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The Pariah Patient: The Lack of Funding for Mental Health Care

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I. INTRODUCTION

In all the furor over the provision of health care in the United States—especially over who will pay for the skyrocketing costs of medical treatment—one class of patient appears to have been overlooked: the mentally ill. This oversight is not new; Anglo-American society historically has viewed the mentally ill as outsiders. In England, for example, inmates at the infamous “Bedlam” hospital for the insane often were displayed for the amusement of the paying public.¹ Society’s disdain of the mentally ill still exists² and has led to public neglect of these unfortunates, especially in the provision of mental health care.³

1. Rael J. Isaac and Virginia C. Armat, *Madness in the Streets: How Psychiatry & the Law Abandoned the Mentally Ill* 1 (Free Press, 1990).

2. For example, a gang of teenage boys in Los Angeles, California, advertises itself as the “Trollbusters” because of its members’ stated purpose of expelling (sometimes violently) the homeless, of which a large percentage are mentally ill, from the local community. Similar behavior has been documented in other cities. *Id.* at 1-2.

3. Only one fifth of the mentally ill receive care. Statement by Lewis L. Judd, M.D., Chairman of the National Mental Health Leadership Forum, at a public hearing on the homeless and the mentally ill, quoted in Deborah S. Pinkney, *Public Hearing Focuses on Homeless Mentally Ill*,

Since the process of deinstitutionalization first began, the law has been involved intimately with mental illness.⁴ In the 1960s scholars criticized the intellectual foundations of psychiatry,⁵ and numerous lawsuits sought to abolish involuntary commitment.⁶ These early critics primarily wanted to protect the right to refuse treatment; specific targets were the somatic treatments for major mental illnesses, particularly psychosurgery, electroconvulsive therapy, and psychoactive drugs.⁷ Some advocates for the mentally ill continue to fight for freedom from treatment,⁸ while others have adopted a more cautious approach.⁹

As with health care in general one of the most difficult mental health care questions facing American society in the 1990s is: Who will fund the rapidly increasing cost of care? This Note examines the role of the private sector in funding emergency and longer-term care for the mentally ill. Part II describes the magnitude of the mental health problem in the United States and documents the failure of public and private insurance programs to fund mental health care adequately. Part III examines indirect funding by primary health care providers and suggests that Congress expand existing federal law to require hospitals and physicians to provide emergency care to the mentally ill who present a danger to themselves or others. Part IV examines direct funding by private insurance, focusing on the continuing validity of mental illness benefits-limitation clauses under common and federal law. Part V concludes that any alternative system likely will perpetuate the inadequate level of mental health care currently provided, unless the stigma associated with mental illness can be overcome by special recognition of the seriousness and treatability of mental illness.

Am. Med. News 2 (Sept. 23/30, 1991) ("Public Hearing").

4. The antipsychiatric movement, deinstitutionalization, and the rise of the mental health bar are documented in Isaac and Armat, *Madness in the Streets* at 19-124 (cited in note 1). See also notes 32-37 and accompanying text (discussing the relationship between deinstitutionalization and mental health care funding).

5. See Isaac and Armat, *Madness in the Streets* at 113-15. For example, a student note published in 1974 argued that mental illness should qualify as a suspect classification. See Note, *Mental Illness: A Suspect Classification?*, 83 Yale L.J. 1237 (1974).

6. Isaac and Armat, *Madness in the Streets* at 115-17.

7. *Id.* at 177-245.

8. See, for example, Note, *The Nightmare of Forcible Medication: The New York Court of Appeals Protects the Rights of the Mentally Ill Under the State Constitution*, 53 Brooklyn L. Rev. 885 (1987); Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. Cal. L. Rev. 291 (1988); Book Note, *One Feud Over the Cuckoo's Nest*, 102 Harv. L. Rev. 528 (1988).

9. See, for example, Comment, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 Ohio St. L. J. 1135 (1987). See also *Washington v. Harper*, 494 U.S. 210 (1990) (holding that the involuntary treatment of a state prisoner with antipsychotic drugs, without a judicial hearing, did not violate the due process clause of the Fourteenth Amendment).

II. MENTAL ILLNESS: THE STATUS QUO

A. *The Prevalence of Mental Illness*

The term "mental illness" covers a broad range of psychiatric problems, from relatively benign personality disorders to severe mental or emotional disturbances that seriously interfere with such basic life functions as self-care, employment, and interpersonal relations.¹⁰ At any given time, one percent of the population of the United States is being treated for severe mental illness.¹¹ Schizophrenia affects from one-half to one percent of the population of the United States during any six-month period,¹² and has a lifetime prevalence of nearly two percent.¹³ The lifetime prevalence of mood disorders, such as bipolar affective disorder, is around nine percent.¹⁴ There are approximately twenty million schizophrenics worldwide, and over ten million Americans will suffer some form of significant depression disorder at least once in their lives.¹⁵ Although the majority of even the most severe mental illnesses can be treated with some degree of success, as few as one fifth of those with mental disorders actually receive care.¹⁶

Mental illness can be fatal. The suicide rate for persons suffering a major affective disorder is fifteen percent, up to thirty times greater than that in the general population.¹⁷ The suicide rate among schizophrenics varies from five to ten percent, and longevity is reduced by approximately ten years in comparison to the general population.¹⁸

10. Agnes Rupp, *Underinsurance for Severe Mental Illness*, 17 *Schizophrenia Bull.* 401, 401 (1991).

The official diagnostic manual of psychiatry, *Diagnostic and Statistical Manual of Mental Disorders* (Am. Psychiatric Ass'n, 3d ed. 1987) ("*DSM-III-R*"), classifies mental illness by certain diagnostic criteria along five "axes," each referring to a different class of information. *Id.* at 15. Axes I through III comprise official diagnostic assessments: (I) Clinical Syndromes, (II) Developmental and Personality Disorders, and (III) Physical Disorders and Conditions. *Id.* Axes IV and V are used in special research and clinical settings to provide supplemental information useful for planning treatments. *Id.* Axis I includes the severe mental illnesses: schizophrenia, delusional (paranoid) disorder, psychotic disorders, and affective (mood) disorders, including major and bipolar depression. For characterizations of each of these illnesses, see generally *id.* at 113-26.

11. Rupp, 17 *Schizophrenia Bull.* at 401 (cited in note 10).

12. Steven S. Sharfstein, *Prospective Cost Allocations for the Chronic Schizophrenic Patient*, 17 *Schizophrenia Bull.* 395, 396 (1991).

13. Rupp, 17 *Schizophrenia Bull.* at 401 (cited in note 10).

Lifetime prevalence describes the probability that a person will suffer from the illness at some time in her lifetime.

14. *Id.*

15. Norman Sartorius and Giovanni de Girolamo, *Preface*, 17 *Schizophrenia Bull.* 371 (1991).

16. Statement of Lewis L. Judd, M.D., Chairman of the National Mental Health Leadership Forum, in *Public Hearing* at 2 (cited in note 3). Dr. Judd estimates that eighty to ninety percent of mental illnesses are treatable. *Id.*

17. Constance B. Caldwell and Irving I. Gottesman, *Schizophrenics Kill Themselves Too: A Review of Risk Factors for Suicide*, 16 *Schizophrenia Bull.* 571, 571 (1990).

18. Sharfstein, 17 *Schizophrenia Bull.* at 395 (cited in note 12). Caldwell and Gottesman

Mental illness is also dangerous to others. While most mentally ill people are non-violent, mental patients on the whole have consistently higher arrest rates and higher rates for certain types of violent crime than the general population.¹⁹ For example, the arrest rate for murder, manslaughter, and assault of a group of patients released in New York in 1973 was three to four times higher than the nonpatient rate.²⁰ The arrest rate of mental patients is usually close to that of the general population, however, for nonviolent crimes such as burglary, auto theft, and larceny.²¹

B. *Mental Illness Among the Homeless*

Mental illness occurs disproportionately among the homeless. A conservative estimate indicates that between twenty-eight to fifty-six percent of homeless adults—about twenty to forty percent of the men and around fifty to sixty percent of the women—suffer some mental disorder.²² The inverse is also true: twenty-eight percent of a sample

estimate a comparable suicide rate of ten to thirteen percent among schizophrenics. Caldwell and Gottesman, 16 *Schizophrenia Bull.* at 571 (cited in note 17). The risk appears greater for women than men. *Id.* at 585.

