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Risks of Disability or Relapse During Pandemic Puts Employers and Insurers in Uncharted Waters

Deciding whether an employee is at risk for disability due to a novel coronavirus remains mostly untested by the courts.

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Employers and group insurers face an insurance conundrum as employees are being required to return to the workplace while the novel coronavirus, known as COVID-19, continues to disrupt our society. Even as drug companies distribute viable vaccines for COVID-19, certain and perhaps many employees will be reluctant to return to the office if they feel they may be exposed to the virus. The big question is whether at-risk employees can claim disability due to the potential risk of infection upon reentering the physical workplace.

Among the many benefits provided to workers by their employers are income replacement policies through short- and long-term disability benefits. These are oftentimes sold as group insurance plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), codified as part of Title 29 of the U.S. Code. In these ERISA-governed plans, employers can provide a range of incentives to protect their employees' income should an employee fall ill or have an accident. These policies may insure against the ability to do one's "own occupation" or "any occupation," depending on the type of plan. For our purposes, we focus on the ability to work, generally: At what point, if any, are these policies required to pay benefits if an insured has not yet contracted COVID-19 but is at high risk of doing so by coming in close contact with an infected person?

What Is Disability Insurance and Whom Does It Cover?

Group insurance is typically tied to an employer and is a benefit paid if an employee becomes disabled from his or her occupation while an active employee. Upon becoming disabled, the insured will typically have to undergo a set elimination period during which he or she remains disabled, and if so, the insured may qualify for a percentage of his or her income while disabled. Generally speaking, a claimant will not be disabled when the claimant remains physically able to perform his or her occupational duties. A sample definition of "disability" under a group disability benefits plan could read as follows:

> "Disability or Disabled: These terms mean that a current Sickness or Injury causes impairment to such a degree that You are:
>
> (a) Not able to perform, on a Full-Time basis, the major duties of Your Own Job; and
> (b) Not able to earn more than the Plan's maximum allowed Disability Earnings."

While the specific terms of the plans may vary—for example, some may have 12- or 24-month limitations on the type of injury or sickness (i.e., mental/nervous versus physical)—these plans generally work in the same way, which enables ERISA to mandate a national set of rules and regulations. However, as we will see, the courts do not always interpret these plans uniformly. Nonetheless, because federal laws protect ERISA-plan insureds and their rights to seek benefits,

it is important for employers, and insurers who underwrite and sell group insurance, to understand what and who is covered and why.

Risk of Disability or Risk of Relapse and How COVID-19 Complicates Group Insurance

According to the Centers for Disease Control, most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. However, those who are older or have underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. *See generally* Centers for Disease Control & Prevention, How to Protect Yourself & Others, June 11, 2020.

Because group disability policies are not designed to cover the prevention of disease, how should employees who have an increased risk of severe illness due to COVID-19 be treated if they claim they *could* become disabled? If these employees can otherwise physically and mentally perform their occupation, there is a strong argument that they have no entitlement to disability coverage.

Courts have opined on the risk of disability or risk of relapse but never in the pandemic context. Most litigation on the federal level has pertained to insureds who have underlying conditions and have claimed disability due to exposure (or potential exposure) to stress at work, cardiac issues, addiction, or psychiatric conditions that prevent them from being able to perform their occupation.

How Courts Have Evaluated the Risk of Disability and Risk of Relapse

Under ERISA, one of the leading cases for the risk of future disability is the seminal 2003 Third Circuit case, *Lasser v. Reliance Standard Life Insurance Co.*, 344 F.3d 381 (3d Cir. 2003). In *Lasser*, based on the stress inherent in the insured's duties as an orthopedic surgeon, the court found the insured's risk of future disability to be "high," and his doctors opined that such stress was "incapacitating."

The court held that the insurer had acted arbitrarily and capriciously in denying benefits to the surgeon because he was precluded by his heart condition from safely continuing to perform on-call and emergency surgery services. The court also found that it was unreasonable to demand statistical proof from the insured that stress would exacerbate his condition, laying that burden on the insurer. The key takeaway from this case is "whether [the] risk of future effects creates a present disability depends on the probability of the future risk's occurrence." *Id.* at 390 n.12.

While *Lasser* serves as the watershed case in risk of disability/relapse, there have been several rulings in this area of law.

Courts sustaining an insurer's denial of benefits. Prior to *Lasser*, the court in the 1997 case *Dang v. Northwestern Mutual Life Insurance Co.* supported an insurer's denial of benefits when the claimant was physically able to work but was prevented otherwise. In *Dang*, the claimant was a hepatitis B virus carrier who was physically able to perform all of his duties as a surgeon, including exposure-prone procedures. The court found it was in the public interest to prevent the transmission of the hepatitis B virus by the restrictions placed on the claimant. Therefore, the limitation was not physical or mental in nature; rather, it was a social disability and one the policy did not insure against. *Dang v. Nw. Mut. Life Ins. Co.*, 960 F. Supp. 215, 218 (D. Neb. 1997).

