

Summer 2010

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Recommended Citation

McGow, Melissa M. (2010) "A Plan for Recovery: Steps to Finally Provide Adequate Insurance Coverage for Those Starving for it the Most," *Roger Williams University Law Review*: Vol. 15: Iss. 2, Article 6.
Available at: http://docs.rwu.edu/rwu_LR/vol15/iss2/6

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A Plan for Recovery: Steps to Finally Provide Adequate Insurance Coverage for Those Starving for it the Most

Melissa M. McGow*

I. INTRODUCTION

“We believe that denying access to care for eating disorders is illegal and immoral.”

-Kitty and Mark Westin, The Anna Westin Foundation¹

In a society that obsesses over beauty and idolizes thinness, constantly discriminating against obese individuals and shunning weight gain, it seems quite ironic that people who obtain the ultimate level of skinniness are left to die and ignored by all. Recent estimates reveal eating disorders affect approximately eleven million people in the United States, including as many as ten million females and one million males.² More specifically,

* Juris Doctor, Roger Williams University School of Law 2010. I would like to extend a special thank you to Professor Jane Rindsberg for her unwavering dedication, and to Derek Cournoyer for his support and edits. To my mother and father, my brother, Diane McCauley, and Joseph Klauder, simply saying thank you will never be enough to express my sincerest appreciation for all that you have given me.

1. Anna Westin Foundation, *Insurance Coverage*, <http://www.annawestinfoundation.org/insurance.htm> (last visited Sept. 30, 2009) [hereinafter Anna Westin Foundation].

2. National Eating Disorders Association, *Information & Resources: General Information*, <http://www.nationaleatingdisorders.org/information-resources/general-information.php> (last visited Sept. 17, 2009) [hereinafter NEDA]. Eating disorders affect people of all race, color, gender and socioeconomic classes. The Alliance For Eating Disorders Awareness, *Eating Disorder Advocacy*, <http://www.eatingdisorderinfo.org/Advocacy/EatingDisordersAdvocacy/tabid/978/Default.aspx> (last visited Sept. 17, 2009)

reports state one out of every one hundred young women in America suffers from anorexia nervosa and about four percent of college-age women in America suffer from bulimia nervosa.³ Binge eating disorder, along with anorexia (self-starvation), and bulimia (binging and purging), establish the three most common eating disorders.⁴ It is likely that the incidence of these eating disorders is even greater in reality because of underreporting, due to the guilt and secrecy that accompanies these disorders.⁵ Although the incidence of eating disorders has increased over the last thirty to forty years⁶ and societal pressures to be thin “remain rampant,” insurance coverage for eating disorder treatment remains fatally inadequate.⁷

Even more problematic than the prevalence of eating disorders, is the high rate of suicide when the disease is left untreated.⁸ A 1995 study in the American Journal of Psychiatry found that anorexia has the highest death rate of any mental illness⁹ and according to the National Eating Disorder Association, more than ten percent of the nation’s anorexics will die from their disease.¹⁰ Eating disorders are serious illnesses

[hereinafter Alliance].

3. Theodore E. Weltzin, *Eating Disorders*, 21 No. 7 GPSOLO 42, 42 (2004).

4. *Id.*

5. *Id.*

6. Academy For Eating Disorders, *About Eating Disorders: Prevalence of Eating Disorders*, http://www.aedweb.org/eating_disorders/prevalence.cfm (last visited Mar. 28, 2009). It is reported that the incidence of eating disorders has doubled since the 1960’s and is becoming more common in younger age groups. NEDA, *supra* note 2.

7. NEDA, *supra* note 2.

8. See David Herzog et al., *Starved for Adequate Care*, L.A. TIMES, June 28, 2008, available at <http://www.latimes.com/news/printedition/opinion/la-oe-herzog28-2008jun28,0,2427331.story>; Megan, *Saint Louis University Journal of Health Law & Policy Health Law Blog: Insurance Coverage of Eating Disorders: Finding The Road To Recovery But At What Cost?* (June 30, 2008), <http://lawblogs.slu.edu/healthlaw/?p=175>.

9. Charlotte Triggs, *An Anorexia Victim Fights Back*, PEOPLE, July 7, 2008, available at <http://www.people.com/people/archive/article/0,,20214231,00.html>. “[Anorexia nervosa] is the leading cause of death in females between the ages of fifteen and twenty-four, and is the deadliest illness in comparison to all mental illnesses.” 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, 585 (2005-2006).

10. Jessica Bennett, *A Whole New Battle*, NEWSWEEK, Nov. 15, 2006, <http://www.newsweek.com/id/44665>; see also Weltzin, *supra* note 3

that can affect a person both physically and emotionally.¹¹ Besides death, physical complications that may result from eating disorders include: concentration and memory problems, bone density loss that leads to osteoporosis, growth retardation, loss of tooth enamel from purging, gum erosion, tears of the esophagus, gastrointestinal problems, kidney disease and/or failure, increased risk of seizures, fluid and electrolyte imbalances, infertility, an irregular heartbeat that can lead to cardiac arrest, dehydration, ruptured stomach, and serious liver damage.¹²

This Comment does not debate nor attempt to argue the precise cause of eating disorders. It is accepted that the exact cause is currently unknown, acknowledging that it is likely due to a variety of contributing factors, one being biological.¹³ This

(confirming the death rate for eating disorders has been reported as high as ten percent, and the death risk is highest for people with both anorexia and bulimia).

11. Weltzin, *supra* note 3.

12. See Brunalli, *supra* note 9, at 588; Weltzin, *supra* note 3; NEDA, *supra* note 2; ANAD: National Association of Anorexia Nervosa and Associated Eating Disorders, <http://www.anad.org> (last visited Sept. 17, 2009) [hereinafter ANAD]. Examples of emotional consequences that can result from eating disorders include depression, low self-esteem, shame and guilt, impaired family and social relationships, mood swings, perfectionism, and “all or nothing” thinking. ANAD, *supra* note 12. Additionally, people suffering from eating disorders often encounter other psychiatric conditions such as anxiety disorders, including obsessive-compulsive disorder. Brunalli, *supra* note 9, at 588-89.

13. Dr. Walter Kaye, director of the University of California eating disorders program, stated “there is little consensus” on what causes eating disorders, researchers once thought that it was mostly a result of societal pressures, but in recent years there has been “strong evidence that a powerful biology is involved.” Triggs, *supra* note 9. Dr. Kaye attempts to analogize eating disorders, “[i]t's like, if you break up with your boyfriend, you'll be depressed[,] [b]ut that's very different from what we see in major depressive disorder.” *Id.* Several experts and clinical studies indeed now agree that eating disorders are biological. Jessica Bennett, *Critical Care*, NEWSWEEK, June 24, 2008, available at <http://www.newsweek.com/id/142988> [hereinafter Bennett, *Critical Care*]. Dr. Thomas Insel, the director of the government's National Institute of Mental Health, and a leading expert in the field, wrote a recent letter to the National Eating Disorders Association, stating “anorexia nervosa is a brain disease” and although its “symptoms are behavioral” the illness has “a biological core, with genetic components.” Bennett, *supra* note 10; Elizabeth Bernstein, *Illness A Costly Burden: Insurance Falls Short For Eating Disorders*, CHI. TRIB., Jan. 24, 2007, available at <http://archives.chicagotribune.com/2007/jan/24/food/chi-0701230312jan24>. Dr. Richard Pesikoff, from the Baylor College of Medicine,

Comment supposes that in light of this medical uncertainty our nation should prefer "safe" over "sorry" and treat eating disorders as if they do have a biological component, at least until there is conclusive proof to the contrary.

