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Mental Illness Claims Under LTD Plans

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Despite legislation such as the Mental Health Parity Act,[1] the Mental Health Parity and Addiction Equity Act, and the Americans with Disability Act (ADA),[2] long-term disability (LTD) policies permissibly frequently cut off benefits after a period of time,[3] generally 24 months (a mental illness limitation or MIL) because of a mental illness or mental disorder.[4] This article addresses some of the issues that courts have considered in dealing with MILs.[5]

Two caveats to practitioners before proceeding further. First, cases dealing with mental illness issues tend to be very detailed and fact specific,[6] limiting their precedential value. Second, even precedents based upon the nature of an illness may be of limited application, as explained by Circuit Judge Edwards in his concurring opinion in *Fitts v. Unum Life Insurance Compan*y:[7]

> The District Court erred insofar as it held that no bipolar disorder can be a mental illness as defined in the Unum policy. Even counsel for Fitts recognized that some disorders can be accurately characterized as mental illness under the policy—if not, the provision in question would be rendered meaningless. Because the phrase "bipolar disorder" covers

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> a range of cases, some of which may be mental illness and some which may not, whether a person's disorder can be characterized as bipolar is not, by itself, dispositive. To the extent that the District Court held that bipolar disorder is never a mental illness, its conclusion was wrong as a matter of law.[8]

DEFINITION OF MENTAL ILLNESS

Although it is highly unlikely that the US Supreme Court will address the issue,[9] it would be difficult to find a clearer dispute among the circuits than the one existing with respect to the definition of mental illness. In *Kunin v. Benefit Trust Life Assurance Company*,[10] the US Court of Appeals for the Ninth Circuit affirmed a district court finding[11] that a plan administrator had acted unreasonably in determining that autism was a mental illness within the meaning of a group health plan's MIL. The district court had relied upon the testimony of two medical experts to determine the "plain and ordinary" meaning of the term "mental illness." The experts had testified that mental illness "refers to behavioral disturbances with no demonstrable organic or physical basis. . . . [It] stems from reaction to environmental conditions as distinguished from organic causes. Thus . . . autism would clearly fall outside the aforementioned criteria and factors for mental illness."[12] The district court agreed with the analysis, noting autism's prevalence throughout the world and that its incidence and characteristics remain constant across sociocultural environments. It further noted that autism cannot be treated by traditional methods of psychotherapy.[13] The Ninth Circuit determined that the district court's holding that the plan administrator had acted unreasonably in its holding that the denial of benefits as a result of treating autism as a mental illness was not clearly erroneous. It is the alternate basis for the decision in *Kunin*, however, that is the proposition for which *Kunin* is usually cited, namely, that the language of the limitation in question was ambiguous:

> It remains only for us to determine if the meaning of the term "mental illness" is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included. If not, in light of the rule that ambiguities in the policy must be construed against the insurer, Kunin must prevail. A plain reading of the language tells us beyond any question that "mental illness" is ambiguous, at least insofar as autism is concerned. The policy contains no definition or explanation of the term "mental illness" and offers no illustrations of the conditions that are included or excluded. Nor does the policy contain any language suggesting whether the cause or the manifestation determines whether an illness is covered; yet in the case of autism the answer to that

> question may well be determinative. Here the failure of the policy to define its terms is fatal to the insurer's attempt to limit payment.
>
> Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning. Great efforts are ordinarily made to eliminate the natural ambiguity that exists in so many of the words and phrases we use daily. In this policy, however, Benefit Trust made no attempt whatsoever to describe the scope of a term that has no precise or generally accepted definition. Under these circumstances, we conclude that the term "mental illness" is ambiguous.[14]

In contrast, in *Brewer v. Lincoln National Life Ins. Co.*, the US Court of Appeals for the Eighth Circuit stated that:

> The cause of a disease is a judgment for experts, while laymen know and understand symptoms. Laymen undoubtedly are aware that some mental illnesses are organically caused while others are not; however, they do not classify illnesses based on their origins. Instead, laypersons are inclined to focus on the symptoms of an illness; illnesses whose primary symptoms are depression, mood swings, and unusual behavior are commonly characterized as mental illnesses regardless of their cause.[15]

Thus, in the Eighth Circuit, "considering the cause of mental disorder is not proper because a layperson classifies the illness by its symptoms, not its causes."[16]

In *Phillips v. Lincoln National Life Insurance Company*,[17] a divided US Court of Appeals for the Seventh Circuit[18] affirmed a district court decision[19] that the term "mental illnesses," in a group health plan that did not define the term, was ambiguous as applied to a participant suffering from congenital encephalopathy, a mental disorder caused by an organic illness and consequently, pursuant to the doctrine of *contra proferentem*, could not be applied to a participant to deny him benefits. The district court explained that both parties had advanced "competing reasonable interpretations"[20] of the plan term "mental illness," commenting that the terms offered by both parties "have intuitive appeal and partly describe the qualities of mental illness."[21] Because the plan offered no definition of mental illness, the district court concluded that the term was ambiguous because it was susceptible to more than one reasonable interpretation. In affirming the district court, the Seventh Circuit, following *Kunin,* explained:

> Faced with these competing definitions of "mental illness," which have divided not only the litigants but also federal and state courts, we have no trouble agreeing with the District Court's finding that the term "mental illness" as used in the Plan is ambiguous. As in

> *Kunin,* where the Ninth Circuit found the term "mental illness" in a welfare plan ambiguous, here the Plan "contains no definition or explanation of the term 'mental illness' and offers no illustration of the conditions that are included or excluded." Nor does the policy contain any language suggesting whether the cause or manifestation [of an illness] determines whether an illness is covered. 910 F.2d at 541. We thus hold that the term "mental illness" is ambiguous as applied to individuals like James who have mental disorders caused by organic illnesses.[22]

In *Lynd v. Standard Life Insurance Company*,[23] a divided US Court of Appeals for the Fifth Circuit[24] affirmed a decision of the US District Court for the Western District of Louisiana that the disability of an employee who was suffering from "major depressive disorder" was due to a "mental or nervous disorder." The Fifth Circuit found the decision of the Eighth Circuit in *Brewer, supra,* instructive, and rejected Lynd's argument that his condition fell outside of the "mental or nervous disorder" provision because every major depressive disorder has physical origins and symptoms. The Fifth Circuit explained:

> If we begin with the premise that the cause of a disability is "mental"—and the Eighth and Ninth Circuits, as well as the American Psychiatric Association, characterize depression as a mental disorder—then to find that a disability falls outside of the term "mental disorder" (as used in an ERISA plan) because the disability has "physical" symptoms would render the term "mental disorder" obsolete in this context. As the ERISA plan in the instant case pointedly refers to "mental or nervous disorders," it would be inappropriate to effectively collapse the term "mental disorder" to include only those illnesses, if they exist, which have no "physical" manifestations. If the exclusion of disability, lasting more than 24 months, due to "mental or nervous disorders" is to mean anything—and we think it must—then there is no principled basis on which to exclude Lynd's "major depressive disorders" from the reach of that exclusion.[25]

Finally, in *Billings v. Unum Life Insurance Co.*,[26] the US Court of Appeals for the Eleventh Circuit considered whether Unum's MIL, which defined a mental illness as a mental, nervous, or emotional disease or disorder of any type, was ambiguous. The Eleventh Circuit recognized the split of authority between the Eighth Circuit and the Fifth Circuit on the one hand, and the Ninth Circuit and the Seventh Circuit on the other. However, the Eleventh Circuit agreed with the reasoning of the Seventh and Ninth Circuits, and held that because the policy contained no definition or explanation of the term "mental disorder," offered no illustration of the conditions that are invalid or excluded, and failed to contain any language suggesting whether the

cause or manifestation determines whether an illness falls within the limitations, its policy was ambiguous as applied to *Billings.* It disagreed with the reasoning of the Fifth Circuit and the Eighth Circuit that any ambiguity could be resolved by applying the plain meaning rule of plan interpretation:

Applying the plain meaning to the limitation does not resolve the ambiguity; doing so merely adopts one reasonable interpretation over the other.[27]

Although the most common approaches for defining mental illness have looked to either its symptoms or its causes, a third approach focuses upon the treatment received. Thus, illnesses treated by psychiatrists employing psychotherapy and psychotropic medication have been considered to be mental illnesses.[28] For example, in *Blake v. Unionmutual Stock Life Ins. Co.*,[29] a pre-*Billings* case, the Eleventh Circuit noted that plaintiff's postpartum depression was properly considered to be a mental illness because "she was treated primarily by psychiatrists receiving well-recognized psychiatric treatment, including individual psychotherapy, psychoactive drug therapy, electroconvulsive therapy, and participation in group sessions."[30] In *Saah v. Centel Corp.*,[31] the plaintiff's position was that an organic mood disorder was subject to a medical rather than a psychiatric limitation. In affirming the determination of the plan administrator denying coverage, the district court stated that:

> Defendant's reason for basing benefit determinations on the treatment received is rational on its merits and is supported by the language of the plan. The distinction between psychiatric treatment and medical treatment is well recognized in the managed care and employee benefit industries.[32]

Similarly, in *Klebe v. Mitre Group Health Care Plan*,[33] the Maryland District Court explained why:

> In all probability, this distinction makes sense. It is undoubtedly far easier to identify the nature of the particular treatment given, *i.e.,* psychiatric or medical, than it is to identify the etiology of a particular disorder, especially to the extent that the disorder may derive from both organic and inorganic causes. A plan that ties benefits to the nature of the treatment is thus likely to operate more certainly and efficiently. The Court thus concludes that Mitre's plan's focus upon the nature was correct.[34]

In *Sharp v. National Rural Electric Cooperative Associates*,[35] the plan's rule for the payment of benefits to persons with mental disorders was (1) as long as a claimant is hospitalized for primarily physical problems, her hospitalization is classified as medical; and (2) when a

claimant is physically able to leave the hospital because her physical condition is stabilized, her treatment is classified as primarily mental. An Arkansas District Court found this methodology to be reasonable.

