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Medical Necessity of Residential Treatment for Anorexia: Can Parity be Achieved?

Abbey Derechin*

ABSTRACT

This Note examines the statutory landscape of mental health parity in the United States. The lens of this Note is through the mental illness of anorexia. Parity laws mandate analogous limitations between mental and physical illness. Therefore, because anorexia has many physical manifestations, it serves as a nice juxtaposition to physical illnesses. This Note will argue for broad interpretation of the Mental Health Parity and Addiction Equity Act (MHPAEA) through comparative analysis of counterpart statute, the California Mental Health Parity Act (CMHPA). It will explore how courts have interpreted the CMHPA broadly to suggest that the MHPAEA should be interpreted the same way.

Keywords: mental health, anorexia, statutory interpretation, California, CMHPA, MHPAEA, eating disorder

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INTRODUCTION

Eating disorders are alarmingly prevalent and dangerous. Historians and psychologists report that people have exhibited symptoms of anorexia for thousands of years.¹ Evidence suggests that genetics can place people at a higher risk of developing an eating disorder.² For instance, family studies have determined that anorexia is largely familial with incidence rates more common amongst family members than the general population.³ However, insurance companies consistently treat mental illnesses, specifically anorexia, with disparate coverage in comparison to traditional physical illnesses. Over many years, Congress has enacted multiple parity laws, such as the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), to remedy this inconsistency in coverage. States have also enacted their own parity laws.⁴

Nonetheless, in practice, the disparity still exists due to narrow interpretations of the Acts. The aim of this Note is to show that, in order to meet the legislature's intent of reaching parity between mental healthcare and medical/surgical healthcare, the MHPAEA should be read broadly as including residential treatment as medically necessary treatment in severe cases of anorexia.

Part I of this Note will introduce the mental illness of anorexia, which will serve as the analytical lens to interpret parity laws. Part I will also discuss the health consequences and mortality rates associated with anorexia. Part II of this Note will lay out the past and present statutory landscape of mental health parity laws in the United States. It will discuss the first federal parity law, the MHPA, and outline the goals and the shortcomings of this law. Part II will then examine the current federal parity law, the MHPAEA and its shortcomings.

Part III will overview an exemplary state parity law. The California Mental Health Parity Act (CMHPA) was chosen for analysis because its broad language and interpretation achieves far more parity than the current implementation of the MHPAEA. Part IV will compare the similar goals of the CMHPA and the MHPAEA as both Acts aim to provide parity in treatment coverage between mental illness and physical illness. Part V analyzes how the CMHPA has been highly successful at achieving parity through case law and suggests that the MHPAEA should be interpreted consistent with the CMHPA. Finally, Part VI will introduce suggestions for the future.

I. ANOREXIA

Historically, anorexia nervosa has been one of the mental disorders most impacted by unequal insurance coverage.⁵ This Note will focus on anorexia because of the

¹ *Anorexia Nervosa*, NAT'L EATING DISORDERS ASS'N, <https://www.nationaleatingdisorders.org/learn/by-eating-disorder/anorexia> (last visited Jan. 16, 2021).

² *What Are Eating Disorders?*, AM. PSYCH. ASS'N, <https://www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders> (last visited Apr. 13, 2021).

³ 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, 589 (2005–2006).

⁴ For example, Public Act 99-480 in Illinois.

⁵ Brunalli, *supra* note 3, at 586.

abundance of case law regarding treatment coverage for this common and deadly mental illness. More specifically, this Note will focus on residential treatment for anorexia, which is an intermediate level of treatment.

Eating disorders are one of the deadliest mental illnesses.⁶ Eating disorders do not discriminate; they impact people of all ages, races, sexual orientations, and genders.⁷ Messages promoting weight loss and glamorizing skinniness are pervasive throughout society. In fact, this messaging is so prevalent that a study found that 81% of 10-year-olds are afraid of becoming fat and 42% of first through third grade girls want to be skinner.⁸ While there are a variety of eating disorders, the most common are binge eating disorder, bulimia nervosa, and anorexia nervosa. Anorexia is by far the deadliest eating disorder.⁹

Anorexia is an eating disorder characterized by excessive dieting, severe weight loss, distorted body image, and a pathological fear of gaining weight.¹⁰ Some people with anorexia also engage in over exercising as well as binge and purge behaviors.¹¹ Under the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), the following criteria must be met in order to be diagnosed with anorexia:

- i. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health;
- ii. Intense fear of gaining weight or becoming fat, even though underweight; [and]
- iii. 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.¹²

Even if all the criteria of the DSM-5 diagnosis of anorexia are not met, an individual can still have a serious eating disorder, such as atypical anorexia.¹³ Atypical anorexia includes those who are not medically underweight but still meet all other requirements for typical anorexia.¹⁴ There is no difference in the medical and psychological impact of classic anorexia and atypical anorexia.¹⁵ Further, less than 6% of people who are diagnosed with eating disorders are medically underweight.¹⁶ Unfortunately, people with larger bodies are

⁶ *Id.*

⁷ *What are Eating Disorders?*, NAT'L EATING DISORDERS ASS'N, <https://www.nationaleatingdisorders.org> (last visited Mar. 17, 2022).