19. Isaac and Armat, *Madness in the Streets* at 271 (cited in note 1). Mental health advocacy groups often cite studies showing lower arrest rates for the mentally ill. These studies, however, primarily date from the earlier half of this century, when most of the mentally ill were hospitalized and thus unable to commit crimes in the community. *Id.* Advocacy groups may seek to minimize the prevalence of violence because associating the mentally ill with violent crime can have stigmatizing practical consequences; for example, the fear of violence may motivate citizens to resist the establishment of services for the mentally ill in their communities. *Id.* at 270-71. See Tom Coakley, *Group Home Plan Meets Protest*, *Boston Globe* 21 (Jan. 16, 1992) (documenting an intense citizen campaign against establishing a proposed group home for eight mentally ill men and women).

20. The patient arrest rate was 12.03 per 1000, in contrast to the nonpatient arrest rate of 3.62 per 1000. Isaac and Armat, *Madness in the Streets* at 272.

21. *Id.*

22. Pamela J. Fischer, *Alcohol, Drug Abuse and Mental Health Problems Among Homeless Persons: A Review of the Literature, 1980-1990* 72 (U.S. Dept. of Health and Human Services, 1991). This percentage can vary widely depending on the particular city surveyed. For example, the percentage of mentally ill among the homeless is reported at twenty-five percent in New York City, thirty-three percent in Baltimore and Los Angeles, and fifty-six percent in St. Louis. Isaac and Armat, *Madness in the Streets* at 4-5.

The conclusion that mental illness and drug addiction are more common among the homeless than the population at large is not unchallenged. See, for example, Note, *Homelessness: A Historical Perspective on Modern Legislation*, 88 *Mich. L. Rev.* 1209, 1209 & n.3 (1990). A major part of the dispute concerns the definition of "homeless." The prevalence of the mentally ill among those living directly on the street is probably higher than among those living in marginal shelters. *Id.*, citing a study reported in Peter Henry Rossi, *Down and Out in America: The Origins of Homelessness* 146-47 (Chicago, 1989). Other studies, however, have found an increased prevalence of mental disorders in shelter populations. See, for example, Isaac and Armat, *Madness in the Streets* at 4-6. Advocates for the homeless may be reluctant to admit the prevalence of the mentally ill among the homeless due to the stigma attached to mental illness. See *id.* at 2-5.

In general, the percentage of homeless women suffering from mental illness is usually higher

group of New York state mental hospital patients had experienced homelessness at some time during their adult life, while nineteen percent had been homeless within the preceding three months.²³

Unfortunately, few of the homeless with mental health problems currently are receiving treatment.²⁴ This may be due to the failure of the mentally ill to recognize their need for treatment, mistrust of the system based on prior experiences of inadequate care, or even irrational fear characteristic of particular mental illnesses.²⁵

Because of the disproportionate representation of the mentally ill among the homeless, economic measures alone, such as programs providing jobs or housing, will not solve the homeless problem. Since their psychiatric disorders prevent a substantial number of the homeless from maintaining either jobs or housing, any proposed solution to the homeless problem must address the provision of mental health care.²⁶

C. *The Failure of Public and Private Insurance Programs*

The costs of mental illness are substantial. The total economic cost of mental illness in the United States in 1985 was estimated to be 103.7 billion dollars, with direct treatment and support accounting for forty-one percent of this amount.²⁷ These costs currently are financed in the United States through a combination of federal, state, local, and private sources.²⁸

Historically, state-funded mental institutions were responsible primarily for the care of the severely mentally ill.²⁹ Despite the rapid

than that of homeless men. In Baltimore, for example, one study showed almost forty-nine percent of the homeless women suffered from mental illness, contrasted with only forty-two percent of the men. In one Boston shelter, approximately ninety percent of the women suffered from mental illness. *Id.* at 5.

23. Ezra S. Susser, Shang P. Lin, and Sarah A. Conover, *Risk Factors for Homelessness Among Patients Admitted to a State Mental Hospital*, 148 *Am. J. Psychiatry* 1659, 1661 (1991).

24. Fischer, *Alcohol, Drug Abuse and Mental Health Problems* at 88 (cited in note 22). For example, a Los Angeles study reported that despite a prevalence rate for chronic mental illness of at least twenty-eight percent in a sample of homeless adults, only approximately eight percent had had outpatient contacts with the mental health treatment system within the previous six months, and only four percent had been hospitalized within the previous year. *Id.*, citing Pamela J. Fischer, et al., *Mental Health and Social Characteristics of the Homeless: A Survey of Mission Users*, 76 *Am. J. Pub. Health* 519 (1986).

25. Council Report, Am. Med. Ass'n Council on Long Range Planning and Development, *The Future of Psychiatry*, 264 *JAMA* 2542, 2543 (1990). This type of behavior is most prevalent among the mentally ill with paranoid disorders. See, for example, *DSM-III-R* at 118-20 (cited in note 10).

26. See Council Report, 264 *JAMA* at 2543 (cited in note 25).

27. Thomas G. McGuire, *Measuring the Economic Costs of Schizophrenia*, 17 *Schizophrenia Bull.* 375, 376 (1991). The remainder is due to reduced or lost productivity (fifty-five percent) and other societal costs, such as accidents, fires, and crime-related expenditures. *Id.* The costs of care provided by families, primarily treatment and legal costs, are also substantial. *Id.* at 379.

28. *Id.* at 376.

29. *Id.* at 377; Rupp, 17 *Schizophrenia Bull.* at 402 (cited in note 10).

growth of private health insurance in the 1950s and 1960s, this arrangement persisted, perhaps due to the belief that mental health care was too expensive to insure privately.³⁰ In 1965 the federal government became a significant contributor to mental health care funding when Congress introduced Medicaid and Medicare in order to provide health benefits to the poor and to the elderly and disabled, respectively.³¹

Advocates of the deinstitutionalization of mental patients accomplished during the past three decades expected that state and local community programs would assume the burden of funding mental health care primarily on an outpatient basis.³² While the number of institutionalized patients has decreased dramatically, the funding has not followed the patients out into the community. While the portion of total mental health care costs expended for outpatient treatment has increased, this rise is due to that sector's growth, and it has not resulted in a decline in the costs of psychiatric institutions providing inpatient treatment.³³ Although publicly-funded outpatient mental health programs are now ubiquitous, they have achieved only limited success.³⁴ The major problem is lack of funding, which often makes patient access to the care provided by clinics difficult.³⁵

While waiting for admission to a public program simply may be one alternative for a mentally ill person with the financial ability to seek immediate assistance from other sources, many others have no choice but to wait, even though their need for treatment is just as immediate. They cannot return to the state institutions because most state hospitals are still downsizing and there is little room for new patients.³⁶ Since the mentally ill are disproportionately represented among the Ameri-

30. Rupp, 17 *Schizophrenia Bull.* at 402. The mentally ill generally were assumed to be incurable, necessitating life-long, expensive care. This assumption has not changed, despite major medical advances in the treatment of mental illness. Isaac and Armat, *Madness in the Streets* at 164-67 (cited in note 1).

31. Rupp, 17 *Schizophrenia Bull.* at 402.

32. Isaac and Armat, *Madness in the Streets* at 67-85.

33. McGuire, 17 *Schizophrenia Bull.* at 378 (cited in note 27).

34. Isaac and Armat, *Madness in the Streets* at 86-106, 287-308.

35. Waiting periods of over half a year are not uncommon. *Id.* See also David Ferrell, *Team is Scrambling to Help Mentally Ill*, L.A. Times B1 (Dec. 20, 1990). The problem of long waiting periods appears to be endemic to community and public health care in general. See, for example, Elaine Herscher, *Health Agencies Face Worst Cuts in Memory*, San Fran. Chronicle A1 (Apr. 15, 1991) (documenting that public health patients wait as long as three months for dental work and over two years for drug treatment).

