

A Time to Heal: Eliminating Barriers to Coverage for Patients with Eating Disorders Under the Affordable Care Act

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Introduction

For decades, the United States has received criticism for its expensive private health care system.¹ As other Western nations adopted universal health care policies, many American citizens continued to suffer the consequences of being uninsured.² Some states—most notably Massachusetts—took steps to enact universal health care plans,³ but efforts to achieve health care equality on a federal level were thwarted time and again during the twentieth century.⁴ Finally, on March 23, 2010, despite an abundance of critics, President Barack Obama signed the Patient

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1. See Lenny Bourin & Dan Harris, *Critics: Healthcare System Fails in Many Ways*, ABC NEWS (Oct. 15, 2006), <http://abcnews.go.com/WNT/Health/story?id=2570911&page=1#.UWinxCvwJAs>; WORLD HEALTH ORG., *THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE* 164 (2000), available at http://www.who.int/whr/2000/en/whr00_en.pdf (ranking the United States' health care system 37th out of 191 nations' systems, despite the fact that the United States spends more of its gross domestic product on health care than any other nation).

2. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE: 2010*, at 23 (2011), available at <http://www.census.gov/prod/2011pubs/p60-239.pdf> (“In 2010, the percentage of people without health insurance, 16.3 percent, was not statistically different from the rate in 2009. The number of uninsured people increased to 49.9 million in 2010 from 49.0 million in 2009.”).

3. See William C. Symonds, *In Massachusetts, Health Care for All?*, BLOOMBERG BUSINESSWEEK (Apr. 3, 2006), <http://www.businessweek.com/stories/2006-04-03/in-massachusetts-health-care-for-all-businessweek-business-news-stock-market-and-financial-advice>.

4. James Abundis & David Butler, *History of Attempts to Reform US Health Insurance Coverage*, BOSTON GLOBE, June 28, 2012, <http://www.bostonglobe.com/2012/06/28/healthcare/QoZG14x1iMlwREEDkvJgTJ/story.html> (tracing efforts to reform the United States health care system back to 1912, when Teddy Roosevelt “endorse[d] national health insurance as part of [his] platform but [lost] the election”).

Protection and Affordable Care Act (ACA) into law.⁵ The Supreme Court upheld the Act's constitutionality in June 2012,⁶ and after President Obama was re-elected for a second term in office, the future of the ACA was secured.⁷ The Act's reforms and provisions are scheduled to continue to take effect through at least 2015.⁸ The ACA prohibits insurance companies from denying coverage to people with pre-existing conditions,⁹ and it mandates that individuals purchase insurance or pay a tax penalty.¹⁰

While the ACA improves general access to health care, it leaves significant gaps unaddressed that will allow for continued injustice for patients suffering from anorexia, bulimia, and Eating Disorders Not Otherwise Specified (ED-NOS).¹¹ Eating disorders¹² are associated with the highest mortality rates among mental illnesses,¹³ and in severe cases they are also among the most expensive mental illnesses to treat.¹⁴ Both public and private

5. Will Dunham, *Timeline: Milestones in Obama's Quest for Healthcare Reform*, REUTERS (Mar. 22, 2010, 1:50 AM), <http://www.reuters.com/article/2010/03/22/us-usa-healthcare-timeline-idUSTRE62L0JA20100322>.

6. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2609 (2012). In a five to four opinion, the Supreme Court found the individual mandate was constitutional as an exercise of Congress's power to levy taxes. *Id.*

7. Abby Goodnough & Robert Pear, *Election Over, States Race on Deadlines in Health Law*, N.Y. TIMES, Nov. 9, 2012, at A16 ("After nearly three years of legal and political threats that kept President Obama's health care law in a constant state of uncertainty, his re-election on Tuesday all but guarantees that the historic legislation will survive.")

8. See *Key Features of the Affordable Care Act, By Year*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/timeline/full.html> (last visited Apr. 4, 2013) (outlining the various provisions of the ACA in order of when they have taken or will take effect).

9. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2705, 124 Stat. 119, 156–60 (2010).

10. Philip Moeller, *How the Health Insurance Mandate Penalty Will Work*, U.S. NEWS (July 13, 2012), <http://money.usnews.com/money/blogs/the-best-life/2012/07/13/how-the-health-insurance-mandate-penalty-will-work>. Under the ACA, "consumers who can afford health insurance but decide not to buy it will owe penalties to the IRS". *Id.*

11. Katrina Womble, *Will Health Reform Provide Coverage for Eating Disorders?*, THINKPROGRESS (Mar. 6, 2010, 4:30 PM), <http://thinkprogress.org/health/2012/03/06/436763/will-health-reform-provide-coverage-for-eating-disorders/>.

12. This Article uses "eating disorders" to refer to *anorexia nervosa*, *bulimia nervosa*, and ED-NOS (Eating Disorder Not Otherwise Specified) as they are defined in the DSM-IV. THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS §§ 307.1, 307.51, 307.50 (Am. Psychiatric Ass'n 4th ed. 1994) [hereinafter DSM-IV].

13. See Michael Strober et al., *The Long-Term, Course of Severe Anorexia Nervosa in Adolescents: Survival Analysis of Recovery, Relapse, and Outcome Predictors over 10–15 Years in a Prospective Study*, 22 INT'L. J. EATING DISORDERS 339, 356 (1997).

14. Lesley Alderman, *Treating Eating Disorders and Paying for It*, N.Y. TIMES,

health insurance plans are designed to stringently limit coverage of eating disorders in two ways: by treating mental illnesses differently from physical illnesses,¹⁵ and by setting conservative criteria for qualification.¹⁶ As a result, only those fortunate enough to obtain the best insurance policies or wealthy enough to personally pay the high costs of residential care can afford the treatment recommended by mental health professionals. Sufferers and their families have sued insurance companies, seeking court-enforced payment of the high costs of treatment programs,¹⁷ but insurers risk very little by litigating such claims.¹⁸ These circumstances disproportionately affect women, who make up the vast majority of eating disorder patients and already face inequality in the American health care system.¹⁹

In late December of 2011, the Department of Health and Human Services (HHS) released a plan²⁰ for determining the details of the ten Essential Health Benefits (EHB) required by the ACA, one of which is “[m]ental health and substance use disorder

Dec. 4, 2010, at B6 (“A residential program costs \$30,000 a month on average. And many patients require three or more months of treatment.”).

15. Catherine G. McLaughlin, *Delays in Treatment for Mental Disorders and Health Insurance Coverage*, 39 HEALTH SERVS. RES. 221, 221 (2004) (“[M]ental health care services are not covered by health insurance packages and health plans to the same degree as physical health care services. Not only are there usually more services excluded as covered benefits, but those services that are covered are often subject to higher co-pays and are capped . . .”).

16. Womble, *supra* note 11 (observing that, since most health insurance plans do not cover ED-NOS, “a female patient who meets all of the diagnostic criteria for anorexia except that she is still having her period . . . would not receive coverage for her eating disorder”).

17. *See, e.g.*, *Simons v. Blue Cross & Blue Shield of Greater N.Y.*, 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

18. Sheila Mulrooney Eldred, *Eating-disorder Patients Fight Double Battle: Their Disorder, and Insurance Firms*, MINNPOST.COM (Feb. 17, 2012), <http://www.minnpost.com/health/2012/02/eating-disorder-patients-fight-double-battle-their-disorder-and-insurance-firms> (“At the end of the day, the insurance company is only liable for the benefits, the attorney’s fees, and interest,’ [attorney Elizabeth] Wrobel said. ‘It’s unfortunate, but from my perspective, there’s not a lot of disincentive for insurers to deny claims.’”).

19. NAT’L EATING DISORDERS ASS’N, STATISTICS: EATING DISORDERS AND THEIR PRECURSORS 1 (2005) (on file with author) [hereinafter NEDA STATISTICS] (“In the United States, as many as 10 million females and 1 million males are fighting a life and death battle with an eating disorder such as anorexia or bulimia.”); NAT’L WOMEN’S L. CTR., HEALTH CARE: MAKING THE GRADE ON WOMEN’S HEALTH: A NATIONAL AND STATE BY STATE REPORT CARD (2010), *available at* <http://hrc.nwlc.org/key-findings> (“Despite some progress on individual health status indicators, overall the nation is still so far from meeting key women’s health objectives that it receives a grade of ‘Unsatisfactory’ in this fifth and last report for this decade.”).

20. CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN (2011) [hereinafter HHS MEMORANDUM], *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

services, including behavioral health treatment.”²¹ The plan proposed by HHS allowed each state to choose a benchmark plan from a list of several existing options in that state,²² some of which severely limited or even excluded eating disorder coverage.²³ If a state did not act to adopt any plan, the state’s largest small group plan became that state’s plan as a default.²⁴

This Article endorses the adoption of a national benchmark plan that would address the inequalities in access to life-saving treatment for sufferers of eating disorders. Part I will examine the unique challenges posed by the treatment of eating disorders, the tactics insurance companies have used to avoid the costs of this treatment, and the public policy reasons for mandating affordable access to eating disorder treatment. Part II will review the proposals, failures, and successes of various legislative efforts to improve access to coverage for sufferers. Part III will discuss the failure of the ACA to protect patients with eating disorders from the very problems and injustices it purports to remedy. Finally, Part IV will evaluate and compare two current options for addressing the ongoing problem of under-insuring and denying coverage for sufferers of eating disorders. This Article’s ultimate conclusion is that a federal benchmark plan under the ACA is the best remedy available.

21. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1)(E), 124 Stat. 119, 164 (2010).

22. States may choose any of the following:

- (1) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national FEHBP [Federal Employees Health Benefits Program] plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS Memorandum, *supra* note 20.

23. The Eating Disorders Coalition for Research, Policy & Action requested that states’ choices be limited to plans that “address the health needs of more than eleven million Americans suffering from eating disorders,” but no such change was made in response. Letter from the Eating Disorders Coalition for Research, Policy & Action to Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services (Jan. 31, 2012), *available at* <http://www.eatingdisorderscoalition.org/documents/EHBcommentsfromEDCjan31-2012.pdf>.

24. In late 2012, three states announced their intentions to default, rather than adopt a plan, which they characterized as cooperating with the still-controversial ACA. See Evan Belanger, *Bentley: Alabama Won’t Adopt Essential Health Benefits Plan*, BIRMINGHAM BUS. J. (Oct. 1, 2012, 4:17 PM), <http://www.bizjournals.com/birmingham/news/2012/10/01/bentley-alabama-wont-adopt-essential.html>; Rich Ehsen, *States Look to Answer “Essential” Health Question*, CAPITOL J., Oct. 8, 2012 (“Three [states]—Alabama, Louisiana and Tennessee—have opted to not choose an EHB plan.”).

I. Expensive and Deadly: The Hidden Costs and Dangers of Eating Disorders

The American public became generally aware of the existence of eating disorders beginning in the 1970s.²⁵ The 1983 death of popular singer Karen Carpenter from anorexia attracted a bevy of interest from the media.²⁶ Almost thirty years later, eating disorders have become a staple in television plots,²⁷ tabloids,²⁸ and popular magazines.²⁹ Famous young women continue to die of complications from eating disorders.³⁰ The public is undoubtedly very aware that eating disorders exist, and the number of new cases continues to rise.³¹ Yet relatively few sufferers receive any treatment for their disorders,³² and many of those who do are forced to curtail treatment when medical bills begin to pile up and

25. See *A Brief Look at the History of Eating Disorders*, THROUGH THE LOOKING GLASS (Eating Disorders Association, Inc.), Aug. 2010, at 4 (“Anorexia nervosa was known to physicians in the 1870’s, [sic] but it wasn’t until the late 70’s/early 80’s [sic] that the general public became aware of the prevalence of eating disorders and their serious nature.”).

26. Rob Hoerburger, *Karen Carpenter’s Second Life*, N.Y. TIMES MAG., Oct. 6, 1996, at 52 (“Anorexia, in the end, claimed victory over [Carpenter’s] body and her name, which became practically synonymous with the affliction.”).

27. See, e.g., *Full House: Shape Up* (ABC television broadcast Nov. 9, 1990); *Lizzie McGuire: Inner Beauty* (Disney Channel television broadcast Aug. 30, 2002); *Degrassi: The Next Generation: Our Lips are Sealed, Parts 1 & 2* (CTV television broadcast Feb. 27, 2006).

28. Kris De Leon, *Tabloids Target ‘90210’ Star for Eating Disorder*, BUDDYTV.COM (Nov. 28, 2008), <http://www.buddytv.com/articles/90210/tabloids-target-90210-star-for-24920.aspx> (“Young actresses who maintain a slim and slender figure have always been the target of tabloids when it comes to eating disorder rumors.”).

29. In fact, in its July 2012 edition, *Cosmopolitan* magazine ran an interview with singer Demi Lovato, featuring her recovery from an eating disorder, and simultaneously ran a heavily edited cover photograph that made Lovato appear thinner. Madeleine Davies, *Demi Lovato Talks Eating Disorders in Cosmo, Gets a Whittled-Down Waist as Thanks*, JEZEBEL.COM (June 8, 2012, 4:00 PM), <http://jezebel.com/5916951/demi-lovato-talks-eating-disorders-in-cosmo-gets-a-whittled-down-waist-as-thanks> (“The article touts Lovato as a role model and hero for her frankness regarding her struggles. . . . However, the feature’s punch is entirely lost when the magazine decides that Lovato’s real body . . . is not good enough to grace their cover.”).

30. *National Eating Disorders Awareness Week 2012: Celebrities Who Had Eating Disorders*, INT’L BUS. TIMES (Mar. 1, 2012, 12:22 PM), <http://www.ibtimes.com/national-eating-disorders-awareness-week-2012-celebrities-who-had-eating-disorders-photos-554476>.

31. Susan J. Campbell, *Eating Disorders on the Rise*, MENTAL HEALTH DIRECTORY (Feb. 4, 2011), <http://www.mentalhealthdirectory.org/eating-disorders-on-the-rise/>.

32. NEDA STATISTICS, *supra* note 19 (“Only one-third of people with anorexia in the community receive mental health care. Only 6% of people with bulimia receive mental health care.”).

insurance companies refuse to pay.³³

Effective treatments for eating disorders exist,³⁴ but the treatment process is often lengthy and expensive.³⁵ While cognitive behavioral therapy is an integral part of treatment, patients also need a physician to oversee their recovery, and many need the oversight of other medical professionals, such as dietitians and psychiatrists.³⁶ Expensive prescription medications often play a role in reducing anxiety, depression, and mood disturbances.³⁷ In severe cases, doctors recommend stabilization at in-patient units in hospitals followed by treatment at residential treatment facilities.³⁸ A single day of residential treatment costs in the range of one thousand dollars,³⁹ and in some cases, patients require months of such care.⁴⁰ However,

33. “A survey of 109 eating disorder specialists around the country, representing most inpatient eating disorders program[s] in the United States found that nearly all specialists (96.7%) believe their patients with anorexia nervosa are put in life threatening situations because of early discharge mandated by health insurance companies” Letter from the Eating Disorders Coalition for Research, Policy & Action, *supra* note 23.

34. Margo Maine, *Securing Eating Disorders Treatment: Ammunition for Arguments with Third Parties*, NAT’L EATING DISORDERS ASS’N (2012), <http://www.nationaleatingdisorders.org/sites/default/files/ResourceHandouts/SecuringEatingDisordersTreatment.pdf> (“If [bulimia is] treated within the first 5 years, the recovery rate is 80%” and “[s]pecialized treatment [of eating disorders] reduces mortality.”).

35. *Id.* (“A full course of treatment, de-intensifying over time, often spans between 5-7 years.”); Tara Parker-Pope, *The Cost of an Eating Disorder*, N.Y. TIMES WELL BLOG (Dec. 3, 2010, 10:45 AM), <http://well.blogs.nytimes.com/2010/12/03/the-cost-of-an-eating-disorder/> (“A residential program costs \$30,000 a month on average. And many patients require three or more months of treatment, often at a facility far from home. Even after leaving a specialized program, patients may need years of follow-up care.”).

36. Alderman, *supra* note 14 (“Many [patients with eating disorders] must be seen on a weekly basis by a team of specialists, including a psychiatrist, a physician and a nutritionist.”).

37. JOEL YAGER ET AL., AM. PSYCHIATRIC ASS’N, TREATMENT OF PATIENTS WITH EATING DISORDERS 18 (2006), <http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243187&PDFSource=6> (“SSRIs in combination with psychotherapy are widely used in treating patients with anorexia nervosa. For example, these medications may be considered for those with persistent depressive, anxiety, or obsessive-compulsive symptoms and for bulimic symptoms in weight-restored patients.”).

38. Shefali S. Kulkarni, *Patients Often Find Getting Coverage for Eating Disorders Is Tough*, KAISER HEALTH NEWS (Oct. 19, 2012), <http://www.kaiserhealthnews.org/Stories/2012/October/19/binge-eating-disorder-insurance-coverage.aspx?p=1> (“In extreme circumstances, patients are hospitalized and [s]ome patients are also referred to a residential facility for mental health care.”).

39. A 2006 study of twenty-two residential treatment facilities revealed that one day of care cost, on average, \$956. M.J. Frisch, et al., *Residential Treatment for Eating Disorders*, 39 INT’L J. EATING DISORDERS 434, 434 (2006).