⁸ *Eating Disorder Statistics*, NAT'L ASS'N OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS, <https://anad.org/get-informed/about-eating-disorders/eating-disorders-statistics/> (last visited Nov. 10, 2021).

⁹ Jon Arcelus, Alex J. Mitchell, Jackie Wales & Søren Nielsen, *Mortality rates in patients with anorexia nervosa and other eating disorders*, 68 ARCHIVES OF GEN. PSYCHIATRY 724, 728 (2011).

¹⁰ *Feeding and Eating Disorders*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets> (follow hyperlink, scroll down, click on "Eating Disorders") (last visited Jan. 17, 2021).

¹¹ NAT'L EATING DISORDER ASS'N, *supra* note 1.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ NAT'L ASS'N OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS, *supra* note 9.

less likely to be diagnosed with eating disorders than those with smaller bodies.¹⁷ This creates a huge issue when eating disorder treatment relies solely on weight-based classifications.

A. Health Consequences

Anorexia is ruthless and unforgiving. Anorexia leads to medical complications that can involve every single organ system.¹⁸ Some of the most severe anorexia complications are related to malnutrition. For instance, anorexia involves consuming fewer calories, which causes the individual's body to begin breaking down its own tissue to utilize as fuel.¹⁹ Some of the first tissue that the body breaks down is muscle, including the heart.²⁰ The breakdown of heart muscle can lead to significant consequences such as reduced heart rate, pulse and blood pressure, which can result in heart failure.²¹ Additionally, impaired immune function and impaired kidney function can also result from severe weight loss and malnutrition,²² which can interfere with the human body's capability to sustain a safe blood glucose level, leading to recurrent hypoglycemia or even death.²³ Furthermore, consuming fewer calories can also lead to hair falling out and dry skin.²⁴ In order to conserve bodily warmth when starved, the body can develop fine hair, called lanugo.²⁵ Other health consequences associated with anorexia are the following: fainting, dizziness, irregular heartbeat, anemia, amenorrhea, severe constipation, bloating, osteoporosis, infertility, and hormonal suppression.²⁶

These severe health consequences lead to an alarmingly high mortality rate for eating disorders. Opioid addiction is the only mental health disorder that has a higher mortality rate than eating disorders.²⁷ One study found that anorexia had a higher mortality rate than both schizophrenia and bipolar disorder.²⁸ There is about one death every fifty-two minutes, or 10,200 deaths every year from eating disorders.²⁹ Around 9% of the US population, which is 28.8 million people, will have an eating disorder at some point in their lives.³⁰ 26% of people with eating disorders will at some point attempt suicide³¹ and one in five anorexics die by suicide.³² Among anorexics, the mortality rate is an alarming

¹⁷ *Id.*

¹⁸ Eating Disorder Statistics, *Health Consequences*, NAT'L EATING DISORDERS ASS'N, <https://www.nationaleatingdisorders.org/health-consequences> (last visited Mar. 12, 2021).

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² Mike Daly, Ronald M. LaRocca & Michael Pertschuk, M.D., *Learning the Language: Eating Disorder Claims Pose Multiple Challenges Under Health Insurance Policies*, FOR THE DEFENSE 45, 45–47 (2015).

²³ *Id.*

²⁴ NAT'L EATING DISORDERS ASS'N, *supra* note 2.

²⁵ *Id.*

²⁶ *Id.*

²⁷ AM. PSYCH. ASS'N, *supra* note 3.

²⁸ Arcelus, *supra* note 9, at 729.

²⁹ NAT'L ASS'N OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS, *supra* note 8.

³⁰ *Id.*

³¹ *Id.*

³² DELOITTE ACCESS ECONOMICS, THE SOCIAL AND ECONOMIC COST OF EATING DISORDERS IN THE UNITED STATES OF AMERICA: A REPORT FOR THE STRATEGIC TRAINING INITIATIVE FOR THE PREVENTION OF EATING DISORDERS AND THE ACADEMY FOR EATING DISORDERS (June 2020) at 27,

10%.³³ “The mortality rate associated with anorexia nervosa is twelve times higher than the death rate of *all* causes of death for females 15–24 years old.”³⁴ With such severe health consequences and high rates of mortality, it is clear that treatment for anorexics is medically necessary.

B. Treatment Methods

Eating disorders can be treated in a variety of different settings depending on the severity of the illness.³⁵ Some common treatment methods include inpatient care, partial hospital care, residential treatment, intensive outpatient programs, and general outpatient services.³⁶ The primary goals for both the physician and the patient in treating anorexia are to restore a healthy weight, treat physical complications, enhance patient’s motivations to engage in healthy eating patterns, treat psychiatric conditions, and engage family for support and prevent relapse.³⁷ This Note focuses on residential treatment for anorexia and the litigation surrounding it. Many insurance companies attempt to exclude coverage of residential treatment.³⁸ Thus, due to the disparity in the way health insurance companies cover mental and physical sicknesses, patients with mental illness often must pay for their own therapy out-of-pocket.

