

1-1-1996

Messing With Our Minds: The Mental Illness Limitation in Health Insurance

Youndy C. Cook

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COMMENTS

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I. INTRODUCTION

A debate over health care and health insurance options continues in the nation today. Authorities cite various statistical ranges for the number of uninsured people in the United States¹ In the race to provide national health care coverage, however, one often overlooked problem is that even many insured people are uninsured or underinsured for certain conditions. Chief among these conditions is mental illness, for which insurance is often strictly limited as to type and amount.²

1. In the United States "approximately 34.4 million persons under the age of 65 [are] uninsured and millions more [are] underinsured." DONALD L. WESTERFIELD, NATIONAL HEALTH CARE LAW, POLICY, STRATEGY 13 (1993). Westerfield attributes the size of this group to the astoundingly high costs of modern medicine. He postulates that by the year 2000 one-sixth of America's annual production dollars will be spent on health care. *Id.* at 3.

2. For example, inpatient mental health care is limited by a cap on the number of days in the hospital that insurers will cover. Often, insureds are limited to 30 or 60 days of inpatient mental health care, whereas the limit for physical illness may be significantly higher or nonexistent. Outpatient mental health care is also strictly controlled with limits on the number of visits allowed and the amount that will be paid for these visits. A 1985 survey of medium and large firms showed that 26% of full-time participants in employer-sponsored health plans limited the number of payable visits per policy period and 71% imposed dollar limits per visit and per policy period. Allan P. Blostin, *Mental Health Benefits Financed by Employers*, 110 MONTHLY LAB. REV. 23, 24 (July 1987).

A. *The Mental Illness Limitation*

The prevalence of underinsurance for mental illness is due in part to the social stigma attached to it. "Anglo-American society historically has viewed the mentally ill as outsiders,"³ and most people continue to view mental illness with a certain amount of suspicion and skepticism.⁴ Despite better education and more publicity, people still tend to believe that the mentally ill create their own problems, or that mental illness is something that a person should be able to overcome or "deal with."⁵

Insurers articulate many reasons for limiting mental health care benefits, stressing cost containment and the relative subjectivity of mental treatment.⁶ Where cost-reduction is the goal, mental health services seem to be an easy target: the services are relatively confined to a single area of medicine, are socially stigmatized, and the efficacy of mental therapy is believed to be less obvious or documented. Furthermore, "mental disorders are not as easy to define as other illnesses," and "mental health problems can be subjective."⁷ As a result, insurers assert that the duration of psychiatric treatment is often indefinite.⁸ Insurers fear a version of adverse selection attributed to mental health care: insurers, believing that people have advance notice of a current or incipient need for psychiatric services or counseling, fear that people will shop around for the best mental health care coverage.⁹

3. Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 951 (1992).

4. David Mechanic, *Mental Health Services in the Context of Health Insurance Reform*, 71 MILBANK Q. 349, 352-53 (1993).

5. Many scholars recognize the continuing stigma associated with mental illness, which rests on a popular belief that somehow the mentally ill have caused their own problems or have "lost control" of their emotions or their minds. Ramage, *supra* note 3, at 972-73; see also Steven S. Sharfstein, *Articulating the Case for Equitable Mental Health Coverage*, 42 HOSP. AND COMMUNITY PSYCHIATRY 453 (1991).

6. Insurers "believe that judgments about medical necessity in mental health are less precise than similar judgments in other areas of medicine. As a result they fear that if mental health services [are] given parity with other medical services . . . insurance funds will be siphoned into a 'bottomless pit.'" James E. Sabin & Norman Daniels, *Determining 'Medical Necessity' in Mental Health Practice*, HASTINGS CENTER REP., Nov.-Dec. 1994, at 5 (footnote omitted). Mental health care costs must be controlled if only because the "[v]ague end points, diagnostic ambiguity, and elastic interventions create considerable 'moral hazard,'" in that people will seek insured care and clinicians will seek to give care in a form that is covered. Barry Blackwell, *No Margin, No Mission*, 271 JAMA 1466 (1994).

7. Blostin, *supra* note 2, at 23 (footnote omitted).

8. *Id.* See also Mechanic, *supra* note 4, at 354.

9. "One reason for insufficient coverage arises from insurers' fear of adverse selection. The insurers are concerned that any plan offering better protection against mental health care costs may attract a disproportionate number of persons who anticipate using mental health care." Jeffrey Rubin, *Financing Mental Health Care*, 28 Hous. LAW REVIEW 143, 157 (1991); see also Sabin & Daniels, *supra* note 6, at 9 ("Insurance underwriters fear that if mental health insurance becomes more available, individuals . . . might claim to suffer from an illness when they are

All health and major medical insurance policies contain limitations and exclusions. There are lifetime aggregates for benefits, as well as caps on coverage during any one policy period. There are also exclusions and limitations affecting certain classes of problems and types of care. Three of the most common are the experimental medical treatment exclusion,¹⁰ the preexisting condition exclusion,¹¹ and the mental illness limitation. This last limitation caps benefits for mental health care at levels far lower than those for "physical" conditions.¹²

actually suffering from life"); *Mechanic*, *supra* note 4, at 352-53 ("Moral hazard," the "inclination to use services more when they are fully insured . . .," is prevalent in mental health services where utilization "is more responsive to price than is use of general medical services," especially psychotherapy.).

10. Insurers use the experimental medical treatment exclusion to deny coverage for procedures that are new or untested and which may have little medical value. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1638 (1992). The generally asserted rationale behind this exclusion, and most other exclusions and limitations, is cost containment. Experimental medical treatment exclusions commonly take the following forms:

In addition to certain exclusions and limitations already described in this rider, we will not pay under this rider when any of the following apply to you: . . . 18. Experimental/Investigative Services. We will not pay for any service or procedure we do not recognize as accepted medical practice as we determine has no proven medical value.

Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc., 815 F. Supp. 571, 575 (N.D.N.Y. 1993) (benefits improperly denied for Autologous Bone Marrow Transplant (ABMT) operation where ABMT had medical value despite labels of "experimental" or "study").

"Exclusions—Medical Services and Supplies which are NOT Covered Medical Expenses. . . (10) Services or supplies which are deemed experimental in terms of generally accepted medical standards." *Westover v. Metropolitan Life Ins. Co.*, 771 F. Supp. 1172, 1173 (M.D. Fla. 1991) (benefits for chelation therapy for arteriosclerosis properly denied where FDA labelled the procedure "experimental" and not generally practiced by the medical profession).

11. The preexisting condition exclusion excludes or limits insurance coverage:

for charges or expenses incurred during a specified period (most often 3, 6, or 12 months) following the insured's effective date of coverage. The term 'preexisting condition' refers to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical . . . care or treatment.

WESTERFIELD, *supra* note 1, at 30 (footnote omitted).

Preexisting condition exclusions tend to be relatively complex. For example:

Part J. PREEXISTING INJURY OR SICKNESS PROVISIONS.