Nor does this Comment prescribe a precise course of treatment for all persons with eating disorders. It acknowledges that adequate help is individualized,¹⁴ with the commonality that it is likely a lengthy process.¹⁵ Treatment of anorexia, which includes weight restoration and relapse-prevention treatment, typically requires ninety to one hundred and twenty days.¹⁶ Experts explain that many anorexics enter treatment thirty to forty pounds underweight, and because it is impossible to safely gain more than two pounds a week, a minimum of four months of

also noted that although the research is inconclusive, it "leans in favor of a genetic predisposition." ABC News, *Families Battle Insurers Over Eating Disorders* (June 10, 2008), <http://abcnews.go.com/TheLaw/story?id=5007753> [hereinafter *Families Battle*]. Another recent article suggests that anorexia may spawn from an addiction to deprivation, sharing similar characteristics to drug addictions. Trisha Gura, *Addicted to Starvation: The Neurological Roots of Anorexia*, SCI. AM. MIND, June 12, 2008. There is also the possibility that eating disorders are only triggered when an individual has a genetic predisposition- roots in a complex combination of genes and brain composition- and then is also faced with external environmental factors that cause the disorder to manifest. *Id.*; Peg Tyre, *Fighting Anorexia: No One To Blame*, NEWSWEEK, Dec. 5, 2005, available at <http://www.newsweek.com/id/51592>; Megan, *supra* note 8. Dr. Cynthia Bulik, a clinical psychologist and director of the eating-disorders program at the University of North Carolina, and a lead eating-disorder researcher, has done twin studies to examine genetic contributions to anorexia, and has concluded that although environmental factors do indeed play a role in the manifestation of anorexia and bulimia, there are "clear" biological contributions. Bennett, *supra* note 10. Dr. Bulik says that the environment "pulls the trigger," but that the child's vulnerabilities are what "load the gun." Tyre, *supra* note 13. More information about the studies of Dr. Bulik and Dr. Kaye can be found at <http://www.nationaleatingdisorders.org/research-efforts/>. Additionally, information about a current genetic study of anorexia can be obtained at <http://www.wpic.pitt.edu/research/angenetics/>.

Overall, although anorexia is understood much better than it once was, further research is needed before doctors can definitely classify the disease. Triggs, *supra* note 9; Megan, *supra* note 8. In the meantime, Dr. Kaye wisely brings our attention to the fact that "[i]f you go back 20 years, people thought autism was a psychosocial disorder," and that now anorexia "faces the exact same dilemma." Triggs, *supra* note 9.

14. Bernstein, *supra* note 13.

15. NEDA, *supra* note 2.

16. Megan, *supra* note 8.

care may be required.¹⁷ It is crucial to acknowledge, however, that proper treatment can lead to successful recovery.¹⁸

People suffering from eating disorders deserve a chance at recovery and many are not currently receiving that chance due to high costs of treatment. Thus, this Comment focuses on the current lack of help due to inadequate insurance coverage for eating disorders and proposes various solutions and proactive responses that should be implemented immediately. Part II first summarizes the basic problem of how and why there is a lack of adequate insurance coverage for eating disorders. Part III then acknowledges the recent civil actions taken by parents of children with eating disorders, and proposes that a major part of the solution is for insurance companies to take initiative on their own and amend their policies to cover treatment for eating disorders. Part IV discusses recent actions taken by certain state legislatures to improve eating disorder coverage and begs that more states follow these paths immediately. Finally, Part V addresses how the federal government should follow through with its recent improvements in mental health parity and pass further legislation to help complete a thorough, nationwide transformation that provides adequate coverage for eating disorders. Ultimately, this Comment concludes that in light of our awareness regarding the prevalence and true damage caused by eating disorders, and our current lack of insurance coverage for such, it is crucial that all aspects of our nation and legal system continue to make the proposed changes and help in whatever way each can.

17. Bennett, *Critical Care*, *supra* note 13. "For many anorexics, solving those problems at home would simply be impossible, no matter how supportive the parents. If treatment is to be effective, patients need constant support and multidisciplinary care, from physicians and social workers to dietitians and occupational therapists, say advocates for those with eating disorders. 'You simply cannot get this type of integrated team work on an outpatient basis,' says Cynthia Bulik." *Id.* Additionally, "[s]tudies show that proper treatment of anorexia nervosa requires inpatient treatment until the individual is close to his or her ideal body weight." Brunalli, *supra* note 9, at 586.

18. See Weltzin, *supra* note 3, at 43; NEDA, *supra* note 2. "With treatment, 60 percent of people with eating disorders recover." Weltzin, *supra* note 3, at 43.

II. ALL-AROUND LACK OF ADEQUATE INSURANCE COVERAGE

"I always thought that insurance would take care of my children if they got[]sick."

-Mike Hall, a forty-eight year-old working father who had been paying insurance premiums for 25 years¹⁹

The mindset of the working father quoted above is presumably the mindset of most American working parents who consistently pay for health insurance. Sadly, this proposition does not always hold true. This father, Mike Hall, has been left to pay almost one million dollars of medical coverage for the treatment of his daughter's eating disorder, as the insurance company paid for only ten days of hospitalization a year, due to their limited mental health coverage.²⁰ Unfortunately, this sad story is not an individualized tragic event, but rather it is becoming a very common reality. Average American families are finding themselves taking home-equity loans, tapping every savings account, and depleting children's college funds and retirement accounts, all to pay for the treatment of their child's eating disorder.²¹ Parents will likely continue to take on such debt when their only remaining option is to abort necessary treatment and risk the death of their child.²² Lynn Grefe, CEO of the National Eating Disorder Association sympathizes, "I see families go broke

19. Bernstein, *supra* note 13.

20. *Id.* "Due to the severe limitations written into insurance policies for the treatment of anorexia nervosa, it is necessary for the individuals with anorexia, either individually or in conjunction with their families, to finance on average \$80,000 worth of treatment, which represents nearly two-thirds of the cost for complete treatment per incident." Brunalli, *supra* note 9, at 586.

21. See Bennett, *supra* note 10. The parents of one child suffering from an eating disorder noted that if she had to stay in treatment any longer they may have needed to sell their house, "[b]ut if it meant we got back our daughter, we'd do it." Bennett, *Critical Care*, *supra* note 13. Other parents of a child with an eating disorder told their daughter, while in treatment, "[w]e may not have the same house when you come home—but it's only a home" and said that the most important thing is that she got the treatment she needed. Bennett, *supra* note 10.

22. Cindy Meiskin, a parent involved in a recent class action against an insurance company to cover eating disorders, identifies that "[n]o family should have to lose a child or not be able to treat their child." Triggs, *supra* note 9.

over this,” “[i]t’s real discrimination as far as I’m concerned.”²³

Medical care treatment for eating disorders can be very costly, sometimes totaling more than \$1,000 a day.²⁴ Many insurance companies, however, refuse to cover the full cost of treatment.²⁵ The insurance companies often have policies and practices in place that deny or severely limit care for eating disorders, often by classifying the disorders as mental illnesses,²⁶ for which care is commonly very limited²⁷ in comparison to physical ailments.²⁸ Thus, the lack of adequate insurance coverage for eating disorder treatment is a small part of the larger national debate concerning inequities in insurance coverage between mental and physical

23. *Families Battle*, *supra* note 13.

24. *Id.* Out-of-pocket expenses for inpatient medical care can range from \$15,000 to \$30,000 a month and some programs may even cost upwards of \$1,500 a day. Bennett, *supra* note 10.

25. *Families Battle*, *supra* note 13. The average length of stay experts say anorexics need to fully restore weight and provide relapse-prevention treatment is ninety to 120 days, however, the average number of inpatient treatment days covered by insurance plans is thirty. Triggs, *supra* note 9. In financial terms, the “Ohio Department of Health estimates that the cost of inpatient treatment is about \$100,000 and the cost of outpatient treatment is around \$30,000 per incident of the disorder, but insurers often cap their coverage at \$40,000 for inpatient care and \$10,000 for outpatient care. This means that the patient or the patient’s parents must finance on average \$80,000 of care, which is nearly two-thirds of the cost of the treatment, per incident of the disorder. This is in stark contrast to the out-of-pocket expense of only \$1,800 that a family would pay for the treatment of a physical injury with \$60,000 of expenses.” Brunalli, *supra* note 9, at 596.

26. Arguably, there is a lack of clarity as to whether anorexia nervosa is a mental or physical illness and that it may lie somewhere in the middle of the two, and therefore the insurer’s common classification of it as a mental illness rather than a physical illness is not proper to begin with. Brunalli, *supra* note 9, at 587-88, 591.