Unfortunately, there has not been extensive research concerning the efficacy of anorexia treatments. However, the University of Sheffield recently conducted a study analyzing the success of residential treatment,³⁹ finding it effective for early intervention of severe anorexia.⁴⁰ Residential treatment is an intermediate, formal level of care characterized by twenty-four hour care and supervision, primarily for medically stabilized patients, with a focus on providing psychological therapy.⁴¹ Patients participate in residential treatment through individual, group, family, and nutritional counseling.⁴² Individuals at residential treatment facilities typically have very severe psychosocial impairments, but may not need immediate medical services.⁴³ Although, residential treatment is extremely expensive, costing about \$1,237 per day per individual on average as of 2018–2019.⁴⁴ In 2019, residential treatment for eating disorders in the United States

<https://www2.deloitte.com/au/en/pages/economics/articles/social-economic-cost-eating-disorders-united-states.html>.

³³ NAT’L EATING DISORDER ASS’N, *supra* note 2.

³⁴ *Eating Disorder Statistics*, S.C. DEP’T OF MENTAL HEALTH, <https://www.state.sc.us/dmh/anorexia/statistics.htm> (last visited Nov. 10, 2021) (emphasis added).

³⁵ Daly, LaRocca & Pertschuk, *supra* note 22, at 46.

³⁶ *Id.*

³⁷ WORK GROUP ON EATING DISORDERS, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH EATING DISORDERS 1, 14 (3d ed. 2010).

³⁸ Brunalli, *supra* note 3, at 591–95.

³⁹ Kate Hiney-Saunders, Leah Ousley, Jeannette Caw, Emma Cassinelli & Glenn Waller, *Effectiveness of Treatment for Adolescents and Adults With Anorexia Nervosa in a Routine Residential Setting*, 29 EATING DISORDERS 2, 5 (2019).

⁴⁰ *Id.* at 11.

⁴¹ DELOITTE ACCESS ECON. *supra* note 34, at 65.

⁴² *Id.*

⁴³ *Id.* at 39.

⁴⁴ *Id.*

totaled about \$796.3 million;⁴⁵ treatment for individuals with anorexia made up \$565.5 million of that amount.⁴⁶

Patients with untreated anorexia typically have low motivation for recovery.⁴⁷ In health studies, longer length of stay at a residential treatment facility has been associated with positive outcomes in patients with anorexia.⁴⁸ Additionally, the American Psychological Association stated that early discharges of patients with low motivation to recover frequently leads to relapses and longer inpatient stays in the future.⁴⁹ Overall, residential treatment of eating disorders is effective and should be utilized in medically necessary circumstances.

II. HISTORY OF MENTAL HEALTH PARITY IN THE UNITED STATES

The following section provides background into the landscape of mental health parity in the United States and comments on the circumstances that led to necessary statutory intervention. Mental illness is extraordinarily common in the United States.⁵⁰ ⁵¹ However, those suffering from mental illness have faced significant barriers in access to treatment because healthcare plans frequently place limitations on mental healthcare coverage.⁵² Prior to the passage of parity laws, mental health coverage under health insurance plans was typically disparate from medical/surgical coverage in five principal ways.⁵³ First, the number of days a patient's care is covered in the hospital was substantially shorter for mental healthcare.⁵⁴ Second, the amount of coinsurance paid by the insurer for mental healthcare was lower.⁵⁵ Third, the quantity of covered visits to outpatient providers was much lower for mental healthcare.⁵⁶ Fourth, the amount of lifetime benefits for mental healthcare differed substantially from medical/surgical benefits.⁵⁷ Finally, annual maximum out-of-pocket protections were vastly different.⁵⁸ Parity laws have narrowed the gap slightly, however, true parity has not yet been achieved.

This lack of parity between mental, medical, and surgical healthcare likely stems from insurance companies' fears that mental illness is expensive and difficult to treat.⁵⁹ Admittedly, treating mental illness can be expensive. However, not treating mental illness

⁴⁵ *Id.* at 40.

⁴⁶ *Id.*

⁴⁷ Matthew D. McHugh, *Readiness for Change and Short-Term Outcomes of Female Adolescents in Residential Treatment for Anorexia Nervosa*, INT'L J. EATING DISORDERS 602 (2007).

⁴⁸ *Id.* at 604.

⁴⁹ *Id.*

⁵⁰ *Mental Illness*, NAT'L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last visited Mar. 16, 2022).

⁵¹ In 2019, approximately one in five adults received a mental illness diagnosis. *Id.*

⁵² Sara Noel, *Parity in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment Under the Mental Health Parity Act of 1996 and Mental Health Equitable Treatment Act of 2001*, 26 HAMLIN L. REV. 377, 380 (2002).