The benefits of this policy will not be payable for any preexisting injury or sickness for the first six months following the Policy Date. Preexisting injury or sickness means an injury of [sic] sickness which:

- (a) manifested itself within six months prior to the Policy Date in such a way that an ordinarily prudent person would seek diagnosis, care or treatment; or
- (b) medical advice or treatment was recommended or advised within six months prior to Policy Date. We will pay for loss or expense incurred after such six-month period.

Indiana Comprehensive Health Ins. Ass'n v. Dye, 531 N.E.2d 505, 506-507 (Ind. Ct. App. 1988).

12. "Coverage for mental disorders is usually for shorter periods and maximum dollar benefits are often lower. Also, plans commonly pay a smaller share of mental health care

This Comment will explain the mental illness limitation and the mental-physical distinction that follows from it. Courts have drawn a mental-physical distinction when insureds challenge their insurers' mental illness coverage determinations. Courts are forced to get involved when the policy language is unclear on the meaning of "mental illness," and a coverage dispute arises. The most common scenario is that an insured receiving treatment for a so-called mental disorder (e.g., affective mood disorder or bipolar disorder) will sue to force the insurer to pay above and beyond the mental illness limitation.

B. *The Three Approaches*

Courts have taken three approaches in making the mental-physical distinction. The first is the symptom/manifestation approach, where the court focuses on actual symptoms of the illness to determine whether it is mental or physical. Courts using this approach interpret the term "mental illness" from the perspective of a layperson, and deny coverage where the symptoms would generally be considered "mental." Symptom courts rely heavily on what they consider to be a layperson's interpretation of mental illness, and tend to ignore expert testimony and scientific evidence that certain illnesses are organically-based diseases of the brain.

The second approach is the treatment approach, where the court focuses on the nature of the care or treatment in determining whether the illness is mental or physical. Courts adopting this approach do not interpret the term "mental illness." Instead, they grant or deny coverage based on their interpretations of standard policy terms such as "psychiatric/medical treatment" and "mental/physical care." To that extent, the treatment approach encompasses a semantic analysis of the specific phrasing of the exclusion or limitation. In making their determinations, treatment courts rely on expert analysis of the type or nature of the

expenses." *Blostin*, *supra* note 2, at 23. A contested plan in one case demonstrates this discrepancy: The employee welfare benefit (major medical) plan provided for a \$1,000,000 maximum lifetime benefit for major medical benefits. In contrast, the maximum benefit for mental illness was limited to \$25,000. The maximum benefit for mental illness was further circumscribed in that it reimbursed the insured a maximum of \$20.00 for each visit, and limited the insured to one visit per day and 50 visits per calendar year. *Phillips v. Lincoln Nat'l Life Ins. Co.*, 774 F. Supp. 495, 496 (N.D. Ill. 1991). In another case, a similar limitation provided that "in connection with treatment or care of nervous, mental or alcoholic conditions. . . [t]he maximum payable . . . will be 50% of the eligible charges subject also to the maximum payable in any one calendar year of \$2,000 for in-patient expenses and \$550 for out-patient expenses." *Malerbi v. Central Reserve Life of N. Am. Ins. Co.*, 407 N.W.2d 157, 161 (Neb. 1987). Such limitations are not unusual in health insurance policies, and many insureds probably do not even realize that the limit exists, much less that it is so much lower than the limit for more traditional physical care.

insured's treatment. Results under this analysis are mixed, due to the variety of treatments in use.

The third approach is the causation approach, where the court focuses on the cause or etiology of the illness to determine whether it is mental or physical. Courts adopting this approach interpret the term "mental illness" to mean those illnesses or disorders that have a purely functional or psychological cause. Illnesses that are shown to have physical or organic origins are considered "physical illness," even though the illnesses manifest themselves in functional or behavioral ways. Causation courts vary in their use of layperson's or expert's definitions of mental illness, but often rely on expert testimony as to the etiology of the disease at issue.¹³

C. *Eliminating the Distinction*

The purpose of the mental-physical distinction is to aid courts in determining insurance coverage where insureds dispute their company's coverage determination and seek to avoid policy exclusions or limitations.¹⁴ More systematically, insurers say the distinction serves their cost containment and risk classification purposes in that it places a heavier burden on those presumed to be at a higher risk for mental problems. But considering that modern medical research has found that many so-called mental illnesses have physical or organic origins,¹⁵ it seems that the mental-physical distinction fosters the social stigmatization of mental illnesses. In other words, the distinction does nothing more than distinguish one group of insureds from another on the basis of the traditional understanding of 'mental' sickness versus the traditional understanding of 'physical' illness.

A more systematic approach to the problem is needed both to relieve courts of the burden of defining mental illness for purposes of insurance coverage, and to achieve an equitable balance between the interests of the insureds and the insurers. This approach could be either judicial or extrajudicial, although if the goal is to relieve the burden on

13. See, e.g., *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342 (C.D. Cal. 1988); *Malerbi*, 407 N.W.2d at 157.

14. See, e.g., Margaret Levy, *Current Coverage Issues in Health Insurance Law: Is There Coverage When There Is No Coverage?*, 26 TORT & INS. L.J. 621, 628 (1991).

15. "Recent medical studies and analyses of the brain have established that serious mental illnesses are organic brain diseases." Brian D. Shannon, *The Brain Gets Sick, Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 ST. MARY'S L.J. 365, 367 (1993). Shannon cites numerous medical studies that have resulted in conclusive evidence that many severe mental illnesses such as schizophrenia, severe depression, and bipolar affective disorder (also known as manic-depression) can be traced to measurable physiological changes or affects in the brain. *Id.* at 368-69. Shannon also notes that these diseases of the brain are treatable. *Id.* at 369.

the courts, an extrajudicial solution would be more appropriate. As it stands now, each jurisdiction has adopted one approach, based on its attitude towards insurance coverage and the mentally ill. In response, insurers alter their policy language at renewal to avoid unfavorable results. There are two potential solutions that would resolve the ambiguity of the term mental illness and, possibly, take the determination away from the courts. One solution clarifies the mental-physical distinction by creating a bright-line rule that courts and insurers can easily follow. The other eliminates the need for the distinction by forcing insurers to standardize their mental illness limitations.

Currently, courts must define "mental illness" in order to grant or deny coverage under most mental illness limitations. To make these determinations, courts have developed the three previously discussed approaches that reflect different attitudes towards insurance coverage and the mentally ill. These approaches all rest on a mental-physical distinction. The courts should recognize that this distinction itself is relatively meaningless. If the courts were to unify their treatment of mental illness limitations by adopting the symptom approach, the result would be less ambiguity and a more objective standard. The weakness in this proposal is that it leaves coverage determinations to the courts, which would still routinely deny coverage to the mentally ill.

