Insurability of the Psychiatrically Ill or Those With a Past History of Psychiatric Disorder

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It is the position of the Canadian Psychiatric Association that patients suffering from a mental disorder, or those with a past history of mental disorder, should be able to obtain insurance without prejudice based on misconceptions about the nature of mental disorder.

This position paper deals with the subjects of medical insurance, life insurance, disability insurance, automobile insurance and insurance for protection or replacement of possessions. It addresses as well the effect of mental disorders on insurance risk.

These points need to be emphasized:

1. Individuals have a right not to be discriminated against simply because they are receiving, or have received, psychiatric treatment.

2. A history of current or past psychiatric treatment should not be used to discriminate disadvantageously against insurance applicants for two reasons:
   a) Most psychiatric disorders do not completely impair a person’s functioning or necessarily reduce life expectancy.
   b) It is known from a recent epidemiological study\(^1\) that of all those in the community having a diagnosable psychiatric disorder, only 20 per cent seek treatment, and of those, only a small fraction are treated by psychiatrists.

3. Psychiatric disorders are common. The recent American study cited\(^1\) found that the lifetime prevalence of psychiatric disorder varied between 28.8 and 38 per cent.

4. Most patients have, or have had, acute treatable conditions.

Aspects of certain psychiatric disorders make it understandable that there are, in individual cases, bona fide reasons for requiring of some individuals increased premiums because of excessive risk, and for excluding others from coverage entirely.

**Medical Insurance**

**Coverage for Psychiatric Treatment**

All provinces have comprehensive health insurance plans which pay for both inpatient and outpatient psychiatric treatment which is deemed necessary if its purpose

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Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.
is to relieve, ameliorate or prevent the appearance of psychiatric disorder. Although, at present, costs of psychiatric treatment given by psychiatrists are not an onerous burden on the health care system, it is not inconceivable that governments will try to identify treatments that may be disqualified from coverage in order to reduce health care costs. In the United States, insurance benefits for outpatient psychiatric treatment were reduced in 1982, possibly because of the view that much outpatient therapy was not treatment for a recognized disorder, but rather an aid to self-fulfillment.\(^2\) The Canadian Psychiatric Association opposes limitations of coverage for necessary psychiatric treatment which includes all psychotherapeutic, social, physical and pharmacological measures used for the amelioration of symptoms and improvement in mental functioning.

This necessary treatment must be distinguished from treatment that is for self-realization. It must be for a disorder recognized by either the International Classification of Diseases or the American Psychiatric Association’s Diagnostic and Statistical Manual.

The Connotations of Psychiatric Disorder
The basic premise underlying a comprehensive medical insurance system is that illness results entirely or mainly from misfortune and that the cost of incurring such misfortune should be spread among members of a whole community rather than being borne only by those individuals who are ill. This premise is the basis for insurance coverage for medical, surgical and psychiatric illness. It is a common misconception that mental disorders are more likely to be under voluntary control than are medical disorders. This is probably one reason for what is referred to as discriminatory insurance coverage. For example, in the United States in 1981, only 12 per cent of the payment for treatment of mental illness came from private insurance money, as compared with 26 per cent of the payment for treatment of general medical conditions.\(^3\)

A strong argument can be made for rating health insurance by risks.\(^4\) Such a rating would also be applicable for certain psychiatric disorders, the features of which are partly under a person’s control (milder impulse control disorders, some substance abuse disorders, factitious disorders, some behavioural symptoms in patients with personality disorder). Diagnosis alone in such cases is of limited help in predicting outcome (risk) and must be augmented by other information pertaining to chronicity, degree of impulse control and insight among other factors. Psychiatrists should be prepared to collaborate with insurance companies in working out risk ratings.

The Canadian Psychiatric Association is aware of the physician’s responsibility to insist that insured services in medicine are used appropriately by both the patient and the physician. This principle applies equally to all fields of medicine. It must be recognized as well that self-reliance or absence of inappropriate dependence is often viewed as one criterion of health. It is not salutary to convey to patients the view that their symptoms and disorder are entirely the result of factors operating outside their control. Comprehensive medical care systems that lack any co-insurance features probably reinforce such misconceptions. Within psychiatry, as in other branches of medicine, some treatment measures may be counter therapeutic because they are based on premises that deny, or at least minimize, any conscious control the patient may have over his symptoms; or, they may unwittingly reinforce maladaptive behaviour. Any effort by psychiatrists to use the health care system fairly and wisely will further add to the stature of the specialty.