⁵³ JENNIFER A. NEISNER, CONG. RSCH. SERV., 96-827 EPW, MENTAL HEALTH PARITY ACT OF 1996: OVERVIEW AND ISSUES 1 (1998).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *See, e.g., id.* at 2.

can be just as expensive and can have catastrophic societal repercussions. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 1994, the United States spent nearly \$204 billion on untreated and undertreated mental illness.⁶⁰ Most of the expenses were in relation to direct treatment costs and lost productivity related to illness or premature death.⁶¹ Nevertheless, the 1999 Surgeon General report found that effective treatments exist for most mental disorders.⁶² Treatment for mental illness exists; the issue here is access.⁶³

The federal statutory landscape tends to encourage stigmatization of patients suffering from mental illnesses. It prevents access by creating a narrative that treatment is readily available—but only to those who can pay out of pocket. Although social acceptance of persons with mental illness has increased in recent years, prejudice surrounding mental illness is still alarmingly prevalent.⁶⁴ In the United States, stigmas attached to mental illness label mental patients as “dangerous” or “unpredictable.”⁶⁵ Even though mental illnesses are largely rooted in biology and are similar to many other medical conditions,⁶⁶ the public has consistently directed animus towards psychiatric patients.⁶⁷

Congress enacted the Mental Health Parity Act (MHPA) in 1996 to attempt to remedy the disparity between treatment of mental illness and physical illness. However, the MHPA left out many vital provisions necessary to effectively reach parity with physical illness treatment. In 2008, Congress replaced the MHPA and enacted the Mental Health Parity and Addiction Equity Act (MHPAEA).

A. *Mental Health Parity Act of 1996*

The MHPA constituted the first attempt at federal parity legislation.⁶⁸ It applied to employment-related group health plans and health insurance coverage offered in connection with a group health plan.⁶⁹ Congress codified the parity provisions of the MHPA in section 2705 of the Public Health Service Act (PHS Act), section 9812 of the Code, and in section 712 of the Employee Retirement Income Security Act (ERISA).⁷⁰ The MHPA prohibited group plans from implementing annual and lifetime dollar limits that are more restrictive for mental health coverage than those placed on medical and surgical coverage.⁷¹ On the surface, this provision seemed like a tangible step toward parity.

⁶⁰ C. STEPHEN REDHEAD, CONG. RSCH. SERV., RL31657, MENTAL HEALTH PARITY 2 (2004).

⁶¹ *Id.*

⁶² *Id.*

⁶³ As of 2018, untreated mental illnesses cost the United States \$300 billion annually. NAT’L ALL. ON MENTAL ILLNESS, HEALTH REFORM & MENTAL ILLNESS, [https://www.nami.org/getattachment/Get-Involved/NAMI-National-Convention/Convention-Program-Schedule/Hill-Day-2017/FINAL-Hill-Day-17-Leave-Behind-all-\(1\).pdf](https://www.nami.org/getattachment/Get-Involved/NAMI-National-Convention/Convention-Program-Schedule/Hill-Day-2017/FINAL-Hill-Day-17-Leave-Behind-all-(1).pdf) (last visited Apr. 22, 2021).

⁶⁴ Wendy F. Hensel & Gregory Todd Jones, *Bridging the Physical-Mental Gap: An Empirical Look at the Impact of Mental Illness Stigma on ADA Outcomes*, 50 TENN. L. REV. 47, 52 (2005).

⁶⁵ *Id.*

⁶⁶ AM. PSYCH. ASS’N, *supra* note 3.

⁶⁷ *Hensel*, *supra* note 64.

⁶⁸ RAMAYA SUNDARARAMAN, CONG. RSCH. SERV., RL33820, THE MENTAL HEALTH PARITY ACT: A LEGIS. HIST. (2008).

⁶⁹ FINAL RULES UNDER THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, 78 Fed. Reg. 68240, (Nov. 13, 2013).

⁷⁰ *Id.*

⁷¹ NEISNER, *supra* note 53, at 3.

However, in practice, MHPA did not establish comprehensive parity between treatment of mental and physical illnesses.⁷²

For instance, the MHPA did not require equality between mental health coverage and medical or surgical coverage in areas such as copayments or limits on inpatient days and outpatient visits.⁷³ The MHPA also did not apply to substance-use disorders.⁷⁴ Further, MHPA had two critical exemptions. First, employers with more than two people but less than fifty were exempt from the bill.⁷⁵ Second, the MHPA did not require employers to provide mental health coverage.⁷⁶ Instead, it only required that, if an employer provided mental health coverage, there had to be parity with lifetime limits on surgical and medical benefits.⁷⁷ These limitations problematically allowed insurance plans to circumvent the purpose of the law by charging higher copays and limiting annual covered inpatient and outpatient visits.⁷⁸ Generally, the MHPA was a step in the right direction. However, it was clear that the MHPA did not accomplish the legislature's ultimate goal of parity. New legislation, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), built upon the foundation laid by the MHPA in attempt to achieve true parity.⁷⁹

B. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

In response to the failures of the MHPA, Congress enacted the second federal mental health parity legislation, the MHPAEA.⁸⁰ The MHPAEA expanded the requirements of the MHPA to include both financial provisions and treatment limitations.⁸¹ It mandated parity between the limitations that are placed on mental health treatment and medical/surgical treatment.⁸² However, the MHPAEA maintained the two exemptions from the MHPA. First, the MHPAEA still only applied to plans for private or public sector employers who had more than 50 employees.⁸³ Second, the MHPAEA did not require insurance plans to provide mental health benefits; yet, if the plan does provide mental health benefits, the insurance plan must comply with parity requirements of the MHPAEA.⁸⁴ The Department of Labor, Department of Treasury, and the Department of Health and Human Services (the Departments) were tasked with publishing the interim final rules and the final rules for the implementation of the MHPAEA.⁸⁵

⁷² Noel, *supra* note 52, at 388–89.

⁷³ Colleen L. Barry, Howard H. Goldman & Haiden A. Huskamp, *Federal Parity in The Evolving Mental And Addiction Care Landscape*, 35 HEALTH AFF. 1009, 1010 (2016).

⁷⁴ *Id.*

⁷⁵ Noel, *supra* note 52, at 388.

⁷⁶ *Id.*

⁷⁷ *Id.* at 387.

⁷⁸ *Id.*

⁷⁹ John G. Kilgour, *Mental Health and Substance Use Disorder Benefits Parity*, 50 COMP. & BENEFITS REV. 95, 98 (2019).

⁸⁰ *Id.*

⁸¹ *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 750 (N. D. Ill. 2015).

⁸² *Id.*

⁸³ U.S. DEP'T OF LAB., THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA) (2010), <https://permanent.fdlp.gov/gpo10380/fsmhpaea.pdf>.

⁸⁴ *Id.*

⁸⁵ *Id.*

C. Interim Final Rules and Final Rules of the MHPAEA

The Departments released the interim final rules in February of 2010.⁸⁶ The interim final rules remained in effect until 2014, when the final rules were executed.⁸⁷ The goal of the interim final rules was to provide a framework for implementation and to clarify possible areas of ambiguity in the MHPAEA.⁸⁸

One of the most critical clarifications of the interim final rules was the application of “treatment” to both “quantitative” and “nonquantitative” limitations. Quantitative treatment limitations are conveyed numerically, such as a limitation on the number of outpatient visits per year.⁸⁹ Nonquantitative treatment limitations are those that are not expressed numerically but otherwise limit the scope or duration of benefits.⁹⁰ These two concepts, and their importance, will be analyzed throughout the rest of this Note.

The interim final rules declared, and the final rules confirmed, that the parity requirements of the MHPAEA applied to both quantitative and nonquantitative treatment limitations.⁹¹ This is important because many mental health treatments can fall into the nonquantitative category. The interim final rules provided a non-exhaustive list of examples of nonquantitative treatment limitations including the following:

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment was experimental or investigative;
- (B) Formulary design for prescription drugs;
- (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- (D) Standards for provider admission to participate in a network, including reimbursement rates;
- (E) Plan methods for determining usual, customary, and reasonable charges;
- (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- (G) Exclusions based on failure to complete a course of treatment; and
- (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.⁹²

The key language for the purpose of this analysis is found in subsection (A): “medical necessity or medical appropriateness.”

⁸⁶ Barry, *supra* note 73, at 1011.

⁸⁷ Final Rules, *supra* note 69.

⁸⁸ Barry, *supra* note 73, at 1011.

⁸⁹ INTERIM FINAL RULES UNDER THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, 75 Fed. Reg. 5410, 5412 (Feb. 2, 2010).

⁹⁰ *Id.*

⁹¹ *Id.* at 5436.

⁹² *Id.*

The interim final rules further outlined that insurance providers must apply treatment limitations on a classification-by-classification basis.⁹³ The interim final rules laid out six classifications and required parity of medical and surgical benefits and mental health benefits within each classification.⁹⁴ The classifications were as follows; (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.⁹⁵ This means that if an insurance plan provides coverage within one of the classifications for a medical/surgical condition, the plan must also provide coverage for a mental health disorder within the same classification. For instance, if an insurance plan provides benefits for outpatient, in network medical/surgical coverage, it must also provide benefits for outpatient, in network mental health services. The interim final rules provided necessary guidance on treatment limitations. However, the interim final rules did not address the extent to which the scope of services a plan offered for mental illness had to be analogous to medical/surgical conditions.⁹⁶

