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Mental Health Legal Advisors Committee Comments on Exclusion of Mental Health-Related Disabilities Coverage From The Proposed Group Disability Income Insurance Uniform Standards October 27, 2015

Mental Health Legal Advisors Committee (MHLAC) is an agency under the Massachusetts Supreme Judicial Court. MHLAC provides legal representation to persons with psychiatric challenges and counsels families, the courts, and the legislature on mental health legal matters. In this capacity, we have seen the devastation to individuals and families caused by exclusions and limitations of coverage for psychiatric disabilities in wage replacement policies. MHLAC asks that the **I**nterstate Insurance Product Regulation Commission amend its proposed Group Disability Income Insurance Uniform Standards to prohibit the exclusion or limitation of benefits to persons with psychiatric disabilities that are not imposed equally upon claimants affected by physical disabilities.

The bases for this request include:

- Mental health diagnosis and treatment have improved since these exclusions and limitations were first introduced into the market.
- Stigma is the basis for excluding and limiting payments for mental health disabilities, which should not be perpetuated by the Commission.
- States, employers and insurers successfully offer policies without these limitations and exclusions.
- The exclusion and limitation of wage replacement benefits to persons with psychiatric disabilities is harmful to individuals and families and impedes recovery and return to work.
- This discriminatory policy shifts the burden of income assistance from insurers to whom premiums have been paid to taxpayer-funded welfare programs.

- At the very least, states should retain the ability to decide whether or not to permit this discriminatory policy, which has so many negative implications.

Improvements in mental health diagnosis and treatment

The limitation of benefits to persons with psychiatric disabilities is based on outdated constructs and perceptions of psychiatric illnesses as chronic and untreatable. If this perception was ever justified, it cannot be sustained any longer. In reality, there have been vast improvements in the treatment of mental illness. As noted by the Congressional Research Service, in light of modern brain research and the emergence of "more effective drugs," there is expert consensus that "effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders."[1]

Furthermore, because both federal[2] and state laws[3] mandate mental health parity in health insurance and the Accountable Care Act[4] has expanded access to health insurance, more people have the opportunity to access mental health care before it becomes disabling, as well as have the ability to afford treatment and medication to achieve recovery.

Stigma and discrimination

The limitation of benefits to persons with psychiatric disabilities is without justification. A key contention of insurers is based on the unfounded notion that psychiatric disabilities cannot be verified and are more prone to fraud. To characterize this rational as flawed is to understate it.

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[1] R. Sundararaman, The U.S. Mental Health Delivery System Infrastructure: A Primer, p. 5 (Congressional Research Service 2009).

[2] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (effective Jan. 1, 2010 for calendar year plans; Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240 (2013) (effective Jan. 1, 2015 for calendar year plans).

[3] A large segment of state mental health parity laws were passed between 2000 and 2011. *See generally,* National Conference of State Legislatures, Mental Health Benefits: State Laws Mandating or Regulating (April 1, 2015) (last accessed at http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx on Oct. 26, 2015).

[4] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Their claim that the potential for fraud is too great to extend equal coverage to psychiatric disabilities suggests that verifications can't be trusted.[5] The suggestion is that either mental health professionals do not have the ability to diagnose and assess the functionality of patients or that they have a proclivity to collude with their patients to defraud insurers. The fraud rationale not only contributes to the stigma afflicting persons with psychiatric disabilities, it serves as an indictment of the whole mental health discipline.

Further support for the conclusion that disability insurers are simply taking advantage of stigma to reduce claims is found in their cost arguments for disparate coverage. Insurers have never been able to offer solid actuarial data in justification for exclusions or duration limitations on payments to persons with mental disabilities. In fact, there is no evidence that it costs more to cover mental disabilities than, for example, musculo-skeletal disabilities.[6] While insurance companies will, of course, avoid claims when any class of disability generating conditions is carved out from coverage, discrimination ought to be based on something more than societal stigma.

In the absence of any objective basis in evidence, there nothing left but prejudice to explain disability insurance coverage discrimination against persons with psychiatric disabilities. Discrimination is unwarranted and unnecessary and should be banned.

