Challenging Psychiatric Discrimination in Insurance

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ABSTRACT

The Mental Health Parity and Addiction Equity Act of 2008 did not include commercial disability insurance and life insurance contracts. Strategies to challenge these discriminatory policies are not widely understood because of confidential, out-of-court settlements. This article elaborates on strategies to challenge such discriminatory insurance contracts by describing the approaches used in a successful challenge on behalf of a patient initially diagnosed with a depressive disorder. **[*Psychiatr Ann*. 2015;45(7):372-376.]**

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Many patients with psychiatric disorders have been affected by discriminatory policies in health insurance, disability insurance, and life insurance coverage. Although public opinion and legislation have moved toward parity between psychiatric and other medical disorders, commercial disability and life insurance policies are not included in the Mental Health Parity and Addiction Equity Act of 2008,[1] and discrimination in these policies is not addressed. The discriminatory terms of such policies are consistently enforced. Challenges to this discrimination are common, but because of confidential out-of-court settlements, their specific arguments are seldom in the public domain and there are few guidelines for clinicians. This article describes the approaches used in a successful challenge on behalf of a patient initially diagnosed with a depressive disorder. The parties are not identified, as the settlement terms are confidential, but the successful strategies can be described without specific identification. The author agreed to become involved

in the case because of its advocacy implications.

A three-step strategy was developed in consultation with the attorney and the treating psychiatrist. First, a general challenge to the vague term "mental disorder" was provided. This general challenge exposed the logical weaknesses of that term. A key element was to delegitimize the reliance of the insurance company on the "everyman" definition of "mental disorder." Second, after a clinical review in collaboration with the treating psychiatrist, further diagnostic testing was obtained, which led to a revised diagnosis of bipolar disorder secondary to a general medical condition. Third, a specific challenge was then tailored for the case at hand. For this, the general challenge was framed in terms of the revised diagnosis. This experience may serve as a template for future successful litigations.

METHOD

Case Outline

The patient was age 64 years at the time of the litigation. At age 52 years, while employed as a salesman, he applied for a long-term disability insurance policy. His application disclosed a history of depression at age 35 years. He stated that he had experienced no psychiatric disorder in the 5 years preceding the application. He disclosed a history of treated hypertension since age 47 years. He also listed a routine physical examination at age 50 years. This application was accepted without demurral.

The patient submitted a claim for disability benefits 1 week before his 56th birthday and 3.5 years after the commencement of the policy. The medical cause of the disability was stated to be depression. Disability payments were approved, but 3 months later the company advised the patient that payments would expire after 5 years, thereby enforcing a restrictive clause of the policy to limit disability benefits in cases of "mental disorder." The policy defined mental disorder as "a mental, emotional, or behavioral disorder." The same policy would have provided indefinite disability payments for medical conditions.

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Case records revealed that the patient was first evaluated by a psychiatrist close to 2 years after the policy's effective date. He continued in regular treatment with the same psychiatrist through the time of litigation. At the first visit, the psychiatrist diagnosed recurrent major depression and prescribed an antidepressant agent. No indication of bipolar disorder was noted. However, after several months the record noted that the patient was "rapid cycling" and had become "manic" while taking sertraline and alprazolam. He proceeded to experience a difficult course of illness, with alternating periods of depression and hypomania. He failed treatment with desipramine, fluoxetine, lithium, and trazodone. Treatment with valproic acid was begun and the working diagnosis was revised to 296.89, Bipolar II Disorder by *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*)[2] criteria. Despite multiple trials of medications and close clinical attention by the experienced treating psychiatrist, the case record revealed ongoing occupational disability due to continuous depressive and hypomanic cycling.

RESULTS

Step 1: General Challenge

The attorney was advised that, independently of the specific aspects of this case, the insurance company's restrictive clause on mental disorders could be challenged as discriminatory. The challenge could be made *a fortiori* in light of the diagnostic revision in this case. The principal basis of the general challenge was the vagueness of the term "mental disorder" that the policy intended to exclude. The policy document referred to mental disorder as "a mental, emotional or behavioral disorder." That tautologic characterization does not constitute an operational definition and it is insufficient to guide a jury. The pertinent dictionary definition of "mental" is "diseased in the mind; mentally ill, as in 'mental patient'."[3] Synonyms given for this definition of "mental" include psychical and psychological.[3]

Neither the dictionary definition nor the company's characterization of the term "mental disorder" is sufficient to determine the status of bipolar disorder as a condition that may be excluded from coverage. That can be determined only by deconstructing the term through an analysis of how it is actually used. At least seven distinct operational meanings and usages of "mental disorder" can be stated. We tested each of these for their applicability to this case.

