Long-Term Discrimination: Addressing the Disparate Treatment of Claimants with Mental Disabilities in Long-Term Disability Insurance

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Introduction

The United States has progressively improved its social and political responses to mental health issues.[1] Public support for neurobiological theories of mental illness has grown steadily in the last several decades, and psychiatric medicine is now universally accepted as legitimate medical practice.[2] In tandem with this shift in public opinion, legislation to achieve parity between physical and mental healthcare has been implemented.[3] Despite several well-meaning legislative efforts, however, gaps still remain in the quest for universal parity.

Discriminatory practices against claimants with mental disabilities are rampant among long-term disability (LTD) insurance policies.[4] In fact, almost all group LTD policies impose arbitrary limits on the benefits available to claimants with mental disabilities.[5] Whereas claimants with chronic physical disabilities are typically able to collect benefits until they reach age sixty-five (or Social Security retirement age), claimants with chronic mental disabilities are typically entitled to an extremely limited benefits period (often only twelve to twenty-four months) regardless of whether their condition improves during that short period.[6] These

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1. *See* Bernice A. Pescosolido, Jack K. Martin, J. Scott Long, Tait R. Medina, Jo C. Phelan & Bruce G. Link, *"A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence*, 167 AM. J. PSYCH. 1321, 1322 (2010).

2. *Id.* at 1325.

3. *See* Mark DeBofsky, *It's Time to End Mental Illness Bias in Disability Insurance*, LAW360 (May 11, 2020), https://www.law360.com/articles/1270173 [https://perma.cc/6E6N-NHZJ].

4. *See* Christopher R. Wilson, *A Failure to Rehabilitate: Leaving Disability Insurance Out of the Mental Health Parity Debate*, 21 WASH. & LEE J. C.R. & SOC. JUST. 472, 473 (2015).

5. DeBofsky, *supra* note 3 ("Almost all group long-term disability insurance policies and a growing number of individual disability income policies flagrantly discriminate against those who suffer from psychiatric impairments by arbitrarily imposing limits on the benefits payable under those policies.").

6. *Id.*

practices are widely accepted, and insurers justify such disparate treatment by citing the unique actuarial challenges associated with providing insurance coverage to claimants with mental disabilities.[7] To be sure, LTD insurers face legitimate difficulties with respect to this issue (e.g., reliance on subjective vs. objective reporting of symptoms). Nonetheless, improvements in the diagnosis and verification of mental illnesses and disabilities have significantly reduced this burden in recent years.[8] Moreover, LTD insurers face similar challenges with respect to certain physical disabilities, and they successfully confront those challenges by numerous non-discriminatory means.[9]

Arbitrarily limiting disability insurance coverage for mental health conditions drastically reduces the amount of compensation available to individuals who are unable to work due to a mental disability.[10] Additionally, such blatantly discriminatory treatment of individuals with mental disabilities contributes to the pervasive stigmatization of mental health conditions, which in turn creates barriers that prevent people from seeking help.[11] Unfortunately, despite these negative outcomes, past attempts to challenge the legality of discriminatory LTD policies have proven unsuccessful.[12] Recently, however, state laws that bar LTD insurers from differentiating between physical and mental disabilities have been upheld in court,[13] indicating that efforts to change the status quo may not be as futile as they once were.

This Article first briefly addresses the history behind the disparate treatment of LTD claimants with mental disabilities. It then analyzes and responds to the potentially legitimate concerns proffered by insurers to justify a lack of parity. Next, it highlights recent administrative and legislative progress in combating arbitrary mental health limitations in LTD insurance, and it concludes by highlighting the numerous benefits that a parity mandate would create.

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7. *Id.*

8. *Id.*

9. *Id.*

10. Wilson, *supra* note 4, at 478.

11. S. Clement, O. Schauman, T. Graham, F. Maggioni, S. Evans-Lacko, N. Bezborodovs, C. Morgan, N. Rüsch, J. S. L. Brown & G. Thornicroft, *What Is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies*, 45 PSYCH. MED. 11, 21 (2015).

12. Wilson, *supra* note 4, at 482–83 (discussing the ambiguous language of the Rehabilitation Act of 1973).

13. *See* Sand-Smith v. Liberty Life Assurance Co. of Bos., No. CV 17-0004, 2017 WL 4169430 (D. Mont. Sept. 20, 2017).

I. Background

A. Legislative Progress Toward Parity in Mental and Physical Health Issues

In the United States, public perception of mental illnesses (and mental disabilities) has improved in recent decades, as shifting societal attitudes have signaled a collective desire to prioritize mental health.[14] As the public has recognized mental health as a legitimate policy concern, the government has responded with legislation designed to put those who suffer from mental illnesses on equal footing with those who suffer from physical illnesses.[15] In 1973, the U.S. Congress passed the Rehabilitation Act to protect individuals with physical and mental disabilities from discrimination: "[1] in programs conducted by federal agencies, [2] in programs receiving federal financial assistance, [3] in federal employment and [4] in the employment practices of federal contractors."[16] The Americans with Disabilities Act (ADA) followed in 1990 as an additional attempt to "end discrimination against disabled individuals."[17] Like the Rehabilitation Act, the ADA prohibits discrimination against physical *and* mental disorders, defining disability as "a physical or mental impairment that substantially limits one or more of the major life activities."[18] Not coincidentally, this definition of disability is identical to the definition used in the text of the Rehabilitation Act.[19] Although both of these legislative initiatives were well-meaning, they fell short of their ambitious goal of serving as "'clear and comprehensive national mandate[s]' to end discrimination against [individuals with disabilities]."[20] For example, having a legitimate disability does not even guarantee protection under the ADA because there are certain specific (additional) criteria that must be met to qualify for coverage.[21]

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14. Andrew B. Borinstein, *Public Attitudes Toward Persons with Mental Illness*, 11 HEALTH AFFS. 186, 186–87 (1992).