Exposure to discrimination should not be a permissible "choice"

In those cases in which employees are offered an opportunity to subscribe to two policies – one with psychiatric disability coverage and one without – disability insurers argue that consumers are offered a "choice," and that giving consumers this freedom justifies the discrimination in the more limited policy option. This simplistic dictum ignores the operation of real life.

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[5] Insurers have multiple means to assess and monitor claims, e.g., periodic medical exams, surveillance, and interviews. One MHLAC client's file included not only photos of the client, but photos of his spouse, father, and children, as well as an extensive interview with the client's landlord.

[6] In December 2013, diseases of the musculoskeletal system and connective tissue were the primary reason disabled workers received Social Security Disability Income benefits. In 2013, the percent of benefit awards for workers disabled by musculo-skeletal system and connective tissue diseases was more than doub1e those for mental disorders that were not developmental disabilities. Social Security Administration, Office of Retirement and Disability Policy, Annual Statistical Report on the Social Security Disability Insurance Program, 2013.

Workers, particularly low-wage workers, may gamble with their future by opting for a low-cost policy rather than a more inclusive disability insurance option. Comparison shopping is difficult, as there is often a host of variables in policies that differ. However, even if workers were able to focus on mental health limitations, they may well unwisely, and incorrectly, predict that they will not be beset by mental illness in the future. Denial of even the potential of becoming mentally ill is common due to a number of prevailing mythologies: mental illness afflicts inordinately weak people, mental illness is shameful and "could not happen to me."

There are many ways in which societal values limit the extent to which people are allowed to make unwise choices and bear the full weight of the consequences of that decision. It is illegal, for example, to drive a car without wearing seat belts, and if someone violates the law and is severely injured they are not denied medical care. This is because public policy dictates that individual choices may be circumscribed when necessary to prevent persons from doing serious harm to their own interests, and that standards of decency in a humane society prohibit exacting harsh punishment for wrong, foolish, or even illegal choices.

The two underlying justifications for the state's imposition of limits on individual freedom manifest in such examples fully pertain to the question of disparate disability insurance. The state often acts as *parens patriae*; that is, to discharge its duty to protect persons from harm. As noted, significant harm may come to a person suddenly without an income due to a disabling psychiatric condition. It is entirely appropriate for government to protect its citizens from this consequence by denying insurers the right to offer discriminatory policies.

Secondly, the state limits individual freedom to do harm to ones' self to protect citizens other than the ones directly affected. Safety belt and helmet laws protect others from bearing high medical costs of underinsured drivers and bikers. The Affordable Care Act requires individual and small group health plans to cover "essential benefits" to protect both the insureds and reduce public expenditures due to uncovered health care costs. Likewise, the IIPRS should protect taxpayers from another's bad choice of disability insurance that causes reliance on public benefits, like housing subsidies and fuel assistance.

Importantly, many workers have only one policy from which to choose. It is the employer, not the employee who decides which, if any, disability policies to offer.

For these reasons, it is entirely appropriate to deny choice of discriminatory disability insurance coverage.

Policies without exclusions and limitations can be offered successfully

Actual history supports the conclusion that disability insurance discrimination is based on unfounded prejudice and nothing more. When mental health parity was proposed for health insurance, the industry floated inflated predictions of premium increases. However, their forecasts of doom did not come to pass. Likewise, parity in disability insurance will not cause the sky to fall. We know this because insurers and employers already successfully offer such policies. We also are informed by the experience of states that have taken steps to end discrimination in disability income insurance.

