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A Failure to Rehabilitate: Leaving Disability Insurance Out of the Mental Health Parity Debate

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A Failure to Rehabilitate: Leaving Disability Insurance Out of the Mental Health Parity Debate

Christopher R. Wilson*

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I. Introduction

Over one quarter of Americans suffer from a mental or addictive disorder in any given year.¹ The World Health Organization has found that mental and behavioral disorders trail only cardiovascular disease and cancer as a cause of disability and premature death in the United States.² Recent events, including multiple mass shootings such as those at Newtown, Connecticut and the Washington Navy Yard,³ have focused public and

1. U.S. DEP’T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 76 (1999), available at <https://www.surgeongeneral.gov/library/reports/>; see also Ronald C. Kessler, et al., *Prevalence, Severity, and Comorbidity of Twelve-Month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)*, 62 ARCHIVES GEN. PSYCHIATRY 617, 619 (2005), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847357/> (placing the 12-month prevalence of mood disorders, including substance-related, at 26.2% and noting that nearly one quarter of such cases were classified as “serious,” indicating a suicide attempt, work disability, or other substantial limitation).

2. INST. FOR HEALTH METRICS AND EVALUATION, UNIV. OF WASH., THE STATE OF U.S. HEALTH: INNOVATIONS, INSIGHTS, AND RECOMMENDATIONS FROM THE GLOBAL BURDEN OF DISEASE STUDY 54–64 (2013), available at <http://www.healthmetricsandevaluation.org/gbd/publications/policy-reports>. The GBD study created a single measure—disability-adjusted life years (DALYs)—to account for years of healthy life lost, either through death or disability. *Id.* at 5. The category of mental and behavioral disorders excludes neurological disorders such as Alzheimer’s disease, but includes psychological disorders such as schizophrenia and depression, as well as drug use disorders. *Id.* at 58–59.

3. See STEPHEN J. SEDENSKY III, REPORT OF THE STATE’S ATTORNEY FOR THE JUDICIAL DISTRICT OF DANBURY ON THE SHOOTINGS AT SANDY HOOK ELEMENTARY SCHOOL AND 36 YOGANANDA STREET, NEWTOWN, CONNECTICUT ON DECEMBER 14, 2012 1, 34 (2013) (reporting on the investigation of the mass shooting that resulted in 27 homicides and noting that the shooter had been diagnosed with Asperger’s Disorder, and suffered from significant social impairments and extreme anxiety); *VA Sheds Light on Mental Health of Navy Yard Gunman Aaron Alexis*, CBSNEWS.COM (Sept. 18, 2013, 4:41 PM),

congressional attention on the issue of improving the Nation's mental health care system, leading President Obama to propose mental health reform as part of a larger strategy to reduce gun violence.⁴ The President's principal domestic achievement, the Patient Protection and Affordable Care Act (ACA),⁵ together with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),⁶ promise to improve access to, and the affordability of, mental health care. The ACA mandates that insurers provide coverage of mental health and substance abuse disorder services in health plans,⁷ and the MHPAEA requires most private group health insurance plans that offer mental health benefits to offer those services in parity with medical/surgical benefits.⁸ Unfortunately, however, these reforms only apply in the context of health insurance and thus leave a significant regulatory gap by failing to address mental health parity in the related—but distinct—field of disability insurance.

Disability insurance differs from health insurance in that benefits are payable only if the beneficiary becomes unable to work for an extended period of time due to illness or injury.⁹ Unlike health insurance, which pays

<http://www.cbsnews.com/news/va-sheds-light-on-mental-health-of-navy-yard-gunman-aaron-alexis/> (reporting that in the month leading up to the shootings, Alexis reported hearing voices and claimed that people were sending microwave vibrations into his body to deprive him of sleep).

4. See THE WHITE HOUSE, NOW IS THE TIME: THE PRESIDENT'S PLAN TO PROTECT OUR CHILDREN AND OUR COMMUNITIES BY REDUCING GUN VIOLENCE 13–15 (2013), available at <http://www.whitehouse.gov/issues/preventing-gun-violence#what-we-can-do> (proposing the creation of programs to identify and treat mental illness in students, training for teachers and mental-health professionals, and continued federal oversight of Medicaid mental health parity standards).

5. Patient Protection and Affordable Care Act (“ACA”), Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010) (codified as amended in scattered sections of 42 U.S.C.).

6. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3881 (2008) (codified as amended at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, & 42 U.S.C. § 300gg-5).

7. See 42 U.S.C. § 18022(b)(1)(E) (2012) (listing “mental health and substances use disorder services, including behavioral health treatment” among the “essential health benefits” that must be covered in non-grandfathered health plans offered by insurers in the individual and small group markets).

8. 26 U.S.C. § 54.9812–1(b)(1) (2012). The MHPAEA's parity requirement does not, however, apply to firms with less than 50 employees or when application of the requirement would increase the overall cost of coverage by 2% in the first year the requirement is applied, or 1% in any year thereafter. *Id.* at § 54.9812–1(f), (g).

9. See EMPLOYEE BENEFIT RESEARCH INST., FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 346–48 (6th ed. 2009) (explaining that in contrast to health insurance, which covers medical care costs, disability income insurance replaces a portion of a disabled worker's lost income). Short-term disability insurance typically provides coverage for 26

the cost of medical treatment, disability benefits are designed to replace the beneficiary's lost earning capacity.¹⁰ Because benefits are tied to earnings, the beneficiary's payment amount reflects a percentage of her pre-disability income rather than the severity of disability suffered.¹¹ Roughly one third of American workers receive disability insurance from their employer,¹² and employers that offer such plans typically pay 100% of the premiums.¹³

The income lost due to a long-term disability can be financially devastating, and while many individuals benefit from the protection against loss of earning power that these plans afford, long-term disability insurers often provide significantly less coverage for mental health disabilities than for physical disabilities, generally through benefit caps and explicit limitations on coverage for mental disabilities.¹⁴ A common example of this practice is a twenty-four month cap on disability benefits for mental health conditions, including those stemming from alcohol or drug abuse.¹⁵ By contrast, the typical practice in cases of physical impairment is to pay benefits from the onset of disability until the beneficiary reaches age 65 and becomes eligible for Medicare and Social Security benefits.¹⁶ Similar

weeks, but in most cases is subject to a waiting period of at least one week. *Id.* at 346. Long-term disability coverage generally begins when short term coverage ends. *Id.* at 347.

10. *Id.* at 348.

11. *See id.* (noting that typically, long-term disability plans cover between 60 and 70 percent of a person's pre-disability monthly pay).

12. *See* BUREAU OF LABOR STATISTICS, BLS BULL. NO. 2776, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES, MARCH 2013, table 16 (2013), <http://www.bls.gov/ncs/ebs/benefits/2013/printing.htm> (finding that 33% of civilian workers—i.e. non-federal employees—received access to long-term disability insurance through their employer while 37% had access to short-term disability insurance).

13. *See id.* at table 23, 28 (noting that 82% of short-term disability plans and 90% of long-term disability plans offered by employers do not require employee contribution).

14. *See* Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental Versus Physical Disabilities in Long-Term Disability Benefit Plans*, 50 BAYLOR L. REV. 361, 362 (1998) (noting that benefits for mental disabilities are often capped at 18 or 24 months, and that some disability plans allow for re-employment of persons with physical disorders if they later become medically able to work, an opportunity unavailable to persons with mental disorders).

15. *See e.g.*, Legal Notices, *Life and Disability Insurance Plans/Policies Exclusions and Limitations*, AETNA.COM, <http://www.aetna.com/legal-notice.html> (last visited Feb. 8, 2015) (placing a limit on benefits for mental health disabilities at 24 months absent a showing of "demonstrable, structural brain damage" or confinement as an inpatient in a hospital or other treatment facility).

16. *See* *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1008 (1997), *cert. denied*, 522 U.S. 1084 (1998) (determining that Title III of the ADA did not prohibit employer's plan offering 24 months of disability benefits for mental disorders and benefits up to age 65 for

inequitable practices in the field of health insurance are now limited under the MHPAEA and final rules implementing that Act,¹⁷ but the MHPAEA applies only to health policies and does not regulate short- or long-term disability insurance.¹⁸

Despite recent changes in federal law addressing some of the more egregious discrimination against mental illness in health insurance, there has been no comparable progress toward achieving parity in disability benefits. Meanwhile, potential state disability insurance reforms continue to be stymied by the Employee Retirement Income Security Act of 1974 (ERISA), which preempts most state regulation of employee benefits.¹⁹ What might seem the most obvious place to look for relief under federal law—the Americans with Disabilities Act (ADA), which bans disability-based discrimination in the workplace—has been interpreted by many courts to exclude claims of discrimination against insurers based on reduced coverage for mental as opposed to physical disabilities in employee disability benefit plans.²⁰ Finally, while most working Americans may qualify for Social Security Disability Insurance (SSDI), which provides federal coverage for workers suffering from mental disabilities, SSDI is less generous than most private disability plans,²¹ employs a very strict

physical disorders).

17. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68, 240 (Nov. 13, 2013) (codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–47); see also 26 C.F.R. § 54.9812–1(b)–(c) (requiring parity in aggregate lifetime and annual dollar limits, financial requirements, and treatment limitations between medical/surgical and mental health benefits within specified benefits classifications, including prescription drugs, and inpatient, outpatient, and emergency care).

18. See 26 C.F.R. § 54.9812–1(e)(1) (2014) (stating that mental health parity requirements apply to “group health plan[s] offering medical/surgical benefits and mental health or substance use disorder benefits”) (emphasis added).

19. ERISA and its preemptive provisions are discussed in detail *infra* Part III.C.

20. The provisions of the ADA that apply to disability benefits plans are explained further *infra* Part III.B.

21. See David Autor et al., *Moral Hazard and Claims Deterrence in Private Disability Insurance* 3, 6–7, Fig.1, (Nat’l Bureau of Econ. Research, Working Paper No. 18172, 2012), available at <http://www.nber.org/papers/w18172> (explaining that the SSDI after-tax income replacement rate is lower than for most private long term disability plans, and that the maximum allowable monthly benefit of most private policies is substantially higher than in the SSDI program, an important factor for higher-income workers). For 2012, the average monthly benefit paid to disabled workers was \$1,049.56. OFFICE OF RESEARCH, EVALUATION, AND STATISTICS, SOC. SEC. ADMIN., ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM 97 (2012).

definition of disability, and includes certain limitations that are not present in private disability insurance policies.²²

This Note examines current efforts to achieve mental health parity in the field of employer-offered long-term group disability insurance, ultimately concluding that in focusing on parity in health insurance, existing federal law has almost entirely overlooked a significant source of discrimination in the related field of employee disability benefits. This oversight may result in part from the ongoing national debate over changes to health insurance under the ACA, which has created a kind of “fog of war,” shielding other important insurance benefits from the public’s view. This note will attempt to lift some of that fog. Part II provides some necessary background on the discrimination and stigmatization faced by individuals suffering from mental impairments, and considers some of the primary arguments for and against parity. Part III surveys existing federal law, noting the difficulties faced by employees bringing claims under the ADA and the significant limitations imposed by ERISA on employee benefits litigation. Part IV examines a recent split between the First and Fourth Circuits on the contentious issue of whether the risk of relapse into drug addiction can constitute a current disability under an ERISA-administered long-term disability plan. Although this circuit split arose over a relatively narrow question, the legal and ethical principles relied on by the courts to decide the issue effectively represent the two sides in the broader debate over mental health parity, thus offering important insight for advocates of parity in disability benefits.

II. Why Do We Need Parity in Disability Benefits?

A. Containing Costs—The Argument Against Parity

The principal argument against parity in disability insurance focuses on the need for cost containment to guarantee broad access to insurance.²³

22. See 42 U.S.C. § 423(d)(1)(A) (2000) (defining disability as “inability to engage in any substantial gainful activity by reason of any . . . physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”). Individuals who apply for SSDI benefits must complete a five-month waiting period and will receive “insured status” only if they meet requirements based on previous work in employment covered by Social Security. *Id.* §423(c).

23. Insurers contain costs in part through a process known as “risk classification,” which involves sorting insurance applicants by various factors, such as age or occupation, thought to correspond to risk. See Baker, *infra* note 27 at 376–78 (“Eliminating particularly

Parity requirements, the argument goes, interfere with the insurer's ability to classify and respond to risks, and may result in increased premiums or even cause employers to terminate benefit plans entirely.²⁴ Cost containment strategies are generally designed to minimize the twin problems of "moral hazard"²⁵ and "adverse selection."²⁶ Moral hazard refers to the tendency of insured individuals to make use of benefits that they would not have relied on if uninsured.²⁷ In the context of disability benefits, the moral hazard problem arises whenever an employee does not try as hard to return to work following an illness or injury or claims disability benefits for a condition that would not have caused the employee to miss work in the absence of insurance.²⁸ The moral hazard problem may be magnified in the context of mental disability, where the existence of an allegedly disabling illness can be more difficult to verify, creating a greater likelihood of false diagnoses and incorrect eligibility determinations.²⁹

Adverse selection, with respect to disability benefits, refers to the tendency of individuals who believe they are more likely to become sick or injured to self-select into generous disability insurance policies while those who perceive their risk to be low "avoid or drop out" of voluntary employee insurance pools.³⁰ Because mental and addictive disorders can be

risky applicants reduces the average cost of insuring the members of the pool, allowing the insurer to offer a lower price and, possibly, obtain a greater profit.").

24. See Brief for The Am. Council of Life Ins. & Health Ins. Ass'n of Am. as Amici Curiae in Support of Defendants-Appellees, *Rogers v. Dept. of Health and Env'tl. Control*, 174 F.3d 431 (1999) (No. 97-2780) (predicting the "pernicious consequences" of mandating parity, including over-utilization, abuse, and "astronomical costs" that could make "employers and individuals unable to afford disability coverage at all").

25. See Richard G. Frank et al., *The Politics and Economics of Mental Health Parity*, 16 HEALTH AFF. 108, 110 (1997) (defining moral hazard as "the tendency for people to demand more services as the price they pay for the service falls").

26. See *id.* at 111 (explaining that adverse selection can occur "when potential enrollees differ in their risks [and] paid premiums . . . do not fully reflect those differences . . .").

27. See Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 373 (2003) (referring to moral hazard as the "change in incentives that can result from insurance protection").

28. See Autor et al., *supra* note 21, at 27 (explaining that a moral hazard problem exists in disability benefits policies because of the difficulty of verifying disability, coupled with the relatively high income replacement rates in many disability plans).

29. See Sheldon Danziger et al., *Mental Illness, Work, and Income Support Programs*, 166 AM. J. PSYCHIATRY 398, 400 (2009) (explaining that claims for disability insurance create a greater potential for "false positive eligibility errors" because determining disability due to mental disorders requires "professional judgment rather than formulaic assessments").

