of "functional impairment." Because the risk of relapse does not necessarily cause a continuous physical inability to perform one's occupation, these courts do not view the risk of relapse as a current disability.

B. Cases Enforcing Continued Benefits

1. Colby v. Union Security Insurance Co.[126]

The First Circuit's *Colby* decision rested on the court's determination that a risk of relapse, while not necessarily a functional impairment, could be so serious as to constitute a "current disability" under an ERISA plan.[127] The opinion cited medical testimony on behalf of Dr. Colby and determined that she faced a very significant risk of relapse following her departure from inpatient treatment.[128] The court noted that the insurer could have possibly "limit[ed] the period of disability by arguing that this risk progressively diminished over the 36-month

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[123] *Id.*

[124] *Id.* at *21–22.

[125] *Id.*

[126] Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013).

[127] *Id.* at 60.

[128] *Id.* at 64.

period,"[129] but instead "took a categorical approach, steadfastly maintaining that risk of relapse, whatever the degree, could not constitute a current disability under the plan."[130] The award of a full three years of benefits therefore "flowed naturally from [the insurer's] all-or-nothing defense of the case."[131]

The First Circuit also relied on a number of policy grounds in reaching its conclusion.[132] For example, the court noted that denying benefits to those in recovery while providing them to those actively using the drug would create "a perverse incentive."[133] In addition, denying benefits to those in recovery would encourage claimants to return to work immediately upon leaving inpatient treatment, which could put their lives and their patients' lives at risk.[134] Finally, such a policy would defeat the very purpose of a disability plan, which is to help people overcome or otherwise cope with medical issues.[135]

However, the court also emphasized the narrowness of its holding. As noted above, though the court held that Dr. Colby was entitled to LTD benefits,[136] the insurer's all-or-nothing approach helped the court reach that conclusion. The court suggested that the insurer might have had more success had it argued for a gradual benefit decrease over the 36-month period.[137] Furthermore, the court pointed out that the insurer could have written into the policy an exclusion for risk of relapse, but it chose not to.[138] Therefore, it ruled that the insurer acted

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[129] *Id.*

[130] *Id.* For an overview of the facts of this case, see *supra* Part I.

[131] *Id.* at 68.

[132] *Id.* at 66–67.

[133] *Id.* at 66.

[134] *Id.*

[135] *Id.* at 67.

[136] *Id.*

[137] *Id.*

[138] *Id.* Judge Wilkinson expressed doubt that such an exclusion would be permissible: "Since I do not think risk of addictive relapse and other medical risk can categorically be excluded from coverage, ..." Stanford v. Continental Cas. Co., 514 F.3d 354, 364 (4th Cir. 2008) (Wilkinson, J., dissenting).

arbitrarily and capriciously in denying LTD benefits to Dr. Colby.[139]

2. Kufner v. Jefferson Pilot Financial Insurance Co.[140]

Dr. Ronald Kufner, an anesthesiologist who suffered from alcohol and opioid dependence, brought an ERISA claim against his insurer similar to the claim brought in *Colby*.[141] Dr. Kufner's substance abuse issues forced him to stop work and undergo detoxification and other treatments, which included a week in the hospital followed by several months in a residential treatment program.[142] Dr. Kufner received short-term disability benefits for thirteen weeks, and his insurer granted his subsequent request for LTD benefits.[143] After several months, however, the insurer terminated Dr. Kufner's benefits since he had increased his work hours and had not experienced a relapse.[144]

Dr. Kufner nevertheless maintained that he remained disabled. While anesthesiologists typically work 70 to 80 hours per week, Dr. Kufner's hours were limited to 40 to 50 per week by orders from his treating physician, who determined that his hours had to be reduced because a stressful work environment was a major factor contributing to his substance abuse problems.[145] The treating physician further restricted him from handling or dispensing opioid analgesics.[146] Dr. Kufner contended that because of these restrictions, his benefit payments should have continued.[147]

The court determined, largely on public policy grounds, that the insurer abused its discretion in discontinuing Dr. Kufner's

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[139] *Colby*, 705 F.3d at 67.

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

[141] *Id.* at 787.

[142] *Id.* at 788–89.

[143] *Id.* at 789.

[144] *Id.*

[145] *Id.* at 794.

[146] *Id.*

[147] *Id.* at 787.

LTD benefits.[148] The court criticized the insurer's decision to cut benefits in spite of "overwhelming medical evidence supporting a contrary decision."[149] It further pointed out the perversity of the insurer's policy, which would force Dr. Kufner to work to the point of relapse at which point he would again be eligible for benefits.[150] The court described this policy as one of "benefits Russian roulette" that put Dr. Kufner's "career and his patients' lives at risk."[151] The court explained that because anesthesiology is incredibly complex and a crucial part of surgery, the insurer's denial of benefits constituted a "breach of the public trust."[152]

The court also based its holding on the insurer's ERISA-imposed obligation to discharge its duties "solely in the interests of the participants and beneficiaries."[153] Those obligations hold insurers to "higher-than-marketplace quality standards" and require that "administrators provide a full and fair review of claim denials."[154] According to the court, the insurer relied on "conclusory 'peer review' opinions" by doctors it retained rather than the extensive medical evidence and treatment records indicating that Dr. Kufner was unable to return to his previous level of employment.[155] The court concluded that the insurer's determination was thus based on financial self-interest and pointed to Dr. Kufner's entitlement to the plan's maximum allowable benefits as further support for this conclusion.[156]

The above case law makes clear that whether a court will

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[148] *Id.* at 796.

[149] *Id.* This evidence included a letter from his treating physician stating that he should avoid on-call duty and not work more than 40 hours per week, another letter from the treating physician saying he could work up to 50 hours per week but that he remained at risk of relapse, and a letter from his treating psychiatrist stating that Dr. Kufner could not return to his previous level of employment. *Id.* at 793–94.

[150] *Id.* at 796.

[151] *Id.*

[152] *Id.*

[153] *Id.* at 796–97.

[154] *Id.* at 797 (quoting Metro. Life Ins. Co. v. Glenn, 552 U.S. 105, 115 (2008)) (internal quotation marks omitted).