15. RAMYA SUNDARARAMAN & C. STEPHEN REDHEAD, CONG. RSCH. SERV., RL33820, THE MENTAL HEALTH PARITY ACT: A LEGISLATIVE HISTORY 1 (2007).

16. Rehabilitation Act of 1973 (Rehab Act), EMP. ASSISTANCE & RES. ON DISABILITY INCLUSION, https://askearn.org/page/the-rehabilitation-act-of-1973-rehab-act [https://perma.cc/A3K3-8SHU].

17. Julie Brandfield, *Undue Hardship: Title I of the Americans with Disabilities Act*, 59 FORDHAM L. REV. 113, 113 (1990); *see also* H. REP. NO. 101-485, pt. 1, at 27 (1990) (prohibiting discrimination against an individual with a disability).

18. H. REP. NO. 101-485, at 3.

19. *See* 29 U.S.C. § 705(20)(B).

20. Brandfield, *supra* note 17, at 113.

21. Michelle Parikh, *Burning the Candle at Both Ends, and There Is Nothing Left for Proof: The Americans with Disabilities Act's Disservice to Persons with Mental Illness*, 89 CORNELL L. REV. 721, 729 (2004).

In 2008, the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was a major milestone for mental health.[22] The MHPAEA prevents group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health claims as compared to medical/surgical (i.e., physical health) claims.[23] Additionally, the financial requirements and treatment limitations imposed on mental health (and substance use disorder) claims cannot be more restrictive than the financial requirements and treatment limitations that apply to physical health claims for a given classification.[24] The MHPAEA expanded on requirements that previously existed under the Mental Health Parity Act of 1996, which required parity in lifetime and annual dollar limits for physical and mental health benefits.[25]

To date, the MHPAEA is the most comprehensive insurance reform combatting discrimination against those suffering from mental illnesses or disabilities. Unfortunately, the provisions of the MHPAEA only apply in the context of health insurance,[26] which still leaves a significant regulatory gap that can be—and is—exploited by other types of insurers. For example, LTD insurance providers regularly offer much more restrictive benefits and limitations on mental disability claims in comparison to those offered for physical disability claims.[27]

B. Continuing Disparities in LTD Insurance

Disability benefits are designed to replace a claimant's lost earning capacity that results from a disabling illness or injury.[28] "Disability insurance differs from health insurance" in many ways.[29] For instance, the benefits offered under a disability insurance policy "are payable *only* if the claimant becomes unable to work for an extended period."[30] Generally speaking, disability insurance plans are very attractive for workers because employers that offer such plans typically pay the entire

22. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet [https://perma.cc/R3RQ-VGRF] [hereinafter *MHPAEA*, CMS]; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881.

23. *MHPAEA*, CMS, *supra* note 22.

24. *See* Mental Health Parity and Addiction Equity Act § 512.

25. Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 712, 110 Stat. 2944, 2945.

26. *See MHPAEA*, CMS, *supra* note 22.

27. *See* Wilson, *supra* note 4, at 473.

28. EMP. BENEFIT RSCH. INST., FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 346–48 (6th ed. 2009).

29. Wilson, *supra* note 4, at 473–74.

30. *Id.* (emphasis added).

cost of the premiums.[31] Roughly one-third of workers in the United States (excluding federal employees) receive employer-provided disability insurance,[32] so discriminatory practices in the disability insurance industry have the potential to affect a significant portion of the U.S. working population.

Regardless of whether a disabling condition has mental or physical origins, income lost due to a long-term disability can be financially devastating.[33] Nonetheless, there are stark differences between how mental and physical disabilities are confronted by insurers. Because mental disabilities are often diagnosed through highly subjective means and can be more difficult to objectively verify than more obvious physical conditions, insurers typically place strict limits on benefits payable for mental disabilities.[34] A common restriction contained in LTD policies is an explicit limitation on the length of time benefits are payable for mental disabilities, whereas no such limits exist for physical disabilities.[35] For example, many policies state that benefits for mental disabilities (including those related to alcohol or drug abuse) are payable for a maximum of twenty-four months, thereafter the claim is terminated and the claimant has no recourse.[36] By contrast, coverage for a disability due to physical impairment is usually offered from the onset of the disability until the beneficiary can either return to work, or "the beneficiary reaches age 65 and becomes eligible for Medicare and Social Security benefits."[37] Of course, this type of inequitable practice is barred in the field of health insurance as a result of the MHPAEA (and the final rules implementing it), yet it continues unabated in both the short and LTD insurance industries.[38]

Because the line between mental and physical disabilities is not always clear, there is no uniformity among insurers with respect to the definition of "mental disability."[39] This inconsistency creates a system in

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31. *Id.* at 474.