36. For example, the State of New York is seeking to reduce the number of institutionalized patients in the state from 12,500 in twenty-two hospitals to 6,000 in about fifteen hospitals. See *Coming Back: Courage on Mental Health*, N.Y. Times A14 (Feb. 3, 1992). Mental health and church groups, fearing that the several hundred million dollars in annual savings will be allocated to reducing the state's budget deficit, have introduced legislation which would direct a substantial portion of the closure savings to community mental health programs. *Id.*

cans under the age of sixty-five who are uninsured,³⁷ they generally cannot afford private care. This fact is not surprising since sixty-four percent of Americans receive health benefits through employer-sponsored insurance programs and many of the mentally ill are not employed.³⁸ Employment, however, does not guarantee health insurance coverage since approximately three quarters of the uninsured are employed or are the dependents of employed persons.³⁹

Moreover, general health insurance coverage does not guarantee coverage for mental illness. Coverage for inpatient mental health care is available for only 82.4 percent of the privately insured, and only 71.4 percent have coverage for outpatient mental health care.⁴⁰ Even when treatment for mental illness is covered, the benefits provided often are subject to more limitations than other illnesses.⁴¹ Seventy-one percent of the participants in the health plans of medium and large firms with mental health coverage have more restrictive inpatient coverage for mental health care than other illnesses.⁴² These restrictions often take the form of shorter durations of hospitalization or lower caps on covered expenses.⁴³ Ninety-five percent of the plans limit outpatient mental health care to fewer visits per year than for other illnesses and set special maximums on annual expenses.⁴⁴ In addition, the coinsurance rate is often fifty percent for outpatient mental health care, rather than the eighty percent rate common for other illnesses.⁴⁵

Public insurance programs also limit mental health care benefits. Medicare Part A (Hospital Insurance) imposes a lifetime limit of one hundred ninety days of paid care in psychiatric hospitals and limits benefit periods to ninety days.⁴⁶ Medicare Part B (Supplemental Medi-

37. The number of uninsured mentally ill people has been estimated at approximately 300,000. Rupp, 17 *Schizophrenia Bull.* at 402 (cited in note 10). The number of Americans lacking health coverage is estimated at 34.7 million as of 1990, with an increase of more than one million expected in 1991. Harris Meyer, *Report: Number of Uninsured Up to 34.7 Million*, *AMA News* 5 (Jan. 20, 1992).

38. Richard G. Frank and Thomas G. McGuire, *Mandating Employer Coverage of Mental Health Care*, 9 *Health Affairs* 31, 32 (1990).

39. *Id.*

40. Rupp, 17 *Schizophrenia Bull.* at 402 (cited in note 10).

41. Inadequate health insurance coverage for a given illness is known as "underinsurance," as opposed to "uninsurance" (the lack of any insurance). *Id.* at 402. In regard to mental illness in particular, underinsurance means mental health care coverage at levels below those provided for other illnesses. *Id.*

42. *Id.*

43. For example, covered hospitalization for mental illness was often limited to thirty or sixty days per year, as compared to one hundred twenty days or unlimited days for other illnesses. *Id.*

44. *Id.*

45. *Id.*

46. A benefit period begins with the first day of hospitalization, and ends when the benefi-

cal Insurance) recently expanded its maximum mental health coverage from \$250 to \$1,100 to bring coverage into line with that of other chronic disorders.⁴⁷

Unless they are personally wealthy, individuals seeking mental health care quickly run out of viable alternatives. If insured, they quickly expend their mental health care benefits. If uninsured, the high cost of mental health care quickly consumes their private resources. If destitute, they face the shortage and delay of public facilities. Many people needing treatment thus must go without.

III. INDIRECT FUNDING BY HOSPITALS AND PHYSICIANS

A. *The Common-Law Duty*

Although hospitals and physicians generally do not provide direct funding for mental health care, they indirectly fund a portion of short-term emergency care by providing unpaid and unreimbursed services. The common law imposes a duty on physicians and hospitals not to release patients who present a danger to themselves or others. Thus, such physicians and hospitals are liable in damages for injuries to the patient or others as a result of patient discharges in violation of this duty.⁴⁸ This liability, however, usually does not extend to consequences that are unforeseeable or that occur at some distant point in the future.⁴⁹

When a patient presents a danger to identifiable third parties, the physician or hospital must take certain steps to protect those third parties. In the leading case of *Tarasoff v. Regents of University of California*,⁵⁰ the court held that when physicians or therapists determine that a patient presents a serious danger to an identifiable third party, they must use reasonable care to protect the intended victim.⁵¹ Reasonable care includes warning the third party or authorities, or, if possible, committing or hospitalizing the patient.⁵² Most courts generally have lim-

ciary has not used Plan A benefits for sixty consecutive days. Judith R. Lave and Howard H. Goldman, *Medicare Financing for Mental Health Care*, 9 Health Affairs 19, 21 (1990).

47. *Id.*

48. See, for example, *Semler v. Psychiatric Institute*, 538 F.2d 121 (5th Cir. 1976) (holding a psychiatrist liable under Virginia law for the death of a girl killed by a probationer released as an outpatient); *O'Shea v. United States*, 623 F. Supp. 380 (E.D.N.Y. 1985) (imposing no liability if a psychiatrist makes a professional medical judgment to the best of her ability); *Martin v. Washington Hospital Center*, 423 A.2d 913 (D.C. 1980); *Bell v. New York City Health & Hospitals Corp.*, 90 A.D.2d 270, 456 N.Y.S.2d 787 (1982); *Homere v. State*, 48 A.D.2d 422, 370 N.Y.S.2d 246 (1975); *Greenfield v. State*, 130 Misc. 2d 161, 495 N.Y.S.2d 611 (Ct. Cl. 1985).

49. See, for example, *Bowers v. DeVito*, 486 F. Supp. 742 (N.D. Ill. 1980).

50. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

51. 551 P.2d at 340.

52. *Id.*

ited the duty to warn to identified victims or to those third parties with which the patient has a special relationship.⁵³ Some courts, however, have expanded liability to include cases in which danger to the public in general is reasonably foreseeable.⁵⁴ In response to the *Tarasoff* decision, a number of state legislatures codified the common-law duty, usually limiting the liability of professionals in a *Tarasoff* situation.⁵⁵

By compelling physicians and hospitals to provide initial mental health care to a certain class of mental patient, at least to the extent of determining whether or not a danger exists, these common-law duties provide a sort of safety net for the most dangerous manifestations of mental illness. This safety net, however, is subject to varying standards and enforcement among states. A congressional enactment establishing in federal law a duty to provide emergency care would result in more consistent and reliable care. The next section examines the most likely vehicle for federal codification of such a duty.

53. See, for example, *Merchants National Bank & Trust Co. v. United States*, 272 F. Supp. 409 (D.N.D. 1967) (finding that the patient's wife had a special relationship); *McDowell v. County of Alameda*, 88 Cal. App. 3d 321, 151 Cal. Rptr. 779 (1979) (recognizing that there is no duty to warn when the threat is against the public in general); *Hoffman v. Blackman*, 241 So. 2d 752 (Fla. Dist. Ct. App. 1970) (finding that the patient's son had a special relationship); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (1979) (holding that a psychiatrist may have breached the duty to warn an identified person of danger from the patient); *Bradley Center, Inc. v. Wessner*, 250 Ga. 199, 296 S.E.2d 693 (1982) (holding that a private mental health hospital had a duty to exercise reasonable care to prevent a patient from killing his wife and her paramour); *Bardoni v. Kim*, 151 Mich. App. 169, 390 N.W.2d 218 (1986) (holding that a psychiatrist has a duty to protect a readily identifiable third party if the psychiatrist knows or should know that the patient presents a danger to that third party).

For an argument that an affirmative duty to report suicide threats should be imposed on anyone hearing them, see Kate E. Bloch, *The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats*, 39 Stan. L. Rev. 929 (1987). A few states have even enacted statutory duties to rescue people or to report crimes. *Id.* at 947-48.

54. See, for example, *Petersen v. State*, 671 P.2d 230 (Wash. 1983) (holding a psychiatrist liable for a pedestrian's injuries caused by a patient); *Cain v. Rijken*, 74 Or. App. 76, 700 P.2d 1061 (1985) (recognizing an issue of material fact as to the foreseeability of an automobile accident); *Rum River Lumber Co. v. State*, 282 N.W.2d 882 (Minn. 1979) (finding liability for property damage caused by an escaped patient).

55. Alaska Stat. § 47.30.790 (1986); Cal. Civ. Code § 43.92 (West Supp. 1988); 1987 Colo. Rev. Stat. § 13-21-117; Ind. Code Ann. §§ 34-4-12.4-1 to 12.4-4 (West Supp. 1988); Ky. Rev. Stat. Ann. § 202A.400 (Michie 1988); La. Rev. Stat. Ann. § 9:2800.2 (West Supp. 1988); Minn. Stat. Ann. § 148.975-.976 (West Supp. 1988); Mont. Code Ann. §§ 27-1-1101 to 27-1-1103 (Supp. 1987); N.H. Rev. Stat. Ann. §§ 329:31, 330-A:22 (Equity Supp. 1987); Utah Code Ann. §§ 78-14a-101 to -102 (Supp. 1988); Wash. Rev. Code Ann. § 71.05.120(2) (West Supp. 1988).