40. *Id.* (“The average length of stay in treatment was 83 days”).

many health insurance plans provide inadequate coverage for eating disorders,⁴¹ and some categorically exclude eating disorders from coverage.⁴²

Insurance companies use several tactics to avoid or minimize the costs of eating disorder coverage. Many private employee benefit plans, which cover the majority of Americans and adolescents,⁴³ place “greater restrictions and limitations on mental illnesses to reduce health care costs.”⁴⁴ Restrictions include lower caps on mental health care than physical health care; limits on the number of covered therapy sessions, days of residential or inpatient treatment, and dietician appointments; and lower “lifetime” and annual maximums.⁴⁵ In addition to these built-in barriers to coverage, insurers often engage in behavior—either willfully or due to insufficient training—that misinforms sufferers and discourages them from pressing further to get coverage approved.⁴⁶ This behavior includes “[f]ailing or refusing to receive medical records or clinical information in support of a treatment request,” “using time parameters offensively against the insured or patients to deny them an appeal,” denying patients their right to an appeals process, and not consulting with eating disorder specialists when making coverage decisions.⁴⁷

Without comprehensive insurance coverage, adequate treatment often proves unaffordable, but sufferers and their families still pay a high price. Some pay with money they do not have, racking up debt and facing bankruptcy rather than halting

41. Kulkarni, *supra* note 38 (“[F]or many . . . patients, getting a full range of insurance coverage can be difficult. Mental health coverage is often less generous than coverage for physical ills.”).

42. Letter from the Eating Disorders Coalition for Research, Policy & Action, *supra* note 23 (“Exclusion of eating disorders is all too common on the part of insurers seeking to limit interventions deemed non-essential. Despite being biologically based mental illnesses with potentially severe physical health ramifications, including death, eating disorders are all too often found on lists of benefit exclusions.”).

43. See CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & CHERYL HILL LEE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 16 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

44. Beth A. Brunalli, *Anorexia Killed Her, But the System Failed Her: Does the American Insurance System Suffer from Anorexia?*, 12 CONN. INS. L.J. 583, 594 (2006).

45. *Id.* at 595.

46. Elizabeth Wrobel, Stonewalling Appropriate Care: Insurance Barriers to Necessary Treatment, Address at the Eating Disorders Coalition Lobby Day (Oct. 4, 2011) (transcript available at <http://www.eatingdisorderscoalition.org/documents/100311LobbyDayspeech.FINAL.pdf>) (outlining a “laundry list of common tactics and violations” by health insurance companies).

47. *Id.*

treatment.⁴⁸ Others pay in the form of long-term health problems caused by years of malnutrition, purging, and drug abuse.⁴⁹ Many sufferers pay with their lives; eating disorders—*anorexia* in particular—have the highest mortality rates of any mental illnesses.⁵⁰ The same programs and treatment centers that are so expensive to run often bear the names of women who died of their disorders.⁵¹

Sufferers and their families sometimes sue insurance companies for their refusal to cover treatment.⁵² In these cases, some plaintiffs want compensation for the thousands of dollars they have personally paid for treatment.⁵³ For several decades, the insurance company defendants have regularly prevailed in such cases.⁵⁴ Others sue after losing family members to

48. Charlotte Triggs, *An Anorexia Victim Fights Back*, PEOPLE, July 7, 2008, at 80 (“As Lynn Greffe, CEO of the National Eating Disorders Association, notes, ‘To pay for treatment, families use their savings. They take out second mortgages. They go broke.’”).

49. See Kelly A. Gendall & Cynthia M. Bulik, *The Long Term Biological Consequences of Anorexia Nervosa*, 1 CURRENT NUTRITION & FOOD SCI. 87, 92–93 (2005) (concluding that patients with a history of anorexia have an increased risk of “low bone density and osteoporosis-related fractures,” and may have higher rates of “birth complication and low birth weight infants”).

50. Letter from the Eating Disorders Coalition for Research, Policy & Action, *supra* note 23 (“Individuals with anorexia nervosa are 11 times more likely to die than their peers and they are 57 times more likely to die of suicide. Mortality rates are also higher for people with bulimia nervosa (3.9%), and [ED-NOS] (5.2%).”).

51. Examples include the “Anna Westin House,” a residential treatment facility; “Sheena’s Place,” a non-profit that hosts support groups for people with eating disorders; and the “Elisa Project,” a charity dedicated to raising awareness. Sheila Mulrooney Eldred, *Eating-disorder Patients Fight Double Battle: Their Disorder, and Insurance Firms*, MINNPOST.COM (Feb. 17, 2012), <http://www.minnpost.com/health/2012/02/eating-disorder-patients-fight-double-battle-their-disorder-and-insurance-firms>; Sandra Williams, *Eating Disorder Awareness Breakfast in Toronto*, EXAMINER (Jan. 28, 2010), <http://www.examiner.com/article/eating-disorder-awareness-breakfast-toronto>; Nancy Churnin, *Treatment Program for Young People Focuses on Family*, CHILDREN’S MED. CTR. (May 8, 2012), <http://www.childrens.com/giving/news-events/eating-disorders-help-is-available.aspx>.

52. Andrew Pollack, *Eating Disorders a New Front in Insurance Fight*, N.Y. TIMES, Oct. 14, 2011, at A1.

53. See, e.g., *Doe v. HMO-CNY*, 14 A.D.3d 102 (N.Y. App. Div. 2004) (involving plaintiffs seeking to recover expenses from eating disorder treatment from defendant insurer).

54. See, e.g., *Douglas S. v. Altius Health Plans, Inc.*, 409 Fed. Appx. 219 (10th Cir. 2010) (holding that under Utah law, defendant insurer was under no obligation to provide coverage for residential eating disorder treatment); *Dibiasi v. Blue Cross, Inc.*, 156 A.D.2d 986 (N.Y. App. Div. 1989) (denying plaintiff recovery of expenses incurred after the time defendant insurer deemed “acute medical treatment” was no longer necessary); *O’Reardon v. Principal Life Ins. Co.*, 17 Fla. L. Weekly 455 (Fla. Dist. Ct. App. 2004) (granting summary judgment to defendant insurer on the basis that the licensed residential facility where plaintiff’s daughter received treatment was not a “hospital” under defendant’s plan).

complications from untreated or under-treated eating disorders.⁵⁵ Wrongful death suits, however, are often impossible to bring due to the lack of a cause of action under the Employee Retirement Income Security Act (ERISA).⁵⁶ Clearly, litigation efforts were not enough to change the landscape of insurance coverage for eating disorders.

II. Legislative Efforts: Federal and State Parity Laws

The battle for fair coverage has not been limited to the courts. Legislation aimed at promoting equality for mental health treatment has been proposed, and in some cases passed, at both the state and federal levels.⁵⁷ As of 2010, ten states, including Minnesota, California, and Washington, “require all health plans to cover anorexia and bulimia on the same basis as other mental health conditions.”⁵⁸

A. Federal Parity Laws

The Mental Health Parity Law (MHPA) of 1996⁵⁹ was signed into law by President Clinton in 1997 and took effect in 1998.⁶⁰ The Act expanded mental health coverage for many Americans by “equat[ing] aggregate lifetime limits and annual limits for mental health benefits with aggregate lifetime limits and annual limits for medical and surgical benefits.”⁶¹ However, the law did not require that plans include mental health coverage—its mandates only applied to plans that elected to cover

55. Associated Press, *Eating Disorder Experts Say Settlement Could Goad Insurers*, READING EAGLE & READING TIMES, Aug. 1, 2001, at A8 (reporting that the parents of a twenty-one-year-old anorectic sued Blue Cross Blue Shield for refusing to pay her treatment costs after she committed suicide).

56. 29 U.S.C. 18 § 1451 (2012). ERISA is a federal law, and plans are not subject to state regulations like mental health parity laws. “[ERISA] plans typically limit benefits to lower levels of coverage with higher deductibles and co-pays, or limit inpatient care to 30 days per year or a 60-day lifetime maximum.” Chris J. Johnson, *The Juggling Act: Hospitalization, Patient Health and Insurance Coverage*, Address at a Congressional Briefing on Eating Disorder Treatments (July 15, 2003) (transcript available at <http://www.eatingdisorderscoalition.org/July2003.htm>).

57. See H.R. 1424, 110th Cong. (2008); *Policy Indicators: Eating Disorder Parity*, NAT’L WOMEN’S L. CTR. (Sept. 2010), <http://hrc.nwlc.org/policy-indicators/eating-disorder-parity>.

58. *Id.* (listing states as having “no policy,” a “limited policy,” or “meets policy”).

59. 29 U.S.C. § 1185a (2012).

60. *The Mental Health Parity Act of 1996: Summary of the Law*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/ContentGroups/E-News/1996/The_Mental_Health_Parity_Act_of_1996.htm (last visited Apr. 6, 2013).