AMBIGUITY IN MENTAL ILLNESS LIMITATIONS[36]

Although the straight forward language in an insurance-regulated ERISA policy is given its natural meaning,[37] it is also well settled that ambiguities in the policy are construed against the insurer.[38] In the context of mental illness exclusions in an ERISA plan or policy, "ambiguity exists if the policy is susceptible to two or more reasonable interpretations that can fairly be made, and one of these interpretations results in coverage, while the other results in exclusion."[39]

A number of cases from the Ninth Circuit indicate the manner in which a MIL can be ambiguous.[40] In *Patterson v. Hughes Aircraft Co.*,[41] the court considered an insurer's application of a two-year MIL to plaintiff's claims of total disability due to headaches. The court began by noting that the plan limited benefits for any disability "caused by or resulting from … mental, nervous, or emotional disorders of any type."[42] However, the plan did not define the term "mental disorder" or otherwise offer illustrations of conditions that were included or excluded. The court therefore concluded that the term "mental disorder" was ambiguous, because it did not specify whether a disability is to be classified as mental by looking to the cause of the disability or to its symptoms. Furthermore, the plan did not make clear whether a disability qualifies as a mental disorder when it results from a combination of physical and mental factors.[43] Accordingly, applying the doctrine of *contra proferentem* because the plan was an insured plan,[44] the Ninth Circuit resolved the issue in the plaintiff's favor and concluded that plaintiff was not within the limitation for mental disorders if his disability was caused in any part by headaches.

Patterson was followed in *Mangeluzo v. Baxter Travel and Long Term Disability Benefit Plan*.[45] The relevant plan language in that case provided that payment would not be made "if the disability is caused by mental illness or functional mental disorder." The Ninth Circuit once again found the Plan language to be ambiguous, because neither the term "mental illness" nor "functional nervous disorder"[46] was defined in the plan. The same considerations that applied in *Patterson* were present in *Mangeluzo:* the plan did not specify whether a disability is to be classified as mental by looking to the cause of the disability or to its symptoms, as well as the plan's failure to make clear whether a disability qualified as a mental disorder when it resulted from a combination of physical and mental factors.[47] In light of this ambiguity, the Ninth Circuit again found that the terms of the policy needed to be interpreted in plaintiff's favor.

Some courts have focused on the uncertain status of the law in determining whether plan language is ambiguous. In *Luton v. Prudential Insurance Co. of America*,[48] the issue before the court was whether depression was a "mental, psychoneurotic, or personality disorder." The plaintiff's position was that depression is caused by a chemical imbalance that is organically or physically based, while defendant's position was that such a reading is contrary to a lay person's understanding and was also contrary to DSM-IV.[49] After a detailed analysis of the case law, the US District Court for the Southern District of Florida concluded that:

> In light of the dispute in the case law concerning the interpretation of the plan language limiting benefits for "mental illness" or "mental disorders" the Eleventh Circuit leaving open the possibility that "mental illness" could be interpreted to exclude organic or physically based illness, and the conflicting expert testimony in this case, the Court concludes that the language of the plan is ambiguous and that both parties have presented reasonable interpretations of "mental, psychoneurotic, or personality disorder.[50]

In *Dorsk v. Unum Life Ins. Co.*,[51] a plaintiff who suffered from obsessive compulsive disorder (OCD) argued that the plan's limitation of benefits for disabilities due to mental illness should not apply because OCD stems from organic causes. In that case, the court reviewed *de novo* plan language that defined mental illness as a "mental, nervous, and emotional disorders of any type." The US District Court for the District of Maine disagreed with the analysis of the Fifth Circuit in *Lynd, supra,* finding that it rendered the definition of mental illness unreasonably broad. It further concluded that the lack of reference to DSM-IV in the policy made reliance upon it unhelpful in determining whether the policy language was ambiguous. The court noted that an overemphasis upon symptoms and what a layperson would characterize as a mental illness ignored the fact that laypersons do not generally rely upon medical expertise to diagnose their disorders. Such an approach would render Alzheimer's disease or brain cancer mental illness because of their symptoms.[52]

Some courts reject the proposition that if the definition of mental illness does not address cause, it is *per se* ambiguous. Thus, in *Johnson v. General American Life Insurance Company*,[53] the US District Court for the Western District of Virginia explained:

> I do not think it is reasonable to apply the term "mental illness" according to its cause in this case, however. To do so would invalidate the functional ordinary meaning of "mental illness," which usually does not consider ultimate causes. Furthermore, a great many mental illnesses are now traceable, at least in part, to chemical imbalances and other underlying physiological conditions.

> That other mental illnesses may not be traceable to physiological conditions is, I suspect, due [more] to the metaphysical nature of some of those particular mental illnesses than it is due to current lack of medical knowledge. To say that an illness is not "mental" because it has an identifiable physical cause would narrow the term "mental illness" to an absurdly low number of conditions about which scientists do not currently have any physiological understanding. The number of such illnesses, in turn, would steadily dwindle with advances in research.[54] If the definition of mental illness depends upon etiology, mental illness could never represent a calculable insurance risk or be used correctly for very long in common discourse.[55]

Although it is clearly a best practice to define the term "mental illness" or "mental disorder" in a policy, merely defining the term "mental illness" may not be sufficient to avoid an ambiguity. Thus, in *Schwartz v. Metropolitan Life Insurance Co.*,[56] mental illness was defined as "a mental, emotional, or nervous condition of any kind." In concluding that this language was ambiguous, the US District Court for the District of Arizona explained that it was not clear whether the plan was limiting benefits based solely upon medical conditions or whether it encompassed LTDs resulting from a combination of physical and mental impairments. Further, the plan did not specify whether a condition is determined by the cause or the symptoms. Similarly, in *Doe v. Hartford Life and Accident Insurance Co.*,[57] in which a policy limited benefits when a participant is disabled because of a mental illness that results from any cause, and defines mental illness as "any psychological, behavioral, or emotional disorder of the mind," the US District Court for the District of New Jersey held the policy to be unclear as to whether bipolar disorder fit within the definition, when there was no reference to a standard medical reference guide or a listing of examples.

With respect to the listing of mental disorders that are included and excluded from coverage, the lack of an explanation as to the excepted medical conditions does not make the policy ambiguous.[58] However, in a recent district court case, the chief magistrate questioned Aetna's basis for denying coverage for schizoaffective disorder:

> Schizoaffective disorder is defined in the DSM-IV-TR as a "disorder in which a mood episode and the active-phase symptoms of Schizophrenia occur together and are preceded or followed by at least two weeks of delusions or hallucinations without prominent mood symptoms." DSM-IV-TR at 298. Aetna's list, an internally generated document, provides a list of exclusions to the mental/nervous limitation for every type of schizophrenia but schizoaffective disorder. This appears to be arbitrary, as schizophrenia is listed as an exclusion from the 24-month limitation while

> schizoaffective disorder, which is a form of schizophrenia, is not. There is no explanation in the administrative record as to how Aetna determined what mental/nervous conditions to include on the list and which ones to omit.[59]

A commonly employed approach for avoiding an ambiguity in defining mental illness is to refer to mental illness and mental disorders in a standard medical reference. Thus, at least when the standard of review is abuse of discretion, a determination of mental illness based upon DSM-IV classification will be upheld.[60] However, despite the practical benefits of a plan or policy cross-referencing DSM-IV, plan administrators might wish to consider some of the limitations in relying upon DSM-IV. As the American Psychiatric Association explained:

> The term mental illness unfortunately implies a distinction between "mental" disorders and physical disorders that is a reductionist anachronism of mind/body dualism. A compelling literature documents that there is much "physical" in "mental" disorder, and much "mental" in "physical" disorders. The problem raised by the term "mental disorders" has been much clearer than the solution and unfortunately the term persists in the title of DSM-IV because we have not found an appropriate substitute. Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies boundaries for the concept of "mental disorder."[61]

Second, "the concept of mental disorders … lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction, and mental disorders [have] also been defined by a variety of concepts (e.g., distress, dysfunction, decontrol, disadvantage, disability, inflexibility, irrationality, syndrome pattern, etiology, and statistical deviation). Each is a useful indicator of a mental disorder, but none is equivalent to the concept, and different situations call for different definitions."[62]

Third, there are limitations to using a categorical approach in defining mental illness. Again, as the American Psychiatric Association explains:

> In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder.[63]

Fourth, clinical judgment is important in using DSM-IV:

> The diagnostic categories, criteria and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV

> not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in cookbook fashion.[64]

Fifth, and perhaps most relevant from an ERISA perspective, there are limitations on the use of the DSM-IV classification outside the psychiatric setting:

> When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that the diagnostic information will be misused or misunderstood. These dangers arise because of an imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (*e.g.*, for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.[65]

Sixth, the DSM-IV classifications are not fixed but vary overtime:

> It must be noted that DSM-IV reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in DSM-IV, to the identification of new disorders, and the removal of some disorders in future publication.[66]

None of these observations is a basis for not relying upon the DSM-IV classification, but a draftsperson should be aware of the inherent limitations in that reliance.