30. See Baker, *supra* note 27, at 375-76 (explaining adverse selection and strategies

more persistent—and thus more costly over time—than other types of illnesses, insurers view individuals suffering from such ailments as “bad risks.”³¹ Insurers thus have an incentive to provide limited coverage for mental disabilities to both avoid attracting these bad risks and to minimize the higher costs associated with mental disability claims. Cost containment strategies based on coverage limitations can be very effective, as evidenced by studies showing that workers whose benefits are capped, or who face longer elimination periods (the time that must elapse between the disabled employee’s initial claim and the beginning of payments) are less likely to claim long term disability benefits.³²

B. The Economic and Social Benefits of Parity

Cost containment arguments are not without force—after all, insurers must remain solvent if they are to provide benefits to anyone—and if the price of private disability benefit plans rises too high, some employees may be priced out of coverage altogether. Nevertheless, there are strong arguments for ending insurers’ ability to discriminate between mental and physical illness in disability policies. First, mental illness limitations in disability plans are a symptom of the pervasive stigma associated with mental illness³³ and ultimately rely on the common misperception that

insurers use to limit its effect).

31. See Frank et al., *supra* note 25, at 111 (“Since many mental and addictive disorders are more persistent than other illnesses, health plans have an incentive to reduce the likelihood that they will be chosen by persons with mental illness, who are generally ‘bad risks’”). Though offered in the context of health insurance, this reasoning also applies to disability insurance, where insurers have similarly strong incentives to limit the likelihood that they will be forced to pay benefits for lifelong (but seldom life-threatening) mental illnesses such as schizophrenia, leading many insurers to place a 24-month cap on disability benefits for mental illnesses. See, e.g., *Nelson v. Standard Ins. Co.*, No. 13cv188–WQH–MDD, 2013 WL 3776936, at *7 (S.D. Cal. July 17, 2013) (upholding insurer’s 24-month cap on mental disability benefits under California insurance parity statute).

32. See Autor et al., *supra* note 21, at 3–4 (finding that higher income replacement rates and shorter waiting times significantly increased the likelihood that workers claimed disability benefits, revealing the impact of moral hazard on long term disability claims).

33. See S. Clement, et al., *What is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies*, 45 PSYCHOL. MED. 1, 11 (2014), available at <http://journals.cambridge.org/action/display>

Abstract?fromPage=online&aid=9452499&fileId=S0033291714000129 (reporting that stigma ranked fourth out of ten barriers to help-seeking by those suffering from mental illness, and was reported as a barrier by over one quarter of those surveyed). The effects of stigma are more significant within certain groups, including males, and those in the military and health professions. *Id.* at 7, 14.

mental illness is a fringe problem suffered only by an unfortunate few.³⁴ Public understanding of, and attitudes toward, mental illness has evolved from the days when a diagnosis often led to institutionalization in an asylum.³⁵ Nevertheless, the stigma associated with mental illness has not fully dissipated, despite greater public awareness of the neurobiological causes of common mental disorders.³⁶ Though severe mental illness by itself has been shown not to predict future violent behavior,³⁷ national surveys reveal that many continue to associate mental illness with violence.³⁸ The stigma felt by those suffering from mental illness may cause them to “hide their symptoms” or delay seeking treatment.³⁹ Untreated mental illness in turn imposes severe social and economic costs

34. See Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 972–73 (suggesting that the “stigma associated with mental illness discourages many people from giving consideration to the possibility that they eventually may suffer from mental illness,” leading to pervasive undervaluation of mental health care); see also Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 596 (2005), available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=208678> (finding that nearly half of Americans will meet the criteria for a mental health disorder at some point during their lifetime).

35. See U.S. DEP’T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 6 (1999) [hereinafter SURGEON GENERAL’S REPORT], <https://www.surgeongeneral.gov/library/reports/> (noting that rapid urbanization in the early 19th century encouraged creation of isolated asylums for the mentally ill, a social policy later abandoned during the deinstitutionalization movement of the 1950s).

36. See Bernice A. Pescosolido et al., “A Disease Like Any Other”? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence, 167 AM. J. OF PSYCHIATRY 1321, 1325 (finding “no reduction” in the stigma surrounding mental illness, despite wide public acceptance of neurobiological theories and support for treatment, including psychiatry); see also NAT’L INST. OF HEALTH, THE SCIENCE OF MENTAL ILLNESS 21 (2005), available at http://science.education.nih.gov/supplements/nih5/Mental/guide/nih_mental_curr-supp.pdf (explaining that mental illness is associated with “changes in the brain’s structure, chemistry, and function”).

37. See Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder*, 66 ARCH. GEN. PSYCHIATRY 152, 152 (2009), available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=210191> (finding that the incidence of violence in individuals suffering from severe mental illness was significantly higher only for those with co-occurring substance abuse issues).

38. See SURGEON GENERAL’S REPORT, *supra* note 35, at 7 (citing a 1997 study concluding that people with mental illnesses were perceived to be more violent than in similar research conducted in the past).

39. CTRS. FOR DISEASE CONTROL AND PREVENTION, ATTITUDES TOWARD MENTAL ILLNESS: RESULTS FROM THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM 4 (2012), http://www.cdc.gov/hrqol/mental_health_reports/mental_health_reports.html.

on society.⁴⁰ By placing mental and physical disabilities on equal footing, parity laws help to reduce the damaging effects of stigma.

More fundamentally, research into the causes of mental illness has discovered a biological basis for disorders such as schizophrenia and clinical depression, blurring the line between physical and mental impairment and calling into question the validity of the mental/physical distinction found in many disability insurance policies.⁴¹ Studies linking mental and physical illnesses suggest that improving overall mental health may help to ameliorate common physical ailments such as heart disease, providing further evidence of the social utility of parity laws.⁴²

The benefits of parity legislation, moreover, are not limited to improvements in health. Nearly two-thirds of all consumer bankruptcies are directly related to illness or medical debt.⁴³ The proportion of bankruptcies attributable to medical causes rose by 49% between 2001 and 2007.⁴⁴ Perhaps surprisingly, most (77.9%) of those who identified illness as a contributing factor in their bankruptcy were insured at the onset of

40. See UNIV. OF TEX. MENTAL HEALTH POLICY ANALYSIS COLLABORATIVE, THE CONSEQUENCES OF UNTREATED MENTAL ILLNESS IN HOUSTON, 3 (2009), <http://www.mhtransformation.org/documents/reports/external/The%20Consequences%20of%20Untreated%20Mental%20Illness%20In%20Houston.pdf> (explaining that the societal costs of Houston's underfunded mental health infrastructure include "economic loss, homelessness, increased juvenile and adult criminal justice system involvement, and about a 25-year decrease in life expectancy").

41. See, e.g., Elain Walker & Kevin Tessner, *Schizophrenia*, 3 PERSP. ON PSYCHOL. SCI. 30, 30 (2008) ("[G]radually, over the past half century, the functional-organic distinction has been abandoned, giving way to the idea that schizophrenia is a brain disorder."). Recent research on schizophrenia's causes suggests that the disease is heritable, and is associated with specific genes as well as physical changes in the brain's composition and structure. *Id.* at 32, 34–35; see also R.H. Belmaker & Galila Agam, *Major Depressive Disorder*, 358 NEW ENG. J. MED. 55, 58–59 (2008) (describing the "considerable evidence" linking physical abnormalities such as elevated cortisol levels with depression and noting that antidepressant treatment resulted in reversal of some of these abnormalities).

42. See Belmaker & Agam, *supra* note 41, at 64 (pointing to "[s]trong epidemiologic data" linking major depressive disorder with "increased cardiovascular morbidity and mortality"). High cortisol levels from depression may increase the risk of coronary artery disease, and antidepressants have been shown to increase the survival rate of patients who become depressed following a heart attack. *Id.*

43. See David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009), available at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf (finding that 62.1% of debtors in bankruptcy reported medical causes, with 37.8% blaming income lost due to illness).

44. *Id.* at 744.

illness, with over 60% receiving private insurance coverage.⁴⁵ A 2008 study of home foreclosures similarly found that nearly half of homeowners on the brink of foreclosure cited medical issues, including lost work arising from a medical problem, as a major contributor to their mortgage defaults.⁴⁶ Clearly, in many cases health insurance is not enough to protect against the financial devastation of an unexpected illness or injury.

Private long-term disability insurance can provide a much-needed financial buffer or “safety net” for individuals who cannot afford to go without income due to a severe illness or injury.⁴⁷ Some commentators have gone as far as to suggest compulsory disability insurance as a solution to the medical bankruptcy problem.⁴⁸ There is no reason the crucial safety net of private disability insurance should be limited to disabled workers suffering from physical ailments. The public safety nets that may be available, such as SSDI benefits, are likely to replace only a small fraction of an individual’s former income and may not be enough to prevent bankruptcy or foreclosure.⁴⁹ In 2012, for example, the average monthly SSDI benefit was \$1,049.56.⁵⁰ Employees rely on private disability benefit plans to ensure that an unexpected illness does not result in financial

45. *Id.*

46. See Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 68 (2008) (reporting that 49% of respondents indicated foreclosure due to a medical problem, with 27% pointing specifically to lost work stemming from a medical problem).

47. See Alena Allen, *State-Mandated Disability Insurance as Salve to the Consumer Bankruptcy Imbroglia*, 2011 BYU L. REV. 1327, 1336–38 (2011) (noting that “most Americans simply are not able to maintain a personal rate of savings that would allow them to survive a loss of income caused by a medical crisis.”).

48. See *id.* at 1358–70 (arguing for state-mandated short term disability insurance as a way of reducing per-capita bankruptcy rates in states that do not already have such laws).

49. Unemployed individuals waiting for SSDI benefits may receive state public assistance income, but the monthly amount of such income is set below the federal poverty level. See Cathryn Miller-Wilson, *Becoming Poor: Stories of the Real “Safety Net” and the Consequences for Middle America*, 13 QUINNIAC HEALTH L.J. 1, 9 (2009). Presumptive SSI benefits may also be available while the disabled individual waits for an SSDI determination, but end after a period of six months even if there has been no determination of permanent disability. See 20 C.F.R. § 416.931 (2010). For 2014, the Presumptive SSI amount was \$721 per month for individuals. SOC. SEC. ADMIN., *2014 Social Security Changes*, <http://www.ssa.gov/pressoffice/factsheets/colafacts2014.html> (last visited Feb. 8, 2015).

50. SOC. SEC. ADMIN., ANNUAL STATISTICAL REPORT ON THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM 97 (2012), available at http://www.ssa.gov/policy/docs/statcomps/di_asr/2012/index.html.

disaster; mental illness limitations undermine the value of the employee's entitlement in a way that may go unnoticed until it is too late.⁵¹

III. Previous Attempts at Achieving Parity in Disability Insurance Benefits

A. First Attempt: The Rehabilitation Act of 1973

Congress' first attempt at addressing disability-based discrimination came with passage of the Rehabilitation Act of 1973,⁵² which prohibits discrimination⁵³ by federal agencies and private entities contracting with the federal government or receiving federal financial assistance.⁵⁴ Though the Act's protections extend to persons with mental disabilities,⁵⁵ they apply in somewhat haphazard fashion: state and local governments that receive federal aid are subject to the Act, while identical entities without federal funding are exempt from the law's mandates.⁵⁶ Perhaps more importantly

51. Plans that include the common 24-month limitation on mental disability benefits discriminate against employees who *in the future* will become disabled due to mental, rather than physical conditions because, as one court explained it, future mentally disabled employees' "present dollars (unbeknownst to them) are buying only 24 months of benefits, instead of benefits lasting much longer." *E.E.O.C. v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir.1996).

52. Pub. L. No. 93-112, 87 Stat. 355 (codified in scattered sections of 29 U.S.C.); 29 U.S.C. § 794 (2002).

53. Under both the Rehabilitation Act and the ADA, discrimination may be proved by evidence of "disparate impact," but the "adverse impact" theory of discrimination is unavailable. *See Alexander v. Choate*, 469 U.S. 287, 299 (1985) (assuming, without deciding, that section 504 of the Rehabilitation Act barred some conduct having an "unjustifiable disparate impact" on the handicapped); S. Rep. No. 101-116 at 27 (1989) (explaining that under the ADA, employers may continue to offer insurance policies with pre-existing conditions exclusions, even if such exclusions "adversely affect" people with disabilities). The Senate report emphasized that the ADA incorporated the disparate impact standard and the Supreme Court's analysis of that standard from *Alexander* to "ensure that the legislative mandate to end discrimination does not ring hollow." *Id.* at 28.

54. *See* 29 U.S.C. § 794(a) (2002) (prohibiting discrimination by "any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service").

55. *See id.* (protecting "qualified individual[s]" with a disability, defined by § 705(20) as including mental impairments, but excluding persons currently engaging in illegal drug use).

56. *See* H.R. Rep. No. 101-485 at 37 (describing the potential for "inconsistent treatment" of people with disabilities by different state or local agencies as "inequitable and illogical for a society committed to full access for people with disabilities"). Subsequent judicial decisions have further limited the law's applicability in certain contexts. *See, e.g., Joren v. Napolitano*, 633 F.3d 1144, 1146 (7th Cir. 2011) (denying plaintiff's claim of disability discrimination and joining other circuit courts in holding that the Aviation and

for those seeking parity in disability benefits, the law was enacted primarily to encourage vocational rehabilitation of the handicapped and not to remedy discrimination against persons unable to work.⁵⁷ Moreover, advocates of mental health parity have lamented the “indeterminate language” of the Act’s key provisions, which many felt represented a “wholesale refusal” to confront disability discrimination head-on.⁵⁸ Congress explicitly responded to these concerns by enacting stronger legislation in the form of the ADA.⁵⁹

B. Title I of the Americans with Disabilities Act

1. History and Purpose

The ADA was enacted in 1990 as a comprehensive piece of civil rights legislation, broadening and entrenching the reforms of the Rehabilitation Act.⁶⁰ Like the Rehabilitation Act, the ADA prohibits discrimination against mental as well as physical disorders, defining disability as “a physical or mental impairment that substantially limits one or more major life activities.”⁶¹ This definition of disability is identical to the one used

Transportation Security Act preempted application of the Rehabilitation Act to airport security screeners).

57. See 29 U.S.C. § 701(b) (1998) (stating the Act’s purpose to “empower individuals to maximize employment” and “ensure that the Federal Government plays a leadership role in promoting the employment of individuals with disabilities . . .”); 119 Cong. Rec. 24, 571 (1973) (declaring the proposed bill’s intent to “place more emphasis on rehabilitating individuals with more severe handicaps”).

58. Note, *Employment Discrimination Against the Handicapped and Section 504 of the Rehabilitation Act: An Essay on Legal Evasiveness*, 97 HARV. L. REV. 997, 999 (1984); see also Julie Brandfield, *Undue Hardship: Title I of the Americans With Disabilities Act*, 59 FORDHAM L. REV. 113, 114–116 (1990) (lamenting the Act’s failure to achieve “as substantial an effect on the lives of the handicapped as was hoped” and attributing this failure to section 504’s “general prohibitions” that lacked “details or definitions”).