32. BUREAU OF LAB. STAT., BLS BULL. NO. 2776, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES (2021) (finding that 35% of non-federal employees received access to LTD insurance through their employer, whereas 40% had access to short-term disability insurance).

33. Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental Versus Physical Disabilities in Long-Term Disability Benefit Plans*, 50 BAYLOR L. REV. 361, 362 (1998) (explaining the disparate policies for LTD benefits that could financially harm employees).

34. DeBofsky, *supra* note 3.

35. *Id.*

36. *See* Wilson, *supra* note 4, at 474.

37. *Id.*

38. *Id.* at 474–75.

39. DeBofsky, *supra* note 3 (explaining that some policies list specific exceptions to the mental illness limitation, such as schizophrenia, dementia, and bipolar disorders, whereas

which it is the insurer that determines which conditions qualify as mental health conditions, and which do not. This environment incentivizes insurers to engage in questionable practices related to their policy-specific mental health limitations.[40] For example, insurers can exploit policy language to define certain ailments as "mental disabilities," even if the condition has a significant physical component.[41] Doing so significantly limits the insurer's exposure on the claim and can potentially save the insurer thousands of dollars per claimant.[42] Because many physical conditions are accompanied by psychological symptoms like depression and anxiety, many claimants are left "at risk of having their benefits disrupted if their disability insurer classifies the disabling impairment as psychiatric."[43]

This phenomenon is illustrated by the case of *Berkoben v. Aetna Life Insurance Co.*, in which the defendant insurer drafted and interpreted its own policy terms, and those terms ultimately worked to its financial advantage.[44] Specifically, the plaintiff's policy in *Berkoben* had a mental health limitation of twenty-four months, although mental health conditions "with demonstrable, structural brain damage" were exempt from that limitation.[45] The plaintiff was diagnosed with schizoaffective disorder, which was subject to the mental health limitation, and the claim was terminated by the insurer after it paid benefits for twenty-four months.[46] Interestingly, the plaintiff's policy excluded schizophrenia from the mental health limitation.[47]

Schizoaffective disorder and schizophrenia share many similar symptoms, including psychosis, hallucinations, and delusions.[48] Although the two conditions have differences, both are severe psychological impairments that can last for life.[49] Therefore, if the plaintiff in *Berkoben* had been diagnosed with schizophrenia rather than schizoaffective disorder, his claim could have continued indefinitely. Instead, he was forced to suffer from the same symptoms yet be subjected to far less favorable policy terms due to the insurer's arbitrary policy drafting.

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other policies are drafted to include *any* condition in the latest version of the Diagnostic and Statistical Manual of Mental Disorders).

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. Berkoben v. Aetna Life Ins. Co., 8 F. Supp. 3d 689 (W.D. Pa. 2014).

45. *Id.* at 693 (emphasis omitted).

46. *Id.* at 695.

47. *Id.* at 715.

48. Adrian Preda, *Schizoaffective Disorder and Schizophrenia: What are the Differences?*, VERYWELL MIND (May 17, 2022), https://www.verywellmind.com/schizophrenia-versus-schizoaffective-disorder-2953129 [https://perma.cc/KU4Q-XYFF].

49. *Id.*

Unfortunately for LTD claimants, policies like the one seen in *Berkoben* are commonplace and do "little more than create a lottery system where lucky individuals can get paid for a longer duration while the unlucky see their benefits prematurely disrupted before they have had adequate time to recover."[50]

With advances in the diagnosis and treatment of mental disorders, the distinction between mental and physical health conditions has only become less clear with time, and recent research indicates that many mental illnesses actually have physical origins.[51] Furthermore, studies linking mental and physical illnesses suggest that improving overall mental health may alleviate common physical ailments such as heart disease.[52] This growing body of research provides evidence that parity laws not only make sense in terms of social utility but also in terms of medical science.[53] Although the legislature in enacting the MHPAEA did not take advantage of this research to demand parity in disability insurance, other administrative bodies and legislatures have begun to do so.[54] Unfortunately, until the practice is no longer legal, claimants with mental disabilities will likely continue to be subjected to this unjust "lottery system."[55]

C. Unsuccessful Challenges to LTD Mental Health Limitations

In general, plaintiffs seeking to challenge mental health limitations in LTD insurance policies have had little success.[56] Most LTD insurance plans are provided through employment,[57] and because the ADA governs workplace and employment discrimination, plaintiffs seeking to challenge mental health limitations have frequently done so under the ADA. Unfortunately for plaintiffs, the ADA's structure and scope create several obstacles to mounting successful challenges to mental health limitations.

First, the ADA does not explicitly prohibit a benefit plan from offering a limited time period of benefits for mental disabilities (e.g., twenty-four months), even if the policy allows benefits to be collected for much longer (e.g., until age sixty-five) for physical disorders.[58] Courts that

50. *See* DeBofsky, *supra* note 3.

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* (noting that the Social Security Administration treats mental and physical disabilities the same and detailing how Montana previously issued a mental health parity law).

55. *Id.*

56. *Id.*

57. *See* BUREAU OF LAB. STAT., *supra* note 32.