MENTAL ILLNESS CAUSED BY PHYSICAL ILLNESS

The issue presented to a plan administrator is not always whether an illness is physical or mental. In some cases, the issue presented is an acknowledged mental illness caused by a physical illness. Thus, in *Michaels v. The Equitable Life Assurance Society of the U.S. Employees, Managers and Agents Long-Term Disability Plan*, plaintiff argued that the plan's 24-month mental illness exclusion should not apply to the period of disability, because the precipitating cause of his disabling mental condition was physical. The District Court disagreed, explaining that:

> Plaintiff's diagnosed bipolar disorder and depression are certainly mental conditions described by … DSM-IV. That the mental

> conditions were caused by a physical injury does not change that fact.[67]

In contrast, in *White v. Prudential*,[68] the District Court held that a disability did not fall within the 24-month limit for disabilities due to mental illness because to the extent that the disability stemmed from mental illness, the mental illness was caused by a traumatic brain injury.

In other instances, a mental illness may be a component part of a physical illness. This relationship was addressed in *Morgan v. Prudential Insurance Co. of America*,[69] in which the District Court, refusing to impose a MIL, explained that:

> Even if the mental illness contributes to the impairment causing the physical disability, it is the physical condition, not the mental condition, that is the cause of the disability. Otherwise, when a claimant's physical disease or condition causes anxiety and depression, the mental illness limitation would always apply. Thus we conclude that a claim such as Morgan's, where a mental condition is a sequalae or a component of a physical disease or condition, a mental illness limitation will not apply.

Other cases address comorbidity,[70] or the simultaneous presence of multiple independent conditions. For example, in *Sheehan v. Metropolitan Life Ins. Co.*,[71] the District Court for the Southern District of New York explained that "where comorbidity exists between coronary artery disease and neurosis, entitlement to disability payments under the plan exists only if the cardiac condition itself would cause a disability."

STANDARD OF REVIEW

Much of the discussion in these cases, both pre-*Glenn* and post-*Glenn*,[72] is on the proper standard of review,[73] which can of course be outcome-determinative. For example, in *Parker v. Metropolitan Life Ins. Co.*,[74] the Court of Appeals for the Sixth Circuit upheld a plan administrator's termination of disability benefits to the plaintiff, who suffered from chronic severe major depression of a physical origin, and who argued that her disability could not be considered completely mental and nervous. The plan administrator determined that irrespective of any chemical factors in its etiology, major depression was a DSM-III-R diagnosis, and Ms. Parker was being treated by a psychiatrist with psychoactive medication.[75] The Court of Appeals for the Sixth Circuit held that under the highly deferential arbitrary and capricious standard, the plan administrator's decision was a rational one. However, the Court noted that "If the standard of review was *de novo,* perhaps there would be a genuine issue of material fact as to whether chemical imbalances which lead to depression are 'physical' or 'mental' disorders."[76]

Similarly, in *Fischer v. Liberty Life Assurance Company of Boston*,[77] plaintiff argued that the 24-month MIL should not apply, and that Liberty's determination was arbitrary and capricious because it ignored objective evidence that his impairment was organic, not psychological, because his illness was the result of organic brain injury. In rejecting his contention, the Court of Appeals for the Seventh Circuit explained:

> If we were making an independent decision about Fischer's disability, his second argument would certainly give us pause. The record, which we have recounted in detail above, contains ample evidence that his illness was in significant part organic. But we are not the finder of fact here. The problem for Fischer is that the record also contains reputable evidence that the sole cause of Fischer's disability (in the sense of his inability to perform any job) was depression, a psychological disease. What Fischer is essentially arguing is that Liberty's decision can be upheld only if the preponderance of the evidence or something like that supports it. As the district court correctly recognized on reconsideration, however, that is not the standard.
>
> Measured against the arbitrary and capricious standard of review, Fischer cannot prevail. The question, we repeat, is whether Liberty's decision to deny Fischer benefits finds rational support in the record. It does. This is not to say that the evidence compelled Liberty's decision; it is merely to say that the evidence permitted it. While Fischer did present substantial evidence that his condition was organic, it was not an abuse of discretion for Liberty to reject Fischer's evidence in favor of contrary and, at least in Liberty's view, more compelling evidence.[78]

Of course, even when the arbitrary and capricious standard is applicable, and the plan administrator can choose any rational alternative,[79] a plan administrator can still overplay its hand, as illustrated by *Eastman v. The Prudential Insurance Company of America*.[80] The mental disability limitation in that case provided that "disabilities which, as determined by Prudential, are due in whole or in part to mental illness have a limited pay period during your lifetime."[81] The issue for the District Court, based upon this particular plan language, was the meaning of the phrase "are due." The Court noted that the phrase is capable of a range of meanings, "ranging from sole and proximate cause at one end of the spectrum to contributing cause at the other."[82] Any interpretation within that range would be acceptable and affirmed by the court, but Prudential's interpretation, "that the limitation applies if a mental illness is in any way disabling, even if the physical illness is also independently disabling, is patently unreasonable."[83]

BURDEN OF PROOF

As a general rule in ERISA cases, the insured has the burden of proving that a benefit is covered, while the insurer has the burden of establishing that an exclusion applies,[84] or as the rule is sometimes expressed in the ERISA benefits context, the plaintiff has the burden of proof in establishing entitlement, and the defendant must prove plaintiff's lack of entitlement.[85] Applying these principles in the disability benefits context, it has been held that once a claimant makes a *prima facie* showing of disability through a physician's report, if an insurer wants to call into question the scientific basis of that report, it has the burden to support the basis of its objection.[86] However, there is a disagreement among the courts as to whether a MIL is an exclusion from benefits transferring the burden of proof to the insurer, or is merely a limit on the amount of benefits that can be paid once a claim has been approved.[87]

INDEPENDENT MEDICAL EXAMINATION

Assuming that all of the evidence is available for review[88] and is considered,[89] a file review of a benefits decision with respect to a mental illness issue is not inherently objectionable if performed by a qualified medical professional.[90] In the same vein, other courts have held that, unless otherwise specified in the plan document, "the decision to rely upon written submissions rather than ordering an independent medical examination (IME), fails to render a plan administrator's decision arbitrary and capricious,"[91] and, at least in the Second Circuit, plan administrators have never been required to conduct an IME.[92] However, while there is general acceptance of file review, particularly when completed by an independent vendor,[93] and no bright line rule requires insurers to arrange for in-person psychiatric examinations,[94] other courts have held that the decision to conduct a file review rather than a physical examination is a factor to be taken into account in determining whether a denial of benefits or loss of benefits is arbitrary and capricious.[95] Other courts have stated that reliance upon an independent file review to the exclusion of equally credible evidence of the participant's treating physician may be inadequate under the arbitrary and capricious standard,[96] where an examination could have helped the plan administrator better evaluate the severity of plaintiff's symptoms.[97] The following statement from a 2009 Eleventh Circuit decision is typical in this regard:

> "Though [plaintiff's file] has been reviewed by the IPCs, [the administrator] never requested an IME to test the veracity of her complaints, even though the plan permitted it to do so. Given that at least two of the IPCs … recognized that the evidence showed that

> she was suffering from headaches that were subjectively incapacitating, such an action might have been warranted. An independent medical examination might have provided a better foundation for analyzing her claim than the paper-based IPC review."[98]

Thus, file reviews are questionable as a basis for determining whether an individual is disabled by mental illness.[99] As the District Court observed in *Sheehan v. Metropolitan Life Insurance Co.*, a psychiatrist's evaluation of a patient's mental health relies heavily upon their ability to observe the patient's mannerisms, demeanor, or expression and therefore inherently involves credibility determinations.[100] Particularly in the Sixth Circuit, reliance upon a file review is inappropriate or inadequate where a claims administrator disputes the credibility of a claimant's complaint.[101]

OBJECTIVE EVIDENCE

While it may be reasonable for a plan to prefer objective verifiable evidence over self-reported symptoms,[102] there is authority for the proposition that a claim cannot be denied for lack of objective medical evidence unless that standard is clearly articulated under the policy.[103] A number of courts also disfavor the disregard of subjective evidence.[104] Further, it is an abuse of discretion for a plan administrator to demand objective tests to establish the existence of a condition for which there is no objective test,[105] although courts may draw a distinction "between requiring objective evidence of the diagnosis, which is impermissible for a condition such as fibromyalgia[106] that does not lend itself to objective verification, and requiring objective evidence that the plaintiff is unable to work, which is allowed."[107]