59. See 42 U.S.C. § 12101(a) (2009) (finding that discrimination against individuals with disabilities “continue[s] to be a serious and pervasive social problem” and that individuals experiencing such discrimination “have often had no legal recourse”); S. Rep. No. 101-116 at 17 (1989) (explaining that current federal law was “inadequate” because it provided no protection against discrimination by private employers, places of public accommodation, or State and local agencies that did not receive federal aid).

60. See H. Rep. No. 101-485 at 26 (“The [ADA] completes the circle . . . with respect to persons with disabilities by extending to them the same civil rights protections provided to women and minorities beginning in 1964. The ADA is a comprehensive piece of civil rights legislation which promises a new future: a future of inclusion and integration . . .”).

61. 42 U.S.C. § 12102(1)(A) (2009); see also 29 C.F.R. 1630.2(h)(2) (2012) (clarifying that “physical or mental impairment,” as defined in the Act, includes “any mental or psychological disorder, such as an intellectual disability . . . organic brain syndrome,

under the Rehabilitation Act.⁶² Title I of the ADA, however, discards the Rehabilitation Act's "federal funding" requirement and extends protection against discrimination based on disability to all "terms, conditions, and privileges of employment" (including fringe benefits such as disability policies), and both public and private employees.⁶³

2. Disabled Former Employees as "Qualified Individuals" Under Title I

The ADA was intended to "level the playing field"⁶⁴ for persons with disabilities; however, plaintiff's attorneys relying on the ADA have generally had little success in challenging common mental illness limitations in long-term disability policies.⁶⁵ This is due in large part to the fact that Title I's protections apply only to "qualified individual[s] with a disability," defined as those who, "with or without reasonable accommodation," are able to perform the "essential functions" of a given employment position.⁶⁶ The Act's legislative history makes clear that the definition of "qualified individual" was intended to allow employers the freedom to retain only individuals capable of performing the relevant job tasks.⁶⁷ Thus, the fact of disability itself is not enough to guarantee

emotional or mental illness, and specific learning disabilities").

62. See 29 U.S.C. § 705(20)(B).

63. See 42 U.S.C. § 12112(a) (prohibiting employment discrimination by "covered entities," defined in 42 U.S.C. § 12111(2) as an "employer, employment agency, labor organization, or joint labor-management committee"); see also 42 U.S.C. § 12112(b)(2) (prohibiting discrimination in fringe benefits); see also H. Rep. No. 101-485 pt. 2 at 84 (1990) (noting that section 202 of the ADA extends the Rehabilitation Act's nondiscrimination policy to cover "all State and local governmental entities").

64. See *Siefken v. Village of Arlington Heights*, 65 F.3d 664, 666 (7th Cir. 1995) (claiming that in enacting the ADA Congress sought to "level the playing field" for the disabled by discouraging employment decisions based on "unfounded stereotypes").

65. Contrary to popular perception, employers win the vast majority of Title I cases. See *Study Finds Employers Win Most ADA Title I Judicial and Administrative Complaints*, 22 MENTAL & PHYSICAL DISABILITY L. REP. 403, 404 (1998) (reviewing 1,248 Title I employment cases and finding that of the 760 cases in which a final decision was rendered, employers won 92% of the time).

66. 42 U.S.C. § 12111(8) (2009).

67. See S. Rep. No. 101-116 at 24 (1989) ("By including the phrase 'qualified individual with a disability,' the Committee intends to reaffirm that this legislation does not undermine the employer's ability to choose and maintain qualified workers."). The Senate Committee on Labor and Human Resources further explained that in determining the "essential functions" of a job, consideration should be given to the employer's judgment regarding what functions qualified as essential as a matter of "business necessity." *Id.*

protection under the ADA.⁶⁸ Read literally, Title I offers little protection to totally disabled *former* employees challenging discrimination by insurers—the scenario in which most claims of discrimination in long term disability benefits arise.

Courts have noted the apparent incongruity between the ADA's restrictive definition of “qualified individual” and the otherwise broad requirement of nondiscrimination in employee disability benefits.⁶⁹ Title I's definition of “qualified individual” has forced those challenging mental illness limitations in disability policies to make the logically incoherent argument that they are totally disabled, yet capable of performing the “essential functions” of their job.⁷⁰ Employers and insurers have focused on this definition to argue that totally disabled former employees are not entitled to protection under the ADA because they do not currently hold an “employment position” and thus are unable to perform the “essential functions” of their job with or without reasonable accommodation.⁷¹ Four out of the six circuits that have considered the issue have agreed.⁷²

68. See Michelle Parikh, *Burning the Candle at Both Ends, and There is Nothing Left for Proof: The Americans with Disabilities Act's Disservice to Persons with Mental Illness*, 89 CORNELL L. REV. 721, 729 (2004) (citing 42 U.S.C. § 12112(a)) (“[A]n individual who seeks protection under the ADA must necessarily conquer two hurdles before claiming entitlement: first, the individual must meet the definition of disability, and second, the individual must be qualified to perform the functions of the position.”).

69. See *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 605 (3d Cir. 1998) (remarking on the “internal contradiction” and disjunction between the ADA's definition of “qualified individual with a disability” and the other rights conferred by the ADA).

70. See 42 U.S.C. § 12111(8) (2009); *E.E.O.C. v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996) (rejecting mentally-disabled former employee's claim of discrimination in long-term disability policy as not “cognizable” under Title I because she had no current “employment position”).

71. The Second and Third Circuits have rejected this defense. See *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 606–7 (3d Cir. 1998) (relying on analogous Supreme Court precedent interpreting the scope of Title VII of the Civil Rights Act of 1964 to hold that the ADA permits suits by disabled individuals against former employers); see also *Castellano v. City of New York*, 142 F.3d 58, 69 (2d Cir. 1998) (noting “textual ambiguity” surrounding the time at which an employee must have been a “qualified individual” and holding that former employees were “qualified individuals” under the ADA so long as they had performed the essential functions of their job for a period sufficient to establish entitlement to benefits).

72. The Sixth, Seventh, Ninth, and Eleventh Circuits have accepted the defense. See *McKnight v. General Motors Corp.*, 550 F.3d 519, 528 (6th Cir. 2008); *Morgan v. Joint Admin. Bd. Retirement Plan of Pillsbury Co.*, 268 F.3d 456, 457 (7th Cir. 2001); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000); *Gonzales v. Garner Food Services, Inc.*, 89 F.3d 1523, 1525–26 (11th Cir. 1996), *overruled by Johnson v. K Mart Corp.*, 273 F.3d 1035 (11th Cir. 2001). *Johnson* was subsequently vacated upon rehearing *en banc*, leaving *Gonzales* as the final word in the Eleventh Circuit. See *Johnson v.*

In several of these cases, the Equal Opportunity Employment Commission (EEOC) argued to no avail that the term “employment position” in the ADA should be interpreted to include the position of post-employment “benefit recipient,” thus sweeping former employees into the ADA’s definition of “qualified individual.”⁷³ The few favorable rulings on this issue have focused instead on Congress’ “broad remedial purpose” of ending disability discrimination in all aspects of employment, reasoning that the “essential functions” requirement does not apply to former employees, where Congress’ concern about employee qualifications is no longer implicated.⁷⁴

Other courts considering challenges to caps on mental disability benefits plans have held that an insurance policy’s distinction between mental and physical disabilities does not itself constitute discrimination under the terms of the ADA.⁷⁵ According to this line of reasoning, a disability policy is nondiscriminatory, regardless of its terms, if it is offered to all employees without respect to the employees’ disability status.⁷⁶ The ADA thus prohibits discrimination between the disabled and non-disabled but does not preclude discrimination within or between categories of disability.⁷⁷

K Mart Corp., 273 F.3d 1035 (11th Cir. 2001), *reh’g granted, vacated* 273 F.3d 1035 (11th Cir. 2001).

73. See, e.g., Brief for Equal Employment Opportunity Commission as Amicus Curiae Supporting Appellant, at 7–13, *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084 (1998) (“[W]hen an individual with a disability seeks access to a post-employment benefit allegedly denied or limited because of her disability, the relevant inquiry is not whether she is qualified to perform the essential functions of a particular job, but whether she is qualified to receive the benefit sought.”).

74. See, e.g., *Castellano v. City of New York*, 142 F.3d 58, 67–68 (2d Cir. 1998) (“Where the alleged discrimination relates to the provision of post-employment benefits, rather than to hiring, promotion, or firing, Congress’s expressed concern about qualifications is no longer implicated.”).

75. See *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998) (“While the defendants’ insurance plan differentiated between types of disabilities, this is a far cry from a specific disabled employee facing differential treatment due to her disability.”).

76. See *id.* (“So long as every employee is offered the same plan regardless of that employee’s contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities.”).

77. See *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir. 1997), *cert. denied*, 522 U.S. 1084 (1998) (holding that the ADA “does not mandate equality between individuals with different disabilities”); *E.E.O.C. v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996) (denying claim that plan’s disparate treatment of mental disability benefits was discriminatory because to do otherwise would “read into” the ADA a rule currently subject to “vigorous, sometimes contentious, national debate”).

Congress addressed concerns that courts had incorrectly narrowed the scope of the ADA's protections with passage of the ADA Amendments Act of 2008 (ADAAA).⁷⁸ The ADAAA expressly overturned four Supreme Court decisions, most notably *Sutton v. United Air Lines, Incorporated*,⁷⁹ in which the Court had determined that "whether an impairment substantially limits a major life activity" was to be ascertained "with reference to the ameliorative effects of mitigating measures."⁸⁰ Though decided in the context of physical impairment, the Court's discussion of mitigating measures also threatened to adversely impact disability claims brought by those with severe mental illnesses that are treated with medication.⁸¹ Many lower courts relied on the Court's reasoning and held that individuals with mental illnesses that could be controlled through the use of medication did not have a disability that "substantially limits one or more major life activities"⁸² as required by the ADA.⁸³ The ADAAA reaffirmed Congress' intent that courts focus primarily on the employer's compliance with ADA regulations rather than on whether an individual's impairment constituted a disability, a question that "should not demand extensive analysis."⁸⁴ Nevertheless, ADA litigation outcomes confirm that even after passage of the 2008 Amendments, the ADA's definition of "qualified individual" remains a substantial hurdle to plaintiffs with mental disabilities.⁸⁵

78. See ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(b)(2)–(5), 122 Stat. 3553, 3554 (asserting that holdings in several Supreme Court cases had "narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect").

79. 527 U.S. 471 (1999), *superseded by statute*, ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (holding that severely myopic job applicants who were denied positions as commercial airline pilots because they did not meet the employer's uncorrected visual acuity standards were not disabled within the meaning of the ADA due to the availability of corrective or mitigating measures).

80. See ADA Amendments Act of 2008 § 2(b)(2) (citing *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 475 (1999)).

81. See Randal I. Goldstein, *Mental Illness in the Workplace After Sutton v. United Air Lines*, 86 CORNELL L. REV. 927, 929 (2001) (explaining that *Sutton* threatened to make the ADA "largely unworkable" for some mentally ill plaintiffs).

82. 42 U.S.C. § 12102(1)(A) (2009).

83. See, e.g., *Swanson v. Univ. of Cincinnati*, 268 F.3d 307, 316 (6th Cir. 2001) (finding individual suffering from depression was "impaired" but not "substantially limited" because his symptoms improved with medication).

84. See ADA Amendments Act of 2008m§ 2(b)(5).

85. See Stephen F. Befort, *An Empirical Examination of Case Outcomes Under The ADA Amendments Act*, 70 WASH. & LEE L. REV. 2027, 2055 (2013) (finding that post-amendment, employers won summary judgment on the qualified individual issue in 69.7% of cases, as opposed to 47.9% pre-amendment). Employers' success rate in summary

3. Section 501(c) and Insurer “Subterfuge”

ADA Section 501(c), left unchanged by the ADAAA, creates a “safe harbor” provision that on its face permits insurers to discriminate in the terms of employee benefit plans.⁸⁶ This so-called “bona fide” benefit plan exemption clarifies that the ADA does not prohibit insurers or employers from “establishing . . . or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law.”⁸⁷ Insurers and self-insured employers thus appear free to discriminate between mental and physical disabilities in disability benefit plans if such discrimination is part of a risk classification strategy.

The Act also provides, however, that employee benefit plans may not be used as a “subterfuge” to evade the ADA’s purposes.⁸⁸ To help resolve the apparent conflict between these two provisions, the EEOC issued guidance in 1993 stating that insurance distinctions based on disability might violate the ADA, and suggesting several ways to prove that a challenged disability-based distinction is not subterfuge, including by showing that the disparate treatment is “attributable to the application of legitimate risk classification and underwriting.”⁸⁹ Reviewing courts faced with challenges to disparate treatment of mental and physical disabilities in long term disability insurance policies have neatly sidestepped these guidelines by finding that the EEOC’s interpretation, because it addresses

judgment decisions on the qualified individual issue involving only plaintiffs with mental impairments rose from 60% to 66.7%, though this finding is based on a small sample of post-amendment rulings. *Id.* at 2056.

86. *See* 42 U.S.C. § 12201(c) (2009). Section 501(c) states: “Titles I through IV of this Act . . . shall not be construed to prohibit or restrict . . . a person or organization . . . from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.” As discussed *infra* Part III.C.2, ERISA’s preemption provisions exempt self-funded employee benefit plans from state laws regulating insurance, meaning that all such plans are covered by section 501(c)(3).

87. *Id.* § 12201(c)(2).

88. *Id.* § 12201(c)(3).

89. EQUAL EMP’T OPPORTUNITY COMM’N, INTERIM GUIDANCE ON APPLICATION OF AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993); *see also* Ruth Colker, *The Americans with Disabilities Act: A Windfall for Defendants*, 34 HARV. C.R.-C.L. L. REV. 99, 158 (1999) (observing that Congress “filled the legislative history with clear and consistent statements that it intended the term ‘subterfuge’ to require insurance companies to base their disability-based distinctions on sound actuarial principles”).

health as opposed to disability benefits, has no application to long term disability benefit programs.⁹⁰

One of the first cases to consider whether differences in coverage between mental and physical health benefits could trigger the “subterfuge” exception to the ADA’s safe harbor provision was *Modderno v. King*.⁹¹ In *Modderno*, the D.C. Circuit Court of Appeals ruled that a benefit plan’s \$75,000 lifetime maximum for mental health benefits did not violate section 504 of the Rehabilitation Act or constitute “subterfuge” under the ADA.⁹² The court relied in large part on the Supreme Court’s decision in *Public Employees Retirement System v. Betts*,⁹³ which had previously interpreted the same term in the Age Discrimination in Employment Act (ADEA),⁹⁴ holding that structuring a plan to provide reduced benefits for mental disabilities was not a discriminatory “subterfuge” so long as the plan was not a method of discriminating in some “other, non-fringe-benefit aspects of the employment relationship.”⁹⁵ While the court noted that Congress had subsequently amended the ADEA to overturn the *Betts* decision,⁹⁶ it reasoned that this congressional response strengthened its argument: *Betts* remained controlling precedent when the ADA was enacted, yet Congress still chose to adopt the “subterfuge” language of section 501(c).⁹⁷

90. See *E.E.O.C. v. Staten Island Sav. Bank*, 207 F.3d 144, 152 (2d Cir. 2000) (“[T]he Interim Guidance states at the outset that it addresses only health insurance . . . We cannot place great reliance on an informal guidance that . . . does not apply to the question at hand.”).

