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# The Brain Gets Sick, Too - The Case for Equal Insurance Coverage for Serious Mental Illness.

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# THE BRAIN GETS SICK, TOO—THE CASE FOR EQUAL INSURANCE COVERAGE FOR SERIOUS MENTAL ILLNESS

BRIAN D. SHANNON*

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"I am losing the vague dread, the fear of the thing. And little by little I can come to look upon madness as a disease like any other."

Vincent van Gogh.[1]

## I. INTRODUCTION

Although the artist Vincent van Gogh penned these words more than a century ago, his insights are pertinent to current research regarding serious mental illnesses. Recent brain research has revealed that the major mental illnesses are organic diseases of the brain. Like other organs of the body, the brain can become ill. Dr. E. Fuller Torrey, a psychiatrist whose sister suffers from schizophrenia, has commented that "[t]he evidence that serious mental illnesses are diseases is now overwhelming. . . ."[2] Notwithstanding recent medical findings regarding the organic underpinnings of mental illnesses, private insurers generally do not provide health insurance coverage for the treatment of these brain diseases at the same coverage levels as for other physical illnesses. In fact, "[m]ost private insurers require larger co-payments and set lower reimbursement ceilings for psychiatric disorders."[3] This disparate treatment in insurance coverage for persons suffering from serious mental illnesses is both discriminatory and wrong. This article will explore the problem of discriminatory insurance practices with respect to serious mental illnesses by examining recent brain research, trends in insurance coverages for serious mental illnesses, and judicial and legislative responses to current insurance practices.

1. Letter from Vincent van Gogh to his brother Theo (May 1889), *in* 3 THE COMPLETE LETTERS OF VINCENT VAN GOGH, at 169 (2d ed. 2d prtg. 1981). Vincent van Gogh suffered from serious mental illness and eventually committed suicide after only ten years of painting. *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 111-12 (rev. ed. 1988) (discussing van Gogh's mental illness).

2. Erica E. Goode, *When Mental Illness Hits Home*, U.S. NEWS & WORLD REP., Apr. 24, 1989, at 63 (quoting Dr. Torrey). Given the origins of these illnesses, Dr. Torrey has queried, "Why should we treat [mental illnesses] any differently than Parkinson's or Alzheimer's or multiple sclerosis?" *Id.* Accordingly, in this article the term "serious mental illness" refers to an organic brain disease such as schizophrenia, bipolar disorder, or severe depressive illness. Correspondingly, the term does not include other purely mental, emotional, behavioral, or coping problems that are not biologically-based.

3. *Id.*

## II. Inconsistencies Between Medical Research and Insurance Coverage for Serious Mental Illnesses

Recent medical studies and analyses of the brain have established that serious mental illnesses are organic brain diseases. Unlike their typical health insurance coverage for other physical abnormalities and illnesses, insurers tend to restrict severely their coverage for treatment of these brain diseases. This section will examine some of the recent medical discoveries about the brain and discuss the insurance industry's approaches to coverage for serious mental illnesses.

### A. *Recent Brain Research*

Medical research over the last decade has revealed more information about the brain than ever before. In the past several years, medical researchers have made numerous findings establishing that serious mental illnesses such as schizophrenia,[4] bipolar affective disorder,[5] and depressive illness[6] are biologically-based diseases of the brain. For example, Dr. E. Fuller Torrey has commented that the "evidence is now overwhelming that brains of persons who have schizophrenia are, as a group, different from brains of persons who do not have this

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4. Many people wrongly confuse schizophrenia with a much rarer condition: multiple personality disorder. *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 109 (rev. ed. 1988) (noting differences between conditions). Instead, schizophrenia is a brain disease in which the victim's "thinking and judgment, sensory perception and the ability to appropriately interpret and respond to situations are affected." *Id.* One commenter explains, "Schizophrenia occurs in about one in one hundred persons and typically appears when the individual is in his or her late teens or early twenties." TEXAS DEP'T OF MENTAL HEALTH & MENTAL RETARDATION & TEXAS ALLIANCE FOR THE MENTALLY ILL, MENTAL ILLNESS: A FAMILY POINT OF VIEW 3 (1990). Symptoms may include poor reasoning, disconnected and confusing language, hallucinations, delusions, and deterioration of appearance and personal hygiene. *Id.*

5. Bipolar affective disorder is also called manic depression. TEXAS DEP'T OF MENTAL HEALTH & MENTAL RETARDATION & TEXAS ALLIANCE FOR THE MENTALLY ILL, MENTAL ILLNESS: A FAMILY POINT OF VIEW 3-4 (1990). Persons who suffer from this disease "swing between extremely high and low moods." *Id.* at 4. Symptoms may include boundless energy, enthusiasm, and activity, followed by a switch to severe depression. *Id.*

6. Depressive illness is also known as unipolar illness or severe depression. TEXAS DEP'T OF MENTAL HEALTH & MENTAL RETARDATION & TEXAS ALLIANCE FOR THE MENTALLY ILL, MENTAL ILLNESS: A FAMILY POINT OF VIEW 4 (1990). Persons suffering from this disease "may lose interest in daily activities; have difficulty in sleeping; lose their appetite; have feelings of worthlessness, guilt and hopelessness; feel despondent or sad; be unable to concentrate; and have suicidal thoughts and actions." *Id.*

disease."[7] High-tech imaging tools that are capable of providing unprecedented views of the brain are providing much of this new evidence.[8]

Perhaps the most widely disseminated research has been a 1990 report by the *New England Journal of Medicine* concerning schizophrenia.[9] Researchers discovered that among pairs of identical twins, when one suffered from schizophrenia and one did not, certain brain abnormalities were present only in the twin who had the disease.[10] Dr. Lewis L. Judd, the director of the National Institute of Mental Health, called the study "irrefutable evidence that schizophrenia is a brain disorder."[11]

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7. *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 131 (rev. ed. 1988). Dr. Torrey also cynically suggests that "[m]ental health professionals who are unaware of this fact have either been on an extended trek in Nepal or restricted their professional reading to the *National Geographic* for the last ten years." *Id.* He points out that schizophrenia is a brain disease that "is a real scientific and biological entity, as clearly as diabetes, multiple sclerosis, and cancer are scientific and biological entities." *Id.* at 5.

8. *See* Rita Rubin, *Schizophrenia Brain Images Show Physical Basis of Debilitating Mental Illness*, DALLAS MORNING NEWS, May 7, 1990, at 8D (noting discoveries made due to new medical technology); *see also* Barry H. Guze, *Magnetic Resonance Spectroscopy: A Technique for Functional Brain Imaging*, 48 ARCHIVES GEN. PSYCHIATRY 572, 572 (1991) (discussing evolving technologies for determining chemical bases of mental disorders).

9. Richard L. Suddath et al., *Anatomical Abnormalities in the Brains of Monozygotic Twins Discordant for Schizophrenia*, 322 NEW ENG. J. MED. 789, 789-94 (1990).

10. *Id.* at 790. The researchers used magnetic resonance imaging to study fifteen pairs of twins. *Id.* In most all of the siblings suffering from the disease, the brain ventricles were physically different from the brains of the non-stricken twins. *Id.* at 791.

11. Daniel Goleman, *Brain Structure Differences Linked to Schizophrenia in Study of Twins*, N.Y. TIMES, Mar. 22, 1990, at B15 (quoting Dr. Judd). Dr. Marsel Mesulam, a neurologist at Harvard Medical School, called the results "definitive evidence that schizophrenia is a brain disease. . . ." *Id.* Another group of researchers have found a reduction of brain tissue in the temporal lobes of the brains of young persons suffering from schizophrenia. *See* Alessandro Rossi et al., *Reduced Temporal Lobe Areas in Schizophrenia: Preliminary Evidences from a Controlled Multiplanar Magnetic Resonance Imaging Study*, 27 BIOL. PSYCHIATRY 61, 61 (1990) (noting two studies which indicated temporal lobe reduction in persons with schizophrenia). These researchers believe that the findings from the twin study may correlate to a more severe form of schizophrenia, while the temporal lobe findings may be characteristic of less severe cases of the disease. *Id.* Modern research is focusing primarily on this type of brain research, and medical scientists' effort at physical subtype grouping of schizophrenia based on biological markers is "one of the most urgent topics in modern psychiatry." Richard B. Rosse et al., *Subtype Diagnosis in Schizophrenia and Its Relation to Neuropsychological and Computerized Tomography Measures*, 30 BIOL. PSYCHIATRY 63, 63 (1991); *see also* Jay W. Pettigrew et al., *Alterations in Brain High-Energy Phosphate and Membrane Phospholipid Metabolism in First-Episode, Drug-Naive Schizophrenics*, 48 ARCHIVES GEN. PSYCHIATRY 563, 563 (1991) (commenting that "[a]ccumulative evidence strongly suggests that schizophrenia is due to a brain disorder"). The studies mentioned in this article are only examples of the type of research that has confirmed the biological bases of serious mental illnesses such as schizophrenia.

In addition to schizophrenia, researchers have investigated other serious mental illnesses for their biological bases. This research has indicated that both depressive illness and bipolar affective disorder are also organic brain diseases. For example, at least two recent studies of persons suffering from severe depression have revealed brain receptor site changes and low brain uptake of a substance vital to proper brain functioning in those persons.[12] Other researchers analyzing biological markers present in bipolar affective disorder have discovered a chemical concentration in the blood of persons suffering from that disease which helps predict both the course of the illness and possible responses to medication.[13] In sum, current brain researchers are identifying genetic and biological bases for the various major mental illnesses.[14] Accordingly, current research "into the causes of mental illness indicates that mental illnesses are the result of biochemical disease, not of flaws or weaknesses in character."[15]

Although serious mental illnesses such as schizophrenia, bipolar affective disorder, and depressive illness are not curable, they are treatable diseases. Indeed, Dr. Torrey commented that "schizophrenia is an eminently treatable disease."[16] He compared the treatment for schizophrenia as being akin to the treatment for diabetes in that "both

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As one recent review of medical research in this area commented, "A complete review of all the biological abnormalities that have been attributed to schizophrenia would fill a volume." Daniel L. Creson & Leo E. Hollister, *Psychosocial and Biological Research in Schizophrenia, in* MENTAL HEALTH RESEARCH IN TEXAS: RETROSPECT AND PROSPECT (PROCEEDINGS OF THE SEVENTH ROBERT LEE SUTHERLAND SEMINAR IN MENTAL HEALTH) 13, 21 (Charles M. Bonjeam & Donald J. Foss eds., Hogg Found. for Mental Health 1990).

12. H. Agren et al., *Low Brain Uptake of L-[11C]5-Hydroxytryptophan in Major Depression: A Positron Emission Tomography Study on Patients and Healthy Volunteers*, 83 ACTA PSYCHIATRICA SCANDINAVICA 449, 449-55 (1991); Ronald E. Dahl et al., *24-Hour Cortisol Measures in Adolescents with Major Depression: A Controlled Study*, 30 BIOL. PSYCHIATRY 25, 25-36 (1991). This latter study indicated that adolescents suffering from depressive illness undergo an abnormal rise of certain brain chemicals at the onset of sleep which may correlate to evidence of altered patterns of secretion of the same chemical in adults suffering from depressive illness. *Id.* at 30.