27. Insurers use health insurance policies with greater restrictions and limitations on mental illnesses to reduce health care costs. *Id.* at 594. One mental illness limitation written into insurance policies is often a cap on mental health benefits that is much lower than the cap for physical or surgical conditions. *Id.* at 594-95. These limitations can be in either fiscal terms or lifetime terms and include the number of days of hospitalization, inpatient treatment, or outpatient visits. *Id.* at 595. In addition to the treatment stipulations, financial stipulations, including cost-sharing arrangements (such as higher co-payments) may also be imposed on mental illnesses. *Id.*

28. See *id.* at 587; Dana L. Kaplan, *Can Legislation Alone Solve America’s Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 325 (2005).

illnesses. In response to this disparity, there has been a recent surge of legislation known as mental health parity laws.²⁹ Mental health parity legislation attempts to eliminate this gap in health insurance coverage by requiring insurance coverage for mental health illnesses to equal that for physical ailments.³⁰

Although both federal and state parity legislation now exists, the level of parity (equity) that is actually achieved by these mandates varies considerably.³¹ The protection afforded by mental health parity legislation varies because it can be limited by four ways: (1) the statutory definition of mental illness; (2) the type of benefit mandate; (3) the terms and conditions that the legislation permits; and (4) exemptions allowed under the parity legislation.³² In regards to the statutory definition of mental illness, although eating disorders are described as mental conditions in the Diagnostic Statistical Manual, under much parity legislation the coverage for extended treatment is often limited to biologically based mental illness cases only, and insurers are now classifying eating disorders as not biologically based.³³ In regards to limitations based on the type of benefit mandate, parity legislation can entail one of three different options.³⁴ First, “mandated-benefits” are the most comprehensive by requiring insurers to satisfy a minimum coverage standard for mental health.³⁵ Second, parity legislation may instead involve “mandated-offering,” which simply requires that the insurer offer

29. Rosalie Liccardo Pacula & Ronald Sturm, *Mental Health Parity Legislation: Much Ado About Nothing?*, 35 HEALTH SERV. RES. 263, 263-64 (2000). “Parity mandates have been among the most salient recent policies to affect health services.” *Id.* at 263.

30. Kaplan, *supra* note 28; Pacula & Sturm, *supra* note 29, at 263. Mental health parity mandates are more specific and demanding than general mental health mandates, which require just that companies providing insurance for physical ailments also offer some coverage for mental health illnesses. Pacula & Sturm, *supra* note 29, at 263.

31. Kaplan, *supra* note 28; Pacula & Sturm, *supra* note 29, at 264.

32. Brunalli, *supra* note 9, at 600-01.

33. *Id.* at 601; Henry Gottlieb, *Law.com: Aetna settles Federal Class Action Seeking Health Coverage for Eating Disorders* (June 3, 2008), <http://www.law.com/jsp/article.jsp?id=1202421880648>. Examples of illnesses that are commonly covered as biologically based mental disorders include schizophrenia, obsessive-compulsive disorder, psychosis, major depression, asthma, bipolar disorder, and autism. Bennett, *supra* note 10.

34. Brunalli, *supra* note 9, at 601.

35. *Id.*

mental health coverage.³⁶ Third, parity legislation may also use a “mandated-if-offered” mandate, which requires that the insurer provide equal coverage for mental illnesses as for physical illnesses if and only if the insurer decides to offer any mental health coverage at all.³⁷ With regard to exemptions allowed under the parity legislation, two common exemptions known as the “small employer exemption” and the “cost increase exemption” can greatly undermine the effectiveness of any parity legislation.³⁸ Therefore, although mental health parity legislation has begun to force insurance providers to cover certain mental illnesses, the parity legislation is not created equally, and eating disorders are still commonly left uncovered.³⁹

A law journal article entitled *Anorexia Killed Her, But The System Failed Her: Does The American Insurance System Suffer From Anorexia?*, written by Beth Brunalli, thoroughly depicts the precise failure of the American insurance system to provide adequate coverage for the treatment of anorexia by describing the above problems.⁴⁰ The article explains how the private insurance market, public insurance market, and the problems associated with being uninsured contribute to the overall inadequate coverage for the treatment of eating disorders.⁴¹ The article explains that in the private insurance industry, employment-based health benefit plans to employees can occur through either “insured” plans or “self-insured” plans.⁴² One limitation in the private insurance industry for the coverage of eating disorders

36. *Id.*

37. *Id.*

38. *Id.* at 602. “The small employer exemption permits employers with a workforce under a statutorily defined size, typically less than twenty-five or fifty employees, to be in noncompliance with the mental health parity legislation [and] [t]he cost increase exemption does not require compliance for employers that experience cost increases from the coverage of mental illnesses that result in total plan cost increases above a statutorily defined percentage, typically one or two percent.” *Id.*

39. See Kaplan, *supra* note 28; NEDA, *supra* note 2; Pacula & Sturm, *supra* note 29, at 264.

40. Brunalli, *supra* note 9, at 587.

41. *Id.* at 587-628.

42. *Id.* at 592. An employer under a self-insured plan self-funds the medical claims, whereas an employer utilizing an insured plan purchases the health insurance coverage for the employees as a group from a third party. *Id.* at 592-93.

derives from the Employment Retirement Income Security Act of 1974 (hereinafter "ERISA"), which creates a two-tiered regulatory scheme under which only insured employment health benefit plans must comply with state as well as federal insurance regulations.⁴³ Therefore, under ERISA self-insured plans need only be in compliance with federal legislation and are not required to comply with state regulations, such as the more demanding state mental health parity laws.⁴⁴

To date, however, concerning the private insurance market, there has been no federal legislation that provides "true success" for equal eating disorder treatment coverage.⁴⁵ As of 2006, the only federally enacted parity legislation was the Mental Health Parity Act of 1996 (hereinafter "MHPA"), which failed to definitely provide insurance coverage for eating disorders in multiple facets.⁴⁶ Although the MHPA did not exclude eating disorders from the list of mental illnesses, it also did not explicitly include them; rather the employer was allowed to define what constitutes mental illnesses and easily excluded eating disorders.⁴⁷ The MHPA as federal law, which amended ERISA, applied to both insured and self-insured employment-based health plans; however, it mandated the least comprehensive benefit type only, being the mandated-if-offered statutory construction.⁴⁸ Finally, the MHPA created parity only in terms of maximum annual and lifetime dollar limits, and allowed for both the small employers and increased costs exemptions.⁴⁹ Therefore, the article made clear that the MHPA and federal law in general failed to provide any type of true parity for eating disorders.⁵⁰ Although additional federal parity legislation, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, has recently been enacted, and has made a number of positive changes to the MHPA, there are also potential limits to this parity

43. *Id.* at 593-94.

44. *Id.* at 594.

45. *See id.* at 602.

46. *See id.*

47. *See id.* at 605.

48. *Id.* at 601, 605-06 (a mandated-if-offered statute requires that the insurer provide equal coverage for mental illnesses as for physical illnesses if and only if the insurer decides to offer any mental health coverage at all).

49. *Id.* at 606-07.

50. *See id.*

legislation.

Because of the limited protection for eating disorder treatment provided by federal legislation in the private insurance market, some state legislatures have decided to enact more protective mental health parity legislation; however, this is likewise not completely effective.⁵¹ As previously explained, in addition to mental parity legislation often being limited in four ways (by definition of mental illness, type of benefit mandate, terms and conditions permitted, and exemptions), state legislation falls short by regulating only insured plans, not self-insured plans.⁵² Therefore, it is noted that protection for eating disorder treatment is still often limited even where there is state action, and “many employees will not benefit even if a state enacts more generous parity protection for the insurance coverage of [eating disorders] than is federally mandated.”⁵³ Additionally, such actions taken by some state legislatures do not exist in all states, and thus do not even provide any uniform improvements.⁵⁴ Therefore, it is clear that the current individual states’ actions and a lack of comprehensive federal legislation have failed to accomplish adequate insurance coverage of eating disorders in the private insurance sector.

