The Commonwealth of Massachusetts
Supreme Judicial Court
MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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Mental Health Legal Advisors Committee Testimony Regarding Long-Term Disability Benefits and Mental Health Disparity

Mental Health Legal Advisors Committee is an agency under the Massachusetts Supreme Judicial Court that provides information and advice on mental health legal matters. MHLAC also represents low-income persons throughout the Commonwealth on such matters. In this capacity, we have witnessed the harm wreaked by discriminatory disability insurance policy provisions. As such, MHLAC advocates for parity in disability insurance policies so as to prevent the exclusion or limitation of benefits to persons with psychiatric disabilities.

Much of the testimony submitted today is based on the research and advocacy of our former Legislative Director and Senior Health Policy Analyst, Susan Fendell, who retired from our office last year. Currently, many short- and long-term disability policies either deny benefits to persons with psychiatric disabilities or limit payment of benefits to one to three years, while not imposing similar limitations on person with most physical disabilities. Workers buy disability insurance to support themselves and their families should they become disabled. MHLAC has seen our clients, people for whom we advocate for, and their family members, faithfully pay premiums to insurers who deny them benefits simply because their disability is mental in origin.

Disability insurance discrimination against persons with psychiatric disabilities is:

- Devastating to individuals and families and delays recovery.
- Shifts costs to government-funded programs.
- Unwarranted by cost considerations.
- Based on stigma against individuals with psychiatric disabilities and the mental health profession.

Impact of discrimination on individuals and families

In Massachusetts, hundreds of people are harmed as a result of current discriminatory disability insurance practices. Our clients are particularly impacted by denials of coverage for which they or their employers paid premiums. They have:

- Lost their homes and their belongings placed in storage were taken by facilities for non-payment,
- Been forced to borrow money from elderly and frail parents,
- Use meager funds set aside for retirement to meet basic and immediate needs,
- Their children are forced to leave college due to loss of parent's financial contribution,
- Their car repossessed, limiting future employment opportunities.

Perhaps worst of all, our clients have been robbed of the financial security that will allow them to focus on their recovery. Financial distress exacerbates the very illness that is keeping them out of work.[1] This delays their return to work, increasing costs to their employers and the general public.[2]

Many individuals who suffer bouts of mental illness can recover and return to productive lives if they are supported during their time of need.[3] But private disability insurance denials diminish the potential for long-term recovery. Thus, exclusions and limitation on wage replacement benefits creates a self-fulfilling prophecy by delaying individuals' return to work.[4]

Discrimination shifts costs to taxpayers

Policy limits create an undue reliance on public benefits like food stamps and heating assistance. As noted, denial of wage replacement worsens prognosis and eventually leads to assistance from publicly-funded medical care, food stamps, heating assistance, and disability funds.[5] This is not

[1] Financial stress has long been linked to common mental health disorders. K.Tsuchiya, *et. Al., Multiple financial stressors and serious psychological distress among adults in the USA.* 65 Int. J. Public Health 335 (2020). In addition, financial problems exacerbate an existing psychiatric condition, impeding recovery. *See, e.g.,* P. Maciejewksi, *etal.,* Self-efficacy as a mediator between stressful life events and depressive symptoms, 176 Brit. J. Psych. 373 (2000). The damage of losing one's income can be devastating. During a hearing on a related bill in 2021, we heard of a man with a psychiatric disability who committed suicide because he did not want to be a financial burden to his family after his disability benefits were prematurely terminated.

[2] Disability insurance contributes positively toward employee retention and hence workplace productivity, which explains why employers allow insurers to market their products at worksites. Removing the ability of disability insurers to exclude or limit payments to persons with disabilities that arise from behavioral health diagnoses will yield benefits not only for employees, but also employers and their communities.

[3] Persons receiving short-term disability benefits for diseases of the blood and immune system, neoplasms, circulatory system, musculoskeletal system, and congenital and chromosomal abnormalities are more likely to transition to long-term disability insurance than persons with psychiatric conditions. Integrated Benefits Institute, *STD Report, Section III,* Calendar-Year Data: 2019 (Sept. 2020), at 14.

[4] Individuals covered by private disability insurers programs return to work, or return to work more quickly, than individuals not covered by private disability insurance. D. Babbel & M. Meyer, "Expanding Private Disability Insurance Coverage to Help the SSDI Program, " Chapter 9 in The McCrery-Pomeroy SSDI Solutions Initiative, a Project of the Committee for a Responsible Federal Budget, SSDI Solutions: Ideas to Strengthen the Social Security Disability Insurance Program (Infinity Publishing 2016).

[5] For example, self-interested and simplistic cost-cutting measures of short- and long-term disability insurers shifts costs to the Social Security Program and Meidcare. See, C. Wagner, *et. Al, Older Workers' Progression from Private Disability Benefits to Social Security Disability Benefits,* 63 Social Security Bulletin 27 (No. 4, 2000), at 28. Denying or prematurely terminating benefits to persons with psychiatric disabilities is one such thoughtless measure that takes from the public. Fis. For lower income workers, the disability insurers' machinations saddle the Commonwealth with increased expenditures for MassHealth, and food and shelter programs.

desirable to the government or the claimants, one of whom said, “It pains me to be supported by taxpayers’ money when I paid premiums for private insurance coverage so that I could be self-sufficient.”