A second option would combine precision in policy language with a series of state mandates. This approach would ensure a minimum level of coverage for the mentally ill while relieving the courts of the burden of deciding how to distribute that coverage. Using more precise language would provide insurers with more predictability in mental health care costs, and the state mandates would ensure that those most in need of mental health care would receive it.

II. THE THREE APPROACHES

A. *The Symptom/Manifestation Approach*

In determining whether a mental illness exclusion or limitation applies, courts adopting the symptom/manifestation approach place more weight on symptoms and manifestations of illness than on etiology. This approach is dependent on the layperson's perception and understanding of mental illness. Symptom courts reason that because a reasonable layperson would characterize a mental illness by its symptoms, then if those symptoms are present, the illness must be mental despite any physical causation or organic basis.¹⁶ The symptom

16. *E.g.*, *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990): "Robert C. Brewer's disease manifested itself in terms of mood swings and aberrant behavior. Regardless of

approach is the most popular with insurers who want to deny coverage, and where courts adopt it, insurers often win.

The case epitomizing the symptom approach is *Equitable Life Assurance Society v. Berry*.¹⁷ The *Berry* court determined that Berry's total disability was not covered under a disability policy that denied coverage for mental disorders unless the insured was confined to specialized institutions.¹⁸ Although Berry was not confined to such an institution at any relevant time, he was totally disabled by manic depression and sought benefits under both his disability policy and his group medical plan. Both insurers denied coverage under the limitations and exclusions relating to mental or nervous disorders, a category which the insurer argued included "manic-depressive illness."¹⁹

The court sustained the denial of benefits despite testimony that manic depression has an organic etiology and is not a functional disorder. The court acknowledged that it is common when interpreting insurance contracts that "exclusions in a policy are strictly construed against the insurer and liberally interpreted in favor of the insured,"²⁰ but went on to say that if there is nothing to interpret, then plain meaning will control. According to the court "plain meaning" is the interpretation that a layperson would give to the language in question.²¹ Where a disorder manifests itself in functional inability to cope, mood swings, and extreme depression, then those symptoms suggest a mental illness as the clear language of the policy intended.²² In the court's words, "[m]anifestation, not cause, is the yardstick."²³

The *Berry* approach to the mental illness limitation was refined in *Brewer v. Lincoln National Life Insurance Co.*,²⁴ where the insured

the cause of his disorder, it is abundantly clear that he suffered from what laypersons would consider to be a 'mental illness.' "

17. 260 Cal. Rptr. 819 (Cal. Ct. App. 1989).

18. The policy stated: "Disabilities Not Covered: Long Term Disability Benefits are not provided for: Mental or nervous disorders, alcoholism or use of hallucinogenic drugs, except while confined to an institution specializing in the care of such disorders." *Id.* at 821. Another provision of Berry's medical policy stated that, "[t]he Plan only pays 50% of physician's charges for mental and/or nervous treatment while not confined in a hospital to a maximum benefit of \$500 in any one calendar year. Mental or nervous treatment means treatment for a neurosis, psycho-neurosis, psychopathy, psychosis, or mental or nervous disease or disorder of any kind." *Id.*

19. *Id.*

20. *Id.* at 822.

21. *Id.* at 823.

22. The court referred indirectly to the type of care Berry had been receiving by noting that all of his physicians were psychiatrists. *Id.* at 824. That the court makes this point suggests some awareness of the treatment approach, but the court did not analyze the implications of receiving care exclusively from psychiatrists.

23. *Id.* (footnote omitted).

24. 921 F.2d 150 (8th Cir. 1990).

sought to recover the costs of hospitalizing his son for acute behavioral problems. The son was treated for affective mood disorder.²⁵ Both of Brewer's medical policies had limits on the coverage for mental health care. One policy limited charges associated with "mental illness, functional nervous disorder(s), . . . or for psychiatric or psychoanalytic care."²⁶ The other policy limited charges associated with treatment of "mental illness."²⁷

The *Brewer* court, in addressing its approach to interpreting such limitations, stated that "[i]t would be improper and unfair to allow experts to define terms that were specifically written for and targeted toward laypersons."²⁸ The court determined that to define mental illness it would therefore have to look to a layperson's general assessment of the symptoms for coverage because "[t]he cause of a disease is a judgment for experts, while laymen know and understand symptoms. Laymen . . . do not classify illnesses based on their origins. . . . [I]llnesses whose primary symptoms are depression, mood swings and unusual behavior are commonly characterized as mental illnesses regardless of their cause."²⁹ The court further pointed out that the language of the policies did not exclude mental illnesses because they had mental or functional *causes*, but rather limited coverage for those illnesses that *manifested* themselves mentally.³⁰ What a layperson would consider mental should control. The *Brewer* court decided that a layperson would consider affective mood disorder to be a mental illness subject to the limitations of the medical policies, due to its behavioral manifestations.

Another case where the court applied the symptom approach and adopted the *Brewer* analysis is *Stauch v. Unisys Corp.*³¹ In *Stauch*, the insured sought long-term disability benefits under a group disability policy beyond the policy's twenty-four month mental illness limitation.³² Despite conflicting medical diagnoses and testimony, the court believed that Stauch was suffering from a "mental illness within the ordinary meaning of that term and within the meaning of that term as it is used in the disability policy."³³ The Eighth Circuit Court of Appeals, relying on *Brewer*, held that the insurer had properly terminated coverage after twenty-four months.³⁴ The court also stated that the varied diagnoses of

25. *Id.* at 152.

26. *Id.*

27. *Id.*

28. *Id.* at 154.

29. *Id.*

30. *Id.*

31. 24 F.3d 1054 (8th Cir. 1994).

32. *Id.* at 1055.

33. *Id.*

34. *Id.* at 1055-56.

Stauch's illness were irrelevant because his symptoms were "what laypersons would consider . . . 'mental, nervous, or emotional . . .'"³⁵ The circuit court concluded that the district court had properly focused on the symptoms of Stauch's illness rather than its irrelevant cause.³⁶

To the extent that the symptom approach allows courts to gloss over ambiguous phrases such as "mental illness" and "nervous disorders," it is contrary to established principles of contract construction. Where policy language states that mental illnesses will be covered to a lesser degree than physical illnesses but does not define either, the court should clarify these terms where to do otherwise leaves insureds without certainty or coverage.

Several questions illustrate the ambiguity of such terms. Is an illness mental merely because a person suffering from it has mood swings and cognitive confusion? Many cancer and other terminally ill patients suffer from bouts of depression and disorientation. Is it fair to consider an illness mental even if medical experts testify that its symptoms are caused by a chemical, *organic* imbalance in the brain that can be treated with medication? Would not the average layperson reassess her opinion of what mental illness is if she heard and believed such medical testimony? These questions highlight the difficulties and weaknesses behind the symptom/manifestation approach. Many courts have noted these problems and have chosen another approach or analysis when confronted with mental illness limitations.