The Departments issued the final rules on November 13, 2013.⁹⁷ The final rules were largely similar to the interim final rules. The final rules maintained the six classifications and the definition of quantitative and nonquantitative treatment limitations articulated in the interim final rules.⁹⁸ However, the final rules clarified and altered multiple provisions of the interim final rules. For instance, the final rules explained that the examples of nonquantitative treatment limitations in the interim final rules were illustrative, but not exhaustive.⁹⁹ Next, the final rules eliminated a provision in the interim final rules that allowed nonquantitative treatment limitations that were based on “clinically appropriate standards of care.”¹⁰⁰ The final rules deemed this provision confusing and vulnerable to abuse.¹⁰¹

The final rules also clarified that within the six broad classifications outlined in the interim final rules, there could be subclassifications in certain circumstances.¹⁰² This provision was necessary given the risk of insurance companies claiming that certain benefits were outside of the six classifications and not subject to the final rules.¹⁰³ For instance, intermediate care levels such as partial hospitalization or residential treatment do not fall neatly into one of the six categories.¹⁰⁴ The final rules explicitly state that insurance plans cannot exclude intermediate levels of care, such as intensive outpatient services, residential treatment, and partial hospitalization.¹⁰⁵ However, the final rules further qualify that intermediate levels of care for both mental health benefits and medical/surgical care

⁹³ *Id.* at 5412.

⁹⁴ *Id.* at 5413.

⁹⁵ *Id.*

⁹⁶ *Id.* at 5412.

⁹⁷ Gerald E. DeLoss, Laura Ashpole & Kelly Whelan, *Mental Health Parity and Addiction Equity Act Final Rules: Limited Enforcement Options Don't Overcome Unequal Treatment*, 7 J. HEALTH & LIFE SCI. 75, 76 (2014).

⁹⁸ *Id.* at 78.

⁹⁹ *Id.* at 86.

¹⁰⁰ Barry, *supra* note 73.

¹⁰¹ *Id.*

¹⁰² DeLoss, Ashpole & Whelan, *supra* note 97, at 84.

¹⁰³ *Id.* at 84–85.

¹⁰⁴ *Id.*

¹⁰⁵ Final Rules, *supra* note 69, at 68247.

must be applied consistently within the six classifications. The final rules give the following example: “if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit.”¹⁰⁶ This example shows how the Departments intended intermediate levels of care to be covered. Overall, the interim final rules and the final rules provided much needed direction to how the language of the MHPAEA should be interpreted.

IV. CALIFORNIA MENTAL HEALTH PARITY ACT

Most states enacted their own parity laws after the passage of MHPA in 1996.¹⁰⁷ These state laws varied in scope and were limited to a subset of each state’s population of privately insured citizens.¹⁰⁸ California adopted one of the most expansive parity laws in the country and exemplifies the most effective steps taken to achieve parity. Governor Davis signed the California Mental Health Parity Act (CMHPA), also known as Assembly Bill 88 (AB 88) into law in 1999.¹⁰⁹ Prior to enacting the CMHPA, the California legislature noticed that most private health insurance policies provided coverage for mental illness at a significantly lower level than coverage for physical illnesses.¹¹⁰ The legislature also found that this disparity in treatment between mental and physical illness resulted in deficient treatment of mental illness, relapse, an increase in crime, an increase in homelessness, and an increase in demands on the state budget.¹¹¹

The CMHPA requires that every health plan that offers medical or surgical coverage must in turn cover the diagnosis and medically necessary treatment of severe mental illnesses.¹¹² The language this Note will analyze is not current. The CMHPA was amended recently and the updated language of the CMHPA is even more broad. However, since this change was recent, much of the relevant case law interprets the old language of the CMHPA. The old language of the CMHPA requires the same coverage for all medically necessary treatment of severe mental illnesses as for medical conditions:

Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child.¹¹³

This language is still relevant and useful because it is most analogous to the medically necessary language from the MHPAEA. The new language is far more broad and arguably not comparable to the MHPAEA. The expenses covered under the CMHPA include:

¹⁰⁶ *Id.*

¹⁰⁷ Barry, *supra* note 73, at 1010.

¹⁰⁸ *Id.*

¹⁰⁹ DISABILITY RIGHTS CAL., THE CAL. MENTAL HEALTH PARITY ACT TOOLKIT: A GUIDE TO APPEALING HEALTH PLAN MENTAL HEALTH CARE DENIALS 4 (1st ed. 2014).

¹¹⁰ Harlick v. Blue Cross of Cal., 686 F.3d 699, 710 (9th Cir. 2012).

¹¹¹ *Id.*

¹¹² DISABILITY RIGHTS CAL., *supra* note 109.

¹¹³ CAL. HEALTH & SAFETY CODE §1374.72(a) (West 2021).

outpatient services, inpatient hospital services, partial hospital services, and prescription drugs (if the policy provides coverage for prescription drugs).¹¹⁴ These expenses covered are analogous to the six classifications of care specified in the interim final rules and the final rules of the MHPAEA. The language of the CMHPA declared that if an insurance plan covers medical/surgical benefits, the plan must also provide coverage for the treatment and diagnosis of medically necessary treatment of mental illness. Notably, the CMHPA does not explicitly define “medically necessary.” The courts in California have interpreted the language “medically necessary” in a broad manner, recognizing that medically necessary treatments for mental illness and physical health may not be directly analogous. Frequently in California, courts have ruled that insurance companies must cover residential treatment for anorexia.

