REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF HEALTH CARE COVERAGE FOR ANOREXIA NERVOSA AND BULIMIA PURSUANT TO HJR 268

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 52

COMMONWEALTH OF VIRGINIA
RICHMOND
1999

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Preface

House Joint Resolution (HJR) 268 directs the Joint Commission on Health Care to:

> study the adequacy of health care coverage for anorexia nervosa and bulimia. The Joint Commission shall (i) receive information concerning the causes of these eating disorders; (ii) analyze current anorexia nervosa and bulimia treatment options; (iii) assess the current means by which health insurers, HMOs, and others are currently providing health care coverage for such treatment options; and (iv) make recommendations concerning improvements for such coverage and care.

The term "eating disorders" encompasses several disorders related to the ability of a person to maintain a health body weight. According to the American Dietetic Association, "onset of an eating disorder typically follows a period of restrictive dieting; however, only a minority of people who diet develop eating disorders." Eating disorders are found in both men and women, however they are most common in women. It is estimated that as many as 5 percent of young women and one percent of young men may have eating disorders.

The most commonly discussed eating disorders are anorexia nervosa and bulimia. Eating disorders can also encompass binge eating and other nonspecific disorders. At present, both anorexia nervosa and bulimia are classified as mental health disorders for purposes of medical coding and in the current (fourth) edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). However, eating disorders can result in serious physical health problems, including starvation, dehydration, electrolyte imbalance, and osteoporosis.

Based on our research and analysis during this review, we concluded the following:

- eating disorders are very difficult to treat, can require long periods of time to successfully treat, and involve both mental health and physical health care treatment;

- limits on insurance coverage for eating disorders are related to the broader question of parity for mental health care;

- eating disorders do not lend themselves to mandated benefits legislation, due to the wide variation in time and therapies required for successful treatment of eating disorders;

- agencies of the Commonwealth, particularly the Department of Health and the Department of Education, have not been particularly active in eating disorder prevention and education.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 16-17.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comment received, which is provided in Appendix C, provides additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Bureau of Insurance and the Virginia Department of Health for their assistance during this study.

Patrick W. Finnerty
Executive Director

February 3, 1999

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Authority for the Study

House Joint Resolution (HJR) 268 directs the Joint Commission on Health Care to:

> study the adequacy of health care coverage for anorexia nervosa and bulimia. The Joint Commission shall (i) receive information concerning the causes of these eating disorders; (ii) analyze current anorexia nervosa and bulimia treatment options; (iii) assess the current means by which health insurers, HMOs, and others are currently providing health care coverage for such treatment options; and (iv) make recommendations concerning improvements for such coverage and care.

This section briefly discussed the authority for this study. The second section of this issue brief offers an overview of eating disorders, treatment for these eating disorders, and current insurance industry practices regarding eating disorders. The third section discusses policy options.

II.
Overview of Eating Disorders

Eating Disorders Is a Term Encompassing Several Diagnoses

The term "eating disorders" encompasses several disorders related to the ability of a person to maintain a health body weight. According to the American Dietetic Association, "onset of an eating disorder typically follows a period of restrictive dieting; however, only a minority of people who diet develop eating disorders." Eating disorders are found in both men and women, however they are most common in women. It is estimated that as many as 5 percent of young women and one percent of young men may have eating disorders.

The most commonly discussed eating disorders are anorexia nervosa and bulimia. Both of these disorders are discussed in more detail later in this section. Eating disorders can also encompass binge eating and other nonspecific disorders. At present, both anorexia nervosa and bulimia are classified as mental health disorders for purposes of medical coding and in the current (fourth) edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). However, eating disorders can result in serious physical health problems, including starvation, dehydration, electrolyte imbalance, and osteoporosis.

Anorexia Nervosa Involves Refusal by the Patient to Maintain a Minimally Healthy Body Weight

Anorexia nervosa is a potentially life threatening eating disorder diagnosed according to the following criteria from DSM-IV:

- Refusal to maintain body weight at or above a minimally normal weight for age and height (for example, weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

- Intense fear of gaining weight or becoming fat, even though underweight.

- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

- Amenorrhea in postmenarchal women, that is, the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her menstrual periods occur only after administration of hormones such as estrogen).

It is estimated that as many as 1,000 people a year in the United States die of anorexia nervosa. The incidence of hospitalization for this diagnosis is difficult to track with certainty, as patients are often coded as presenting the hospital with physical ailments resulting from the refusal to maintain a minimally healthy body weight such as dehydration. For 1996, according to data provided by the Virginia Department of Health, there were 166 hospitalizations due to anorexia nervosa. This number is probably significantly lower than the actual number.

Anorexia is Typically Treated on an Outpatient Basis

Anorexia nervosa is typically treated on an outpatient basis through a variety of settings including but not limited to outpatient medical treatment (involving specialists such as gastroenterologists), individual psychotherapy, nutrition counseling, and family therapy. Family therapy is viewed as potentially useful in almost all cases, but particularly important for younger adolescents (those fifteen and under). Most literature on eating disorders emphasizes the importance of a team approach in treating the eating disorder.

Anorexia can be treated successfully on an entirely outpatient basis in some instances. However, in some cases inpatient hospitalization to treat anorexia nervosa is required either to stabilize a patient medically, to conduct intensive inpatient psychiatric treatment, or (as is frequently the case) both.

Inpatient Treatment for Anorexia May Be Reimbursed Either as a Medical or as a Mental Health Care Benefit

Inpatient hospitalization for treatment of anorexia nervosa can involve (i) medical stabilization (for example rehydrating the patient), (ii) inpatient behavioral health care, or (iii) a combination of medical and behavioral health treatment. In some cases, hospitalization for anorexia nervosa can exceed the thirty-day limit contained within many insurance policies for behavioral health care benefits. However, in some cases inpatient treatment is counted as part of a patient's medical benefits, not part of the mental health benefit. For example, if an anorexia patient is admitted to the hospital on a medical unit in a dehydrated condition, a health plan will typically count the hospital stay as a medical admission at least to the point where the patient is sufficiently rehydrated.

Anorexia Nervosa Has the Highest Mortality Rate of Any Behavioral Health Diagnosis

In some cases anorexia nervosa patients actually starve themselves to death. It is estimated that as many as 1,000 Americans die each year from anorexia nervosa. It is also estimated that about five percent of anorexia patients die per decade they have the disease.

Bulimia Nervosa Involves Recurrent Binge Eating Followed by Recurrent Inappropriate Compensatory Behavior

Bulimia nervosa is a condition for which the following diagnostic criteria have been established in DSM-IV:

- Recurrent episodes of binge eating;
- Recurrent inappropriate compensatory behavior in order to prevent weight gain (self-induced vomiting; misuse of laxatives, diuretics, enemas, other medications; fasting; or excessive exercise);
- Both the binge eating and inappropriate compensatory behaviors occur at least twice per week for three months;
- Self-evaluation is unduly influenced by body shape and weight; and
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

While bulimia nervosa is often referred to as involving "binge and purge," there are in fact two types of patients presenting with bulimia nervosa. The purging type of person regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. The nonpurging type uses other inappropriate compensatory behaviors such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or other purging behaviors.

Bulimia Nervosa is Often Treated on an Outpatient Basis

While bulimia nervosa, like all eating disorders, can be chronic and difficult to treat, there is somewhat more agreement as to the most appropriate course for treating bulimia nervosa than is the case for anorexia nervosa. Often, bulimia can be successfully treated with a course of outpatient therapy and related nutritional counseling and medical follow-up. However, in some cases a bulimia nervosa patient may require hospitalization.