TREATING PHYSICIAN

Another procedural consideration is the weight to be given to the report of a plaintiff's treating physician, who concludes that the disability did not result from a mental illness. Since the Supreme Court decision in *Black and Decker Disability Plan v. Nord*,[108] it is clear that

> "Courts have no warrant to require administrators automatically to accord special weight to the opinions of a treating physician, nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation."[109]

Thus:

> "When there is a conflict of opinion between a claimant's treating physician and plan administrator's reviewing physicians, the plan

> administrator has the discretion to deny benefits unless the record clearly does not support a denial of benefits."[110]

Similarly, a District Court in New York in 2010 concluded that

> "In the face of conflicting medical opinion regarding the relationship between [plaintiff's] depressed mental illness and his disability, where [a plan administrator] lacks objective evidence supporting a non-medical cause of the disability, it was not unreasonable for administrators to conclude that the cause of the disability was a mental illness."[111]

However, while a plan administrator need not accept a treating physician's opinion, it cannot reject it without providing a reason.[112] More generally, a plan administrator may not arbitrarily refuse to credit a claimant's reliable evidence, including that of a treating physician.[113]

CONCLUSION

The distinction between mental illness and physical illness may be a false one, or at least an artificial one, but it is nonetheless one that is likely to persist for the foreseeable future in LTD plans. Practitioners wishing to preserve this distinction should carefully review the definition section of plans to avoid ambiguity to the extent possible. Also, even where a plan contains *Firestone* language and steps are taken to avoid conflicts of interest, plan administrators need to be sensitive to procedural issues such as burden of proof, when objective evidence can be required, the weight to be given to subjective evidence, whether an independent medical examination would be appropriate, and ensuring that there is a reasoned basis for not following the report of a participant's treating physician.

NOTES

1. Both the Mental Health Parity Act and the Mental Health Parity and Addiction Equity Act apply only to health insurance policies and group health plans.

2. Numerous Circuit Courts of Appeal have held that the ADA does not bar entities from offering different long-term disability benefits for mental and physical disabilities. *See*, for example, *Weyer v. Twentieth Century Fox Film Corp,* 198 F.3d 1104 (9th Cir. 2000); *EEOC v. Staten Island Savings Bank,* 207 F.3d 144 (2nd Cir. 2000) (collecting cases). But *see Iwata v. Intel Corp*., 349 F. Supp. 2d 135 (D. Mass. 2004) (distinguishing between mental and physical disabilities motivated by stereotype views of mental illness may violate ADA), *Fletcher v. Tufts University,* 367 F. Supp. 2d 99 (D. Mass. 2005); *Colby v. Assurant Employee Benefits* (D. Mass. 2009) No. 07-11488-CL. There is also contrary authority at the District Court level and the Court of Appeals for the First Circuit has not addressed this issue. *Colonial Life & Accident Insurance Company v. Medley,* 572 F.3d 22 (1st Cir. 2009), cited in *Sirva Relocation LLC v. Tynes,* 2014 WL 3892202 (D. Mass 2014). *See also* Matthew G. Simon, "Not All Illnesses are

Treated Equally—Does a Disability Benefits Plan Violate the ADA by Providing Less Generous Long-Term Benefits for Mentally Disabled Employees?" 8 *University of Pennsylvania Journal of Labor and Employment Law* 943 (2006).

3. Frequently, long-term disability policies that contain a mental illness limitation will have a carve-out for Alzheimer's and demonstrable structural brain damage. With respect to the latter, the resolution of the case depends upon the evidence that the plaintiff can provide. *See,* for example, *Berkoben v. Aetna Life Ins. Co.,* 2014 WL 1235915 (W.D. Pa. March 25, 2014); *Hurse v. Hartford Life and Accident Insurance Company,* 77 Fed. App'x 310 (6th Cir. 2003); *Veryzer v. Amer. Intl. Life Assurance Company of New York,* 2012 WL 6720932 (S.D.N.Y. Dec. 27, 2012), aff'd summary order by 2nd Cir. October 27, 2013. Cf. *Henane v. The Prudential Insurance Company of America,* 2013 WL 2359009 (D. Ore. 2013) (plaintiff established his disability was due to a post-concussion syndrome or PCS, which qualifies as dementia caused by trauma, and is not subject to the 24-month MIL).

4. For purposes of this article, these two terms are used interchangeably. Sometimes a plan will refer to a "psychiatric disorder" and present the same types of issues as those discussed in the article. *See,* for example, *Grady v. The Paul Revere Life Ins. Co.,* 10 F. Supp. 2d 100 (D.R.I. 1998) (no evidence that psychiatric disorder limitation applied, where there was no evidence that depression and stress constituted neurosis, psychoneurosis, psychopathy, or psychosis).

5. This article focuses upon mental illness generally, rather than specific mental disorders. For practitioners interested in a listing of cases addressing specific illnesses, *see* Jay M. Zitter, "What constitutes mental illness or disorder, insanity, or the like under provision limiting or excluding coverage under health or disability policy," 19 A.L.R. 5th 533.

6. *Berkoben v. Aetna Life Ins. Co.,* 2014 WL 1235915 at *24 (W.D. Pa. 2014).

7. 520 F.3d 499 (D.C. Cir. 2008), 2008 WL 819999.

8. 2008 WL 819999 at *2.

9. The Supreme Court denied *certiorari* in both Kunin and Brewer, *supra.*

10. 910 F.2d 534 (9th Cir. 1990), superseding 898 F.2d 1421, *cert. den.* 498 U.S. 1013 (1990). Kunin was followed in *Arbana v. Metropolitan Life Ins. Co.,* 2006 WL 889499 (N.D. Cal. 2006).

11. 696 F. Supp. 1342 (C.D. Cal. 1989).

12. *Id.* at 1346.

13. *Id.* at 1347.

14. 910 F.2d 534, 541 (9th Cir. 1990). *See also Neurocare, Inc. v. Principal Life Ins. Co.,* 24 EBC 1780, 1999 WL 3322123 (N.D. Cal. 1999) ("the failure to affirmatively define the term upon which denial hinges is damaging").

15. 921 F.2d 150, 15. One critique of this approach is that the average layperson's understanding should be constantly changing with advances in medical research. As the public learns more about the actual causes and treatment for mental illness, it follows that the average layperson's understanding of terms such as "mental illness" and psychiatric treatment will change as well. *Lynd v. Reliance Standard Life Ins. Co.,* 94 F.3d 979 (Dennis dissent).

16. *Goff v. Standard Ins. Co.,* 2008 WL 3539663 at *8 (E.D. Ark. August 11, 2008).

17. 978 F.2d 302(7th Cir. 1992).

18. Chief Judge Bauer would have followed *Brewer*.

19. 774 F. Supp. 445 (N.D. Ill. 1991).

20. *Id*. at 499.

21. *Id*. at 501.

22. 978 F.2d 310-311. As an example of a case outside of the Seventh or Ninth Circuit focusing upon the origin rather than the symptoms, *see Akins v. Washington Metro Area Transit Authority,* 729 F. Supp. 903, 906 (D.D.C. 1990) (mental illness limitation is ambiguous, because it appears to cover a mental disability caused by a physical injury, including depression following heart surgery).

23. 94 F.3d 579 (5th Cir. 1996).

24. Circuit Judge Dennis, dissenting, would have reversed the summary judgment in favor of plaintiffs and remanded the case for trial or further proceedings.

25. 94 F.3d at 583. Brewer and Lynd have been followed in numerous cases focusing upon symptoms as evidence of mental illness. *See,* for example, *Tolson v. Avondale Industries, Inc.,* 141 F.3d 604, 610 (5th Cir. 1998) (depression is a mental illness); *Pelletier v. Fleet Financial Group,* 2000 WL 1513711 (D.N.H. September 19, 2000) (major depressive disorder is a mental illness); *Attar v. Unum Life Insurance Company,* 1997 WL 446439 (N.D. Tex. 1997) (bipolar disorder is a mental illness); *Park v. Schering Plough,* 875 F. Supp. 1321 (W.D. Tenn. 1995); *Stauch v. Unisys Corp.,* 24 F.3d 1054, 1056 (8th Cir. 1990); *Tumbleston v. A.O. Smith,* 28 Fed. App'x 231 (4th Cir. 2000) ("We have no trouble accepting that the common and ordinary meaning of nervous mental disease would encompass depression and anxiety.") Prior to Brewer and Lynd, the California Supreme Court conducted a similar analysis. In *Equitable Life Ins. Society v. Berry,* 260 Cal. Rptr. 819 (1989) in concluding that manic depression was a mental illness, Equitable Life Insurance Society v. Berry was followed in *Parker v. Sunlife Assurance Co. of Canada,* 2005 U.S. Dist. LEXIS 45436 (M.D. Fla. July 29, 2005), in holding that bipolar disorder was a mental or nervous disorder. *But see* Arkansas Blue Cross & Blue Shield v. Doe, 22 Ark. App. 89, 733 (S.W. 2d 429 (Ark. 1987)) (bipolar disorder is a physical illness), cited in *Fitts v. Unum Life Ins. Co. of America,* 2006 WL 449299 (D.D.C., February 23, 2006).

26. 459 F.3d 1088, 2006 WL 2254261 (11th Cir. 2006). For a detailed discussion of the Billings decision, *see* 58 *Mercer Law Review* 1303-1397 (2007).