Judicial interpretation of the CMHPA has acknowledged residential treatment for anorexia as medically necessary on multiple occasions. Courts recognized that parity is an elusive concept, and that the legislature intended to leave room for flexibility in interpretation.¹¹⁵ These interpretations have determined that there may not be a direct analogue between physical health treatments and mental health treatments.¹¹⁶

For instance, in *Rea v. Blue Shield*, plaintiffs Marissa Rea and Kelly Melachouris suffered from severe eating disorders.¹¹⁷ The respective medical providers of each plaintiff advised that residential treatment was medically necessary for their eating disorders.¹¹⁸ The plaintiffs sought coverage for medically necessary residential treatment for their eating disorders from their insurance companies.¹¹⁹ The court in *Rea* concluded that residential treatment for eating disorders must be covered by the insurance plan in question.¹²⁰ The court reasoned that the concept of parity does not require identical treatments for likely dissimilar mental and physical illnesses.¹²¹ Rather, the court interpreted parity as mental illnesses receiving the same quality of care afforded to physical illnesses.¹²² There may not be a completely analogous treatment for physical illnesses and mental illnesses, thus making the search for an identical treatment difficult or even impossible.¹²³ The court declared:

We do not interpret the concept of ‘parity’ to require treatments for mental illnesses to be identical to those mandated for physical illnesses; rather, given the principle that treatments for the two types of illnesses are in many cases not comparable, parity instead requires treatment of mental illnesses sufficient to reach the same quality of care afforded physical illnesses.¹²⁴

¹¹⁴ *Id.* §1374.72(b).

¹¹⁵ *Rea v. Blue Shield of Cal.*, 226 Cal. App. 4th 1209, 1226 (2014).

¹¹⁶ *Id.* at 1214.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 1219.

¹¹⁹ *Id.* at 1214.

¹²⁰ *Id.* at 1238.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Id.*

This broad interpretation of the medically necessary treatment upholds the California legislature’s intent of parity.

Harlick v. Blue Shield provides an exemplary demonstration of courts reading the medically necessary language of the CMHPA broadly.¹²⁵ The plaintiff, Jeanne Harlick, suffered from anorexia nervosa for over twenty years.¹²⁶ At the time she sought treatment, Harlick was only 65% of her ideal body weight.¹²⁷ Her doctors decided that residential treatment was medically necessary and that a lower level of care would not suffice.¹²⁸ Harlick’s insurance company denied coverage claiming that the plan did not cover residential treatment.¹²⁹ Harlick filed suit seeking coverage for her residential treatment.¹³⁰ Harlick’s plan had a categorical exclusion for residential treatment.¹³¹ However, her plan covered sub-acute care in a skilled nursing facility.¹³²

Harlick’s insurance company argued that residential treatment was not required to be covered even if it were medically necessary. The CMHPA lists four categories of potentially medically necessary care: outpatient services, inpatient hospital services, partial hospital services, and prescription drugs.¹³³ Noticeably, residential treatment is not listed. The *Harlick* court determined that this list was illustrative, not exhaustive because of the language “shall include” prior to enumerating the levels of care.¹³⁴

The court ultimately declared that Harlick’s treatment was medically necessary, and Harlick’s insurance plan fell within the scope of the CMHPA.¹³⁵ The court also reasoned those plans within the scope of the act must provide coverage for “all medically necessary treatment” for “severe mental illness” under equal financial terms as physical illness.¹³⁶ The court in *Harlick* elaborated:

Some medically necessary treatments for severe mental illness have no analogue in treatments for physical illnesses. For example, it makes no sense in a case such as Harlick’s to pay for time in a Skilled Nursing Facility—which cannot effectively treat her anorexia nervosa—but not to pay for time in a residential treatment facility that specializes in treating eating disorders.¹³⁷

Harlick and *Rea* exemplify expansive interpretations of mental health parity and courts interpreting the MHPAEA should follow suit. This comprehensive view of the CMHPA more closely achieves the goals of mental health parity.

¹²⁵ *Harlick v. Blue Cross of Cal.*, 686 F.3d 699 (9th Cir. 2012).

¹²⁶ *Id.* at 703.

¹²⁷ *Id.* at 704.

¹²⁸ *Id.* at 703.

¹²⁹ *Id.* at 705.

¹³⁰ *Id.* at 706.

¹³¹ *Id.* at 705.

¹³² *Id.* at 704.

¹³³ CAL. HEALTH & SAFETY CODE § 1374.72(b) (West 2021).

¹³⁴ *Harlick v. Blue Cross of Cal.*, 686 F.3d 699, 705 (9th Cir. 2012).