Hospitalization for Bulimia Can Involve Both Medical and Psychiatric Care

Hospitalization for bulimia nervosa can be required for a variety of medical reasons. These include but are not limited to electrolyte imbalances and negative consequences of purging behaviors (such as esophageal tears). Bulimia nervosa patients may also require inpatient psychiatric admissions in order to receive intensive counseling and round-the-clock nursing care. In many (perhaps most) cases when a bulimia patient is admitted to the hospital, a patient receives both medical and psychiatric services. According to data provided by the Virginia Department of Health, there were 100 patients hospitalized with bulimia nervosa in 1996 in Virginia.

Other Eating Disorders Exist Besides Anorexia Nervosa and Bulimia Nervosa

A patient may present with both anorexia nervosa and bulimia nervosa. This combination of diseases is one of the most challenging eating disorders to treat. A patient with anorexia nervosa may also have diabetes (in some cases the anorexia nervosa stems from the intense focus on nutritional intake that is required to effectively manage diabetes).

There are also a number of eating disorders that do not meet all of the criteria for anorexia nervosa or bulimia nervosa. These eating disorders are grouped together as eating disorders not otherwise specified in DSM-IV. While there is a wide range of these types of disorders, some examples include:

- a patient meets all of the criteria for anorexia nervosa except that the patient has regular menses;
- a patient meets all of the criteria for anorexia nervosa except that, despite substantial weight loss, the patient's current weight is in the normal range;
- an individual who regularly chews and then spits out large amounts of food; and
- an individual who regularly engages in inappropriate compensatory behavior similar to that of bulimia nervosa patients, except that these behaviors are displayed after the patient has consumed only a small amount of food.

Binge Eating Disorder Is Another Eating Disorder Identified in DSM-IV

Another type of eating disorder that is specified in DSM-IV is binge eating disorder. A binge eating episode is typified by eating within a given period of time an amount of food substantially greater than most people would eat during

that time period and a feeling of lack of control over eating. Binge eating disorder is characterized by:

- recurrent episodes of binge eating;
- marked distress regarding binge eating;
- the binge eating occurs at least two days per week for six months;
- the binge eating is not associated with the use of inappropriate compensatory behaviors like those found in bulimia nervosa patients;
- the binge eating episodes include at least three of the following: eating more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating lone due to embarrassment regarding overeating, feeling self-disgust, depression, or guilt after overeating.

It is not uncommon for binge eating disorder to result in obesity. Obesity can be a serious health problem in that it is a risk factor for stroke, heart disease, and a variety of other health problems. Obesity can also contribute to or worsen other health problems such as orthopedic problems or incontinence.

Providers Have Voiced Concern Over the Difficulties Insurance Coverage Can Pose for Treatment of Eating Disorders

The time frames associated with treating eating disorders, in many cases, defy easy quantification to establish norms to guide payors or public policy makers. While the time limitations involved in this study precluded a systematic survey of medical professionals, structured interviews during this review did indicate frustration among providers regarding time limits imposed by payors on both inpatient and outpatient treatment for eating disorders.

In terms of outpatient care, one area of frustration expressed by providers regards coverage for nutritional counseling. Nutritional counseling is viewed as important by health care professionals to treating eating disorders. Such counseling is sometimes, but not always available from health plans.

Regarding inpatient treatment, providers expressed concern that, for example, a payor will sometimes push for discharge of an anorexia nervosa patient once the patient is medically stabilized (e.g. electrolyte imbalances have been corrected) but without correction of the underlying behavioral health condition. Similarly, subsequent to a hospital admission for inpatient mental health care, providers expressed frustration that an anorexia nervosa patient would need to be discharged once the patient reached 85 percent of minimally healthy body weight, without sufficient time being allowed to correct the underlying mental health issues that lead the patient to reduce their body

weight. This potentially results in a seesawing type of effect, where a patient is discharged after regaining some weight, fails to maintain a minimally healthy body weight, and then needs to be readmitted.