In addition to the abundant obstacles preventing adequate insurance coverage for eating disorders in the private insurance market, other obstacles in public insurance and the problem of people being uninsured create even more impediments to adequate health care.⁵⁵ Public health insurance includes Medicare, Medicaid, and the State Children’s Health Insurance Program, all of which seemingly fail to provide full coverage for eating disorder treatment.⁵⁶ Furthermore, there is the problem that adolescents are aged out of insurance, whether public or private, often during a “critical age period with respect to the onset and recovery from [eating disorders].”⁵⁷ For example, the incidence rates for anorexia are highest for females between the

51. *Id.* at 610-11.

52. *Id.*

53. *Id.* at 611.

54. *Id.* at 610-11.

55. *See id.* at 622-27.

56. *See id.* at 622-26.

57. *See id.* at 626.

ages of fifteen and nineteen, and the typical time allotted for recovery is four to five years, placing them in their early twenties, which is an age group where the percentage of uninsured is very high.⁵⁸ Although the actions proposed in this Comment for insurance companies, state legislatures and federal legislatures speak more to problems in the private insurance market, it is hoped that the resulting nationwide movement to provide proper coverage for eating disorders will have a spill-over effect and eventually lead to solutions that solve remaining coverage problems in the public insurance and uninsured sectors.

Overall, there is a lack of adequate insurance coverage for eating disorders in each sector and changes need to be made across the board before any real progression will be made in this area.

III. PARENTS AND INSURANCE COMPANIES GO HEAD-TO-HEAD

“The paramount purpose of these eating disorder coverage class actions is to ensure that the carriers affirmatively declare that they will cover eating disorder claims now and in the future—forever—on full parity with other illnesses and that the carriers will do so for any and all persons that have been, currently are and will be in the future, diagnosed with any type of eating disorder.”

-Attorney Eric Katz⁵⁹

Support groups, including the National Association of Anorexia Nervosa and Associated Disorders, have recently encouraged parents to become their own advocates, and parents are doing just that.⁶⁰ In an effort to get insurance carriers to cover eating disorders as they would any other biological or physical illness, families and advocacy organizations are filing lawsuits against insurers, lobbying for new legislation, and teaching other parents how to appeal denied insurance claims.⁶¹ Support groups urge parents to “[r]emember that what you are

58. See *id.* at 626-27.

59. Gottlieb, *supra* note 33.

60. Bernstein, *supra* note 13; Anna Westin Foundation, *supra* note 1.

61. Bernstein, *supra* note 13.

asking for is reasonable[,] and that you have been paying for insurance so you and your family would be covered in case of a life threatening illness.”⁶² Now while patients with eating disorders struggle to overcome their diseases, their families are busy battling insurance companies to cover the treatment. “The good news is that most recent lawsuits have been decided in favor of the patients, forcing insurers to pay for treatment. The bad news is that, too often the lawsuits are decided too late to save those patients.”⁶³ Given the escalating amount of recent lawsuits filed and the direction of settlements, it is urged that every insurance company take initiative on their own, prior to a lawsuit being filed against them, in order to do what is right before lives are lost.

One of the recent groundbreaking lawsuits in this field⁶⁴ was brought by parents of Anna Westin, who committed suicide in 2000 at age twenty-one, after her insurer, Blue Cross and Blue Shield (hereinafter “BCBS”) of Minnesota, denied coverage for her anorexia.⁶⁵ Attorney General Hatch filed this lawsuit against BCBS for their illegal practice of misconduct in denying, delaying, and withholding necessary mental health, chemical dependency, and eating disorder treatment for children and young adults.⁶⁶ In June 2001, less than a year after the initial complaint was filed, the suit was settled out of court.⁶⁷ The company agreed to pay \$8.2 million to the state⁶⁸ and to redesign its medical assessment procedure to expand coverage for eating disorders and other mental diseases.⁶⁹ There has indeed been greatly improved care

62. Anna Westin Foundation, *supra* note 1.

63. *Life After Recovery: The fight for insurance coverage for EDs*, http://www.eatingdisordersblogs.com/life_after_recovery/2008/06/the-fight-for-i.html (June 28, 2008, 16:12 EST).

64. Although several recent lawsuits have been monumental, it is noted that successful lawsuits arguing for the coverage of eating disorders trace all the way back to 1989 when a case was argued before the New York Supreme Court, Appellate Division, and resulted in the insurer having to pay for the hospitalization. See *Simons v. Blue Cross & Blue Shield of Greater N.Y.*, 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

65. Complaint at 10-12, *Minn. v. Blue Cross Blue Shield of Minn.*, (D. Minn. Oct. 3, 2000), available at <http://www.annawestinfoundation.org/downloads/complaint.pdf>.

66. *Id.* at Introduction; Anna Westin Foundation, *supra* note 1.

67. Complaint, *supra* note 65, at 24; Bennett, *supra* note 10.

68. *Id.*

69. See Settlement Agreement And Consent Order For Final Judgment, *Minn. v. Blue Cross Blue Shield of Minn.*, No.00-014012, (D. Minn. Oct. 3,

for people with eating disorders in Minnesota who have BCBS, and surprisingly, several other insurance companies have voluntarily agreed to the provisions of the settlement.⁷⁰

In 2003, Janell Smith, a twenty-six year-old female, was admitted into a hospital and put on a feeding tube, weighing only sixty-eight pounds.⁷¹ Smith's insurance company, Magellan, soon discharged her despite the dissenting view of her caregivers.⁷² Within days of her release, Smith committed suicide by overdosing on a mix of Tylenol, vodka, cocaine and other drugs.⁷³ Parents Mary and Brian sued Magellan and its subsidiaries for wrongful death and acting in bad faith. The suit has worked its way through the state court system up to the California Supreme Court, having survived a motion for summary judgment on appeal.⁷⁴ Hopefully this case will bring positive results in the very near future.⁷⁵

Even more promising is the very recent flurry of class action lawsuits in New Jersey, which has led many insurers to agree to cover eating disorders upon being challenged. One such class action brought by insured individuals in New Jersey was against Aetna insurance.⁷⁶ In New Jersey, mental health parity laws mandate equal coverage for biologically based mental illnesses only;⁷⁷ thus, the suit against Aetna argued that anorexia and bulimia were biologically based and should receive the same benefits available for other biologically based mental illnesses.⁷⁸ The Meiskins were one of the many families involved in this class action. At age thirteen, daughter Marisa Meiskin began to eat healthier, but by fifteen she had developed a severe eating disorder, osteopenia (the precursor to osteoporosis) and her pulse

2000), available at <http://www.annawestinfoundation.org/downloads/settle.pdf> [hereinafter Settlement Agreement]; Herzog, *supra* note 8; Anna Westin Foundation, *supra* note 1.

70. Settlement Agreement, *supra* note 69; Anna Westin Foundation, *supra* note 1.

71. *Families Battle*, *supra* note 13.

72. *Id.*

73. Herzog, *supra* note 8; *Families Battle*, *supra* note 13.

74. *Smith v. Vista Behavior Health Plans, Inc.*, No. B191271, 2007 WL 2380776, at *1 (Cal. Ct. App. Aug. 22, 2007); Herzog, *supra* note 8.

75. Herzog, *supra* note 8.

76. Gottlieb, *supra* note 33.

77. *See id.*

78. *Id.*

was so faint that “the doctor said [that if] she went to sleep it could stop.”⁷⁹ Meiskin spent four months at a private treatment facility,⁸⁰ at the cost of \$120,000, of which her insurer, Aetna, covered about only a quarter.⁸¹

In March 2008, United States District Court Judge Faith Hochberg denied Aetna’s motion for dismissal.⁸² In June 2008, a settlement was approved, under which Aetna agreed to pay \$250,000 in reimbursements to one hundred New Jersey policyholders with past-denied claims, dating back to 2001.⁸³ Aetna further agreed to cover future claims by fully insured customers for the diagnosis, care and treatment of eating disorders, to the same extent as biologically based mental illnesses.⁸⁴ Additionally, Aetna agreed to pay the firm who brought the suit up to \$350,000 in legal fees.⁸⁵ It is hoped that

79. Triggs, *supra* note 9.

80. Bennett, *Critical Care*, *supra* note 13.

81. *Id.* Aetna limited its coverage for eating disorders to twenty outpatient visits per calendar year and thirty days for inpatient visits, due to classifying them as non-biologically based mental illnesses. Gottlieb, *supra* note 33.

