The seminar paper entitled The Stigma of Mental Illness and How it Directly Relates to the Lack of Insurance Equity Coverage is

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THE STIGMA OF MENTAL ILLNESS AND HOW IT DIRECTLY RELATES TO THE LACK OF INSURANCE EQUITY COVERAGE

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Abstract

This issue presented in this paper is to recognize that the stigma of mental illness correlates with a lack of equitable mental health insurance coverage. An additional purpose of this paper was to discuss whether current law does anything to modify the long-established societal views of mental illness. A brief review of literature on the history of mental illness and the stigma surrounding it was conducted. An additional review of literature regarding research and subjective evidence of discriminatory insurance industry practices was conducted. During the course of review of the literature, it becomes apparent that additional research needs to be completed on the inequality of mental health coverage and health coverage. A large sample of the research establishes that the mental illness stigma has a continual impact on the lack of mental health insurance coverage.

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CHAPTER ONE

INTRODUCTION

The stigma of mental illness is an indignity, especially in a country as progressive and prosperous as the United States. Individuals with mental illness are treated inferior to individuals with physically disabling ailments. This stigma is the primary explanation of why there is a lack of equity regarding coverage within the insurance industry. Mental illness is often seen as a fabricated disease, and is rarely treated in accordance with procedure for other major illnesses; such as heart disease, diabetes or cancer.

However, work has begun on this significant yet cumbersome issue. The Wellstone-Domenici Parity Act of 2008, which strives for equal treatment and compensation of mental illness, is a stride in the right direction. This act will end health insurance benefits inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees (APA, 2009). According to the American Psychological Association's website, equitable coverage will apply to all financial conditions, including lifetime and yearly maximum limits, deductibles, co-payments, co-insurance, out of pocket costs, and to all treatment restrictions. These restrictions include; frequency and duration of treatment, limitation of inpatient visits, and days of coverage. Furthermore, the Wellstone-Domenici Parity Act of 2008 modified and significantly improved the mental health benefits protection allowed

under the federal Mental Health Parity Act of 1996. The Mental Health Parity Act of 1996 only mandated parity coverage for lifetime and yearly maximum limits and did not apply to benefits for substance use disorders (APA, 2009).

Nonetheless, more work needs to be done. Small businesses with less than 50 employees are not required to provide equitable mental health coverage. This needs to be modified so that all employers providing health care coverage afford their employees mental health coverage as well. Additionally, coverage for substance abuse treatment is not mandated under this current law, and this needs to be amended.

Statement of the Problem

Mental illness and how it is viewed in society relates to the compensation methods used by the insurance industry. This tends to present an immeasurable predicament for individuals afflicted with mental illness, as well as the providers who care for them. Why is mental illness thought of so differently than physical illness? How can society's view of mental illness change? How can society encourage equitable compensation practices by the insurance industry?

Purpose of the Research

Mental illness is viewed negatively, by many, in society. This stigma directly relates to the compensation inequalities the insurance industry places on mental health coverage. Research suggests societal view of mental illness might improve if the insurance industry recognized it as a legitimate illness. The purpose of this research paper was to establish that current research supports the correlation of the stigma of mental illness and the inequitable practices within the insurance industry.

Significance of the Problem

On average the co-insurance amount required to see a mental health provider is double that of the coinsurance amount required to see a physical health specialist. This fact alone suggests there are numerous discriminating practices taking place on the part of the insurance industry. However, research suggests that these discriminatory practices are changing. Despite that, more needs to be done to ensure coverage equality for all illnesses.

Delimitations of Research

The research will be conducted through the Karmann library (University of Wisconsin-Platteville) over a period of 61 days. Primary searches will be conducted via Internet through EBSCO Host and Academic Search Elite. Key search topics will include “stigma of mental illness”, “mental illness insurance parity”, and “federal law mandate of mental health parity.

Method of Approach

A review of literature directly relating to research, studies and anecdotal evidence of the stigma of mental illness, how it has transformed throughout the years and how the insurance industry plays a role regarding the continuation of the stigma, will be accomplished. The findings will be summarized and recommendations made.

Definition of Terms

Co-insurance. A form of insurance in which an insurer assumes liability only for that proportion of a loss which the amount of insurance bears to a specified percentage of the value of the loss.

Co-payment. A small fixed amount required by the health insurer to be paid by the insured for each outpatient visit or drug prescription.

Deductible. The amount of money the insured party must pay before the insurance company's own coverage plan begins.

Mental Illness. A mental condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological and often social functioning of the individual.

Parity. Equality between mental health coverage and other health coverage.

Stigma. A mark of disgrace or infamy; a stain or reproach, as on one's reputation.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

The stigma of mental illness affects millions of individuals in the United States. This stigma correlates with the health insurance industry's lack of equitable practice. With this stigma in place, health insurance companies can pick and choose what qualifies as compensable and what does not. This stigma needs to be eliminated to ensure fair practice from the insurance industry.