91. See *Modderno v. King*, 82 F.3d 1059, 1065 (D.C. Cir. 1996) (finding that an insurance plan’s reduced lifetime maximum for mental health benefits was not a “subterfuge” to avoid ADA requirements).

92. *Id.*

93. See *Pub. Emps. Ret. Sys. v. Betts*, 492 U.S. 158, 180 (1989) (interpreting former § 4(f)(2) of the ADEA to exempt employee benefit plans from the Act’s coverage except when such plans were used as a subterfuge for age discrimination in other, non-benefit aspects of the employment relationship), *superseded by statute*, Older Workers Benefit Protection Act of 1990, Pub. L. No. 101-433, 104 Stat. 978, *as recognized in* *Meacham v. Knolls Atomic Power Lab.*, 554 U.S. 84, 94 (2008).

94. Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621–634 (2008).

95. *Betts*, 492 U.S. at 177.

96. See *Modderno*, 82 F.3d at 1064–65 (noting that after *Betts*, Congress removed the “subterfuge” language from the ADEA entirely and reflecting that this response “presumably” indicated Congress’s opinion that “‘subterfuge,’ as understood by the Court, was not a suitable way to accomplish the congressional purpose in the context of the ADEA”).

97. See *id.* at 1065 (“[W]hen Congress chose the term ‘subterfuge’ for the insurance safe-harbor of the ADA, it was on full alert as to what the Court understood the word to

There is some reason to doubt Congress' intention to incorporate *Betts* into the ADA's definition of "subterfuge,"⁹⁸ but the fact remains that 501(c)'s subterfuge provision has proved ineffectual as a means of challenging insurer discrimination in employer-offered disability benefits.⁹⁹ More broadly, the reason behind the unsuccessful outcome of many challenges may be that claims brought by totally disabled former employees suffering from mental disabilities seek to redress a type of discrimination that was simply not envisioned by Congress when enacting the ADA.¹⁰⁰ The prototypical Title I case involves a claim by an employee that she was terminated despite her ability to "perform the essential functions" of her job with or without reasonable accommodation.¹⁰¹ By contrast, claims of discrimination in long-term disability benefits are by definition brought by individuals unable to perform essential work functions. Claims alleging discrimination based on mental impairment in the terms of employee disability insurance thus do not fit neatly within the ADA's regulatory structure. Indeed, mental disabilities—although not quite an afterthought—

mean and possessed (obviously) a full grasp of the linguistic devices available to avoid that meaning.”).

98. See 136 Cong. Rec. H4624 (daily ed. May 17, 1990) (statement of Rep. Edwards). Explaining that:

The term “subterfuge” is used in the ADA simply to denote a means of evading the purposes of the ADA. It does not mean that there must be some malicious intent on the part of the insurance company or other organization, nor does it mean that a plan is automatically shielded because it was put into place before the ADA was passed. Indeed, there is currently a bill moving through Congress to overturn the *Betts* decision and we have no intention of repeating a decision with which we do not agree.

99. Appellate courts that have considered “subterfuge” claims have uniformly rejected the EEOC’s interpretation and instead adopted the Supreme Court’s narrow reading of the term in *Betts*. See *Moddero v. King*, 82 F.3d 1059, 1064 (D.C. Cir. 1996); See generally *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 36 (2d Cir. 1999); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 611 (3d Cir. 1998); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 679 (8th Cir. 1996); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116–17 (9th Cir. 2000). The same courts have declined to require insurers to justify their coverage plans through actuarial data demonstrating that the plans are not a “subterfuge,” under the theory that this would place courts in the position of “super-actuary.” See, e.g., *Ford*, 145 F.3d at 612.

100. See *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 150–51 (D. Mass. 2004) (noting that despite evidence in ADA’s legislative history suggesting that Congress considered and rejected certain prohibitions on differential coverage in health insurance, Congress “fail[ed] to discuss the ADA’s application to welfare benefit plans . . .”).

101. See *id.* at 146 (asserting that disputes over an employee’s ability to perform the essential functions of a job with reasonable accommodation are the “most common” form of claim under the ADA).

received much less attention than physical disabilities by drafters of the ADA.¹⁰²

C. Restrictions to State Reform Under the Employee Retirement Income Security Act of 1974

1. Introduction

In addition to regulation under the ADA, employer-offered long-term disability benefits plans are subject to extensive federal regulation under the Employee Retirement Income Security Act of 1974 (ERISA).¹⁰³ While Congress originally enacted ERISA to rectify the problem of mismanagement in private pension funds,¹⁰⁴ ERISA regulation also extends to employer-offered “welfare benefit” plans, defined broadly as plans “maintained for the purpose of providing . . . medical, surgical, or hospital care benefits, or benefits in the event of sickness, accident, disability, death or unemployment”¹⁰⁵ Although Congress has generally allowed states to serve as the primary regulators of most types of insurance,¹⁰⁶ ERISA

102. See Goldstein, *supra* note 81, at 942 n.123 (explaining that a survey of the ADA’s legislative history reveals that experts who testified before Congress primarily addressed physical disabilities and that none of the hypothetical “reasonable accommodations” mentioned in the House Report address mental disabilities). See, e.g., H.R. Rep. No. 101-485 pt. 2 at 33–34 (1990) (mentioning only accommodations for physical disabilities such as deafness or cerebral palsy).

103. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93–406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C. §§ 1001 et seq. (2012)). Government plans and most church plans, however, are exempt from ERISA regulation. ERISA §4(b); 29 U.S.C. §1003(b). ERISA similarly does not extend to individually purchased health or disability plans and other benefit plans not provided by employers, such as uninsured motorist insurance and worker’s compensation policies. *Id.*

104. See S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4838 (declaring ERISA’s purpose to “prescribe legislative remedies for the various deficiencies existing in the private pension plan systems”); H.R. Rep. No. 93-807, at 13 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4680 (recounting the widely-publicized 1964 closing of the Studebaker plant, which resulted in termination of an underfunded pension benefit plan and nonpayment of benefits to large numbers of employees, many of whom had vested rights).

105. 29 U.S.C. § 1002(1) (2008).

106. The Supreme Court held that “[i]ssuing a policy of insurance is not a transaction of commerce,” and thus that states were free to regulate the business of insurance. *Paul v. Virginia*, 75 U.S. 168, 183 (1868), *overruled by* *United States v. Se. Underwriters Ass’n*, 322 U.S. 533 (1944). The Court later overturned its decision in *Paul*, which led Congress in 1945 to enact the McCarran-Ferguson Act, reaffirming Congress’ belief that continued state regulation of the business of insurance is “in the public interest.” 15 U.S.C. § 1011 (2012).

represents a significant departure from this general rule by federalizing the regulation of employee insurance benefits. It is important to understand ERISA's effect on employee benefits because most disability insurance plans in the United States are provided by employers,¹⁰⁷ and many employers rely on provisions in ERISA to avoid state-mandated benefits, including state mental health parity laws.¹⁰⁸ Meanwhile, ERISA itself does not require that employers provide particular benefits or prohibit discrimination between mental and physical impairments.¹⁰⁹

Despite preempting many traditional state remedies, such as tort liability for bad faith breaches of insurance contracts,¹¹⁰ the remedial scheme ERISA offers in return is intentionally limited and provides little to replace the state laws it supersedes.¹¹¹ For example, many courts have held that beneficiaries are not entitled to jury trials when seeking to recover benefits due under the terms of their employee disability plan,¹¹² and

107. See David J. Christianson, *Disability Income Insurance: The Private Market and the Impact of Genetic Testing*, 35 J.L. MED. & ETHICS 40, 44 (2007) (noting that employer-offered group disability insurance policies cover roughly 30 percent of the labor force, while only 3.3 percent of workers are covered by individually-purchased long term disability plans).

108. See *infra* notes 122–126 and accompanying text (explaining employers' ability to self-insure as a means of avoiding state regulation).

109. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (“ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits.”); *Wilson v. Globe Specialty Prods, Inc.*, 117 F. Supp. 2d 92, 97 (D. Mass. 2000) (dismissing ERISA beneficiary's claim alleging disparate treatment of mental and physical disability benefits and emphasizing that “ERISA does not require . . . equal benefits for different disabilities.”).

110. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (concluding that ERISA preempted Mississippi common law claim for insurer's bad faith breach of insurance contract based on improper claims processing); *Barber v. Unum Life Ins. Co.*, 383 F.3d 134, 140 (3d Cir. 2004) (holding state statute was conflict preempted under 502(a) because it allowed the plan participant to recover punitive damages for bad faith conduct by insurer).

111. See discussion of ERISA remedies *infra* Part III.C.3.

112. ERISA does not specifically address the right to jury trial, and courts have uniformly held that beneficiaries suing under § 502(a)(3) for “other appropriate equitable relief” are not entitled to jury trial due to the equitable nature of the cause of action. See, e.g., *Cox v. Keystone Carbon Co.*, 861 F.2d 390, 393 (3d Cir. 1988) (“In using the words ‘equitable relief’, we can infer that Congress knew the significance of the term equitable and intended that no jury be available on demand.”). Courts are divided on whether a beneficiary relying on § 502(a)(1)(B) to recover “benefits due” under the terms of the plan is entitled to a jury trial. Compare *Stamps v. Michigan Teamsters Joint Council No. 43*, 431 F. Supp. 745, 747 (E.D. Mich. 1977) (finding that 502(a)(1)(B) created an action for legal relief, triable to a jury upon demand), with *Graham v. Hartford Life & Accident Ins. Co.*, 589 F.3d 1345, 1355 (10th Cir. 2009) (concluding that 502(a)(1)(B) did not create a right to jury trial because the “threshold question” was equitable in nature, requiring determination

ERISA does not permit compensatory damages, removing a crucial check on unprincipled claims handling in ERISA disability plans.¹¹³ ERISA's exclusive regulatory scheme was intended to bring uniformity to the field of employee pension and welfare benefits law, with the aim of lowering the cost to employers of providing such benefits.¹¹⁴ Supreme Court decisions interpreting ERISA, however, have narrowed the statute's already narrow range of remedies, leading Justice White to remark on the "anomaly" of interpreting ERISA so as to "leave those Congress set out to protect . . . with 'less protection than they enjoyed before ERISA was enacted.'"¹¹⁵

2. ERISA Preemption

of plaintiff's entitlement to assets held in trust by defendant).

113. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) (finding "nothing at all" in the regulations or the statute to support recovery of extra-contractual damages, compensatory or punitive relief). After *Russell*, individuals wrongfully denied benefits under an ERISA plan were generally limited to recovering "benefits due" under the plan terms according to ERISA § 502(a)(1)(B). *Id.* at 214. This encouraged abuse because insurers found to have wrongfully accepted premiums or denied coverage would at most be forced to repay ill-gotten gains or pay benefits due. See *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 182–83 (4th Cir. 2012) (noting that absent "remedies beyond mere premium refunds" ERISA plan fiduciaries had "every incentive to wrongfully accept premiums" even if they knew that no coverage existed). See also Thomas P. Kelly III, *A Call for the Overhaul of ERISA: How the Employee Retirement Income Security Act of 1974 Rewards Employers for Bad Faith Denials of Legitimate Claims for Employee Disability Benefits, A Multi-Case Study Involving One Philadelphia-Based Insurance Carrier*, 37 SETON HALL LEGIS. J. 283, 302 (2013) (opining that "it makes good business sense for companies . . . to intentionally and knowingly violate ERISA because there is no penalty for doing so beyond a possible award of attorney fees.").

114. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 388 (2002) (Thomas, J., dissenting) ("[E]xclusivity of remedies is necessary to further Congress' interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees . . .").

115. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 267 (1993) (White, J., dissenting) (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114 (1989)); see also John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1336–37 (2003) (arguing that a series of Supreme Court decisions misinterpreted ERISA's remedial provisions, incorrectly excluding equitable forms of relief such as consequential damages); Nancy Lee Firak, *Threshold Barriers to Title I and Title III of the Americans with Disabilities Act: Discrimination Against Mental Illness in Long-Term Disability Benefits*, 12 J.L. & HEALTH 205, 219 (1998) ("Many commentators believe that ERISA, which was intended to be a pro-employee measure, has become a tool through which employers have successfully limited employees' access to courts and to meaningful remedies . . .").

Perhaps the most damaging feature of ERISA, at least with respect to mentally disabled claimants challenging discriminatory terms in employee disability insurance policies, are ERISA's comprehensive preemption provisions. ERISA preemption comes in three varieties. First, express preemption under section 514(a), as noted above, provides that ERISA "supersede[s] any and all State laws [that] relate to any employee benefit plan"¹¹⁶ The broad sweep of this clause is then curtailed by the "savings" clause exception of section 514(b)(2)(A), which exempts some state laws from preemption, including those that regulate insurance.¹¹⁷ Finally, the "savings" clause itself is subject to an exception in the form of the section 514(b)(2)(B) "deemer" clause, which provides that no employee benefit plan may be "deemed" to be an insurance company under any state law purporting to regulate insurance.¹¹⁸

State laws that are saved from section 514(a) preemption may still be subject to "implied" preemption under ERISA's 502(a) civil enforcement provisions. The Supreme Court has held that this section constitutes a "complete preemption" exception to the well-pleaded complaint rule, permitting removal to federal court of any cause of action within the scope of section 502(a).¹¹⁹ Section 502(a) also serves a second preemptive function by providing exclusive federal remedies that preclude plaintiffs from asserting any state-law cause of action that "duplicates, supplements, or supplants" the remedies available under section 502(a).¹²⁰

Despite a handful of more recent Supreme Court decisions that somewhat limit the reach of ERISA preemption,¹²¹ the statute still

116. 29 U.S.C. § 1144(a).

117. *Id.* at § 1144(b)(2)(A).

118. *Id.* at § 1144(b)(2)(B).

119. *See* *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004) (stating that ERISA's civil enforcement mechanism has "such 'extraordinary preemptive power'" that it converts a state common-law complaint into a federal claim under the well-pleaded complaint rule) (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65–66 (1987)).

120. *Id.* at 201.