[155] *Id.*

[156] *Id.*

uphold LTD benefit payments to a recovering addict will depend largely upon how broadly or narrowly the court construes "current disability." Courts denying benefits commonly interpret the phrase in a strictly literal sense, at least with regard to recovering addicts.[157] In that vein, they are more likely to view an addict's relapse into drug abuse as the choice of an otherwise healthy person.[158] On the other hand, courts ruling that benefits must be provided generally view addiction as a current disability—essentially, an ongoing condition.[159]

IV. THE PSYCHOLOGY OF ADDICTION

The preceding section demonstrated how a court's understanding of addiction can affect the result of a case. If a court views an addict as one who is not functionally impaired yet chooses to use drugs, it will likely deny benefits. On the other hand, if a court views an addict as one who suffers from an ongoing, current disability, it will likely require that benefits be paid.

The following section places these differing views of addiction in the context of recent psychology literature.

A. Basics of Addiction and Environmental Factors that Precipitate Relapse

Recent psychology literature is at odds with the Fourth Circuit's contention that addiction is a choice.[160] The *New*

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[157] *See* Stanford v. Continental Cas. Co., 514 F.3d 354, 363 (4th Cir. 2008) (Wilkinson, J., dissenting) (describing the majority's inconsistency in denying benefits to Mr. Stanford when it would likely provide them to an individual capable of lifting heavy objects but only at risk of a serious injury).

[158] *See supra* Part III.A.1.

[159] Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013) ("In our view, a risk of relapse into substance abuse—like risk of relapse into cardiac distress or risk of relapse into orthopedic complications—can swell to so significant a level as to constitute a current disability.").

[160] *See generally* David P. Friedman, *Drug Addiction: A Chronically Relapsing Brain Disease*, 70 N.C. MED. J. 35 (2009); *see also* Philip Gorwood et al., *Genetics of Dopamine Receptors and Drug Addiction*, 131 HUM.

England Journal of Medicine describes drug addiction as a "chronic, relapsing disorder in which compulsive drug-seeking and drug-taking behavior persists despite serious negative consequences."[161] While outdated but long-held views often see addiction as a moral failure or lack of willpower,[162] recent neurobiological research indicates that drug addiction is in fact a brain disease.[163] Drug addiction also has a strong genetic component: one study estimated that genetic factors are responsible for approximately half of addiction vulnerability.[164] Other research compared drug addiction to atherosclerosis, type 2 diabetes, and hypertension by noting common characteristics such as incurability, the importance of genetic risk factors, the influence of lifestyle choices, and the frequency of relapse.[165] Finally, one study described drug addiction as a "chronic relapsing disorder" due to similar rates of treatment adherence and relapse when compared to type 2 diabetes, hypertension, and asthma.[166] As with these other chronic illnesses, the majority of recovering addicts experience relapse, often after periods of significant improvement.[167]

Despite the similarities between addiction and other chronic ailments, insurance companies place much greater limitations upon benefits for recovering addicts.[168] Researchers have

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GENETICS 803 (2012) (describing drug dependence as a "chronic, relapsing disorder"); Doug Sellman, *The 10 Most Important Things Known About Addiction*, 105 ADDICTION 6, 7 (2010) (describing addiction as a "complex genetic disease").

[161] Jordi Cami & Magi Farré, *Mechanisms of Disease: Drug Addiction*, 349 NEW ENG. J. MED. 975, 975 (2003).

[162] Friedman, *supra* note 160, at 35 (citing Stephen J. Morse, *Medicine and Morals, Craving and Compulsion*, 39 SUBSTANCE ABUSE & MISUSE 437, 438–39 (2004) (arguing that addicts should, to some degree, be "held responsible for addiction-related behavior, such as seeking and using drugs")).

[163] Friedman, *supra* note 160, at 35.

[164] Chuan-Yun Li et al., *Genes and (Common) Pathways Underlying Drug Addiction*, 4 PLOS COMPUTATIONAL BIOLOGY 28, 28 (2008).

[165] Friedman, *supra* note 160, at 36.

[166] Sellman, *supra* note 160, at 8.

[167] *See id.*

[168] Friedman, *supra* note 160, at 36.

attributed this discrepancy to deeply-held biases and a lack of positive humanitarian feelings toward addicted individuals,[169] which often lead to stigmatization and incarceration rather than proper treatment.[170] The reasons for this lack of "positive humanitarian attitudes" toward addicts are undoubtedly complex, but likely explanations include the history of drug illegalization and the illegal drug trade, as well as a lack of understanding of addiction science.

Drug addiction has biological effects on the human body that are not easily overcome. Addiction triggers learning mechanisms[171] and induces chemical and anatomical changes in the brain.[172] Importantly, these changes are not quickly undone, even during abstinence, and are likely to be a significant factor contributing to relapse.[173] In fact, these drug-induced changes may take many months or even years to reverse themselves.[174] In addition, brain damage associated with drug addiction may harm parts of the brain responsible for making long-term decisions, such as those maximizing long-term welfare over short-term pleasure.[175] Drug abuse can therefore lead to abnormal functioning in parts of the brain that would normally control compulsive behavior. These physical changes in a person's brain can thus reduce an individual's ability to resist a drug when exposed to it.[176]

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[169] *Id.*; Sellman, *supra* note 160, at 8.

[170] Friedman, *supra* note 160, at 37.

[171] A learning mechanism is, as its name implies, a way that the brain incorporates past experiences to apply them to future situations. Such mechanisms can include, for example, trial and error comparisons between an expected reward and an actual reward, and a model-based mechanism in which the brain makes predictions about an environment and then adapts that predictive model based on new experiences. *See* Rick Nauert, *Brain Images Reveal How Learning Strategies Work*, PSYCH CENT. NEWS (June 3, 2010), http://psychcentral.com/news/2010/06/01/brain-images-reveal-how-learning-strategies-work.

[172] Friedman, *supra* note 160, at 35.

[173] *Id.*

[174] *Id.* at 36.

[175] *Id.*

[176] Nora Volkow & Ting-Kai Li, *Drug Addiction: The Neurobiology of*

Unsurprisingly then, the risk of relapse is one of the most significant problems in treatment even among individuals who have sustained a prolonged abstinence period.[177] Laboratory experiments on both humans and animals indicate that primary triggers of relapse include exposure to cues associated with previous drug taking, exposure to stressors, and exposure to the drug itself.[178] Other evidence indicates that these factors do not necessarily operate independently. For example, one study on rats found that the most potent factors in precipitating relapse after both short and long periods of abstinence were exposure to a brief period of stress and exposure to the drug itself.[179] It further found that exposure to the drug itself increases the effect of exposure to drug-related cues.[180] Another study found that exposure to stressful events can similarly exacerbate the impact of exposure to drug-related cues on drug-seeking behavior, and vice versa.[181] These factors are examined in further detail below.