In addition to defining the duty to warn, some statutes also require physicians to take other appropriate action such as hospitalizing the patient. See, for example, 1987 Colo. Rev. Stat. § 13-21-117.

B. *The Emergency Medical Treatment and Active Labor Act*

The Emergency Medical Treatment and Active Labor Act (EMTALA)⁵⁶ was Congress's response to the increasing problem of "patient-dumping."⁵⁷ EMTALA requires all hospitals that participate in the Medicare program and provide emergency medical services to treat any patient in a medically unstable condition, regardless of ability to pay.⁵⁸ EMTALA provides for civil penalties against hospitals and physicians that negligently transfer patients in violation of the statute.⁵⁹ By its terms, EMTALA applies to nearly eight-five percent of the hospitals in the United States and its territories.⁶⁰ EMTALA defines the term "emergency medical condition" broadly to include any medical condition manifesting sufficient severity so that the absence of immediate treatment would seriously jeopardize the patient's health, seriously impair bodily functions, or result in the serious dysfunction of any bodily organ or part.⁶¹ In enacting EMTALA Congress employed the same def-

56. 42 U.S.C. § 1395dd (1988). Congress enacted EMTALA as part of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), Pub. L. No. 99-272 § 9121, 100 Stat. 164 (1986), codified at 42 U.S.C. § 1395dd, and it frequently has been referred to by the acronym, COBRA. Following the lead of several recent cases, however, this Note will use the more precise acronym EMTALA. See, for example, *Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991); *Burditt v. U.S. Dept. of Health and Human Services*, 934 F.2d 1362 (5th Cir. 1991).

57. "Patient dumping" occurs when a hospital capable of providing needed medical care turns patients away or transfers them to another medical facility because the patient is unable to pay for the needed care. See Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. Rev. 1186, 1186-87 (1986).

58. See 42 U.S.C. § 1395dd. For a general history of common-law and state remedies for patient dumping and a detailed analysis of the requirements of EMTALA, see Note, 61 N.Y.U. L. Rev. 1186 (cited in note 57), and Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 Wake Forest L. Rev. 173 (1989).

59. The maximum penalty is \$50,000 for each violation. 42 U.S.C. § 1395dd(d)(1) (West Supp. 1992). Congress recently lowered the standard of liability, requiring only negligence rather than a knowing violation. Compare *id.* (negligent violation) with 42 U.S.C. § 1395dd(1)-(2) (Supp. IV 1987) (knowing violation). A physician recently was fined \$20,000 under the previous penalty provision for knowingly transferring a woman in active labor. See *Burditt*, 934 F.2d 1362. Although *Burditt* was the first case in which a court of appeals upheld a fine against a physician, the change in the standard of liability certainly will lead to more such cases.

60. In 1986, about ninety-eight percent of the approximately 7,000 hospitals registered with the American Hospital Association in the United States and its territories participate in Medicare, and approximately eighty-five percent of these have emergency departments. Note, 61 N.Y.U. L. Rev. at 1189 n.19 (cited in note 57).

61. As defined in the EMTALA, the term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 (ii) serious impairment to bodily functions, or
 (iii) serious dysfunction of any bodily organ or part . . .

42 U.S.C. § 1395dd(e)(1)(A). The statute also applies to women in labor. *Id.* § 1395dd(e)(1)(B).

inition of "emergency medical condition" as that then used by the American College of Emergency Physicians (ACEP).⁶² ACEP's definition, in turn, had resulted from negotiations between ACEP and the Department of Health and Human Services over the appropriate Medicare reimbursement standard.⁶³ Prior to these negotiations, ACEP defined "medical emergency" to include any patient suspected suffering from a mental illness and posing an apparent danger to the safety of him/herself or others."⁶⁴ ACEP physicians consider the former ACEP definition of "medical emergency" to be superior to the current one Congress adopted for EMTALA.⁶⁵ The former ACEP definition is more specific than its current counterpart.⁶⁶

Congress should amend EMTALA to conform more closely to the previous ACEP definition. Such an amendment would clarify the inherent ambiguities⁶⁷ in the current definition and would provide needed guidance to emergency physicians. Providing physicians and hospitals with an unambiguous definition of medical emergency is especially important in light of the recent change in the standard of liability.⁶⁸

62. Note, 61 N.Y.U. L. Rev. at 1210 (cited in note 57).

63. Id.

64. Id. at 1210-11. The earlier ACEP definition of "medical emergency" includes:

- 1) Any condition resulting in admission of the patient to a hospital or nursing home within 24 hours;
- 2) Evaluation or repair of acute (less than 72 hours) trauma;
- 3) Relief of acute or severe pain;
- 4) Investigation or relief of acute infection;
- 5) Protection of public health;
- 6) Obstetrical crises and/or labor;
- 7) Hemorrhage or threat of hemorrhage;
- 8) Shock or impending shock;
- 9) Investigation and management of suspected abuse or neglect of a person which, if not interrupted, could result in temporary or permanent physical or psychological harm;
- 10) Congenital defects or abnormalities in a newborn infant best managed by prompt intervention;
- 11) Decompensation or threat of decompensation of vital functions, such as sensorism [sic], respiration, circulation, excretion, mobility, or sensory organs;
- 12) Management of a patient suspected to be suffering from a mental illness and posing an apparent danger to the safety of himself, herself or others; or
- 13) Any sudden and/or serious symptom(s) which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible deterioration, disability or death.

Id. at 1211 & n.170, quoting *ACEP Board Reviews Definitions of Bona Fide Emergencies*, ACEP News 1 (Dec. 1982).

65. Id.

66. See, for example, Note, 61 N.Y.U. L. Rev. at 1209-14 (cited in note 57); Helene Hoffman, *Does Cobra Work? The Problem of Patient Dumping and Possible Solutions*, 25 J. Health & Hosp. 1, 6-7 (1992).

67. For example, Congress could clarify the term "serious." Note, 61 N.Y.U. L. Rev. at 1212 (cited in note 57).

68. See note 59 and accompanying text.

Amending EMTALA explicitly to include mentally ill patients who present a danger to themselves or others would ensure that such patients receive emergency treatment regardless of their ability to pay. In contrast, the current definition may not include mental patients who pose a danger to themselves and definitely does not require emergency treatment of those who may endanger others.⁶⁹

Adopting the broader definition should not increase the cost of complying with EMTALA substantially, at least with regard to mental patients, because the obligation to manage dangerous mental patients already is imposed by the common law.⁷⁰ It will, however, provide an additional incentive in the form of possible federal civil penalties to ensure that the dangerous mental patient is managed properly. Federal penalties are a more certain cost of failure to provide emergency treatment to a mentally ill patient than a possible tort action subject to varying state standards⁷¹ and, thus, are a more effective deterrent.

Amending EMTALA to require emergency treatment of mental health patients may impose more burdensome additional costs on smaller, outlying hospitals, which often provide only limited emergency services and are unlikely to have a full-time staff psychiatrist. It may be more cost effective for these hospitals simply to close their emergency departments entirely⁷² than to hire a staff psychiatrist to comply with the statute.⁷³ Alternatively, such hospitals could arrange to have a psychiatrist available on call to provide treatment or to advise the existing emergency staff in deciding whether to transfer the patient to another facility.

Although requiring hospitals and physicians to provide emergency care to mentally ill patients is vitally important and potentially life-saving, such provisions still would leave a large number of nonviolent patients in need of treatment but unable to afford it. Even those with medical insurance soon exhaust their benefits due to the limited mental health care coverage provided by most insurance programs.⁷⁴ Equalizing mental health care coverage with that for physical illnesses would provide necessary mental health care, at least to insured patients.

69. While an argument can be made that posing a danger to oneself (for example, through risk of suicide) is an emergency condition that could result in placing one's health in "serious jeopardy" if untreated, see 42 U.S.C. § 1395dd(e)(1)(A), the threat of injury to others is not covered under EMTALA's current definition.