82. *DeVito v. Aetna Inc.*, 536 F. Supp. 2d 523, 534 (D.N.J. 2008); Gottlieb, *supra* note 33.

83. *DeVito v. Aetna Inc.*, No. CIV.A.0700418FSHPS, 2008 WL 2594619 (D.N.J. Jun 25, 2008); Verdict and Settlement Summary, *DeVito et al. v. Aetna Inc.*, NO. 207-CV-00418-FSH-PS, 2008 WL 5119722 (D.N.J. Oct. 21, 2008); Herzog, *supra* note 8; Triggs, *supra* note 9. The Meiskin family hopes to recover 60,000 from this suit, which they had previously managed to pay out of pocket by taking out a line of credit. Megan, *supra* note 8.

84. Triggs, *supra* note 9. Aetna is indeed currently recognizing eating disorders as biological. Jason Butkowski, *Vitale Bill to Require Insurance Coverage for Eating Disorders Advance* (Dec. 8, 2008), <http://www.politickernj.com/jbutkowski/25942/vitale-bill-require-insurance-coverage-eating-disorders-advances>. Unfortunately, some critics still contend that the settlement here is unlikely to change the bottom line, claiming the \$2,500 each family will get in the settlement will not begin to cover what some have paid out of pocket already, that Aetna already did treat eating disorders to some extent, and that although the company will put eating disorders on par with other biological illnesses for the moment, they do not plan on implementing that policy on a permanent basis. Bennett, *Critical Care*, *supra* note 13. Furthermore, a lawyer involved in a similar suit filed a court objection to the Aetna settlement, arguing that its limited terms undermine his case for full and unlimited parity, pointing out that only 100 people will receive coverage for past claims under the Aetna settlement when statistics show that possibly more than 25,000 were actually denied coverage over the past seven years. *Id.*

85. Gottlieb, *supra* note 33.

the effects of the recent Aetna settlement will be “far-reaching” by leading to an increase in suits against insurance companies, and by leading to more individuals receiving insurance coverage for the eating disorder treatment they require, which can save lives.⁸⁶

United States District Court Judge Faith Hochberg, who approved the previous Aetna settlement, is also now handling a similar class action against Horizon Blue Cross Blue Shield of New Jersey (hereinafter “HBCBS”).⁸⁷ Lara Drazin started starving herself at age fourteen,⁸⁸ and when her weight dropped to eighty-eight pounds, she spent three months at a hospital and three months at a residential treatment center.⁸⁹ The treatment has transformed Lara into a successful high school senior, getting ready for college; however, it also left her family in great debt after coverage was denied by insurance.⁹⁰ Lara’s father, Ronald Drazin, is now the lead plaintiff in the class action⁹¹ against HBCBS of New Jersey. This suit is arguably more significant than the prior suit against Aetna because it affects a greater number of New Jersey residents, being that HBCBS is the largest health insurance provider in New Jersey, with more than 3.6 million members.⁹² This suit likewise claims that eating disorders should be treated as biologically based illnesses, which would provide greater coverage.⁹³ The suit dates back a few years when

86. Megan, *supra* note 8.

87. See *Beye v. Horizon Blue Cross Blue Shield of N.J.*, 568 F. Supp. 2d 556 (D.N.J. 2008); Carly J. Rothman, *Insurer Agrees To \$1.2M Settlement In Anorexia Lawsuit*, NJ.com, (Nov. 25, 2008), http://www.nj.com/news/index.ssf/2008/11/insurer_agrees_to_12m_settleme.html.

88. Vanessa Tyler, *Women at Center of Anorexia Lawsuit Against Horizon Talks to WPIX*, WPIX, (Dec. 5, 2008), <http://www.wpix.com/landing/?Woman-at-Center-of-Anorexia-Lawsuit-Agai=1&blockID=153162&feedID=1404>.

89. Rothman, *supra* note 87.

90. *Id.* Drazin was denied coverage for in-patient care by the insurance company because of her elusive weight gain; “[t]hey seemed to be more concerned with the body weight issue and it was much more than a body weight issue,” said father Ronald Drazin. Tyler, *supra* note 88.

91. Rothman, *supra* note 87.

92. Scott Michels, *Insurer Agrees to Expanded Coverage for Eating Disorders: Insurer To Classify Eating Disorders As Biologically Based Illnesses*, ABC News, (Nov. 26, 2008), <http://abcnews.go.com/print?id=6340653>; Rothman, *supra* note 87.

93. *Beye v. Horizon Blue Cross Blue Shield of N.J.*, 568 F. Supp. 2d 556, 559-61 (D.N.J. 2008); *Families Battle*, *supra* note 13.

Dawn Beye first filed suit after being denied coverage for her daughter's long-term anorexia.⁹⁴ Dawn Beye said her daughter's struggle with anorexia required her to spend more than a year in the hospital⁹⁵ and when HBCBS refused to cover more than thirty days of hospital treatment a year,⁹⁶ the family was left to pay more than \$300,000.⁹⁷

HBCBS entered into settlement on November 24, 2008.⁹⁸ Under the tentative agreement, which still must be approved by the federal judge,⁹⁹ HBCBS agrees to pay for past-denied claims and waive coverage limitations.¹⁰⁰ HBCBS will pay about \$1.2 million to 500 past patients,¹⁰¹ and will provide "parity treatment to eating disorder claims in the future for all current members who are fully insured,"¹⁰² treating eating disorders as biologically based illnesses. Attorney Bruce Nagel, the plaintiffs' lawyer,¹⁰³ said in court papers that the expanded coverage for eating disorders would apply to more than one million people and would likely pay out twenty million dollars over the next fifteen years.¹⁰⁴ HBCBS will also make it easier for insured individuals to appeal denied claims by providing an eating disorder specialist to review each case.¹⁰⁵ Previously, doctors without backgrounds in eating disorders conducted these reviews.¹⁰⁶ Finally, HBCBS agrees to pay Nagel's law firm \$2.45 million in legal fees.¹⁰⁷ HBCBS spokesperson Tom Rubino said: "[HBCBS] of New Jersey believes

94. Rothman, *supra* note 87.

95. Anorexia has caused Dawn Beye's daughter serious long-term medical problems, including a reduced heart rate and bone thinning. *Families Battle*, *supra* note 13.

96. *Id.*

97. "Financially, we were devastated," Beye said. "We lost everything that we worked for, for a college education. We had to tap into every resource that was available." *Id.*

98. Verdict and Settlement Summary, *Drazin v. Horizon Blue Cross Blue Shield of N.J.*, NO. 206-CV-06219-FSH-PS, 2008 WL 5455763 (D.N.J. Nov. 24, 2008); Butkowski, *supra* note 84.

99. Michels, *supra* note 92.

100. Sterling, *supra* note 87.

101. Michels, *supra* note 92.

102. Sterling, *supra* note 87.

103. *Id.*

104. Michels, *supra* note 92; Sterling, *supra* note 87.

105. Tyler, *supra* note 88.

106. Sterling, *supra* note 87.

107. *Id.*

the settlement is in the best interest of all the parties involved and in line with the direction of federal parity law for mental health.”¹⁰⁸ Attorney Bruce Nagel remarked, “[t]his is a landmark settlement which should change the way carriers view eating disorders,”¹⁰⁹ “I hope other carriers in New Jersey will get in line with this settlement.”¹¹⁰

In light of and in accordance with these reoccurring settlements, this Comment advises other insurance companies to avoid the high legal expenses associated with lawsuits by making the proper changes on their own initiative and to do the right thing by changing their policies to provide adequate coverage for eating disorders. With some insurers already making changes, such as classifying eating disorders as biologically based mental illnesses, the pressure is indeed on other insurers to follow.¹¹¹ The Anna Westin Foundation notes that “[i]t is [] helpful to keep in mind that insurance companies are . . . generally uneducated about eating disorders [and] [a parent’s] job is to educate them so they understand the necessity of the requested treatment.”¹¹² With the more abundant knowledge regarding eating disorders, and the publicly available results from these recent class-action suits, insurers should no longer be allowed to hide behind an ignorance defense. Additionally, because changes in state and federal law only cover certain groups of patients and take a significant amount of time to enact, insurance companies themselves are in the best position to make the quickest and most effective changes by simply changing their own policies. Furthermore, it is insisted that “these are people who need treatment for serious, potentially life-threatening mental illnesses [and] [i]nsurance providers have a responsibility to cover the treatment that people need in order to overcome the epidemic of eating disorders.”¹¹³ This concept of a responsibility was further revealed by a nationwide poll commissioned by the National Eating Disorders Association, which reported that three out of every four Americans believe that insurance companies should

108. Michels, *supra* note 92.

109. Tyler, *supra* note 88.

110. Rothman, *supra* note 87.

111. Triggs, *supra* note 9.

112. Anna Westin Foundation, *supra* note 1.

113. Butkowski, *supra* note 84.

cover eating disorders the same as any other illness.¹¹⁴

These lawsuit results reveal that insurers are beginning to finally recognize their responsibility to help persons with eating disorders, and because they are also in the best position to do so, all insurers need to begin fulfilling such responsibilities immediately.

