11th Circ.'s 6-Step Review May Be Ripe For Insurer Challenge

By **Scott Garosshen** (December 4, 2025)

Scott Garosshen

By a 2-1 vote in Johnson v. Reliance Standard Life Insurance Co., the U.S. Court of Appeals for the Eleventh Circuit has held that a policy interpretation endorsed by the dissenting opinion, suggested by a prior Eleventh Circuit panel, and adopted by other courts around the country was not just wrong, but so unreasonable that it failed arbitrary-and-capricious review.

The Nov. 21 decision is a cautionary tale in several respects.[1]

The dispute arose under a long-term disability, or LTD, policy that excluded coverage for preexisting conditions, defined as "any Sickness or Injury for which the Insured received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines."

For two years prepolicy, the plaintiff had symptoms of a rare autoimmune disease, scleroderma. She received treatment, took medicines, and underwent diagnostic procedures. But none of her doctors could figure out what it was, diagnosing her with nearly a dozen other ailments instead. After the policy kicked in, her doctors landed on the correct diagnosis.

The question for the court was whether something counts as a preexisting condition if the insured was treated for it prepolicy, but her doctors didn't name it correctly.

The Result

The majority answered no, holding that the insurer thus wrongly denied coverage. This outcome was unlikely for two main reasons.

First, this was an LTD policy under the Employee Retirement Income Security Act that granted the insurer "discretionary authority" to interpret it. The insurer could lose only if its interpretation was not just wrong, but so unreasonable as to be "arbitrary and capricious." Second, multiple judges already had interpreted similar policy language in line with the insurer's interpretation.

The deferential standard of review may have been diluted in part due to a quirk of the Eleventh Circuit. In contrast to other circuits that apply regular abuse-of-discretion review to an insurer's discretionary interpretation of its own ERISA policy, the Eleventh Circuit uses a bespoke six-step sequence that starts by asking whether the insurer's interpretation is wrong under de novo review, then only later asks if it is so wrong as to be arbitrary and capricious.

This sequence triggers what influence scholar and renowned psychologist Robert Cialdini calls "commitment-and-consistency bias": Someone is more likely to agree with a stance if they first agree with it a little. Here, once a judge convinces themself that an interpretation is wrong, there is a stronger cognitive temptation to believe it is also very wrong. By contrast, leading with the abuse-of-discretion question creates a more level playing field.

Second, at the policy interpretation stage, things got metaphysical. The majority viewed the

prepolicy doctors' activities as treating symptoms rather than a medical condition. Because they repeatedly misdiagnosed the plaintiff with other ailments instead of scleroderma, the majority reasoned, they could not have been treating her "for" scleroderma. The "symptoms are not the disease" and "an indication of something is not the thing itself," just as "a wet umbrella is [not] 'the same thing' as a hurricane."

The dissent saw it differently.

The plaintiff had been treated, prescribed medication, and undergone diagnostics "for the 'various symptoms and conditions of scleroderma.'" There was "more than mere 'consistency' between what [she] was treated for and scleroderma; they are the same thing." Borrowing an umbrella of its own, the dissent reasoned that if one "us[es] an umbrella to stay dry without knowing whether the current rainstorm is a hurricane or quick summer shower," either way, "the umbrella fends off the rains."

Since both majority and dissent found different dictionaries and prior cases siding with their respective interpretations, one would expect the insurer to prevail under arbitrary-and-capricious review.

Instead, the majority seized on a stray answer at oral argument, construing it as an admission that the insurer would deny coverage if any prepolicy symptom was not inconsistent with the later diagnosis. The majority held that that position, albeit taken from another party in a different case, "is unreasonable — full stop." So, it reversed the judgment of the U.S. District Court for the Northern District of Georgia.

Looking Ahead

This appeal seems ripe for rehearing en banc; although, this is quite rare, especially in insurance coverage cases. As to standard of review, even the majority acknowledged that the Eleventh Circuit's six-step sequence "is likely unnecessarily complex (and may even obscure the lawful result in certain cases)" — the result here is a prime example.

If not now, then when the right case comes along, insurers may consider investing in overturning this framework and the subtle cognitive bias it creates.

Doing so will aid not just litigants, but also the court. That six-step structure does not only obscure the correct result; it is also unwieldy to apply. The majority nodded to this when it suggested in passing that the contra proferentem rule, requiring a court to defer to the policyholder's reasonable interpretation of ambiguous language, might bolster its conclusion at interpretive step one — i.e., whether, under de novo review, the insurer's interpretation was wrong.

Critically, that rule goes out the window at step three — during abuse-of-discretion review, a court must defer to the insurer's reasonable interpretation of ambiguous language. So, the court winds up disregarding its earlier work.

Other circuits hold overwhelmingly that contra proferentem simply plays no role in abuse-of-discretion review.[2] Only the U.S. Court of Appeals for the Fifth Circuit, in its 2019 decision in Dialysis Newco Inc. v. Community Health Systems Group Health Plan, has come out differently in the limited context of interpreting anti-assignment clauses, while acknowledging that this outlier holding created "some tension in [its] caselaw" and may be due for correction.[3]

It is thus no wonder that the Eleventh Circuit majority here, after invoking contra proferentem, disavowed any reliance on it, even in step one. That awkward dance (and the makework it entails) could be avoided if the Eleventh Circuit jettisons the six-step framework and joins the rest of the country in assessing simply whether the insurer has discretion, and, if so, whether its interpretation passes abuse-of-discretion review.

Turning to the Eleventh Circuit majority's merits policy interpretation, how lower courts apply that test will be key. The test seems to be that the right disease need not be formally diagnosed prepolicy so long as it at least is "suspected."

The majority suggests that "strong indications" of the particular illness, "reasonable cause" to diagnose the particular illness, or "a distinct symptom or condition from which one learned in medicine can diagnose the disease" all trigger the preexisting conditions exclusion but were not satisfied on the facts here. Whether that blurry line will yield consistent results in practice remains to be seen.

Key Takeaways for Insurers

1. Look out for interpretive frameworks that create commitment-and-consistency bias.

Experiments have shown that judges are susceptible to this type of cognitive effect. Although hard to prove in any given case, the long-term effect can be significant. Investing in reshaping the law into a more level playing field affects not just the individual cases but also their broader ripples into adjacent case law.

2. Pay special attention to outlier circuits.

When a circuit decision flags one of its own rules as out-of-step with the modern trend, it may be vulnerable to reconsideration en banc, without the need for a trip all the way to One First Street, Washington, D.C. This is especially true when experience has shown the rule to be unworkable.

3. Issue framing and careful answers at oral argument matter.

Insurers are often held to a higher standard, even when the law requires more lenient treatment. The effect of this can be mitigated by having a firm theory of the case and knowing exactly when one can, cannot, or must cede ground.

Scott Garosshen is counsel at Robinson & Cole LLP.

[1] Johnson v. Reliance Standard Life Insurance Company, No. 23-13443, 2025 WL 3251015 (11th Cir. Nov. 21, 2025).

[2] Dialysis Newco Inc. v. Cmty. Health Sys. Grp. Health Plan, 938 F.3d 246, 251 n.4 (5th Cir. 2019) (noting decisions from the First, Second, Fourth, Sixth, Seventh, Ninth, Tenth

and Eleventh Circuits).

[3] Dialysis Newco, 938 F.3d at 251.