Learning the Language

Eating Disorder Claims Pose Multiple Challenges Under Health Insurance Policies

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The insurance coverage disputes can be as complicated as the treatments for the conditions. Attorneys will benefit from understanding the treatments and the distinction between medically necessary and medically appropriate treatments.

Eating disorders have become a country-wide epidemic that has exacted physical and emotional tolls from those suffering from the disorders and their families. Any person suffering from an eating disorder needs treatment.

But what level of treatment? That question has led to increased litigation over health insurance coverage available to treat eating disorders.

Determining whether eating disorder treatment qualifies for coverage can be a difficult question under difficult circumstances for claimants and their families. Often a claimant has suffered from an eating disorder for several months or years, having received physical and psychiatric treatments from several providers and at varying levels of intensity. Many treatment options are available, and there is no shortage of opinions about which treatment is best suited to which disorder. Some treatment options may be covered by insurance, while others may be expressly excluded. If an insurer denies coverage for a particular treatment, it is no surprise that a claimant would turn to external reviewers, and if necessary, to a court to obtain coverage.

Between 2011 and 2015, no less than five circuit courts of appeals and 27 federal district courts issued decisions in disputes concerning whether a health insurance policy covered a certain eating disorder treatment. The disputes in these cases often focus on two issues: (1) whether the particular service at issue is "medically necessary," which is a central requirement for health insurance coverage; or (2) whether a denial of coverage for a particular service

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violates federal or state mental health parity acts. *See, e.g.*, *Hurst v. Siemens Corp. Grp. Ins.*, 42 F. Supp. 3d 714, 732 (E.D. Pa. 2014); *Brigolin v. Blue Cross Blue Shield of Mich.*, 516 F. App'x 532, 539 (6th Cir. 2013); *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 721 (9th Cir. 2012). Cases have come in the ERISA and non-ERISA contexts and have featured class claims. *See, e.g., Rea v. Blue Shield of Cal.*, 226 Cal. App. 4th 1209, 1219 (2014); *Alison O. v. Anthem Blue Cross Life & Health Ins. Co.*, 2013 WL 5979515 (N.D. Cal. Nov. 8, 2013).

Eating disorders present a complicated mix of psychological and physical symptomology that is subject to a wide spectrum of treatment options.

Many insurers have successfully defended their decisions. *See, e.g., M.K. v. Visa Cigna Network POS Plan*, 2014 WL 5163908, at *6 (D. Utah Oct. 14, 2014); *Nystrom v. AmerisourceBergen Drug Corp.*, 2014 WL 4348234 (D. Minn. Sept. 2, 2014). But some have not. *See, e.g., Demonchaux v. Unitedhealthcare Oxford*, 2012 WL 6700017, at *10 (S.D.N.Y. Dec. 20, 2012).

Eating disorders present a complicated mix of psychological and physical symptomology that is subject to a wide spectrum of treatment options. These treatments range from very intensive, round-the-clock care, to a few hours of therapy per week or month. Understanding the treatment options, and the health conditions that underlie them, is critical to understanding whether insurance coverage would exist. Indeed, "learning the language" of eating disorder treatment is the first step toward successfully representing defendants in these cases. From there, counsel can gain a better understanding of which treatments are "medically necessary" and the role that mental health parity acts play in coverage cases.

The Nature of Eating Disorders

Eating disorders are unique in psychiatry, combining both psychological and physical symptoms. Until 2013, only two primary eating disorder diagnoses existed: anorexia nervosa and bulimia nervosa.

Anorexia consists of a drive for thinness resulting in self-induced weight loss to potentially life-threatening levels. It is often associated with impaired or distorted sense of body size. When weight is lost primarily through dietary restriction with or without exercise, the disorder is referred to as "restricting" subtype. If weight loss also involves self-induced vomiting, it is referred to as "purging" subtype.

Bulimia consists of binge episodes during which large quantities of food are consumed over discrete periods of time. Binges are followed by some compensatory behavior such as self-induced vomiting, laxative abuse, or compulsive exercise as well as efforts at strict dieting.

These are not rare disorders. In the general population, anorexia affects between 0.3 percent and 0.7 percent and bulimia between 1.0 percent and 3 percent of females. *See* Hans Wijbrand Hoek & Daphne van Hoeken, *Review of the Prevalence and Incidence of Eating Disorders*, Int. J. Eat. Disord., 34: 383–96 (2003). Estimates of male to female prevalence range from 1:6 to 1:20. *See id.*; Hans-Christoph Steinhausen & C.M. Jensen, *Time Trends in Lifetime Incidence Rates of First-Time Diagnosed Anorexia Nervosa and Bulimia Nervosa Across 16 years in a Danish Nationwide Psychiatric Registry Study*, Int. J. Eat. Disord. (forthcoming 2015).