Disability products with parity are successfully offered in Massachusetts and other states

History demonstrates that disability insurance discrimination is often based on unfounded prejudice. When Massachusetts mental health parity laws were proposed for health insurance in 2000 and 2008, the industry floated inflated predictions of premium increases attributable to mental health coverage. However, these predictions did not come to fruition. Similarly, parity in disability insurance will not create the rise in premiums that providers project. We know this because insurers and employers, like the Massachusetts Institute of Technology, successfully offer such policies. We also are informed by the experience of states that have taken steps to end discrimination in disability income insurance.

In 2008, the Insurance Division of Vermont's Department of Banking, Insurance, Securities, and Health Care Administration promulgated its Revised HCA Bulletin 127, the aim of which was to clarify the state's prohibition of "discrimination against persons disabled due to a mental health condition in the context of disability income replacement insurance." The Division of Insurance mandated that new disability income replacement policies could not limit or exclude coverage to persons disabled due to mental health conditions unless other disabling conditions are similarly limited or excluded.[6]

The actual experience of Vermont did not differ significantly from nationwide trends, according to insurers’ own policy memoranda filed with the Vermont Insurance Division. To that end, we looked at available disability insurance filings with the Vermont Insurance Division since 2007

[6] Revised HCA Bulletin 127: Discrimination Against Disability Due to a Mental Health Condition Prohibited in Disability Income Replacement Insurance (VT 2008).

by five major insurers,[7] including insurer calculations of variables such as actual and projected premium dollars collected, number and duration of claims made, and market penetration rates. These data, according to insurers' own policy memoranda, do not differ significantly from nationwide trends, notwithstanding the discrimination ban.[8]

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

While we recognize that many variables account for these numbers,[9] we believe that Vermont's data rebuts the contention that equitable coverage will be prohibitively expensive for disability income insurers and their customers.

Stigma is the basis for discrimination against persons with psychiatric disabilities

The limitation of benefits to persons with psychiatric disabilities is based on outdated constructs and perceptions of psychiatric illnesses as chronic and untreatable. If this perception was ever justified, it cannot be sustained any longer. In reality, there have been vast improvements in the treatment of mental illness. As noted by the Congressional Research Service, in light of modern brain research and the emergence of "more effective drugs," there is expert consensus that "effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders."[10]

Furthermore, because both federal[11] and state laws[12] mandate mental health parity in health insurance has expanded access to health insurance, more people have the opportunity to access

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

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

[9] Variables include, among other things, whether there is a cap on the salary on which a percentage of income is paid, how the salary bands are structured, industry, age of population covered, availability of wellness programs, and investment returns.

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

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

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

mental health care before it becomes disabling, as well as have the ability to afford treatment and medication to achieve recovery.

A key contention of insurers is based on the unfounded notion that psychiatric disabilities cannot be verified and are more prone to fraud.[13] To characterize this rationale as flawed is to understate it. Insurers' claim that the potential for fraud is too great to extend equal coverage to psychiatric disabilities suggests that verifications can't be trusted.[14] The suggestion is that either mental health professionals do not have the ability to diagnose and assess the functionality of patients or that they have a proclivity to collude with their patients to defraud insurers. The fraud rationale not only contributes to the stigma afflicting persons with psychiatric disabilities, it serves as an indictment of the whole mental health discipline.

Further support for the conclusion that disability insurers are simply taking advantage of stigma to reduce coverage is found in their cost arguments for disparate coverage. Insurers have never been able to show that the origination of limitations on psychiatric disabilities are based on solid actuarial evidence[15]. Other physical disabilities are responsible for a higher percent of new claims[16], more lost workdays[17] more cases that convert LTD,[18]and approximately the same or higher total of STD payments at closure.[19]

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[13] We are not arguing against the ability of insurers to manage benefits; we simply advocate for limiting the ability of insurers to discriminate.

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

[15] Given the prevalence of limitations on the duration of LTD payments for psychiatric disabilities, insurers often point to SSA statistics. Far before limitations were placed on musculoskeletal disabilities, insurers had limited payments for psychiatric disabilities because of stigma. In December 2013, diseases of the musculoskeletal system and connective tissue were the primary reason disabled workers received Social Security Disability Income benefits. In 2013, the percent of benefit awards for workers disabled by Musculo-skeletal system and connective tissue diseases was more than double those for mental disorders that were not developmental disabilities. Social Security Administration, Office of Retirement and Disability Policy, Annual Statistical Report on the Social Security Disability Insurance Program, 2013.