Having stated this, it is impossible to state categorically that improved insurance coverage for eating disorders is the only thing necessary to improve patient outcomes from treatments of these disorders. Eating disorders generally have a relatively high relapse rate from both inpatient and outpatient treatment. For example, more than 90 percent of patients treated for binge eating (typically on an outpatient basis) have some form of relapse. After inpatient hospitalization, only about a quarter of anorexia nervosa patients remain fully free of the eating disorder. At the same time, it is difficult to state a level of care (either in terms if inpatient hospitalization, partial hospitalization, or outpatient treatment) that is minimally adequate for treatment of eating disorders in all cases (or even a level of care that is minimally adequate for even one kind of eating disorder).

Mandated Benefit Options Would Be Difficult to Craft for Eating Disorders

The difficulty in treating anorexia nervosa, bulimia nervosa, and other eating disorders is frustrating for patients, family members, health care providers, and payors. There is significant variation in the treatment protocols for eating disorders, outcomes from treatment are uncertain, patients with eating disorders frequently have mental health or medical co-morbidities such as depression, diabetes, or cardiac problems. Hospital stays for eating disorder patients can vary widely, and, based on discussions with health care professionals who treat eating disorders, it appears to be difficult to put an upward boundary on the time needed to successfully treat an eating disorder.

Mandated benefits are a controversial public policy approach of mandating that health plans offer coverage for certain types of services or a certain level of care. For example, a number of states have adopted laws governing the minimum hospital stay after delivery that is to be offered, to prevent so-called "drive through deliveries." Irrespective of whether one views mandated benefits as appropriate public policy, it is clear that it would be difficult to craft a mandated benefit for eating disorder treatment. In the case of post-partum hospital stays, there are standards and guidelines that fall with a relatively narrow band of time. In contrast, there is no equivalent standard for treatment of eating disorders. In fact, some health care providers interviewed stated concern about a mandated benefit in terms of time of treatment, expressing concern that the mandated time frame would become a ceiling, not a floor, thereby preventing them from convincing a health plan to approve a longer period of hospitalization when appropriate.

Examination of Treatment for Eating Disorders Illustrates Some of the Complexities in the Mental Health Parity Debate

The mental health parity debate, in essence, addresses whether or not health plans should be required to offer the same level of coverage for mental health treatment as for medical treatment. At present, there are typically more stringent limits in most health insurance plans for mental health care than for medical care. Further, mental health care is frequently "carved out" of a health plan's normal administration and handled by a subcontractor.

Nationwide, states and the federal government have begun addressing the issue of mental health parity. In Virginia, during the 1998 session of the General Assembly, HB 1052 and SB 430 were introduced. Both of these bills would require "health insurers, health services plans and health maintenance organizations to provide benefits for inpatient, partial hospitalization, medication management and outpatient treatment of mental disorders that are as favorable as the benefits for any other illness, condition, or disorder that is covered by the policy or contract." These bills have been referred to the Special Advisory Commission on Mandated Health Benefits for consideration.

Eating disorders illustrate some of the complexities of this debate. For example, while anorexia nervosa and bulimia nervosa are mental health disorders, both can have serious medical consequences. Similarly, successfully intervening to treat an eating disorder can consume significant health care resources, but doing so can also prevent expenditure of significant health care resources that would have been required to treat the medical complications caused by the eating disorder. Indeed, in the case of an anorexia nervosa patient, hospitalizations are often to medical units and are reimbursed as medical care, because the disorder in its advanced state results in life-threatening, sometimes fatal medical complications. Even if death does not result from these complications, chronic medical conditions such as osteoporosis can result.

At the same time, eating disorders are difficult to treat, have high relapse rates, and uncertain duration of treatment. As a result, the decision on when coverage of care is medically necessary and appropriate is rendered all the more difficult. With regard to an eating disorder, it is not only difficult to determine when care is medically necessary, it is sometimes difficult to determine whether such care is medical or mental health in nature, since successful treatment of an advanced eating disorder requires addressing both types of issues.

The deliberations of the Special Advisory Commission on Mandated Health Benefits may benefit from consideration of the specific case of eating

disorders. Examination of the complexity of the insurance issues involved in treating these disorders may be illustrative for the larger question of mental health parity.