121. The Supreme Court defined the limits of ERISA preemption in *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). Prior to *Travelers*, the Court had interpreted ERISA § 514(a) to preempt any state law that had a "connection with or reference to" an employee benefit plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983). Recognizing the near-boundless reach of this interpretation, the Court relied on what it considered ERISA's objectives—namely, "eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans"—to conclude that ERISA preemption did not extend to state laws that only indirectly influenced the cost of covered benefits. *Travelers*, 514 U.S. at 657 (quoting remarks of Senator Williams, 120 Cong. Rec. 29933 (1974)). The modest trend in favor of

effectively shields many long-term disability plans from both state regulation and tort claims. As interpreted by the Supreme Court, section 514(b)(2)(B)'s deemer clause exempts self-funded ERISA plans from state laws "regulating insurance" within the meaning of the savings clause.¹²² State laws "directed toward" such plans are thus preempted because they "relate to" the employee benefit plan, but are not "saved" because the state law is not held to be a law regulating insurance.¹²³ Increasingly both large and small employers rely on the deemer clause to self-insure, taking on the burden of funding and administering the plan in return for near-total exemption from state regulation, including benefit mandates.¹²⁴ Employers themselves are liable for employee benefit claims made under a self-insured plan, but courts have almost uniformly held that employers do not lose self-insured status by purchasing separate stop-loss insurance policies to mitigate their risk, further encouraging the shift to self-insurance.¹²⁵ Sixty-one percent of employees insured through ERISA plans are covered by partially or completely self-funded plans, a figure that has steadily

according states greater authority to regulate insurers continued with the Supreme Court's decision in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), which held that state laws are exempt from ERISA preemption if they are "directed toward entities engaged in insurance" and "substantially affect the risk pooling arrangement between the insurer and insured." *Id.* at 342; *see also* Matthew O. Gatewood, *The New Map: The Supreme Court's New Guide to Curing Thirty Years of Confusion in ERISA Savings Clause Analysis*, 62 WASH. & LEE L. REV. 643, 674–76 (2005) (arguing that the *Miller* test "bolsters the Insurance Savings Clause").

122. *See* *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (holding that ERISA's deemer clause preempted application of Pennsylvania anti-subrogation law to self-funded health benefit plan).

123. *Id.*; *see also* *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 747 (1985) ("[O]ur decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause' . . .").

124. *See* KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS 2013 ANNUAL SURVEY 1, 178 (2013) [hereinafter KAISER SURVEY], available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf> (finding that in 2013, 94% of large firms—defined as those with 5,000 or more workers—chose to self insure).

125. *See e.g.*, *Am. Med. Sec. Inc. v. Bartlett*, 111 F.3d 358, 361 (4th Cir. 1997), *cert. denied*, 524 U.S. 936 (1998) ("[P]lans that are self-funded or self-insured may not themselves be regulated as insurance companies [under the "savings clause"] even if the self-funded or self-insured plan purchases stop-loss insurance to cover losses or benefits payments beyond a specified level."); *Pariseau v. Albany Int'l Corp.*, 822 F. Supp. 843, 846 n.5 (D. Mass. 1993) (lamenting the shift to self-insurance that "significantly reduced the class of workers for whom the benefits of state insurance regulation [were] available").

increased over time.¹²⁶ Thus, while state laws may be more protective of mental health disability benefits than federal legislation, the scope of ERISA preemption and the prevalence of self-insured plans means that such laws affect only a fraction of the employees receiving disability benefits.

3. ERISA Limits the Remedies Available to Disabled Employees Wrongfully Denied Benefits

For many mentally disabled employees with employer-provided long-term disability policies, ERISA preemption of state common law remedies may be even more troubling than preemption of state statutory protections. The remedies available under ERISA section 502(a) are very limited, and generally track those available under the law of trusts.¹²⁷ ERISA's primary remedial provision, section 502(a)(1)(B), permits a participant or beneficiary to bring a civil action "to recover benefits due" under the terms of the plan.¹²⁸ Section 502(a)(2) authorizes a beneficiary to invoke liability for breach of fiduciary duty, but any recovery in such cases inures to the benefit of the plan rather than to the beneficiary directly.¹²⁹ Finally, section 502(a)(3) authorizes injunctive relief against practices that violate ERISA fiduciary law or the terms of a plan, as well as suits to obtain "other appropriate equitable relief . . . to redress such violations."¹³⁰ The Supreme Court's decision in *Aetna Health Incorporated v. Davila*¹³¹ reaffirmed the exclusivity of these remedial provisions, finding that the Congressional purpose of creating a "comprehensive statute for the regulation of employee benefit plans" demands preemption of any state remedy that "duplicates,

126. See KAISER SURVEY, *supra* note 124 at 176–78 (finding that across all firms, the percentage of covered workers in partially or completely self-funded plans rose from 44% to 61% from 1999 to 2013).

127. See Langbein, *supra* note 115, at 1333–34 (claiming that ERISA "absorbs" trust law's three-part remedial system, which allows "recovery for loss, restitution of profits, and recovery of foregone gains").

128. 29 U.S.C. § 1132(a)(1)(B) (2009).

129. See *id.* at § 1109(a) ("Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to *such plan* any losses to the plan resulting from each such breach . . .") (emphasis added).

130. *Id.* at § 1132(a)(3) (2009).

131. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 210 (2004) (holding that ERISA § 502(a)(1)(B) prevents individuals from bringing any claim—either state or federal—that the individual "could have brought" under § 502(a)(1)(B)).

supplements, or supplants” ERISA’s civil enforcement scheme.¹³² As mentioned above,¹³³ preemption of traditional state-law remedies leaves disabled former employees with few options when seeking to redress bad faith denials by insurers.

For many years the Supreme Court further narrowed the range of remedies available to ERISA beneficiaries by construing section 502(a)(3) to include only those categories of relief that were “typically available in equity” before the merger of law and equity.¹³⁴ Thus both punitive damages and make-whole remedies such as compensatory damages were not available because such forms of relief were primarily legal in nature.¹³⁵ The Supreme Court’s decision in *CIGNA Corporation v. Amara*¹³⁶ signaled a modest shift toward expanding the scope of allowable equitable remedies under section 502(a)(3).¹³⁷ Legal remedies remain unavailable, but Justice Breyer’s majority opinion described three potential bases of equitable relief: reformation, estoppel, and surcharge.¹³⁸ While this portion of the opinion is arguably dictum,¹³⁹ some Circuit Court opinions have relied on Breyer’s discussion “almost as firmly” as an outright holding.¹⁴⁰

The Fourth Circuit cited *Amara* in reversing a decision it had issued the same day *Amara* was decided, finding on rehearing that equitable

132. *Id.* at 208–9.

133. *See supra* notes 112–115 and accompanying text (discussing the Supreme Court’s narrow interpretation of the already narrow range of remedies provided by ERISA).

134. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (listing injunction, mandamus, and restitution among the remedies typically available in equity, but excluding compensatory damages).

135. *See id.* at 255 (“Money damages are, of course, the classic form of *legal* relief.”).

136. *See CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1877 (2010) (holding that disclosures contained in statutorily-required summary plan document could not be enforced under section 502(a)(1)(B) as the terms of the plan itself).

137. *See id.* at 1880 ([T]he fact that . . . relief takes the form of a money payment does not remove it from the category of traditionally equitable relief.”).

138. *Id.* at 1879–80.

139. *Id.* at 1884 (“The Court’s discussion of the relief available under § 502(a)(3) and *Mertens* is purely dicta, binding upon neither us nor the District Court.”). *But see* Susan Harthill, *The Supreme Court Fills a Gaping Hole: Cigna Corp. v. Amara Clarifies the Scope of Equitable Relief Under ERISA*, 45 J. MARSHALL L. REV. 767, 791 (2012) (claiming that the majority’s discussion of estoppel, reformation, and surcharge in *Amara* was not dicta because it was “fully debated” and was an essential part of the Court’s grant of certiorari and oral argument).

140. *See McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 181 n.2 (4th Cir. 2012) (citing *Gaylor v. U.S.*, 74 F.3d 214, 217 (10th Cir. 1996) for the proposition that courts are “bound by Supreme Court dicta almost as firmly as by the Court’s outright holdings, particularly when the dicta is recent and not enfeebled by later statements”).

remedies of estoppel and surcharge were potentially available to the plaintiff.¹⁴¹ The court received the *Amara* decision with evident relief, noting that the existing “stifled” state of the law interpreting section 502(a)(3) encouraged abuse by fiduciaries.¹⁴² Even after *Amara*, however, ERISA’s remedial scheme leaves aggrieved beneficiaries in the unenviable position of either shoehorning their request for relief into one of the statute’s defined remedial categories (i.e. filing suit under section 502(a)(1)(B) for “benefits due”) or seeking “appropriate equitable relief” under ERISA’s 502(a)(3) “catch-all” provision, the exact outlines of which may vary according to circuit precedent.¹⁴³

The Fourth Circuit was not alone in welcoming *Amara*’s clarification of the scope of equitable remedies under ERISA.¹⁴⁴ The Supreme Court’s use of the law-equity distinction to support excluding money damages had been sharply criticized,¹⁴⁵ and the lack of consequential damages, coupled with ERISA’s broad preemptive power, created what was aptly termed a “regulatory vacuum,”¹⁴⁶ or more viscerally, a “gaping wound.”¹⁴⁷ Yet, *Amara* has not resulted in a sea-change in ERISA remedies law. The Supreme Court’s recent decision in *U.S. Airways, Incorporated v. McCutchen*¹⁴⁸ reiterated ERISA’s “principal function” of protecting contractually-defined benefits, citing pre-*Amara* case law for the proposition that section 502(a)(3) does not authorize equitable relief “at

141. *Id.* at 181–82.

142. *See id.* at 183 (noting that with its decision in *Amara*, the Supreme Court put to rest many of the “perverse incentives” created by interpreting ERISA’s remedial provisions to exclude many forms of equitable relief).

143. *See* Harthill, *supra* note 139, at 789 (directing plaintiffs to thoroughly research the parameters of equitable relief under existing circuit jurisprudence, including looking for bases of relief beyond the three mentioned in *Amara*).

144. *See* Eichorn v. AT&T Corp., 489 F.3d 590, 593–94 (2007) (collecting judicial and scholarly authorities in favor of revising ERISA’s remedial regime and urging either Congress or the Supreme Court to “reconsider” the availability of make-whole relief under 502(a)(3)).

145. *See* Langbein, *supra* note 115, at 1352–53 (arguing that monetary damages were historically available under both law and equity, and that there was “no basis either in the text of ERISA or in its legislative history” for excluding money damages from the relief Congress intended to make available under 502(a)(3)).

146. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).

147. *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part), *vacated*, 124 S. Ct. 2902 (2004).

148. *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1542–43 (2013) (holding that in a suit under section 502(a)(3), equitable defenses cannot override the unambiguous terms of an ERISA plan’s reimbursement provision).

large” but instead “countenances only such relief as will enforce ‘the terms of the plan’ or the statute.”¹⁴⁹ *Amara* is therefore in accord with the Court’s oft-repeated assertion that ERISA’s restrictive civil enforcement provisions represent a “careful balancing” by Congress of the need for “prompt and fair” settlement procedures against the public’s general interest in “encouraging the formation of employee benefit plans.”¹⁵⁰ This careful balancing often tilts away from providing effective relief for injured beneficiaries.

4. Judicial Deference to Plan Administrators

A further obstacle that disabled beneficiaries must confront when alleging improper benefit denials or other fiduciary misconduct is the deferential standard of judicial review that applies in most ERISA cases. ERISA beneficiaries whose claims for disability benefits are denied must first exhaust a plan’s internal review procedures, after which they may enter an external review process or pursue a claim in federal court for benefits due under § 502(a)(1)(B).¹⁵¹ ERISA itself is silent on the crucial issue of how much deference a reviewing court should give to the eligibility determinations of ERISA plan administrators, a category that includes both insurers and self-insured employers.¹⁵² The degree of deference to be afforded the plan administrator is nevertheless of extreme importance because, as Judge Posner has noted, the broader that discretion, “the less solid an entitlement the employee has, and the more important it may be to him . . . to supplement his ERISA plan with other forms of insurance.”¹⁵³

149. *Id.* (citing *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 253 (1993)).

150. *Davila*, 542 U.S. at 208 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 42 (1987)).

151. 29 U.S.C. § 1132(a)(1)(B); *see also* *Sawyer v. USAA Ins. Co.*, 912 F. Supp. 2d 1118, 1150 (2012) (holding ERISA beneficiary’s claim barred for failure to follow grievance procedures provided by her policy). Exhaustion of remedies is a judicial requirement, rather than an express provision of ERISA. *McGraw v. Prudential Ins. Co. of America*, 137 F.3d 1253, 1263 (1998).

152. *See* *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989) (“ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations.”).

153. *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000). The court further explained that the “very existence of ‘rights’ under such plans depends on the degree of discretion lodged in the administrator.” *Id.* Interestingly, the court went on to suggest its own “safe harbor” language: “Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them.” *Id.*

The Supreme Court first addressed this question in *Firestone Tire & Rubber Company v. Bruch*.¹⁵⁴ The Court held that the default standard of review for ERISA plan decisions was *de novo*, but nevertheless reasoned that if the terms of the benefit plan granted the administrator discretionary authority to construe the terms of the plan, courts should engage in a more deferential form of review.¹⁵⁵ If a plan administrator or fiduciary was found to be operating under a possible or actual conflict of interest, this conflict should be weighed as a factor in determining whether there was an abuse of discretion.¹⁵⁶ The Court's subsequent decision in *Metropolitan Life Insurance Company v. Glenn*¹⁵⁷ clarified that an administrator engaged in the common "dual role" of both evaluating and paying benefits claims necessarily created the kind of conflict of interest referred to in *Firestone*.¹⁵⁸ The plan administrator's conflict in this situation arises from the fact that "every dollar saved by the administrator on behalf of his employer is a dollar in [the employer's] pocket."¹⁵⁹ Nevertheless, the presence of this conflict did not itself dictate a change in the standard of review from deferential to *de novo*.¹⁶⁰

Not surprisingly, following *Firestone* discretionary clauses in plan documents became the norm, rather than the exception.¹⁶¹ Application of what is essentially an arbitrary or capricious standard of review is highly beneficial to defendants.¹⁶² For example, under this deferential standard, a

154. See *Firestone Tire*, 489 U.S. at 115 (holding that the denial of benefits under ERISA § 502(a)(1)(B) is reviewable under a *de novo* standard unless the plan document grants the administrator discretionary authority to determine eligibility for benefits).

155. *Id.*

156. See *id.* ("Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r]' in determining whether there is an abuse of discretion") (citing RESTATEMENT (SECOND) OF TRUSTS § 187 cmt. d (1959)).

157. See *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 112, 115 (2008) (finding that where an employer or insurance company both funds a plan and determines eligibility for benefits, a conflict of interest exists that must be weighed when considering whether a plan administrator abused its discretion in denying benefits).

158. *Id.* at 108.

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

160. See *Metro. Life*, 554 U.S. at 115 ("We do not believe that *Firestone's* statement implies a change in the *standard* of review, say, from deferential to *de novo* review.").

161. See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. L. REV. 1315, 1324 (2007) ("Plan drafters routinely seize upon Bruch's invitation to instruct the courts to defer to plan decision making. . . . [D]eferential review pervades the ERISA-plan world . . .").