[16] Disabilities with higher rates of STD new claims: Diseases of the digestive system, musculoskeletal system, and injury/poisoning. Disabilities with higher rates of LTD new claims: musculoskeletal diseases and injury/poisoning-LTD. Integrated Benefits Institute, *STD Report, Section III, and LTD Report, Section III.* Calendar-Year Data: 2019 (Sept. 2020), at 13-14 and at 4-5. The number of new claims for psychiatric disabilities is overstated because the category includes neurodevelopmental disorders.

[17] Disabilities that lost more workdays per short-term disability closed claim: neoplasms, and diseases of the nervous system, circulatory system, and musculoskeletal system. Integrated Benefits Institute, *STD Report, Section III.* Calendar-Year Data: 2019 (Sept. 2020), at 13-14.

[18] Disabilities with more STD closed claims that convert to LTD claims: neoplasms, congenital malformations and chromosomal abnormalities, and diseases of the blood and immune system, nervous system, circulatory system, and musculoskeletal system. Id.

[19] Disabilities with approximately the same or higher total benefits paid per closed STD claim: neoplasms, conditions originating in the perinatal period, external causes/health services, and diseases of the circulatory system and musculoskeletal system. Id.

While insurance companies will, of course, avoid claims when any class of disability generating conditions is carved out from coverage, discrimination ought to be based on something more than societal stigma.[20]

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

The time is ripe to implement parity in disability insurance

Insurers argue that discriminatory policies should be a permissible choice for workers and employers. The reality is that workers are not often presented with any actual choices:

- Workers have no choice if the employer offers only one policy.
- Disclosure of discrimination is an insufficient remedy, both practically and ethically.

Employees who purchase disability insurance at their place of work may not have the option of a plan that does not discriminate against mental disabilities. And even if they do have a choice, comparison shopping is difficult, as there is often a host of variables in policies that differ.[21]

Workers able to focus on mental health limitations still may unwisely and incorrectly predict that they will not be beset by mental illness in the future. Denial of even the potential of becoming mentally ill is common due to a number of prevailing mythologies: mental illness afflicts inordinately weak people, mental illness is shameful and "could not happen to me."

[20] Without evidence, insurers claim that premiums will have to increase if mental disabilities are covered without discriminatory limitations, thereby causing fewer people to buy disability insurance and thereby damning the industry to extinction. In reality, the purchase of disability insurance by employees who must contribute to tis cost has remained rather steady (if not increased) despite increases in premiums.
Furthermore, there are ways for employers and insurers to reduce the cost of coverage through prevention and assistance returning to work: employee assistance programs (G. Hargrave, *et.al, EAP Treatment Impact on Presenteeism and Absenteeism: Implications for Return on Investment,* J. Workplace Behavioral Health 283 (2008)), return to work programs, and training on providing reasonable accommodations. In fact, one survey found that transitional- or modified-duty return-to-work policies were a primary tool in reducing disability insurance costs. Washington Business Group on Health and Watson Wyatt, *Staying@Work – Increasing Shareholder Value Through Integrated Disability Management, Fourth Annual Survey Report* (Washington, D.C.1999), at 10.
When California initiated its disability insurance parity, there was an increase in covered lives. A larger risk pool spreads risk and costs, minimizing any impact on premiums. Insurers recognize that the breadth of policies and customer experience are factors that affect how competitive their products are in the market. See, e.g., Cigna Corporation, Form 10-K, ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 (2019).
Finally, multiple factors go into disability insurance premiums, many of which are under insurer control, e.g. how reserves are invested and administrative expenses. Id. ("Premium rates reflect assumptions about future claims, expenses, credit risk, investment returns and profit margins."), at 17.

[21] For example, elimination periods, percent of salary reimbursed, pre-existing condition provisions.

For the above reasons, prominent disclosure of limitations on payments to persons with mental disabilities is insufficient on a practical level. Prior notice to the effect that "we may render you a victim of discrimination" also is not sufficient on an ethical level. Discrimination against a person with mental disabilities is no different from other, universally reviled, forms of discrimination.

Fairness and the needs of society render costs considerations irrelevant, particularly in light of nationwide efforts to stamp out disability discrimination and move toward mental health parity.[22] When California took steps in 2013 to implement mental health parity in disability insurance, cost was not the preeminent consideration. Though California did not go as far as Vermont in prohibiting limitations on disability coverage, the state enacted a law that mandated disability insurers cover psychiatric disability claims.[23] This bill passed with overwhelming support, despite the fact that the Committee that reported the bill out favorably did not review cost data. The motivation was fairness and compassion: "When these [disability] policies exclude coverage for mental illness or injury, families are left with choosing to work against their Doctor's orders or bearing unmanageable financial burdens."[24]

[22] 42 U.S.C. §§12101, *et. seq.*; notes 7 and 8.

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

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

In conclusion, there is no good reason to exempt disability insurance from anti-discrimination protection. We therefore urge the ERISA Advisory Council to recommend parity provisions in long-term disability benefits so as to prevent discrimination against people with psychiatric conditions.

Sincerely,

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Mental Health Legal Advisors Committee