B. *The Treatment Approach*

One alternative means of analysis is the so-called treatment approach.³⁷ This approach is the least utilized, partly because the policy language determines whether this approach can be used. It can be used only if the policy language places limits on coverage according to the

35. *Id.* at 1056.

36. *Id.*

37. Some commentators have suggested that the treatment approach is not an approach to the mental illness limitation at all, but rather a response to a slightly different kind of exclusion. Generally, courts apply the treatment approach where the policy language excludes certain kinds of treatment, such as treatment for psychiatric care or mental health treatment. This is not the same as the average mental illness limitation to which the symptom or the causation approach could easily be applied. The mental illness limitation excludes coverage for mental illnesses, apparently regardless of the type of care an illness would require. At issue in the treatment cases are one coverage exclusions for particular kinds of *treatment*, apparently regardless of the illness for which care is needed. However, to the extent that courts using the treatment approach draw a mental/physical distinction, that approach is often categorized with the symptom and causation approaches. The treatment approach probably is more appropriately catalogued as a different distinction altogether, but there are certain similarities that make grouping the treatment analysis with the other two approaches beneficial.

type of care or limits psychiatric *treatment* regardless of cause or need.³⁸

Courts adopting the treatment analysis focus on the *type* of care involved rather than the *reason* for that care. Courts look at the type of care either to determine whether the illness itself is mental or physical, or to classify different treatments where the policy in question limits coverage for one kind of care but not another. In either situation courts do not interpret the terms "mental illness" or "nervous disorder." Rather, they distinguish between, for example, "psychiatric" and "medical" *treatments* based on the nature of the care. To the extent that treatment courts are making a mental-physical treatment distinction, they do not follow the patterns of the symptom and causation courts. However, it is appropriate that some courts use the treatment approach where an insurer invokes a mental illness or mental health care limitation to deny coverage.

Two cases typify the mixed results that flow from the treatment analysis. In *Simons v. Blue Cross and Blue Shield*,³⁹ the court held that hospitalization costs resulting from malnourishment caused by acute anorexia nervosa were covered, regardless of the mental illness limitation. The limits in the policy at issue were based on treatment, regardless of cause, and the patient was receiving physical care for anorexia-induced dehydration and malnourishment. The court felt it was irrelevant that anorexia nervosa is considered a mental disorder, because its effects led to a need for physical, as opposed to solely psychiatric, care.⁴⁰ The court glossed over the fact that the patient received some psychiatric treatment and counseling, because the bulk of the expenses at issue related to necessary medical care.

In *Saah v. Contel Corp.*,⁴¹ the insured unsuccessfully sought coverage for her son's treatment in a medical rehabilitation center after he suffered brain damage in a car accident.⁴² The insurer denied coverage beyond the policy limit because the son was to receive "behavior modification and group therapy," both of which the court considered to be psychiatric in nature, regardless of why the son needed treatment.⁴³ The court held that the insurer's coverage determination was reasonable

38. For example, the group medical plan at issue in *Saah v. Contel Corp.*, 780 F. Supp. 311 (D. Md. 1991), stated that "benefits for psychiatric and substance abuse care are subject to a combined \$100,000 lifetime individual maximum." *Id.* at 315 n.1. The policy in *Garred v. General American Life Insurance Co.*, 774 F. Supp. 1190 (W.D. Ark. 1991), stated that "Major Medical Expense Benefits are not payable for: . . . psychological testing, counseling and group therapy . . . [and] treatment of nervous and mental condition." *Id.* at 1192.

39. 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

40. *Id.* at 434.

41. 780 F. Supp. 311 (D. Md. 1991).

42. *Id.* at 313.

43. *Id.*

because it was "supported by the plain language of the plan."⁴⁴ The policy clearly limited benefits for "psychiatric or substance abuse care" more than benefits for physical care.⁴⁵ The court held this way despite the fact that the patient's psychiatric care was directly linked to his brain damage and resulting problems.

Both the *Simons* and *Saah* courts looked to the treatment in question and ignored the causes of the need for treatment. In *Simons*, this approach resulted in a judgment for the insured solely because the patient was receiving medical care. It did not matter that the insured's mental condition—anorexia nervosa—caused her to need that medical care. In *Saah* this approach resulted in a judgment for the insurer solely because the patient received "psychiatric" care. It did not matter that the patient needed the care because of a car accident and subsequent brain damage. The results of both cases seem counterintuitive. Where a policy excludes care for mental illness, it does not seem logical that a policy would cover any care, physical or psychiatric, for an illness such as anorexia nervosa. Similarly, where insurance apparently covers an insured for all treatment for a serious injury, it is not logical to leave a brain-damaged patient effectively uninsured for therapy that accompanies treatment for his brain damage. In this respect, the treatment approach is unreliable, and runs counter to the apparent intent of the contracting parties.

C. *The Causation Approach*

The final analysis when addressing a mental illness limitation is the causation approach. This approach is the most favorable from the insured's perspective, because it embodies the argument that treatment for mental illness is not intended to be limited under a policy's mental illness limitation where the illness has a physical or organic basis. The issue under the causation approach is whether an illness can be considered mental where it is caused by a chemical imbalance or some other organic feature, but is manifested by mental symptoms. If a disease has a physical cause, is it not a physical illness, as that term is commonly understood, despite the fact that its symptoms may be psychological?

Although it was not the first to adopt the causation approach, *Kunin v. Benefit Trust Life Insurance Co.*⁴⁶ is likely the best known case on the matter due to the court's well-reasoned analysis. In *Kunin*, an insured father sought coverage for the treatment of his son's autism, a "syndrome" considered secondary to the diagnosis of organic brain dysfunc-

44. *Id.* at 318.

45. *Id.* at 315 n.1.

46. 696 F. Supp. 1342 (C.D. Cal. 1988).

tion.⁴⁷ Kunin's insurance policy limited "medical benefits for 'mental illness or nervous disorders' to a maximum of \$10,000 in any calendar year."⁴⁸

The court began with the proposition that autism is a syndrome because it is identified by its symptoms, which are mostly behavioral. The court analyzed the medical evidence presented by both parties. It concluded that the evidence supported a finding that autism has a demonstrable physical basis, even though the behavioral aspects of the syndrome are used to identify the illness.⁴⁹ The court then defined mental illness for purposes of policy limitation using a layperson's definition, and concluded that "mental illness is often thought of by lay persons as having nonphysical, psychological causes . . . as opposed to an organic basis. Where dysfunctions of the brain derive from an identifiable organic basis . . . , the condition would not commonly be understood as mental illness."⁵⁰ The court ultimately held that autism was not a mental illness within the meaning of the mental illness limitation at issue because the syndrome had an identifiable organic basis.⁵¹

The *Kunin* court also discussed the nature of the treatment, stating that because autism is not treatable with traditional psychotherapy, it is even less like a mental illness in the lay sense.⁵² This is strikingly similar to the analysis of the treatment approach courts. The *Kunin* court, however, used the nature of the treatment merely as a factor in its causation analysis.