Insurance carriers may resist making such changes, arguing that it will raise premiums and affect the ability of individuals to become insured.¹¹⁵ This fear holds no ground. First, reports show that mental health parity does not cost as much as insurance companies and employers believe it will.¹¹⁶ Even in a Congressional Budget Office report on a version of a Federal House bill that aimed to include coverage for every illness listed in the Diagnostic Statistical Manual,¹¹⁷ it was estimated that premiums for group health insurance would increase by an average of just four-tenths of a percent, which is very minimal.¹¹⁸ Secondly, even if premiums and expenses rise slightly, insurers are still likely to be saving money overall by preventing the costs the insurer may later incur from physical complications that result from an untreated eating disorder. Beth Brunalli explains that “[t]he recycling of the chronically anorexic eventually leads to costly physical health consequences that cannot be classified as mental illnesses, such as complications from osteoporosis, kidney problems, and cardiac episodes,” which insurance will have to pay for.¹¹⁹ Lynn Grefe, CEO of the National Eating Disorders Association, confirms that insurance companies could save money if they help when someone begins to show signs of disordered

114. See NEDA, *supra* note 2.

115. See Bennett, *Critical Care*, *supra* note 13.

116. *Id.*

117. Some people hoped that the previously discussed class actions against insurance companies would result in not just coverage for eating disorders, but rather would set a precedent that all DSM diagnostic categories are biologically based and should be treated accordingly by insurance companies. Joan Arehart-Treichel, *Insurers' Refusal to Cover Eating Disorders Prompts Lawsuits*, 42 (2) PSYCHIATRIC NEWS 1 (2007), available at <http://pn.psychiatryonline.org/cgi/content/full/42/2/1a?maxto show=&HITS=&hits=&RESULTFORMAT=&andorexacttitle=and&andorexacttitleabs=and&fulltext=anorexia+nervosa&andorexactfulltext=phrase&searchid=1&usestrictdates=yes&resourcectype=HWCIT&ct>.

118. Bennett, *Critical Care*, *supra* note 13.

119. Brunalli, *supra* note 9, at 598.

eating.¹²⁰ President and CEO of the California Association of Health Plans, also corroborates that “it would be more cost effective for insurers to treat anorexia th[a]n to fund the increased care and treatment costs that result from protracted anorexia, such as major medical complications.”¹²¹

Insurance companies should be able to “find a way to balance the rising need of individuals struggling with eating disorders who need long term treatment without raising the cost of their coverage.”¹²² It is implored that all insurance companies look into this situation and modify their policies in order to save the countless lives that may be lost before legislation can be enacted that would legally mandate insurance companies to provide such coverage.

IV. LEGISLATIVE “PUSH” FROM STATES

“Some insurers are already following their consciences and doing the right thing in terms of coverage parity for eating disorders . . . [f]or those insurers still bucking the trend and refusing to provide sufficient coverage, we need to give them a push. This legislation is that push, and would ensure that equal coverage for eating disorder treatment – on par with other biologically-based mental disorders – would be the law of the land in the Garden State.”

-Senator Joseph Vitale ¹²³

In early 2007, articles reported that about forty states had enacted varying mental health parity laws prohibiting insurance discrimination between mental and physical illnesses.¹²⁴ The scope of these parity laws and the true protection they provide,

120. Bennett, *Critical Care*, *supra* note 13.

121. Brunalli, *supra* note 9, at 598. Furthermore, “[t]he effects of the mental illness limitations on the treatment of anorexia nervosa . . . reach further than just the patient, the patient’s family, and the long term costs for the insurers. Employers are also affected by the loss in productivity caused by either the patients themselves or their parents being absent from work, and society is affected by an increased likelihood that an untreated individual will end up on disability due to being unable to work.” *Id.*

122. Megan, *supra* note 8.

123. Butkowski, *supra* note 84.

124. Bernstein, *supra* note 13.

however, vary dramatically by means previously explained¹²⁵ and approximately less than half¹²⁶ of these laws actually include and cover eating disorders.¹²⁷ Fortunately, there are a number of states that have recently demonstrated exemplary initiative in attaining better coverage for eating disorders, which should be modeled nationwide.

For example, New Jersey's limited parity law, like that of several other states, mandates that all coverage for biologically based mental illnesses must be analogous to coverage for other medical illnesses, but does not explicitly include eating disorders in the given examples of biologically based mental illnesses.¹²⁸ The way insurance providers define mental illnesses is a way to exclude eating disorders from mental health parity legislation, and as the cases previously discussed demonstrate, insurance companies are able to easily categorize eating disorders as not being biologically based to avoid covering them.¹²⁹ New Jersey Senator Vitale remarked that "[t]he current standards for eating disorder insurance coverage simply aren't good enough for people really suffering with the disease."¹³⁰ In response to the Aetna class action settlement, New Jersey is considering legislation that would mandate equal insurance coverage for anorexia and bulimia, by requiring that all health insurance providers in New

125. Arehart-Treichel, *supra* note 117.

126. Reports suggest that the following states now require, or are in the process of trying to require, at least partial parity insurance coverage for eating disorders: Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, Tennessee, Vermont, Washington and West Virginia. Bonnie Miller Rubin & Ashley Wiehle, *Anorexia, Bulimia May Soon Become Part Of Mandatory Health Insurance In Illinois*, CHI. TRIB., June 24, 2008, available at <http://www.united-healthinsurance.com/2008/06/health-insurance-in-illinois/>; NEDA, *supra* note 2; National Women's Law Center, *National Report Card on Women's Health: Mental Health*, <http://hrc.nwlc.org/Policy-Indicators/Womens-Access-to-Health-Care-Services/Mental-Health.aspx> (last visited Sept. 18, 2009).

127. Bernstein, *supra* note 13. Additionally, some doctors and insurers in states where equal coverage for eating disorders is required dispute the meaning of medically necessary treatment. Triggs, *supra* note 9.

128. Arehart-Treichel, *supra* note 117; Bennett, *Critical Care*, *supra* note 13.

129. Bennett, *Critical Care*, *supra* note 13.

130. Butkowski, *supra* note 84.

Jersey and the State Health Benefits Plan provide the same coverage for eating disorders as provided for other biologically based mental illnesses.¹³¹ The bill, S-1940, explicitly adds eating disorders to the list of biologically based mental illnesses and proceeds to define “eating disorders” as “including but not limited to anorexia, bulimia and binge-eating disorder.”¹³² The bill is sponsored by Senator Vitale and was approved by the Senate Health, Human Services and Senior Citizens Committee on December 8, 2008.¹³³ The bill next heads to the Senate Budget and Appropriations Committee, before going to the full Senate for consideration.¹³⁴

North Carolina is another example of a state taking initiative to improve insurance coverage for eating disorders, and recently advanced a step ahead of New Jersey. A short time ago, a North Carolina law requiring better coverage for eating disorders made its way through the entire state legislature.¹³⁵ As of July 1, 2008, insurance companies in North Carolina are required to provide the same level of coverage for nine biological mental illnesses as they do for physical illnesses; explicitly included in this list of biological mental illnesses are anorexia nervosa and bulimia.¹³⁶

With a similar goal in mind, Illinois also recently enacted legislation to mandate insurance companies to pay for the treatment of anorexia and bulimia.¹³⁷ The Illinois bill, H.B. 1432, was approved by lawmakers in 2008 and enacted into law by Governor Rod Blagojevich.¹³⁸ The new law became effective

131. S. 1940, 213th Leg. § 1 (N.J. 2008); Butkowski, *supra* note 84; Megan, *supra* note 8.

132. S. 1940, 213th Leg. § 1 (N.J. 2008); Butkowski, *supra* note 84.

133. S. HEALTH, HUMAN SERV. AND SENIOR CITIZENS COMM., STATEMENT TO S., No. 1940 (N.J. 2008), *available* at http://www.njleg.state.nj.us/2008/Bills/S2000/1940_S1.PDF; Butkowski, *supra* note 84.