27. 2006 WL 2254261 at *5.

28. While a number of courts have noted this distinction in analysis among the Circuits, *Fitts v. Unum Life Ins. Co.,* 37 EBC 2308, 2006 WL 449299 (D.D.C. 2006), rev'd on other grounds, 520 F.3d 499 (D.D.C. 2008), is one of the few cases to set forth three different analytic approaches.

29. 906 F.2d 1525 (11th Cir. 1990). However, as noted by the Court of Appeals for the Seventh Circuit in Phillips v. Lincoln National Life Insurance Company, *supra.,* had plaintiff demonstrated an organic basis for her illness, the Eleventh Circuit might have held that the policy's mental illness limitation did not apply.

30. 906 F.2d 1530.

31. 780 F. Supp. 311 (D. Md. 1991), aff'd 978 F.2d 1256 (4th Cir. 1992).

32. 780 F. Supp. 2d. 315, 318.

33. 894 F. Supp. 898 (D. Md. 1995), aff'd 91 F.3d 131 (4th Cir. 1996).

34. 1995 WL 493106 at *11.

35. 878 F. Supp. 1216 (E.D. Ark. 1994).

36. A plan or policy containing a mental illness exclusion is not required to define every term in its policy. A court is authorized to take judicial notice of additional sources of medical authority in its review of technical medical terminology. *Reid v. Metropolitan Life Ins. Co.,* 944 F. Supp. 2d 1279 (N.D. Ga. 2013), fn. 27; Wangenstein v. Equifax, Inc., 191 Fed. Appx. 905, 917 (11th Cir. 2006) (citing *Dorland's Illustrated Medical Dictionary 1564* and 295 *Journal of American Medical Association* for definitions and diagnostic features of cervical spondylosis, myelopathy, and migraines); *Krohmer-Burkett v. Hartford Life and Accident Ins.* Co., 2005 WL 2614503 at *3, n. 6 and 8 (M.D. Fla. October 14, 2005) (taking judicial notice of the meaning of stenosis from *Merriam Webster Medical Dictionary's* Web site; and of the American Occupational Therapist's Association's Web site definition of the acronym FCE as functional capacity evaluation); *In Re Campbell,* 2000 WL 1567943 (M.D. Tenn. 2000) (a policy is not ambiguous because it does not define organic brain syndrome, neurosis, or psychosis whose definitions are found in DSM-IV, *International Classification of Diseases,* or a medical dictionary). *Cf. McDonnell v. First Unum Life Ins. Company,* 2013 WL 3975941 (S.D.N.Y. August 5, 2013), fn. 33 (court can take judicial notice of background information on Lyme disease, its diagnosis and treatment, all of which is drawn from the Center of Disease Control Web site). Also, while a definition of the relevant terms reduces, although it does not eliminate, the likelihood of an ambiguity, the Court of Appeals for the Fifth Circuit observed in *Tolson v. Avondale Industries, Inc.,* 141 F.3d 604, 606-07 (5th Cir. 1998) that the ERISA requirement that summary plan descriptions are to be couched in ordinary conversational language explains the lack of a definition of mental illness. While a summary plan description should be a separate document from the plan, that is not always the case with respect to certain ERISA welfare plans.

37. *Turner v. Safeco Life Ins. Co.,* 17 F.3d 141, 145 (6th Cir. 1994), cited in *In Re Campbell,* 116 F. Supp. 2d 937 (M.D. Tenn. 2000); *Wheeler v. Dynamic Engineering, Inc.,* 62 F.3d 634, 638 (4th Cir. 1995) (enforcing the plain language of an ERISA group health plan in its ordinary sense).

38. *Lee v. Blue Cross Blue Shield,* 10 F.3d 1547, 1551 (11th Cir. 1994).

39. *Luton v. Prudential Ins. Co. of America,* 88 F. Supp. 2d 1364, 1370 (S.D. Fla. 2000) (citations omitted).

40. Cases finding the definition of mental illness to be ambiguous are not restricted to the Ninth and Eleventh Circuits. *See,* for example, *Akins v. Washington Metro Area Trans. Authority,* 729 F. Supp. 9033 (D.D.C. 1990) (a limitation was ambiguous where it appeared to cover a disability caused by a physical injury, including depression following heart surgery).

41. 11 F.3d 948 (9th Cir. 1993).

42. 11 F.3d 950.

43. *Id.*

44. The Ninth Circuit does not apply the rule of *contra proferentem* to self-insured plans when they bestow explicit discretionary authority to determine eligibility for benefit or to construe the terms of a plan. *See Winters v. Costco Wholesale Corporation,* 49 F.3d 550 (9th Cir. 1995), *Shane v. Albertson's Inc.,* 504 F.3d 1166 (9th Cir. 2007); *Schoettler v. Wachovia Corporation,* 2008 WL 5101367 (E. D. Cal. 2008).

45. 46 F.3d 938 (9th Cir. 1995). Other Ninth Circuit cases in this line include *Lang v. Long Term Disability Plan of Sponsor Applied Remote Technology,* 125 F.3d 794, 795 (9th

Cir. 1997) (language limiting disability benefits "caused or contributed to by a mental disorder" presents "an almost classic ambiguity," with respect to whether it should be interpreted according to its symptoms or its causes); *LaMarra v. Cigna Corporation,* 2000 WL 1456949 (N.D. Cal. 2000) and *Arbanas v. Metropolitan Life Ins. Co.,* 2006 WL 889499 (N.D. Cal. 2006). Similarly, there are cases in the Eleventh Circuit following Billings, such as *Miller v. The Prudential Ins. Co. of America,* 2008 WL 4540998 (S.D. Fla. 2008), finding that a plan limiting coverage for any disability that was due in whole or in part to mental illness was ambiguous and failed to specify whether an illness is properly characterized as a mental illness based upon its symptoms or its etiology.

46. 46 F.3d 940.

47. 46 F.3d 942-43.

48. 88 F. Supp. 2d 1384 (S.D. Fla. 2000).

49. DSM refers to the American Psychiatric Association's *Diagnostic and Statistical Manual.* It is the standard classification of mental disorders used by mental health professionals in the United States. *See Kelly v. Unum Life Ins. Co.,* 2009 WL 996051 (D. Ariz. April 4, 2009).

50. 88 F. Supp. 2d at 1393. The case was a pre-Glenn case that applied a heightened arbitrary and capricious standard of review, and a different outcome might have resulted post-Glenn.

51. 8 F. Supp. 2d 19 (D. Me. 1998), discussed in *Luton v. Prudential Ins. Co. of America,* 88 F. Supp. 2d 1364 (S.D. Fla. 2000).

52. 8 F. Supp. 2d at 21-22.

53. 178 F. Supp. 2d 644 (W.D. Va. 2001).

54. In a 2014 District Court case, *Berkoben v. Aetna Life Ins. Co.,* 2014 WL 1235915 (W.D. Pa. March 25, 2014), the court quoted a physician's statement that "there is emerging clinical evidence that schizophrenia and bipolar illnesses have a biological base … and also there is emerging evidence that most mental nervous categories in the DSM-IV have a neurobiological basis." While evidence of the physical basis of mental illness may be increasing Senator Domenici of New Mexico had observed in 1996 that "we now understand that mental illnesses are, … for the most part, physical illnesses." 142 *Cong. Rec.* S 3588-89 (Daily Ed. April 18, 1996), quoted in Matthew Smith, "Not All Illnesses are Treated Equally—Does A Disability Benefit Plan Violate the ADA by Providing Less Generous Long-Term Benefits for Mentally Disabled Employees than for Physically Disabled Employees?" 8 *University of Pennsylvania Journal of Labor and Employment Law* 943, n.1 (2006). In Lynd v. Reliance Standard Life Ins. Co., Judge Dennis in his dissent noted that "before the development of brain research, reasonably intelligent persons could reach a broad consensus on what was mental or physical disorders. However, because of medical findings that serious illness once considered purely mental, such as schizophrenia, bipolar affective disorder and depressive illnesses are physical brain disease, reasonable persons differ sharply on the meaning of mental or physical disorder."

55. 178 F. Supp. 2d 657.

56. 463 F. Supp. 2d 971 (D. Ariz. 2006).

57. 2008 WL 5400984 (D.N.J. December 23, 2008).

58. *Martinez v. Pacific Gas Electric Company LTD Plan,* 2006 WL 3349565 (E.D. Col. 2006).