1. Stress

Exposure to a stressful environment is a significant risk factor contributing to drug addiction relapse in humans.[182] In one study, opiate-addicted individuals who were shown "stress related

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Behavior Gone Awry, 5 NATURE REVIEWS 963, 965 (2004).

[177] M.W. Feltenstein & R.E. See, *The Neurocircuitry of Addiction: An Overview*, 154 BRIT. J. PHARMACOLOGY 261, 261 (2008).

[178] Jane Stewart, *Psychological and Neural Mechanisms of Relapse*, 363 PHIL. TRANSACTIONS ROYAL SOC'Y: BIOLOGICAL SCI. 3147, 3147 (2008) [hereinafter Stewart, *Psychological and Neural Mechanisms*].

[179] Jane Stewart, *Pathways to Relapse: The Neurobiology of Drug- and Stress-Induced Relapse to Drug-Taking*, 25 J. PSYCHIATRY & NEUROSCIENCE 125, 125 (2000) [hereinafter Stewart, *Pathways to Relapse*].

[180] *Id.*

[181] Xiu Liu & Friedbert Weiss, *Additive Effect of Stress and Drug Cues on Reinstatement of Ethanol Seeking: Exacerbation by History of Dependence and Role of Concurrent Activation of Corticotropin-Releasing Factor and Opioid Mechanisms*, 22 J. NEUROSCIENCE 7856, 7859 (2002).

[182] Robyn M. Brown & Andrew Lawrence, *Neurochemistry Underlying Relapse to Opiate Seeking Behavior*, 34 NEUROCHEMICAL RES. 1876, 1879 (2009).

imagery" experienced heightened drug cravings.[183] Researchers found similar results in cocaine-addicted individuals, for whom stress-induced hypothalamic-pituitary-adrenal axis responses predicted future drug use quantities.[184] Animal research likewise indicates increased drug cravings in response to stress. Researchers studying relapse behavior found that opiate-addicted animals that experience foot shock (a small electrical shock to the foot to induce stress) are more likely to exhibit drug-seeking behavior.[185] This demonstrates a strong correlation between stressful experiences and heightened drug cravings.

Additionally, research shows that a stressful environment can actually increase a drug's pleasurable effect. Stress does this by "priming" the brain's reward pathways,[186] meaning it increases the drugs' efficacy and thus encourages the addict's continued use.[187] Such research is supported by clinical studies of drug abusers and alcoholics, in which subjects frequently cite stress as a reason for relapse.[188] Other research indicates that a history of drug abuse can make individuals more sensitive to stressful events and thus more vulnerable to relapse.[189] These relapse-inducing

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[183] *Id.* This "stress-related imagery" was based on the participants' descriptions of recent stressful personal events. After viewing the imagery, participants rated how vividly they could imagine the scenario, the extent of their opioid craving, and how anxious they felt. *See* Scott M. Hyman et al., *Stress and Drug-Cue-Induced Craving in Opioid-Dependent Individuals in Naltrexone Treatment*, 15 EXPERIMENTAL & CLINICAL PSYCHOPHARMACOLOGY 134.

[184] Brown & Lawrence, *supra* note 182, at 1879. The hypothalamic-pituitary-adrenal axis (HPA) is a system in the brain that triggers the production and release of various hormones and neurotransmitters in response to stressful events. These hormones, inter alia, help systems throughout the body respond to stressful situations. *See Anxiety In-Depth Report*, N.Y. TIMES, http://www.nytimes.com/health/guides/symptoms/stress-and-anxiety/print.html (last visited Mar. 5, 2014).

[185] Brown & Lawrence, *supra* note 182, at 1881.

[186] *See The Reward Pathway Reinforces Behavior*, *supra* note 11.

[187] Rajita Sinha, *How Does Stress Increase the Risk of Drug Relapse and Abuse?*, 158 PSYCHOPHARMACOLOGY 343, 345 (2001).

[188] *Id.* at 351.

[189] Stewart, *Pathways to Relapse*, *supra* note 179, at 133.

factors are clearly at play in the anesthesiology context, with its 70 to 80-hour workweeks and on-call duties.

2. Drug-related Cues

As a number of studies have shown, exposure to drug cues can precipitate relapse by increasing drug cravings.[190] These drug cues fall into two general categories: "discrete" cues and "contextual" cues.[191] A "discrete" cue is a physical object associated with drug-taking, such as drug paraphernalia.[192] A "contextual" cue is one associated with a background setting, such as a room in which drugs have been previously used.[193] The resultant heightened craving has been described as a form of Pavlovian conditioning[194] in which drug-addicted organisms can experience withdrawal symptoms in the presence of the usual cues, even absent consumption.[195] Furthermore, there is evidence that drug-related cues tend to capture the attention of drug addicts even when they are involved in an unrelated task.[196] This suggests that the presence of drug cues may cause impulsive drug-seeking behavior.[197]

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[190] *See generally* Dan I. Lubman et al., *Electrophysiological Evidence of the Motivational Salience of Drug Cues in Opiate Addiction*, 37 PSYCHOL. MED. 1203 (2007); Shepard Siegel, *Drug Tolerance, Drug Addiction, and Drug Anticipation*, 14 CURRENT DIRECTIONS PSYCHOL. SCI. 296 (2005); Sinha, *supra* note 187, at 343.

[191] Brown & Lawrence, *supra* note 182, at 1882.

[192] *Id.*

[193] *Id.*

[194] Pavlovian (classical) conditioning is a learned association between stimuli. "[T]he subject learns to associate a previously unrelated neutral stimulus with another stimulus that reliably elicits some kind of reaction." *Pavlovian (Classical) Conditioning*, IND. UNIV., http://www.indiana.edu/~p1013447/dictionary/pavcond.htm (last visited Mar. 29, 2014).

[195] Siegel, *supra* note 190, at 297.

[196] Lubman et al., *supra* note 190, at 1208. In this study, the participants' task was to press a button as quickly as possible whenever a white cup was displayed. *Id.* at 1205.

[197] *Id.* at 1208.