58. *See* Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1008 (1997).

have overseen challenges to mental health limitations have held that an insurance policy's distinction between physical and mental disabilities is not discrimination under the terms of the ADA.[59] The ADA merely prohibits discrimination between those with disabilities and those without them, but it (oddly) does not bar discrimination within or between types or categories of disability.[60]

Second, successfully challenging mental health limitations under the ADA is further complicated by the fact that the ADA allows insurers (and self-insured employers) to discriminate between physical and mental disabilities in a benefit plan as long as such discrimination is part of a "risk classification strategy."[61] Specifically, ADA Section 501(c) creates a "safe harbor" provision that explicitly enables insurers to discriminate in benefit plans.[62] Referred to as the "bona fide" benefit plan exemption, the provision states that the ADA does not prohibit insurers from establishing or administering the terms of its benefit plan if the terms are "based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law."[63]

Third, because the ADA defines a "qualified individual with a disability" (i.e., an individual who is protected under the ADA) as "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires,"[64] defendant insurers have found success by arguing that LTD claimants fall outside the protections of the ADA.[65] Specifically, defendant insurers assert that the former employee (i.e., claimant) does not *currently* hold an "employment position," and is thus "unable to perform the 'essential functions' of their job with or without reasonable accommodation."[66] In addition to proving successful for defendants in district courts, this argument has been affirmed by four out of the six circuit courts that have considered this issue.[67]

In 2008, Congress passed the ADA Amendments Act (ADAAA), explicitly expressing that whether an impairment is a disability "should not demand extensive analysis" by the courts, and courts should instead

59. *Id.*
60. Wilson, *supra* note 4, at 486.
61. *Id.* at 488.
62. *Id.*
63. Americans with Disabilities Act of 1990 § 501(c)(2), 42 U.S.C. § 12201(c)(2).
64. *Id.* § 12111(8).
65. Wilson, *supra* note 4, at 484–85.
66. *Id.*
67. *Id.*

focus on the defendant insurer's actual compliance with ADA regulations.[68] Although this proclamation seemed to give plaintiffs a glimmer of hope to once again challenge the legality of discriminatory LTD policies, ADA litigation outcomes have continued to favor insurers, confirming that the ADA definition of "qualified individual with a disability" places plaintiffs with a mental disability at a disadvantage.[69]

Another argument commonly invoked by plaintiffs is that mental health limitations are a form of illegal "subterfuge" used by insurers,[70] but this argument has had little success in the courtroom. The ADA states that employee benefit plans may not be used as a "subterfuge" to evade the ADA's purposes (e.g., to prevent discrimination).[71] One case that considered whether different coverage limits for mental and physical health benefits triggered the exception was *Modderno v. King*, where the D.C. Circuit held that a benefit plan's lifetime cap on mental health benefits did not constitute subterfuge under the ADA.[72] The *Modderno* court cited the Supreme Court's decision in *Public Employees Retirement System v. Betts*, which had interpreted the same term in the Age Discrimination in Employment Act (ADEA).[73] The Court in *Betts* held that providing reduced benefits for mental disabilities was not discriminatory subterfuge if the plan itself was not implemented as a way to discriminate in some "other, non-fringe-benefit aspects of the employment relationship."[74] Interestingly, the *Modderno* court acknowledged that Congress subsequently amended the ADEA to repudiate the *Betts* decision, but it reasoned that this congressional response actually strengthened its argument because the subterfuge language of Section 501(c) remained unchanged after the amendment.[75]

Ultimately, the drafters of the ADA were less focused on mental disabilities than they were on physical disabilities.[76] As a result, claims alleging discrimination based on mental disability do not fit neatly within the ADA's regulatory structure, and plaintiffs invoking the ADA have had a difficult time achieving success in the courtroom.[77] These unfortunate

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68. *See* ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(a)(5), 122 Stat. 3553, 3554.

69. *See* Wilson, *supra* note 4, at 487.

70. *See* Americans with Disabilities Act of 1990 § 501(c), 42 U.S.C. § 12201(c).

71. *Id.*

72. *See* Modderno v. King, 82 F.3d 1059, 1065 (D.C. Cir. 1996) (holding that the plan's lower benefit amount for mental health was not "subterfuge" by the insurer).

73. *See id.* at 1064 (citing Pub. Emps. Ret. Sys. v. Betts, 492 U.S. 158 (1989)).

74. *Betts*, 492 U.S. at 177.

75. *See Modderno*, 82 F.3d at 1064.

76. Randal I. Goldstein, *Mental Illness in the Workplace After* Sutton v. United Air Lines, 86 CORNELL L. REV. 927, 929 (2001).

77. *Id.*

defeats eliminate a potential source of remediation for individuals who are wrongly denied LTD benefits due to a mental illness.