61. *Id.*

mental health.⁶² Furthermore, the MHPA exempted employers with fewer than fifty employees, and employers who saw their costs rise by more than one percent could apply for exemptions.⁶³ Finally, the law “[did] not apply to other forms of benefit limits, such as per episode limits on length of stay or visit limits, co-payments [or] deductibles.”⁶⁴

The MHPA was updated in 2008 when Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.⁶⁵ This Act applies to substance abuse disorders and “requires that large group health plans and Medicaid managed-care plans provide coverage for mental or substance-use disorders on par with the coverage offered for physical ailments.”⁶⁶ The Obama administration took steps to implement the update by releasing interim rules in early 2010,⁶⁷ but “[t]he final rule that would provide clarity to the millions who have a mental illness or substance-use disorder, and to their employers, has not been issued.”⁶⁸ Like the MHPA of 1996, the update includes no requirement that plans cover mental health benefits.⁶⁹ Additionally, current federal parity law “allows states to determine which mental illnesses will be covered,”⁷⁰ allowing them to exclude eating disorders from coverage or to limit coverage to patients who meet the strict clinical criteria for anorexia or bulimia, as set out in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).⁷¹

62. See 29 U.S.C. § 1185a(b)(1) (2006 & Supp. IV 2010) (“Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance abuse disorder benefits.”).

63. KARLA BALLING, A FAMILY IMPACT ANALYSIS OF THE FAMILY MENTAL HEALTH PARITY ACT, POL’Y INST. FOR FAM. IMPACT SEMINARS 2 (2003), available at http://www.familyimpactseminars.org/fia_analyses_fpmhp.pdf.

64. *Id.*

65. H.R. 1424, 110th Cong. (2008), available at <https://www.cms.gov/HealthInsReformforConsume/Downloads/MHPAEA.pdf> (amending 29 U.S.C. 1185a, § 712 (ERISA)); 42 U.S.C. 300gg-5, § 2705 (Public Health Service Act); and I.R.C. § 9812).

66. Pete Domenici & Gordon H. Smith, Editorial, *Mental Illnesses Deserve Insurance, Too*, WASH. POST (Apr. 12, 2012), http://articles.washingtonpost.com/2012-04-12/opinions/35453237_1_mental-illness-addiction-equity-act-mental-health.

67. News Release, Dep’t of Health & Hum. Servs., Obama Administration Issues Rules Requiring Parity in Treatment of Mental, Substance Use Disorders (Jan. 29, 2010), available at <http://www.hhs.gov/news/press/2010pres/01/20100129a.html>.

68. Domenici, *supra* note 66.

69. Womble, *supra* note 11.

70. *Id.*

71. For example, in order to qualify for a diagnosis of anorexia, the DSM-IV requires that female patients experience the “absence of at least 3 consecutive

B. State Parity Laws

Almost every state has passed some version of mental health parity laws.⁷² This trend began in the 1970s as states passed laws mainly focusing on coverage for alcoholism and other chemical dependencies.⁷³ In the 1980s and 1990s, states passed laws mandating broader mental health coverage generally,⁷⁴ and such laws continue to pass yearly. These laws are not superseded by federal parity law(s) to the extent that they require stricter provisions.⁷⁵ Still, state parity legislation often suffers from the same shortcomings as the federal legislation; most state parity laws only apply to large group plans, cover only an enumerated list of mental illnesses, and allow exemptions for insurers whose costs would increase by more than a small percent.⁷⁶ Fewer than half of states have parity laws that actually require some degree of coverage for the treatment of eating disorders.⁷⁷

Some states, such as New Jersey and California, do have substantial parity laws that create positive changes.⁷⁸ For plaintiffs whose plans are covered under these strong state parity laws, the provisions have given more clout to lawsuits against insurers who refuse to cover eating disorder treatment.⁷⁹ The Ninth Circuit recently decided that “residential treatment was medically necessary for eating disorders, and therefore [must] be

menstrual cycles.” *Eating Disorder Diagnostic Criteria from DSM IV-TR*, CASTAT.UNR.EDU, http://casat.unr.edu/docs/eatingdisorders_criteria.pdf (last visited Apr. 4, 2013).

72. See *State Laws Mandating or Regulating Mental Health Benefits*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/mental-health-benefits-state-laws-mandating-or-re.aspx> (last visited Apr. 6, 2013) (listing forty-nine states that “currently have some type of enacted law” regulating or mandating mental health benefit coverage).

73. See, e.g., MISS. CODE ANN. § 83-9-27 (1975); NEV. REV. STAT. § 689A.046 (1979).

74. See, e.g., ARK. CODE ANN. § 23-86-113 (1983); KY. REV. STAT. ANN. § 304-17-318 (West 1986); N.H. REV. STAT. ANN. § 417-E:1 (1994).

75. HHS MEMORANDUM, *supra* note 20.

76. See NAT’L CONFERENCE OF STATE LEGISLATURES *supra* note 72 (stating that some state coverage laws “allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses” and others, like federal parity law, “do not require (or mandate) benefits be provided at all” (emphasis in original)).

77. As of 2007, thirty states do not have “laws that ensure health insurance reimbursement for the treatment of eating disorders.” *Summary of State Parity Laws That Include Eating Disorders as of 2007*, EATING DISORDERS COALITION, <http://www.eatingdisorderscoalition.org/documents/talkingpointsparity.pdf> (last visited Apr. 12, 2013).

78. Pollack, *supra* note 52 (“In New Jersey, Aetna, Horizon and AmeriHealth have agreed to end limits on the number of days of residential treatment they will cover for eating disorders, according to Bruce Nagel, a lawyer who sued the insurers under the state’s parity law.”).

79. *Id.*

covered under the [California] parity law,” despite Blue Shield’s argument that there is no “exact equivalent” of residential treatment for physical illnesses.⁸⁰ Unfortunately, California is an exception to the general rule: state parity laws do not usually require insurers to cover eating disorder treatments.⁸¹

C. Proposed Legislation: The FREED Act

In response to the inadequacies of federal and state parity legislation to address eating disorders, advocates drafted the Federal Response to Eliminate Eating Disorders (FREED) Act.⁸² The Act is a “comprehensive bill addressing research, treatment, education and prevention of eating disorders”⁸³ that includes in its Treatment section provisions that would require “any insurer that provides health coverage for physical illness [to] provide coverage for eating disorders” and require insurers “to follow standards of care as written in the Practice Guidelines for the Treatment of Patients with Eating Disorders by the American Psychiatric Association.”⁸⁴ This means that insurers would need to cover treatments such as residential care, long-term therapy, and dietician appointments.⁸⁵

Coverage under the FREED Act would extend not only to patients who meet the strict criteria for anorexia and bulimia, but

80. *See id.*; Harlick v. Blue Shield of CA, 686 F.3d 699, 703 (9th Cir. 2012) (“We conclude that [Harlick’s] insurance plan, considered alone, does not [require coverage of residential treatment], but that [California’s] Mental Health Parity Act does so require.”).

81. *See supra* notes 76–77 and accompanying text.

82. H.R. 1448, 112th Cong. (2011); S. 481, 112th Cong. (2011); Lauren Linhard, *FREED Act to Provide Medical Coverage for Eating Disorder Recovery*, ADVANCED REPORTING TIMES (Apr. 22, 2010, 3:01 PM), <http://janehall1.wordpress.com/2010/04/22/freed-act-to-provide-medical-coverage-for-eating-disorder-recovery/> (“Eating disorders are psychiatric mental health disorders that lead to physical consequences . . . This leaves eating disorders in a limbo where insurance companies can deny coverage or reduce coverage since they don’t fall into a straight forward mental health or physical health problem.”) (quoting Alan Duffy).

83. Dave Moore & Bill Manville, *FREED Act Offers Hope for Those Afflicted With Anorexia, Bulimia, and Other Eating Disorders*, N.Y. DAILY NEWS (Mar. 31, 2009, 1:10 PM), <http://www.nydailynews.com/life-style/health/freed-act-offers-hope-afflicted-anorexia-bulimia-eating-disorders-article-1.364093>.

84. Kathleen MacDonald, *What is the FREED Act?*, EATING DISORDERS COALITION (July 16, 2011), <http://eatingdisorderscoalition.blogspot.com/2011/07/what-is-freed-act.html>; *Practice Guideline for the Treatment of Patients with Eating Disorders*, AM. PSYCHIATRIC ASS’N (2006), available at <http://psychiatryonline.org/content.aspx?bookid=28§ionid=2021669>.