One Challenge in Treating Eating Disorders Is Coordination of Care Between Mental Health Sub-Contractors and the Health Plan

As noted previously, health plans often subcontract the administration of their mental health benefits to subcontractors. For example, in the most commonly used state employee plan, Key Advantage, Trigon serves as the plan administrator but subcontracts administration of the plan's mental health benefits to Green Springs. During structured interviews conducted with health care professionals as part of this study, a common theme that emerged was concern about coordination of care between health plans and their mental health subcontractors. Such coordination is necessary in treatment of eating disorders, because the subcontractor is administering mental health benefits while the health plan is administering medical benefits, and in an eating disorder case both may well be involved.

The scope of this study did not allow collection of systematic data to determine empirically whether or not coordination of care issues exist for treatment of patients who have conditions with both mental health and medical care components. However, this question appears to be worthy of further study to identify if potential opportunities for improving quality of care exist. It may be appropriate for the Virginia Department of Health to examine this question as the Board of Health crafts regulations to address its quality of care responsibilities established in Senate Bill 712, approved by the 1998 General Assembly.

Education and Public Health Outreach Efforts Could Be Directed at Eating Disorders

There are several factors which make eating disorders a potential target for education and public health efforts. First, there is a relatively high prevalence of eating disorders among a certain population cohort. Five percent of adolescent and adult women and one percent of men are estimated to have an eating disorder. There is some evidence that the prevalence of such disorders is growing. Moreover, these disorders are difficult and expensive to treat, cause related medical problems, and (particularly in the case of anorexia nervosa) can be fatal.

The Virginia Department of Health has conducted some public health education related to eating disorders. The Virginia Department of Education has

some staff expertise regarding eating disorders but has not been recently active in addressing this problem (nor have the Health Standards of Learning incorporated up-to-date information on eating disorders). Virginia's academic health centers also possess substantial expertise in treatment of eating disorders. One option in addressing eating disorders from the perspective of state government would be to introduce a joint resolution asking the Commissioner of Health and the Superintendent of Public Instruction to jointly identify opportunities for improving the Commonwealth's public health and public education efforts regarding eating disorder prevention. These efforts could include but are not limited to (i) identifying expert resources at the state's academic health centers, (ii) examining the appropriateness of including up-to-date information about eating disorders in the health standards of learning, and (iii) determining the role of local health districts in eating disorder prevention and education.

III.
Policy Options

The following policy options are for consideration by the Joint Commission on Health Care. With the exception of Option I, these options are not intended to be mutually exclusive; the Joint Commission on Health Care may chose to pursue two or more of these options simultaneously.

Option I: **Take No Action.**

Option II: **Introduce a joint resolution requesting the Commissioner of Health, with the assistance of the Superintendent of Public Instruction and the state's academic health centers to examine opportunities for improving the Commonwealth's efforts at eating disorder prevention. The Commissioner of Health's review should examine but should not be limited to (i) identifying expert resources at the state's academic health centers, (ii) examining the appropriateness of including up-to-date information about eating disorders in the health standards of learning, and (iii) determining the role of local health districts in eating disorder prevention and education.**

Option III: **Introduce a joint resolution requesting the Special Advisory Commission on Mandated Health Benefits to examine coverage for eating disorders as part of their review of the mental health parity issue (this options is based on the assumption that the Special Advisory Commission's Review of mental health parity will not be completed this year due to a lack of a quorum on the Special Advisory Commission).**

Option IV: **Introduce a budget amendment directing the Department of Health and the Board of Health to examine the issue of coordination of care between mental health subcontractors and health plans as part of their regulatory process for the implementation of Senate Bill 712, approved by the 1998 General Assembly.**

APPENDIX A

Appendix A
HOUSE JOINT RESOLUTION NO. 268

Directing the Joint Commission on Health Care to study the adequacy of health care coverage for anorexia nervosa and bulimia.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, anorexia nervosa and bulimia are physically debilitating eating disorders associated with mental illness; and