13. *See* Andrew L. Stoll et al., *Erythrocyte Choline Concentration in Bipolar Disorder: A Predictor of Clinical Course and Medication Response*, 29 BIOL. PSYCHIATRY 1171, 1172 (1991) (explaining function of choline and implications of concentration in blood).

14. *See, e.g.*, T.J. Crow, *Nature of the Genetic Contribution to Psychotic Illness—A Continuum Viewpoint*, 81 ACTA PSYCHIATRICA SCANDINAVICA 401, 407 (1990) (concluding that variations in certain mental illnesses due to variations in genetic base).

15. TEXAS DEP'T OF MENTAL HEALTH & MENTAL RETARDATION & TEXAS ALLIANCE FOR THE MENTALLY ILL, MENTAL ILLNESS: A FAMILY POINT OF VIEW 4 (1990).

16. E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 170 (rev. ed. 1988).

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can usually be well controlled, but not cured, by drugs. Just as we don't talk of curing diabetes but rather of controlling its symptoms and allowing the diabetic to lead a comparatively normal life, so we should also do with schizophrenia."[17] Treatment for serious mental illnesses includes a number of medications that can alleviate or reduce the symptoms of the diseases.[18] For example, lithium has proven very helpful to a number of persons suffering from bipolar affective disorder.[19] Similarly, psychiatrists have found that a number of antipsychotic medications can help alleviate the biochemical imbalances present in persons suffering from schizophrenia.[20]

### B. *Typical Insurance Coverage for Serious Mental Illness*

Despite the overwhelming medical findings that serious mental illnesses are in fact organic diseases of the brain, health insurance policies tend to treat these illnesses differently from other physical ailments. Although extensive coverage is available for most medical disorders, "insurance policies generally restrict coverage for mental illnesses to a limited number of days of hospitalization and a dollar ceiling on outpatient treatment. . . ."[21]

What accounts for this disparity in coverage? Stigma certainly rep-

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17. *Id.*

18. TEXAS DEP'T OF MENTAL HEALTH & MENTAL RETARDATION & TEXAS ALLIANCE FOR THE MENTALLY ILL, MENTAL ILLNESS: A FAMILY POINT OF VIEW 5 (1990).

19. *See* E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 93 (rev. ed. 1988) (explaining that lithium can reduce number and severity of manic episodes).

20. *See* AMERICAN PSYCHIATRIC ASS'N, LET'S TALK FACTS ABOUT SCHIZOPHRENIA 7 (1988) (stating that medication can reduce hallucinations and delusions and increase person's ability to maintain coherent thought).

21. Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 993, 993 (1989). These restrictions on coverage for mental illnesses include such measures as

> capping benefits at arbitrary, and often very low levels, on a per-treatment basis, an annual basis or through lifetime limits; requiring insurers to pay a high deductible, i.e., to make a major out-of-pocket investment before services are reimbursed; [and] requiring high co-payments by policyholders, e.g., limiting reimbursement to 50% of actual costs. . . .

ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 13-14 (1991). Although the American Psychiatric Association has made efforts to end insurance discrimination against the mentally ill since the 1950s, the insurers' limitations on "insurance reimbursement for mental illness beyond the limitations for treatment of general medical illness—has remained the rule rather than becoming the exception." STEVEN S. SHARFSTEIN ET AL., HEALTH INSURANCE AND PSYCHIATRIC CARE: UPDATE AND APPRAISAL 3 (1984).

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resents part of the problem. Many members of the public and the insurance industry still view individuals with mental illness as causing their own mental problems. Consequently, this segment of the public believes that persons with mental illness should be able to overcome their illness simply by their own efforts. As one medical commentator has observed, "[s]tigma is reflected in the attitudes of payers who view mentally ill individuals as bringing on their own anxiety states . . . [or] depressions. . . ."[22] The public has persisted in the view that somehow the patient or the patient's family is to blame for the person's mental illness.[23] In addition, remnants of outdated propositions that mental illnesses such as schizophrenia are mythical and do not exist still haunt current mental health law and policy.[24] Given medical findings that serious mental illnesses such as schizophrenia, bipolar affective

22. Steven S. Sharfstein, *Articulating the Case for Equitable Mental Health Coverage*, 42 HOSP. & COMMUNITY PSYCHIATRY 453, 453 (1991). Dr. Sharfstein observes further that these insurance problems "are mired in continuing stigma, expectations that the public sector should care for the mentally ill, and *irrational beliefs* about the nature of mental illness. . . ." *Id.* (emphasis added); *accord* Steven Findlay, *The Revolution in Psychiatric Care*, U.S. NEWS & WORLD REP., Aug. 5, 1991, at 50 (observing that "insurance limitations testify to a lingering stigma" and that despite recent medical advances and discoveries, "it probably will still take years before people with mental illnesses are treated with the same degree of compassion—and insurance protection—as are victims of . . . heart disease or cancer"). Even as late as the mid-1980s, one government policy analyst appeared oblivious to the differences between serious mental illnesses and other emotional types of psychological problems. *See* Gloria Ruby, *The Policy Implications of Insurance Coverage for Psychiatric Services*, 7 INT'L J. OF LAW & PSYCHIATRY 269, 280 (1984) (broadly assuming mental illness to be "a medical problem that is not physical in origin").

23. *See* Erica E. Goode, *When Mental Illness Hits Home*, U.S. NEWS & WORLD REP., Apr. 24, 1989, at 63 (noting society's tendency to place blame). "With the rise of psychoanalysis in the United States in the mid-20th century came a view of mental illness that held mothers and fathers responsible" even though "Freud himself doubted that schizophrenia and other psychotic disorders could be ameliorated through his 'talking cure'." *Id.* The medical community has discarded these "blame" theories with the advances in medical knowledge about diseases such as schizophrenia. E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 162, 164 (rev. ed. 1988).

24. *See* RAEL J. ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 19-64 (1990) (suggesting that largely abandoned and discredited ideas about mental illness, which so-called "anti-psychiatrists" such as Thomas Szasz and R. D. Laing pursued in the 1960s, have influenced today's legal concepts about mental illness). Modern psychiatry has certainly rejected such theories. For example, Dr. Torrey has commented that the "only myth is that Dr. Szasz knows anything whatsoever about schizophrenia." E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL 380 (rev. ed. 1988); *accord* RAEL J. ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL, 34 (1990) (quoting Dr. Torrey as stating, "Szasz knows nothing about schizophrenia . . . and doesn't know what he is talking about.").

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disorder, and depressive illness are physical brain diseases, attitudes that the patients somehow caused their own problems or should just will themselves to get better are as ludicrous as suggesting that sufferers of brain tumors, lung cancer, diabetes, or Parkinson's disease could be cured if they simply tried hard enough or wanted to be well. Ignorant stigmatization, however, should not serve as a barrier to appropriate insurance coverage for a medical illness, even if that illness affects the patient's brain.[25]

Another basis for the current limits on coverage for mental illness relates to the nature of what is being covered. A typical policy may provide benefits for "mental health" coverage or for "mental/nervous disorders" without further definition of what is intended to be covered by the clause.[26] This type of clause could cover a broad spectrum of problems.

Before the advent of current brain research into the causes of serious mental illnesses, perhaps it was an easier matter to distinguish a mental disorder from a physical illness.[27] Given the current medical understanding that a variety of serious mental illnesses are physical diseases of the brain, however, it now seems incongruous to characterize these brain diseases as being the same as mental problems that are entirely emotional and non-organic in nature. Yet, this is precisely the approach that insurers are pursuing by including biologically-based serious mental illnesses with all other mental, emotional, and

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25. The chief resident psychiatrist at Boston's New England Medical Center has sharply criticized limits on insurance for mental illness such as an annual limit of $500 for outpatient coverage. He commented, "Imagine the outrage that would greet an insurance company policy to limit breast cancer treatment reimbursement to $500. Or reimbursement for high blood pressure. Or arthritis. Is psychiatry still so cloaked in stigma that no one dares speak forcefully for it? Where is our anger?" Keith R. Ablow, *When Money Is a Factor in Treatment; Some Tenets of For-Profit Medicine Are at Odds with Good Care*, WASH. POST, Mar. 17, 1992, at Z11.

26. *See* Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS. L. REV. 143, 162 n.126 (1991) (observing that undefined terms like "mental illness" and "nervous disorders" lend themselves to ambiguity about what conditions or treatments are covered by such limitations).

27. *See* Steven P. Garmisa, *"Mental Illness" Limitation in Health Insurance Policies*, CHI. DAILY L. BULL., Nov. 6, 1990, at 2 (distinguishing between mental and physical illnesses). This commentator observed, "At one time it may have seemed fairly easy to distinguish between 'mental illness' and other medical disorders. There was the 'mind' (the seat of human consciousness) where mental and emotional problems occurred, and there was the 'brain' (. . . that controlled bodily activities)." *Id.* This author indicated that under this type of distinction, an illness such as bipolar affective disorder would be mental in nature because of the effects on the mind and emotions, while "[s]omething like epilepsy, on the other hand, would be readily recognized as a physical illness—a disease of the brain." *Id.*

behavioral problems under policy limitations that employ broad rubrics such as "mental health" or "mental/nervous disorders."

Insurance companies are reluctant to provide equal coverages for mental illnesses because they view "mental health" benefits as one of the fastest growing segments of health care.[28] However, one must examine which aspects or components of "mental health" benefits are actually expanding. Behavioral disorders, not physical diseases, account for the largest portion of the escalating costs.[29] Nonetheless,

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28. *See* ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 13-14 (1991) (recognizing insurers strategies to avoid coverage for treatment of mental illnesses).

29. *See id.* at 14-15. Ms. O'Keefe's research revealed the following:

> The two main areas of escalating costs in the "mental health" category are treatments for alcohol and substance abuse and the psychiatric hospitalization of adolescents. In both cases, the problems being addressed are behavioral disorders, not physical diseases. From 1986 through 1988, inpatient substance abuse and adolescent treatment were almost entirely responsible for the cost increases in mental health. During this same period, charges for inpatient psychiatric services for adults (with serious mental illnesses) *grew less rapidly* than did overall health care costs.

*Id.* at 15 (emphasis added); *accord* American Psychiatric Ass'n, Press Release (Jan. 4, 1991) (on file with *St. Mary's Law Journal*) (announcing that American Psychiatric Association-funded study revealed that increases in most psychiatric services had been modest, except for substance abuse and treatment of children and adolescents).