"Mental illnesses are real health conditions that are characterized by alterations in thinking, mood, or behavior—all mental, behavioral, and psychological symptoms mediated by the brain. Mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole (www.surgeongeneral.gov, 2009)". However, if treatment is sought, mental illness sufferers can gain tremendous relief from their debilitating symptoms. After seeking treatment, most individuals can progress to a more functional work and personal life. However, treatment needs to be unique to the individual. There are various psychotherapeutic treatments, but each plan needs to be tailored to the symptoms of the individual.

The stigma of mental illness has existed for as long as mental illness has been recognized as legitimate. With regard to mental illness, a stigma is a damaging opinion supported by a label or stereotype. An example of this stigma would be an individual who is apprehensive or fearful

of another individual purely because that individual has been labeled as a "schizophrenic". Whatever the motivation for the fear, the stereotype still controls how the individual is perceived. To some, it has been thought that having a mental illness was due to some kind of personal weakness (MayoClinic.com, 2009). Fortunately, the public has become fairly receptive to the idea that mental illness has a biological foundation. Scientists and physicians now know that mental illness is the direct result of a chemical imbalance, much like diabetes or other physical ailments. Still, there are individuals who consistently perpetuate the fallacies, labels and stereotypes surrounding mental illness. This results in negative attitudes toward individuals with mental illness and mental health providers. These obstructive attitudes can result in individuals refusing to acknowledge, seek and accept psychological treatment. According to the United States Surgeon General, "Stigma impedes people from seeking help for fear that the confidentiality of their diagnosis or treatment will be breached. It gives insurers—in the public sector as well as the private—tacit permission to restrict coverage for mental health services in ways that would not be tolerated for other illnesses (www.surgeongeneral.gov, 2009)". Individuals are less likely to seek treatment when the negative stigma of mental illness exists. If an individual feels shame or reproach for their mental illness, it can hinder their personal progression. Furthermore, individuals without mental illness might be hesitant to work, live or socialize with individuals who suffer from mental illness.

Public ideation of mental illness has only served to create an excuse for the insurance industry to pick and choose what they will cover. The stigma surrounding mental illness only ensures that the insurance industry can rely on this stigma to help keep their profit margin high.

It would truly damage the insurance industry's best interest to admit mental illness is a true illness, thus accepting the fact that they must cover mental illness like anything else.

It is not uncommon for insurance companies to place limits on the amount of days a patient can be admitted to a psychiatric ward or hospital. Hospital inpatient admissions almost always require pre-authorization from the insurance company. According to the website, ehow.com, "Most insurance companies require that the hospital facility contact them within 24 to 48 business hours of hospital admission and require notification of observation stays. You may want to contact your insurance company to notify them of a hospital admission to ensure that the process has been started and that they are aware of the admission. An insurance company may give you the approval or authorization number or even a reference number for the call, while others may refuse to give this to you. Insurance companies will often put a hospital admission under a case or utilization management review, where they attain medical records from the hospital's case manager or UR department to ensure that the hospital stay was medically necessary. Many insurance companies will not give out any authorization number until this process is complete. You may call back after the utilization review is finished to receive an authorization number. You should receive a letter in the mail from your insurance company within a few weeks of discharge stating whether the stay was approved and if additional information is needed. Such a letter is also sent to the hospital that provided care for you during your hospitalization (www.ehow.com, 2009)". However, it is important to always remember that getting a preauthorization does not mean that an insurance company will cover the entire bill. It is always important to be familiar with what your specific insurance co-pays and deductible amounts are before you seek medical treatment. Unfortunately, the previous text only

refers to medical inpatient stays and has little to do with mental health stays. While the criteria for a medical inpatient stay sounds difficult to navigate, the process for mental illness admissions is much more stringent than that.

The insurance company, Humana, is particularly predatory. Not only do they have high premiums, co-pays, deductibles and out-of-pocket costs for all medical illness, their practice on mental illness is awful, at best. Not only is the deductible for mental health treatment higher than it is for medical treatment, consumers are required to pay for 50% of all services after they meet their deductible. This is in comparison to the 80% the same consumer must pay for medical treatment (www.humana-one.com, 2009). In their fine print, Humana becomes even more appalling. According to Humana-one.com, "Benefits payable after 90-day waiting period for preventive care and 12-month waiting period for mental health." Additionally, Humana states in their quoted benefits that outpatient services (therapy sessions, etc.) must not exceed five hundred dollars of the total benefit. Today, that equals about two outpatient visits with a licensed provider. Furthermore, per the fine print, counseling for a hospice patient is limited to 15 visits per calendar year, and there is a lifetime benefit of one hundred dollars for medical social services. Why are these insurance companies continually allowed to practice this way? Unfortunately, because the mental illness stigma still exists and actually thrives in this progressive society.