D. ERISA Provides Another Layer of Defense for Insurers

Another hurdle confronted by plaintiffs challenging the legality of mental health limitations is the Employee Retirement Income Security Act of 1974 (ERISA). Employer-sponsored LTD benefit plans are regulated extensively by ERISA.[78] ERISA, a federal law, "does not require that employers provide particular benefits or prohibit discrimination between mental and physical impairments."[79] Although ERISA preemption of state law does not apply directly to laws regulating insurance, insurers have nonetheless been able to rely on ERISA for some protection against legal challenges.[80]

For example, the standard of review in ERISA cases favors defendant insurers; insurers are given broad discretionary authority to draft and administer plans how they see fit.[81] This standard of review was established in *Firestone Tire & Rubber Co. v. Bruch*, where the Supreme Court held that if the terms of the policy or plan grant the administrator (i.e., the insurer) discretionary authority to interpret the terms of the plan, courts engage in a more deferential form of review.[82] Naturally, in the wake of *Firestone*, discretionary clauses in plan documents became the norm instead of the exception, and most ERISA claims are evaluated by courts under a standard of review that is highly deferential to plan administrators.[83] This deferential review gives insurers freedom to create policies like the one challenged in *Berkoben*, and claimants are at a significant and often insurmountable disadvantage when challenging an insurer's discriminatory policy terms.[84] In fact, although ERISA's intent was to bring uniformity to the field of employee benefits law and protect those entitled to benefits, Supreme Court decisions interpreting ERISA have narrowed its already limited remedies, possibly "leav[ing] those Congress set out to protect . . . with 'less protection than they enjoyed before ERISA was enacted.'"[85]

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78. Peter A. Meyers, *Discretionary Language, Conflicts of Interest, and Standard of Review for ERISA Disability Plans*, 28 SEATTLE U. L. REV. 925, 928 (2004).

79. *See* Wilson, *supra* note 4, at 492.

80. *Id.* at 494.

81. *See* Meyers, *supra* note 78, at 929–30.

82. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 114–15 (1988).

83. *See* Wilson, *supra* note 4, at 500–01.

84. *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 384 (2002).

85. *See* Wilson, *supra* note 4, at 493 (quotations omitted).

II. Analysis

LTD insurers continue to place limitations on the benefits available to those with mental disabilities. Insurers justify their discriminatory policies with actuarial arguments related to the greater risks associated with covering mental disabilities.[86] Concepts such as *moral hazard* and *adverse selection* are commonly invoked to argue against parity.[87] LTD insurers argue that a level playing field for claimants with mental disabilities will lead to higher premiums at best, and at worst it would lead many employers to simply refuse to offer disability insurance because of the increased costs.[88]

The following analysis will first address these actuarial concerns and argue that although the concerns do have some merit, insurers can address them through non-discriminatory means.[89] For example, because the mental health profession now universally uses the Diagnostic and Statistical Manual of Mental Disorders (DSM) for identification and treatment of mental health issues, insurers no longer need to rely on arbitrary time limitations for mental disability claims; they should instead rely on the same non-discriminatory procedures and policies they use to assess physical disability claims.[90] The analysis will then discuss recent case law and legislative action (both in the United States and internationally) that indicate a change to the status quo may be forthcoming.[91] Finally, the analysis will conclude by arguing that achieving complete parity in the LTD insurance realm would not only provide justice for a traditionally ostracized community, but it would also come with social benefits. The social movement to prioritize mental health and achieve parity between mental and physical health continues to progress, and the day is likely nearing where it will simply no longer be acceptable for insurers to treat mental disabilities less favorably than physical disabilities.

A. Debunking the Actuarial Concerns Regarding Parity for LTD Claimants with Mental Disabilities

Opponents of parity in LTD insurance rely on two actuarial concepts to justify their position. The first concept is referred to as *moral hazard*. Moral hazard is the concern that covered individuals do not have an incentive to guard against risk because they are protected from the

86. *Id.* at 518.
87. *Id.* at 477.
88. *Id.*
89. *See* DeBofsky, *supra* note 3.
90. *Id.*
91. *See* Sand-Smith v. Liberty Life Assurance Co. of Bos., No. CV 17-0004, 2017 WL 4169430 (D. Mont. Sept. 20, 2017).

consequences of that risk through insurance coverage.[92] The second concept is known as *adverse selection*. Like moral hazard, adverse selection refers to the tendency of those who are more likely to require health care to choose more generous insurance plans from the start.[93]

In the context of disability benefits, a prototypical moral hazard problem arises when an employee puts in less effort to return to work following a disabling illness or injury simply because they are covered by disability insurance.[94] Moral hazard is also demonstrated by a situation in which an employee covered by disability insurance claims benefits for a condition that would not have caused the employee to miss work in the absence of that insurance.[95] Insurers fear that moral hazard problems are magnified in the context of mental disabilities because such conditions are often difficult to verify objectively.[96] As a result, there may be a higher likelihood of false diagnoses, incorrect eligibility determinations, or symptom exaggeration to initiate a benefits claim.[97] Due to this uncertainty, insurers argue that requiring parity interferes with their ability to classify risks which inevitably will result in higher premiums—or even prevent employers from offering benefit plans entirely.[98]

These concerns are rooted in an antiquated stereotype of mental illness. The current practices used by disability insurers were established well before a uniform system of diagnosis and treatment for mental disabilities had been implemented on a universal scale.[99] Decades ago, the mental healthcare field lacked diagnostic standardization, and few effective treatments or medications existed.[100] As a result, insurers were left in the dark with respect to evaluating and verifying mental disability claims.[101] This lack of uniformity in the mental healthcare field may have justified placing arbitrary time limits on disability policies in the past, but the comprehensive development of the mental healthcare field no longer

92. *E.g.*, Steve Maas, *Moral Hazard and Adverse Selection in Health Insurance*, NAT'L BUREAU OF ECON. RSCH: THE DIGEST, Apr. 2016, at 4, 4, https://www.nber.org/digest/apr16/moral-hazard-and-adverse-selection-health-insurance [https://perma.cc/5QDG-6S7M] (describing moral hazard as the idea that "[w]hen insured individuals bear a smaller share of their medical care costs, they are likely to consume more care").