In fairness to the insurance companies' cost concerns, however, recent revelations have indicated that private, "for-profit" psychiatric hospital chains may have been involved in widespread insurance fraud and abuse by abducting patients, detaining patients until insurance benefits have been exhausted, and altering diagnoses of patients to increase insurance reimbursements. *See, e.g.*, Peter Kerr, *Mental Hospital Chains Accused of Much Cheating on Insurance*, N.Y. TIMES, Nov. 24, 1991, at A1 (stating that evidence of fraudulent insurance claims by psychiatric hospitals could total loss of millions of dollars); Peter Kerr, *Chain of Mental Hospitals Faces Inquiry in 4 States*, N.Y. TIMES, Oct. 22, 1991, at A1 (reporting investigation into psychiatric hospital chain accused of improper treatment of patients in effort to get profits from insurance claims); Susan Moffat, *Healing Patients, or Profits?; Pressures on Private Psychiatric Hospitals Have Led to Aggressive Recruiting of Patients. Diagnoses, Critics Say, Are Often Based on Insurance Practices Rather than People's Needs*, L.A. TIMES, Feb. 2, 1992, at A1 (describing patients' claims that psychiatric hospital held patients against their will in order to milk insurance benefits). The Texas Attorney General has recently settled a lawsuit involving such allegations with a large chain of private, "for-profit" psychiatric hospitals. *See* State v. Psychiatric Inst. of America, Inc., No. 92-07848 (Dist. Ct. of Travis County, 250th Judicial Dist. of Texas, June 3, 1992) (agreed final judgment); *see also* Mark Langford, *Texas Reaches Settlement with Psychiatric Hospital Chain*, UPI, June 3, 1992, *available in* LEXIS, Nexis Library, UPST92 File (reporting settlement); Mark Smith & Cindy Rugely, *Profitable Addictions; Psychiatric Suit Settled at $9 Million*, HOUS. CHRON., June 4, 1992, at A19 (commenting on terms of settlement). Although these abuses are unconscionable, the appropriate response for insurance companies is not "to throw the baby out with the bath water" by limiting coverages or refusing to insure persons who suffer from serious mental illnesses. The American Psychiatric Association has suggested that firms interested in cost savings in the mental health area should not trim benefits indiscriminately. American Psychiatric Ass'n, Press Release

insurers are creating coverage limits that shrink or deny benefits for both behavioral problems and physical diseases of the brain. Policy limitations or other cost controls may be entirely appropriate for purely behavioral or emotional problems.[30] Like sufferers of cancer, epilepsy, or Alzheimer's Disease, however, persons who have been afflicted with diseases such as schizophrenia or bipolar affective disorder cannot will themselves into recovery without medical care. Yet, through the use of overbroad terms setting policy limits or exclusions for "mental health" or "mental/nervous" benefits, insurance companies are covering serious mental illnesses in the same manner as the purely emotional or coping problems of the "worried well."[31] This practice results in unfair, discriminatory insurance treatment against persons whose mental illnesses are, in fact, organically- or biologically-based brain diseases.

Another reason that insurance companies have discriminated in coverages for mental illnesses is that insurers "are reluctant to cover what is paid for in public programs."[32] In turn, those patients with serious mental illnesses who cannot afford to pay for their own care,

(Jan. 4, 1991) (on file with *St. Mary's Law Journal*). Instead, the proper focus should be on halting and preventing abuses to assure that persons who actually need the care are receiving it. Persons who truly have these diseases are not the causes of the private psychiatric chains' abuses and greed.

30. *See* ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 15 (1991) (discussing current insurance coverage for mental illness). After all, "people who only have emotional problems can exercise choice about whether or not to seek treatment." *Id.*

31. *Id.* Anne M. O'Keefe writes, "[F]or the seriously mentally ill, there is no choice. Treatment is not a means for personal insight or self-fulfillment. . . . Yet the mentally ill are under the same limits designed to control the utilization of discretionary mental health services." *Id.*; *see also*, Erica E. Goode, *When Mental Illness Hits Home*, U.S. NEWS & WORLD REP., Apr. 24, 1989, at 63. Goode suggests that this insurance discrimination is "just another bitter legacy of an emphasis on mental 'health' instead of mental illness, a focus that blurred distinctions between the 'worried well' and the 'walking wounded'." *Id.*

32. Steven S. Sharfstein, *Articulating the Case for Equitable Mental Health Coverage*, 42 HOSP. & COMMUNITY PSYCHIATRY 453, 453 (1991). Aside from private insurance, Medicaid, Medicare, and state and local governments are responsible for much of the treatment of persons with chronic mental illnesses. Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS. L. REV. 143, 147-56 (1991). Other theories exist concerning the reasons why insurers limit coverage for mental health services. *See* Richard G. Frank & Thomas G. McGuire, *Mandating Employer Coverage of Mental Health Care*, HEALTH AFFAIRS, Spring 1990, at 31, 34-35 (noting that "insurance coverage will attract high-cost enrollees to the plan; . . . [and] enrollees are not interested in mental health coverage . . ."). The latter of these theories underscores the ignorance and stigma associated with severe mental illnesses. *See id.* at 35-36 (noting bases for assertion that lack of enrollee interest exists).

or who have quickly exhausted their limited insurance benefits, "are usually forced into an underfunded and overcrowded public mental health system."[33] This creates a vicious cycle. As more people with severe mental illnesses cannot obtain care through private insurance because of shrinking coverages, more must resort to the already overburdened and poorly-funded public sector to obtain treatment. Faced with that alternative, some of these people will not receive medical attention for their mental illnesses at all.[34]

## III. JUDICIAL CHALLENGES TO INSURANCE POLICIES THAT DISCRIMINATE AGAINST SERIOUS MENTAL ILLNESSES

In the last five years, several courts have considered challenges to

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33. Paul S. Appelbaum, *What Are the Prospects for Insurance Coverage of Mental Disorders?*, HARV. MENTAL HEALTH LETTER, (Harvard College, Boston, Mass.) Dec. 1990 (on file with *St. Mary's Law Journal*). State and local governments often have difficulties in providing adequate services for the mentally ill populations that they serve. For example, a recent survey rated Texas forty-fifth among the states in overall services for people with mental illnesses. E. FULLER TORREY ET AL., CARE OF THE SERIOUSLY MENTALLY ILL: A RATING OF STATE PROGRAMS 165 (3d ed. 1990). Calling Texas "stingy," this survey opined, "Texas has always prided itself on being the biggest. In funding of public services for people with mental illnesses it is indeed the biggest—the biggest skinflint." *Id.* Another report ranked Texas forty-ninth among all states in per capita spending on services for the severely mentally ill. *See* COMMISSION ON COMMUNITY CARE OF THE MENTALLY ILL, TEXANS WITH SEVERE MENTAL ILLNESS 8 (Hogg Found. for Mental Health 1990).

34. Approximately one-third of the nation's homeless suffer from severe mental illness. *See* THE 1990 ANNUAL REPORT OF THE INTERAGENCY COUNCIL ON THE HOMELESS 22 (Department of Veterans Affairs ed., 1991) (reporting statistical correlation between homelessness and mental illness); *see also* ROEL J. ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 4 (1990) (stating that persons who are mentally ill make up 30-40% of population). *See generally* E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988) (presenting compelling series of theories regarding vast increases in population among nation's homeless mentally ill). Of course, many homeless persons have no health insurance at all. Indeed, thirty-four to thirty-seven million Americans, homeless or otherwise, have no health insurance. *Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991 at 4. General access to health insurance is a broad, albeit important, issue that is beyond the intended scope of this article. *But see infra* notes 140-44 & accompanying test. On the other hand, one investigation has suggested that "largely because of insurance discrimination, an estimated 150,000 seriously mentally ill people are living in public shelters and on our city streets." ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 18 (1991). As the president of the American Psychiatric Association has stated, "Inappropriately cutting off benefits will lead to insufficient treatment, the shifting of care to the public sector, and increased homelessness." American Psychiatric Ass'n, Press Release (Jan. 4, 1991) at 3 (on file with *St. Mary's Law Journal*).

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insurance policies that discriminate against serious mental illness. The challengers have met with mixed results. In several cases, challengers to insurance limitations for mental health coverage have succeeded in persuading the courts to focus on the causes of the illness or condition involved. In other cases, the courts have instead accepted insurers' arguments that for determining insurance coverage the manifestations or symptoms of the illness involved are more critical than the origin of the problem. Accordingly, it is necessary to explore the various judicial treatments of challenges to policy limits on coverage for serious mental illness.

Advocates for persons suffering from serious mental illness achieved a significant judicial victory in a 1987 Arkansas decision, *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*.[35] In *Doe*, the challenger and his minor daughter were insured under a group health insurance policy issued by Blue Cross.[36] The insured's daughter, who suffered from bipolar affective disorder, underwent hospitalization and other treatment.[37] Although the Blue Cross policy provided broad coverage for other physical illnesses, the group policy included only limited benefits for "mental, psychiatric, or nervous conditions."[38] Moreover, the policy did not set forth definitions of either mental or psychiatric conditions.[39] When the insured submitted a claim for his daughter's hospitalization and medical care, Blue Cross paid only those limited benefits for mental conditions.[40] The insured sued for recovery of the full policy benefits for physical illnesses and prevailed at the trial court.[41] The Arkansas Court of Appeals affirmed, agreeing that "the issue for [the trial court's] determination was whether bipolar affective disorder is a physical illness or a mental or psychiatric condition within the terms of the policy."[42] The Court of Appeals then refused to overturn the trial court's factual finding that the patient's illness was a physical condition.[43] Accordingly, *Doe*

35. 733 S.W.2d 429 (Ark. Ct. App. 1987) (en banc).
36. *Id.* at 430.
37. *Id.* at 431.
38. *Id.* at 430.
39. *Doe*, 733 S.W.2d at 430.
40. *Id.* at 431.
41. *Id.* at 430.
42. *Id.* at 432.
43. *Doe*, 733 S.W.2d at 432. At the trial court one of the insured's experts testified that the medical research identifying bipolar affective disorder as a physical illness was overwhelming. *Id.* at 431. That expert also testified that "most physicians and most people in psychiatry

represents the first judicial recognition that bipolar affective disorder, one of the serious mental illnesses, is actually a physical illness of the brain.[44]

Similarly, in *Kunin v. Benefit Trust Life Insurance Co.*,[45] an insured sued for reimbursement for the treatment of his son's autism.[46] The health insurance policy at issue did not define mental illnesses for purposes of coverage, but the insurer paid only the $10,000 policy limit for "mental illness or nervous disorders."[47] The insured sought to establish that autism was not a "mental illness" for purposes of the policy and argued that the insurance company should have paid the full amount of all medical bills.[48] Accordingly, Kunin offered expert testimony from psychiatrists that the term "mental illness" refers to "a behavioral disturbance with no demonstrable organic or physical basis" and that autism falls outside that definition of mental illness.[49] The expert for the insurance company offered definitions of "mental illness" that focused on the affected individual's symptoms and func-

now classify illnesses by cause or origin." *Id.* Although Blue Cross urged that bipolar affective disorder should be considered a mental condition because its symptoms impact a person's mental state, the court of appeals concluded that there was credible evidence before the trier of fact that medical professionals are classifying these illnesses by their cause or origin, and not by the symptoms. *Id.* at 432.

44. For a more recent case that follows *Doe*, see Rosenthal v. Mut. Life Ins. Co., 732 F. Supp. 108, 109-11 (S.D. Fla. 1990). In *Rosenthal*, the insured sought medical expenses for the treatment of his son's bipolar affective disorder. *Id.* at 109. The insurance company paid only the $10,000 lifetime limit for the treatment of "mental and nervous disorders." *Id.* As in *Doe*, the policy did not further define mental illness. *Id.* The court denied the insurance company's motion for summary judgment determining that "reasonable persons could find that Bipolar Affective Disorder is a physical illness which manifests itself through mental symptoms, such that the medical expenses incurred . . . are not limited by the limitations clause of the policy." *Rosenthal*, 732 F. Supp. at 110-11.

