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Eating Disorders Information

Securing Eating Disorders Treatment: Ammunition for Arguments with Third Parties

Although eating disorders can be treated successfully, some insurance companies refuse payment for much needed care. Even when health care costs are covered in part, the reimbursement to families remains inadequate for patients with eating disorders. Each state and its insurance carriers are allowed to create their own definitional criteria for treatment. As a result, insurers in some parts of the country are able to refuse coverage of eating disorders.

The following arguments will help you fight for quality care and coverage on behalf of yourself or someone you love. This fight is harder than ever due to the managed care environment and the addition of intrusive treatment guidelines, universal changes in reimbursement, and the substitution of short-term treatment models in place of more thorough and extended interventions. The public misunderstanding and trivialization of eating disorders are also great hurdles to overcome.

Argument #1: Eating disorders are serious bio-psychosocial conditions. Treatment must focus on the biological/medical, mental, and environmental aspects of the illness.

- Eating disorders are associated with some of the highest levels of medical and social disability of any psychiatric disorder (Klump et al., 2009). Eating disorders must be addressed from both a medical and a mental health perspective, and full treatment will not occur if either component—either medical or psychiatric—is neglected.
- To promote and sustain recovery, changes in the social environment are also an important aspect of treatment. For this reason, it is most sensible for someone who is in intensive treatment to gradually acclimate back into social activities, and to assess the degree to which relationships and social settings feel supportive or, conversely, triggering.
- Treatment is best administered in stages, from full inpatient care when warranted, to day treatment and then intensive outpatient care. Group and individual therapies should be carried on concurrently. A full course of treatment, de-intensifying over time, often spans between 5-7 years.

Argument #2: According to the position of the Academy for Eating Disorders, eating disorders qualify "serious mental illnesses" (SMIs), "biologically based mental illnesses" (BBMIs), and, in children, "serious emotional disturbances" (SEDs).

- In 1996, Congress passed the Mental Health Parity Act, a law that requires plans to provide the same annual and lifetime overall limits for mental health benefits as for other health conditions (Lock, 2003).
- Eating disorders ought to receive health care coverage and research funding that is equal to that of medical disorders as well as psychiatric conditions categorized as serious forms of mental illness (Klump et al., 2009).

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Argument #3: A full course of specialized treatment is cost-effective for eating disorders.

- Relative to other accepted medical interventions, the treatment of eating disorders has been shown to be cost-effective and, in fact, quite reasonable (Crow and Nyman, 2004).
- Still, due to the complexity and tenacity of eating disorders, in the United States, people with eating disorders tend to spend more on health care than those with other forms of mental illness, including depression (Striegel-Moore et al., 2007).
- Yet to respond to high costs by 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 (Halmi et al., 2000). Emphasize to insurers the fact that shorter periods of treatment for eating disorders are associated with less successful outcomes (Commerford, Licino, and Halmi, 1997).

Unfortunately, many health practitioners miss early signs of eating disorders; by the time they begin treating the disorder, it may be nearly intractable. In such cases, specialized treatment not only reduces mortality (Crisp, Callender, Halek and Hsu, 1992), coupled with early detection and early intervention, it offers the best hope for recovery and reduces health care costs.

Argument #4: Eating disorders treatment costs extend beyond the direct cost of hospitalization and affect the national economy and public health.

- Eating disorders are all-consuming, and can compromise emotional and physical health to the point of non-productivity and incapacity to earn a living. Vocational and educational functioning in people with anorexia nervosa and bulimia nervosa is below average due in part to absences from work and school (Byford, Barrett, Roberts, 2007), and in some cases, premature death.
- Ongoing medical problems such as osteoporosis persist after treatment and recovery from anorexia nervosa.
- Women with anorexia nervosa have higher rates of pregnancy complications than women without eating disorders (Bulik et al., 1999).
- Children of women with eating disorders have later emotional and nutritional problems (Park, Senior, & Stein, 2003).

Argument #5: Early intervention reduces the cost of treatment

- 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 (Lock, 2003).
- Problematic eating symptoms develop long before full-syndrome anorexia nervosa (Franko & Omori, 1999).
- According to international efficacy studies, early treatment can lead to faster recovery, prevent symptoms from becoming chronic, and reduce the likelihood of a fatal outcome (Krauth, Buser, & Vogel, 2002). For instance, people with bulimia nervosa demonstrate a better recovery rate if they receive treatment early in their illness. If treated within the first 5 years, the recovery rate is 80%. If not treated until after 15 years of symptoms, recovery falls to 20%.