70. See notes 59-65 and accompanying text.

71. See notes 48-55 and accompanying text.

72. EMTALA already has forced many hospitals to reevaluate the cost effectiveness of their emergency departments. See, for example, Hoffman, 25 J. Health & Hosp. at 7 (cited in note 66).

73. The median net income of a psychiatrist in the United States is approximately \$107,000 per year. Mike Mitka, *Doctor Pay Stalled for Second Year*, AMA News 9 (Dec. 2, 1991).

74. See notes 40-45 and accompanying text.

IV. THIRD- AND FOURTH-PARTY PAYORS

A. *Benefits Limitations in Private Insurance Contracts*

Many private insurers limit coverage for mental illness to a certain number of days or a set monetary limit. Courts traditionally have considered these limitations to be valid contractual provisions.⁷⁵ Under contract theory, the insurer and the insured have bargained freely, and the insurer's responsibilities are limited to the contract's terms. Given the freedom of contract principle, many courts likely would be reluctant to extend the insurer's financial liability beyond the time limitation.

Benefits-limitations clauses may be subject to attack as contracts of adhesion due to the unequal bargaining power between individuals and insurance companies.⁷⁶ This argument is most effective when the individual is privately insured. Since the difference in bargaining power is lessened when the insurance company bargains with the employer,⁷⁷ the final result may depend on whether the court focuses on the individual employee or the employer.⁷⁸ Even a large employer, however, still may be in an unfair bargaining position if the insurance company dominates or monopolizes the local market.⁷⁹ In many circumstances, the employer's options are limited to substantially similar plans with restricted mental health care coverage.⁸⁰

Clauses limiting mental health care benefits also may be ambiguous or unclear. Since exclusions in an insurance contract are construed against the insurer strictly and are interpreted liberally in favor of the insured, courts typically resolve any such ambiguities in favor of the insured.⁸¹ In *Arkansas Blue Cross v. Doe*,⁸² for example, the court sustained the trial court's finding that bipolar affective disorder⁸³ was not a mental illness within the meaning of a standard clause limiting

75. See, for example, *Equitable Life Assur. Soc. v. Berry*, 212 Cal. App. 3d 832, 260 Cal. Rptr. 819 (1989).

76. See, for example, *Madden v. Kaiser Foundation Hospitals*, 17 Cal. 3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976).

77. See notes 47-54 and accompanying text.

78. Compare *Jones v. Crown Life Ins. Co.*, 86 Cal. App. 3d 630, 150 Cal. Rptr. 375 (1978) (focusing on the bargaining power of the individual employee) with *Berry*, 260 Cal. Rptr. 819 (1989) (focusing on the bargaining power of the employer).

79. See Note, *Limiting Provider Participation in Health Insurer Reimbursement Decisions: An Antitrust Cure for a Crisis in Medical Care Costs*, 72 Georgetown L.J. 161 (1983). The author states that "[i]n some markets, effective employer choice may be impossible due to Blue Cross' or Blue Shield's monopoly power," and points to a number of antitrust suits alleging monopolization under the Sherman Act. *Id.* at 163 n.14.

80. *Id.*

81. See, for example, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539-40 (9th Cir. 1991); *Berry*, 260 Cal. Rptr. at 822.

82. 22 Ark. App. 89, 733 S.W.2d 429 (1987).

83. Bipolar affective disorder also is known as manic-depressive disorder.

mental health care benefits. The trial court distinguished between the cause of the illness and its symptoms, stating that although the symptoms of bipolar affective disorder may be described as those of a mental condition, the disorder's cause was biological and, thus, qualified as a physical illness.⁸⁴ The court rejected the insurer's argument that bipolar affective disorder is a mental condition because it is classified in mental health care manuals; nearly all of the expert witnesses agreed that such classifications are made by symptom rather than cause.⁸⁵ A federal district court in Florida reached a similar result for the same disorder and likewise refused to rely on the disorder's inclusion in the DSM-III-R.⁸⁶

Similarly, in *Kunin v. Benefit Trust Life Insurance Company*⁸⁷ the Ninth Circuit applied the rule of liberal interpretation in favor of the insured to determine that autism was not a mental illness under the terms of the policy.⁸⁸ As with bipolar affective disorder, evidence suggests that autism is an "organically based" disease that manifests mental symptoms. Since the insurance contract failed to define "mental illness," the court construed the term against the insurer.⁸⁹

Not all courts have followed suit, however. In *Equitable Life Insurance Society v. Berry*⁹⁰ the California Court of Appeals disagreed with *Arkansas Blue Cross* and held that bipolar affective disorder is a mental illness. The California court rejected the *Arkansas Blue Cross* approach of classification by origin and, instead, focused on the illness's

84. *Arkansas Blue Cross*, 733 S.W.2d at 432.

85. *Id.*

86. *Rosenthal v. Mutual Life Ins. Co. of New York*, 732 F. Supp. 108, 110 (S.D. Fla. 1990).

The district court stated that DSM-III-R is merely a diagnostic tool used by the psychiatric profession for treating patients, and the manual itself cautioned against any other use:

The purpose of the DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for non-clinical purposes, such as determination of legal responsibility, . . . , or justification of third-party payment, must be critically examined in each instance within the appropriate institutional context.

Id.

87. 910 F.2d 534 (9th Cir. 1990).

88. *Id.* at 535.

89. *Id.* at 537-40.

As noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of the coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament.

Id. at 540.

90. 212 Cal. App. 3d 832, 260 Cal. Rptr. 819 (1989).

manifestation.⁹¹ The court also rejected the idea that any reasonable layperson⁹² would view a person with bipolar affective disorder as suffering anything but a mental illness.⁹³

A recent decision by the California Court of Appeals in *Wilson v. Blue Cross of Southern California*⁹⁴ may herald a new line of attack on benefits-limitation clauses. Howard Wilson, Jr., suffering from major depression, drug dependency, and anorexia, was admitted to a Los Angeles psychiatric hospital for treatment. Although the treating physician determined that Wilson needed three to four weeks of in-patient care, the hospital discharged him after ten days when Western Medical, a fourth-party medical utilization review company hired by the insurer,⁹⁵ refused to approve payment for further treatment.⁹⁶ Twenty days after his discharge from the hospital, Wilson committed suicide.⁹⁷

Wilson's family brought suit against his insurer, Blue Cross and Blue Shield of Alabama; the insurer's sister organizations, Blue Cross of Southern California and Blue Cross of California; Western Medical Review; and the Western Medical physician who reviewed the decedent's case. The plaintiffs raised claims of tortious breach of insurance contract, inducing a breach of contract, and wrongful death.⁹⁸

Relying on an earlier California case, *Wickline v. State*,⁹⁹ the defendants sought summary judgment on every claim. First, the defendants argued that liability for the consequences of a discharge lies solely with the treating physician even when the patient is discharged because an insurance company terminates benefits. *Wickline* had indicated that the physician has the ultimate responsibility for a discharge decision.¹⁰⁰

91. "Manifestation, not cause, is the yardstick." *Berry*, 260 Cal. Rptr. at 824, 824 n.2.

92. The general rule is that terms in an insurance contract should be interpreted according to a layperson's understanding. *Id.* at 824. Of course, the court then must determine what a layperson would understand.

93. *Id.* Both the *Kunin* and the *Arkansas Blue Cross* courts took a different view of what a layperson's understanding would be. See *Kunin*, 910 F.2d at 542 n.9; *Arkansas Blue Cross*, 733 S.W.2d at 431 (stating that "most laymen, and actually I think most physicians and most people in psychiatry now classify illnesses by cause or origin").

94. 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (1990).

95. Concurrent utilization review, sometimes termed prospective utilization review, is the "process by which an insurance company determines during a [patient's] hospital stay whether to terminate the payment of benefits." 271 Cal. Rptr. at 881. Utilization review has been fairly successful at reaching its goals of cost containment and reduction. Rex O'Neal, *Safe Harbor for Health Care Cost Containment*, 43 Stan. L. Rev. 399, 406-07 (1991).

96. The patient apparently was not committable and voluntarily discharged himself.

97. *Wilson*, 271 Cal. Rptr. at 878.

98. *Id.* at 880-81.

99. 183 Cal. App. 3d 1064, 228 Cal. Rptr. 661 (1986).