45. 910 F.2d 534 (9th Cir.), *cert. denied*, __ U.S. __, 111 S. Ct. 581, 112 L. Ed. 2d 587 (1990). The case was litigated in federal court because the group health and medical policy in question was an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461 (1988).

46. *Kunin*, 910 F.2d at 535. Autism is a pervasive developmental disorder in which a child is very unresponsive to other people, has grossly impaired communication skills, and demonstrates bizarre responses to certain elements in the environment. ROBERT J. WALDINGER, FUNDAMENTALS OF PSYCHIATRY 259-60 (1986). The precise cause is unknown, but research suggests that genetic and organic factors play a prominent role. *Id.* at 261.

47. *Kunin*, 910 F.2d at 535. The actual medical bills for treatment of the child's autism exceeded $50,000. *Id.*

48. *Id.*

49. *Id.* at 536. Experts also opined that families of persons with autism do not commonly consider it to be a mental illness. *Id.*

tional impairment.[50] The Ninth Circuit determined that the term "mental illness" as used in the policy was ambiguous, at least with respect to autism.[51] Accordingly, the court invoked the rule of *contra proferentem* and construed the ambiguity against the insurance company.[52] The court of appeals accepted the trial court's finding that autism was not a mental illness for purposes of the policy in question.[53]

Another recent case addressing the nature of the term "mental illness" was *Phillips v. Lincoln National Life Insurance Co.*[54] In *Phillips*, the insured's son suffered from organic brain syndrome, a disease classified by the American Psychiatric Association as a mental disorder.[55] The insured sued to recover medical expenses in excess of a lifetime cap that the policy provided for "mental illness," a term that the policy left undefined.[56] The insured, much like the insured in *Kunin*, urged that the term "mental illness" must apply "only to those illnesses with non-physical causes, such as illnesses traceable to abuse suffered in one's childhood or to other types of traumatic experiences."[57] The insurance company maintained that "an illness is a mental illness if its symptoms are extremely abnormal behavior."[58] The court found that the term "mental illness" was ambiguous in the policy and followed the lead of the *Kunin* court in applying the rule of *contra proferentem*.[59] Accordingly, the court opined that it was "by no means clear" that the average reader of the insurance policy would

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50. *Id.*

51. *Kunin*, 910 F.2d at 541. The court observed that the policy contained no definitions, explanations, or illustrations of any conditions included or excluded by the term "mental illness." *Id.*

52. *Id.* at 539. The court explained that under the rule of *contra proferentem*, a court must construe ambiguities in insurance contracts against the insurer. *Id.* The court noted that the rule stems from the principle of contract construction that ambiguities "will be resolved against the drafter" of an instrument. *Id.* (quoting ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES § 6.02, at 286 (2d ed. 1988)). The court rejected the argument that the principle of *contra proferentem* was inapplicable in ERISA cases. *Id.* at 540-41.

53. *Id.* at 541-42.

54. 774 F. Supp. 495 (N.D. Ill. 1991).

55. *Id.* at 497 (citing AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed., 1987) (DSM-III-R)). Doctors believe that Phillips's condition involved a physical abnormality in the right posterior part of his brain. *Id.*

56. *Id.* at 496-97.

57. *Id.* at 499. Accordingly, the term "mental illness" would not include "behavioral problems traceable to an organic or physical cause. . . ." *Id.*

58. *Phillips*, 744 F. Supp. at 499.

59. *Id.* at 502.

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recognize organic brain syndrome as a mental illness.[60] Thus, the court held that the limitation of coverage for mental illness did not apply to the illness in question.[61]

In cases such as *Doe*, *Kunin*, and *Phillips*, the courts have been receptive to arguments about the physical origins or causes of the diseases in question. Upon finding the various illnesses at issue in those cases to be physical in origin, those courts have refused to find applicable the insurance policies' limits for mental illness coverage. Given the recent findings concerning the biological bases for the severe mental illnesses, these cases provide encouragement for persons challenging insurance coverage limits for mental illness.

On the other hand, several recent challenges to insurance policy limits for mental illness have proven to be unsuccessful. For example, in *Equitable Life Assurance Society v. Berry*,[62] the insured became totally disabled with respect to his occupation as a result of manic-depressive illness, also known as bipolar affective disorder.[63] Although Berry's employer provided both medical insurance and long-term disability coverage, both policies limited coverage for mental illness.[64] Similar to the insured in *Doe*, Berry asserted that manic depression is a physical illness, not a mental disorder, and that the policy coverage limitations for "mental/nervous disorders" should not apply to him.[65] However, the California Court of Appeals declined to focus on the cause of a person's illness to determine whether that illness falls within an insurance policy's exclusion or limitation for mental illness coverage.[66] Instead, the *Berry* court opined that "[m]anifestation, not cause, is the yardstick" for determining whether a person's disorder is to be considered a mental illness for purposes of an insurance policy.[67]

60. *Id.*

61. *Id.*; *accord* Malerbi v. Central Reserve Life of North Am. Ins. Co., 407 N.W.2d 157, 163-64 (Neb. 1987) (upholding trial court's finding that organic brain syndrome was not mental illness for purposes of limited policy coverage for mental illness).

62. 260 Cal. Rptr. 819 (Cal. Ct. App. 1989).

63. *Id.* at 821.

64. *Id.* The medical plan provided coverage of only $500 per year for outpatient "mental and/or nervous" treatment, and the long-term disability policy completely excluded "mental or nervous disorders" from coverage. *Id.* Berry submitted claims under both policies which the insurer rejected in full except for the $500 annual limit under the medical plan. *Id.*

65. *Id.* at 821.

66. *Berry*, 260 Cal. Rptr. at 824 n.2.

67. *Id.* at 824. The court also suggested that it is "hornbook law that words in an insurance policy are to be interpreted according to the plain meaning which a layman would ordinarily attach to them." *Id.* at 823.

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Because Berry's experts described some of the symptoms of manic depression to include delusions and hallucinations, the court concluded that "[e]very reasonable layman would view a person manifesting such derangement as suffering from a mental disease" excluded from coverage.[68] Accordingly, the court reasoned that the policy excluded any mental disease, regardless of the cause.[69]

The Eighth Circuit has also accepted the argument that a biologically-based mental illness should be subject to an insurance policy's limits for mental disorders. In *Brewer v. Lincoln National Life Insurance Co.*[70] the court, like the California court in *Berry*, focused on the symptoms of mental illness, rather than the causes.[71] In *Brewer*, the insured's son suffered from affective mood disorder and required hospitalization.[72] The insured filed claims for his son's treatment under two different policies that were in effect at different phases of his son's medical care.[73] The trial court ruled that the benefits limitations applied under the first policy, which limited benefits for "psychiatric care."[74] The trial court also found that the coverage limitations under the second policy did not apply.[75] The Eighth Circuit, however, de-

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68. *Id.* at 824. Although Berry's experts testified that the illness had a physical origin and is a physiological disease, implicit in the court's opinion is that a "reasonable layman" would only focus on manifestations of the illness. *See id.* (noting court's assessment of probable laymen's opinion). In addition, the court found probative that Berry's only physicians had been psychiatrists. *See id.* (discussing policy's hospitalization requirement for coverage). Presumably, the court's "reasonable layman" would somehow rely on that information to "know" that Berry's illness was an excluded mental illness. *Id.*

69. *Id.* at 824-25. Apparently, the court believed that any illness or even physical injury that affected the brain was excluded. *See id.* at 824 (emphasizing policy exclusion for mental disease of any kind). The court commented that "regardless of whether the disability was caused by a chemical imbalance, a blow on the head, [or] being frightened by a black cat . . . mental disorders are expressly 'not covered.' Period." *Id.*

70. 921 F.2d 150 (8th Cir. 1990), *cert. denied*, __ U.S. __, 111 S. Ct. 2872, 115 L. Ed. 2d 1038 (1991).

71. *See id.* at 154 (drawing conclusion based upon manifestations of disorder).

72. *Id.* at 152. Based on the testimony of the treating physician, the trial court found that Rob Brewer's disorder was "a hereditary disease characterized by a disturbance of catecholamines in the brain which produces a symptom of depression." Brewer v. Lincoln Nat'l Life Ins. Co., 730 F. Supp. 292, 295 (E.D. Mo. 1989), *aff'd in part and rev'd in part*, 921 F.2d 150 (8th Cir. 1990), *and cert. denied*, __ U.S. __, 111 S. Ct. 2872, 115 L. Ed. 2d 1038 (1991).

73. *Brewer*, 921 F.2d at 152.

74. *Id.* The first policy limited its coverage for "charges associated with 'mental illness(es), functional nervous disorder(s) . . . or for psychiatric or psychoanalytic care' to a maximum of $50,000." *Id.*

75. *Id.* The second policy also had a $50,000 monetary limit, but that limit applied to charges for the care of "mental illness(es)." *Id.* Neither policy further defined the term "mental illness." *Id.* The trial court reasoned that, although Brewer did not suffer from a

termined that the limitations set forth in both policies should apply to the medical expenses at issue in the case.[76] The court reasoned that it should construe the terms of the insurance contracts according to ordinary laypersons' understandings.[77] Accordingly, the court concluded that laypersons are inclined to focus on the symptoms of an illness rather than the cause of those symptoms.[78]

Thus, the courts in both *Berry* and *Brewer* refused to recognize the significance of recent medical findings regarding the causes of serious mental illness. Instead, these courts construed insurance policy limitations by focusing upon the manifestations or symptoms of a mental illness.[79]

Another somewhat recent case resulted in a New York court's fo-

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mental illness, because of the physical aspects of his condition, the hospital charges had been for "psychiatric care" for purposes of the first policy's limits. *Id.* at 152-53.

76. *Id.* at 154.

77. *Brewer*, 921 F.2d at 154. Since ERISA governed the two insurance plans at issue, the court examined whether Missouri's rule of construction requiring that ambiguities in insurance contracts be construed against the insurer—the *contra proferentem* rule—should apply. *Id.* at 153. In declining to apply the *contra proferentem* rule, the court specifically rejected the approach taken by the Ninth Circuit in *Kunin. See id.* at 154 n.2 (stating explicitly court's rejection of *Kunin*). Instead, the *Brewer* court determined that ERISA preempts state rules of construction involving employee benefit plans and requires an application of a federal common law rule of construction. *Id.* at 153-54. The court opined that because ERISA requires that drafters of benefit plans use language calculated to be understood by the average plan participant, the court should accord all plan terms their ordinary laypersons' meaning. *Brewer*, 921 F.2d at 154.

78. *Id.* Ironically, the court reached this conclusion despite commenting that "[l]aymen undoubtedly are aware that some mental illnesses are organically caused . . . ." *Id.* The trial court had concluded that "mental illness stems from reaction to environmental conditions as distinguished from organic causes" and that "mental illness is often thought by lay persons as having nonphysical, psychological causes, in the Freudian sense, as opposed to an organic basis." *Brewer*, 730 F. Supp. at 297 (quoting *Kunin*, 696 F. Supp. at 1346-47). The National Depressive and Manic Depressive Association has indicated that "some 2.5 million people suffering from manic depression are losing out on benefits because the insurance industry focuses on the condition's symptoms and not its cause." *High Court Will Not Review Denial of Benefits for Bipolar Disorder*, 9 MENTAL HEALTH L. REP. 61, 62 (1991).