WHEREAS, the mortality rate associated with these eating disorders is reportedly higher than that of any other mental illness; and

WHEREAS, treatment for anorexia nervosa and bulimia requires coordinated medical and mental health treatment, frequently involving extensive inpatient hospitalization; and

WHEREAS, insurers in some states outside the Commonwealth have refused to provide coverage for prolonged, inpatient medical and mental health treatment required by some anorexics and persons with bulimia, contending that such eating disorders are only emotional disorders, thereby seeking to limit inpatient coverage to statutory limits prescribed for mental health treatment, rather than providing inpatient benefit coverages applicable to medical conditions requiring hospitalization generally; and

WHEREAS, Virginia regulated health insurers, health maintenance organizations, and corporations furnishing health care subscription contracts are not required under the current provisions of Virginia's insurance laws to provide more than 20 days per year in covered inpatient hospitalization for mental health treatment; and

WHEREAS, limiting citizens of the Commonwealth suffering from anorexia nervosa and bulimia to mental health inpatient hospitalization benefits for purposes of medical and mental health treatment requiring hospitalization would be wholly inadequate in many instances; and

WHEREAS, it would be beneficial to the citizens of the Commonwealth suffering from anorexia nervosa and bulimia to have hospitalization and other health care coverage issues associated with these severe disorders, including the causes and appropriate treatments, examined at length; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study the adequacy of health care coverage for anorexia nervosa and bulimia. The Joint Commission shall (i) receive information concerning the causes of these eating disorders; (ii) analyze current anorexia nervosa and bulimia treatment options; (iii) assess the current means by which health insurers, HMOs, and others are currently providing health care coverage for such treatment

options; and (iv) make recommendations concerning improvements for such coverage and care.

Technical assistance shall be provided to the Joint Commission by the Bureau of Insurance and the Department of Health.

All agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: STUDY ON INSURANCE COVERAGE FOR EATING DISORDERS (HJR 268)

Individuals/Organizations Submitting Comments

One organization, the Virginia Association of Health Plans, submitted comments on the draft issue brief regarding insurance coverage for anorexia, bulimia, and other eating disorders.

Policy Options Included In the Issue Brief

Option I: **Take No Action.**

Option II: **Introduce a joint resolution requesting the Commissioner of Health, with the assistance of the Superintendent of Public Instruction and the state's academic health centers to examine opportunities for improving the Commonwealth's efforts at eating disorder prevention. The Commissioner of Health's review should examine but should not be limited to (i) identifying expert resources at the state's academic health centers, (ii) examining the appropriateness of including up-to-date information about eating disorders in the health standards of learning, and (iii) determining the role of local health districts in eating disorder prevention and education.**

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completed this year due to a lack of a quorum on the Special Advisory Commission).

Option IV: Introduce a budget amendment directing the Department of Health and the Board of Health to examine the issue of coordination of care between mental health subcontractors and health plans as part of their regulatory process for the implementation of Senate Bill 712, approved by the 1998 General Assembly.

Summary of Comments Received

Mark C. Pratt, Executive Director of VAHP, commented in support of Option I, take no action. Mr. Pratt stated that "though VAHP appreciates the destructive nature of anorexia nervosa and bulimia and recognizes the difficulty in treating these complex mental health disorders, VAHP believes that Option I . . . is the most appropriate option at this time. Regarding Option II, Mr. Pratt stated "VAHP is concerned about the ability of [the Superintendent of Public Instruction and the Commissioner of Health] to have a meaningful impact on these very complex mental health disorders."

JOINT COMMISSION ON HEALTH CARE

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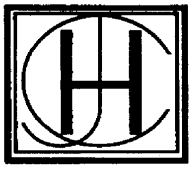

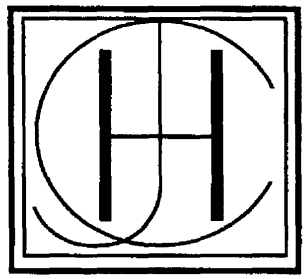

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