93. *E.g.*, *id.*

94. *See* Wilson, *supra* note 4, at 477.

95. *Id.*

96. *Id.*; Sheldon Danziger, Richard G. Frank & Ellen Meara, *Mental Illness, Work, and Income Support Programs*, 166 AM. J. PSYCH. 398, 400 (2009).

97. *See* Danzinger et al., *supra* note 96, at 400.

98. *See* Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 373 (2003); *see also* Wilson, *supra* note 4, at 515–16 (describing the argument an insurer made in an amicus brief).

99. *See* DeBofsky, *supra* note 3.

100. *Id.*

101. *Id.*

supports such a practice. Indeed, widespread use of the DSM provides a reliable and objective means of assessing mental disability claims.[102] This has resulted in vast improvements in the identification of psychological conditions.[103]

Of course, even with recent progress in the diagnosis and treatment of mental health disorders, some conditions remain inherently difficult to objectively verify.[104] However, the same can be said for many physical disabilities.[105] Nevertheless, in cases where there is a dispute regarding the veracity of a claim for a physical disability, insurers cannot rely on an extremely limited period of benefits eligibility like they can with mental disabilities. Instead, they rely on a variety of procedural safeguards to differentiate between legitimate and illegitimate claims, including: independent medical examinations, peer reviews, and the submission of minimally objective evidence of the claimed conditions (for conditions where such evidence is possible to obtain).[106]

For example, in *Johnson v. Metropolitan Life Insurance Co.*, the defendant insurer used several effective, non-discriminatory means to combat a questionable physical disability claim.[107] In *Johnson*, the claimant was denied LTD benefits due to a lack of objective medical evidence supporting her claim.[108] Although two of the claimant's treating physicians diagnosed her with fibromyalgia (a disabling condition under the terms of her policy), an independent physician, requested by the insurer, reviewed the claimant's file and concluded that her symptoms were inconsistent with fibromyalgia.[109] Fibromyalgia is difficult to diagnose because there is no definitive, objective medical test to verify its existence in a patient.[110] Nonetheless, based on the results of this independent medical review, the claimant was denied LTD benefits, and she subsequently sued the insurer in pursuit of those benefits.[111] The court ultimately held that the insurer's denial of benefits was reasonable

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102. *Id.*

103. *Id.*

104. *See, e.g.*, J. Roen Chiriboga & David Rosenberg, *The Importance of Objective Markers in Psychiatric Illness*, PSYCH. TODAY (Aug. 31, 2020), https://www.psychologytoday.com/us/blog/changing-times-changing-mental-health/202008/the-importance-objective-markers-in-psychiatric [https://perma.cc/7QAX-WW6Y] ("[T]here are no current objective markers of psychiatric illness, making it difficult to pin down.").

105. *See, e.g.*, notes 108–10 and accompanying text (describing a case involving the difficulties of verifying fibromyalgia).

106. *See* Wilson, *supra* note 4.

107. *See* Johnson v. Metro. Life Ins. Co., 437 F.3d 809 (8th Cir. 2006).

108. *Id.* at 812.

109. *Id.*

110. *Fibromyalgia*, PHYSIOPEDIA, https://www.physio-pedia.com/Fibromyalgia [https://perma.cc/RM88-B96J].

111. *Johnson*, 437 F.3d at 812.

because (1) requiring objective evidence of a claimant's physical condition was considered appropriate if the claimant was given notice in the policy, and (2) the insurer is not obligated to give greater weight to a claimant's treating physician when an independent medical reviewer reaches a contrary conclusion.[112] The *Johnson* case demonstrates a few of the non-discriminatory means that insurers can use to effectively address concerns about moral hazard.

As discussed previously, adverse selection is defined as the tendency of individuals who are more likely to (or who believe that they are more likely to) become sick or injured to opt into more generous insurance policies.[113] Adverse selection is often cited with respect to addictive disorders, which can be more persistent (i.e., more costly) over time than other types of illnesses. Individuals who suffer from such disabilities are "bad risks" for insurers, and insurers have an incentive to provide them with limited coverage because doing so (1) avoids attracting the bad risk in the first place, and (2) the limited coverage minimizes the costs associated with the long-lasting claims that are likely to arise.[114] Outside the context of an employer-sponsored disability insurance plan, an insurer could charge a higher premium to (or simply refuse to cover) an individual deemed a bad risk. ERISA prohibits this type of discrimination in employer-sponsored benefits plans, so disability insurers rely on limiting terms instead.[115] Notwithstanding these concerns, there are ample non-discriminatory means available to account for adverse selection. For example, elimination periods (i.e., the time that must elapse between the disabled employee's initial claim and the start of payments) can be very effective at reducing the number of claims paid by an insurer.[116] Additionally, recent research suggests that insurers' fears about adverse selection in mental health related LTD claims may be overblown.[117]

Ultimately, moral hazard and adverse selection issues are not exclusive to mental health conditions, and disability insurers must

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112. *Id.* at 814.