59. Berkoben v. Aetna Life Ins. Co., *supra*.

60. *See,* for example, *Colby v. Assurant Employee Benefits,* # 07-11488-RCL (D. Mass. February 23, 2007) (opioid disorders, including opioid disorders, are mental disorders); *Berquist v. Aetna U.S. Healthcare,* 289 F. Supp. 2d 400, 410 (S.D.N.Y. 2003) (classifying post-traumatic stress syndrome as a mental disorder not arbitrary or capricious, since that classification is recognized in DSM-IV). *Burgie v. EuroBrokers, Inc.,* 2007 WL 210419 (E.D.N.Y. 2007) (because both depression and post-traumatic stress disorder are classified as mental illnesses by the American Psychiatric Association and a determination by UNUM consistent with such a finding cannot be arbitrary and capricious); *Kelly v. Unum Life Ins. Co.,* 2009 WL 996051(D. Ariz. April 4, 2009) (DSM-IV classifies addiction as a mental disorder); *Michaels v. The Equitable Life Assurance Society of the United States Employees, Managers, and Agents Long Term Disability Plan,* 2007 WL 3024571 (E.D. Pa. October 15, 2007); rev'd in part on other grounds 305 Fed. Appx. 896 (3rd Cir. 2009) (even though they may have been caused by a physical injury, bipolar disorder and depression are mental conditions described in DSM-IV); *Lee v. Kaiser Foundation Health Plan,* 812 F. Supp. 2d 1027 (N.D. Cal. 2011) (chronic depression covered by plan exclusion, where a mental or nervous disorder or disease is defined as a condition sufficient to meet the diagnostic criteria in the DSM); *Simonia v. The Hartford Ins. Co.,* 606 F. Supp. 2d 1091 (C.D. Cal. 2009), *aff'd Simonia v. Glendale/Nissan Infiniti Disability Plan,* 378 Fed. Appx. 725 (9th Cir. 2010) (where a plan defined mental disorder as a disorder found in the current diagnostic standard manual of the American Psychiatric Association, and plaintiff suffered from major depressive disorder, there was no ambiguity in the plan); *Finfrock v. Anthem Insurance Company,* 56 E.B.C. 1189, 2012 WL 4097190 (N.D. Ind. Sept. 17, 2012) (accepting as a basis for upholding an insurer's decision not to cover a vision problem that vision problems or vision disturbances are not listed as part of the DSM criteria for pervasive development disorders). *Cf. Byse v. Horizon Blue Cross Blue Shield of New Jersey* (D.N.J. 2008) (using DSM-IV to distinguish between biologically based and non-biologically based mental illnesses in future classifications).

61. Reid v. Metropolitan Life Ins. Co., *supra*.

62. *Id*.

63. *Id*.

64. *Id*. In the District Court opinion in Kunin, *supra,* the District Court stated that DSM "is clearly intended to provide diagnostic categories for use by medical professionals. Its use for other purposes would not be justified."

65. *Id*.

66. *Id*.

67. 2007 WL 3024571(E.D. Pa. October 15, 2007), rev'd on other grounds 305 Fed. Appx. 896 (3rd Cir. 2009). *See also Fuller v. J.P. Morgan & Co,* 423 F.3d 104 (2nd Cir. 2005) (upholding application of a 24 month disability limitation and holding that whether the claimant's disability "arises from" a mental disorder is a question quite distinct from whether the disease itself arises from a physical cause). *Tolson v. Avondale Industries, Inc.,* 141 F.3d 604, 610 (5th Cir. 1998) (upholding the application of a 24-month limitation to a disability based upon depression that itself was either the product of other pathological disease or the medicine used to treat it); *Pelletier v. Fleet Financial Group,* 2000 WL 1513711 (D.N.H. September 19, 2000) (mental illness limitation is properly applied to disorders typically identified as mental, regardless of their cause).

68. 908 F. Supp. 2d 618 (E.D. Pa. 2012). *See also* Lang v. Long Term Disability Plan of Sponsor Applied Remote Tech, Inc. *supra,* (interpreting plan limitation for disability

"caused or contributed to by mental disorder" and finding that depression resulting from physical disorder did not constitute a mental disorder).

69. 755 F.Supp. 2d 639 (E.D. Pa. 2010).

70. In a recent Sixth Circuit case involving comorbidity, *Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program,* 763 F.3d 598 (6th Cir. 2014), the court split over the question whether the plan structure, which contemplated that mental and physical disabilities would be considered separately, precluded the plan administrator from taking a cumulative approach to plaintiff's mental and physical health.

71. 368 F. Supp. 2d 228 (S.D.N.Y. 2005), cited in *Freeland v. Unum Life Ins. Co.,* 2013 WL 4482995 (W.D. Wisc. 2013). *Cf. Grady v. The Paul Revere Life Insurance Company,* 10 F. Supp. 2d 100 (D.R.I. 1998).

72. *Metropolitan Life Insurance Co. v. Glenn,* 554 U.S. 105 (2008).

73. Where the applicable standard is arbitrary and capricious, plaintiff bears the heavy burden of showing not only the disability, but also that the decision denying or terminating benefits was arbitrary and capricious. *Atkins v, Guardian Life Insurance Company of America,* 2013 WL 4520995, 969 F. Supp. 2d 789 (E.D. Ky. 2013); *Rockau v. Life Insurance Company of America,* 482 F.3d 860, 865 (6th Cir. 2007).

74. 99 F.3d 181 (6th Cir. 1996), discussed in *In Re Campbell,* 116 F. Supp. 2d 937 (M.D. Tenn. 2000).

75. *Id*. At 184.

76. *Id*.

77. 576 F.3d 369 (7th Cir. 2009).

78. *Id*. at 376, 377.

79. *Kimber v. Throkol Corp.,* 196 F.3d 1092, 1100 (10th Cir. 1999).

80. 2008 WL 250597.

81. *Id*. at *15.

82. Kimber v. Throkol Corp., *supra.,* quoted in Eastman v. The Prudential Insurance Company of America, *supra; Adams v. Director,* OWCP 886 F.2d 818, 821 (6th Cir. 1989). For a further discussion of the phrase "due to" in the mental illness context, *see Johnson v. General American Life Insurance Company,* 178 F. Supp. 2d 644 (W.D. Va. 2001).

83. 2008 WL 250597 at *15 (D. Minn. January 29, 2008). *See also Michaels v. The Equitable Life Insurance Society,* 305 Fed. Appx. 896 (3rd Cir. 2009).

84. *Marian v. P & C Food Markets,* 313 F.3d 758, 766 (2nd Cir. 2000); *Ferguson v. United of Omaha Life Ins.,* 2014 WL 956886 (D. 2014); *Jenkins v. Montgomery Industries,* 77 F.3d 740, 743 (4th Cir. 1996); *Reid v. Metlife,* 944 F. Supp. 2d 1279 (N.D. Ga. 2013). *See also Faight v. UNUM Life Ins. Co.,* 379 F.3d 997, 1007 (10th Cir. 2004) (under ERISA, an insurer bears the burden to prove facts supporting an exclusion of coverage, because federal courts treat insurer claims of policy exclusions as affirmative defenses); *Coffey v. Unum Life Ins. Co.,* 302 F.3d 576, 580 (6th Cir. 2002); *Farley v. Benefit Life Insurance Company,* 979 F.2d 653, 658 (8th Cir. 1992); *Sabatini v. Liberty Life Assurance Co. of Boston,* 286 F. Supp. 2d 122, 12321 (N.D. Col. 2003); *Jewell v. Life Insurance Company of North America,* 2009 WL 792227 at *11 (D. Colo. 2009), cited in D. Seth Holliday, "When an Insurance Company Tries to Redefine a Physical Illness as a Mental Illness to Limit the Benefit Duration, It is the Insurance Company

that Bears the Burden of Proof." However, in the Ninth Circuit, on *de novo* review, it is plaintiff's burden to establish that he or she was disabled under the terms of the plan, and the burden continues to rest with the plaintiff when disability benefits are terminated after the initial grant. *Rovell v. Aziza Technology Health and Welfare Plan,* 2012 WL 1672497 (N.D. Cal. 2012); *Muniz v. Ames Construction Management, Inc.,* 623 F.3d 1290 (9th Cir. 2010); *Sullivan v. Deutsche Bank American Holding Corporation,* 2011 WL 4961973 (S.D. Cal. 2011); *Warsum v. Life Insurance Co. of North America,* 2010 WL 329957 (N.D. Cal. 2010). In *Johnson v. General Life Insurance Co.,* 178 F. Supp. 2d 644 (W.D. Va. 2001), the District Court indicated that both under Georgia law and Fourth Circuit precedent, the insurer has the burden under *de novo* review of proving that the plaintiff's case falls within the mental illness limitation.

85. *Diaz v. Prudential Ins. Co of America,* 499 F.3d 640, 643 (7th Cir. 2007), quoted in *Steckel v. Central Reserve Life Ins.,* Co., 2011 WL 53095 (N.D. Ind. 2011).

86. *Lasser v. Reliance Standard Life Ins. Co.,* 344 F.3d 381, 391 (3rd Cir. 2003); *Blakey v. WSMW Industries, Inc.,* 2004 WL 1739717 (D. Del. July 20, 2004); *Seeman v. Metropolitan Life,* 2013 WL 3948945 (D. Del. 2013). But *see Miller v. the Prudential Insurance Company of America,* 2008 WL 4540998 (S.D. Fla. 2008) (burden on plaintiff to show objective evidence that a physically based or organic illness or condition prevented her from performing any occupation in order to qualify for long term disability benefits beyond the 24-month mental illness limitation period).