162. For an example of the remarkable degree of deference afforded plan

plan administrator is not required to obtain an expert opinion, such as the opinion of the beneficiary's treating physician, prior to denying benefits based on its interpretation of the plan documents.¹⁶³ Courts may still apply the de novo standard of review where the plan administrator has failed to exercise any discretion, such as by ignoring or summarily rejecting requests for benefits.¹⁶⁴ As a practical matter, however, most ERISA claims are evaluated by courts under a standard of review that is highly deferential to plan administrators.¹⁶⁵ This deferential review standard places aggrieved beneficiaries of employee disability insurance policies at a significant and often insurmountable disadvantage.¹⁶⁶

IV. A Contemporary Example: The Circuit Split over Risk of Relapse into Addiction

Only two circuit courts have ruled on the issue of whether the risk of relapse into addiction can constitute a current disability under an ERISA-administered group long-term disability benefit policy.¹⁶⁷ Though this particular issue tends to arise under distinct factual circumstances—plaintiffs in cases addressing the issue are invariably anesthesiologists or nurse anesthetists who have become addicted to various types of pain

administrators, see *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990), asserting that when the plan terms imbue the administrator with discretion to interpret the plan, an administrative determination can be overturned only where it is “not just clearly incorrect, but downright unreasonable.”

163. See *Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1309 (5th Cir. 1994) (declining to hold that plan administrator abused discretion in not consulting vocational rehabilitation expert where plan granted administrator discretionary authority to construe terms of plan).

164. See *Gritzer v. CBS, Inc.*, 275 F.3d 291, 295–96 (3d Cir. 2002) (finding plan administrator's denial of benefits subject to de novo review where administrator undertook no independent analysis of the claim and provided no written reasoning for the benefit denial until after onset of litigation).

165. See *Rush Prudential HMO, Inc., v. Moran*, 536 U.S. 355, 384 (2002) (noting the deferential standard was a feature of judicial review “highly prized” by benefit plans).

166. See Maria O'Brian Hylton, *Post-Firestone Skirmishes: The Patient Protection and Affordable Care Act, Discretionary Clauses, and Judicial Review of ERISA Plan Administrator Decisions*, 2 WM. & MARY POL'Y REV. 1, 1–2 (2010) (stating that after *Firestone*, even plaintiffs who “seem to have a strong claim to promised benefits” often find themselves unable to meet the “very high bar required for a finding of arbitrary and capricious behavior”).

167. The Fourth Circuit in *Stanford v. Cont. Cas. Co.*, 514 F.3d 354 (4th Cir. 2008), and the First Circuit in *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58 (1st Cir. 2013).

medication—several factors combine to allow meaningful generalizations from these cases to the broader context of mental disability benefits and efforts toward achieving parity. First, there is significant uniformity in the terms of most disability insurance policies, particularly with respect to the provisions relevant here. Typical definitions of “total disability,” and the most common form of discrimination against those with mental disabilities—the twenty-four month cap on mental disability benefits—are essentially identical across most policies. Second, because claiming disability based on the risk of relapse into substance abuse is perhaps the most controversial way an employee can seek to obtain disability benefits, these decisions provide a uniquely useful roadmap for any mentally disabled employee (or her attorney) on the border of qualifying for disability benefits. Lastly, the circuit split provides an interesting opportunity to view two courts grappling with the larger policy issues at the heart of the parity debate, including problems of moral hazard and the public interest in rehabilitation of the mentally ill.

A. The Fourth Circuit’s Approach

1. The Majority Opinion

On September 28, 2003, Robert Stanford left his position as a Certified Nurse Anesthetist (“CRNA”) at Beaufort Memorial Hospital in South Carolina and entered an inpatient substance abuse treatment program.¹⁶⁸ In an alarmingly common scenario, Stanford had become addicted to Fentanyl, a powerful opiate administered by anesthetists during surgical procedures.¹⁶⁹ Stanford completed a twenty-eight day addiction rehabilitation program, but relapsed within a week.¹⁷⁰ He then entered a second, ninety-day treatment program, eventually returning to his original

168. Plaintiff’s Brief in Support of His Motion for Summary Judgment at 3, *Stanford v. Cont’l Cas. Co.*, 455 F. Supp. 2d 438 (E.D.N.C. 2006) [hereinafter Plaintiff’s Brief].

169. *Id.*; see also Ethan O. Bryson & Jeffrey H Silverstein, *Addiction and Substance Abuse in Anesthesiology*, 109(5) ANESTHESIOLOGY 905, 905–6 (2008) (noting the “drug of choice” for anesthesiologists entering treatment is typically an opioid and describing factors that may explain this result, including proximity to highly addictive drugs and the “relative ease of diverting . . . small quantities . . . for personal use”); *Fentanyl: Incapacitating Agent*, Emergency Response Safety and Health Database, CDC.GOV, http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html (last updated Nov. 20, 2014) (explaining that Fentanyl is estimated to be 80 times as potent as morphine and hundreds of times more potent than heroin).

170. Plaintiff’s Brief, *supra* note 168, at 3.

position at the hospital on March 12, 2004.¹⁷¹ Shortly after returning to work, however, Stanford experienced a second relapse and again left work to enter a third treatment center.¹⁷²

Continental Casualty Company insured and administered Beaufort Hospital's employee benefits plans, and paid Stanford long term disability benefits for the duration of Stanford's inpatient treatment program.¹⁷³ Continental nevertheless terminated Stanford's disability benefits after Stanford had completed his third addiction treatment program,¹⁷⁴ explaining its decision by asserting that Stanford was no longer "functionally impaired" from performing his regular job duties.¹⁷⁵ In response to an administrative appeal letter submitted by Stanford, Continental asserted that although Stanford's treatment providers indicated a potential risk of relapse if he returned to work, Stanford's policy "[did] not cover potential risk."¹⁷⁶

The Fourth Circuit ruled on Stanford's challenge to the denial of his long-term disability benefits in *Stanford v. Continental Casualty Company*¹⁷⁷ finding that Continental's interpretation of its benefit plan as excluding the "potential risk" of relapse was reasonable.¹⁷⁸ Stanford had presented two claims on appeal: first, that Continental applied an unreasonably restrictive interpretation of the plan language¹⁷⁹ when it concluded that the plan did not cover the risk of relapse, and second, that Continental had violated ERISA internal review procedures by failing to

171. *Id.* at 3–4.

172. *Id.* at 4.

173. *Id.* at 3–4.

174. *Id.* at 5.

175. *Id.*

176. Plaintiff's Brief, *supra* note 168, at 6.

177. *See* *Stanford v. Cont'l Cas. Co.*, 514 F.3d 354, 361 (4th Cir. 2008) (holding that insurer did not abuse its discretion under ERISA disability plan in denying benefits for risk of relapse into addiction), *abrogated on other grounds by* *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), *as recognized in* *Champion v. Black & Decker Inc.*, 550 F.3d 353, 359 (4th Cir. 2008).

178. *See id.* at 358 ("We cannot say that Continental's conclusion is unreasonable, even in light of Continental's conflict of interest as insurer and administrator of the benefit plan . . .").

179. The relevant portion of Stanford's policy provided that he would be considered "disabled" if "injury or sickness causes physical or mental impairment to such a degree of severity that you are 1) continuously unable to perform the material and substantial duties of your regular occupation; and 2) not gainfully employed." *See* Plaintiff's Brief, *supra* note 168, at 8.

consult a health care professional when reviewing its initial denial of benefits.¹⁸⁰

As to Stanford's first claim, the court noted that Continental "did not contest Stanford's characterization of his addiction as a sickness," and went on to accept Continental's claim that Stanford "no longer suffered from physical or mental impairments."¹⁸¹ Moreover, the court found unpersuasive several cases cited by Stanford in which physicians had been found disabled based on the risk of recurrence of a heart attack.¹⁸² A high-stress operating room, the court emphasized, may "cause" a heart attack in a doctor with a preexisting heart condition, but an addict who enters an environment where drugs are readily available "risks relapse" only in the sense that the environment heightens his temptation.¹⁸³ The majority noted that it was "not unsympathetic" to the argument that Continental's policy created what it termed a "perverse-incentive structure:" the plan entitled Stanford to disability benefits if he continued to abuse drugs, but upon achieving sobriety he would lose those benefits unless he relapsed into addiction.¹⁸⁴ Nevertheless, this argument relied on the "false assumption" that disability benefits operate as a "reward for sobriety."¹⁸⁵

Stanford's second claim relied on a Department of Labor regulation requiring insurers to "consult with a health care professional who has appropriate training and experience" when reviewing an adverse benefit determination based "in whole or in part on a medical judgment."¹⁸⁶ The Fourth Circuit agreed with Continental that Stanford's claim did not necessarily implicate a matter of medical judgment because the insurer's determination that "risk of relapse" did not fall within the plan's definition of disability was "contractual, not medical."¹⁸⁷ Continental's failure to

180. *See Stanford*, 514 F.3d at 357–58.

181. *Id.* at 358.

182. *See id.* at 358 (explaining that "the risk of a heart attack is different from the risk of relapse into drug use").

183. *See id.* ("Whether he succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice.").

184. *Id.* at 359.

185. *See id.* ("Although this argument is not without force, it operates on a false assumption, namely that disability benefits are a sort of reward for sobriety. In fact, sobriety's reward is the creation of innumerable opportunities that were closed to Stanford as long as he continued to use drugs.").

186. 29 C.F.R. § 2560.503–1(h)(3)(iii); *Stanford v Cont'l Cas. Co.*, 514 F.3d 354, 360 (4th Cir. 2008).

187. *See Stanford*, 514 F.3d at 360 ("Continental's denial of benefits was based solely on its determination that such a risk of relapse did not fall within the benefit plan's definition

consult a medical professional was thus immaterial; the plan's discretionary clause gave Continental "sole discretionary authority" to interpret the provisions of its plan and Continental had no obligation to consult medical professionals in exercising this authority.¹⁸⁸ "Put differently," the majority reasoned, consultation with a health care professional would not have yielded information relevant to "the appropriate interpretation of the term 'disability' in the benefit plan."¹⁸⁹

2. Judge Wilkinson's Dissenting Opinion in Stanford

In his dissenting opinion, Judge Wilkinson chastised the *Stanford* majority for resting its decision on "abstractions" not grounded in law and employing its equitable power to "authorize an unwritten exception to Continental's textual promise of coverage."¹⁹⁰ Importantly, Continental did not dispute that Stanford could not safely perform the duties of his regular occupation, a situation that could only arise from an existing rather than future impairment, "namely, Stanford's fentanyl addiction."¹⁹¹

The plan's "Exclusion's and Limitations" section made no mention of "potential risk," and in any case, Judge Wilkinson wrote, the phrase was a redundancy: "'potential risk' is just risk."¹⁹² The plan's stated definition of disability was functional, by its terms including any "injury or sickness caus[ing] physical or mental impairment . . ."¹⁹³ Moreover, Continental's interpretation of the term "disability" was not in accord with the common understanding of that term in insurance law, which held simply that an insured was disabled "when the activity in question would aggravate a serious condition affecting the insured's health."¹⁹⁴ ERISA, Judge Wilkinson reasoned, did not prevent a plan administrator from writing an exclusion into the plan for risk of relapse into addiction, but such an exclusion was "manifestly absent" in Stanford's policy.¹⁹⁵ The majority's

of 'disability.' This determination was contractual, not medical.').

188. *Id.*

189. *Id.*

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

191. *Id.* at 362.

192. *Id.* at 361.

193. *Stanford v. Cont'l Cas. Co.*, 514 F.3d 354, 361 (4th Cir. 2008) (Wilkinson, J., dissenting).

194. *See id.* at 362–63 (quoting *Lasser v. Reliance Standard Life Ins. Co.*, 146 F. Supp. 2d 619, 628 (D.N.J. 2001)).

195. *Id.* at 363.

conclusion that Continental's plan did not cover the risk of relapse thus seemed to rely on a fabricated dichotomy between "choice and temptation" on the one hand, and actual physical inability on the other.¹⁹⁶ Stanford's policy made no such distinction.¹⁹⁷

3. Critiquing Stanford

As a preliminary matter, it is important to note that many long-term disability insurance policies, including Stanford's, are "hybrid" policies containing two distinct periods of coverage, each with different requirements.¹⁹⁸ During an initial "own occupation" period, typical plan terms provide that the insured may receive disability benefits if she is unable to perform the regular duties of her own occupation due to illness or injury.¹⁹⁹ At the end of the own occupation period, which commonly lasts between twenty-four and thirty-six months, the insured will qualify for benefits only if she can show that she is unable to perform the regular duties of any occupation.²⁰⁰

The *Stanford* majority emphasized its worry that it would be "perverse" should Stanford "go on to great success in another occupation but was still able to collect insurance checks on the basis of 'disability.'"²⁰¹ But that possibility was already foreclosed by plan language providing that

196. *Id.* at 363 ("The majority's opinion] appears to rest on moral considerations of choice and temptation on the one hand, and medical considerations of physical inability on the other, neither of which are to be found in the language of a Plan that puts addiction squarely on all fours with other impairments.").

197. *See id.* (claiming that the language of the plan "puts addiction squarely on all fours with other impairments").

198. 10A COUCH ON INSURANCE § 147:107 (3d ed. 2013) ("Some policies are of a hybrid occupational and general nature, providing benefits for a stated period of occupational disability and, thereafter, for general disability. . . . [I]t is, therefore, error to interpret both as requiring that the insured be unable to perform the essential tasks of only his or her occupation.").

199. *See id.* (noting that "inability to work at one's usual occupation" does not require "total helplessness of the insured"). An interesting example of insurer overreaching in this regard is *Helms v. Monsanto Co. Inc.*, 728 F.2d 1416, 1419 (11th Cir. 1984), where the insurance company denied disability benefits on the basis that "total disability" could only be shown by the absence of "conscious human life". The insurer's action was found to be arbitrary and capricious. *Id.* at 1420.

200. *See* COUCH ON INSURANCE, *supra* note 198 (describing the "any occupation" standard as a "general disability" provision).

201. *Stanford v. Cont'l. Cas. Co.*, 514 F.3d 354, 359–360 (4th Cir. 2008).

a claimant could not be disabled if “gainfully employed.”²⁰² A much greater oversight was the court’s caution that “it is important to remember that Stanford is physically and mentally capable of performing . . . countless other jobs.”²⁰³ This statement not only rings hollow in Stanford’s particular case, given the years of specialized training necessary to become a nurse anesthetist, but ignores both the language of Continental’s disability plan and the substance of Stanford’s claim. Stanford’s policy included the common twenty-four month “own occupation” period²⁰⁴ and conditioned payment of benefits after that period on proof that the employee was disabled from performing “any occupation” for which he could become qualified through “education, training, or experience.”²⁰⁵

Stanford challenged Continental’s denial of benefits only for the initial twenty-four month period, and thus was only required to provide proof of his inability to perform the “material and substantial duties” of his “regular occupation.”²⁰⁶ Stanford’s ability to perform the material duties of another occupation thus had no bearing on his right to benefits under the terms of Continental’s disability policy—at least during the period in which the less stringent “own occupation” standard applied. The majority’s speculation about Stanford’s ability to perform the responsibilities of other jobs misunderstands the nature of the common “own occupation” standard in long-term disability policies and appears to create an additional hurdle that lacks any basis in the language of Stanford’s plan.