These percentages translate to up to 30 million men and women in the United States suffering from a clinically significant eating disorder at some point in their life. *See* Tracy Wade *et al.*, *Textbook in Psychiatric Epidemiology* 343–60 (3d ed., 2011). These numbers are expected to grow.

In 2013, the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th Edition—considered the authority for psychiatric diagnosis—expanded what the psychiatric community considered to be an "eating disorder." Included in this expansion was binge-eating disorder. Binge-eating disorder is similar to bulimia minus the compensatory behavior of vomiting, laxative abuse, or compulsive exercise. There is a subjective and distressing loss of control over eating with consumption of large quantities of food. Without the compensating behavior mentioned in the previous sentence, binge-eating disorder is frequently associated with weight gain and obesity.

Binge-eating disorder is by far the most prevalent of the eating disorders with an estimated lifetime prevalence of 2.4 percent, affecting close to as many men as women. *See* Ronald Kessler, *The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys*, 73 Biol. Psychiatry 904–14 (2013); Ruth Striegel *et al.*, *Why Men Should Be Included in Research on Binge Eating: Results from a Comparison of Psychosocial Impairment in Men and Women*, Int. J. Eat. Disord., 45:233–40 (2012). Although it is unclear if the numbers of those with anorexia or bulimia are increasing or decreasing, with the inclusion of binge-eating disorder in the DSM V as a separate diagnosis, the total population with a diagnosed eating disorder has almost doubled since 2013.

Eating Disorder Treatment

Eating disorders come with major health consequences that can trigger significant medical intervention. Anorexia commonly results in reduction in blood count, hormonal suppression, reduced blood pressure, and reduced pulse rate. Sustained weight loss and malnutrition lead to impaired immune and renal function and could eventually interfere with the body's ability to maintain a safe blood glucose level, resulting in recurrent hypoglycemia and potentially death. Mortality rate estimates for anorexia vary but are in the range of 5 percent to 10 percent with about 80 percent of these from direct medical causes and the remaining 20 percent from suicide. *See* Carl Birmingham *et al., The Mortality Rate from Anorexia Nervosa*, Int. J. Eat. Disord., 38: 143–46 (2005); Jon Arcelus *et al.*, *Mortality Rates in Patients with Anorexia and Other Eating Disorders: A Meta-Analysis of 36 Studies*, Arch. Gen Psychiatry, 68: 724–31 (2011).

Medical complications with bulimia include fluid and electrolyte problems from vomiting or laxative abuse with potential risk of cardiac arrhythmia, syncope (loss of consciousness), or seizure. Chronic laxative

abuse can result in impaired bowel function. Bulimia in combination with diabetes can accelerate the medical complications of that disease by compromising blood glucose control. Despite the potential of medical complications, the mortality rate for bulimia appears to be much lower than for anorexia. *See* Hans-Christoph Steinhausen *et al.*, *The Outcome of Bulimia Nervosa: Findings from One-Quarter Century of Research*, Am. J. Psychiatry, 166: 1331–41 (2009).

The medical complications of binge-eating disorder are essentially those of obesity or morbid obesity including hypertension, type 2 diabetes, cardiovascular disease, degenerative arthritis, and sleep apnea.

Anorexia, bulimia, and binge-eating disorder are typically accompanied by other mental health issues, most commonly depression and anxiety. *See* Regina Casper, *Depression and Eating Disorder,* Depress. Anxiety, 8 Suppl. 1:96–104 (1998); Nicholas Troop *et al.*, *Specificity in the Relationship Between Depressive and Eating Disorder Symptoms in Remitted and Nonremitted Women*, Int. J. Eat. Disord., 30: 306–11 (2001); Walter Kaye *et al.*, *Comorbidity of Anxiety Disorders with Anorexia and Bulimia Nervosa*, Am. J. Psychiatry, 161: 2215–21 (2004).

Obsessive-compulsive symptoms have been associated with anorexia and substance abuse with bulimia. *See* Michael Strober *et al.*, *The Association of Anxiety Disorders and Obsessive Compulsive Personality Disorder with Anorexia Nervosa: Evidence from a Family Study with Discussion of Nosological and Neurodevelopmental Implications*, Int. J. Eat. Disord., 40 Suppl.: S46–51 (2007); Cynthia Bulik *et al.*, *Alcohol Use Disorder Comorbidity in Eating Disorders: A Multicenter Study*, J. Clin. Psychiatry, 65: 1000–06 (2004); Claire Holderness *et al.*, *Co-Morbidity of Eating Disorders and Substance Abuse Review of the Literature*, Int. J. Eat. Disord., 16: 1–34 (1994).