3. Drug Exposure and its Effects on Stressors and Cues

Greater levels of past drug use often correlate with greater levels of cue sensitivity.[198] In addition, repeated drug use increases the brain's stimulus-award associations and forms a type of "addiction memory" that increases craving.[199] Drug exposure can also change sensitivity to future drug exposure and stressors.[200] To make matters worse for recovering addicts, stimuli that lead to this type of conditioned response maintain their effect well into abstinence.[201] Even after "extinction training,"[202] in which the ability of cues to provoke relapse is reduced or eliminated, exposure to stress or the drug itself can rejuvenate the effects of the conditioned response to environmental cues.[203]

As the above studies show, researchers consistently identify (1) cues associated with previous drug taking; (2) exposure to stressors; and (3) exposure to the drug itself, as primary triggers of relapse into drug use. Courts should take a practical approach and keep these factors in mind when considering whether a recovering addict should be awarded LTD benefits.

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[198] Rajita Sinha, *Modeling Stress and Drug Craving in the Laboratory: Implications for Addiction Treatment Development*, 14 ADDICTION BIOLOGY 84, 85 (2008).

[199] Bryon Adinoff, *Neurobiologic Processes in Drug Reward and Addiction*, 12 HARV. REV. PSYCHIATRY 305, 311 (2004).

[200] Stewart, *Psychological and Neural Mechanisms*, *supra* note 178, at 3153.

[201] *Id.*

[202] "Extinction training" refers to a process that attempts to disassociate the drug cue from the drug itself. In animal experimentation this is done, for example, by training an animal to perform a task that results in the drug's administration and then performing "extinction training," in which the previous task no longer provides the drug. *Id.* at 3148.

[203] *Id.* at 3153–54.

B. Additional Factor: Genetics

Genetics also plays a role in drug addiction.[204] Alcoholism has been shown to have a strong genetic component, and recent research has provided evidence that drug addiction is also a heritable disorder.[205] It is estimated that genetic factors are responsible for forty to sixty percent of drug addiction vulnerability, with environmental factors responsible for the remainder.[206] Animal research indicates the heritability of drug addiction at 0.4 for hallucinogens, 0.7 for cocaine, and slightly above 0.5 for alcohol.[207] As a result of such studies, addiction has come to be regarded as a "complex genetic disease."[208]

The specific genes involved in addiction are unknown, but recent data indicate a relationship between drug addiction and the genes that encode dopamine receptors.[209] Specifically, a study of 2,364 current opiate abusers or dependents indicated that the dopamine D2 receptor bears a highly significant link to the risk of opiate addiction.[210] Dopamine release is necessary for brain "reward," and all addictive drugs produce enhanced dopamine levels.[211] This process not only "hijacks" the system normally

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[204] Sellman, *supra* note 160, at 7; Jerzy Vetulani, *Drug Addiction. Part II. Neurobiology of Addiction.*, 53 POLISH J. PHARMACOLOGY 303, 313 (2001).

[205] Sellman, *supra* note 160, at 7; Vetulani, *supra* note 204, at 313.

[206] *See* Chuan-Yun Li et al., *supra* note 164, at 28.

[207] Sellman, *supra* note 160, at 7. "Heritability" is an estimate of the genetic component of a trait, and ranges from zero to one. David Goldman et al., *The Genetics of Addictions: Uncovering the Genes*, 6 NATURE REVIEWS: GENETICS 521, 522 (2005).

[208] Sellman, *supra* note 160, at 7.

[209] Gorwood et al., *supra* note 160, at 803.

[210] *Id.* at 810. "Abuse" is the recurrent use of drugs despite adverse consequences. "Dependence" is another word for addiction, and manifests itself through symptoms such as heightened tolerance and withdrawal symptoms. *See* U.S. DEPT. OF HEALTH & HUMAN SERVS., APPENDIX E: SUBSTANCE USE, ABUSE, DEPENDENCE CONTINUUM, AND PRINCIPLES OF EFFECTIVE TREATMENT, *available at* http://www.ncsacw.samhsa.gov/files/SAFERR_AppendixE.pdf. The cases cited in this Note involve both abusers and dependents.

[211] Feltenstein & See, *supra* note 177, at 265.

used to experience the rewarding effects of natural survival functions, such as eating, but creates a lasting effect that promotes further use of the substance.[212]

As mentioned, however, more research is needed to determine the specific genes involved in drug addiction susceptibility.[213] Mapping of the human genome at the beginning of the century stirred hopes of isolating a handful of genes primarily affecting drug addiction.[214] These hopes have not yet been realized, and researchers are still examining hundreds of enormously complex, linked, and variant genes.[215] Despite these challenges, the concept of addiction as an interaction of genetic and environmental factors is now the "dominant paradigm" over the traditional view of drug abuse as an exercise of free will.[216]

Taken as a whole, this research indicates that drug relapse is anything but a choice. Instead, it provides strong support for the view that addiction and relapse are the products of genetics, stress, and external stimuli, including the drug itself. Notably, these factors are often unavoidable because they are a result of genetics or are inherent in the addict's occupation.

V. ANALYSIS

A. Why Stanford *is Flawed*

The Fourth Circuit's *Stanford* decision is flawed for five reasons. First, *Stanford* contravenes ERISA's underlying purpose. Second, it is at odds with the current understanding of addiction science. Third, it fails to distinguish the risk of relapse from other chronic ailments and thus fails to show why it should be treated differently than those ailments. Fourth, it runs counter to recently enacted legislation on mental health and addiction. Finally, it disregards strong public policy arguments supporting a

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[212] *Id.*

[213] *See* Gorwood et al., *supra* note 160, at 803.

[214] Sellman, *supra* note 160, at 7.

[215] *Id.*

[216] *Id.*

contrary decision. For these reasons, courts should follow the First Circuit's approach outlined in *Colby* and regard the risk of relapse into substance abuse as a current disability.

1. The Fourth Circuit's Stanford *Decision is Contrary to ERISA's Purpose and Supreme Court Precedent Regarding the Interpretation of ERISA*

Congress made its purpose clear when it passed ERISA.[217] Its stated goal was to "protect interstate commerce and employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility and obligation for fiduciaries of employee benefit plans . . . ."[218] As the Supreme Court noted in *Firestone Tire & Rubber Co. v. Bruch*, "ERISA abounds with the language of trust law," and requires that plan administrators, as fiduciaries, uphold "certain principles developed in the evolution of the law of trusts."[219] When ERISA administrators violate their fiduciary duties, ERISA allows policyholders to bring a cause of action against them.[220] In *Firestone*, the Court referred to ERISA section 1104, which states "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" and "for the exclusive purpose of providing benefits to participants and their beneficiaries."[221] The *Kufner* court explained that ERISA imposes "higher than marketplace quality standards on insurers."[222] The implication of this requirement is that insurers must sometimes interpret ERISA benefit plans in a way that does not maximize profitability. Insurers who wish to avoid covering particular conditions must write their plans in a way that clearly circumscribes their obligations.