Provincial Government Medical Insurance
Comprehensive medical insurance allows liberal coverage for treatment of psychiatric disorders. Such coverage has been a boon by making psychiatric assessment and treatment available to all members of the community, regardless of their ability to pay.\(^5\)

In order to justify the retention of complete coverage for psychiatric treatment, all psychiatrists have a responsibility to choose patients carefully and to be aware of studies that demonstrate the effectiveness of certain kinds of psychiatric treatment\(^6-7\) and of offset research studies\(^8-10\) which compare the effectiveness of outpatient psychiatric treatment in reducing the number of medical clinic visits made by some patients. Many of these studies show that psychiatric treatment provides a reasonable treatment alternative to repeated medical assessments of patients whose chronic or recurrent physical symptoms are not in keeping with organic disease that can be demonstrated. In addition, continuing outpatient psychiatric treatment may be necessary to prevent exacerbations in chronic psychiatric disorders that often require admission of patients to hospital.

Life Insurance

Definition
Life insurance protects survivors of the deceased against the financial penalties consequent on premature death of a person on whom the survivors are financially dependent.

The Rights of the Psychiatric Patient or Former Psychiatric Patient
The Equality Rights Section 15 of the Canadian Charter of Rights and Freedoms which took effect on April 17, 1985, provides the following relevant subsection 13 (1):
“Every individual is equal before and under the law and has the right to equal protection and equal benefits of the law without discrimination based on race, national or ethnic origin, culture, religion, sex, age, or mental or physical disability” (emphasis added).

This ensures that individuals who are currently receiving psychiatric treatment or who have received treatment in the past are not denied life insurance because of stereotypes regarding proneness to suicide or tendencies to impulsive risk-taking behaviour. General questions regarding “mental illness” or “psychiatric illness” on life insurance applications should always be followed by specific questions regarding specific suicidal tendencies or tendencies to risk-taking behaviour. Knowing only that an applicant for life insurance has been treated for a psychiatric disorder may lead to a false inference. A limited amount of information regarding severity of disorder, chronicity, and risk or self-injurious behaviour is conveyed by a diagnostic term alone. Appropriate information can be obtained by asking an applicant what medical practitioners he/she has consulted in the past, and then requesting of these practitioners information about health in all respects. It should be possible for those who have disorders associated with premature death to obtain life insurance either with specific exclusions or with special risk ratings (i.e., increased premiums). If life insurance coverage is denied a person with a psychiatric history, there should be an appeal process.

If the standard medical information form sent by the insurance company is not deemed adequate by the psychiatrist, a letter containing detailed information may be used to replace the form or to augment the information on the form. Insurance companies should be prepared to provide appropriate compensation for lengthy and detailed reports.

**Psychiatric Disorder and Life Expectancy**

Epidemiological studies indicate clearly that some psychiatric disorder is directly responsible for premature death, for example by suicide or from the serious effects of psychiatric disorder on general health, or from unnatural causes. For example, patients with anorexia nervosa may die of inanition. The mortality in patients suffering from schizophrenia and mania has been found to be increased. Increased mortality from suicide and other causes has been found in panic disorder patients although this finding has not been confirmed by other studies. In addition, psychiatric disorders such as mania or impulse disorders increase the tendency for risk-taking behaviour. Patients who are substance abusers may show impaired judgment in appraising the risks present in everyday society and in responding appropriately to protect themselves from such risks.

Self-injurious behaviour (most commonly overdoses of medicine) is extremely common. Psychiatry should be in a position to advise on what connection there is between repetitive self-injurious behaviour and increased risk for successful suicide. One study produced results indicating that premature deaths due to suicide are strongly associated with a history of suicide attempts. A more recent study found that the personal and clinical characteristics of those who attempted suicide and those who were successful at suicide could be used to separate the two groups with a fair degree of accuracy: 91 per cent and 83 per cent of the combined sample were allocated to their correct group by the first and third discriminant function analysis respectively. Clearly, further research is needed. The Canadian Psychiatric Association is prepared to collaborate with insurance companies on specific risk factors in psychiatric patients.

**Disability Insurance**

**Coverage**

Coverage for disability resulting from psychiatric disorder should be available just as it is for disability resulting from either medical or surgical illness.