113. *See* Baker, *supra* note 98, at 375–76 (explaining adverse selection and strategies insurers use to limit its effect).

114. *See* Richard G. Frank, Chris Koyanagi & Thomas G. McGuire, *The Politics and Economics of Mental Health Parity*, 16 HEALTH AFFS. 108, 110–11 (1997).

115. Wilson, *supra* note 4, at 518.

116. *See "Elimination Period" (EP) and LTD Benefits Under ERISA*, LAWMED ATT'YS, LLP, https://www.ocdisabilityattorneys.com/ltd-topics/ltd-terminology-elimination-period-ep [https://perma.cc/G6DU-J9A5] (discussing how elimination periods lead to a greater denial of disability claims); *cf.* Frank et al., *supra* note 114, at 116–17 (discussing the success of managed care in reducing use and costs for insurers).

117. *See* THE STANDARD, EMPLOYEE DISABILITY LEAVE STUDY 3 (2018) (noting that 47% of employees surveyed reported chronic conditions, and of this percentage only 5% reported mental health conditions).

address the same concerns when assessing physical conditions as well. When disputes arise regarding the veracity of physical disability claims, insurers regularly rely on non-discriminatory procedural safeguards to counter the inherent uncertainty involved in analyzing claims. There is no reason that these procedural safeguards cannot be duplicated without arbitrary time limitations in the context of mental disabilities.

To be sure, if mental health limitations were barred by some act of state or federal legislation, insurers would likely need to make actuarial adjustments due to the inherent uncertainties related to mental health conditions. Still, the precise effects of such a shift in policy (e.g., on premium costs) are unknown and likely overstated by insurers.[118] Indeed, even if a shift in policy resulted in significant changes to the disability insurance industry, preventing the unjust economic and social harm that results from current discriminatory practices justifies a change.[119] In fact, the case for parity in disability insurance coverage for mental and physical conditions may be even stronger than the argument for parity in health insurance.[120] Addressing many of the concerns touted by insurers to defend their discriminatory practices, one scholar notes:

> Many of the financial and actuarial reasons that might justify treating mentally and physically disabled health insurance participants differently are largely absent in the disability benefit context because the costs of income replacement (unlike the costs of providing health care) do not vary according to whether an individual's inability to work results from mental or physical disability. Furthermore, even a sweeping federal requirement mandating parity in mental disability benefits across all disability insurance policies would leave undisturbed numerous nondiscriminatory means of combating problems of moral hazard in long term disability policies.[121]

If a parity mandate was implemented, insurers would retain the ability to employ elimination periods which effectively screen out many short-term impairments by delaying the start of benefits for a specified time.[122] In the end, even if insurers were unable to rely on arbitrary time limitations for mental health claims, they would easily be able to maintain the profitability of the disability insurance industry, which is their primary concern.

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118. *See* DeBofsky, *supra* note 3.

119. *Id.*

120. Wilson, *supra* note 4, at 518.

121. *Id.*

122. *Id.* Other common non-discriminatory policy limitations, such as the "any occupation" standard, could also remain in place, although an in-depth discussion on this topic is beyond the scope of this Article. *See id.* at 506 (describing the "any occupation" standard).

B. Recent Case Law and Legislative Action Provide a Blueprint for Successfully Challenging Discriminatory LTD Policy Terms

LTD insurers' practice of discriminating against those who suffer from mental disabilities has been occurring for decades,[123] and it is therefore not surprising that the fight for change has been difficult. Nevertheless, administrative and legislative actions barring the practice have been implemented, and several challenges to such legislation have even been upheld in court, indicating that the fight to upend the status quo may not be as futile as once thought. For example, the Social Security Administration, the agency that administers federal disability benefits, does not distinguish between mental and physical disabilities.[124] Although this is not a new development, a governmental entity's recognition that a disability is a disability, regardless of whether it affects the body or the mind, is noteworthy. More recently, Canada and several other governments have made it unlawful for disability insurance providers to offer inferior mental disability benefits.[125] In the United States, progress at the federal level has been slower than in Canada, but several states have implemented legislation designed to combat LTD discrimination.[126]

Vermont, for example, implemented an administrative ban on mental health limitations.[127] The Vermont regulations appear to be safe from legal scrutiny because the state has a series of statutes protecting consumers from unfair and unconscionable practices, and these statutes grant its Insurance Director the authority to issue regulations prohibiting unjust and unfair terms in insurance policies.[128] Similarly, the Montana state legislature implemented a mental health parity law that explicitly includes disability insurance and disability income assurance.[129] This type of legislative action is usually challenged by insurers on ERISA preemption grounds, which indeed happened, although the law was upheld by the Montana judiciary.[130]

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123. *See* DeBofsky, *supra* note 3.

124. 20 C.F.R. § 404.1505 (2023) ("The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.").

125. *See* Battlefords & Dist. Coop. v. Gibbs, [1996] 3 S.C.R. 556 (Can.).