79. This approach is not new. *See, e.g.*, Rakoff v. World Ins. Co., 191 So. 2d 476, 477 (Fla. Dist. Ct. App. 1966) (holding despite assertions that patient's schizophrenia was physical in origin, that because illness affected her brain, insurance policy exclusions applied). Notwithstanding its holding, the *Rakoff* court asserted that its decision was "not to be construed to stand for the proposition that . . . mental disorders resulting incidently [sic] or inevitably from a prior physical infirmity, or *disease*, might not be covered under this type of insurance." *Id.* at 477-78 (emphasis added). Given the revelations of recent medical research that many of the serious mental illnesses are brain *diseases*, it is intriguing to speculate about the weight that Florida courts will give to *Rakoff* given that court's own suggested distinction for disease-induced mental disorders.

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cusing on neither the cause nor symptoms of a psychiatric condition, but on the nature of the treatment involved. In *Simons v. Blue Cross & Blue Shield*,[80] the insured's daughter suffered from anorexia nervosa and required multiple hospitalizations to stabilize her physical condition.[81] The insurance company refused to pay the full hospitalization charges, relying on the policy's limitation for psychiatric care.[82] The court decided the case without having to ascertain whether anorexia nervosa constituted a mental illness for purposes of the insurance policy.[83] Instead, the court reasoned that the purpose of the hospitalizations was to treat the physical aspects of malnutrition and hypotension, including naso-gastric feeding and medication.[84] Therefore, the court concluded that the hospitalizations constituted medical treatment, not psychiatric care.[85] The court stated that "[i]t is the physical condition, and the treatment required to deal with that condition, which is crucial, not the reason for the disorder."[86] Accordingly, the *Simons* court centered its analysis on the specific treatment involved in caring for the patient.

Both the manifestation/symptom approach, reflected in cases such as *Berry* and *Brewer*, and the *Simons* court's "manner of treatment" analysis are flawed methods of analyzing whether a particular mental illness should be subject to insurance coverage limits or exclusions. The Eighth Circuit postulated that because laypersons are inclined to

80. 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

81. *Id.* at 432. The court identified anorexia nervosa as an eating disorder, which although a psychiatric disease, often results in physical infirmities brought on by malnutrition. *Id.*

82. *Id.*

83. *See id.* at 434 (focusing on issue of care rather than cause).

84. *Simons*, 536 N.Y.S.2d at 434.

85. *Id.* at 434-35; *see* Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 993, 993 (1989) (noting court's reasoning in *Simons*). Although the *Simons* court avoided focusing on the cause of the patient's condition, Dr. Appelbaum has observed that *Simons* has elements in common with both *Doe* and *Kunin*. *Id.* at 993-94. Specifically, Dr. Appelbaum has observed that in all three cases

> the plaintiffs were successful in defining the disorder or the treatment as "physical," "medical," or simply nonpsychiatric. Second, they were able to obtain supportive and persuasive expert testimony. Third, all three courts applied a presumption that requires exclusionary terms in insurance policies to be interpreted narrowly, so as to favor policyholders.

*Id.*

86. *Simons*, 536 N.Y.S.2d at 434. The court opined that the policy's exclusion for psychiatric care would include "treatment, such as electroshock therapy and psychotropic medication, rendered to a patient who has been admitted to a psychiatric ward . . . ." *Id.*

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focus on the symptoms of illnesses, illnesses whose primary symptoms include "depression, mood swings and unusual behavior" would be "commonly characterized as mental illnesses [by laypersons] regardless of their cause."[87] One problem with this "layperson's understanding of symptoms" 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 treatments for mental illness, it follows that the average layperson's understanding of the term "mental illness" will change as well. Drafting insurance contracts in understandable language is a noble goal. However, it is also important not to limit or exclude health insurance coverage for serious brain diseases, or any other serious physical disease, based on a court's perception that the public is ignorant.

Moreover, to concentrate only on a disease's symptoms for purposes of identifying whether it is a physical or mental illness is unsatisfactory. Although the California court in *Berry* offered dictum that a coverage limitation for mental illness would exclude all mental disease "regardless of whether the disability was caused by a chemical imbalance, a blow on the head, [or] being frightened by a black cat,"[88] that view is questionable. If a court focuses only on the patient's symptoms regardless of cause, "an accident victim who exhibits abnormal behavior as the result of a traumatic head injury, a person suffering from brain cancer who develops unusual behavior and an elderly person who has contracted Alzheimer's Disease would all be considered mentally ill."[89] Presumably, the mythical "average layperson" would consider brain cancer or Alzheimer's to be physical diseases, despite symptomatologies that include bizarre behavior, mood swings, or depression. Correspondingly, similar manifestations or symptoms should not be enough to characterize mental illnesses that are inherently physical in etiology as being the same as mental conditions which are merely the result of stress, family problems, or similar, non-organic causes.

The *Simons* court's analysis that linked the definition of mental illness contained in an insurance policy exclusion to the nature of the

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87. *Brewer*, 921 F.2d at 154.

88. *Berry*, 260 Cal. Rptr. at 824.

89. *Phillips*, 774 F. Supp. at 501. The *Phillips* court commented further that certain conditions marked by symptoms of aberrant behavior "would not be considered mental illnesses." *Id.* Accordingly, the *Phillips* court specifically rejected the manifestations/symptom approach to identifying mental illnesses for purposes of insurance policy exclusions. *Id.*

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patient's treatment also has its shortcomings. In *Simons*, this approach enabled the sufferer of anorexia nervosa to recover full benefits because the nature of the treatment was for a physical condition—malnutrition—which the court deemed to be "medical treatment."[90] Accordingly, the court distinguished medical treatment from psychiatric treatment for purposes of the policy's coverage exclusion. Despite helping the insured in *Simons*, however, the court's approach may be of little assistance to those who suffer from the most serious mental illnesses.

For example, the medical world now recognizes serious mental illnesses such as schizophrenia and bipolar affective disorder as being biologically-based brain diseases. The primary treatment method for these diseases involves the use of antipsychotic drugs. Although taking medications is part of many types of medical treatment, the *Simons* court appeared to regard the administration of psychotropic drugs as merely being part of "psychiatric" treatment, not medical treatment.[91] This dictum by the *Simons* court is inconsistent with both the medical origins of major mental illnesses, such as schizophrenia and bipolar affective disorder, and the treatment of these diseases with medication.

Perhaps the treatment test suggested by the *Simons* court would have been more helpful had the court drawn a distinction between medical types of treatment—including the administration of antipsychotic medications—and treatment methods that are more psychological in their orientation, such as talk therapy or other counseling. This approach would create distinctions for coverage purposes between the biologically-based mental illnesses and emotional, behavioral, or coping problems that do not have a physical origin.

Given the advances in medical knowledge concerning serious mental illnesses, the *Doe*, *Kunin*, and *Phillips* courts have taken the best approach to analyzing insurance coverage limitations and exclusions for mental illness. If the insurer has not defined the term "mental illness" in its policy, then that term should be construed against the insurer and physical diseases of the brain should not be classified as mental illnesses. Thus, coverage limitations would not

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90. *Simons*, 536 N.Y.S.2d at 434-35.

91. *See id.* at 434. The court also seemed to rule out the possibility that a person "admitted to a psychiatric ward" or psychiatric hospital could receive medical treatment for a brain disease. *Id.*

apply to physical diseases of the brain despite the manifestations or symptoms of that disease. If a patient has a physical disorder, it is both unfair and discriminatory to provide less coverage for the disease merely because it affects the brain.

Despite the few successes that challengers to coverage limitations for mental illness have enjoyed in the courts, judicial victories may result in only short-term benefits for persons suffering from serious mental illnesses. Certainly, the prevailing plaintiffs in *Doe*, *Kunin*, and *Phillips* received full coverage for their prior medical bills. But these plaintiffs, as well as other sufferers of these diseases, might receive only limited benefits for treatment of their mental illnesses notwithstanding these judicial triumphs. In Arkansas, when the time came to renew policies following the decision in *Doe*, Arkansas Blue Cross & Blue Shield simply revised its exclusionary language to limit coverage for psychiatric illnesses "whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement."[92] Thus, despite judicial determinations about the physical origins of the major mental illnesses, insurers may simply react to such decrees by amending their policies to assure the continued discrimination against persons suffering from serious mental illnesses.[93] Accordingly, the pursuit of judi-

92. *See* Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 993, 994 (1989) (discussing exclusionary revision).

93. *Id.* Despite the potential that insurance companies will simply amend future policies, other persons suffering from severe mental illness are pursuing judicial actions to remedy discriminatory coverage limitations in current and former policies. The National Depressive and Manic Depressive Association is pursuing litigation against four large insurers asserting that the companies violated ERISA by classifying manic depression as a mental illness, not a physical disorder of the brain. *See* Doe v. Guardian Life Ins. Co., No. 89-C-7955, 1992 U.S. Dist. LEXIS 3214, at *2 (N.D. Ill. Mar. 19, 1992) (denying class status); Kevin Conlon, *Manic Depressives Face Tough Legal Battle for Greater Insurance Benefits*, CHI. DAILY L. BULL., Nov. 6, 1990, at 2 (discussing NDMDA'S actions). To avoid the problem of possibly prevailing in the litigation, but then having the insurers revise the policy limitations, the plaintiffs in *Doe* are seeking injunctive relief to prevent the insurers from classifying manic depression as a mental illness in future policies. *See Doe*, 1992 U.S. Dist. LEXIS 3214, at *3 (noting that plaintiffs are seeking injunctive relief); Kevin Conlon, *Manic Depressives Face Tough Legal Battle for Greater Insurance Benefits*, CHI. DAILY L. BULL., Nov. 6, 1990, at 2 (describing plaintiffs' goals). The plaintiffs in *Doe* are relying principally on the Ninth Circuit's decision in *Kunin* to support their arguments that manic depression is a physical or biological illness and that the court should construe ambiguous terms against the insurer. *Doe*, 1992 U.S. Dist. LEXIS 3214, at *4-*5 (citing *Kunin*, 910 F.2d at 536, 541). Not surprisingly, the insurance companies are relying heavily on an Eighth Circuit Court of Appeals decision which proposes that the court should not apply the *contra proferentum* rule because of ERISA but should, instead, construe the mental illness coverage limitations in the context of an "ordinary layper-

cial challenges to discriminatory insurance coverage for severe mental illnesses is probably not the best method to effect broad policy change.[94]

## IV. Legislative Responses to Discriminatory Insurance Practices

Because of both the mixed success of judicial challenges to discriminatory insurance coverage for serious mental illnesses and the potential that insurance companies will merely revise their policy limitations after losing a court case, state and federal legislation may be necessary to end the discrimination that insurers are waging against persons suffering from serious mental illness. Recently, advocates for persons with these diseases have taken significant initial steps at the state and federal level to alter the status quo with respect to mental illness coverage limitations and exclusions. Indeed, the halls of state legislatures and Congress are becoming the new battlegrounds in the fight for insurance parity for mental illnesses.