87. *Doe v. Hartford Life & Accident General American Life Ins. Co.,* 2008 WL 5400984 (D. N.J. 2008), cited in *Bland v. Metropolitan Life Ins. Co.,* 2013 WL 56117 (M.D. Ga. January 3, 2013). In *Gunn v. Reliance Standard Life Ins.,* 399 Fed. Appx. 145, 151 (9th Cir. 2010), quoted in *McDonnell v. First Unum Life Ins. Co.,* 2013 WL 3975941 (S.D. N.Y. August 5, 2013) (mental illness limitation is an exclusion). In contrast, in the Second Circuit, which has not directly ruled on whether a mental illness limitation is a limitation on benefits or an exclusion, but has held in the non-ERISA context that a limitation on the amount of benefits defines the scope of coverage and is not a policy exclusion (*Zurich America Ins. Co. v. ABM Industries, Inc.,* 397 F.3d 158 (2nd Cir. 2005), discussed in *McDonnell v. First Unum Life Ins.,* 2013 WL 397594 (S.D.N.Y. 2013), District Courts have consistently held that it is the claimant's burden to prove that his or her disability is not mental where the plan limits coverage for mental disabilities. *See Katsanis v. Blue Cross and Blue Shield Association,* 803 F. Supp. 2d 256 (W.D.N.Y. 2011); *Seaman v. Memorial Sloan Kettering,* 2010 WL 785298 (S.D.N.Y. March 9, 2010); *Sheehan v. Metropolitan Life Ins. Co.,* 368 F. Supp. 2d 228 (S.D.N.Y. 2005); McDonnell v. First Unum, *supra*. In part, the rationale for these holdings may be that it is reasonable to place the burden of proof upon the claimant who has easier access to his or her medical records than the insurer. Seeman v. Memorial Sloan Kettering Medical Center, *supra*. *Cf. Gent v. CUNA Mutual Insurance Society,* 611 F.3d 83 (1st Cir. 2010), cited in *Reid v. Metlife,* 944 F. Supp. 2d. 1279 (N.D. Ga. 2013) (declining to determine which party had the burden of proof as to the applicability of a mental illness limitation provision because the manner in which the burden is allocated does not much matter unless one or both parties fail to produce evidence or the evidence presented by both parties is perfectly in equipoise). In Reid v. Metropolitan Life Ins. Co., *supra.,* the District Court noted the divergent views among District Courts in the Eleventh Circuit on this issue, comparing *Owens v. Robbins,* 2010 WL 3843765 (E.D. Tenn. September 27, 2010 (burden of proof on defendant, when defendant did not contest plaintiff's assertion on the issue and the plan was silent as to the burden of proof) with *Aleksiev v. Metropolitan Life Insurance Company,* 1:10-cv-3322 SCJ (N.D. Georgia March 9, 2012) (in the absence of Eleventh Circuit guidance, plaintiff retains the burden of proof). In *Craig v. Metropolitan Life,* the District Court also held that the burden of proof is on the plaintiff, cited in *Bland v. Metropolitan Life,* 2013 WL 56117 (M.D. Ga. 2013).

88. *Helfman v. GE Group Life Assurance Co.,* 573 F.3d 383, 393 (6th Cir. 2009) (plan must provide a physician performing a file review with all of the letters and records from a claimant's physician); Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program, *supra; Cannon v. Aetna Life Ins. Co.,* 2013 WL 527655 (D. Mass. 2013) (may be necessary to acquire additional medical records, if insurer's independent reviewer requests it).

89. *Shelly v. Lubrizol Corp. Wage Employees Pension Plan,* 2009 WL 4730203 (W.D. Ky., December 4, 2009), cited in Hayden v. Martin Marietta Materials, Inc Flexible Benefits Program, *supra; Miller v. American Airlines,* 632 F.3d 837, 853 (3rd Cir. 2011); *Oliver v. Coca Cola Co.,* 497 F.3d 1181, 1199 (11th Cir. 2003).

90. *Calvert v. Firstar Fin., Inc.,* 409 F.3d 286, 296 (6th Cir. 2005); Hayden v. Martin Marietta Materials, Inc. Flexible Benefits Program, *supra; Javery v. Lucent Technologies,* 2014 WL 349741 (6th Cir. 2014).

91. *Marshall v. Connecticut General Life Insurance Co.,* 2005 WL 1463472 (E.D. Pa. June 17, 2005); *Fisher v. Aetna Life Ins. Co.,* 890 F. Supp. 2d 473 (D. Del. 2012).

92. *See,* for example, *Hobson v. Metropolitan Life Ins. Co.,* 574 F.3d 76, 91 (2nd Cir. 2009); *Preizler v. First Unum Life Ins. Co.,* 2012 WL 1871640 (S.D.N.Y. 2012) (plan had the right but not the obligation to conduct an independent medical examination); *Rotondi v. Hartford Life and Accident Group,* 2010 WL 3720830 (S.D.N.Y. 2010).

93. *Zenadocchio v. BAE Systems Unfunded Welfare Benefit Plan,* 2013 WL 1327122 (S.D. Ohio March 29, 2013).

94. *Caudill v. The Hartford Life and Accident Insurance Company,* 2014 WL 1922828 (S.D. Ohio May 14, 2014).

95. *Hunter v. Life Ins. Co. of North America,* 437 Fed. Appx. 372, 378 (6th Cir. 2011); *Zenadocchio v. BAE Systems Unfunded Welfare Benefit Plan,* 936 F. Supp. 2d 868, 872 (S.D. Ohio 2013); *Caudill v. The Hartford Life and Accident Ins. Co.,* 2014 WL 1922828 (S.D. Ohio May 14, 2014); *Kalish v. Liberty Mutual Life Assurance Co.,* 419 F.3d 501 (6th Cir. 2005); *Calvert v. Firstar Fin. Inc.,* 409 F.3d 286, 295 (6th Cir. 2005); *Schnor v. Walgreen Income Protection Plan for Pharmacists and Registered Nurses,* 2013 WL 4248225 (W.D. Mich. 2013).

96. Reid v. Metropolitan Life Ins. Co., *supra*.

97. *Smith v. Bayer,* 275 Fed. Appx. 495, 508 (6th Cir. 2008); *Zhou v. Metropolitan Life Ins. Co.,* 2011 WL 3882460 (D. Md. 2011) (where claimant suffers from a disability condition encompassing subjective complaints, an independent medical examination is appropriate).

98. *Creel v. Wachovia Corp.,* 2009 WL 179584 (11th Cir. January 27, 2009); *See also Elliott v. Metropolitan Life Insurance Co.,* 473 F.3d 613, 621 (6th Cir. 2006) (while continuing to believe that plans are not obligated to order additional tests, "plans can assist themselves, claimants and the courts by helping to produce evidence sufficient to support reasoned and principled benefit determinations") and *Brucks v. Coca-Cola Co.,* 391 F. Supp. 2d 1193, 1205 (N.D. Ga. 2005) (in a case involving a termination of benefits, "it is not surprising that a court … would look for an independent medical examination, to explain the administrator's decision."). IPC is an acronym for independent physician consultants.

99. *Jarvey v. Lucent Technologies,* 2014 WL 349741 (6th Cir. 2014) and *Smith v. Bayer Long Term Disability Plan,* 275 Fed. Appx. 495, 505-09 (6th Cir. 2008).

100. 368 F. Supp. 2d 228 (S.D.N.Y. 2005).

101. Jarvey v. Lucent Technologies, *supra*.; *Evans v. Unum Provident Corp.,* 434 F.3d 866, 878 (6th Cir. 2006); *Helfman v. GE Group Life Assurance Co.,* 573 F.3d 383, 395-96 (6th Cir. 2009); Caudill v. Hartford Life, *supra*.;*Vocharski v. Metropolitan Life Ins. Co.,* 2014 WL 222116 (W.D. Mich. January 21, 2014); *Juager v. Metropolitan Life Ins Co.,* 710 F.3d 651, 663 (6th Cir. 2013); *Smith v. Continental Casualty Co.,* 450 F.3d 253, 263 (6th Cir. 2006); Reid v. Metropolitan Life Ins. Co., *supra*.; Calvert v. Firstar Fin. Co., *supra*., (where credibility determinations regarding a claimant's medical history and symptomology are required, reliance on a file review may be inadequate, particularly where the right to conduct a physical exam is provided for under the plan); *Winkler v. Metropolitan Life Ins. Co.,* 170 Fed. Appx. 167, 168 (2nd Cir. 2006) ("first hand observation is especially important in the context of assessing psychiatric disabilities"); *Kinser v. Plan Administration Committee of Citigroup, Inc.,* 488 F. Supp. 2d 1369, 1383 (M.D. Ga. 2007) (there can be "no serious doubt that a psychiatric opinion of a treating physician is more reliable than an opinion based on a one time file review.") Of course, the timing of the independent medical review may also be relevant. Thus, in *Sidau Unumprovident Corp.,* 245 F. Supp. 2d 207 (D. Me. 2007), the District Court concluded that it was unreasonable for a plan administrator to request a claimant to submit to a medical examination after the deadline for ruling on his appeal had expired for the sole purpose of supplementing a final decision that had already been made.

102. *Manicatty v. Unum Provident Corp.,* 218 F. Supp. 2d 500 (S.D.N.Y. 2002); Rotondi v. Hartford Life and Accident, *supra*.

103. *Saltarelli v. Bob Baker Group Medical Trust,* 35 F.3d 382, 387 (9th Cir. 1994); *Duncan v. Continental Casualty Corp.,* 1997 WL 88374 (N.D. Cal. 1997); *White v. Callentz, Patch & Brass LLP Long Term Disability Plan,* 2011 WL 2531193 (N.D. Cal. 2011); Sullivan v. Deutsche Bank America Holding Corp., *supra*.