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[217] 29 U.S.C. § 1001 (2012).

[218] *Id.*

[219] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989).

[220] *Id.*

[221] *Id.* (construing 29 U.S.C. § 1104(a)(1) and § 1104(a)(1)(A)(i) (1974)).

[222] Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F. Supp. 2d 785, 797 (W.D. Mich. 2009) (quoting Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008)).

This conception of ERISA is difficult to square with the Fourth Circuit's contention that Mr. Stanford was not entitled to disability benefits unless he was actively abusing a drug.[223] The court argued that Mr. Stanford's inability to return to his former job as a nurse anesthetist was not a result of a physical or mental impairment but rather "the result of a license limitation and the prudence of employers."[224] The court's narrow understanding of "mental impairment," which excluded addiction, is in stark contrast to the plain language of ERISA. As the statute states, fiduciaries are to discharge their duties "solely in the interest of participants and beneficiaries" and "for the exclusive purpose of providing benefits to the participants and their beneficiaries."[225] This language indicates that addicts should be entitled to benefits during the recovery period. While administrators have some discretion in deciding whether a particular condition constitutes a current disability, administrators (and the courts reviewing their decisions) may not ignore the statute's plain text. The insurer's decision to deny benefits to Mr. Stanford unless he relapsed, upheld by the Fourth Circuit, was clearly not "solely" in his interest and was thus contrary to the statute's plain language.

Stanford also failed to properly account for the conflict of interest that resulted from the insurer's dual role as the evaluator and payer of claims. In *Firestone*, the Court explained that ERISA plan administrators often operate under a conflict of interest and that reviewing courts should therefore consider this as a factor in reviewing benefit denials.[226] The Fourth Circuit determined that it was to review the insurer's determination under

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[223] Stanford v. Continental Cas. Co., 514 F.3d 354, 359 (4th Cir. 2008).

[224] *Id.*

[225] 29 U.S.C. § 1104(a)(1) (2012).

[226] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); *see also* Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 108 (2008) ("Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case." (citation omitted)).

a "modified abuse of discretion" standard: this standard required it to "reduce [its] deference only to the degree necessary to neutralize any untoward influence resulting from the insurer's conflict of interest, as shown in the record."[227] Because Mr. Stanford did not demonstrate a conflict of interest, the court did not reduce its deference.[228]

Several months after *Stanford* was decided, the Supreme Court clarified the "conflict of interest" addressed in *Firestone*. In *Metropolitan Life Insurance Co. v. Glenn*,[229] Supreme Court explicitly stated that an administrator, which both evaluates claims and make payments, operates under a conflict of interest (which the plaintiff need not demonstrate). It further stated that the significance of this element is fact-specific.[230] The Court noted that while ERISA's trust law basis requires deference to the fiduciary's determination, courts must take this conflict of interest into account.[231]

While the Fourth Circuit later acknowledged in *Champion v. Black & Decker*[232] that *Glenn* would have required it to weigh this conflict as a factor despite Mr. Stanford's failure to demonstrate a conflict, it is unlikely that this weighing would have changed the result.[233] In *Stanford*, the court explained that a plaintiff must produce evidence that an administrator's decision was motivated by a conflict of interest.[234] Since Mr. Stanford failed to produce evidence of this motivation, the court stated that a decision to

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[227] Stanford v. Continental Cas. Co., 514 F.3d 354, 357 (4th Cir. 2008).

[228] *Id.* at 359.

[229] *See Metro. Life Ins. Co.*, 554 U.S. at 118.

[230] *Id.* at 108.

[231] *See id.* at 115.

[232] Champion v. Black & Decker Inc., 550 F.3d 353, 355–56 (4th. Cir. 2008).

[233] In *Champion*, the court stated that *Glenn* required it to apply the abuse of discretion standard, not the more deferential "modified abuse of discretion standard," to cases such as *Stanford*. *Id.* at 355. In *Champion*, applying the abuse of discretion standard, the court determined that the conflict of interest factor carried little weight. The court acknowledged the conflict but considered it as "one among many factors" and ruled that the ERISA administrator's denial of benefits was not an abuse of discretion. *Id.* at 355–56.

[234] Stanford v. Continental Cas. Co., 514 F.3d 354, 357 (4th Cir. 2008).

overturn the denial would be based upon the mere existence of a conflict, which would eliminate deference entirely.[235] However, the court indicated that the result would have been the same even if Mr. Stanford had demonstrated a conflict: "[w]e cannot say that [the insurer's] conclusion is unreasonable, even in light of [its] conflict of interest as insurer and administrator of the benefit plan . . . ."[236] The court held that the insurer's interpretation of the plan, that the plan did not cover the "potential risk of relapse," was reasonable whether or not a conflict existed.

Stanford therefore rested primarily upon the premise that the "risk of relapse" is not a "current disability." Such an interpretation is inconsistent with an insurer's requirement to "discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries."[237]

2. Recent Psychology Research Further Undermines Stanford

A fundamental problem with the Fourth Circuit's ruling in *Stanford* is that it is based on the discredited notion that an addict's decision to use drugs is the result of choice, and not of disease.[238] According to the Fourth Circuit, "[w]hether [a recovering addict] succumbs to [the temptation to use drugs] remains his choice; the heart-attack prone doctor has no such choice."[239] This notion is contrary to current psychology research indicating that relapses can occur well into abstinence because of lasting physical changes to the brain that result in a loss of control over drug use.[240] Recent evidence strongly undermines the notion that continued drug use is a choice.[241] With this research in mind,

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[235] *Id.* at 359.

[236] *Id.* at 358.

[237] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 110 (1989) (construing 29 U.S.C. § 1104(a)(1) and § 1104(a)(1)(A)(i) (1974)).

[238] *See* Friedman, *supra* note 160, at 35.

[239] *Stanford*, 514 F.3d at 358.

[240] *See* Friedman, *supra* note 160, at 35.