### A. *State Mandates*

State legislation mandating insurance coverage for mental illnesses is not new.[95] The traditional form of legislative mandate, however,

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son's" understanding about the symptoms, not the causes, of the illness. *See* Doe, 1992 U.S. Dist. LEXIS 3214, at *5-*7 (noting insurance companies' reliance on *Brewer* decision). Although the court has denied the plaintiffs' motion for class certification, the court did suggest a manner in which the plaintiffs could restructure their motion for class status. *Doe*, 1992 U.S. Dist. LEXIS 3214, at *61-*62, *75.

94. *See* ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 23 (1991) (suggesting that although "lawsuits cannot produce the kind of sweeping change that is needed in insurance[,] . . . legal action can serve as an important adjunct to other advocacy efforts"); *cf.* Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS. L. REV. 143, 159 (1991) (stating that developing case law may be impetus for benefits under worker's compensation); Jeffrey Rubin, *Discrimination and Insurance Coverage of the Mentally Ill, in* 8 ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH 195, 196-97 (1987) (describing unreported New Jersey decision sustaining challenge to insurance plan that extended health benefits to mentally retarded and physically disabled dependent adults—whose disability began in childhood—but did not extend coverage to disabled dependents who suffered from mental illness). Unlike the discrimination in insurance practices that is the focus of this article, the New Jersey litigation that Professor Rubin has addressed involved an insurer's complete exclusion of an entire class of disabled persons—the mentally ill. Jeffrey Rubin, *Discrimination and Insurance Coverage of the Mentally Ill, in* 8 ADVANCES IN HEALTH ECONOMICS AND HEALTH SERVICES RESEARCH 195, 196 (1987).

95. *See States Passed 41 New Coverage Mandates*, BNA PENSIONS & BENEFITS DAILY

has merely required insurers to provide some level of coverage for mental illnesses, not coverage similar to that provided for other physical illnesses.[96] That approach is beginning to change. State legislatures in California, Maine, and Texas have enacted statutes in recent years that have attempted to establish some level of parity for insurance coverage for serious mental illnesses. These legislative efforts represent an initial attempt to eradicate insurance discrimination against persons suffering from serious mental illnesses.[97]

State legislatures have the authority to mandate certain coverage levels for mental illness, or other ailments, as part of their ability to regulate insurance.[98] The United States Supreme Court has upheld the states' right to impose mandates for mental illness coverage on insurers.[99] Conversely, the Supreme Court has indicated that federal

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(BNA, Inc., Arlington, Va.), Mar. 31, 1992 (noting that at least 32 states mandate some level of coverage for "mental health care"). This type of legislation requires that insurers sell health insurance policies that include certain coverages or benefits. *See* Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS L. REV. 143, 156-57 (1991) (discussing current insurance mandates).

96. Although these mandates helped expand the pool of persons receiving mental health services, the insurance coverage has become "more shallow." *See* ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 14 (1991) (observing that by 1989 parity for inpatient coverage existed in only 21% of insurance plans, and only 3% of plans included outpatient coverage that was same as for general health care). An American Psychiatric Association Study of some 300 insurance plans revealed that only 6% of those plans provided coverage levels for inpatient and outpatient care for mental illness that equalled the coverage for other physical conditions. *See Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 4. *But cf.* LA. REV. STAT. ANN. § 22:669 (West Supp. 1992) (mandating that insurers offer policyholders optional provision that requires reimbursement for treatment of mental disorders at same level as "all other diagnoses, illnesses, or accidents").

97. The co-director of the Program for Humanities in Medicine at Yale Medical School has praised such legislative initiatives, commenting that "[m]andating that people must be granted insurance coverage for these conditions on a par with other medical diseases would not only make good medical sense, it would make good economic sense for . . . America." Enid Peschel, *Connecticut Opinion; Science Redefines Mental Illnesses*, N.Y. TIMES, May 6, 1990, § 12CN, at 42. Similarly, the National Alliance for the Mentally Ill has asserted, "These new laws will remove the artificial barriers to seeking mental illness services and alleviate the severe financial drain on personal resources." *Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 7.

98. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 758 (1985) (holding that mandated mental health insurance regulation was valid exercise of state power).

99. *See id.* at 746-47 (declining to impose limitation on savings clause). The statute at issue in *Metropolitan Life* merely specified minimum benefits for mental health care, not equal coverage. *See id.* at 727 (requiring minimum benefits to be provided). In *Metropolitan Life*,

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law preempts the ability of the states to impose similar mandates on fully self-insured employee benefit plans.[100] In turn, lower courts have determined that fully self-insured health care plans do not constitute insurance and, therefore, are not subject to state regulation.[101] Accordingly, state mandates may not reach a number of employees because their employers have chosen to self-insure.[102] However, state legislative initiatives requiring insurers to afford coverage levels for

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insurance companies asserted that ERISA preempted the states' ability to impose this type of mandated coverage on insured employee benefit plans covered by the act. *Id.* The court rejected this argument, reasoning that ERISA reserved the states' right to regulate insurance. *Id.* at 746. The court did, however, indicate that ERISA would preempt the states' ability to impose similar mandates on uninsured employee benefit plans because those mandates would not involve the regulation of insurance. *See Metropolitan Life*, 471 U.S. at 747 (reasoning that distinction created by Congress exists between insured and uninsured plans). *See generally* David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT L. REV. 427, 468-69 (1987) (outlining arguments presented in *Metropolitan Life*).

100. *See Metropolitan Life*, 471 U.S. at 748 (claiming that party which is self-insured may avoid state mandate).

101. *See, e.g.*, Insurance Bd. of Bethlehem Steel Corp. v. Muir, 819 F.2d 408, 412-13 (3d Cir. 1987) (holding that Blue Cross & Blue Shield was providing merely administrative services); Children's Hosp. v. Whitcomb, 778 F.2d 239, 242 (5th Cir. 1985) (concluding self-insured plan preempted by ERISA). *But see* Michigan United Food & Commercial Workers Union v. Baerwaldt, 767 F.2d 308, 313 (6th Cir. 1985) (refusing to find that ERISA preempted state mandate for substance abuse coverage with respect to employee benefit plan that was not entirely self-insured); Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS. L. REV. 143, 157-58 (1991) (noting court decision which held that company processing claims for self-insured firm not subject to state regulation).

102. *See* Richard G. Frank, *Regulatory Responses to Information Deficiencies in the Market for Mental Health Services, in* THE FUTURE OF MENTAL HEALTH SERVICES RESEARCH 113, 129 (Carl A. Taube et al. eds., 1989) (stating that increased state regulation has caused growth in number of self-insured firms). Although "[s]elf-insurance has been viewed as a means of escaping minimum benefit" laws, other factors such as avoiding state premium taxes and other tax advantages are also responsible for this trend. *Id.* Notwithstanding increases in the numbers of the self-insured, many employers with self-insured plans will opt to provide coverage for mental illnesses—despite the inapplicability of state mandates—either out of a sense of moral obligation or competitive practice. *See Mental Health Benefits Growing in Use and Cost*, J. OF ACCOUNTANCY, Mar. 1987, at 42 (citing reasons why companies offer mental health coverage to employees); *see also* Richard G. Frank, *Regulatory Responses to Information Deficiencies: The Market for Mental Health Services, in* THE FUTURE OF MENTAL HEALTH SERVICES RESEARCH 113, 129 (Carl A. Taube et al. eds., 1989) (commenting on empirical data that most self-insured employers have complied with state mandates). Of course, those self-insured plans that are exempt from state mandates because of ERISA need not comply with the mandate's terms. As one commentator has proffered, "ERISA has unintentionally given employers freedom from both federal and state regulations regarding what must, at minimum, be covered by employee health insurance plans." ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 8 (1991).

serious mental illnesses equal to the levels for other physical ailments can directly assist a significant number of insured individuals and can set a good example for the exempt, self-funded plans.[103]

Recently, California became the first state to pass legislation that requires insurers which offer any coverage for disorders of the brain, to cover "biologically-based severe mental disorders" in the same manner.[104] Enacted in 1989, the California legislation requires group disability insurers to provide coverages for specifically-enumerated mental illnesses with the same policy terms and conditions as for other brain impairments.[105] Although limited to coverages under disability policies, the statute represents the seminal legislative effort to distinguish benefits for biologically-based, serious mental illnesses from coverage for other "mental health" concerns.[106]

Maine is the most recent state to enact legislation providing insurance parity for persons suffering from serious mental illnesses. Governor McKernan signed the bill, entitled, *An Act to Provide Equitable Insurance Coverage for Mental Illness*, on April 10, 1992.[107] The new statute requires a four-year phase-in to establish equal coverages for certain enumerated mental illnesses.[108] Accordingly, the Act directs certain increasing levels of treatment coverages until 1996, when all

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103. Of course, even a legislative mandate for equal insurance coverage cannot assist those persons suffering from serious mental illnesses who have no health insurance. *Special Report: the Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 4.

104. CAL. INS. CODE § 10123.15 (West Supp. 1992). *But see* LA. REV. STAT. ANN. § 22:669 (West Supp. 1992) (requiring optional plan). The Louisiana statute enacted in 1981 did not directly mandate equal insurance coverages but required insurers to *offer* policyholders an optional provision for reimbursement of treatment for mental disorders at levels equal to benefits for "all other diagnoses, illnesses, or accidents." *Id.*

105. CAL. INS. CODE § 10123.15 (West Supp. 1992). The statute defines "biologically-based severe mental disorders" to include "schizophrenia, schizo-affective disorders, bipolar and delusional depressions, and pervasive developmental disorder [autism]." *Id.*

106. California Assemblyman Bruce Bronzan, the sponsor of the legislation, commented, "Medical technology is making daily advances in the research and detection of mental disorders. We need to continually work toward enacting public policy which reflects these advances." ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 83 (1991) (containing press release issued by NAMI on Sept. 25, 1989, which quotes Mr. Bronzan). The bill sponsor also stressed that "[i]t is time we accepted that mental disorders such as schizophrenia and manic depression can be just as debilitating, costly, and tragic to patients and their families as heart disease or cancer." *Id.*

107. 1991 Me. Laws 881.

108. *Id.* The new statute is applicable to the "usual, customary and reasonable" charges for medical treatment for schizophrenia, bipolar disorder, autism, childhood schizophrenia,

state policies "must provide benefits equal to benefits provided for other illnesses."[109] Thus, Maine has taken significant strides in recognizing that serious mental illnesses are diseases much like other physical diseases of the body.[110]

### B. *A Legislative Case Study: Texas*

Like California and Maine, the Texas Legislature has also recently enacted legislation attempting to afford insurance coverages for serious mental illnesses at the same levels as those for other physical maladies.[111] Similar to the California and Maine enactments, the Texas legislation identifies certain mental illnesses that insurers must cover in the same manner as other physical illnesses.[112] The legislative process associated with the enactment of this Texas statute offers illuminating insights into the battles that proponents of equal insurance coverages for serious mental illnesses must face in attempting to obtain favorable legislation.