Personality disorders have been associated with all eating disorders. *See* Stephanie Cassin *et al.*, *Personality and Eating Disorders: A Decade in Review*, Clin. Psychol. Rev., 25: 895–916 (2005).

Eating disorders may be treated in a range of settings that vary in intensity. The commonly recognized categories of treatment environments and their characteristic traits include inpatient care, residential care, partial hospital care, intensive outpatient program care, and general outpatient services.

Inpatient care provides around-the-clock nursing supervision, 24-hour access to physician services as well as intensive individual, family, group, and nutritional counseling. An attending psychiatrist meets daily with patients. All meals are supervised and when necessary supplemental tube feeding may be administered. Individuals receiving this level of care typically are significantly medically compromised or present an acute psychiatric risk in addition to their eating disorder (*e.g.*, suicidal impulses).

Residential care provides around-the-clock supervision but not necessarily by medical personnel. Intensive individual, family, group, and nutritional counseling are provided, but psychiatric services are less frequent. Meal supervision is provided but usually not supplemental tube feeding. Individuals typically demonstrate frequent symptom use and serious psychosocial impairment. They are usually not at such acute health risk as to require immediately available medical services or supervision for safety.

Partial hospital care may be a step down from inpatient or residential care or an alternative to these services. Individuals participate typically for at least four to five hours four or more days per week. Services usually include individual, family, group, and nutritional counseling, although usually not on as frequent a basis as provided by inpatient or residential care. Meals during program hours are supervised. Individuals must be medically stable and have a stable home environment to follow through with recommended changes.

Intensive outpatient program care provides some of the services of a partial hospital program, typically three to four hours per day, two to three days per week. Therapies tend to be in group format and may include nutrition and family and psychoeducational groups. This may be supplemented with brief individual contact. Psychiatric input may be available on a limited basis. Meals may be supervised during program hours.

General outpatient services are typically both the starting point of care and the final level of care when more intensive levels were previously required. Frequency of visits can range from twice a month to two or three times per week. Elements of outpatient care can include individual and family counseling as well as nutritional counseling. Duration of outpatient counseling is highly variable and can range from a few weeks to a number of years for more chronic patients.

The transition between various treatment levels is often central to disputes between claimants and insurers.

Generally, most people that suffer from eating disorders become somewhat better but few are completely cured. *See* Tracy Wade *et al.*, *Prevalence and Long-Term Course of Lifetime Eating Disorders in an Adult Australian Twin Cohort*, Aust. *N.Z. J. Psychiatry,* 40: 121–28 (2006). One study estimated the five-year recovery rates for anorexia and bulimia at 69 percent and 55 percent respectively. *See* Frederique Smink *et al.*, *Epidemiology, Course and Outcome of Eating Disorders*, Curr. Opin. Psychiatry, 26: 543–48 (2013). These authors noted no reliable data for binge-eating disorder recovery with remission rates in the few studies available ranging from 19 to 65 percent.

While it is clear that the large majority of individuals with eating disorders improve over time, studies have shown that a subgroup does not improve. *See* Hans-Christoph Steinhausen, *The Outcome of Anorexia Nervosa in the 20th Century*, Am. J. Psychiatry, 159: 1284–93 (2002); Y. Nakai *et al.*, *Outcome of Eating Disorders in a Japanese Sample: A 4- to 9-Year Follow-Up Study*, Eur. Eat. Disord. Rev., 22: 206–11 (2014).

The transition between various treatment levels is often central to disputes between claimants and insurers. It is generally accepted that health insurance only covers "medically necessary" services. But which level of care is "medically necessary" to treat an insured's condition at any given

time—inpatient, residential, partial hospitalization, intensive outpatient? This question is ripe for litigation.

Is a Treatment "Medically Necessary"?

An insurer will only pay for coverage that it considers medically necessary for purposes of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. No universal definition exists for "medically necessary" in insurance policies and applicable statutes and regulations, but common themes exist. For instance, to be "medically necessary," policies typically require that treatments be

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for a patient's illness, injury, or disease;
3. Not primarily for the convenience of the patient or physician; and
4. Compared to the other alternatives, the least expensive or a less intensive service likely produce therapeutic or diagnostic results equivalent to the more expensive or intensive services for the particular diagnosis or treatment.