85. MacDonald, *supra* note 84 (explaining that under the FREED Act, “[a]ll treatment modalities should be covered, including but not limited to family, individual and group therapies, nutrition counseling, psychopharmacology, body Image therapy, and medical treatment”).

also those diagnosed with ED-NOS.⁸⁶ This means that patients with Binge Eating Disorder (BED),⁸⁷ the most commonly occurring eating disorder,⁸⁸ would also be eligible for coverage.⁸⁹ However, it remains unclear when, if ever, Congress might pass the FREED Act. The 2011 House and Senate bills are both currently assigned to committees.⁹⁰

III. The Promise and Disappointment of the ACA

In the twentieth and twenty-first centuries, both Republicans and Democrats have regularly attempted to pass health care reform bills.⁹¹ It was not until 2010 that Congress finally passed legislation that would provide for universal health care.⁹² The new legislation seemed to promise the coverage and parity for mental illnesses that had been lacking in previous reforms.⁹³ Hopes were high among advocates that these reforms would make comprehensive coverage of eating disorders a mandatory feature of insurance plans.⁹⁴

86. Amy Sanders, *The Federal Response to Eliminate Eating Disorders: Does the FREED Act Have a Fighting Chance?*, 3 HEALTH L. & PUB. POLY FORUM 10, 15 (2011) (“Both the House and Senate bills “suggest parity by defining ‘eating disorder’ according to the DSM.””).

87. Listed under the section for ED-NOS in the DSM-IV, Binge Eating Disorder is described as “recurrent episodes of binge eating in the absence of regular inappropriate compensatory behavior characteristic of bulimia nervosa.” DSM-IV § 309.81(6) (Am. Psychiatric Ass’n 4th ed. 1994).

88. Rick Nauert, *Binge Eating Is Top Eating Disorder*, PSYCHCENTRAL (Feb. 1, 2007), <http://psychcentral.com/news/2007/02/01/binge-eating-is-top-eating-disorder/593.html> (reporting that 3.5% of women and 2% of men are affected by BED).

89. Sanders, *supra* note 86, at 14.

90. *Id.*

91. Abundis & Butler, *supra* note 4.

92. Dunham, *supra* note 5.

93. Richard A. Friedman, *Good News for Mental Illness in Health Law*, N.Y. TIMES, JULY 10, 2012, at D6 (praising the ACA and pronouncing that “Americans with mental illness finally have the prize that has eluded patients and clinicians for decades: the recognition that psychiatric illness should be on a par with all other medical disorders, and the near-universal mandate to make that happen.”).

94. Letter from the Eating Disorders Coalition for Research, Policy & Action, *supra* note 23, at 1 (“We were optimistic that with the passage of the ACA and the inclusion of mental health as a specific EHB category, the continued and widespread insurance discrimination experienced by people with eating disorders would come to an end.”); Julie O’Toole, *Will Healthcare Reform Affect Eating Disorder Treatment?*, KARTINI EATING DISORDER BLOG (Apr. 19, 2010, 5:03 PM), <http://www.kartiniclinic.com/blog/post/will-healthcare-reform-affect-eating-disorder-treatment/> (“Whatever the collective merits of the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, its impact on eating disorder treatment for children and young adults promises to be highly significant, and overwhelmingly positive.”).

A. *The History and Context of the ACA*

During the Democratic primary campaign for the 2008 Presidential election, each of the three major candidates pledged to introduce new legislation to reform the health care system.⁹⁵ After winning the party nomination, Senator Obama made health care reform a centerpiece of his presidential campaign, announcing in his acceptance speech at the Democratic Convention that he would “make certain [insurance] companies stop discriminating against those who are sick and need care the most.”⁹⁶ In his remarks at both the second and third Presidential Debates, Senator Obama specified that his plan included a focus on providing preventative care.⁹⁷ Additionally, the Obama campaign’s website specifically addressed the need for improved access to mental health care as part of his proposed health care plan.⁹⁸

In the first year of Obama’s presidency, bitter debate between Democrats and Republicans in Congress in 2009 halted progress on health care reform.⁹⁹ On February 22, 2010, the President “unveil[ed] his own healthcare proposal, drawn heavily from the Senate bill.”¹⁰⁰ This new proposal was quickly approved by the House and Senate, and it was signed into law as the ACA

95. Perry Bacon Jr., *A Renewed Health Care Focus for Clinton*, WASH. POST (May 9, 2008, 2:33 PM) (“[Senator Hillary] Clinton has long been an advocate of universal health care, but it has not always been at the center of her campaign, as she announced her proposal months after Obama and former North Carolina senator John Edwards offered their plans.”).

96. Senator Barack Obama, Acceptance Speech at the Democratic National Convention in Denver (Aug. 28, 2008) (transcript available at <http://www.nytimes.com/2008/08/28/us/politics/28text-obama.html?pagewanted=all>).

97. Senator Barack Obama, Second Presidential Debate (Oct. 7, 2008) (transcript available at <http://elections.nytimes.com/2008/president/debates/transcripts/second-presidential-debate.html>) (“And we’re going to [lower health care premiums] by investing in prevention.”); Senator Barack Obama, Third Presidential Debate (Oct. 15, 2008) (transcript available at <http://elections.nytimes.com/2008/president/debates/transcripts/third-presidential-debate.html>) (“And we are going to make sure that we manage chronic illnesses, like diabetes and heart disease, that cost a huge amount, but could be prevented. We’ve got to put more money into preventive care.”).

98. Mike Nichols, *Obama’s and McCain’s Positions on Mental Health Care*, ANXIETY, PANIC, & HEALTH (Aug. 6, 2008), <http://anxietypanichealth.com/2008/08/06/obamas-and-mccains-positions-on-mental-health-care/> (citing material on Barack Obama’s 2008 Presidential Campaign Site (no longer available)) (“As president, Obama will support mental health parity so that coverage for serious mental illnesses are provided on the same terms and conditions as other illnesses and diseases.”).

99. See Dunham, *supra* note 5 (“August 2009: Congress fails to meet Obama’s deadline of passing initial healthcare legislation by August, as Republican and industry opposition hardens.”).

100. *Id.*

on March 23, 2010.¹⁰¹

B. Essential Health Benefits: Allowing States to Choose Benchmark Plans Allows Injustice to Continue

One of the key provisions of the ACA is a list of ten “Essential Health Benefits” (EHB)—categories that establish a “minimum floor of services that all health plans in the individual and small group market will be required to cover starting in 2014.”¹⁰² The EHB categories must be covered by plans offered in state exchanges under the new reforms.¹⁰³ The categories compose what is meant to be “a comprehensive package of items and services.”¹⁰⁴ One of the ten EHB categories is “[m]ental health and substance use disorder services, including behavioral health treatment.”¹⁰⁵

The EHB provision of the ACA allows the Secretary of HHS to define the listed benefits and to expand categories of coverage beyond the ten enumerated areas.¹⁰⁶ However, “[r]ather than create one federal definition, HHS gave each state the authority to define exactly what items and services will be included in its essential health benefits package in 2014 and 2015. This package must be based on a benchmark plan selected by the state.”¹⁰⁷ This task proved difficult for some states, as HHS gave little guidance on the details of defining EHB.¹⁰⁸ Other states postponed choosing a benchmark plan as they waited to learn whether President Obama would be reelected.¹⁰⁹ States were initially given until

101. *Id.*

102. *Designing the Essential Health Benefits for Your State: An Advocate’s Guide*, FAMILIES USA (July 2012), available at <http://familiesusa2.org/assets/pdfs/Designing-Essential-Health-Benefits.pdf> [hereinafter *Designing EHB*].

103. U.S. Dep’t of Health & Hum. Servs., *Essential Health Benefits*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/e/essential.html> (last visited Apr. 6, 2013).

104. U.S. Dep’t of Health & Humans Servs., *Essential Health Benefits: HHS Informational Bulletin*, HEALTHCARE.GOV, <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html> (last visited Apr. 6, 2013).

105. 42 U.S.C. § 18022(b)(1)(E) (2010).

106. 42 U.S.C. § 18022(b)(1) (2010) (“[T]he Secretary shall define the essential health benefits, except that such benefits shall include at least” the ten categories listed).

107. *Designing EHB*, *supra* note 102.

108. Jonathan Block, *State Officials Lash Out at HHS for Insufficiency of EHB Guidance*, 3 AIF’S HEALTH REFORM WEEK, 20, 24 (2012) (“The only pieces of information for states released by HHS were an ‘Essential Health Benefits Bulletin’ issued Dec. 16, 2011 . . . and an FAQ document released Feb. 17, 2012.”).

109. Phil Galewitz, *Obama Administration Extends Deadline For State Exchanges*, KAISER HEALTH NEWS (Nov. 9, 2012),

November 16, 2012 to choose a benchmark plan, but this deadline was eventually extended to December 14, 2012.¹¹⁰

Allowing states to select benchmark plans from among their existing plans gave states the option to effectively continue letting health insurance companies deny or limit coverage for patients with eating disorders.¹¹¹ Because the HHS left “the definition of a required ‘mental health service’ to the discretion of the states and insurance companies,” there may be no improvement in the coverage of eating disorder treatment in some states.¹¹² If even such bold, sweeping health care reform as a universal health plan cannot achieve coverage for sufferers, the future looks grim for individuals with eating disorders.