100. The *Wickline* court stated:

However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scape-

The *Wilson* court, however, rejected that portion of *Wickline* as mere dicta. According to the *Wilson* court, the issue of whether the defendants' actions were a substantial factor in causing Wilson's death did not turn on the potential joint liability of the treating physician.¹⁰¹

Second, the defendants argued that courts should not impose liability on insurance companies or their agents conducting concurrent utilization review because of important public policy considerations determinative in *Wickline*.¹⁰² The defendants apparently claimed that utilization review served the public good by keeping mental health care costs down.¹⁰³ The *Wilson* court, however, found that the clearly expressed public policy present in *Wickline* was not present in this case. The specific statutes at issue in *Wickline* expressed a public policy preference for utilization review only in state-funded programs, not private insurance contracts.¹⁰⁴

Finally, the defendants argued that a doctor who complies without protest, with the limitations imposed by a third-party payor cannot avoid ultimate responsibility for the patient's care.¹⁰⁵ Again characterizing similar reasoning in *Wickline* as dicta, the *Wilson* court refused to hold that a physician's failure to follow an informal procedure for requesting reconsideration by the reviewing agency immunized the insurers and their agents from liability.¹⁰⁶

Under a straightforward interpretation, *Wilson* may be viewed as

goat when the consequences of his own determinative medical decisions go sour. *Wickline*, 228 Cal. Rptr. at 671.

101. The court observed:

This broadly stated language was unnecessary to the decision and in all contexts does not state the law relative to causation issues in a tort case. . . . The legitimate rationale of *Wickline* was that the normal tort responsibility principles in Civil Code section 1714 were modified were modified by the provisions of the California Administrative Code and the Welfare and Institutions Code so that a Medi-Cal recipient was entitled to medical care within "the usual standards of medical practice in the community" and that the discharge decision in that case fell within the standard of medical practice. The language in *Wickline* which suggests that civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta.

Wilson, 271 Cal. Rptr. at 880 (citation omitted).

102. *Id.* at 884.

103. *Id.*

104. *Id.* at 884.

105. *Id.* at 883.

106. According to the court, the *Wickline* dicta has no application to this case. The present case involves a claim by a decedent's estate and relatives directly against insurance companies and their agents, not against a physician. In any event the failure of [the treating physician] to follow an informal policy allowing for reconsideration by Western Medical did not warrant granting summary judgment. . . . [T]here is a triable issue as to whether the refusal to allow the decedent to stay in the hospital was a "substantial factor" in bringing about his death and the availability of an avenue of appeal fails to prove as a matter of law that his demise was unrelated to his denial of benefits. *Wilson*, 271 Cal. Rptr. at 884-85.

primarily a breach of contract case with no implications for the validity of benefits limitations for mental health care. Wilson's Blue Cross policy provided mental health benefits for up to thirty days;¹⁰⁷ the failure to provide coverage for up to thirty days alone constituted a breach of the insurance contract. Moreover, since the insurance contract did not provide for concurrent utilization review, Western Medical's determination was itself a breach.¹⁰⁸ The liability of the utilization review company, then, can be established through a simple application of settled doctrines of vicarious or simple corporate liability.¹⁰⁹

A broader interpretation of *Wilson*, however, focuses on the decision's implications concerning tort liability for wrongful death due to the termination of care. Under this view, *Wilson* and *Wickline* establish that a health care insurer and reviewing agency may be liable for injuries resulting from the wrongful termination of benefits.¹¹⁰ The central question then becomes what constitutes a "wrongful" termination.

Wilson demonstrates that wrongful termination includes the termination of benefits by a reviewing agency against the recommendation of the treating physician who acts in conformity with the prevailing medical standard, at least when the insurance contract does not provide for utilization review. The presence or absence of a review provision does not appear to be critical, however. While the *Wilson* court refused to hear the issue because the plaintiffs did not raise it in the trial court, the court did note that Western Medical had failed to prove that the denial of benefits was legally proper. Thus, even if an insurance contract expressly provides for concurrent utilization review, the termination of necessary care by a reviewing agency against the recommendation of the treating physician acting in conformity with prevailing medical standards still may be wrongful. This certainly would be true if the reviewing agency followed a policy of arbitrarily terminating benefits after a certain period of time without any medical or contractual justification whatsoever, assuming that coverage was not otherwise temporally limited.

Incorporating a standard time limit into the insurance contract

107. *Id.* at 880.

108. The appellate court did not consider this argument because the plaintiffs did not raise it in the trial court. *Id.* at 884 n.7.

109. See, for example, *Boyd v. Albert Einstein Medical Center*, 377 Pa. Super. 609, 547 A.2d 1229 (1988) (finding an issue of material fact whether participating physicians were ostensible agents of the HMO); *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. App. 1987) (recognizing an issue of material fact whether the physician was an agent or employee of the HMO to establish vicarious liability); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill.2d 326, 211 N.E.2d 253 (1965) (finding that hospitals are liable for a wide range of factors affecting the quality of care offered).

110. See *Wilson*, 271 Cal. Rptr. at 883.

complicates the analysis by pitting contract law against medical necessity. In this situation courts must weigh the potentially life-threatening consequences of premature termination of care due to the cessation of insurance benefits against concerns regarding the freedom of contract and equity. The *Arkansas Blue Cross* and *Kunin* decisions appear to be an attempt by the courts to avoid directly confronting this issue by ostensibly satisfying both sides of the balance.

The different conclusions reached by these courts demonstrate that state court attacks on clauses limiting mental health benefits are likely to produce erratic and inconsistent results. These cases are particularly susceptible to small variations in state law and the findings of fact in a particular case. A recently-enacted federal statute may provide a more effective standard applicable to all insurance contracts.

B. *The Americans with Disabilities Act*

Certain provisions of the Americans with Disabilities Act of 1990 (ADA)¹¹¹ may accomplish statutorily what state court litigation cannot: establishing the invalidity of clauses limiting mental health care benefits. Congress enacted the ADA to eliminate discrimination against people with disabilities¹¹² in the areas of employment, public services, and privately provided public services.¹¹³

The ADA defines disability to include any physical or mental impairment that substantially limits one or more of the major life activities, a record of such impairment, or being regarded as having such impairment.¹¹⁴ The limitations of major life activities that the ADA recognizes include caring for one's self and working,¹¹⁵ limitations charac-

111. Pub. L. No. 101-336, 104 Stat. 327-378 (1990), codified at 42 U.S.C.A. §§ 12101 - 12213 (Supp. 1992); 47 U.S.C.A. § 225, 611 (1991).

112. Section 12101(b) states:

It is the purpose of this chapter-

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

42 U.S.C. § 12101(b).

113. See H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2 (1990). See generally Evan J. Kemp, Jr. and Christopher G. Bell, *A Labor Lawyer's Guide to the Americans with Disabilities Act of 1990*, 15 *Nova L. Rev.* 31 (1991).

114. 42 U.S.C. § 12102(2)(A), (B), (C).

115. H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2 52 (1990).

teristic of most major mental illnesses.¹¹⁶

The ADA expressly prohibits disability-based discrimination in employment.¹¹⁷ Under the ADA, a "covered entity"¹¹⁸ cannot discriminate in the hiring or discharge of employees, employee compensation, job training, or terms, conditions, and privileges of employment against a qualified individual with a disability¹¹⁹ because of the disability.¹²⁰ Prohibited acts include subjecting the qualified employee to discrimination through the employer's contractual relationship with an employment or referral agency, labor union, or an organization providing fringe benefits.¹²¹ The ADA also prohibits the use of standards, criteria, or methods of administration that have the effect of discrimination or that perpetuate discrimination.¹²²

Although the provision of health insurance is a fringe benefit provided to employees, the ADA explicitly states that it does not restrict the ability of insurance companies to limit benefits for disabilities such as mental illness.¹²³ Most analyses of the ADA interpret its provisions as not disrupting the current scheme of underwriting, classifying, and

116. See *DSM-III-R* at 12 (cited in note 10).

117. 42 U.S.C. §§ 12111-12117.

118. "Covered entity" is defined to include employers, employment agencies, labor organizations, and joint labor-management committees. 42 U.S.C. § 12111(2). An employer is "a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person"; for the first two years following enactment, however, the number of employees must be 25 or more. 42 U.S.C. § 12111(5).

119. "Qualified individual with a disability" is defined 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." 42 U.S.C. § 12111(8).

120. 42 U.S.C. § 12112(a).

121. 42 U.S.C. § 12111(b)(2).

122. 42 U.S.C. § 12112(b)(3).