The Texas legislation originated as separate bills filed in the Texas Senate and House of Representatives.[113] Although the Texas Senate passed a version of this stand-alone legislation, Senate Bill 644,[114] the bill died in the Texas House. Nonetheless, in the closing days of the legislative session—after it became apparent that the bill was hopelessly stalled in the Texas House—Senator Mike Moncrief offered the

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psychotic depression, major depressive disorder, paranoia, panic disorder, and obsessive-compulsive disorder. *Id.* at §§ 1, 3.

109. *Id.*

110. *See* National Alliance for the Mentally Ill, *Maine Alliance Champions Fairness in Health Insurance*, NAMI ADVOCATE, May/June 1992, at 1 (indicating that executive director of Maine Alliance for the Mentally Ill felt that state legislature was persuaded by fairness concerns). The director stated, "Once the legislators acknowledged that biological mental illnesses exist, they clearly recognized the fundamental unfairness of higher co-payments and deductibles for mental illness." *Id.* The legislative sponsor of the act, Susan Dore, is a member of the National Alliance for the Mentally Ill and "won the empathy of her colleagues and the governor by telling of growing up in a family impoverished by lack of insurance coverage for a family member with bipolar illness." *Id.*

111. *See* TEX. INS. CODE ANN. arts. 3.50-2, 3.50-3, 3.51-5A, 3.51-14 (Vernon Supp. 1992) (amending several sections of Texas Insurance Code).

112. *Id.* The statute defines "serious mental illness" to include schizophrenia, paranoid and other psychotic disorders, bipolar disorder, major depressive disorder, and schizo-affective disorder as those illnesses are "defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM-III-R)." *Id.* art. 3.50-2, § 3 (19), art. 3.50-3 § 3 (16), art. 3.51-14 § 1.

113. Tex. S.B. 644, 72d Leg., R.S. (1991); Tex. H.B. 1255, 72d Leg. R.S. (1991).

114. S.J. of Tex., 72d Leg., R.S. 1017-20 (1991).

text of Senate Bill 644 as an amendment to a lengthy insurance reform bill.[115] This tactic was successful, and after further amendment,[116] the Texas Legislature enacted the language requiring equal insurance coverages for serious mental illnesses as part of the broader insurance reform legislation.[117]

The legislative process involved in the ultimate passage of the Texas insurance statute reveals the dichotomy between the views held by advocates for equal coverages for serious mental illnesses and the views of the insurance industry. During state senate committee hearings on the legislation, the senate sponsor of the bill emphasized that it was his intent "to end discrimination in health insurance policies to provide the same coverage for biologically-based mental illnesses as for other physical illnesses such as liver disease [and] diabetes."[118] Indicating that serious mental illnesses are the diseases most discriminated against by insurers, the senate sponsor observed that "discrimination does not reflect sound economics, but is the product of confusion, misunderstanding, and prejudice."[119] Similarly, the chief medical officer for the Texas Department of Mental Health and Mental Retardation testified in support of the bill by discussing the

115. *See* S.J. of Tex., 72d Leg., R.S. 2221-24 (1991) (containing sweeping changes to insurance regulation). *Id.*

116. S.J. of Tex., 72d Leg., R.S. 2814 (1991).

117. *See* Act of June 6, 1991, 72d Leg., R.S., ch. 242, §§ 11.106-.112, 1991 Tex. Sess. Law Serv. 939, § 1118-20 (Vernon) (now codified as TEX. INS. CODE ANN. art. 3.50-2, §§ 3(19), 5(j), art. 3.50-3, § 3(a), art. 3.50-3, § 4A, arts. 3.51-5A, 3.51-14 (Vernon Supp. 1992)). The legislation as finally enacted specifically requires insurance parity in coverages for serious mental illnesses in policies provided to employees of state agencies, institutions of higher education, school districts, cities, counties, and other units of local government. TEX. INS. CODE ANN. § 3.50-2, §§ 3 (19), 5(j), art. 3.50-3, § 3(a), art. 3.50-3, § 4A, art. 3.51-5A (Vernon Supp. 1992). The legislature deleted another section of the bill in the last days of the session that would have specifically precluded group health insurers for private sector policies from providing coverages for serious mental illnesses at levels less than those provided for other physical illnesses. S.J. of Tex., 72d Leg., R.S. 2814 (1991). Instead, the legislature enacted a similar provision in another section of the bill which requires that insurers for the private sector must "offer and make available" to employers or other group policyholders coverage for serious mental illnesses that is "at least as favorable as the coverage . . . for other major illnesses . . . ." TEX. INS. CODE ANN. art. 3.51-14 (Vernon Supp. 1992). The legislature titled this section, "Mandatory Provision of Benefits for Certain Serious Mental Illnesses." *Id.*

118. *Hearing on Tex. S.B. 644 Before the Senate Economic Dev. Comm., Subcomm. on Ins.*, 72d Leg., R.S. (Apr. 4, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (introductory remarks by Sen. Moncrief).

119. *Id.*

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medical nature of serious mental illnesses.[120] In addition, the state house committee that considered the bill made findings that serious mental illnesses, such as schizophrenia and bipolar disorder, "are biologically-based and are not deficiencies of mind or character."[121] By way of contrast, opponents of the legislation warned of increased costs associated with expanded coverage levels and the problems of distinguishing serious mental illnesses from other emotional problems.[122]

The primary argument against new legislation requiring equal insurance coverages for the severe mental illnesses centered on potential cost increases.[123] When the Texas Senate first debated Senate Bill 644 in 1991, one of the opposition senators argued that "we are never going to be able to get a reduction in premiums if we continue to expand these coverages."[124] That same senator also suggested that insurance costs and premiums "would skyrocket if insurance companies are forced to cover mental illnesses."[125] The insurance industry raised similar concerns about the prospects of increased costs in Maine prior to the enactment of that state's new equal insurance law.[126]

Proponents of legislative changes regarding insurance coverages for severe mental illnesses, however, have strongly refuted the industry's arguments about increased costs. In Texas, for example, the insurance industry based its claims about rising costs for mental health

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120. *Id.* He testified that the "brain is no less physical than the heart or stomach and these illnesses are accepted as medical conditions by every reasonable medical authority." *Id.*

121. HOUSE COMM. ON INS., BILL ANALYSIS, Tex. S.B. 644, 72d Leg., R.S. (1991).

122. *See, e.g., Hearing on Tex. S.B. 644 Before the Senate Economic Dev. Comm., Subcomm. on Ins.*, 72d Leg., R.S. (Apr. 4, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (recording testimony of opposition witnesses); Debate on Tex. S.B. 644 on the Floor of the Senate, 72d Leg., R.S. (Apr. 24, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (containing remarks by Sen. Montford & Sen. Leedom).

123. For example, the Texas House Insurance Committee found that "[i]nsurance companies are quick to claim that mental health benefits are among the fastest rising health-care expenses." HOUSE COMM. ON INS., BILL ANALYSIS, Tex. S.B. 644, 72d Leg., R.S. (1991); *see Senate Bill Would Require Insurance to Cover Mental Illness*, UPI, Apr. 24, 1991, *available in* LEXIS, Nexis Library, UPST91 File, at 1 (noting findings of committee).

124. Debate on Tex. S.B. 644 on the Floor of the Senate, 72d Leg., R.S. (Apr. 24, 1991) (tape of debate on file with *St. Mary's Law Journal*) (comments of Sen. Montford).

125. *See Senate Bill Would Require Insurance to Cover Mental Illness*, UPI, Apr. 24, 1991, *available in* LEXIS, Nexis Library, UPST91 File, at 1 (quoting Sen. Montford).

126. *See* National Alliance for the Mentally Ill, *Maine Alliance Champions Fairness in Health Insurance*, NAMI ADVOCATE, May/June 1992, at 1. The governor of Maine threatened to veto the legislation because of the specter of increased costs, but he ultimately signed the bill. *Id.*

care on figures for all mental care coverage, not on an analysis of charges for just the biologically-based, serious mental illnesses.[127] Once the costs for treating these other problems such as substance abuse and emotional or behavioral troubles are excluded, the cost of providing equal levels of coverage for the serious mental illnesses is relatively modest. For instance, the Coopers & Lybrand accounting firm undertook a study for the California Medical Association and California Psychiatric Association which reflected an expected health premium increase of $0.78 per month to cover the severe mental illnesses on an unlimited basis.[128] Similarly, a Minnesota study revealed that providing non-discriminatory insurance coverage for the biologically-based mental illnesses in that state would increase premiums approximately $0.50 per month,[129] and a Maryland study opined that this coverage would add only about $0.89 per month.[130]

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127. *See* Bill Analysis, HOUSE COMM. ON INS., BILL ANALYSIS, Tex. S.B. 644, 72d Leg., R.S. (1991) (finding that "the statistics and references used by these [insurance] companies include all costs for treatments for nicotine dependency, alcohol and drug abuses, stress problems, and childhood behavioral problems, in addition to serious mental illness"). Focusing on the costs of these other treatments distorts the cost of insurance and treatment for serious mental illnesses. In addition, at the Texas legislative hearings on Senate Bill 644, the Texas Alliance for the Mentally Ill directed the senators' attention to a state insurance board regulation that identifies as unfair discrimination by an insurer's limitation of coverages "solely because of a physical or mental impairment" unless the limitation "is based on actuarial principles or is related to actual or reasonably anticipated experience." *See Hearing on Tex. S.B. 644 Before the Senate Economic Dev. Comm., Subcomm. on Ins.*, 72d Leg., R.S. (Apr. 4, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (testimony of Jacqueline Shannon). Ironically, when queried about actual insurance cost experiences regarding biologically-based mental illnesses, insurance representatives at the Texas hearings indicated that they did not have any actual data for just those illnesses. Interview with Jacqueline Shannon, President, Texas Alliance for the Mentally Ill, in San Angelo, Tex. (June 6, 1992). Ms. Shannon, who is the author's mother, was present and testified at the state senate hearings on Senate Bill 644.

128. Memorandum from Sue North, Cal. Psychiatric Ass'n to Interested Parties (Mar. 18, 1991) (on file with *St. Mary's Law Journal*); *see Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 4 (noting report of projected cost increases). A representative of the Texas Society of Psychiatric Physicians provided testimony about the Coopers & Lybrand study to the Texas Senate during hearings on the Texas insurance parity bill. *See Hearing Tex. on S.B. 644 Before the Senate Economic Dev. Comm., Sub Comm. on Ins.*, 72d Leg., R.S. (Apr. 4, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (recording testimony of Bob McFarland).

129. *See* John Krizay, *Analysis & Cost Estimates; Proposed Equal Mental Illness Coverage: Minnesota Residents*, *in* ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 87, 88 (1991) (noting results of Minnesota study).

130. *See Maine Alliance Champions Fairness in Health Insurance*, NAMI ADVOCATE, May/June, 1992, at 1 (reporting Maryland study).

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Although there is the potential for a slight increase in costs associated with requiring insurers to cover serious mental illnesses at the same levels as coverages for other physical diseases, this type of legislation may actually reduce state expenditures for persons with these illnesses. With a greater availability of private insurance, patients in state mental health facilities or those who receive care from community mental health centers may be able to obtain care in private facilities.[131] Similarly, if patients who are receiving services from state or community mental health facilities opt to continue to receive services from public providers, insurance reimbursement for those persons would flow to the state or community mental health center.[132] In connection with the recent Texas legislative effort, the Texas Legislative Budget Board concluded that the bill would cause some insurance reimbursement to be paid to the state and to community mental health centers for patients who continue to obtain care through public facilities.[133] Thus, from a public policy perspective, state legislators could consider legislation of this type to be a method of shifting expenses from the public sector to the private sector.