IV. The Inequalities in Eating Disorder Coverage Can Be Remedied Through the Adoption of a National Benchmark System

In 2011, HHS declined to define mental health care as an EHB, shifting the burden to the states.¹¹³ In 2016, HHS will be required to review this decision taking into account its consequences during 2014 and 2015.¹¹⁴ It will likely be apparent at that time that coverage for some mental illnesses—eating disorders particularly—is not adequately covered in all fifty states.¹¹⁵ The nature of this long-entrenched problem, involving complex illnesses that are difficult to classify, calls for a clear and definite standard.

<http://www.kaiserhealthnews.org/Stories/2012/November/09/exchange-deadline.aspx> (“[M]any states had delayed planning until they saw who won the presidential election.”).

110. Letter from Kathleen Sebelius, Secretary of the U.S. Dep’t of Health and Hum. Services to State Governors (Nov. 9, 2012), *available at* <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/11/Dear-Governor-letter-re-Exchange-Blueprints-11-9-12-pdf-pdf-pdf-pdf.pdf> (“HHS is extending the deadline for State-based Exchange Blueprint application submissions to Friday, December 14, 2012.”).

111. Womble, *supra* note 11 (explaining that under the HHS rules for EHB, “states can adopt a benchmark plan based on a state employer plan that may exclude coverage for eating disorders”).

112. Sy Mukherjee, *Eating Disorder Patients Lack Sufficient Health Coverage*, THINKPROGRESS (Oct. 19, 2012, 5:45 PM), <http://thinkprogress.org/health/2012/10/19/1050541/eating-disorder-patients-lack-sufficient-health-coverage/?mobile=nc>.

113. *See Designing EHB*, *supra* note 102.

114. 42 U.S.C. § 18022(b)(4)(G)(i) (2010) (providing that the Secretary of HHS “periodically review the essential health benefits . . . and provide a report to Congress and the public that contains . . . an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost”).

115. *See supra* Part III.B.

A. *It is Poor Public Policy to Deny Sufferers Effective Treatment*

Currently, a significant majority of people who suffer from eating disorders do not receive mental health care.¹¹⁶ The symptoms of eating disorders likely contribute to this gap in treatment, as “[i]ndividuals with eating disorders are often highly secretive about their struggle, which compounds problems of denial and resistance to treatment.”¹¹⁷ Additionally, people who suffer from mental illnesses are still stigmatized in modern culture.¹¹⁸ Patients and families may be reluctant to pursue treatment for fear of being judged by their friends, relatives, or colleagues.¹¹⁹ Yet when Americans with eating disorders overcome their secrecy and embarrassment, taking the brave step of seeking treatment, they often find that treatment is prohibitively expensive and not covered by their insurers.¹²⁰ By limiting or barring coverage, health insurance companies keep sufferers from receiving intensive treatment, and force others to prematurely discontinue less expensive treatment, such as therapy.¹²¹

This denial of coverage is not cost effective.¹²² When treatment is unavailable in the early stages of an eating disorder, there is a greater likelihood that more intensive, expensive

116. See *NEDA Statistics*, *supra* note 19.

117. Sanders, *supra* note 86, at 12 (citing Emily Sohn, *The Hunger Artists*, U.S. NEWS & WORLD REP. (June 10, 2002), http://health.usnews.com/usnews/health/articles/020610/archive_021599.htm).

118. Traci Pedersen, *Stigma for Mental Illness High, Possibly Worsening*, PSYCHCENTRAL (Sept. 23, 2010), <http://psychcentral.com/news/2010/09/23/stigma-for-mental-illness-high-possibly-worsening/18524.html> (“Despite widespread efforts to educate the public of the neurobiological basis for mental illness, researchers have found no improvement in discrimination toward people suffering with serious mental health or substance abuse problems.”).

119. *Id.* (“For many Americans suffering with mental illness, a fear of stigma often keeps them from seeking the medical help they need. When others find out, the sufferer can experience discrimination in employment, housing, medical care and social relationships.”).

120. See *supra*, Part I.

121. *Securing Eating Disorder Treatment*, NAT’L EATING DISORDER ASS’N, <http://www.nationaleatingdisorders.org/securing-eating-disorders-treatment> (last visited Apr. 4, 2013) (“In short, empirical studies do not support the notion that eating disorders can be adequately treated in short-term therapy” and “[w]hen therapists are pressured to manage cases in less time by third-party payers, quality of care and attention to the complex medical, emotional, and interpersonal dimensions are compromised.”).

122. *Id.* (“[T]o respond to high costs, shortening the length of inpatient treatment, studies have shown, will backfire. As length of stay decreases and weight at discharge becomes lower, the need for readmission increases.”); Sanders, *supra* note 86, at 12–13 (“This ‘pennywise but pound foolish’ approach disregards the cost-effectiveness of treating eating disorders early, before increased care is necessary or medical complications emerge.”) (citations omitted).

treatment will be necessary later as the disorder worsens.¹²³ Without access to affordable treatment, or with insufficient treatment, many patients never make full recoveries.¹²⁴ As years pass, sufferers may develop irreversible physical conditions.¹²⁵ Osteoporosis is a common result of low calcium intake due to prolonged starvation and can result in hip fractures costing more than \$37,000 per incident.¹²⁶ Sufferers also face continuing health risks resulting from starvation, bingeing, purging, and other symptomatic behaviors.¹²⁷ One major health consequence associated with anorexia, bulimia, and ED-NOS is an increased rate of heart failure.¹²⁸ Treatment for a single, severe heart attack is estimated to cost an average of one million dollars.¹²⁹ A less severe heart attack costs an estimated average of \$760,000—more than twenty-five times the cost of an entire month of eating disorder treatment at a residential care facility.¹³⁰

123. NAT'L EATING DISORDER ASS'N, *supra* note 121 (“When patients do not receive specialized care early in the course of their illness, they are often referred to treatment later. Due to this delay, acute hospitalizations are increasing.”).

124. An analysis of 119 studies on outcomes of anorexia in the second half of the twentieth century showed that “mortality rates were high.” *Id.* Among the surviving patients, “less than a half of the patients, or exactly 46%, fully recovered from anorexia nervosa, whereas a third improved . . . and 20% remained chronically ill.” *Id.* The analysis concluded, “the global outcome . . . clearly improves with increasing duration of follow-up.” Hans-Christoph Steinhausen, *The Outcome of Anorexia Nervosa in the 20th Century*, 159 AM. J. PSYCHIATRY 1284, 1288–89 (2002).

125. NAT'L EATING DISORDER ASS'N, *supra* note 121 (“Irreversible risks associated with Anorexia Nervosa are growth retardation, pubertal delay or arrest, impaired acquisition of peak bone mass, and increased risk of osteoporosis. Bulimic behaviors may result in . . . peripheral muscle weakness, cardiomyopathy, and hypometabolism.”).

126. *Id.*; OSTEOPOROSIS, AM. ACAD. OF ORTHOPAEDIC SURGEONS, <http://orthoinfo.aaos.org/topic.cfm?topic=A00232> (last visited Apr. 6, 2013) (“Health care costs from hip fractures total more than \$11 billion annually, or about \$37,000 per patient.”).

127. *See* NAT'L EATING DISORDER ASS'N, HEALTH CONSEQUENCES OF EATING DISORDERS, <http://www.nationaleatingdisorders.org/health-consequences-eating-disorders> (last visited Apr. 6, 2013).

128. *Id.* (explaining that as anorectics starve, they develop “abnormally slow heart rate and low blood pressure, which mean that the heart muscle is changing. The risk [of] heart failure rises as the heart rate and blood pressure levels sink lower and lower.” Bingeing and purging create “[e]lectrolyte imbalances that can lead to irregular heartbeats and possibly heart failure.”).

129. Steve Vernon, *How Much Would a Heart Attack Cost You?*, CBS NEWS (Apr. 23, 2010, 9:00 AM), http://www.cbsnews.com/8301-505146_162-39940799/how-much-would-a-heart-attack-cost-you/ (“[T]he average total cost of a severe heart attack—including direct and indirect costs—is about \$1 million. Direct costs include charges for hospitals, doctors and prescription drugs, while the indirect costs include lost productivity and time away from work.”).

130. *Id.* (“The average cost of a less severe heart attack is about \$760,000.”); Alderman, *supra* note 14 (“A residential program costs \$30,000 a month on average.”).