Argument #6: An eating disorder is typically precipitated by and/or creates additional emotional and physical problems that require treatment.

- Psychiatric conditions, such as major depression and anxiety disorders, often accompany eating disorders. Substance use and personality disorders frequently coexist with eating disorders.
- Anorexia nervosa, bulimia nervosa, and Eating Disorders Not Otherwise Specified (EDNOS) are serious mental illnesses that limit the life activities of sufferers and severely compromise quality of life. Social adjustment tends to be impaired, social communication is often poor, and social networks tend to be small.
- In addition to the emotional despair often experienced by people with eating disorders, medical complications can create serious physical disabilities. These include damage to every organ system in the body, osteoporosis, cognitive losses, gastrointestinal bleeding, bowel paralysis, dehydration, electrolyte abnormality, and cardiac arrest (Mitchell & Crow, 1998).

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Argument #7: Determining the severity of an eating disorder cannot be based solely on weight or a BMI score.

- Health care companies may refuse coverage if a person's body mass index (BMI) is not "low enough" or may discharge a patient prematurely if she has entered treatment with a low BMI but has reached a target BMI, even while other therapeutic changes have not occurred.
- Outcome studies vary considerably in their determination of a cut-off weight for the diagnosis of anorexia nervosa, and the oft-cited 85%-of-normal-weight criterion creates a false consensus (Thomas, Roberto, & Brownell, 2009). In fact there is no universal standard by which anorexia nervosa is diagnosed. This means that a particular cluster of symptoms may be diagnosed and treated as anorexia at one treatment center and as bulimia or EDNOS at another.
- The problem is that weight thresholds alone are being used to determine treatment (and insurance coverage), even though other variables such as gender, age, and height are also critical. Average weight tables fail to account for these variables. A recent study found that other than admission weight, there were no clinical differences between anorexia nervosa and EDNOS participants. 95% of that group responded favorably to interdisciplinary treatment (Kalisvaart & Hergenroeder, 2007).
- Although they do not fit the criteria for anorexia nervosa or bulimia nervosa and thus have been less rigorously studied, EDNOS is nonetheless a serious and debilitating set of conditions that deserves therapeutic response.

Argument #8: Recovery takes place over a long period of time and is as much about quality as quantity.

- The course of anorexia nervosa is protracted, and the therapeutic relationship is a key to psychological change. Given the nature of the disease, prolonged treatment with a therapist is effective.
- When 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.
- In short, empirical studies do not support the notion that eating disorders can be adequately treated in short-term therapy (Franko & Erb, 1998).

Argument #9: Eating disorders are serious and lethal.

- Eating disorders are the third most common chronic illness in adolescent females in the United States (Kalisvaart & Hergenroeder, 2007), Crow and Nyman (2004).
- Long-term studies of anorexia nervosa report a mortality rate of 10% or up to 20% when suicide is accounted for (Sullivan, 1995).
- A six year follow-up of 196 female bulimic patients indicated 59.9% had achieved a good outcome; 29.9% a poor outcome, and 1.1% were deceased (Fichter and Quadflieg (1997).
- Mortality rate increases with the duration of symptoms (APA, 2000).

Argument #10: Younger patients require intense and aggressive treatment.

- Society for Adolescent Medicine (2003)

  "Because of the potentially irreversible effects of an eating disorder on physical and emotional growth and development in adolescents, the high mortality and the evidence suggesting improved outcome with early treatment, the threshold for intervention in adolescents should be lower than in adults." (p.500)

  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 electrolyte, fluid and mineral imbalance; cardiac risk; gastric irritation and bleeds; large bowel abnormalities; dental enamel erosion; peripheral muscle weakness, cardiomyopathy, and hypometabolism.

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Argument #11: Using mental health benefits may prevent high medical costs associated with eating disorders.

APA Practice Guidelines (2000 & 1993), reports these medical findings:

- Physical consequences of eating disorders include all serious disorders caused by malnutrition, especially cardiovascular compromise.
- Prepubertal patients may have arrested sexual maturity and growth failure.
- Even those who "look and feel deceptively well," with normal EKGs may have cardiac irregularities, variations with pulse and blood pressure, and are at risk for sudden death.
- Prolonged amenorrhea (>6 months) may result in irreversible osteopenia and a high rate of fractures.
- Abnormal CT scans of the brain are found in >50% of patients with anorexia nervosa.

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