Another case of organic brain syndrome resulting in coverage for the insured is *Phillips v. Lincoln National Life Insurance Co.*⁵³ There, the insured's son suffered from a congenital organic brain disorder that resulted in "abnormal behavioral symptoms" and required extensive psychiatric treatment.⁵⁴ Lincoln National refused to reimburse Phillips for his son's treatment beyond the mental illness limit of a lifetime aggregate of \$25,000 for "charges for mental illness(es)."⁵⁵ The insurance policy, however, did not define mental illness. Therefore, the court had to determine whether organic brain syndrome, by definition a condition with an organic basis, was a mental illness under the policy.

The *Phillips* court specifically relied on *Kunin* and agreed that

47. *Id.* at 1343.

48. *Id.*

49. *Id.*

50. *Id.* at 1347. In that respect, consider brain cancer or a tumor located in the brain. Those two conditions are likely to have behavior effects, but are not "mental illness" in any real sense.

51. *Id.* at 1347.

52. *Id.*

53. 774 F. Supp. 495 (N.D. Ill. 1991).

54. *Id.* at 497.

55. *Id.* at 496.

mental illness is a "behavioral disturbance with *no* demonstrable organic or physical causes" ⁵⁶ In contrast, medical evidence indicates that organic brain syndrome has a physical origin, although that cause has not been pinpointed to an exact location in the brain. Whereas Lincoln National wanted to focus on the abnormal behavioral patterns of the patient, the court stated that "aberrant behavioral symptoms . . . without more, can not determine that a particular illness is a mental illness." ⁵⁷

The court indicated in dicta that the insurer could have avoided litigation by defining mental illness or by incorporating the classifications found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III). ⁵⁸ This dicta supports this author's suggestion that insurers define mental illness more precisely and incorporate the diagnostic manuals created by the psychiatric profession.

An earlier example of the causation approach occurred in *Prince v. United States Life Insurance Co.* ⁵⁹ There, the insured was treated for psychological trauma resulting from the accidental loss of an eye. The insurance company denied coverage for the trauma based on an exclusion for "mental disease . . . psychotic or psychoneurotic disorders or reactions." ⁶⁰ The court held for the insured, finding that the average person would believe that this exclusion applied only where the underlying cause of the psychotic reaction was unrelated to a bodily injury. ⁶¹

The *Prince* decision exemplifies the reasoning behind the causation approach. Where the policy contains an ambiguous limitation or exclusion, courts will interpret it against the insurer according to the rule of *contra proferentem*. When the ambiguous term is mental illness, which is often undefined in older policies, ⁶² causation courts will look to factors that the insurer may have intended to leave out, such as the cause or etiology of the illness or disorder. Where that etiology is organic or physical, causation courts will find that the term mental illness meant

56. *Id.* at 500 (emphasis added), citing *Kunin*, 696 F. Supp. at 1346.

57. *Id.* at 501.

58. *Id.* at 502. For a discussion of the DSM-III see, *infra*, note 67.

59. 257 N.Y.S.2d 891 (N.Y. App. Div. 1965).

60. *Id.* at 892.

61. *Id.*

62. It should be noted that merely by including a definition of mental illness, insurers would avoid most of this litigation. Recently, insurers have begun to include very broad definitions of the term in their policies. Often the definition will follow *Phillips* and refer to diagnostic manuals that classify mental disorders by symptom. When an insurer takes these few simple steps in drafting, none of which are burdensome and which are in insurer's own interest, the policy language is likely to preempt the causation approach. In the case of a specific definition of mental illness, where a determination must be made, the symptom approach will be more appropriate. It could be argued that an insurer who neglected this obvious step in drafting, especially after so many cases, did not intend to exclude coverage.

only those illnesses that could be classified as completely mental, both in cause and effect.

Using that rationale, most causation approach cases result in judgments for the insured. There are, however, exceptions. Consider *Killebrew v. Abbott Laboratories*,⁶³ where the insured became disabled due to emotional problems and headaches after he suffered from viral encephalitis.⁶⁴ Because the insured's doctors could find no organic basis for his problems (although they did not rule out some link to the viral encephalitis), the court held that the disability was "due to a functional nervous disorder,"⁶⁵ for which policy benefits were limited to twenty-four months.⁶⁶ The court cited the testimony of several doctors. The doctors attributed the insured's condition to a functional problem for which they could not locate a precise physical cause, although they agreed that the viral encephalitis could have been the primary cause.⁶⁷ *Killebrew* illustrates the limits of the causation approach: where no cause can be shown, the unproven cause cannot be assumed to be physical, and the nature of the symptoms will support an inference that the illness and the symptoms are the same. In *Killebrew*, the symptoms were mental. Therefore, the court presumed that the illness was mental as well.

Most of the cases exemplifying the causation approach⁶⁸ focus on a layperson's understanding of what a mental illness is or should be, but also take into account an expert's analysis of what caused the illness. Where there is any physiological explanation for a "mental" result (such as organic brain disease causing a behavioral or coping problem), causation courts will generally hold that the mental illness is not really mental

63. 352 So. 2d 332 (La. Ct. App. 1977), *aff'd* 359 So. 2d 1275 (La. 1978).

64. 352 So. 2d at 334.

65. *Id.*

66. *Id.* at 333.

67. *Id.* at 334.

68. Another important case using the causation approach is *Arkansas Blue Cross and Blue Shield, Inc. v. Doe*, 733 S.W.2d 429 (Ark. Ct. App. 1987), where the court held that the insured should be covered beyond the mental illness limits of the policy when bipolar affective disorder was at issue. The disorder was shown to be an organically-based illness of the brain. *Id.* Thus, the court held that the disorder was a physical illness. *Id.* at 431-33. For another example, see *Malerbi v. Central Reserve Life of N. Am. Ins. Co.*, 407 N.W.2d 157 (Neb. 1987), where the court affirmed coverage for the insured based on a finding that the physical causation of a child's behavioral problems was due to atypical organic brain syndrome. See also *Gareis v. Benefit Ass'n of Ry. Employees Ins. Co.*, 169 N.W.2d 730 (Minn. 1969) in which the court found coverage for an insured suffering from mental problems and damage to the central nervous system due to the deterioration of cells in the brain. Finally, the court in *Akins v. Washington Metro. Area Transit Auth.*, 729 F. Supp. 903 (D.D.C. 1990), found that an insured who suffered from various mental ailments after a stabbing incident was covered under a disability policy where the policy included coverage for all disability as a "result of" physical injury. *Id.* at 906. The court held that the psychological problems were the result of the physical trauma.

at all, and should not be subject to the mental illness limitation of the insurance policy.