Meaning #1: *The condition is a mental disorder because it is included in the DSM-IV*.[2] Bipolar disorder certainly is included in *DSM-IV*. This fact is not conclusive, however, as many disorders that would have been covered are included in *DSM-IV*. Examples are vascular dementia and Alzheimer's disease. Thus, bipolar disorder does not qualify as an excluded mental disorder simply because it is listed in *DSM-IV*. This meaning of the term "mental disorder" is not sufficient. Moreover, the challenged policy did not stipulate this meaning of the term.

Meaning #2: *The condition is a mental disorder because it is caused by an emotional factor.* This meaning of the term "mental disorder" does not apply to bipolar disorder. Primary bipolar disorder has a high heritability index,[4] whereas secondary bipolar disorder is, by definition, caused by neurologic or medical factors.[5] Emotional factors are not established as causes of bipolar disorder any more than they are as causes of bronchial asthma or peptic ulcer or hypertension, which would be covered conditions. Thus, bipolar disorder does not qualify as an excluded condition within this meaning of the term "mental disorder."

Meaning #3: *The condition is a mental disorder because it is not caused by physical factors.* This meaning does not apply to bipolar disorder. On the contrary, primary bipolar disorder has a recognized genetic loading[4] as well as identified regional abnormalities of functional, macroscopic, and microscopic brain anatomy.[6-8] Moreover, secondary bipolar disorder is, by definition, caused by pathologic factors such as cerebrovascular disease, a brain lesion, or hormonal disorders.[5] Thus, bipolar disorder does not qualify as an excluded condition within this meaning of the term "mental disorder."

Meaning #4: *The condition is a mental disorder because there is no demonstrable brain pathology*. This meaning is related to Meaning #3, and it does not apply to bipolar disorder. First, as just discussed, brain pathology is demonstrable in primary bipolar disorder,[6-8] whereas secondary bipolar disorder is by definition caused by pathology affecting the brain.[5] Second, this meaning of the term "mental disorder" is insufficient because certain medical conditions exist for which no consistent pathology is demonstrable. Examples include idiopathic epilepsy and migraine. Thus, this meaning of the term "mental disorder" is insufficient to qualify bipolar disorder as an excluded condition.

Meaning #5: *The condition is a mental disorder because, per the policy, the major symptoms are "mental, emotional, or behavioral."* This meaning does apply to bipolar disorder. However, although this meaning may be necessary, it is not sufficient to qualify a condition as excluded under the disability insurance policy. For example, the major symptoms of post-head injury syndrome are "mental, emotional, or behavioral" but that condition would be covered by the policy. Likewise, the major symptoms of the frontal lobe dementias are "mental, emotional, or behavioral" but these dementias also would have been covered under this patient's policy. In addition, the "mental symptoms" in bipolar disorder include cognitive features, especially frontal executive and attentional deficits, that cannot be ascribed simply to aberrant emotions or to maladaptive behaviors.[9]

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Meaning #6: *The condition is a mental disorder because the standard of care requires only "mental" treatment (ie, psychotherapy or counseling).* This meaning does not apply to bipolar disorder. The standard of care for bipolar disorder specifically requires administration of a preventive, mood-stabilizing medication such as lithium, valproic acid, or carbamazepine. Formal psychotherapy for patients with bipolar disorder is recommended when the course of illness under drug treatment is unsatisfactory. In this respect, bipolar disorder is no different from bronchial asthma. Thus, bipolar disorder does not qualify as an excluded condition within this meaning of the term "mental disorder."