134. Butkowski, *supra* note 84.

135. James Romoser, *New Mental-Health Law to Start*, WINSTON-SALEM J., July 1, 2008, *available* at <http://www2.journalnow.com/content/2008/jul/01/new-mental-health-law-to-start/>.

136. *Id.*

137. The Digest: Health Insurance, Brittany Snow and Resources for ED Caregivers, <http://the-f-word.org/blog/index.php/2008/06/24/the-digest-health-insurance-brittany-snow-and-resources-for-ed-caregivers/> (June 24, 2008, 13:40 EST) [hereinafter Digest].

138. Victory in Illinois! Lawmakers Pass Eating Disorder Coverage Bill, <http://the-f-word.org/blog/index.php/2008/09/19/victory-in-illinois-lawmakers->

January 1, 2009,¹³⁹ and explicitly adds “anorexia nervosa and bulimia nervosa” to the list of “serious mental illnesses,” thus requiring coverage for forty five days of inpatient treatment and sixty visits for outpatient treatment each calendar year.¹⁴⁰ Although experts say this is still not enough for the most severe cases, it will at least cover more of the expenses than are generally being covered at the current time¹⁴¹ and represents a start in parity coverage for eating disorders.¹⁴² Although this is not as ideal as the previously mentioned legislation enacted in North Carolina, it is noted that the legislation in Illinois was still positive because it represents “an unusual action” for 2008 when the trend and pressure was to move away from mandates on businesses and governments.¹⁴³

This Comment urges that other legislatures in states that do not currently provide sufficient parity for eating disorder coverage begin to formulate similar legislation to those highlighted above. Because this issue is likely to continue to gain national exposure, other state senators will hopefully feel compelled to engage in similar legislative debates.¹⁴⁴ An approach mirroring that of North Carolina and what is being attempted by New Jersey, which explicitly lists eating disorders within the list of covered mental illnesses for the parity legislation, is seemingly the most efficient and effective, and thus is what is recommended by this Comment. It is acknowledged that legislation increasing coverage slightly is still better than nothing, and thus, it is stressed that each and every state should at least aim to provide partial improvement in eating disorder coverage by mandating an increase in the required number of days covered, as done very recently in Illinois.

As previously explained, one downfall with such state legislation is that it will not affect everyone, for example “self-insured” employers,¹⁴⁵ who are covered by federal law only and

pass-eating-disorder-coverage-bill/ (Sept. 19, 2008, 14:16 EST).

139. H.B. 1432, 95th Gen. Assem. (Ill. 2008).

140. *Id.*

141. Rubin & Wiehle, *supra* note 126.

142. Digest, *supra* note 137.

143. Rubin & Wiehle, *supra* note 126.

144. See Megan, *supra* note 8.

145. At the time of the legislation in North Carolina, about half the state's

therefore do not have to comply with such state laws.¹⁴⁶ However, this Comment urges states to realize that this is not an excuse for states to avoid acting. State legislation will be able to help some people and save some lives, and the potential to save one life alone should be sufficient reason to act. Additionally, it is hoped that if enough states act in this regard, it will demonstrate that the nation feels strongly on the matter and compel the federal government to follow suit by enacting similar legislation to aid the uncovered portion of the population.

Critics may oppose state legislatures' efforts to require expanded coverage of eating disorders by contending that it will raise the cost of buying insurance.¹⁴⁷ As previously explained, this fear is not grounded, and certainly insufficient to override the needs of those suffering from eating disorders. Specifically, Lew Borman, a spokesman for Blue Cross and Blue Shield of North Carolina, said that there will likely be a minor initial increase in health insurance rates after the law takes effect, "but we're anticipating it to be less than half of one percent."¹⁴⁸ Additionally, in states where mental health parity laws are already in effect, the mandates have not caused large increases in health insurance coverage costs.¹⁴⁹ The executive director of the Mental Health Association in North Carolina reaffirms that greater access to preventive health care for eating disorders will actually help to reduce these costs in the long run.¹⁵⁰

V. FEDERAL FOLLOW THROUGH

"Congress has finally agreed to end the senseless discrimination in health insurance coverage that [has] plague[d] persons living with mental illness[es] for so long."

-Senator Edward Kennedy ¹⁵¹

workers were employed by self-insured companies. Romoser, *supra* note 135.

146. *Id.*

147. *See id.* (as was the case in North Carolina).

148. *Id.*

149. *Id.*

150. *Id.*

151. Fred Frommer, *After 12 Years, Wellstone Mental Health Parity Act Is Law*, ASSOCIATED PRESS, Oct. 3, 2008, available at

As previously explained, a large group of insured individuals are covered solely by federal law, making future actions by state legislatures alone insufficient.¹⁵² It is thus recommended by this Comment that the federal government also takes measures to ensure adequate coverage for eating disorders. Recent activity exemplifies that the federal government is already on its way. On October 3, 2008, President Bush signed into law a limited parity bill, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as part of a \$700 billion financial bailout bill, H.R. 1424 (Emergency Economic Stabilization Act of 2008).¹⁵³ The law will become effective in January 2010.¹⁵⁴ This mental health legislation has been in the works for over ten years and was originally proposed by the late¹⁵⁵ Minnesota Senator Paul Wellstone.¹⁵⁶ Paul Wellstone and

http://minnesota.publicradio.org/display/web/2008/10/03/parity_finalpassage/?refid=0.

152. As discussed, multiple states do already have mental health parity laws, but these do not apply to employers that fund their own insurance plans, including many large companies, whereas federal legislation extends coverage to workers in health plans with more than 50 employees, including self-insured employers. ANAD, *supra* note 12; Rachel, *Congress Passes Groundbreaking Mental Health Parity Bill* (Oct. 6, 2008), <http://disorderedtimes.com/?p=383>.

153. Frommer, *supra* note 151; Govtrack.us, *H.R. 1424: Emergency Economic Stabilization Act of 2008*, <http://www.govtrack.us/congress/bill.xpd?bill=h110-1424>; Rachel, *supra* note 152. The bill was set to pass in September 2008, but then economic disaster struck our nation, and many feared the bill would languish and die in Congress because members would turn their energies towards the economy. However, the bill was efficiently rolled in with the recently passed economic bail-out bill. Rachel, *supra* note 152. David Wellstone said "in a strange way" it made sense to include the bill in a financial bailout because due to "the [economic] state of the country . . . [e]verybody is nervous, [and therefore] you'll have more issues with mental health and substance abuse." Frommer, *supra* note 151.

154. ANAD, *supra* note 12.

155. Wellstone was killed in a plane crash in 2002. Frommer, *supra* note 151. Since Wellstone's death, his son, David Wellstone, has somewhat filled his void by furiously lobbying Congress for mental health parity. *Id.* Ironically, like many of the civil suits being brought by parents of children lost to eating disorders, it was commented that "[i]t's a bittersweet victory since Paul Wellstone isn't here to celebrate it with us[, b]ut millions of Americans and their families will benefit." *Id.*

156. ANAD, *supra* note 12; Frommer, *supra* note 151; Rachel, *supra* note 152. Kitty Westin, mother of Anna Westin, actually worked with Senator Wellstone on this parity cause. Frommer, *supra* note 151.