The story of Danielle Moles illustrates the significantly higher costs that result when insurers refuse or delay coverage.¹³¹ Moles was “prescribed long-term care in a residential psychiatric facility” after being diagnosed with anorexia.¹³² Her eating disorder had already resulted in permanent damage to her digestive system, a miscarriage, a stress fracture in her foot, and periodic seizures.¹³³ Still, her insurer insisted that her treatment was not covered, and the company only agreed to pay after stalling for several years—years during which Moles’s condition worsened.¹³⁴ “Had Moles gotten the help she needed at the beginning, her treatment might have cost her insurers roughly \$80,000 instead of the \$500,000 to \$750,000 she estimates they eventually paid. (Moles estimates she has paid \$150,000 out of her own pocket.)”¹³⁵

Economics aside, denying individuals with eating disorders the treatment they need to recover runs directly counter to the stated goals of mental health parity legislation and universal health care. President Obama has repeatedly justified his health care plan by invoking anecdotes of Americans of all ages suffering from treatable conditions but unable to pay for treatment without the existence of the ACA. In the second Presidential Debate of 2008, then-Senator Obama spoke of his fifty-three-year-old mother spending “the last months of her life in the hospital room arguing with insurance companies because they’re saying . . . they don’t have to pay her treatment,” and declaring that “there’s something fundamentally wrong about that.”¹³⁶ During the 2012 presidential election, President Obama “was introduced at one of his final rallies by a father whose eight-year-old daughter got treatment for leukemia thanks to the [ACA], an anecdote he repeated in his victory speech.”¹³⁷ Yet the ACA, as it is currently implemented, will not help anorectics, bulimics, or other sufferers who need life-

131. See Michael Ollove, *Parity for Behavioral Health Coverage Delayed by Lack of Federal Rules*, STATELINE (Nov. 30, 2012), <http://www.pewstates.org/projects/stateline/headlines/parity-for-behavioral-health-coverage-delayed-by-lack-of-federal-rules-85899433333>.

132. *Id.*

133. *Id.*

134. *Id.* (“Susan McClanahan, Danielle Moles’ psychologist, is convinced that Danielle has paid a heavy price because of the unequal treatment accorded behavioral health patients. ‘If she had been able to have a residential stay earlier,’ says McClanahan, ‘the course of her illness would not have been so long.’”).

135. *Id.*

136. Second Presidential Debate, *supra* note 97.

137. Noam N. Levey, *Health Law as Reality; Obama Faces Challenges to Carry out his Overhaul, as do Republican State Leaders who Have Resisted It*, L.A. TIMES, Nov. 9, 2012, at A1.

saving treatment.¹³⁸ Patients with eating disorders and their families still must spend months arguing with their insurers, who are still permitted to refuse coverage.¹³⁹

Kathleen Sebelius, the current Secretary of HHS, issued a press release acknowledging May of 2012 as Mental Health Month, asserting that “mental health is essential for a person’s overall health; prevention works; treatment is effective; and people can recover from mental disorders and live full and productive lives.”¹⁴⁰ People with eating disorders need affordable access to preventative care and effective treatments if they are to fit into the government’s vision for the future of health care.

B. *The FREED Act is Unlikely to Become Law*

If passed, combining the House and Senate versions of the bill, the FREED Act would significantly improve the state of eating disorder treatment in the United States.¹⁴¹ Its proposed expansions in research, education, preventative care, and standards for health insurance coverage are very comprehensive.¹⁴² This is perhaps the result of the Act’s contributors’ approach, as they were encouraged to write their “Dream Bill.”¹⁴³

With that said, the vast majority of the bills introduced to Congress each year are never passed into law.¹⁴⁴ Even fewer bills are passed during periods when the House of Representatives and the Senate are controlled by different political parties.¹⁴⁵

138. *See supra*, Section III.B.

139. *See supra*, Section III.B.

140. Press Release, U.S. Dep’t of Health & Hum. Servs., Statement from HHS Secretary Kathleen Sebelius on Mental Health Month (May 11, 2012), *available at* <http://www.hhs.gov/news/press/2012pres/05/20120511b.html>.

141. Press Release, Sen. Tom Harkin, Harkin, Klobuchar, Franken Work to Combat Eating Disorders (Mar. 3, 2011), *available at* <http://www.harkin.senate.gov/press/release.cfm?i=331643> (“This legislation is critical because it will allow us to fight eating disorders on every level: prevention, diagnosis, and treatment.”) (quoting Sen. Al Franken).

142. Sanders, *supra* note 86, at 11 (“The FREED Act addresses the [various eating] disorders with remarkable comprehensiveness, reflecting input from dozens of advocacy organizations.”).

143. Linhard, *supra* note 82 (quoting Laurel Havaz quoting Rep. Patrick Kennedy).

144. Josh Tauberer, *Kill Bill: How Many Bills Are There? How Many Are Enacted?*, GOVTRACK.US (Aug. 4, 2011), <http://www.govtrack.us/blog/2011/08/04/kill-bill-how-many-bills-are-there-how-many-are-enacted/> (“Since 1999, Congress has been consistently passing about 5% of the bills it introduces . . .”).

145. Jonathan Strong & Humberto Sanchez, *Congress on Pace to Be Least Productive*, CQ ROLL CALL (Sept. 13, 2012, 12:01 AM), http://www.rollcall.com/features/Guide-to-Congress_2012/guide/Congress-On-Pace-to-Be-Least-Productive-217538-1.html (“[Enacting legislation] becomes all the more

Ultimately, the FREED Act attempts to remedy so many issues that its broad approach creates problems for achieving the practical goal of passing it into law.¹⁴⁶ The ACA, on the other hand, has been passed into law, and it clearly gives HHS the authority to require health plans to cover eating disorder treatment.¹⁴⁷

C. *The ACA Can Still Fulfill Its Promise*

The ACA requires the Secretary of HHS to “periodically review the essential health benefits . . . and provide a report to Congress and the public that contains . . . an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost.”¹⁴⁸ The efficacy of allowing states to decide on their own definitions of EHB will come under examination in 2016.¹⁴⁹ At that point, it will become clear that some enrollees—those seeking eating disorder treatment—face significant barriers to receiving affordable treatment.¹⁵⁰

Several options exist for modifying the ACA in order to mandate insurance coverage for eating disorder treatment. These options include amending the mental health provision in the EHB, adding an eleventh category to the EHB, and defining the EHB on a federal level, creating a federal benchmark plan for the states to follow.

1. Amending or Adding to the EHB

The addition of just a few words into the EHB provisions of the ACA could make a world of difference. The ACA gives HHS the power to add to the areas that currently make up EHB, setting the enumerated list as a minimum floor, rather than a ceiling.¹⁵¹ HHS could provide coverage for eating disorder treatment by

difficult when the parties are polarized and in control of opposite bodies.”) (quoting Donald Ritchie).

146. Sanders, *supra* note 86, at 19 (“[T]he FREED Act will likely buckle under the weight of its own comprehensiveness and similar efforts of the last decade.”).

147. See *infra* Section IV.C for a discussion of the ways in which the ACA could require plans to cover treatment for eating disorders.

148. 42 U.S.C. § 18022(b)(4)(G)(i) (2010).

149. Ctrs. for Medicare & Medicaid Servs., *Frequently Asked Questions on Essential Health Benefits Bulletin*, DEP’T OF HEALTH & HUM. SERVS. (Feb. 17, 2012), available at <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf> (“HHS intends to revisit this approach for plan years starting in 2016.”).

150. See *supra* Section III.B.

151. 42 U.S.C. § 18022(b)(1) (2010) (“[T]he Secretary shall define the essential health benefits, except that such benefits shall include at least” the ten enumerated categories listed.”); *Designing EHB*, *supra* note 102 (explaining that the EHB provide a “*minimum floor* of services that all health plans in the individual and small group market will be required to cover”) (emphasis added).

amending the EHB in either of two ways. The first option is to add the words “and treatment for eating disorders, as defined by the DSM-V” to the fifth EHB category.¹⁵² The wording already specifies that services include “behavioral health treatment.”¹⁵³ Additional wording to specify that services also include treatment for eating disorders would fit naturally in the context of the provision.

The second option is to simply add eating disorder treatment as an eleventh category to the EHB.¹⁵⁴ This would make sense given the confusion over whether eating disorders are more properly categorized as physical or mental illnesses.¹⁵⁵

The problem with both these options is their lack of detail. While each would mandate treatment for the DSM-recognized eating disorders, they fail to address what “treatment” means in the context of caring for patients. It would remain up to states and insurers how to define “treatment” in this context, leaving room for insurers to continue refusing coverage for residential care.