123. The provision states:

Subchapters I through III of this chapter and title IV of this Act shall not be construed to prohibit or restrict—

(1) an insurer, hospital, or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapters I and III of this chapter.

42 U.S.C. § 12201(c).

administering risks.¹²⁴ The ADA's legislative history also supports this conclusion.¹²⁵

An employer, however, could not directly discriminate against a disabled person by denying her a job because the employer's insurance plan does not cover that particular disability or because of an anticipated increase in insurance costs.¹²⁶ The ADA also prevents indirect discrimination: the last sentence of Section 12201(c) provides that the section may not be used as a "subterfuge" to evade the purposes of the ADA.¹²⁷

This provision may provide the key to the equalization of mental health benefits with those for physical illnesses. A limitation on insurance benefits for mental illness can be a "subterfuge" designed to evade the purposes of the ADA because it specifically discriminates against a protected class of disabled people: the mentally ill. While ostensibly applying to all employees, such a limitation would have a disparate impact on an expressly protected group. For example, the clear limits in coverage for mental health care, including more restrictive eligibility and higher coinsurance rates might discourage the mentally ill from working for employers offering such limited coverage. The ADA would not prohibit disparities in coverage that have a solid actuarial basis.¹²⁸ At least one court, however, already has rejected the actuarial argument in the context of interpreting ambiguous clauses.¹²⁹ In addition, the

124. See, for example, *Americans with Disabilities Act of 1990: Law and Explanation* ¶ 501 at 99-100 (CCH, 1990); Note, *Addiction as Disability: The Protection of Alcoholics and Drug Addicts Under the Americans with Disabilities Act of 1990*, 44 Vand. L. Rev. 713, 718 n.39 (1991).

125. H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 1 45 (1990); H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2 59 (1990); H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 3 70 (1990); H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 4 70 (1990); S. Rep. No. 115, 101st Cong., 1st Sess. pt. 2 (1989). For example, the House Judiciary Committee report states:

[W]hile a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles, or is related to actual or reasonably anticipated experience.

H.R. Rep. No. 485, pt. 3 at 71 (emphasis added).

126. H.R. Rep. No. 485, pt 3 at 71 (cited in note 125).

127. 42 U.S.C. § 12201(c). Congress's use of the word "subterfuge" includes any "malicious, purposeful or inadvertent" evasion of the antidiscriminatory principles established in the ADA; this liberal use rejects the Supreme Court's more restricted interpretation of the term in *Public Employment Retirement Sys. of Ohio v. Betts*, 492 U.S. 158 (1989), which required some malicious or purposeful intent. Larry Gostin, *Genetic Discrimination: The Use of Genetically Based Diagnostic and Prognostic Tests by Employers and Insurers*, 17 Am. J. L. & Med. 109, 136 (1991).

128. See notes 123-25 and accompanying text. The burden of proof should lie with the employer and the insurer, as the employer's agent. See 42 U.S.C. § 12112(b)(6) (recognizing business necessity as an affirmative defense). An examination of the actuarial basis of mental health care benefits limitations is beyond the scope of this Note.

129. See, for example, *Arkansas Blue Cross*, 733 S.W.2d at 432-33 (finding that the actuarial

preference in current insurance plans for inpatient as opposed to outpatient treatment¹³⁰ indicates that such limitations may not be financially based on the experience of insurance companies, since the costs of community-based care generally are lower than inpatient care.¹³¹

Moreover, even a sound actuarial basis for an employer's argument that expanded coverage would be too costly should fail, since an employer could save as much money by taking nondiscriminatory measures affecting all employees.¹³² Across-the-board limitations on services that the majority of employees use more often do not discriminate against a particular disabled group. Moreover, these limitations could lower premiums at least as much as limiting mental health care alone. Spreading the burden of providing health care for a disabled group across a larger community is well within the expressed goals of the ADA.¹³³

If courts interpreted the "subterfuge" provision of the ADA as mandating a certain level of mental health care, a large portion of the cost of caring for the mentally ill would shift from tax-supported to insurance-supported care. Such a shift has both costs and benefits to society. By requiring a particular level of mental health insurance benefits, efficiency costs will be incurred due to distortions in the labor mar-

testimony dealt with the entire field of mental illness in general, with no evidence as to how coverage for a particular illness would affect premiums).

130. See notes 55-56 and accompanying text.

131. See David Goldberg, *Cost-Effectiveness Studies in the Treatment of Schizophrenia: A Review*, 17 *Schizophrenia Bull.* 453 (1991); McGuire, 17 *Schizophrenia Bull.* 375 (cited in note 27).

While it may be argued that private insurance contracts' preference for inpatient care is due to the fact that outpatient care is more prone to fraud, recent scandals at psychiatric hospitals indicate the contrary. See, for example, Susan Moffat, *Industry Under Fire: Psychiatric Hospitals in Crisis*, L.A. Times A1 (Feb. 2, 1992) (documenting that some psychiatric hospitals have misdiagnosed patients to hospitalize them and "milk" insurance payments); Peter Kerr, *Paying for Fraud*, N.Y. Times 1 (Nov. 24, 1991) (reporting investigations of fraud in several psychiatric hospitals). Nor is this type of abuse limited to mental health care. See, for example, Gordon Witkin, Dorian Friedman and Monika Guttman, *Health Care Fraud*, 112 U.S. News & World Rep. 34 (Feb. 24, 1992) (estimating that health-care fraud costs between \$50 billion and \$80 billion each year). A more likely explanation may be the perception that public mental health programs provide a form of catastrophic mental health insurance; private insurance plans presumably can provide minimal amounts of mental health care without leaving insureds without any alternatives. Frank and McGuire, 9 *Health Care Affairs* at 35 (cited in note 38). These public programs are underfunded and very limited, however, and should be used primarily by those who cannot pay not by those persons whose insurer has chosen not to cover mental illness. Moreover, since public health care systems are intended primarily to provide care for the indigent, privately insured individuals may be denied these resources. Several states, in fact, will not admit a patient to a state mental hospital if the patient has any kind of insurance, even if the benefits are exhausted for the year. Rupp, 17 *Schizophrenia Bull.* at 403 (cited in note 10).

132. This argument applies to all disabled individuals as well as to those suffering mental illness. See Jeanne Saddler, *Bush's Lending Push, Disabilities Law Create Concerns*, Wall St. J. B2 (Oct. 16, 1991).

133. See 42 U.S.C. § 12101 (Findings and Purposes of the ADA).

ket as a result of requiring greater benefits than those voluntarily negotiated between employers and employees.¹³⁴ These efficiency costs, however, might be offset by reductions in direct state expenditures for mental health.¹³⁵ If not, an increase in costs still may be justified because the current demand for mental health care insurance may be too low from a social perspective.¹³⁶ If an individual goes untreated because of inadequate coverage, deterioration of the individual's job-related skills and abilities eventually may lead to indigency. The deterioration of job-related skills impairs job performance, which, if impairment is severe enough, leads to unemployment and, eventually indigency. Thus, even if the individual finally reaches the "safety net" of the public mental health system, the fall probably will be very long and very painful.¹³⁷ The individual also may fall through this net if not qualified to receive public assistance, as many in this country are not.

Although application of the ADA to invalidate certain benefits limitations would increase the proportion of the mentally ill covered by private insurance and arguably would free up state resources, a large percentage of the mentally ill still would go untreated. The ADA only applies to health insurance obtained in the context of employment. Since many of the mentally ill are unemployed, and probably incapable of obtaining or holding jobs,¹³⁸ many of the people who most require immediate care would not be covered. Furthermore, as previously noted, many of the employed themselves are underinsured or not insured at all.

C. *Stigmatization and Prioritization in Health Care Funding*

Interpreting the ADA to mandate equal benefits for mental health care also resolves the problem of societal undervaluation of mental health care, a problem which may contribute to the shortage of mental health care funding. The low prioritization of mental health care reflected in current funding schemes may result from the same stigma that causes individuals to undervalue mental health care. While most people are willing to consider the possibility of becoming ill or suffering an accident, the stigma associated with mental illness discourages many

134. See Frank and McGuire, 9 *Health Care Affairs* at 36-38 (cited in note 38).

135. *Id.* at 38-39.

136. *Id.* at 36.