A stigma can represent itself in many different ways. Attitudes toward individuals with mental illness can range from indifference to hatred. This is because people typically fear the unknown. If an individual feels uncomfortable around others with mental illness, it is likely

related to a lack of knowledge. Whether there is a lack of education, or indifference to the subject matter, ignorance plays a large role regarding societal attitudes. With a lack of mental health education, people are left to assume individuals with mental illness are "crazy", "psycho" or just plain dangerous. These unconstructive attitudes can go a long way to emotionally damage sufferers of mental illness. The individuals on the receiving end of these attitudes may experience resentment, anger, shame and low self-esteem (Mayoclinic.com, 2009).

To ensure ignorance does not play a role in public attitude, it is essential to have a well-educated society. There are various ways to educate society about mental health and mental illness. Mental health providers, family physicians and the media all have a responsibility to provide accurate knowledge regarding mental illness. Numerous resources exist to help educate society about mental health and related mental illness. Individual organizations should promote their own types of stigma reduction programs; however, there is assistance available from various public and private agencies. The Substance Abuse and Mental Health Services Administration within the United States Department of Health and Human Services offers various techniques while developing a stigma reduction initiative. The process of education should implement techniques and methods best suited to dispelling myths of mental illness, as well as offer methods of coping with discrimination. According to the Stigma Reduction Initiative from the Substance Abuse and Mental Health Services division, there are key steps for an organization to follow when undertaking this initiative. First an organization should perform a Situational Analysis to establish the particular obstacles to altering stigma and discrimination related to

mental illness. It is also critical to develop a marketing plan for the initiative. Without a marketing plan, the community would be unaware of the offered education. Finally, at some point, the educational initiative must be critiqued to ensure success. There are several common points to remember when developing a stigma reduction initiative. It is imperative to make the public aware of the myths surrounding mental illness. Remind the audience that mental illness affects nearly every family in the United States. Mental illness is treatable, and sufferers can move on to have a fully functioning life. Additionally, it is important to stress that fear, shame and reproach are obstacles that work to only further harm sufferers of mental illness (www.allmentalhealth.samhsa.gov).

As individuals, challenging and eradicating stigma can only progress the society. Every member of the mental health community can do something to confront current stigma of mental illness. It is important to gain knowledge of the facts about mental health and mental illness. Then individuals can share this knowledge with others. Everyone deserves to be treated with dignity and respect. Never discriminate against sufferers of mental illness, it only gives additional momentum to stigma (www.allmentalhealth.samhsa.gov).

The insurance industry in the United States has traditionally differentiated mental illness from physical illness by mandating high out of pocket costs and placing limitations on the frequency and duration of mental health treatment. This policy has been a continuous debate among the insurance industry, federal and state representatives and sufferers of mental illness. Supporters for equitable coverage feel that limitations on mental health treatment represent discrimination by the insurance industry. The insurance industry quietly propagates the idea that this type of discrimination is acceptable, thus strengthening the current negative stigma. Society clings to these discrimination techniques for a variety of factors; ignorance, few resources, apathy and lack of will.

Legislation regarding insurance parity for mental illnesses has been proposed and enacted. The Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008 (APA.org, 2009), requires most group health plans to provide comparable benefits for mental health and physical conditions. Per the Wellstone and Domenici Act, "Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and all out-of-pocket expenses and to all treatment limitations, including frequency of treatment, number of visits, days of coverage and similar limits." While this act does work to reduce some of the stigma and insurance discrimination encompassing mental illness treatment, it lacks firm guidelines for all employers that provide insurance coverage for their workers. Supplementary legislation has been enacted relating to insurance coverage for mental health treatment. "On July 15, 2008, the US Congress enacted a Medicare law that reduced co-insurance in the Medicare program for outpatient mental health services from 50% to 20%, which is equivalent to the Medicare Part B co-insurance rate for other medical and surgical services, to be phased in over 5 years starting in 2010 (Trivedi et al., pp 10-12, 2008)." The current legislation representing the mental health parity strives to achieve equity of mental health coverage for insured consumers. However, loopholes still exist. The Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008, only succeeds at securing equitable insurance benefits for employers with more than 50 employees. The small businesses of America typically have less than 50 employees, and they could all go without mandated mental health coverage (Mandersheid, 2009). Unfortunately, neither of these laws addresses the fact that there are 50 million completely uninsured Americans. These Americans have no access to any care, much less mental health care. They are required to pay out of pocket for any doctor visit, and are very reluctant to

see a mental health specialist. For patients with no health insurance, mental health care is seen as a luxury expense, and it should not have to be that way. Unfortunately, this bill does nothing to protect the millions of Americans without access to any kind of health insurance. In America, Health care coverage needs to be considered a right, not a privilege (www.thehill.com). Senator Edward Kennedy was instrumental in the passage of the Mental Health Parity Act of 2008. As a co-author of the bill, Senator Kennedy used his influence in the Senate to help with passage of the bill. He spent days urging other senators to vote for the bill to expedite the passage. Edward Kennedy felt the Mental Health Parity Act of 2008 had the power to help individuals with mental illness. If it were not for Senator Kennedy's service to the underprivileged, poor and sick, this bill would have had a much more difficult time passing. His dedication was instrumental in ensuring mental health parity for existing health insurance plans.