[241] *See generally* Friedman, *supra* note 160; *see also* Gorwood et al., *supra* note 160 (describing drug dependence as a "chronic, relapsing disorder"); Sellman, *supra* note 160 (describing addiction as a "complex

it is clear that the court's reasoning in *Stanford* is based on the flawed notion that addiction is a choice, not a disease with a strong genetic component.[242]

In *Stanford*, the insurer argued that an addict's decision to use drugs is a choice by defining "choice" in extremely narrow terms. The insurer contrasted an addict to "a patient with an unacceptably high susceptibility to suffering from a heart attack" and declared that the patient "cannot avoid such heart attack by choosing not to have it."[243] It is true that a recovering addict could presumably encounter a situation in which drugs are readily available, yet decide not to use them. In this sense, he has a "choice" that one who is susceptible to heart attacks does not. However, this "choice" evaporates when the addict with a genetic predisposition and a physically altered brain is placed in a situation in which drugs are readily available. His decision to use drugs in such circumstances seems, if anything, less of a "choice" than a heart attack-prone patient's decision not to exercise or to eat fatty foods. The insurer's interpretation of the word "choice" is thus extremely narrow and unfairly applied to recovering addicts.

Even if we do accept the Fourth Circuit's notion of addiction as a choice, many other chronic medical conditions (for which benefits are generally provided) are also the result of choice.[244] For example, atherosclerosis, type 2 diabetes, and hypertension are all chronic conditions that are partially the result of voluntary behavior, such as diet.[245] Unsurprisingly, the treatment for each of these conditions often involves voluntary lifestyle changes.[246] An addict's "choice" to use drugs is not easily distinguished from the lifestyle choices that contribute to these ailments, so to treat addiction differently on this basis is simply unjust.

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genetic disease").

[242] *Stanford*, 514 F.3d at 358.

[243] Defendant's Response to Plaintiff's Motion for Summary Judgment at 7, Stanford v. Continental Cas. Co., 455 F. Supp. 2d 438 (E.D.N.C. 2006) (No. 5:05-CV-372-BR(3)).

[244] *See* Friedman, *supra* note 160, at 36.

[245] *Id.*

[246] *See id.*

One could perhaps argue that an addict's initial decision to use drugs was a choice, and the lasting changes that the drugs caused to his brain only occurred as a result of this initial choice. Leaving addiction's strong genetic component aside, this argument fails to distinguish addiction for the same reasons described in the preceding paragraph. One could argue that the individual suffering from atherosclerosis, type 2 diabetes, or hypertension only developed his condition as a result of his initial unhealthy lifestyle choices, and that the continued risk of a heart attack, for example, is a result of those earlier choices.

As argued above, psychology research has demonstrated that drug addiction is a genetic disease, and future courts should consider this in making their decisions. Courts often rely on psychology research to support their holdings in areas where the law is not settled, and the Supreme Court has done so in some landmark decisions.[247] Most notably, in *Brown v. Board of Education*, the Court cited psychology research indicating that "[s]egregation of white and colored children in public schools has a detrimental effect upon the colored children. The impact is greater when it has the sanction of the law . . . ."[248] More recently, in *Miller v. Alabama*, the Court held that the Eighth Amendment prohibits mandatory life imprisonment without parole for those who committed crimes prior to age eighteen.[249] In support of its position, the Court stated "that developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds . . . in parts of the brain involved in behavior control."[250] *Stanford* was based on the discredited notion that an addict's use of drugs is a "choice" and courts should look to current research to support decisions that recognize addiction as a genetic disease, and thus treat it as a "current disability."[251] Scientific research is particularly useful on this issue because the law remains unsettled.

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[247] *See, e.g.*, Miller v. Alabama, 132 S. Ct. 2455, 2464 (2012); Brown v. Board of Ed., 347 U.S. 483, 494 (1954).

[248] *Brown*, 347 U.S. at 494.

[249] *Miller*, 132 S. Ct. at 2460.

[250] *Id.* at 2464 (internal quotation marks omitted).

[251] *See generally* sources cited *supra* note 160 and accompanying text.

Stanford is further flawed because the court denied LTD benefits to an individual for whom returning to work would place his health and life, as well as the health and lives of his patients, at tremendous risk.[252] An overview of current addiction research provides overwhelming evidence that the greatest risk factors in precipitating drug relapse are (1) stress; (2) exposure to the drug itself; and (3) environmental cues.[253] In light of these factors, it is difficult to imagine a set of circumstances better able to precipitate relapse than the placement of an anesthesiologist back into a hospital setting where he previously succumbed to opioid addiction. The high-pressure hospital setting, combined with long hours and easily obtainable drugs of choice, makes relapse all too likely.

3. The Fourth Circuit Failed to Distinguish the Risk of Addictive Relapse from the Risk of Relapse of Other Chronic Ailments

The *Stanford* majority determined that the risk of relapse into drug use was fundamentally different from the risk of relapse into other chronic ailments.[254] According to the court,

> [a] doctor with a heart condition who enters a high stress environment . . . "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.

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[252] Stanford v. Continental Cas. Co., 514 F.3d 354, 362–63 (4th Cir. 2008) (Wilkinson, J., dissenting).

[253] *See* Stewart, *Psychological and Neural Mechanisms*, *supra* note 178, at 3153; *see also* Liu & Weiss, *supra* note 181, at 7856 (describing stress and conditioned responses to drug cues as "critical factors in relapse to drug use"); Stewart, *Pathways to Relapse*, *supra* note 179, at 125 (describing re-exposure to the drug and exposure to stress as the two most important factors in reinstating drug-seeking behavior).

[254] *Stanford*, 514 F.3d at 358.

> The heart-attack prone doctor has no such choice.[255]

In his dissent, Judge Wilkinson was harshly critical of this attempt to distinguish the risk of relapse from other chronic ailments.[256] As noted in Part III.A, Judge Wilkinson described the majority's attempt to distinguish drug addiction as "legally ungrounded."[257] He said their attempt was based on moral and medical considerations that the court had no authority to make when the plan "put[] addiction squarely on all fours with other impairments."[258] The court's failure to distinguish addiction from other ailments, and yet still deny benefits to Mr. Stanford, indicates that the ongoing stigmatization of drug addiction played a role in the court's decision.