Meaning #7: *The condition is a mental disorder because it is one of the conditions the average person understands by that term.* This meaning is often relied upon by insurance companies as an *ad hoc* definition that suits their purpose. Although insurance companies have succeeded in the past with this argument under contract law, it is plainly discriminatory and legally challengeable as arbitrary and capricious. No court would be interested in the opinion of the average person on other questions of medical classification and management, such as whether AIDS is or is not a contagious disease that requires quarantine. In litigation in the United States, that role is reserved for qualified experts.

In summary, bipolar disorder satisfies only 2 of the 7 meanings discussed above. Those two meanings (#1 and #5) are weak tests and they are not sufficient individually or together to qualify bipolar disorder as a mental disorder that could be excluded from disability insurance coverage.

Step 2: Diagnostic Review

At the time of litigation, the case record was consistent with the psychiatrist's *DSM-IV* diagnostic coding 296.89, Bipolar II Disorder.[2] This *DSM-IV* diagnosis is purely descriptive and it can apply to both primary and secondary presentations of bipolar disorder. Other features documented in the clinical record suggested a secondary form of bipolar disorder with a vascular, hypertensive etiology. These aspects were (1) late age of onset of bipolar features at age 55 years;[10] (2) history of hypertension with unsatisfactory control since age 47 years;[10] and (3) prominent antidepressant drug-induced neurotoxicity, such as severe tremor, myoclonus, and confusion. Such antidepressant drug-induced

neurotoxicity is recognized not only with the early tricyclic antidepressant drugs but also with newer agents such as fluoxetine and trazodone, to which this patient was exposed.[11-13] Patients at risk of this antidepressant drug-related neurotoxicity have subcortical cerebrovascular disease, affecting especially the basal ganglia (caudate nucleus, putamen, and globus pallidus)[11] or preexisting brain damage.[13] Additional entries in the record were consistent with emergent hypertension-related brain disease. These included notations concerning profound apathy, inability to work in psychotherapy, personality change, and emotional incontinence.[14]

Based on this clinical evidence, a brain magnetic resonance imaging (MRI) scan was obtained. It showed typical hypertensive vascular pathology, with prominent lacunar infarcts bilaterally in the basal ganglia, and subcortical areas of leukoaraiosis or white matter hyperintensities. Such changes are typical of vascular mood disorders and vascular dementias.[14] Follow-up neuropsychologic assessments further supported the impression of hypertension-related cerebrovascular disease. The patient's full-scale IQ had declined from 116 2 years earlier to 95 at the time of this litigation, and his performance on a test of complex visual-motor coordination was markedly impaired. Moreover, his performance on that task was surprisingly worse with the dominant right hand than with the nondominant left hand. This pattern of bilateral impairment with reversal of functional dominance is consistent with patchy hypertensive cerebrovascular disease such as was revealed by the MRI scan.[14]

The patient does have a positive family history of mood disorder. His mother has a history of depression; a brother has been diagnosed with bipolar disorder and is treated with lithium; and a sister has experienced periodic recurrent depressions. This genetic background puts the patient at increased risk of bipolar disorder. However, the fact that bipolar features did not emerge until age 55 years suggests that a second factor (ie, cerebrovascular disease) led to the appearance of his bipolar features.[10]

All of these considerations led to a reassessment of the diagnosis. Although the experienced psychiatrist was aware of the patient's hypertension, he had not strongly considered a vascular contribution to the patient's difficult course of illness and to the switch to bipolar status. In retrospect, however, and with the benefit of new data from the brain MRI scan and the neuropsychologic testing, the diagnosis of a hypertensive vascular cause of the patient's bipolar disorder was readily agreed to. The new neuropsychologic test results also were consistent with a prodrome of vascular dementia comorbid with the late-onset bipolar presentation.[14] This revision of the diagnosis served the patient well in his challenge to the insurance company.