More importantly for other employees in Stanford’s position, and indeed for all mentally disabled former employees seeking benefits under a disability insurance policy, the *Stanford* court placed great emphasis on what it viewed as a clear distinction between involuntary physical illnesses and the addict’s “choice” to relapse.²⁰⁷ A similar (and similarly misguided)

202. See Plaintiff’s Brief, *supra* note 168, at 8–9.

203. *Stanford*, 514 F.3d at 359.

204. *Id.* Note that this “own occupation” period in Stanford’s policy is distinct from the familiar twenty-four month cap on mental disability benefits. See COUCH ON INSURANCE, *supra* note 198 (explaining the meaning of “usual” or “own occupation”). The “own occupation” standard creates a more lenient test for receipt of benefits during an initial period, while the twenty-four month cap operates as an absolute bar to mental disability benefits after the first twenty-four months. *Id.* Stanford’s policy, like most long-term disability policies, included both an “own occupation” period and a cap on mental disability benefits. See Plaintiff’s Brief, *supra* note 168, at 3. In Stanford’s case, the two provisions happened to be coterminous. *Id.*

205. See Plaintiff’s Brief, *supra* note 168, at 3.

206. *Id.* at 8.

207. See *Stanford*, 514 F.3d at 358 (whether [the addict] succumbs to . . . temptation

argument is often applied to mental illness more generally.²⁰⁸ The typical claim, like the one made by the *Stanford* court, is that mental illness, unlike physical ailments, is a matter of the will—a failure of individual self-control rather than a disease that can be treated and cured.²⁰⁹

The court's characterization of relapse as a choice is not only misguided, but overlooks the purpose of disability benefits. The strength of addiction, particularly to drugs as powerful as Fentanyl, is such that many addicts do not have a meaningful choice in whether they relapse: one study found that anesthesiologists who returned to their original practice after treatment for addiction relapsed at a rate over eight times higher than those who found other types of work.²¹⁰ Moreover, presence or absence of choice does not provide a useful means of distinguishing between covered and non-covered illnesses in disability policies. Voluntary choice is equally a component of numerous physical ailments, such as heart disease and diabetes, in which individuals may choose (or not) to control the symptoms of their disease through diet, exercise, and proper medical treatment.²¹¹ The *Stanford* majority's "choice" argument simply misses the point: the real question was whether *Stanford* could safely perform the duties of his position as a nurse anesthetist. The answer in *Stanford*'s case was clearly no—his return to work posed a serious risk not only to his own health, but to the health of his potential patients.²¹² Given that there was never any

remains his choice; the heart-attack prone doctor has no such choice.”).

208. See, e.g., Christopher White, 7 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 76 (2005) (reviewing WILLIAM GLASSER, WARNING: PSYCHIATRY CAN BE HAZARDOUS TO YOUR MENTAL HEALTH (2003)) (commenting on Dr. William Glasser's "choice theory," which posits that "everything contained in the DSM-IV-TR is a result of an individual's brain creatively expressing its unhappiness. . . . When one meets [one's internal] needs, the brain should feel less psychic stress and stop manifesting what we refer to as mental illness”).

209. For example, the insurer in *Colby v. Union Security Insurance Company & Management Company for Merrimack Anesthesia Associates Long Term Disability Plan*, discussed more fully *infra* at Part IV.A., claimed in its motion for summary judgment that the “mere risk of relapse into a prior, *self controlled condition*” could not preclude the insured from working in her occupation. *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 64 (1st Cir. 2013) (emphasis added).

210. See Karen B. Domino et al., *Risk Factors for Relapse in Health Care Professionals with Substance Use Disorders*, 293 JAMA 1453, 1456 (2005).

211. See A. Thomas McLellan et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1693 (2000) (noting that treatment adherence rates among drug addicts are comparable to “other chronic disorders” such as hypertension, diabetes, and asthma).

212. Courts have recognized the danger posed by an anesthesiologist's return to the

intimation that Stanford was “faking it” to receive benefits, his situation clearly implicated the primary purpose of long term disability benefits—“to help people overcome medical adversity if possible, and otherwise to cope with it.”²¹³

B. The 1st Circuit’s Response

1. Introduction

The First Circuit considered whether the risk of relapse into addiction can rise to the level of a current disability in *Colby v. Union Security Insurance Company & Management Company for Merrimack Anesthesia Associates Long Term Disability Plan*,²¹⁴ creating a split with the Fourth Circuit in the process.²¹⁵ The facts in *Colby* are remarkably similar to those in *Stanford*.²¹⁶ Dr. Colby worked as a staff anesthesiologist at a hospital in Massachusetts, and had access to opioids, including Fentanyl, as part of her practice.²¹⁷ Colby’s schedule was grueling: she worked between 60 and 90 hours per week, and a combination of her heavy work responsibilities and persistent lower back pain due to a degenerative disc disease lead Colby to begin self-medicating with waste opioids.²¹⁸ Colby’s Fentanyl addiction

same employment position following relapse. *See, e.g., Kufner v. Jefferson Pilot Financial Ins. Co.*, 595 F. Supp. 2d 785, 796 (W.D. Mich. 2009) (noting that denying benefits to an anesthesiologist “unless and until . . . an actual relapse of [] narcotics addiction [occurs]. . . . is untenable given the serious risk this poses to public health and safety . . .”).

213. *Stanford v. Cont’l. Cas. Co.*, 514 F.3d 354, 362 (4th Cir. 2008) (Wilkinson, J., dissenting).

214. *See Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 67 (1st Cir. 2013) (finding that insurer acted arbitrarily and capriciously in refusing to consider whether the plaintiff’s risk of relapse constituted a current disability).

215. *See id.* at 59 (“Although we recognize that our decision creates a circuit split . . .”).

216. Just as importantly, the relevant language in the long-term disability policies at issue is substantively very similar. Colby’s plan provided that an individual was totally disabled if an “injury, sickness, or pregnancy” required the “regular care and attendance of a doctor” and prevented the individual from performing at least one of the material duties of that individual’s regular occupation. Complaint, *infra* note 222, at 4. The term “sickness” was left undefined, but the plan elsewhere made clear that the term included both physical and mental illness. *Colby v. Assurant Emp. Benefits*, 603 F. Supp. 2d 223, 237 (D. Mass. 2009).

217. Complaint, *infra* note 222, at 5–6, *Colby v. Assurant Emp. Benefits*, 818 F. Supp. 2d 365 (D. Mass. 2011), 2007 WL 4581436.

218. *Id.*

was discovered roughly one year later when she was found asleep at a table in the hospital and asked to undergo a urine drug screen.²¹⁹ Within weeks, Colby was admitted to an intensive inpatient substance abuse treatment program, where she was diagnosed with opioid dependence, as well as major depression and obsessive-compulsive personality traits.²²⁰ Like Stanford, Colby's plan administrator, Union Security Insurance Company (USIC), terminated her long term disability benefits after Colby ended inpatient treatment.²²¹

Colby's plan defined total disability as an "injury, sickness, or pregnancy" that required the "regular care and attendance of a doctor," and prevented Colby from performing at least one of the "material duties" of her regular occupation.²²² Coverage according to the initial "own occupation" standard could continue for up to 36 months.²²³ After the initial 36-month period, Colby would be required to meet the more demanding "any occupation" test, requiring proof of her inability to perform any "gainful occupation for which [her] education, training, and experience qualifie[d] [her], with reasonable accommodations."²²⁴ On appeal to the First Circuit, Colby challenged only USIC's denial of disability benefits for the 36-month "own occupation" period.²²⁵

2. The Insurer's "All or Nothing" Defense

Before reaching the First Circuit, USIC had argued before the district court that Colby could not be disabled within the meaning of her disability policy unless she was currently addicted to opioids.²²⁶ Unpersuaded, the

219. *Id.* at 7.

220. *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 67 (1st Cir. 2013).

221. *Id.* The insurer's reasoning echoed that employed by Continental in *Stanford*: "[R]isk for relapse is not the same as a current disability." *Colby v. Assurant Emp. Benefits*, 603 F. Supp. 2d 223, 235 (D. Mass. 2009).

222. Complaint at 4, *Colby v. Assurant Emp. Benefits*, 818 F. Supp. 2d 365 (D. Mass. 2011).

223. *Id.*

224. *Id.*

225. *See Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d at 62 n.4 (explaining that the district court found Colby ineligible for benefits beyond the 36-month period, a finding that Colby did not dispute).

226. *See* Memorandum of Law in Support of Defendant USIC's Cross-Motion for Judgment on the Record and in Opposition to Plaintiff's Motion for Judgment on the Record at 16, *Colby v. Assurant Emp. Benefits*, 605 F. Supp. 2d 223 (D. Mass. 2009) ("There is no

district court remanded USIC's denial of benefits.²²⁷ The district court emphasized that the terms of the plan did not distinguish between mental and physical disability, and USIC had admitted at oral argument that an employee suffering from a physical ailment—such as coronary artery disease—that created a “dangerously high risk of heart attack,” would be covered.²²⁸ The district court reasoned that the same standard should have been applied to future risk caused by mental disabilities.²²⁹ USIC's categorical exclusion of the risk of relapse as a possible basis for disability was therefore arbitrary and capricious.²³⁰ USIC had failed to conduct the proper factual analysis—“i.e. whether the probability of Dr. Colby relapsing upon a return to the practice of medicine was so high that she could not perform a material duty of a physician.”²³¹ On remand, USIC displayed some stubbornness by simply reiterating its former conclusion that “risk of potential future disability is not considered a current disability for which benefits are available.”²³² Rather than remanding a second time, the district court retroactively awarded Colby her long-term disability benefits for the entire initial 36-month “own occupation” period.²³³

USIC was technically correct in claiming that it was not obligated to pay benefits for a “potential risk:” insurers promise coverage for specified events (a car accident or broken leg) and not the risk that such an event will occur. The risk itself, i.e. the likelihood that a contemplated event will actually occur, is incorporated into the insured's cost of coverage. But USIC's claim merely avoids the real question: under what circumstances, if any, can the risk of future injury rise to the level of a current disability? USIC had already admitted that so-called “potential risk” could constitute a current disability in the case of heart-attack patients in high-stress work

evidence that plaintiff was addicted to opioids after November 20, 2004. Therefore, plaintiff was not disabled after that date.”).

227. *Colby v. Assurant Emp. Benefits*, 603 F. Supp. 2d 223, 246 (D. Mass. 2009).

228. *Id.* at 241.

229. *See id.* (“[I]f, as USIC admits, the Plan covers future risk of relapse resulting from physical sickness, the terms of the plan require that future risk of relapse caused by mental illness, such as opioid dependence, be covered as well.”).

230. *See id.* (“Fabricating an exception out of whole cloth that contravenes existing terms and interpretations of the Plan is the very definition of arbitrary and capricious.”).

231. *Id.* at 246.

232. *Id.* 374 (D. Mass. 2011).

233. *Id.* at 384.

environments.²³⁴ Categorically excluding the risk of relapse into addiction smacked of discrimination.²³⁵

The Court of Appeal's analysis followed along the lines of Judge Wilkinson's dissenting opinion in *Stanford*: the language of the plan did not mention risk of relapse, "let alone exclude risk of relapse as a potential basis for a finding of disability."²³⁶ The plan administrator's discretion to interpret the text of the plan, furthermore, did not extend to importing an "unwritten proviso."²³⁷ Thus, even under the deferential abuse of discretion standard of review dictated by *Firestone*, an insurer's blanket exclusion of risk of relapse—with no support in the terms of the plan—could not withstand scrutiny.²³⁸

The First Circuit's decision in *Colby* thus suggests but does not provide a sure answer to the question of what evidence would be sufficient for a finding of disability based on the risk of relapse into addiction.²³⁹ The court notes that the "record generally suggests that the plaintiff was at a high risk of relapse into opioid dependence following her discharge from inpatient care," but offers little further guidance on how courts should weigh such evidence.²⁴⁰ Instead, the decision appears to rest to a large extent on the insurer's obstinacy: numerous statements by the court reference USIC's "categorical approach," "single-minded insistence," and its decision to "[stick] to its guns" in the face of the district court's order to "find the facts" relating to the significance of the risk of relapse.²⁴¹ The

234. *Colby v. Assurant Emp. Benefits*, 603 F. Supp. 2d 223, 241 (D. Mass. 2009).

235. The district court went as far as to assert that the *Stanford* court—on which USIC relied for its categorical exclusion argument—had committed a "moralistic error" in separating risk of relapse into physical sickness from relapse into mental illness. *Id.* at 242.

236. *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 65 (1st Cir. 2013).

237. *Id.*

238. *See id.* (noting that the disability benefit plan's total silence on risk of relapse was "telling," because the discretion of ERISA plan administrators is "cabined by the text of the plan and the plain meaning of the words used.").

239. For one proposed test, see Jonah Kind, *Future Harm as a Current Disability: Insurance Coverage for a Risk of Substance Abuse Relapse Under ERISA*, 108 Nw. U. L. REV. 639, 657 (2014) (arguing that whether a given employee's risk of relapse into addiction constitutes a current disability should be assessed from the standpoint of the "reasonable, non-insured person"). This standard would alleviate some moral hazard concerns by ruling out "minor job-associated risks" that would not deter the reasonable uninsured person from continuing to work, while still allowing recovery for substantial risks that would cause the reasonable person to leave work even in the absence of disability insurance.

240. *Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d at 63.

241. *Id.* at 64–65.

court emphasized that its holding was narrow, pivoting on the “plain language of the plan and USIC’s all-or-nothing approach to its benefits determination.”²⁴²

Colby suggests that courts are likely to be unreceptive to an insurer’s outright refusal to entertain a beneficiary’s argument that her risk of relapse into addiction constitutes a disability, at least where the terms of the plan do not expressly preclude that interpretation. Importantly, however, *Colby* did not hold that the plan administrator unlawfully discriminated between mental and physical conditions.²⁴³ Thus, even in the First Circuit, *Colby* is no panacea for a mentally disabled employee seeking benefits under her employer’s long-term disability policy. Much more is needed if employees who become mentally disabled are to be assured non-discriminatory treatment under their employee disability insurance policies.

V. Proposed Reforms

Long-term disability insurance is often overlooked by employees and employers alike, and has long fallen under the shadow of health insurance. Consequently, despite important recent advances toward full mental health parity in health insurance, such as passage of final rules implementing the Mental Health Parity and Addiction Equity Act,²⁴⁴ there has been little corresponding effort to achieve parity in the field of disability benefits.²⁴⁵ Nevertheless, long-term disability insurance remains a viable and often indispensable tool for protecting the most valuable financial resource of most employees—their income. This tool should not be limited by insurers according to whether a particular disability is categorized as mental or physical.

242. *Id.* at 67.

243. The court found that a benefits determination like USIC’s could not be “reasoned” when the plan administrator “sidesteps the central inquiry,” but emphasized in a footnote that although the district court below had held that USIC “unlawfully discriminated between physical and mental conditions,” it “[took] no view of this reasoning.” *Id.* at 67, n.10.

244. *See supra* notes 6–8, 17 and accompanying text (explaining the impact of the MHPAEA on mental health insurance).

245. One notable exception is a state bill recently introduced in the Massachusetts House of Representatives that would require parity in both short and long term disability benefits. *See* H.R. 836, 188th Gen. Ct. (Mass. 2013).