2. Creating a Federal Benchmark Plan for Mental Illness

After examining the results of the various states’ approaches to defining mental health as an EHB category, HHS could choose to exercise its power to define the category.¹⁵⁶ The first step would be to include all DSM-recognized eating disorders—including ED-NOS—as falling into the category of “mental illness” in the EHB.¹⁵⁷ Then, perhaps by combining the best of the states’ definitions, or perhaps by taking guidance from the American Psychological Association’s Practice Guideline, HHS could define the parameters for what constitutes eating disorder

152. By 2014, when the EHB provisions take effect, the DSM-IV will have been replaced by the new edition. Providers would have more than six months to prepare to accommodate changes from the DSM-IV. *DSM-5 Development: Timeline*, AM. PSYCHIATRIC ASS’N (2012), <http://www.dsm5.org/ABOUT/Pages/Timeline.aspx> (“May 18-22, 2013: The release of DSM-5 will take place during the APA’s 2013 Annual Meeting in San Francisco, CA.”).

153. 42 U.S.C. § 18022(b)(1)(E) (2010).

154. Thus creating what would become, once codified, 42 U.S.C. § 18022(b)(1)(K).

155. See Linhard, *supra* note 82 (explaining that, from the perspective of insurers, eating disorders “don’t fall into a straight forward mental health or physical health problem”) (quoting Alan Duffy).

156. This was the request of the Eating Disorders Coalition for Research, Policy & Action in their response to the 2011 HHS Memo. Letter from the Eating Disorders Coalition for Research, Policy & Action, *supra* note 23.

157. See Womble, *supra* note 11.

treatment.¹⁵⁸ This approach is superior to simply adding “eating disorder treatment” as a new EHB category or part of an existing category because, in addition to mandating coverage for eating disorders, it allows for consideration of what kinds of treatment should be covered.¹⁵⁹

D. Potential Challenges to a Federal Benchmark Plan

Although the Secretary of HHS will ultimately decide whether or not to implement a federal plan defining the EHB categories, it is possible that public opinion will impact the decision.¹⁶⁰ This Part examines two potential threats to popular support of expanding coverage of eating disorders.

Clinicians regularly recommend residential care for patients with eating disorders, and it is recommended in the APA Treatment Guideline.¹⁶¹ However, insurers argue that the effectiveness of residential care is questionable, and residential care is often not covered even by insurers that cover other kinds of eating disorder treatment.¹⁶² They criticize residential care as largely untested and under-regulated.¹⁶³

Proponents of residential care argue that such facilities provide a necessary step between hospitalization and returning to

158. The approach taken by the FREED Act adopts the APA’s Practice Guideline. Sanders, *supra* note 86, at 15 (“The bill also prohibits denial of coverage for “medically necessary” treatment, effecting a ceasefire in the clinician-insurer battle by requiring use of the standards established in the APA’s Practice Guideline.”).

159. For example, insurers could be required to cover nutritionist appointments and residential care, which are two of the most frequent gaps in coverage. See *infra* note 162; *Common Reasons for Insurance Denials and How You Can Respond, EATING DISORDERS TREATMENT HELP: A TOOL KIT* (2008), http://www.edtreatmenthelp.org/attorneys/reasons_insurance_denial.html (“Insurers frequently deny multidisciplinary care, especially care by a dietician.”).

160. HHS explicitly sought feedback from the public when it announced its initial plan for EHB, noting that public input had already influenced its plan. It also referenced “State flexibility” as a factor in its development of the plan, and this would naturally decrease significantly under a federal plan. See HHS MEMORANDUM, *supra* note 20, at 1 (“In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date. Public input is welcome on this intended approach.”).

161. Am. Psychiatric Ass’n, *Practice Guideline for the Treatment of Patients with Eating Disorders*, in *PRACTICE GUIDELINES FOR THE TREATMENT OF PSYCHIATRIC DISORDERS* 725, 735–41 (2d ed. 2000).

162. Pollack, *supra* note 52 (“[I]n the last few years, some insurance companies have re-emphasized that they do not cover residential treatment for eating disorders or other mental or emotional conditions. The insurers consider residential treatments . . . unproven and more akin to education than to medicine.”).

163. *Id.* (“Even some doctors who treat eating disorders concede there are few studies proving that residential care is effective, although they believe it has value.”).

life at home.¹⁶⁴ They argue that patients require close monitoring as they begin recovery, and that with the oversight of medical staff and therapists, patients can make steps toward integrating that recovery into everyday life.¹⁶⁵ Further studies are necessary to determine the effectiveness of residential treatment centers, but it would be premature for HHS to take this form of treatment off the “menu” available to patients under the EHB.

Another possible hurdle is the likely inclusion of Binge Eating Disorder (BED) as an official diagnosis in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).¹⁶⁶ The updated manual is expected to be released for publication in May of 2013.¹⁶⁷ While the drafters cite an “extraordinary amount of data” supporting the inclusion of BED,¹⁶⁸ the proposal has met some controversy.¹⁶⁹ The American public, well-known for its negative reactions to the overweight and obese,¹⁷⁰ might view the inclusion of binge eating as a psychiatric

164. *Id.*

Advocates and some doctors who treat eating disorders say that hospitalization, which insurers typically cover, might stabilize a patient and restore weight but does not generally treat the underlying psychological issues. Outpatient treatment, which might also be covered, does provide counseling but not full time supervision and care. Residential treatment, they say, occupies a vital niche between those two.

165. *See id.*

166. The drafters of the DSM-V are considering a proposal to add BED as an official diagnosis, with the proposed section including:

Criteria [for BED] include frequent overeating—at least once a week for three months—combined with lack of control, marked feelings of distress, and are associated with three or more of the following:

- eating much more rapidly than normal
- eating until feeling uncomfortably full
- eating large amounts of food when not feeling physically hungry
- eating alone because of feeling embarrassed by how much one is eating
- feeling disgusted with oneself, depressed, or very guilty afterward

Mark Moran, *Binge Eating Disorder May Be Added to DSM-5*, PSYCHIATRIC NEWS (Jan. 6, 2012), <http://psychnews.psychiatryonline.org/newsArticle.aspx?journalid=61&articleid=181255>.

167. *DSM-V Development*, *supra* note 152.

168. Moran, *supra* note 166 (quoting Timothy Walsh, M.D., chair of the Feeding and Eating Disorders Work Group for *DSM-V*).

169. *See, e.g.*, Melissa Healy, *Eating Away*, L.A. TIMES, Nov. 23, 2009, at E5.

170. Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 AM. J. PUB. HEALTH 1019 (2010) (“Negative attitudes toward obese persons are pervasive in North American society. Numerous studies have documented harmful weight-based stereotypes that overweight and obese individuals are lazy, weak-willed, unsuccessful, unintelligent, lack self-discipline, have poor willpower, and are noncompliant with weight-loss

disorder as “absolv[ing] weak-willed people of their responsibility to rein in a dangerous habit.”¹⁷¹ If BED is included in the DSM-V but is not taken seriously by the general public as a disorder, HHS may not go further than specifying coverage for anorexia and bulimia, allowing health insurance companies to keep excluding sufferers with ED-NOS from coverage. This would be a mistake. When a mental disorder is misunderstood or maligned by the public, this should not cast doubt on professional consensus, but rather increase concerns about the wellbeing of sufferers who risk ridicule when they seek treatment.¹⁷²

Conclusion

Health care legislation in the United States has done a poor job of protecting individuals with eating disorders—primarily women—from health insurance companies that stubbornly refuse to cover the expenses of effective treatment.¹⁷³ Despite decades during which eating disorders were known to have a higher mortality rate than any other kind of mental illness, federal efforts at health care reform continue to fail to address this pressing problem. During his first term, President Barack Obama enacted an expansion of federal mental health parity and passed universal health care legislation.¹⁷⁴ Although both of these achievements have improved access to affordable mental health care for Americans, neither has closed the loopholes used by insurance companies to deny treatment to anorectics, bulimics, and others suffering from eating disorders.¹⁷⁵

Although the ACA’s initial implementation did not remedy this injustice, there is still an opportunity for HHS to define “mental health . . . services,”¹⁷⁶ one of the ACA’s areas of mandatory coverage, so that it includes treatment for eating disorders.¹⁷⁷ A federal benchmark plan for EHB, adhering to the ADA Guideline, would finally guarantee that sufferers of all eating disorders received coverage for the lengthy, comprehensive treatment needed for their recovery.¹⁷⁸ History has shown that achieving change in health care legislation is difficult.¹⁷⁹ Lobbying

treatment.”).

171. Healy, *supra* note 169, at E5.

172. *See supra* note 118.

173. *See supra* Part I.

174. *See* News Release, *supra* note 67; Abundis & Butler, *supra* note 4.

175. *See supra* Part II.A and Part II.B.

176. 42 U.S.C. § 18022(b)(1)(E) (2010).

177. *See supra* Part IV.C.ii.

178. *See supra* Part I and Part IV.C.ii.

179. *See* Introduction; Abundis & Butler, *supra* note 4.

groups, advocate organizations, medical professionals, families, and individuals suffering from eating disorders should unite to voice strong support for this further reform. In order for the United States to take one step closer toward truly universal health care, their voices must be heard.