As courts hold this way, however, insurers are adjusting their policy language to foreclose this avenue of attack.⁶⁹ Instead of simply limiting benefits for mental illness, insurers have begun expanding their definition of mental illness in policies. They define mental illness as "sickness which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause."⁷⁰

III. THE PURPOSE OF THE DISTINCTION

The exact purposes of the mental-physical distinction are varied and unclear. For courts, the distinction is a way to interpret ambiguous or incomplete policy language. For insureds, the distinction is a way of attacking coverage denials that saddle them with tremendous mental health care bills. For insurers, however, the purpose of the distinction is as ambiguous as the mental illness limitation itself.

Insurers generally make coverage distinctions and exclusions for purposes of risk classification.⁷¹ They seek out information on insurance applications to determine who is at high risk for developing certain illnesses that may be very costly to cover. By declining to cover those

69. Paul Appelbaum recognized this trend in Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. AND COMMUNITY PSYCHIATRY 993 (1989), and pointed specifically to the changes implemented by the insurers involved in the *Arkansas Blue Cross and Blue Shield* case. *Id.* at 994. In the new policies, psychiatric conditions were changed to "include (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions." *Id.* "The definition then lists several classes of psychiatric disorders and notes that it intends to include all axis I and II disorders listed in the current edition of DSM-III." *Id.*

Changes such as the one Appelbaum noted are certainly not isolated. Insurers are hastening to respond to judicial commentary suggesting that if insurers would specify by which method (symptom, cause or treatment) they intended to classify mental illnesses, the courts would follow that specification. See *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 950 (9th Cir. 1993).

70. This is the exact language of the author's health insurance policy, issued by the Guardian Life Insurance Company. The policy limits mental health care benefits to a \$50,000 lifetime aggregate while there is absolutely no limit for "most sicknesses or injuries." Guardian Life Insurance Policy (on file with the author). The policy further states that "[w]e include a sickness under this provision [limiting mental health benefits] if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause." *Id.*

71. The traditional explanation of risk classification is that it is an exercise in "fair discrimination." Leah Wortham, *Insurance Classification: Too Important to be Left to the Actuaries*, 19 J.L. REFORM 349, 361 (1986). In other words, the insurer seeks to quantify the burden that a particular policyholder places on the insurance pool, and then charge the policyholder in accordance with that burden. *Id.* The most significant obstacle to "fair discrimination" is the fact that Congress and most states have adopted antidiscrimination measures. *Id.* at 361-70. The result is a series of arbitrary limitations and exclusions to avoid all risk in particular categories. *Id.*

illnesses, or covering them only up to a very low amount, insurers can hold down costs and presumably maintain premium levels for other insureds. The mental illness limitation, however, does not serve to classify risk, because it is not feasible to predict mental illness with enough accuracy to classify the risk of contracting those mental illnesses. Therefore, insurers create across-the-board limitations to avoid the expenses incurred by those few who are at high risk for mental illness.⁷²

Another problem with the mental illness limitation is that since it was designed to limit coverage for illnesses traditionally considered mental, it has become dated. Modern medical research is breaking down the traditional distinction between mental and physical diseases and causing people to rethink their position on when an illness or disorder should be recognized as mental. Considering the evidence that many mental illnesses are caused by measurable physiological affects in the brain,⁷³ the distinction drawn between mental and physical for insurance coverage seems to distinguish nothing. The only distinction at this point seems to be between one group of insureds whose illnesses manifest themselves in socially stigmatized ways and another group of insureds whose illnesses are more acceptable as physical injury or disease.

Another argument for the distinction is that mental treatment is not considered to be as efficacious as, say, a cast on a broken leg. Whereas the cast will have definite, predictable results, psychiatric treatment could go on for years with only slight improvement.⁷⁴ That, of course, is the extreme example. Many of the classic mental illnesses such as schizophrenia and bipolar affective mood disorder are considered to be highly treatable conditions that respond well to therapy in tandem with medications such as lithium.⁷⁵ The mental illness limitation is problem-

72. Insurers give various reasons for their fear of the moral hazard of offering mental health insurance. Specifically, they point out that "demand for mental health services has been shown to be highly responsive to the presence or absence of insurance coverage" and that "some forms of treatment . . . [are] similar to nonprofessional forms of human support and interaction." Sabin & Daniels, *supra* note 6, at 10. Insurers are also "acutely aware that clinicians can always find ways to circumvent insurance restrictions." *Id.* at 12.

73. Brian Shannon discusses several medical research projects to illustrate this point: "[M]edical researchers have made numerous findings establishing that serious mental illnesses such as schizophrenia, bipolar affective disorder, and depressive illness are biologically-based diseases of the brain." Shannon, *supra* note 15, at 361 (footnotes omitted).

74. See Blostin, *supra* note 2, at 23. Consider the long-term nature of psychoanalysis: patients often have regular appointments for months so that a psychiatrist, psychologist, or other mental health care provider can slowly explore the patients' problems and then address them in a non-traumatic fashion.

75. See generally Shannon, *supra* note 15, at 367-70. Shannon comments that "[a]lthough serious mental illnesses such as schizophrenia, bipolar affective disorder, and depressive illness are not curable, they are treatable diseases." *Id.* at 369. However, insurers are correct that even

atic because it implicitly assumes things about health care that are not necessarily true, namely that the mentally ill can control their sickness and that treating them will be ineffective over the long run.

Aware that many courts have adopted the causation approach, insurers are quickly adjusting their policy language. As one commentator noted, "[t]he cases themselves demonstrate the inherent limitations of a judicially oriented strategy for seeking equivalent coverage for psychiatric and medical illnesses."⁷⁶ Where a court expresses in dicta, as in *Rosenthal v. Mutual Life Insurance Co.*,⁷⁷ that it will give effect to whatever choice of approaches the policy itself makes, insurers are more than happy to adjust policy language to redefine mental illness to exclude as much mental health care coverage as possible, usually incorporating the symptom courts' definition of mental illness.

Perhaps it is time to recognize that the mental illness limitation is ineffective in fulfilling individual needs, and actually perpetuates societal discomfiture with mental illness. The stigmatization of mental illness over the years seems to have slowly become limited to severe mental illness, while it has become more acceptable to use professional services and counseling to cope with stress and to ease life transitions. This new attitude towards routine psychiatric services frightens insurers who offer mental health coverage. They fear that insureds will begin to act more like consumers of such services if their "consumption" will be reimbursed by a third party. Insurance companies would like to avoid this result. To that end, insurance policies cover very small percentages of out-patient mental services. This, in turn, acts as a disincentive to long-term, regular psychiatric visits or therapy.⁷⁸

treatment for these severe but treatable mental illnesses is long-term. For many manic depressive people, the medication can never be discontinued without significant regression.

76. Appelbaum, *supra* note 69, at 993. Appelbaum notes changing policy language that forecloses the results previously obtained in litigation, and he agrees that the "current distinction between physical and mental disorders is a false one." *Id.* at 994.

77. 732 F. Supp. 108, 109 (S.D. Fla. 1990).