MHLAC reviewed the actual experience of Vermont, which implemented a ban on discrimination. To that end, we looked at available disability insurance filings with the Vermont Insurance Division since 2007 by five major insurers,[7] including insurer calculations of variables such as actual and projected premium dollars collected, number and duration of claims made, and market penetration rates. These data, according to insurers' own policy memoranda, do not differ significantly from nationwide trends, notwithstanding the discrimination ban.[8]

The majority of filings submitted to bring policies into compliance with Vermont's anti-discrimination law do not call for concomitant rate adjustments. Among those policies for which rates were adjusted to reflect mental health parity, changes ranged from an increase of 9% to a decrease of 4.0%, depending on claims experience. In the case of one insurer, several years' worth of data for both short-term (2006-2011) and long-term (2008-2013) group disability policies show that in all but one year (2011), Vermont's loss ratios (claims paid over premiums collected) were actually lower than national averages.

While we recognize that many variables account for these numbers, we believe that Vermont's data rebuts the contention that equitable coverage will be prohibitively expensive for disability income insurers and their customers.

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[7] Colonial Life and Accident Insurance Company, the Massachusetts Mutual Life Insurance Company, the Metropolitan Life Insurance Company, Provident Life and Accident Insurance Company, and the Unum Group.

[8] It is fair to extrapolate the effect of a ban on discrimination to other jurisdiction from Vermont's experience. As noted above, the insurers themselves saw no difference in trends between Vermont and the rest of the country.

The real cost of disability insurance discrimination

Discrimination in disability insurance policies denies workers income on which they and their families are dependent. Low-income workers are particularly harmed by denials of coverage for which they or their employers paid premiums: MHLAC clients have lost their homes and their belongings placed in storage taken by facilities for non-payment. They used up retirement savings to meet basic and immediate needs and were forced onto taxpayer-supported public benefit programs.

Perhaps worst of all, these workers are robbed of the financial security that will allow them to focus on their recovery.[9] Thus, exclusions and limitation on wage replacement benefits creates a self-fulfilling prophecy; delaying individuals return to work and further increasing costs to the general public.

Disability insurance discrimination is wrong

Discrimination against a person with mental disabilities is no different from other, universally reviled, forms of discrimination. Certainly the Commission would not condone policy language that allowed insurers to take premiums from persons of color but then deny them benefits. Like the color of one's skin, a person does not choose to have a propensity for being disabled from a psychiatric disorder.

In fact, fairness and the needs of society render costs considerations irrelevant, particularly in light of nationwide efforts to stamp out disability discrimination and move toward mental health parity.[10] When California took steps in 2013 to implement mental health parity in disability insurance, cost was not the preeminent consideration. The bill requiring short-term disability insurers to cover persons with severe mental illness[11] passed with overwhelming support, despite the fact that the Committee that reported the bill out favorably did not review cost data. The motivation was fairness and compassion: "When these [disability] policies

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[9] Financial stress has long been linked to common mental health disorders. In addition, financial problems exacerbate an existing psychiatric condition, impeding recovery. *See, e.g.,* P. Maciejewski, *et al.*, Self-efficacy as a mediator between stressful life events and depressive symptoms, 176 Brit. J. Psych. 373 (2000).

[10] 42 U.S.C. §§12101, *et. seq.*; notes 2 and 3.

[11] Assembly Bill No. 402, An act to add Section 10144.55 to the Insurance Code, relating to disability income insurance (Oct. 4, 2013).

exclude coverage for mental illness or injury, families are left with choosing to work against their Doctor's orders or bearing unmanageable financial burdens."[12]

Like Vermont, the Interstate Insurance Product Regulation Commission should declare that policy terms that discriminating against persons with psychiatric disabilities are "unfair" and "unjust." The Commission should not attach its imprimatur to discriminatory insurance policies.

At the very least, the IIPRC should leave the decision as to whether such terms are permissible to the states. The Massachusetts legislature is currently considering a bill that would require mental health parity for disability policies. H.786 is sponsored by 46 legislators and is endorsed by over 50 organizations throughout the Commonwealth. The IIPRC should not adopt standards that would render the issue addressed by this bill moot and disempower state legislatures generally from making a moral and ethical decision to prohibit discrimination against a significant portion of the population.

Respectfully submitted,

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[12] Assembly Committee on Insurance, Bill Analysis, AB402 (2013). The Committee's analyst also highlighted the state's adoption of mental health parity in health insurance over a decade before.