The majority's attempt to cast disability as a "reward for sobriety," but only in the addiction context, is similarly unpersuasive.[259] In ruling for the insurer, the court acknowledged that its denial of benefits to Mr. Stanford created a perverse incentive by denying benefits to those in recovery while providing them to those who relapse.[260] Nevertheless, the court argued that such reasoning assumed that disability was a "reward for sobriety" when, in fact, the reward for sobriety was "the creation of innumerable opportunities that were closed to Stanford as long as he continued to use drugs."[261] It is unclear why the Fourth Circuit apparently confined this logic to recovering addicts. The court's logic seems to imply that, like the recovering addict, the heart attack-prone doctor should *not* be entitled to benefits because his reward for adopting a healthier lifestyle is the "innumerable opportunities that were closed to" him before he changed his ways. Despite this obvious inconsistency, the court suggested that a heart attack-prone doctor should be entitled to benefits.

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[255] *Id.*

[256] *Id.* at 363 (Wilkinson, J., dissenting).

[257] *Id.*

[258] *Id.*

[259] *See id.* at 359.

[260] *Stanford*, 514 F.3d at 359.

[261] *Id.*

The *Stanford* majority's contention that Mr. Stanford could work "countless other jobs" and therefore should not be entitled to benefits is similarly flawed.[262] First, as Judge Wilkinson argued in his dissent, the plan's plain language defined disability as an inability "to perform the material and substantial duties *of your regular occupation*."[263] Even with this plain language issue aside, the situation the majority describes is not unique to individuals recovering from drug addiction. For example, in *Evans v. UnumProvident Corp.*,[264] the court held that an insurer's denial of LTD benefits to a plaintiff who suffered from a form of epilepsy was arbitrary and capricious.[265] In making its determination, the court noted that while the plaintiff was capable of performing sedentary work, she was still disabled because the stressful nature of her work contributed to her recurrent seizures.[266] Presumably, the plaintiff was capable of performing other, less stressful jobs, but this fact did not render her ineligible for LTD benefits. In this sense, her condition was no different from that of an anesthesiologist who is physically capable of performing other jobs, yet cannot return to anesthesiology because the stressful nature of the job contributes to relapse. In either case, the individual lacks a functional impairment that renders him unable to physically perform some type of occupation, yet LTD benefits will still be provided; there is no compelling reason to treat the two conditions differently.

4. Recent Policy Enactments Support the View that Addiction Should be Treated Like Other Ailments

The notion that addiction should be treated like other ailments is supported by congressional legislation.[267] On November 8,

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[262] *See id.* at 359–60.

[263] *Id.* at 362 (Wilkinson, J., dissenting) (emphasis in original).

[264] Evans v. UnumProvident Corp., 434 F.3d 866, 879–80 (6th Cir. 2006).

[265] *Id.* at 869.

[266] *Id.* at 879–80.

[267] *See, e.g.*, 29 U.S.C. § 1185a (1996); *see also* Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and*

2013, Secretary of the Department of Health and Human Services Kathleen Sebelius announced regulations that would enforce the Mental Health Parity and Addiction Equity Act of 2008 (Parity Act)[268] and extend its reach to those receiving coverage under the Affordable Care Act.[269] Congress enacted the Parity Act in order to prevent health plans from discriminating against individuals with mental and substance abuse disorders by requiring that the plans' standards for those conditions be comparable to those for other medical conditions.[270] The Parity Act prohibits "limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment" when such conditions are not imposed upon coverage for other medical conditions.[271] It also prohibits plans from imposing more stringent financial requirements upon those suffering from mental health issues or addiction.[272] This means that plans cannot impose different "deductibles, copayments, coinsurance, [or] out-of-pocket expenses" on mental health and addiction treatment.[273]

The Parity Act's legislative history reveals that Congress intended to curtail the widespread practice of insurer discrimination against those with mental illness and substance-related disorders.[274] The Committee on Ways and Means issued a report stating: "[t]he Committee believes that the discrimination

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Addiction Act End the Discrimination?, 43 GOLDEN GATE U. L. REV. 179, 207–08 (2013).

[268] 29 U.S.C. § 1185a (2008).

[269] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.). *See also* Jackie Calmes & Robert Pear, *Rules to Require Equal Coverage for Mental Ills*, N.Y. TIMES (Nov. 8, 2013), http://www.nytimes.com/2013/11/08/us/politics/rules-to-require-equal-coverage-for-mental-ills.html.

[270] Weber, *supra* note 267, at 207–08.

[271] *Id.* at 210.

[272] *Id.*

[273] *Id.* It is important to note that the Parity Act does not *require* plans to cover mental health or substance disorder benefits. It only requires that when such benefits are provided, they must be on equal footing with medical and surgical benefits. *See* 29 U.S.C. § 1185(a)–(b) (2012).

[274] H.R. REP. NO. 110-374, at 1551 (2007).

that exists under many group health plans with respect to mental health and substance-related disorder benefits must be prohibited. Diseases of the mind should be afforded the same treatment as diseases of the body."[275] The Committee went on to describe addiction and mental health disorders as "the only disorders that have been systematically and unfairly excluded from equal coverage."[276] The Parity Act and its legislative history demonstrate Congress' intent to fight arbitrary and discriminatory treatment of those suffering from addiction or mental illness.[277]

In *Stanford*, the insurer had apparently discriminated against Mr. Stanford because his impairment was "mental." The plan required benefits once the claimant established an "injury or sickness caus[ing] physical or mental impairment to such a degree of severity that [he is] . . . continuously unable to perform the material and substantial duties of [his] regular occupation."[278] The insurer explained that Mr. Stanford did not suffer "a physical or mental impairment as a result of his drug use or recovery" and that being an addict did not render him unable to perform the material duties of his occupation.[279] The insurer's narrow understanding of "mental impairment" was unjustified, and the Fourth Circuit should not have upheld it.

5. Providing LTD Benefits to Recovering Addicts is Good Public Policy

There are compelling public policy arguments for providing LTD benefits to recovering drug addicts. The Committee on Ways and Means' reasons for passing the Parity Act are equally applicable to the "addiction as a current disability" debate.[280] The Committee cited a 2006 study that described the prevalence of mental and substance abuse-related disorders, which affected nearly a quarter of the U.S. population and cost more than $300

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[275] *Id.*

[276] *Id.*

[277] *Id.*

[278] Stanford v. Continental Cas. Co., 514 F.3d 354, 358 (4th Cir. 2008).