137. Rupp, 17 *Schizophrenia Bull.* at 403 (cited in note 10).

138. The nature of several of the most severe mental illnesses would render most sufferers unable to perform the essential functions of most jobs, even with reasonable accommodation. Thus, employers would be permitted by the ADA to refuse to hire the mentally ill on that basis. See notes 12-19 and accompanying text; 42 U.S.C. § 12111(8) and (9). As demonstrated in the process of deinstitutionalization, the funds supposedly freed by releasing patients from state hospitals did not follow the patients. See notes 33-35 and accompanying text.

people from giving serious consideration to the possibility that they eventually may suffer from mental illness.¹³⁹ This stigma is particularly prevalent in Anglo-American culture, which typically perceives mental illness as resulting from a personality weakness or personal failing.¹⁴⁰ Americans place a high premium on individual autonomy, self-determination, and will-power. It is difficult to shed these cultural assumptions. Many Americans do not understand why those with schizophrenia cannot simply will themselves to recover.¹⁴¹ A recent survey reported that forty-three percent of Americans still view depression as a personal weakness rather than a true health problem.¹⁴² In addition, the people most likely to oppose the placement of mental health care homes in their communities are white, affluent, professional men who own homes, a group that tends to believe in individual control and Social Darwinism.¹⁴³ People who fail to exercise such "control" are stigmatized.

An additional reason why individuals tend to undervalue mental health care is the belief that mental illness is chronic and incurable.¹⁴⁴ Such a belief probably originated in the time, only a few decades ago, when little actually could be done to cure mental illness.¹⁴⁵ Modern psychiatry, however, has made great strides in treatment, and most mental illnesses can be treated with some degree of success.¹⁴⁶

The personal and cultural stigma attached to mental illness may hamper the effectiveness of legislation designed to solve the insurance imbalance.¹⁴⁷ For example, several states that mandate insurance coverage of mental health care have established minimum floors below those mandated for other illnesses.¹⁴⁸ State-mandated insurance benefits for

139. See notes 33-34 and accompanying text.

140. Statement of Janis Jenkins, Ass't Professor of Anthropology and Psychology, Case Western Reserve University, quoted in Alison Bass, *Illness Coupled with Stigma; Researchers See a Cultural Bias Against Mental Disease*, Boston Globe 1 (Feb. 3, 1992).

141. Id.

142. Survey conducted December 1991 by the National Mental Health Association, reported in Bass, Boston Globe 1 (Feb. 3, 1992) (cited in note 140).

143. Id.

144. Id.

145. Id.

146. See note 16 and accompanying text. See also Isaac and Armat, *Madness in the Streets* at 20-21 (cited in note 1).

147. For example, President Bush's recent proposal for health care reform fails to ensure adequate mental care, and may actually hurt state-sponsored reforms:

This plan entrenches stigma against the mentally ill. . . . By overriding state mental health benefit mandates now in place, it is actually worse than no reform at all. This plan could abandon patients and bankrupt their families. The President is sending the clear message to all Americans who suffer mental illness: We do not care if you get the treatment you need.

Statement by Melvin Sabshin, M.D., Am. Psychiatric Ass'n Med. Director, quoted in *Bush's Health Care Proposal Leaves Mentally Ill in "Darkness"*, Psychiatric News 1, 11 (Mar. 6, 1992).

148. See, for example, Mass. Gen. Laws Ann. ch. 175, § 47B (West, 1984) (mandating minimum sixty days inpatient care per year and minimum \$500 outpatient care per twelve-month pe-

general health care actually may cause an overall reduction in coverage for mental illnesses. Since mandating benefits likely will result in an increase in the cost of health insurance, fewer employers, especially small businesses operating on tight margins, may choose to offer any form of health insurance.¹⁴⁹

Moreover, the undervaluation of health care will exist in any universal health care scheme, such as the Canadian plan, where health care must be rationed by some representative body.¹⁵⁰ Such plans do offer the advantage of looking at the subjective and objective value of health care in the aggregate, removing the variability of individuals.¹⁵¹ The Canadian health care system and Oregon's proposed health care prioritization scheme are examples of this approach. Oregon's plan, for example, applies limited funds to a list of health care procedures prioritized in terms of their health benefit by an independent board of physicians, legislators, and citizens.¹⁵² The state would not fund procedures for which funds are not available.¹⁵³

While limited societal resources require some prioritization of health care options and an allocation of health care resources, the danger is that the rationing will not be entirely rational. Like many individuals, the Oregon allocation procedure and others like it may undervalue mental health care. Both the stigma associated with mental illness and the underestimation of the effectiveness of treatment can place mental health care far down the prioritized list.¹⁵⁴ In fact, the use of the word

riod); Kansas Stat. Ann. § 40-2,105 (1986) (mandating minimum thirty days inpatient or outpatient care and a minimum lifetime mental health benefit of \$7,500). Some states require an insurer to offer mental health coverage at least to the same extent and degree as coverage for physical illnesses. See, for example, Ky. Rev. Stat. Ann. § 304-17-318 (Michie 1988). As discussed above, the insureds are unlikely or unwilling to recognize the need for mental health care coverage.

149. Michael Tanner, *As Washington Dithers, State Reform Health Care*, Heritage Found. Rep., Backgrounder No. 868 (Nov. 1991). In order to make health insurance more affordable to small businesses, many states are beginning to allow small employers to buy "bare bones" health insurance. *Id.* This option usually means scrapping so-called "peripheral" benefits like mental health care. *Id.*

150. Robert G. Evans, et al. *Controlling Health Expenditures—The Canadian Reality*, 320 *New Eng. J. Med.* 571 (1989).

151. See O'Neal, 43 *Stan. L. Rev.* at 439-40 (cited in note 95).

152. See *id.* at 439-40; Linda Williams, *John Kitzhaber: Reforming Oregon's Health System Long Before National Debate Began*, L.A. Times M3 (Jan. 19, 1992). John Kitzhaber, president of the Oregon State Senate, is one of the prime movers behind the Oregon health care plan.

153. O'Neal, 3 *Stan. L. Rev.* at 440 (cited in note 95).

154. Oregon has attempted to remove stigma from the prioritization process by focusing on the end result of treatment, rather than on the treatment itself. A prioritization survey's description of the end result of mental health care, however, may fail to disguise adequately the nature of the illness, or may be so general as to cover many different treatments. In the latter case, bias may reassert itself through the committee that finally decides the ranking of treatments. Moreover, the committee has the discretion to adjust the rankings regardless of the prioritization survey results. See Special Project, *The Oregon Basic Health Services Act: A Model for State Reform?*, 45 *Vand.*

“procedure” illustrates an inherent bias in the calculation towards relatively short-term, acute care: the patient is treated and hopefully gets better. In contrast, mental health care treatment can last for years, and thus measuring its benefits can be more difficult. If society is to adequately treat its mentally ill population, society and the representative bodies allocating health care resources must recognize the existence of subconscious influences tending towards undervaluation of mental health care.

V. CONCLUSION

Public perception of mental illness—and the stigma associated with it—perpetuates the inadequate medical treatment accorded the mentally ill. This stigma can permeate any system of health care, be it the current combination of public and private sources or the frequently proposed uniform national health care. Any system with limited resources requires making choices and prioritizing options. Failing to objectively evaluate mental health care, however, certainly will place it artificially low on any list.

Mental health care may not be the top health care priority. It should, however, be very high on any list. Mental health problems reach across society, imposing costs including lost productivity, early death, and the additional burden on society's resources. Many of the more pressing problems today—homelessness, crime, and drug and alcohol abuse—are connected to some extent to mental illness. Complete solutions to these problems must provide for treatment for the mentally ill. The family, the basic building block of American society, also is affected by mental health problems. Families of the mentally ill often bear the initial burden of care, and soon collapse under it.¹⁵⁵ Mental illness has more than one victim.

Beyond the economic cost-benefit analysis, society has certain moral obligations towards the mentally ill. The process of deinstitutionalization removed the mentally ill from situations in which they could be treated. Although there were undeniable instances of abuse and mistreatment, the abuse mandated reform and better treatment, not necessarily the cessation of all care. Society has not supported adequately the hoped-for alternative of community-based treatment, breaking the implied promise of better care. Instead of a bed—be it in a hospital or community center—many of the mentally ill will sleep on a sidewalk

L. Rev. 977, part III.B (1992).

155. Isaac and Armat, *Madness in the Streets* at 249-83 (cited in note 1).

grate tonight. Society owes it to these people, and to itself, to provide adequate care.

*Wayne Edward Ramage**

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