104. *Saffron v. Wells Fargo Long Term Disability Plan,* 522 F.3d 863, 872-73 (9th Cir. 2008); *Patrick v. Hewlett Packard Co-Employee Benefit Organization Income Protection Plan,* 638 F. Supp. 2d 1195, 1215 (S.D. Cal. 2009); Sullivan v. Deutsche Bank America Holding Corporation, *supra*.

105. *Lemaire v. Hartford Life and Accident Insurance Co.,* 69 Fed. Appx. 88, 92 (3rd Cir. 2003) (arbitrary and capricious to require "objective" medical evidence to establish the etiology of chronic fatigue syndrome, which is defined by the absence of objective medical evidence), discussed in *Michaels v. Equitable Life Assurance Society of the United States, Employees, Managers and Agents LTD Plan,* 2007 WL 3024571 (E.D. Pa. 2007), rev'd on other grounds 305 Fed. Appx. 896 (3rd Cir. 2009); *Fisher v. Aetna Life Insurance Co.,* 890 F. Supp. 2d 473, 48-81(D. Del. 2012); *Steele v. Boeing Co.,* 225 Fed. Appx. 71, 74-75 (3rd Cir. 2007); *Mitchell v. Eastman Kodak Co.,* 113 F.3d 433, 442-443 (3rd Cir. 1987), abrogated on other grounds in *Miller v. American Airlines,* 632 F.3d 837, 853 (3rd Cir. 2011); *Salomuci v. Honda Long Term Disability Plan,* 642 F.3d 666, 679 (9th Cir. 2011).(plaintiffs are not required to provide evidence of structural brain damage, where there is no test that reveals or confirms the diagnosis); Fitts v. Unum Life Insurance Co. of America, *supra*. *Cf. Berkoben v. Aetna Life Ins. Co.,* 2014 WL 1235915 (W.D. Pa. 2014) (not clear whether any test could confirm the presence of brain damage at this stage of the disease).

106. For an interesting discussion of the treatment by some courts of fibromyalgia as psychogenic, *see* Cassie Springer Sullivan, "The Resurrection of Female Hysteria in Present Day ERISA Disability Law," 20 *Berkeley Journal of Gender, Law, and Justice* (September 2005).

107. *Denmark v. Liberty Life Assurance Co.,* 481 F.3d 16, 37 (1st Cir. 2007),vacated on other grounds 566 F.3d 1 (1st Cir. 2009); *Fisher v. Continental Casualty Co.,* 2012 WL 3100560 (D. Mont. 2012) (collecting cases).

108. 538 U.S. 822 (2003).

109. *Id*. At. *See Sloncenski v. Citibank, N.A.,* 432 F.3d 1271 (11th Cir. 2005) (no abuse of discretion in giving more weight to the contrary position of its own physician over a claimant's treating physician); *Miller v. Prudential Life Ins. Co. of North America,* 2008 WL 4540998 (S.D. Fla. 2008) (same). Numerous cases have also upheld an administrator's decision where the administrator chose to rely upon medical opinions from doctors other than the treating physician, even from doctors selected by the administrator to review the claim. *Dowdy v. Hartford Life and Accident Insurance Co.,* 458 F. Supp. 2d 287 (S.D. Miss. 2006) (citing cases).

110. *Johnson v. Metropolitan Life Ins. Co,* 437 F.3d 809, 814 (8th Cir. 2006). *See also Midgett v. Washington Group Intern. Long Term Disability Plan,* 561 F.3d 87 (8th Cir. 2009); Brewer v. Reliance Standard Life Ins. Co., *supra*.

111. *Seaman v. Sloan Memorial Kettering,* 2010 WL 785298 at *15 (S.D.N.Y. 2010); *Williams v. Aetna Life Ins. Co.,* 509 F.3d 317, 321-22 (7th Cir. 2007) (plan administrator can depart from a treating physician's opinion so long as a non-arbitrary explanation based on evidence is provided for the departure). *Ascherwan v. Aetna Life Ins. Co.,* 2011 WL 688840 (S.D. Ind. 2007) (same). By the same token, ERISA does not grant a plan administrator carte blanche to adopt the opinions of its reviewing physicians, such as where a reviewing physician's report is inadequate, (*Kalish v. Liberty Life Assurance Co. of Boston,* 419 F.3d 501, 509-11 (6th Cir. 2005); Hayden v. Martin Marietta Materials, Inc. *supra*.), or applies standards that conflict with the terms of the plan. *Elliott v. Metropolitan Life Ins. Co.,* 473 F.3d 613, 619-620 (6th Cir. 2006).

112. *Vocharska v. Metropolitan Life Ins. Co.,* 2014 WL 222116 (W.D. Mich. January 21, 2014); Caudill v. Hartford Life, *supra*.

113. *Michaels v. Equitable Life Assurance Society,* 305 Fed. Appx. 896 (3rd Cir. 2009); *Marshall v. AT&T Umbrella Benefit Plan,* 804 F. Supp. 2d 408 (W.D. Pa. 2011); *Lane v. National Cit Corp Welfare Benefit Plan,* 574 F.3d 392 (7th Cir. 2009); *Hergapin v. Johnson Financial Group,* 2010 WL 3808666 (E.D. Wisc. 2010); *Lamanna v. Special Agents Mutual Benefits Assn.,* 2008 WL 622743 (W.D. Pa. 2008) (failure to even acknowledge the opinion of a treating physician was arbitrary and capricious); *Klasson v. Allstate Cafeteria Plan,* 2007 U.S. Dist. LEXIS 62886 (M.D. Pa. August 27, 2007) (unjustified refusal to credit the report of a treating physician was arbitrary and capricious); *Kosiba v. Merck & Co.,* 384 F.3d 58, 66 (3rd Cir. 2004) cert. den. 544 U.S. 1044 (2005); (a procedural irregularity to rely upon the opinion of a non-treating physician over the opinion of the treating physician without explanation); *McGuigan v. Reliance Standard Life Ins. Co.,* 2003 U.S. Dist. LEXIS 17592 at *21 (E.D. Pa. 2003) (a cursory review of the conclusions of a treating physician was evidence of an inattentive review process); *Patton v. Continental Casualty Co.,* 2005 U.S. Dist. LEXIS 5463 (E.D. Pa. March 21, 2005) (insurer's reliance on consultant's report was arbitrary and capricious where, inter alia, the report did not discuss the treating doctor's findings, nor explain why the consultant discounted them); *Hoover v. Provident Life & Accident Ins. Co.,* 290 F.3d 801, 809 (6th Cir. 2002) (evidence in the administrative record did not support the revocation of benefits because the only doctors that disagreed with the treating physician were non-examining consultants hired by the insurance company); Reid v. Metropolitan Life Ins. Co., *supra* (insurer's exclusive reliance on second hand opinions and refusal to credit reliable evidence of plaintiff's treating physician or seek physician's consideration of the significance of an MRI showing plaintiff's brain atrophy as part of the diagnosis was arbitrary and capricious); *Adams v. El Pueblo Boys and Girls [Branch], Inc. LTD Plan* 2013 WL 4775927 (D. Colo. September 5, 2013) (questioning a decision to discount without explanation the written opinion of a treating physician, and noting that the

administrator may have relied upon hearsay). It is also an abuse of discretion for a plan administrator to rely upon the report of a doctor who does not have the requisite expertise. *Monroe v. Pacific Telesis Group Comprehensive Disability Benefit Plan,* 971 F. Supp. 1310, 1315 (C.D. Cal. 1997); *Lamarco v. Cigna Corporation,* 2000 WL 1456949 (N.D. Cal. 2000); *Zavora v. Paul Revere Life Assurance Company,* 145 F.3d 1118 (9th Cir. 1998). However, a plan can rely upon a physician's original opinion, even if he or she later changes his or her mind. *Dowdy v. Hartford Life and Accident Insurance Co.,* 458 F. Supp. 2d 289 (S.D. Miss. 2006); *Gooden v. Provident Life and Accident Ins. Co.,* 250 F.3d 329, 333-34 (5th Cir. 2001); *Schultz v. Progressive Health and Disability Benefits Plan,* 380 F. Supp. 2d 780, 787 (S.D. Miss. 2005) (no abuse of discretion in relying upon initial opinion, where no evidence or explanation as to change in opinion). Also, Daubert standards are inapplicable to a court's review of the administrative record in an ERISA case. Dowdy v. Hartford Life and Accident Ins. Co., *supra; Wyatt v. AMEC Choices Benefits Program Long Term Disability Plan,* 2005 WL 1186114 (S.D. Tex. May 19, 2005); *Hufford v. Harris Corp.,* 322 F. Supp. 2d 1345 (M.D. Fla. 2004). *Daubert v. Merrill Dow Pharmaceuticals, Inc*. 509 U.S. 579 (1993) governs the admissibility of expert opinions at trial. Additionally, a diagnosis is not invalid simply because it is retrospective, so long as it is predicated on a medically accepted technique. *Tritt v. ADP, Inc. LTD Plan,* 2012 WL 3309380 (D. Conn. 2012).