See, e.g., Hurst v. Siemens Corp. Group Ins., 42 F. Supp. 3d 714, 717–18 (E.D. Penn. 2014).

It is important to distinguish between "medically necessary" and "medically appropriate." The fact that a particular medical treatment or service may be "appropriate" does not automatically mean that it will satisfy the definition of "necessary." For example, a condition may *appropriately* be treated by aggressive intervention, but that level of care will not be covered if the equivalent result could be expected to be achieved through less intensive or expensive alternatives.

Policies are typically clear that insurers, not treatment providers, determine which treatment or service is medically necessary. To facilitate that determination, many insurers use guidelines to evaluate whether a treatment or service qualifies as "medically necessary." These guidelines provide information to assist insurers in coverage decisions concerning admission and access to treatment and continued-stay criteria for each treatment level and for each form of eating disorder diagnosis.

Courts routinely uphold the use of such guidelines. *See, e.g., M.K.*, 2014 WL 5163908, at *6 (acknowledging an insurer's use of internal guidelines in an ERISA case and approving of the function of internal guidelines pursuant to the plan and ERISA regulations); *Bonanno v. Blue Cross Blue Shield of Mass., Inc.*, 2011 WL 4899902, at *10 (D. Mass. Oct. 14, 2011) (affirming denial reported in letters that "referenced the relevant specific plan requirements for receiving coverage for medically necessary services and the [ ]criteria to meet the medical necessity test"); *Smith v. Blue Cross Blue Shield of Mass., Inc.*, 597 F. Supp. 2d 214, 221–22 (D. Mass. 2009) ("Even if Plaintiff did meet requirements for severe impairment, he still did not merit inpatient rehabilitation because the [ ]criteria require at least two treatment episodes within the last year, and Plaintiff had only had one."); *Doe v. Mamsi Life & Health Ins. Co.*, 471 F. Supp. 2d 139, 148 (D.D.C. 2007) (approving of guidelines but holding an insurer failed to adhere to them).

For instance, a guideline for whether residential treatment is medically necessary may require an individual to show the ability and motivation to recover but the inability to do so within the individual's home environment. An insurer may also require other criteria, depending on various factors, such as the examples below, among others:

1. An individual weighs less than a certain percentage of the estimated healthy weight (such as 85 percent) or has a certain BMI (if weight restoration is the goal).
2. An individual shows no signs or symptoms of acute medical instability that would require daily physician evaluation, intravenous fluids, or multiple daily lab tests.
3. An individual needs structured treatment with 24-hour nurse availability and supervision during meals.
4. An individual with purging behavior can ask for and use support from others or can use some cognitive or behavioral skills to stop purging.
5. Another psychiatric or substance use disorder is present that also requires 24-hour structured treatment.
6. If suicidality is present, the level of risk can be safely managed at this level of care.

It is the interpretation of these guidelines for determining medical necessity where the bulk of disputes exist between insurers, treatment providers, and claimants. For instance, someone may question whether guidelines reflect current standards and best practices, or whether an insurer relies on physical factors such as weight to the exclusion of psychological, social, and environmental factors. *See, e.g., Jennifer A. v. United Healthcare Ins. Co.,* 2012 WL 3996877, at *12 (C.D. Cal. Sept. 11, 2012) (entering judgment in favor of the insurer and rejecting the plaintiff's contention that the American Psychiatric Association guidelines for eating disorder treatment created a standard of care and should have factored into the insurer's decision); *Mirsky v. Horizon Blue Cross & Blue Shield of N.J.*, 2013 WL 5503659, at *8 (D.N.J. Sept. 30, 2013), *aff'd*, 586 F. App'x 893 (3d Cir. 2014) (holding that the claimant satisfied guidelines for continued stay in inpatient treatment based on psychological, social and environmental factors). Generally, courts have reached favorable decisions for insurers that complied with their internal guidelines and considered all relevant evidence. *See, e.g., Hurst*, 42 F. Supp. 3d at 731 (affirming the insurer's denial of coverage under ERISA's arbitrary and capricious standard of review).

Determining medical necessity is inherently factually intensive and case specific, particularly in the context of treatments for eating disorders. But to undertake the analysis and articulate the issue with authority, counsel must have a fundamental understanding of what each level of care contemplates.