78. Recognition of routine counseling is also recognition of a possible sub-distinction: that between the severely mentally ill and the temporarily or mildly mentally ill (which would include those who could be colloquially called "stress cases"). It is remotely possible that this second distinction could be drawn in such a way as to expand coverage for severe mental illness by imposing high deductibles on mental health care. With a high enough deductible, only those truly in need would reach it. After that, they would be fully covered for the remainder of their treatment. Those in short-term care or other types of care, such as substance abuse treatment, could be effectively eliminated from the expansion of coverage. The challenge is to not exclude those severely mentally ill people who cannot afford treatment. The deductible must still be low enough not to impoverish those in need.

In some circles, this would seem to be a workable and desirable approach, considering that short-term and substance abuse care account for the largest increases in mental health care expenditures: "[R]elatively few people incur a high proportion of mental health costs." Rubin, *supra* note 9, at 164. And although those with severe mental illnesses experience longer periods

A. *Eliminating the Distinction*

As discussed above, the mental-physical distinction masquerades as a risk classification. The mental illness limitation does not separate high risk from low risk groups. All it does is make it economically unreasonable for people to obtain insurance to cover particular treatment, the need for which is unpredictable without intensive investigation not normally required for health insurance.⁷⁹ The result is that the mental-physical distinction becomes a way for society's prejudices and insurers' fears of increasing costs to burden a relatively small, but needy, group of people. Currently, courts are being forced to make this distinction when an insured has the resources to challenge an insurer's coverage determination. Either the courts should be relieved of this burden altogether, or the distinction should be simplified so that it becomes more objective and predictable.

To that end, this Comment suggests two solutions, both of which would remove some level of the mental-physical distinction from the purview of the courts. Neither solution can entirely eliminate the courts' role in the process, because creative lawyering will always find a way to mount challenges. But the propositions, if implemented, make it likely that such conflicts will be reduced and simplified.

B. *Systemizing the Approaches*

First, the ambiguity of the distinction could be eliminated if the courts moved towards one approach that would lead to predictable results. The symptom approach would be the most enforceable and uniform, because it offers the benefit of focusing on the more easily observed manifestations of disease and not the more difficult underlying causes of illness. The symptom approach also reduces the need for expert testimony, because symptom courts rely on layperson interpreta-

of hospitalization than those patients with other illnesses, these costs are confined to a relatively small, needy group. *Id.*; see also Shannon, *supra* note 15, at 373 n.29, for the proposition that substance abuse treatment and adolescent psychiatric care are "[t]he two main areas of escalating costs." (citing ANNE M. O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM: A NAMI HANDBOOK 14-15 (1991)).

This sub-distinction, however, would lead to its own problems by countering some very beneficial recent trends to expand coverage for substance abuse treatment as well as preventative mental health care. Furthermore, it is doubtful whether insurers would be any more successful at distinguishing these two roughly defined groups of mental health care consumers.

79. "Persons with chronic disabling illness, and especially persons with serious and persistent mental illness, are likely to have high and often *unpredictable* health expenditures." Mechanic, *supra* note 4, at 359 (emphasis added). Mechanic's article suggests several interesting insurance reforms in the area of mental health care. Where high costs for disabling illness are involved, he proposes a cap on what primary insurance should pay, beyond which a reinsurance plan should provide coverage. *Id.* at 359-60.

tions of mental illness. While causation courts would be required to alter their analyses, symptom courts could still base their determinations on the symptoms the patient displays. This is more preferable than searching for evidence that a particular symptom is brought about by, for example, a chemical imbalance or cellular breakdown in the brain. Furthermore, the symptom approach has the advantage of being compatible with the Diagnostic and Statistical Manual of Mental Disorders that the medical profession uses to classify mental illnesses.⁸⁰ Because the DSM-III already classifies by symptom, it can be incorporated into existing policies and case law to ease the decision-making process.

By focusing merely on the manifestation of illness, courts, insurers, and insureds would have a baseline that could not be easily disputed by conflicting medical expert diagnoses and opinions. The symptom approach could possibly eliminate the battle of the experts and the necessity of testing for a wide range of possible physical causes of a mental illness. Furthermore, the language of most insurance policies expresses or suggests the intent of insurers to avoid coverage for mental illnesses as commonly defined. The symptom approach defers to this intention and seems to be more true to the language of the insurance policy.

The symptom approach, however, has the distinct disadvantage of eliminating coverage for many mentally ill patients whose problems stem from an organic or physiological cause, and who could be treated with medicine as well as psychotherapy. At the same time, the symptom approach avoids the real issue of exactly what the insurance policy means by mental illness. In simpler terms, the symptom approach is unfair and callous.

An insured person expects to be covered, with reasonable limitations and restrictions, for all *illness* as that term is commonly understood. The average insured believes that she will be covered when something goes wrong with her body and there is readily available treatment for the problem. In the case of mental illness, there are various modes of treatment, none of which the average insured can utilize above a minimal level because of the debate over whether a mental illness

80. Many courts refer to the DSM-III-R when making the distinction between mental and physical illness. As the *Rosenthal* court noted, the manual is a diagnostic tool for the profession that classifies mental disorders according to symptoms in order for appropriate treatments to be chosen. *Rosenthal*, 732 F. Supp. at 110.

The DSM-III-R, published by the American Psychiatric Association, is described as the "official diagnostic manual of psychiatry." Ramage, *supra* note 3, at 953 n.10. The manual "classifies mental illness by certain diagnostic criteria along five 'axes,' each referring to a different class of information. Axes I through III comprise official diagnostic assessments . . . Axis I includes the severe mental illnesses: [for example,] schizophrenia . . . and affective (mood) disorders." *Id.* (citation omitted).

qualifies as something going wrong with the body. Many people know today that mental illnesses can be physically or organically caused, such as by a chemical imbalance in the brain, hormonal imbalance, or slight brain damage. For example, Alzheimer's disease is a devastating physical illness that reduces the workings of a bright mind to a series of misfiring synapses. People are aware that some physiological problems will have mental results. They expect that these problems, including the mental results, will be covered.

The final weakness of this first solution is the fact that it would be unreasonable to expect courts in multiple jurisdictions to settle on one approach to a problem and consistently apply that approach in the face of changing fact patterns and sympathetic plaintiffs. Each court has differing opinions that will not be erased solely by a recognized need for uniformity. That goal, worthy though it may be, will not justify what some would see as manifest unfairness and incursion into the judicial sphere.

C. *Fine Tuning the Mental Illness Limitation*

There is another option. Designed to eliminate the need for the mental-physical distinction drawn by the courts, the second solution would require or strongly encourage the insurance companies to make their policy language so clear and precise that courts would rarely be involved. This solution, requiring a combination of precise policy language, limited exclusions, and state mandates, is more predictable and objective, virtually eliminates the distinction, and expands coverage for the mentally ill to what many would consider an equitable level.