Opponents of the Texas legislation not only expressed concerns about costs but also questioned the scope of the intended coverage of the bill. As introduced, the proposed legislation addressed insurance coverage for "biologically-based mental illness" which was defined as a "serious mental illness that current medical science affirms is caused by a physiological disorder of the brain and that substantially limits the life activities of the person" affected by the illness.[134] On the floor of the Texas Senate, one of the opposition senators expressed concerns

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131. *See* Richard G. Frank & Thomas G. McGuire, *Mandating Employer Coverage of Mental Health Care*, HEALTH AFFAIRS, Spring 1990, at 35 (discussing availability of insurance and care centers). By way of contrast, if insurance benefits for these diseases continue to decline, more persons will have to rely exclusively on the public mental health system for care. *Id.*

132. *See id.* (noting possibility that state might receive reimbursement).

133. *See* FISCAL NOTE, Tex. S.B. 644, 72d Leg., R.S. (1991) (attempting to reform insurance coverage for diseases of the brain). The fiscal note did not analyze the extent to which the state could save money through the shift from the public sector of patients who would become able to opt for care through private providers because of increased insurance benefits. *Cf. Hearing on Tex. S.B. 644 Before the Senate Economic Dev. Comm., Subcomm. on Ins.*, 72d Leg., R.S. (Apr. 4, 1991) (tape of hearing on file with *St. Mary's Law Journal*) (commenting that "it seems logical that private coverage funded by premiums and managed largely in the private sector, might eventually ease some of the burden on state and community mental health services").

134. Tex. S.B. 644, 72d Leg., R.S. (1991). The bill further defined "biologically-based

about the definition of "biologically-based mental illness," contending the term was too open-ended.[135] Certainly, if the purpose of the legislation is to assure equal coverages for those mental illnesses with a physiological or organic cause rather than other mental conditions or emotional problems, this type of legislation must not be overly broad in its use of terminology. In recognition of this concern, proponents of the legislation worked with the opposition senators to reach a compromise regarding the definition of "serious mental illness."[136] Accordingly, the Texas Senate amended the bill and adopted language defining certain biologically-based mental illnesses as defined by the American Psychiatric Association.[137] Although this version of the legislation died in the Texas House, the compromise language defining the covered illnesses became part of the statutory sections that the legislature ultimately adopted.[138] Thus, after much effort, Texas has made strides in attempting to end discriminatory insurance treatment for persons suffering from serious mental illnesses.[139]

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mental illness" as including such illnesses as schizophrenia, bipolar disorder, and major depressive illness. *Id.*

135. Debate on Tex. S.B. 644 on the Floor of the Senate, 72d Leg., R.S. (Apr. 24, 1991) (tape of debate on file with *St. Mary's Law Journal*) (testimony of Sen. Montford). Senator Montford also queried the bill sponsor about whether the identification of these illnesses was subjective in nature. *Id.* Interestingly, during the committee hearings on the bill, the chief medical officer for the Texas Department of Mental Health and Mental Retardation testified, "S.B. 644 does not address parity for non-serious mental illness, for stress disorders, family problems, and the like. The fears expressed by insurance carriers that they will be deluged with claims are largely unfounded." Hearing on S.B. 644, Senate Economic Dev. Comm., Subcomm. on Ins., 72d Leg., R.S. (Apr. 4, 1991) (tape of debate on file with *St. Mary's Law Journal*) (testimony of Dr. William H. Reid).

136. *See* Debate on Tex. S.B. 644 on the Floor of the Senate, 72d Leg., R.S. (Apr. 25, 1991) (tape of debate on file with *St. Mary's Law Journal*) (remarks of Sen. Moncrief, the bill sponsor).

137. *See* S.J OF TEX., 72d Leg., R.S. 1018-20 (1991) (incorporating by reference definitions from American Psychiatric Association's diagnostic manual, DSM-III-R).

138. TEX. INS. CODE ANN. arts. 3.50-2, 3.50-3, 3.51-5A, 3.51-14 (Vernon Supp. 1992).

139. Subsequent to the legislative initiative, the Texas Department of Insurance has taken additional steps to eradicate discriminatory insurance treatment through regulatory action. With respect to long-term care insurance, the state insurance board has previously permitted insurers to limit or exclude coverage for "mental or nervous disorders." Tex. Ins. Bd., 28 TEX. ADMIN. CODE § 3.3826 (West Supp. Oct. 1, 1991). Recently, however, the board has proposed excepting "biologically-based brain diseases/serious mental illness" from the exception for "mental or nervous disorders." Tex. Ins. Bd., 17 Tex. Reg. 1511 (1992) (prop. amend. to 28 TEX. ADMIN. CODE § 3.3826).

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### C. *Federal Initiatives*

Because of the rising costs of health care generally and the millions of persons in the United States who have no health insurance at all, several health reform initiatives are working their way through Congress.[140] These health care reform bills are intended to increase access to health care. The National Alliance for the Mentally Ill has been critical of some of these bills, however, because they maintain discrimination against coverages for severe mental illnesses.[141] Partly out of concern that many health reform bills are not addressing coverage for mental illness, on May 12, 1992, Senator Pete Domenici of New Mexico introduced legislation that would establish a comprehensive policy regarding the provision of insurance coverage and services to persons suffering from severe mental illnesses.[142] The Domenici bill would require that public or private health care coverage "provide for the treatment of severe mental illnesses in a manner that is equitable and commensurate with that provided for other major physical

140. *See Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 1-3 (noting legislative action).

141. *See id.* (criticizing bills); *see also Update: Health Insurance Reform for Persons with Mental Illness*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), June 1992, at 2-4 (citing problems with proposed legislation). For example, the National Alliance for the Mentally Ill [NAMI] has criticized Senate Bill 1227, S. 1227, 102d Cong., 1st Sess. (1991), which is a multi-payer plan that would allow businesses to choose whether to provide certain minimum health care benefits or contribute approximately 7% of their payrolls to fund a new public insurance program. *Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 5. NAMI chose not to endorse the bill because it "continues to unfairly differentiate between diseases of the brain and diseases affecting other organs of the body" with respect to copayments and low caps on inpatient days and outpatient medical visits. *Id.* Additionally, NAMI has been sharply critical of Senate Bill 1872, S. 1872, 102d Cong., 1st Sess. (1991), sponsored by Senator Bentsen. *See Update: Health Insurance Reform for Persons with Mental Illness*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), June 1992, at 2-3 (criticizing bill deficiencies). The Bentsen bill would create a "standard" benefit package and a "basic" benefit package. NAMI concluded that the Bentsen bill could result in persons with severe mental illnesses being worse off than under the current system, in particular because the bill would also disallow all state mandates. *Id.* at 3.

142. S. 2696, 102d Cong., 2d Sess. (1992). In observing that Congress should include mental illness coverage in the debate over health insurance reform, Senator Domenici stated, "We must see that people with mental illness are not left on the sidelines under the guise of cost containment." *See NAMI Petitions Congress to End Health Insurance Discrimination*, NAMI ADVOCATE, May/June 1992, at 1, 6.

illnesses."[143] The Domenici bill represents a sensible and fair approach. Because serious mental illnesses are actually biologically-based brain diseases, insurers should treat them the same as other physical illnesses for coverage purposes. Accordingly, legislation such as the proposed Domenici bill should be a part of the debate for health care reform in this country. Given current medical knowledge, federal health care reform legislation should not perpetuate discriminatory coverage levels and outdated stigmas and stereotypes about serious mental illnesses.[144]

## V. Conclusion

In the last several years, medical science has made great advances in discovering many of the mysteries of the brain, including the identification of organic bases for a variety of severe mental illnesses. Accordingly, the medical world generally recognizes illnesses such as schizophrenia, bipolar disorder, and severe depressive illness as biologically-based diseases of the brain. Unlike insurance practices for other physical diseases, including other organic brain disorders, insurers generally provide much less coverage for serious mental illnesses than for other physical maladies.[145] If insurance companies are not

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143. S. 2696, 102d Cong., 2d sess. § 3 (1992). The Domenici bill delineates proposed findings concerning current discrimination in insurance coverages for treatments of severe mental illnesses and the problems associated with such unequal health insurance. *Id.* § 2. NAMI has indicated that the Domenici bill "could easily be inserted into any of the broader insurance reform plans" now before Congress. *Senator Domenici Introduces Landmark "Equitable Health Insurance Coverage of Severe Mental Illness Act,"* NAMI ADVOCATE, May/June 1992, at 1.

144. *Special Report: The Health Insurance Crisis in America*, NAMI LEGIS. NETWORK NEWS (Nat'l Alliance for the Mentally Ill, Arlington, Va.), Nov. 1991, at 7 (noting need for federal legislation). In addition, a federal statutory approach such as the Domenici bill may ultimately be superior to state mandates for insurance parity for mental illnesses because of another federal statute, ERISA. Since ERISA preempts efforts of state legislatures to require that fully self-funded employee benefit plans provide equal insurance coverage for serious mental illnesses, federal legislation is needed to direct an end to insurance discrimination against serious mental illnesses by these self-funded plans. *Id.*

145. For example, as part of the effort to pass insurance parity legislation in Texas, the bill sponsor provided a persuasive comparison between Parkinson's disease—a brain disorder that insurance plans typically cover as a physical illness—and schizophrenia, which insurers usually cover only on a limited basis. *See* Debate on Tex. S.B. 644 on the Floor of the Senate, 72d Leg., R.S. (Apr. 25, 1991) (tape of debate on file with *St. Mary's Law Journal*) (noting comments of Sen. Moncrief regarding comparison). Senator Moncrief then observed that insurers provided this disparate treatment for the two conditions notwithstanding that the "chemical factor in the brain involved in both of these diseases is the same; it's dopamine. One

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willing to change their current practices and distinguish between biologically-based serious mental illnesses and other mental and emotional problems, then legislation is needed to correct the insurer's discriminatory practices.

Indeed, the insurance industry has no sound basis for discriminating against the insured individuals who suffer from serious mental illnesses. Empirical studies have largely refuted the industry's principal objection of increased costs. Moreover, if the cost factor is the primary criterion for deciding which benefits are to be covered, what physical maladies are next on the list for discrimination in coverage levels? Will insurance coverage for treatment of heart disease, cancer, or diabetes be next in line for elimination or severe reduction? Obviously, insurers could significantly reduce insurance costs if they simply stopped or reduced benefits for treatment for many types of physical diseases. The public outcry, however, would be tremendous if insurers eliminated or drastically reduced benefits for such diseases.

Perhaps in large measure because the public has long stigmatized and ostracized persons suffering from serious mental illnesses and their families, little outrage has been engendered regarding insurance coverages for mental illnesses. Given recent medical, judicial, and legislative activity, however, advocates for persons suffering from mental illnesses are quite properly attempting to change past and current insurance practices. From a fairness perspective, it is important that they succeed.

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disease involves an overabundance of dopamine while the other is a shortage of the identical neurotransmitter." *Id.*