Another obstacle lurking in the background is that of primary care physicians treating patients with mental illness. Cunningham (Web Exclusive, 14 April 2009) states that two-thirds of primary care physicians have a difficult time obtaining outpatient mental health services for their patients. This trend, among others, ensures that primary care physicians will continue to write prescriptions for psychotropic medications. According to some individuals in the mental health field, primary care physicians have no place writing prescriptions for patients they don't continually monitor. Even so, in the article, Should Psychologists Have Prescribing Authority?, "Primary care physicians are the "de facto mental health system" in the United States and treat 70 percent of persons receiving mental health care without the aid of a mental health specialist (Yates et al, 2004)". Mental health treatment by primary care physicians can also reinforce the

negative stigma of mental illness. If primary care physicians continue to allow patients to obtain psychotropic medications from their offices, patients can internally deny the need to see a mental health specialist. There are numerous reasons why a patient would prefer to see their own physician over a mental health specialist. Unfortunately, several of those reasons correspond to the reality that insurance companies do not want to give equivalent compensation value to mental illness.

The insurance industry must end discrimination practices if American citizens are supposed to receive fair and equitable health care coverage. Nearly a decade ago, the majority of insurance companies put maximum lifetime limits of mental health benefits at $50,000. This is a pittance compared to the nearly two to five million dollar lifetime limits placed on medical illness. The Wellstone and Domenici Mental Health Parity and Addiction Equity Act of 2008 takes a step in the right direction of ending the discrimination practices of health insurance companies. Unfortunately, there are several areas of concern in this bill that require a second look. Alcohol and other drug abuse treatments are not required to be covered under health insurance policies. The insurance industry feels that there are good reasons behind this decision. Insurance companies don't believe that substance abuse should garner the same classification as physical or mental illness. However, mental illness is often co-morbid with substance abuse. This means that individuals with mental illness are much likelier to turn to illicit substances to self-medicate and substance abusers are much likelier to have underlying mental illness (APA, 2009). Individuals afflicted with mental illnesses typically suffer from what has been termed "downward drift." The website, NAMI.org describes this phenomenon best, "This means that as a consequence of their illness they may find themselves living in marginal neighborhoods where drug use prevails.

Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness (NAMI.org, 2009)".

Another perplexing detail about The Wellstone-Domenici Parity Act of 2008 is that this act does not require a health plan to provide mental health and substance use benefits. However, if the insurance policy already included mental health benefits, it must cover those benefits at the same cost as medical illness benefits. The authors of this bill must have been under the assumption that insurance policies would not drop the mental health coverage just to avoid parity with physical health benefits (APA, 2009). Unfortunately, the free market principle dictates that if no law is in place, mere "guidelines" should not pertain. The insurance industry consistently benefits from this assumption.

To change the discrimination that exists, society, as a whole, must act to encourage eradication of mental illness stigma. This is the only way to assure the insurance industry admits mental illness is as legitimate and equally compensable as medical illness.

CHAPTER 3

CONCLUSIONS AND RECOMMENDATIONS

Through review of the literature, it becomes apparent that most research conducted on mental health stigma and the correlation of compensable insurance practices is incomplete. Although evidence suggests that stigma plays a large role in the insurance industry's determination of compensable illness, not enough research has been conducted on this topic. Further research must be conducted to show a stronger correlation between societal stigma and insurance industry practices. Just because something seems obvious to most involved, it does not make it factual.

Furthermore, additional research on the societal mental illness stigma will help to eliminate the misconception that individuals with mental illness are unusual or abnormal. It is important to remember that familiarity breeds conformity. If a negative societal stigma is not repeatedly challenged, it will persist. Consider the idea that supplementary research will work to diminish any problem, and realize that knowledge is powerful.

It is significant to note that the proposal that stigma causes inequitable insurance compensation discrimination was a common theme in this paper. This proposal was repeatedly researched and reiterated throughout this paper. Because of this, it is important to note that the correlation proposed was strong.

Finally, to even begin to deal with the convoluted and discriminatory insurance practices, lawmakers, physicians, mental health specialists and patients need to release stigma and accept mental illness as legitimate. Once this happens, progress can finally begin.

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