A. Expand the Scope of Allowable Remedies Under ERISA

The extent to which ERISA limits the remedies available to insured plaintiffs is evident when one compares the Fourth Circuit's holding in *Stanford* and other cases governed by ERISA, with insurance decisions in other contexts not governed by ERISA. In *Liberty Mutual Fire Insurance Company v. JT Walker Industries, Incorporated*,²⁴⁶ the Fourth Circuit reversed a district court's ruling that punitive damages could not be awarded absent a concurrent award of actual or consequential damages.²⁴⁷ Punitive damages, the court held, may be awarded whenever the plaintiff makes out a cause of action in tort for the insurer's bad faith conduct in "willful, wanton, or reckless" disregard of the plaintiff's rights.²⁴⁸ This rule stands in marked contrast to the rule governing ERISA disability benefits policies, which permits no punitive damages for the insurer's bad faith—no matter how discriminatory, and regardless of how clearly an ERISA beneficiary's rights under her policy have been violated by the plan administrator's "wanton disregard."²⁴⁹ Similarly, in *Ace v. Aetna Life Ins. Co.*,²⁵⁰ a state employee in a non-ERISA plan successfully recovered damages for both wrongful denial of benefits and emotional distress.²⁵¹

While punitive damages are unlikely ever to be available under ERISA, even a slight expansion of the scope of available equitable remedies under section 502(a)(3) could represent a significant move forward for mentally disabled plaintiffs challenging denials of benefits. This expansion should follow along the lines of Justice Breyer's majority opinion in *CIGNA Corporation v. Amara*, which suggested the availability of equitable money damages (surcharge) within ERISA's remedial provisions.²⁵² Surcharge would allow employees wrongfully denied

246. See *Liberty Mutual Fire Ins. Co. v. JT Walker Ind., Inc.*, No. 12–2256, 12–2350, 2014 WL 504086, at *10 (4th Cir. Feb. 10, 2014) (rejecting the district court's holding that failure to award actual or consequential damages precluded jury's award of punitive damages to insured party).

247. *Id.*

248. *Id.*

249. See *supra* Parts III.C.1 and III.C.3., discussing the limited nature of ERISA's remedial scheme.

250. See *Ace v. Aetna Life Ins. Co.*, 139 F.3d 1241, 1249 (9th Cir. 1998) (upholding the district court's finding that insurer acted in bad faith by, *inter alia*, failing to investigate insured's claim or gather medical evidence, failing to disclose its review standards, and failing to provide a reasonable explanation of its denial).

251. *Id.* at 1250.

252. See *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1879–80 (2010) (explaining that the

benefits to recover monetary relief for losses suffered.²⁵³ Breathing life into ERISA's neglected equitable relief provision would provide beneficiaries a meaningful way to redress fiduciary breaches by ERISA plan administrators—relief that is not provided by mere recovery of “benefits due” under the terms of the plan.²⁵⁴ Nevertheless, it is still unclear how receptive courts will be to any expansion in the scope of ERISA remedies. Any positive changes are likely to be incremental at best, and the inherent costs and long duration of most insurance litigation will no doubt discourage many plaintiffs from bringing even meritorious claims.

Even more concerning, insurers fight tooth and nail against any expansion of the potential remedies available under ERISA. Recent litigation over the availability of equitable disgorgement as a remedy under ERISA 502(a)(3) provides the perfect example of this phenomenon.²⁵⁵ In *Rochow v. Life Insurance Company of North America*,²⁵⁶ the Sixth Circuit upheld a district court's award to an ERISA beneficiary of \$910,629.24 in past due benefits, plus nearly \$3.8 million in disgorged profits under the equitable theory of unjust enrichment.²⁵⁷ The court held that disgorgement of this sum, which represented a reasonable estimate of the insurer's profit on the wrongfully withheld benefit amount, was an appropriate remedy under § 502(a)(3) despite a prior award of “benefits due” under § 502(a)(1)(B).²⁵⁸ The decision predictably triggered the filing of an amicus brief by the American Council of Life Insurers, which argued that

remedy of surcharge was exclusively equitable prior to the merger of law and equity, and extended to a breach of trust committed by a fiduciary).

253. See Brief for the Sec'y of Labor as Amicus Curiae Supporting Appellant's Petition for Panel and En Bank Rehearing, *Pereira v. Farace*, 413 F.3d 330 (2005) (Nos. 03-5035, -5055) (explaining that surcharge is “akin to the legal remedy of damages in that it can include monetary relief for losses suffered by the plaintiff”).

254. See *Rochow v. Life Ins. Co. of N. Am.*, No. 12-2074, 2015 WL 925794, at *14 (6th Cir. Mar. 5, 2015) (Helene, J., concurring in part and dissenting in part) (opining that equitable relief was justified based on insurer's “extraordinary delay” of nearly seven years between the wrongful denial of benefits and when it finally paid all benefits due to the injured beneficiary).

255. Section 502(a)(3) permits suits to obtain “other appropriate equitable relief” to redress violations of the fiduciary obligations which ERISA impose on plan administrators. 29 U.S.C. § 1132(a)(3) (2009).

256. *Rochow v. Life Ins. Co. of N. Am.*, 737 F.3d 415, 426 (6th Cir. 2013), *rev'd en banc*, No. 12-2074, 2015 WL 925794 (6th Cir. Mar. 5, 2015) (upholding a district court's award ordering the insurer to disgorge \$3.8 million under the equitable theory of unjust enrichment).

257. *Id.* at 431.

258. *Id.* at 428-31.

the ruling would “significantly increase the risk, cost, and uncertainty associated with offering [employee benefits], as well as the expense and burden associated with litigating denial of benefit cases.”²⁵⁹ One week later, the Sixth Circuit vacated *Rochow* and granted rehearing en banc.²⁶⁰

On rehearing, the *en banc* Sixth Circuit held that an ERISA plan participant whose benefits are wrongfully denied cannot recover both “benefits due” under section 502(a)(1)(B) and disgorged profits under section 502(a)(3), absent a showing that the remedy under section 502(a)(1)(B) is “inadequate.”²⁶¹ The majority viewed *Rochow*’s claims under the two sections as essentially identical; permitting relief under both would thus amount to an “impermissible duplicative recovery,” contrary to both Sixth Circuit and Supreme Court precedent, and “beyond the ken of ERISA make-whole remedies.”²⁶² A six-judge dissent argued to the contrary that *Rochow* had in fact suffered two distinct injuries: first through the insurer’s arbitrary and capricious denial of benefits, and second through the insurer’s breach of its fiduciary obligation to “discharge [its] duties . . . solely in the interest of the [plan’s] beneficiaries.”²⁶³

Interestingly, Judge Helene N. White, concurring in part and dissenting in part, noted that both the majority and the dissenting opinions agreed that equitable disgorgement was a remedy available under ERISA, at least in appropriate circumstances.²⁶⁴ Judge White emphasized, moreover, that in remanding the case to the district court for a possible award of prejudgment interest (an equitable remedy),²⁶⁵ even the majority seemed to recognize that *Rochow* was not “made whole” by the award of

259. Brief for the Am. Council of Life Insurers as Amicus Curiae in Support of Petition for Rehearing En Banc of Defendant-Appellant, Life Ins. Co. of N. Am. at 2, *Rochow v. Life Ins. Co. of N. Am.*, 737 F.3d 415 (6th Cir. 2013), *rev’d en banc*, No. 12–2074, 2015 WL 925794 (6th Cir. Mar. 5, 2015).

260. Order at 1, *Rochow v. Life Ins. Co. of N. Am.* (6th Cir. Feb. 19, 2014) (No. 12–2074).

261. *Rochow v. Life Ins. Co. of N. Am.*, No. 12–2074, 2015 WL 925794, at *4 (6th Cir. Mar. 5, 2015).

262. *Id.* at *4–*5.

263. *Id.* at *17–*18 (Stranch, J., dissenting).

264. *See id.* at *13 (White, J., concurring in part and dissenting in part) (“[A]ll appear to agree disgorgement of profits is a potential remedy under ERISA. The two opinions part on whether *Rochow*’s fiduciary-duty claim is merely a repackaging of his benefits-denial claim.”).

265. *See Fotta v. Trs. of United Mine Workers of Am., Health & Ret. Fund of 1974*, 165 F.3d 209, 214 (3d Cir. 1998) (finding that “an award of interest is an equitable remedy enforcing an ERISA plan provision, albeit an implied one, within the meaning of section 502(a)(3)(B)”).

benefits and attorney's fees.²⁶⁶ Rather than announcing, as the majority seemed to, that equitable relief is always unavailable in a benefits-denial case, Judge White would have focused the court's inquiry on whether equitable relief is "appropriate under the circumstances" of each case, with the question whether the beneficiary's equitable claim duplicates his benefits-denial claim as merely one factor to be considered.²⁶⁷

The facts of *Rochow* illustrate the need for equitable remedies in the ERISA context even when there has been a previous award of "benefits due" under the terms of a plan. Rochow's insurer avoided paying benefits for nearly seven years, and tripled its returns on those wrongfully withheld benefits.²⁶⁸ ERISA plan administrators have a clear financial incentive to deny disability claims even if such denials are later overturned on appeal, because profits on the wrongfully denied claim amounts may far exceed the cost of litigation.²⁶⁹ Permitting equitable remedies such as disgorgement of profits under ERISA section 502(a)(3) promotes fairness in claims processing and is consistent with the "higher-than-marketplace" standards of conduct that ERISA places on insurers.²⁷⁰ There is little reason to create a blanket rule denying concurrent awards of both benefits due and "other appropriate equitable relief" in the relatively small number of cases, like Rochow's, that involve insurer misconduct and truly "call for an equitable judicial response geared toward deterring similar decision making in the future."²⁷¹

266. See Rochow, 2015 WL 925794, at *14 (White, J., concurring in part and dissenting in part) ("Clearly, Rochow was not made whole by the award of benefits and attorney's fees. . . . The majority concedes as much in its remand order directing the district court to consider the award of interest . . .").

267. See *id.* at *13 ("I do not agree that the dispositive inquiry governing the availability of equitable relief under § 502(a)(3) is whether the claim is a repackaging of a benefits-denial claim.").

268. See *id.* at *14 ("Nearly seven years elapsed between the time [Rochow] sought benefits and when LINA finally paid all benefits that were due.").

269. See Rochow v. Life Ins. Co. of N. Am., 737 F.3d 415, 426 (6th Cir. 2013), *rev'd en banc*, No. 12–2074, 2015 WL 925794 (6th Cir. Mar. 5, 2015) ("If no remedy beyond the award of benefits were allowed, insurance companies would have the perverse incentive to deny benefits for as long as possible, risking only litigation costs in the process.").

270. See Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008) (explaining that ERISA § 1104(a)(1) imposes a duty on plan administrators to process claims solely in the interest of plan beneficiaries).

271. See Rochow v. Life Ins. Co. of N. Am., No. 12–2074, 2015 WL 925794, at *15 (6th Cir. Mar. 5, 2015) (White, J., concurring in part and dissenting in part) (opining that equitable remedies would be appropriate when, for example, a denial of benefits is not the product of an individual claim evaluator's "misguided evaluation," but rather an organizational policy to "delay paying valid claims for as long as possible").

B. Amend the MHPAEA to Include Protections Against Discrimination in Disability Insurance

Congress should amend the MHPAEA to include provisions mandating non-discrimination in the terms of individual and group disability insurance policies. The case for parity in mental disability benefits is, if anything, even stronger than the argument for parity in mental health benefits.²⁷² Many of the financial and actuarial reasons that might justify treating mentally and physically disabled health insurance participants differently are largely absent in the disability benefit context because the costs of income replacement (unlike the costs of providing health care) do not vary according to whether an individual's inability to work results from mental or physical disability.²⁷³ Furthermore, even a sweeping federal requirement mandating parity in mental disability benefits across all disability insurance policies would leave undisturbed numerous nondiscriminatory means of combating problems of moral hazard in long term disability policies. For example, insurers would retain the ability to employ elimination periods, which effectively screen out many temporary impairments by delaying the onset of benefit payments for a stated period.²⁷⁴ Other common nondiscriminatory policy limitations, such as the "any occupation" standard discussed above, would also remain in place.²⁷⁵

272. There are legitimate arguments for treating mental disabilities differently in a health plan, such as limiting exposure to "skyrocketing drug prices," but such arguments are inapposite when applied to disability plans, in which benefits are tied to wages and thus do not reflect the cost of treating a given disability. *See Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 150 (2004) ("[T]he basic element of actuarial risk in a disability benefit plan is the likelihood that an employee will become disabled. There is virtually no volatility in the amount the plan will have to pay out to individual employees, because [benefit amounts] will generally be fixed within a limited range.").

273. *See id.* at 151 (asserting that because it is more difficult to find actuarial justifications for disparities between mental and physical disability benefits in disability plans, differential treatment is likely the result of "beliefs that mental illness is less 'real' or debilitating than physical injury" or that the mentally disabled are "'faking it'").

274. *See, e.g., Castle v. Reliance Standard Life Ins. Co.*, 162 F. Supp. 2d 842, 843–46 (S.D. Ohio 2001) (describing ERISA beneficiary's plan terms, including an "elimination period" of 180 days from first day of total disability, during which no benefits were payable). During the elimination period, the insured must satisfy the plan's definition of "own occupation" total disability—typically the inability to "perform each and every material duty" of the beneficiary's "regular occupation"—but may not begin to receive benefits until after the elimination period has elapsed. *Id.* at 845.

275. *See supra* notes 197–199 and accompanying text (explaining the difference between the "own occupation" and "any occupation" standards found in disability insurance policies).

Insurers will not be left without the tools they need to counter the twin problems of moral hazard and adverse selection,²⁷⁶ and thus maintain the profitability of the disability insurance industry. What insurers should not be able to do is profit by offering reduced coverage to persons suffering from mental as opposed to physical disabilities.

VI. Conclusion

The Mental Health Parity and Addiction Equity Act of 2008 has been hailed by some as the “final word” on mental health parity.²⁷⁷ It is not. Much work remains to be done to ensure that those suffering from disabling mental impairments are able to receive the rehabilitation they need in order to participate as active members of society. Part of this rehabilitation may come in the form of long term disability insurance, which can provide an invaluable safety net by replacing needed income when mental illness prevents an individual from working. An employee who contracts with her employer or an insurer for disability benefits to protect herself and her family in the event of an unexpected and disabling illness should not face a twenty-four month cap on those benefits simply because her illness is classified as “mental” rather than “physical.”

276. See *supra* Part II.A. (describing the impact of moral hazard and adverse selection on the disability insurance market).

277. See Jackie Calmes & Robert Pear, *Rules to Require Equal Coverage for Mental Ills*, N.Y. TIMES (Nov. 8, 2004), at A1, available at http://www.nytimes.com/2013/11/08/us/politics/rules-to-require-equal-coverage-for-mental-ills.html?_r=0 (quoting an unnamed “senior [Obama] administration official” as claiming that the MHPAEA is “kind of the final word on parity”).