[279] *Id.*

[280] H.R. REP. NO. 110-374, at 1569–70.

billion annually.[281] A recent study found that 22.2 million Americans suffered from substance abuse or dependence in 2012, a number that had remained stable over the prior decade.[282]

As mentioned, a number of courts have also made compelling public policy arguments for treating the risk of relapse into drug addiction as a "current disability."[283] Even in *Stanford*, the majority acknowledged that its denial of benefits to Mr. Stanford "create[d] 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 choosing sobriety will lose those benefits unless he again begins to use drugs."[284] As Judge Wilkinson argued in his dissent, "[f]orcing Stanford to relapse into addiction or lose his benefits would. . .thwart the very purpose for which disability plans exist: to help people overcome medical adversity if possible, and otherwise to cope with it."[285] Few would argue that a bartender who was forced to leave work as a result of alcoholism should be compelled to return to work during recovery because his benefits would discontinue. Disability plans should not force addicted individuals to choose between losing benefit payments on the one hand and relapsing on the other.

The *Kufner* court also considered public policy implications in its decision to treat the risk of relapse as a current disability.[286] It described the insurer's implication that the plaintiff could return to work until he suffered a relapse as "untenable given the serious risk this poses to public health and safety, which the Court considers an additional factor weighing against defendant's

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[281] *Id.*

[282] U.S. DEPT. OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS, *available at* http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#ch7.

[283] *See, e.g.*, Colby v. Union Sec. Ins. Co., 705 F.3d 58 (1st Cir. 2013); Kufner v. Jefferson Pilot Fin. Ins. Co., 595 F. Supp. 2d 785 (W.D. Mich. 2009).

[284] Stanford v. Continental Cas. Co., 514 F.3d 354, 359 (4th Cir. 2008).

[285] *Id.* at 362 (Wilkinson, J., dissenting).

[286] *Kufner*, 595 F. Supp. 2d at 796.

benefits determination."[287] As described in Part III.B, the court labeled this risk "a form of 'benefits Russian roulette' with plaintiff's career and his patients' lives at risk."[288] The court further described the insurer's position as "tantamount to a breach of the public trust" and clearly contrary to its duties under ERISA.[289] While danger to the public is particularly acute in the anesthesiology context, it is also a serious concern in other areas as well. For example, a relapsed crane operator, air traffic controller, or train engineer could pose tremendous risks to the public. None should be forced to choose between relapsing and losing benefits.

B. A Middle Ground Between Colby *and* Stanford*?*

In *Colby*, the First Circuit proposed an untenable middle ground between its own holding and that in *Stanford*. According to the court, on remand, the insurer could have examined whether the risk of relapse decreased over time and, if it did, argued for a corresponding benefit reduction.[290] Instead, the insurer took a categorical approach and argued that any risk of relapse, no matter how severe, did not constitute a current disability under the plan.[291] The result of this all-or-nothing approach was the court's award of a full thirty-six months of benefits.[292]

This argument, that the risk of relapse progressively diminishes over time, is unsupported by current psychology research.[293] As noted previously, substance abuse causes lasting changes in the brain, and these changes play a significant role in precipitating relapse.[294] Research also demonstrates that "exposure to a drug can initiate neurochemical changes with

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[287] *Id.*

[288] *Id.*

[289] *Id.* at 796–97.

[290] Colby v. Union Sec. Ins. Co., 705 F.3d 58, 64 (1st Cir. 2013).

[291] *Id.*

[292] *Id.* at 68.

[293] Stewart, *Psychological and Neural Mechanisms*, *supra* note 178, at 3147.

[294] *Id.*

enduring molecular and anatomical consequences that affect subsequent responses to events that induce relapse."[295] These changes "continue to manifest themselves well into abstinence and may be a cause of the relapses into compulsive drug use that can occur long after the drug has been cleared from the body."[296] While a recent study of methamphetamine-dependent individuals found some evidence that impulsive decision making decreases over time, the study also found evidence that cue-induced cravings *increase* over time, and therefore concluded that the risk of relapse does not decline with abstinence.[297] The First Circuit's proposed alternative argument finds little support in recent psychology research.

VI. CONCLUSION

Under LTD plans, there is no principled reason to differentiate the risk of addictive relapse from other medical impairments.[298] Accordingly, other courts should follow the First Circuit's *Colby* decision. The Fourth Circuit's *Stanford* decision contravenes Supreme Court precedent, which had illustrated the high standards that ERISA places upon plan administrators. These standards require administrators to discharge their duties "solely in the interest of the participants and beneficiaries," not in their own financial self-interest, as the insurer apparently did in *Stanford*.[299] *Stanford* also contravenes current psychology research, which shows that addiction is not a "choice" but a disease that physically changes the brain in ways that last well into abstinence.[300] Thus, a recovering addict who is not actively

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[295] *Id.*

[296] Friedman, *supra* note 160, at 35.

[297] Guibin Wang et al., *Effects of Length of Abstinence on Decision-Making and Craving in Methamphetamine Abusers*, PLOS ONE, July 24, 2013, at 6.

[298] With the exception of *Allen*, this Note has focused on ERISA claims. While the arguments in *supra* Part V.A.1. are applicable only to ERISA claims, the other arguments are equally applicable to non-ERISA claims.

[299] 29 U.S.C. § 1104(a)(1) (2012).

[300] Friedman, *supra* note 160, at 35.

using drugs is still "currently disabled" and should be entitled to LTD benefits under ERISA-governed LTD benefit plans.

Furthermore, *Stanford* could have dire ramifications. It incentivizes recovering addicts to return to work before they are ready. With regard to anesthesiology, this inhibits the recovery process by placing addicts into an environment that is extremely conducive to relapse due to high stress levels and easily accessible drugs. Patients are similarly put at risk because anesthesiology is a crucial and complex component of many medical procedures. The risks of *Stanford*-like decisions are not limited to anesthesiology, but extend to any occupation that affects public safety and health.

The First Circuit's *Colby* decision, holding that the risk of relapse into drug addiction can be so severe as to constitute a current disability, avoids these potentially disastrous consequences. Further, *Colby* holds true to the congressional intent behind ERISA and the Parity Act. The Parity Act reflects a larger societal trend that recognizes the devastating effects of addiction and sees it as a disease rather than a choice or lack of willpower. Additionally, society has increasingly come to recognize that the way to deal with the pervasive problem of drug addiction is not to stigmatize users or blame them for poor decision-making, but to treat their condition as a chronic ailment on par with any other. Courts should therefore follow the First Circuit's lead and do their part to move society forward on this issue.