Senator Pete Domenici first paired up in 1996 to pass the MHPA that banned plans from setting lower annual and lifetime spending limits for mental health treatments.¹⁵⁷ This new law builds on that by banning, among other things, differences in co-payments, deductibles, and treatment limitations.¹⁵⁸ The new law provides equity in the coverage of mental health and substance abuse disorders by requiring insurance companies to treat mental health and physical illnesses the same¹⁵⁹ when policies cover both.¹⁶⁰ Thus, although the law unfortunately does not require health insurers to cover mental health care, if insurers choose to, they'll have to do so in the same way as done for other medical conditions.¹⁶¹ Overall, the law will help by increasing coverage of eating disorders for employees whose group health insurance benefits already cover eating disorders.¹⁶² The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act does not provide complete relief for all, but it does significantly "narrow[] the gap" in eating disorder coverage and "is a giant step forward in the struggle to obtain equal coverage of eating disorders."¹⁶³

The passage of this recent bill has been noted as "historic."¹⁶⁴ Minnesotan Representative Jim Ramstad, a recovering alcoholic himself, predicted that "as many as 16 million people could now have access to complete treatment for their mental illness or addiction."¹⁶⁵ It was expressed that "[f]or far too long, health insurance companies have used the stigma of mental illness and substance abuse as an excuse to deny coverage for those biological

157. Frommer, *supra* note 151; Rachel, *supra* note 152.

158. Frommer, *supra* note 151.

159. It specifically ensures that group health care plans "do not charge higher co-payments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits." Rachel, *supra* note 152. Additionally, "[t]he new law prohibits plans from imposing treatment limitations and financial requirements that are more restrictive than medical and surgical benefits. If a plan offers out-of-network benefits for medical or surgical care, the plan must also offer the same out-of-network benefits for mental health and addiction treatment." ANAD, *supra* note 12.

160. Rachel, *supra* note 152.

161. ANAD, *supra* note 12; Rachel, *supra* note 152.

162. ANAD, *supra* note 12.

163. *Id.*

164. Frommer, *supra* note 151.

165. *Id.*

disorders.”¹⁶⁶ “This legislation is one more step in the long civil rights struggle to ensure that all Americans have the opportunity to reach their potential,” said Patrick Kennedy.¹⁶⁷

While this Comment commends Congress for their recent proactive action in helping attain adequate insurance for eating disorders, it begs that Congress not stop there. It is noted that although the passage was “an important victory in the fight to end discrimination against people with mental illness,” it did not win the war.¹⁶⁸ First and foremost, the bill does not seem to explicitly list eating disorders in any part of the text, and thus it is advised that Congress continually follow up on the bill’s implementation to assure that eating disorders are included in the interpretation of mental illnesses, and that insurers are covering all that the legislation intended them to cover.¹⁶⁹ Additionally, as mentioned, the bill still does not mandate mental health insurance coverage, but rather just mandates equality if it is provided (a mandated-if-offered plan).¹⁷⁰ Therefore, as more insurance companies and states begin to mandate the coverage of eating disorder treatment in the future, it is recommended that Congress follow and begin another proactive step: create legislation that does indeed always mandate such coverage.

In the future, Congress can make such recommended changes in eating disorder policies by either adding to already existing mental health parity, or by introducing and passing new bills.¹⁷¹ Fortunately for Congress, such a new bill is already presented before them. The Eating Disorders Coalition (hereinafter “EDC”), a nonprofit advocacy group, is advocating a bill entitled, “Federal Response to Eliminate Eating Disorders Act” (hereinafter “FREED Act”).¹⁷² The FREED Act is a comprehensive bill on

166. *Id.*

167. *Id.*

168. *Id.*

169. See Bennett, *Critical Care*, *supra* note 13.

170. ANAD, *supra* note 12; Rachel, *supra* note 152.

171. Eating Disorders Coalition For Research, Policy & Action, <http://www.eatingdisorderscoalition.org> (last visited Sept. 27, 2009) [hereinafter Eating].

172. Eating, *supra* note 171; Miss America 2008 Kristen Haglund Joins Citizens to Lobby Congress on Eating Disorders, The Gail R. Schoenbach F.R.E.E.D. Foundation, <http://www/freedfoundation.org/activism.php> (Mar. 2008) [hereinafter FREED].

eating disorders addressing research, treatment, education and prevention,¹⁷³ which was conceptualized and drafted by the EDC and members of Congress, with input from dozens of eating disorder organizations around the country.¹⁷⁴ Representatives Patrick Kennedy of Rhode Island¹⁷⁵ and Michael Ferguson of New Jersey are sponsors of the FREED Act.¹⁷⁶ In April 2008, advocates lobbied for the FREED Act and delivered a message to Congress: “[e]ating [d]isorders are deadly illnesses but there is HOPE. With adequate education and prevention, treatment and research[,] people recover and LIVE. Congress can make a difference; we urge Congress to pass the first comprehensive eating disorder legislation in US history.”¹⁷⁷ Miss America 2008, Kirsten Haglund, who selected eating disorders awareness as her personal platform due to personal experience with anorexia beginning at age 13, joined in lobbying Congress.¹⁷⁸ Kirsten states, “I realize the seriousness of the illness[] and the desperate need for national attention.”¹⁷⁹ In accordance with all the previous proposals, this Comment advises that the Federal Government not stop after making minor improvements in federal parity law, but rather complete its part in helping to “overhaul things” and really change coverage for eating disorders by passing the FREED Act.¹⁸⁰ “Without [t]he FREED Act, countless will continue to suffer without insurance coverage, proper treatment, and hope for recovery.”¹⁸¹

173. More specifically, the FREED Act will create Centers of Excellence dedicated to research collaboration in order to fill current gaps in eating disorder research, provide for evidence-based standards of care, enforce insurance reimbursement for eating disorder treatment on par with physical illnesses, and establish education and prevention programs for medical professionals and schools at all levels. NEDA, *supra* note 2; Eating, *supra* note 171; FREED, *supra* note 172.

174. Eating, *supra* note 171.

175. Kennedy often spoke out in favor of The Paul Wellstone Mental Health Equitable Treatment Act. FREED, *supra* note 172.

176. *Id.*

177. Eating, *supra* note 171.

178. *Id.*; FREED, *supra* note 172.

179. Eating, *supra* note 171.

180. See Bennett, *Critical Care*, *supra* note 13.

181. FREED, *supra* note 172.

VI. CONCLUSION

Although eating disorders are commonly viewed in a very negative light and often unspoken of, parents who have lost precious loved ones to such diseases are refusing to remain silent. With the recent, consistent, nationwide efforts to get adequate insurance coverage for people with eating disorders, it is now past due that we as a nation and legal system mature, listen, and actually address this serious health problem head on. Thus far, attempts to change our system and provide adequate care for eating disorders have been successful only in a "piecemeal fashion."¹⁸² With the magnitude and danger of eating disorders, such tedious and sporadic progress can no longer be tolerated. Our nation must be inspired by the recent progressions made in this area and it is pleaded that all groups involved in this issue, throughout the insurance and legal systems, must take action to allow for a thorough, comprehensive and uniform change across the board.

It is clear that there are wide gaps between what the doctors and researchers know about the deadly risks of eating disorders, how Americans believe eating disorders should be treated, and how they are actually being treated in the insurance system.¹⁸³ "Narrowing that gap will require bringing healthcare professionals, insurers, lawmakers and consumers together," and unless that happens, those who cannot afford treatment for their eating disorder "will be out of luck."¹⁸⁴ With lives on the line, our nation cannot tolerate leaving people out of luck any longer.

As quoted in the first line of this Comment, it is believed by the Anna Westin Foundation that "denying access to care for eating disorders is illegal and immoral."¹⁸⁵ Insurance companies have the power to quickly eliminate the immoral aspect involved in inadequate eating disorder coverage by voluntarily revising their policies to provide for better coverage. State and federal legislatures can do their part to enact legislation that also makes such inadequate coverage truly illegal across the board. These changes are needed now.

182. Herzog, *supra* note 8.

183. *See id.*

184. *Id.*

185. *See* Anna Westin Foundation, *supra* note 1.