Courts are in the habit of giving effect to the language of contracts, including insurance policies wherever possible.⁸¹ It is only where language is ambiguous or missing that courts must step in.⁸² Under the second solution, because insurance companies would be required to make their policy language more precise and public, the courts would no longer have to distinguish between mental and physical illness, regardless of who benefits from the clarity. Insurance companies have already taken the lead in this respect, tailoring the language of their newer poli-

81. See Levy, *supra* note 14, at 625; see also *Equitable Life Assurance Soc'y v. Berry*, 260 Cal. Rptr. 819, 822 (Cal. Ct. App. 1989); *Rakoff v. World Ins. Co.*, 191 So. 2d 476, 477 (Fla. 3d DCA 1966).

82. Ambiguities in insurance policies are to be construed as much as possible in favor of the insured and against the insurer. This "contra insurer" rule of contract interpretation permeates state court approaches around the country. See, e.g. *Simons v. Blue Cross and Blue Shield*, 536 N.Y.S.2d 431, 434 (N.Y. App. Div. 1989); *Brewer v. Lincoln Nat. Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990); *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 950 (9th Cir. 1993).

cies to the holdings of the symptom courts.⁸³

In order to achieve this precision, insurance companies that have not already done so could create policies containing a non-exhaustive list of mental illnesses that they will cover or exclude. Such a list could incorporate existing lists found in the DSM-III-R. Once companies make such a list, other illnesses could be categorized according to similar illnesses on the list. By creating very specific definitions and limitations, insurers could avoid the challenges that have plagued them in the past.

Were the task to be left entirely to the insurance companies, however, coverage for mental illnesses would certainly remain fixed at current levels or even be reduced. To guarantee a minimum amount of coverage to the mentally ill under these more precise policies will require legislative initiative. State law governs most insurance regimes and allows insurance companies flexibility in their exclusions and limitations in order to hold down costs.⁸⁴ While it remains to be seen whether the Americans with Disabilities Act (ADA),⁸⁵ which includes severe mental illness as a qualified disability, will mandate some coverage not otherwise possible, even the ADA will not be able to affect all areas. State mandates will be needed to fill the gaps left both by the insurance companies and the ADA.

Many states have already attempted mandates on limited scales, with varying degrees of success.⁸⁶ Most mandates are qualified with various exemptions and waivers. Texas and Maryland, in particular, have taken significant, symbolic steps towards equalizing coverage for mental and physical illnesses. The Texas Insurance Code⁸⁷ provides that insurers operating in the state must "offer and make available"⁸⁸ coverage for "serious mental illness"⁸⁹ at the same level as coverage for other

83. Consider the change in the policy language of the policy challenged in *Arkansas Blue Cross and Blue Shield, Inc. v. Doe*, 733 S.W.2d 429 (Ark. Ct. App. 1987), which at the time of the suit merely limited care for "mental" illness. After the court found for the insured, the insurer expansively amended the policy language. For a verbatim reading of the language, see Appelbaum, *supra* note 69, at 944. The amended policy refers to the DSM-III-R to expand its already-broad definition. *Id.*

84. Appelbaum, *supra* note 69, at 994.

85. 42 U.S.C. §§ 12101-12213 (1994 Supp.).

86. The newest mandate for mental health coverage in Texas requires equalized coverage for "severe mental illnesses" (a limited category that includes schizophrenia, bipolar disorder, and a few other organically-based brain disorders). For a discussion, see Shannon, *supra* note 15, at 390-95.

87. TEX. REV. CIV. STAT. ANN. art. 3.51-14 (West Supp. 1995).

88. *Id.*

89. Defined to include "(1) schizophrenia; (2) paranoid and other psychotic disorders; (3) bipolar disorders (mixed, manic, and depressive); (4) major depressive disorders (single episode or recurrent); and (5) schizo-affective disorders (bipolar or depressive)." *Id.* § 1.

types of illnesses. The most serious flaw in this provision is that the equalized coverage need only be offered and *made available*, suggesting that insureds⁹⁰ may decline to accept it in order to lower their premium costs. Maryland's Insurance Code,⁹¹ which mandates coverage for mental illness to the same extent as any other illness covered by an insurance policy, seems to suffer from a similar defect: it provides that insurers operating in the state "may not discriminate against any person with a mental illness"⁹² through different coverage terms and conditions, but it then limits the benefits that must be paid based on the number of outpatient visits per calendar year.⁹³

A state law mandating equalized coverage for mental and physical illness would be optimal. But for many reasons, this type of mandate is very unlikely to find political support. A more realistic approach would be to start on a smaller scale, one more palatable to political constituencies. State mandates that create packages of mental health benefits would have different requirements and might not entail equalized coverage of mental care, but would be a start towards expanded coverage of mental health care.⁹⁴ The goal is either to decrease the mental illness limitations or to reduce those diseases that qualify as mental illnesses under the limitations. Some courts have already attempted the latter idea through use of the mental-physical distinction. This distinction, however, has failed to improve the lot of the insured mentally ill, because insurance companies can adjust their policy language to circumvent the reasoning of the causation courts and incorporate the reasoning of the symptom courts.

State mandates, then, should decrease the mental illness limitations in some way without also increasing current limitations on physical illness. While it is possible that the ADA will offer some guidance, it should be the states that take the initiative in equalizing mental health care coverage, because state law governs most insurance plans.⁹⁵

90. The term "insured" here also includes employers and other group representatives who speak for the individual insureds of their groups. *Id.* § 2.

91. MD. CODE ANN., INS. § 490V (1992 Supp.).

92. *Id.* at (b).

93. *Id.* Because health insurance is often a benefit of employment and chosen or negotiated by the employer, this limit will often occur on a group basis. This is a rational response by employers, because omitting certain categories of coverage reduces the premiums that both the employees and the employer will have to pay.

94. In this respect, the Texas Insurance Code provision seems to be a very acceptable start. It should, however, be made mandatory. As phrased now, it is similar to many other state insurance provisions that require insurers to offer an endorsement for mental health care. The problem with these endorsements is that they are prohibitively expensive and, therefore, likely to be waived or declined.

95. State mandates would also tend to extend assistance to the ever-increasing group of uninsureds, either through mandates to nonprofit providers or state-sponsored health care

III. CONCLUSION

The best solution to the problem of the mental illness limitation is to eliminate the need for the mental-physical distinction with more precise language and better coverage, even if that requires state mandates in the form of legislated mental health care packages. Insurers should be able to contain costs without discriminating against the mentally ill. By wording the mental illness limitations more precisely, insurers will eliminate the confusion caused by judicially created distinctions. Insurers could incorporate statistical manuals or list the covered disorders to create this precision. Insurance companies have a recognized right to bargain their way out of certain obligations. But they can not conscionably eliminate or reduce to embarrassing levels coverage for all mentally ill people simply because they fear that some unpredictable group with only minor psychological problems will increase costs for short-term mental care. Insurers should find a different way to contain these costs.

YOUNDY C. COOK

programs. However, this Comment is limited in scope to the problems of those *insureds* who are underinsured with respect to mental health care.