In *Brandeburg v. Corning Inc.*, the claimant was employed as a finishing operator by Corning for over 20 years. He stopped working in 2000 due to "idiopathic cardiomyopathy." Relying on *Lasser*, the claimant argued that the claims administrator had failed to consider the issue of whether a "risk of disability" rendered him disabled as defined by the specific plan language. The court distinguished *Lasser*, which was based on an occupation-specific disability policy, whereas the policy in *Brandeburg* was whether the claimant could perform "any substantial gainful activity," which is typically a lower bar. Based on the administrator's finding that the claimant was capable of other substantial gainful work, he did not qualify for disability under the risk theory. *Brandeburg v. Corning Inc. Pension Plan for Hourly Emps.*, 243 F. App'x 671, 672 (3d Cir. 2007).

In a case that could closely align with COVID-19 implications, the claimant in *Rhodes v. Principal Financial Group* worked as a regional sales manager who traveled heavily (one or two trips per month), and about 65 percent of the time, these trips would require overnight stays. The claimant was diagnosed with type 1 insulin-dependent diabetes mellitus and claimed his underlying medical condition made him an at-risk individual. Although the

treating physician warned that full-time duties would put the plaintiff at risk of future disability, denial of further short-term disability benefits was proper because the plaintiff's medical needs and insulin regimen did not make it impossible for him to work. *Rhodes v. Principal Fin. Grp., Inc.*, No. 3:10-CV-290, 2011 WL 6888684 (M.D. Pa. Dec. 30, 2011). This was largely based on the reasoning that the claimant could take proactive measures to manage his type 2 diabetes, and through proper management, he would avoid risking future injury or sickness.

Finally, in a case that distinguishes itself from *Lasser* but later finds two contrary results in other circuits, a 2008 Fourth Circuit opinion, *Stanford v. Continental Casualty Co.*, found that the risk of relapse into an addiction was distinguishable from a heart condition:

> [T]he risk of a heart attack is different from the risk of relapse into drug use. A doctor with a heart condition who enters a high-stress environment like an operating room "risks relapse" in the sense that the performance of his job duties may cause a heart attack. But an anesthetist with a drug addiction who enters an environment where drugs are readily available "risks relapse" only in the sense that the ready availability of drugs increases his temptation to resume his drug use. Whether he succumbs to that temptation remains his choice; the heart-attack prone doctor has no such choice.

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

The court opined that an addict's succumbing to addiction, or "temptation," was his choice, which is clearly a less empathetic view on addiction and led to a split of authority with later opinions from the First Circuit and within the Eighth Circuit, discussed below.

So where a claimant may be prone to or have an increased likelihood of injury due to COVID-19 based on an underlying illness but can otherwise physically and mentally perform his or her occupation, there is a strong argument for no entitlement to disability. This may be especially true where the insured, like the insured in *Rhodes*, can take proactive measures to prevent future illness or injury.

Courts overturning an insurer's denial of benefits. However, there are cases in which the prospect of harm is so apparent or understood to be possible, unlike in the now controversial *Stanford* decision, that an insured can be

rendered disabled when he or she is physically and mentally able to work.

In *Hannagan v. Piedmont Airlines*, the claimant was a pilot who suffered from functional limitations—which included obsessive behavior and an inability to focus—that prevented him from flying before taking medication. Taking the medication was necessary to correct these functional limitations. Because of his diagnoses and treatment, the claimant failed his annual medical examination required by the Federal Aviation Administration and, accordingly, had his pilot's license suspended. The claimant claimed that his diagnosis of obsessive-compulsive disorder and anaphylaxis rendered him disabled pursuant to the policy's terms. *Hannagan v. Piedmont Airlines, Inc.*, 2010 WL 1235395 (N.D.N.Y. Mar. 31, 2010). In this case, the court distinguished between the "risk of relapse" preventing work in *Stanford* and the claimant's undisputed disability that could be mitigated by treatment. Further, the court put considerable emphasis on the danger to public health and safety from any failure of treatment.

In *Colby v. Union Security Insurance Co.*, the claimant, an anesthesiologist with an opioid addiction, tested positive for fentanyl after being found unconscious at work. She subsequently entered inpatient substance abuse treatment, and her intake examination revealed severe back pain associated with degenerative disc disease and a history of major depression. The insurer paid 12 days of benefits for inpatient care following a 90-day elimination period. Substantial evidence, including statements by her attending physician, linked the plaintiff's opioid dependence to her back pain, turbulent personal life, and job stresses.

The court found that categorically excluding a risk of relapse as a source of disability was "unreasonable," noting that it was a common aspect of conditions beyond substance abuse (e.g., stress-induced heart attacks for a doctor as in *Lasser* or seizure disorders for an air traffic controller). In the court's view, under the terms of the long-term disability plan, the anesthesiologist's risk of relapse into substance dependence could be significant enough to constitute a current disability. Therefore, the court found the plan administrator acted arbitrarily and capriciously in refusing categorically to consider whether the anesthesiologist's risk of relapse constituted a disability under the plan. *Colby v. Union Sec. Ins. Co.*, 705 F.3d 58 (1st Cir. 2013). The court was "keenly aware that the only court of appeals to have considered this precise issue has—albeit in a two-to-one decision—reached a contrary conclusion," but the court concluded that the dissenting judge in *Stanford*, who noted that requiring relapse defeated the purpose of disability insurance to help overcome and cope with medical adversity, had the

better argument. *Id.* at 66–67. The court also put emphasis on the danger to third parties from requiring an anesthetist to relapse before finding her disabled.