The Role of Mental Health Parity Legislation

Mental health parity legislation also is a factor in many eating disorder-related health insurance coverage cases. Although various state and federal parity acts differ, their fundamental aims are typically consistent: to ensure equally comparable coverage for mental and physical illnesses in terms of cost, network, and limitations. This issue arises in eating disorder and other mental health cases when a health insurance plan provides a certain benefit class to treat a physical ailment, but not a mental disorder.

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The effect of mental health parity legislation remains a hotly contested area of health insurance coverage litigation in a variety of contexts, and eating disorder coverage cases have been at the forefront of this litigation. *See, e.g., Harlick*, 686 F.3d at 699; *Daniel F. v. Blue Shield of Cal.*, 305 F.R.D. 115, 120 (N.D. Cal. 2014); *Drazin v. Horizon Blue Cross Blue Shield of N.J, Inc.*, 832 F. Supp. 2d 432, 434 (D.N.J. 2011), *aff'd*, 528 F. App'x 211 (3d Cir. 2013); *Douglas S. v. Altius Health Plans, Inc.*, 409 F. App'x 219, 225 (10th Cir. 2010).

Most of these eating disorder cases examined whether respective state mental health parity laws required insurers to cover allegedly medically necessary residential treatment for eating disorder claims, and the cases reached opposite conclusions. *Compare Harlick*, 686 F.3d at 721 (holding that California's Mental Health Parity Act required coverage of medically necessary residential treatment for eating disorders), *with Douglas S*, 409 F. App'x at 226 (holding that Utah's Catastrophic Mental Health Coverage statute did not require coverage for any residential treatment for eating disorders). The disparate holdings result in the patchwork of requirements that insurers face, especially in the absence of ERISA preemption.

The only commonality in determining parity requirements comes from the federal Mental Health Parity and Addiction Equity Act of 2008. *See* 29 U.S.C. §1185a, *et seq.* The statute requires most health plans to ensure that financial requirements such as co-pays and deductibles and "treatment limitations" that apply to mental health or substance-use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. *Id.* Based on this, health insurers cannot generally charge different out-of-pocket expenses for physical and mental health treatment, claims procedures should be equivalent, an "in network" of qualified providers should be accessible, and an equivalent "out of network" must be available. *See* 29 U.S.C. §1185a(a)(1)–(5). Most important for purposes here, the statute defines "treatment limitations" as limits on the frequency of treatment, number of visits, days of coverage, or "other similar limits" on the scope or duration of treatment, which all must have parity with medical and surgical benefits. *See* 29 U.S.C. §1185a(a)(3)(A)(ii)–(B)(iii).

To date, only one court has published a consideration of whether "other similar limits" includes a prohibition on insurers excluding residential treatment from coverage. *See Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748 (N.D. Ill. 2015) (refusing to dismiss a complaint contending that the federal Mental Health Parity Act required coverage for residential treatment). Rejecting a motion to dismiss, the U.S. District Court for the Northern District of Illinois relied extensively on regulations promulgated by the U.S. Departments of Labor, Health and Human Services, and the Treasury that pointed to a need to cover residential treatment for eating disorders. *Id.* It reasoned that the defendant had waived its argument that the regulations were invalid based upon principles of statutory construction and was not persuaded "at this stage of the case" that a residential treatment exclusion would pass muster. *Id.*

But the question is far from decided. Whether another court will follow *Craft* is still up in the air given that the court did not address one of the defendant's primary arguments and the case had yet to develop a full record of what was comparable coverage under the subject policy. *Id.* Further, the federal Mental Health Parity Act does not apply to every insurance plan. For example, it exempts "small employers," defining small employers as those that have employed "an average of at least 2… but not more than 50 employees on business days during the preceding calendar year" and plans for which the actual costs of coverage will rise by certain percentages by the application of the act. *See* 29 U.S.C.A. §1185a(c).

Consequently, until courts reach a consensus about what the federal Mental Health Parity act requires—and assuming that the act applies to a particular plan in question—counsel only have the conflicting conclusions of cases based upon conflicting state laws and a caveated, not fully developed district court case from which to base their arguments concerning the federal parity act.

Key Takeaways

Eating disorder health insurance coverage disputes can be as complicated as the treatments to combat the conditions. But defense counsel handling these cases will benefit greatly by gaining a good understanding of the nuances of the various levels of treatment typically used to address the disorders. Only with that can counsel begin to appreciate and articulate how guidelines for making medical necessity determinations apply and avoid overlooking the important distinction between what may be medically "appropriate" and what is actually medically "necessary." Additionally, in many cases, counsel must become well versed in the federal and state mental health parity acts to be prepared to address challenges over coverage for treatments that may be administered over the course of several weeks, months, and years. FD