**The Relationship Between Work and Psychiatric Disorder**

Disability insurance for any illness requires a precise definition of that illness. Whereas it is important that disabled psychiatric patients receive an adequate income to protect themselves from serious financial reverses over the time that they are not able to work, it is just as important to recognize that disability payments may constitute a major secondary gain actually impeding a patient’s progress and delaying rehabilitation. There are two factors to be considered:

a) The prevalent misconception that work is ipso facto stressful and likely to aggravate a diagnosed psychiatric disorder.

b) The recognition that some patients who have undergone a serious psychiatric disorder may want to avoid exposure to what they presume to be stressful factors at work because of lack of confidence even after they have improved clinically. It should be recognized that return to work as soon as possible is likely to improve the patient’s self-esteem, re-establish him/her in a familiar social network and otherwise aid rehabilitation.

There is some evidence that work deprivation may be one of the causes of psychiatric disorder.

**Adequacy of Coverage**

In the absence of an official opinion from the insurance business, there is a general impression that insurance companies are liberal in providing disability payments
for patients who are away from work because of psychiatric disorder. Insurance companies may request detailed reports from psychiatrists, but they are generally fair in agreeing to disability payments as long as the psychiatrist attests that there continues to be disability that prevents the patient from doing his job, or some disability likely to be aggravated by work or factors in the work environment. However, psychiatrists need to remember that, generally, return to work is therapeutic.\textsuperscript{21}

\textbf{Automobile Insurance}

Psychiatric patients, or those who have received psychiatric treatment, should not be discriminated against when they apply for automobile insurance. Although it should be recognized that some patterns of behaviour that indicate persistent maladaptive personality traits put some drivers at greater risk for accidents than the average driver,\textsuperscript{22–24} most of the offenders have not been identified as psychiatric patients, and in most cases, they would not even consider the possibility that what others view as maladaptive personality characteristics might be viewed by them as symptoms to be changed or problems to be solved. It would be unfairly discriminatory to distinguish between those who have sought treatment and those who have not.

\textbf{Insurance for Protection or Replacement of Possessions}

Psychiatric patients and those who have previously received psychiatric treatment should enjoy the same rights as other citizens. There may be certain factors which are relevant to this kind of insurance coverage which have to be taken into account. Existing policies usually contain exclusion clauses covering such eventualities.

\textbf{Conclusion and Recommendations}

1. It is essential that medical insurance coverage be available for psychiatric disorders, but psychiatric treatment provided must be deemed necessary and not simply optional.

2. Medical insurance coverage should not include “treatment” for self-realization but only for disorders that are recognized in standard diagnostic classifications such as the International Classification of Diseases or the Diagnostic and Statistical Manual.

3. Psychiatrists accept the responsibility to assure that treatment does not reward or reinforce disability.

4. Psychiatrists also accept the responsibility of careful patient selection for treatments that prove to be the most prolonged and costly, recognizing that such treatments may prevent worsening of a condition that could eventually be more expensive for the health care system.

5. Those suffering from a psychiatric disorder that increases the risk of premature death must face the possibility of accepting specific exclusions or special risk ratings. Otherwise, psychiatric patients generally should be accepted for life insurance coverage without prejudice.

6. Disability insurance coverage should be available for psychiatric patients away from work because of a psychiatric disorder just as it is for other patients who are off work for medical or surgical reasons.

7. For those individuals with a current psychiatric disorder or a prior history, comprehensive disability insurance coverage should be available on the same terms and conditions that prevail with any other illness.

8. Psychiatrists accept the responsibility to see that patients do not fail to return to work for psychopathological reasons or that disability insurance payments do not serve as a secondary gain reinforcing disability.

9. Automobile insurance and insurance for replacement of possessions should be available to psychiatric patients or former psychiatric patients without prejudice.

10. Insurance companies should not simply categorize applicants as to whether or not they have received psychiatric treatment. It is appropriate for them to ask for specific information about what conditions have been treated and what physicians they have consulted.

11. Psychiatrists must remain aware of those disorders which are likely to result in premature mortality and those disorders which are associated with an increased risk of medical and surgical illness. The Canadian Psychiatric Association is ready to collaborate with insurance companies in working out risk factors.

12. If a standardized form is used by insurance companies to obtain information from psychiatrists about patients, psychiatrists should be encouraged to augment the information recorded with a letter.

\textbf{References}