Conversely, only a few months earlier, the District of Idaho in the Ninth Circuit agreed with *Stanford* when it found that a nurse anesthetist claimant was not disabled and that "there is a widespread, thoughtful, and reasonable disagreement among the circuits 'as to whether the risk of relapse renders an addict unable to perform the material and substantial duties of his work.'" *Wilstead v. United Heritage Life Ins. Co.*, No. 1:19-CV-00276 WBS, 2020 WL 5441911, at *6 (D. Idaho Sept. 9, 2020) (quoting *Stanford*, 514 F.3d at 359–60). While the claimant in *Wilstead* was distinguishable from the claimant *Colby*, who had unique characteristics that made her risk of relapse more severe, the *Wilstead* court drew attention to the continuing split on risk of relapse and future disability.

A notable through-line in these cases is that they involved conditions the claimant already had and the occurrence of which would, because of the nature of the claimant's occupation, cause harm to the public health or safety. These rationales should be less salient in the COVID-19 context, where the issue is contracting the disease and the danger to the claimant, not a sudden onset causing harm to third parties. Nonetheless, they provide guidance on how courts may look at potential risks to insureds and whether they are susceptible to infection and could therefore be disabled.

COVID-19 Guidance for Employers and Insurers

Based on the rulings discussed above, to evaluate a claim for benefits due to an alleged risk of contracting COVID-19, courts will likely consider the following factors in assessing an insurer's investigation and claims determination.

1. the probability of a claimant contracting COVID-19 when performing his or her occupation;
2. the occupational duties of the insured (if the plan defines occupation as his or her "own occupation" or "any occupation") and if performing those duties could affect the health or welfare of others;
3. the impact of any underlying or comorbid medical conditions; and

4 the seriousness of the health risk to the claimant if he or she is infected with COVID-19.

However, there is still no coherent test as to whether the risk of a future disability will constitute a current disability. In a case that was remanded from the Second Circuit, the Southern District of New York proposed an approach adopted by Judge John S. Martin wherein a "practical way" to assess disability is to ask, "Is it likely that the person would have returned to work, even if he did not have disability insurance or other substantial assets?" *Napoli v. First Unum Life Ins. Co.*, 2003 WL 118504, at *3 (S.D.N.Y. Jan. 14, 2003). In other words, when assessing the risk of disability or relapse by the insured, an insurer should consider whether the risk would prevent a reasonable person from returning to work if he or she did not have disability insurance.

This approach, coupled with some proactive steps, can help insurers properly evaluate a claim for disability benefits and could provide the best solution going forward. Those steps may include a thorough review of the following:

- **Contract language.** When a claim is submitted, it is important to consider and discuss all applicable terms of the disability policy, plan, or certificate, and carefully evaluate how those terms apply to the disability claim. The most important of these will be the occupational standard—whether the insured must be able to perform his or her "own" or "any" occupation.

- **Medical condition.** A claimant's medical condition should be carefully evaluated to see if there is past medical history that poses an immediate and serious risk of injury or death if the claimant returns to or remains at work. This involves restrictions and limitations, what is considered appropriate care, and whether the claimant has performed any duties differently since COVID-19. Also, are there any reasonable accommodations that can make the occupation safer or make the employee less prone to contracting COVID-19 (personal protective equipment, masks, protective measures, etc.)?

- **Occupational duties.** It is important to identify and evaluate the material and substantial occupational duties of the claimant and what measures the claimant can take to reduce the risk of illness, injury, or death. Another step is to determine if any state or regulatory agency has instituted directives or guidelines applicable to the occupation and whether any other employees of the plan have been infected with COVID-19.

- **External factors.** Finally, insurers should consider the external factors that have an impact on a claimant's ability to work, such as governmental limitations, whether the insured is in a "hot spot" for contraction, access to safety equipment, or whether the employer is recommending or requiring the employee to engage in dangerous tasks.

The review and analysis involved in these steps should be well documented so that the insurer and insured have a complete picture of the disability claim, especially if the claim is litigated.

Conclusion

In the end, disability insurers that provide ERISA-governed benefits will face hard questions. Do they deny disability benefits if an insured is not currently disabled but could be if the insured returns to the office after working remotely and contracts COVID-19, even after being vaccinated? Should an at-risk insured be forced to contract COVID-19 in order to claim disability, or is there a way of identifying those most likely to contract COVID-19 and become disabled?

The "reasonable person" approach formulated by Judge Martin may provide the best guidance to insurers once they have reviewed the medical and occupational history of a claimant. The approach is premised on the dual public interest of working when physically able and not abusing the availability of disability insurance. Employers and insurers should adhere to this approach in their review of claims, especially when courts will be sympathetic to protecting insureds who have underlying conditions. If insurers can demonstrate that a reasonable person would or would not return to work, then their benefits determination as to whether the claimant is disabled is more likely to pass muster with the courts.

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