126. DeBofsky, *supra* note 3; *see, e.g.*, VT. STAT. ANN. tit. 8, § 4062 (2022).

127. STATE OF VT., DEP'T OF BANKING, INS., SEC. & HEALTH CARE ADMIN., REVISED HCA BULLETIN 127: DISCRIMINATION AGAINST DISABILITY DUE TO A MENTAL HEALTH CONDITION PROHIBITED IN DISABILITY INCOME REPLACEMENT INSURANCE (2008).

128. *See* VT. STAT. ANN. tit. 8, §§ 10, 4062 (2022).

129. Sand-Smith v. Liberty Life Assurance Co. of Bos., No. CV 17-0004, 2017 WL 4169430 (D. Mont. Sept. 20, 2017).

130. *Id.* at *2.

The Montana statute was challenged in *Sand-Smith v. Liberty Life Assurance Co. of Boston*, where the plaintiff argued that her insurance policy's mental health limitation of twenty-four months was void under Montana's mental health parity law.[131] The defendant, on the other hand, argued that the Montana law was not applicable because the plan at issue was governed by ERISA.[132] Citing the "savings clause" in ERISA, which excludes from preemption "any law of any State which regulates insurance, banking, or securities," the court held that the Montana mental health parity law was not preempted by ERISA.[133] Ultimately, the court ruled that the insurer was obligated to act pursuant to the mental health parity law, and therefore, provide the plaintiff with the "same benefits for her mental illness that it would have had her disability been physical."[134] Ironically and unfortunately, following the decision in this case, the Montana state legislature amended its mental health parity law and eliminated disability insurance from the statute.[135]

Nevertheless, the outcome in *Sand-Smith* is critical because it allays concerns that any state initiatives to mandate mental health parity in disability insurance would be futile due to ERISA preemption concerns. In other words, laws that regulate insurance and the content of insurance policies can be exempt from ERISA preemption which means that states can strategically implement mental health parity legislation that will survive judicial review.[136] Additionally, this type of law would not apply to all benefits plans (e.g., self-insured plans, which are subject to ERISA preemption), but the case does provide one blueprint for states to take action.

C. The Social Benefits of Parity

Public perception of mental health conditions has evolved over time. Although the social stigma associated with mental illnesses has lessened in recent years, it still undoubtedly exists.[137] Unfortunately, LTD insurance limitations for mental disabilities contributes to the pervasiveness of such stigma, which can indirectly prevent people from seeking help for mental health conditions.[138] In order to eliminate the

131. *Id.*

132. *Id.* at *3.

133. *Id.* at *4.

134. *Id.* at *6.

135. DeBofsky, *supra* note 3.

136. *See Sand-Smith*, 2017 WL 4169430, at *6 (holding that Montana's law was not preempted by ERISA).

137. *See* Pescosolido et al., *supra* note 1, at 1321; *see also* Debofsky, *supra* note 3 (describing the different jurisdictions making strides in ending mental illness discrimination).

138. CDC, ATTITUDES TOWARD MENTAL ILLNESS: RESULTS FROM THE BEHAVIORAL RISK FACTOR

stigma attached to mental illnesses, discriminatory policies such as those practiced by the LTD insurance industry must be barred.

In addition to eliminating stigma, expanding the benefits available to individuals with mental disabilities would have significant socioeconomic implications. First, LTD insurance is a safety net, and those with mental health conditions should be entitled to as much protection as those with physical health conditions.[139] Second, given that many modern bankruptcies are caused by accrued medical debt, providing a wider safety net for those unable to work due to mental disabilities could drastically reduce the number of individuals subjected to bankruptcy because they lack regular income.[140] With this in mind, the social utility of parity laws becomes clear.

In the end, physical and mental health are now recognized as equally contributing to individuals' overall wellbeing. Therefore, it simply no longer makes sense to divide the issues into distinct categories.[141] Fortunately, recent legislative movements in combination with the changing social views on mental illnesses reveal progress toward a change in the status quo. In fact, the time appears to be nearing when it will no longer be permissible to treat mental disabilities as lesser than physical disabilities.

Conclusion

The legal and social quest to achieve parity between mental and physical health issues has made great progress in the past several decades, and the time has now come for this parity to extend into the realm of LTD insurance. Despite past difficulties in challenging the widely accepted practice of discriminating against individuals with mental disabilities, recent case law and legislative action may provide a blueprint for successful future challenges.[142] However, such efforts will likely receive strong pushback from insurers. Although the actuarial concerns relied upon by insurers to support their policies may have some merit, these concerns are likely overstated due to improvements in the diagnosis and verification of mental illnesses in addition to the myriad of

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SURVEILLANCE SYSTEM 1 (2012).

139. Alena Allen, *State-Mandated Disability Insurance as Salve to the Consumer Bankruptcy Imbroglio*, 2011 BYU L. REV. 1327, 1336–38 (2011) (noting that most Americans do not save enough to survive the income loss associated with a serious medical crisis).

140. Christopher Tarver Robertson, Richard Egelhof & Michael Hoke, *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 68, 76 (2008); *see also* Wilson, *supra* note 4, at 480–81 (explaining that being insured did not insolate many individuals with illnesses from bankruptcy due to medical debt).

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

142. *See supra* Section II.B.

non-discriminatory tools at insurers' disposal to limit risk. In the end, any drawbacks that a parity mandate would have on the insurance industry simply are eclipsed by the benefits that would result from achieving justice and fairness for a group of traditionally marginalized individuals.