Step 3: Specific Challenge in the Particular Case

Based on the issues raised in the general challenge and on the diagnostic reassessment (Steps 1 and 2), a focused and specific challenge on behalf of the litigating patient was developed. The attorney was briefed on the nature of bipolar disorder, especially the secondary form that results from an organic condition like hypertensive cerebrovascular disease, with symptoms resembling those of primary bipolar disorder but accompanied by more prominent cognitive decline than is expected in primary bipolar disorder. The briefing also addressed the cardinal symptoms of bipolar disorder (ie, mood swings), manifest as depressive episodes and manic or hypomanic episodes with variable severity over time, and with mixed states characterized by simultaneous depressive and manic features also recognized. The highly recurrent form of bipolar disorder known as rapid cycling, which applied to this patient, also was addressed. Both the hypomanic and the depressive phases and especially the absence of enduring normal periods interfered with this patient's ability to work and to concentrate normally. Those functional deficits were aggravated by the hypertension-related cognitive decline and apathy (clinically considered to be a prodrome of vascular dementia, which is a common complication of vascular depression).[14]

This three-step challenge altered the dynamic of the litigation, persuaded the insurance company to reconsider its position, and served the patient by facilitating a satisfactory negotiated settlement before a scheduled court hearing. The key strengths brought to the patient's case were the general challenge (Step 1) and the diagnostic refinement (Step 2), and thus removal of the assumption that the patient suffered from a self-evident "mental disorder."

DISCUSSION

The three-step strategy outlined here may assist other patients, psychiatrists, and attorneys in successfully litigating discriminatory insurance exclusions for "mental disorder." The seven elements of the general challenge (Step 1) unpacked the meanings of "mental disorder" in relation to the specific case. That approach can readily be applied, *mutatis mutandis*, to other major psychiatric disorders. The confidence of the insurance company and of its legal advisors did not survive the demonstration that there exist no logically coherent, comprehensively inclusive, and mutually exclusive meanings of "mental disorder" and "nonmental disorder" that applied to this case. The insurance company concluded that its past reliance on the "everyman" definition of mental disorder risked being disallowed at trial as discriminatory.

This case also illustrates the benefit of a fresh look at the totality of clinical data and course of illness, based on which

strategic new diagnostic investigations were advised (Step 2). In the process of this re-evaluation, participation of the treating psychiatrist was crucial in assisting the patient to understand the reasons for new diagnostic studies. Of course, not all patients with diagnoses of bipolar disorder will have the specific comorbidities that lead to the diagnostic reformulation in this case. However, the standard of civil litigation requires only that the preponderance of evidence should support the claimant, and in that context it is well worth scrutinizing each case for information that signals organic pathology (eg, MRI evidence of leukoaraiosis in younger, nonhypertensive patients with bipolar disorder,[15,16] and in older patients[17]). Any clinical or laboratory evidence that might support the possibility of a secondary rather than a primary mental disorder should be considered in such litigation.

Many patients affected by discriminatory insurance policies will appropriately carry diagnoses of primary psychiatric disorders. For them, the general challenge described above can be a tool for litigation. Although it is beyond the scope of this article to consider other disorders in relation to the seven elements of the general challenge, the deconstruction of the term "mental disorder" provided here may serve as a framework for other cases. The more closely the analysis for another diagnosis resembles the analysis here presented for bipolar disorder, the greater the chance of success in litigation will be. These considerations continue to apply today, notwithstanding the passage of the Mental Health Parity and Addiction Equity Act of 2008, because privately purchased, commercial disability insurance, as in this case, is not covered by the 2008 Act.[1] The same is true of privately purchased, commercial life insurance.[1]

Pending complete societal abandonment of the concept of discriminatory insurance, the overall strategy for mental health advocacy will be aided by case law precedents that eliminate specific conditions such as bipolar disorder from the vague and imprecise category of "mental disorders." As this approach succeeds, diagnosis by diagnosis, the ability of insurance companies to enforce "mental disorder" exclusions will lessen. At present, insurance companies are motivated to avoid establishing diagnosis-related case law precedents and instead to offer case-wise settlements out of court under confidential terms. Mental health advocacy organizations, attorneys, and psychiatrists may confront here a tension between their duty to serve the patient and their broader goal of removing the discriminatory practice. Mindful of the stress, expense, and uncertain outcome involved in a civil trial, patients in litigation understandably prefer to decline the option of going to trial when an acceptable out-of-court settlement is offered. This unavoidable dilemma almost guarantees that the advocacy battle mostly will be fought case by case rather than diagnosis by diagnosis. Meanwhile, efforts continue by health insurance companies to find new ways of discriminating against patients with psychiatric disorders.[18] Thus, the litigation strategies presented here will remain important for the case-by-case battle into the foreseeable future.

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