¹³⁵ *Id.* at 710.

¹³⁶ *Id.* at 719.

¹³⁷ *Id.* at 716.

V. SIMILARITIES OF THE MHPAEA AND THE CMHPA

Despite the severity of anorexia, there has been a plethora of litigation surrounding insurance coverage for residential treatment on both federal and state levels. Both the CMHPA and the MHPAEA have the same goal—to establish parity in treatment of mental illness and physical illness. Ultimately, Congress enacted the MHPAEA to build upon the foundation laid by the MHPA and to eradicate the historical disparity in coverage between mental health and physical health by insurance companies.¹³⁸ The Departments were tasked with outlining implementation through the interim final rules and the final rules.¹³⁹

Courts have read the CMHPA broadly to include residential treatment as medically necessary in appropriate circumstances. These expansive interpretations of the CMHPA allow for vital treatment coverage, whereas a narrow interpretation would exclude certain treatments. However, courts have not read the MHPAEA as broadly. A narrow reading of the MHPAEA excluding residential treatment for anorexia would not achieve parity and would be inconsistent with legislative intent. The MHPAEA should be read in a similar way as the CMHPA to stay consistent with the overall legislative intent of achieving parity.

A. Medical Necessity

Through the guidance of interim final rules and the final rules, it is reasonable to interpret the MHPAEA as requiring medically necessary treatment for all mental illness in line with physical illness. The Departments have issued both the interim final rules and the final rules to assist in the interpretation and implementation of the language of the MHPAEA. As stated above, residential treatment is an effective and medically necessary treatment in severe cases of anorexia. The language of the MHPAEA does not explicitly require all medically necessary treatment for mental health in parity to medical/surgical treatments as in the CMHPA.¹⁴⁰

Through the interpretations in the interim final rules and the final rules, the MHPAEA does require medically necessary treatment for mental health in parity with medical/surgical treatments. However, the interim final rules and the final rules place restrictions on the types of treatment limitations insurance companies may place on mental healthcare. For instance, the interim final rules and the final rules require parity for nonquantitative treatment limitations in medical/surgical benefits and mental health benefits. Nonquantitative treatment limitations are not expressed numerically, but rather limit in terms of scope or duration of benefits.¹⁴¹ Medical necessity is outlined in both the interim final rules and the final rules as a nonquantitative treatment limitation. Thus, a limitation based on medical necessity for mental health must be in parity to medical/surgical limitations. Therefore, although the language of the CMHPA and MHPAEA differ slightly, through the interim final rules and the final rules, both Acts mandate the same form of parity. Thus, relevant courts should interpret the MHPAEA in

¹³⁸ Barry, *supra* note 73, at 1009.

¹³⁹ U.S. DEP'T OF LAB., FACT SHEET: THE MENTAL HEALTH PARITY & ADDICTION EQUITY ACT OF 2008 (MHPAEA) (2010).

¹⁴⁰ 29 U.S.C.A. § 1185(a) (Westlaw through Pub. L. No. 116–259).

¹⁴¹ Interim Final Rules, *supra* note 89, at 5412.

line with how courts have interpreted the CMHPA. Overall, the MHPAEA should be read to require all medically necessary treatment for mental health in parity with medical/surgical benefits.

B. Classification of Treatment

The interim final rules and the final rules of the MHPAEA lay out six classifications of care that require coverage: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drugs.¹⁴² These levels of classification are similar to those of the CMHPA, which are outpatient services, inpatient hospital services, partial hospital services, and prescription drugs. The *Harlick* court ruled that the list in the CMHPA is not exhaustive. Within each classification listed, the MHPAEA declares that health plans are required to implement the same treatment limitations for mental health conditions and medical/surgical conditions.¹⁴³ This means that health plans cannot implement a more stringent standard for mental health conditions than for medical/surgical conditions.¹⁴⁴ However, not all methods of treatment fall neatly into each classification. One treatment method that has sparked significant litigation is residential treatment, an intermediate level of care that does not fall into one of the six categories.

The final rules address the scope of the six classifications. They declare that MHPAEA does not intend to completely exclude intermediate levels of care, such as residential treatment.¹⁴⁵ Under these rules, the MHPAEA does not plan for mental healthcare to receive greater benefits than medical or surgical healthcare.¹⁴⁶ Explicitly stating in the final rules that the MHPAEA did not intentionally exclude intermediate levels of care such as residential treatment implies that the list of six classifications are not exhaustive.¹⁴⁷ Similarly, the four levels of care outlined in the CMHPA are not exhaustive.¹⁴⁸ If the list of six classifications were exhaustive, the legislature would have intended to prohibit intermediate levels of care such as residential treatment explicitly. Therefore, residential treatment can qualify for parity in treatment with physical treatment.

Furthermore, providing residential treatment for eating disorders would not result in those patients receiving greater benefits. These patients would only receive medically necessary treatment, which is ultimately the same standard.¹⁴⁹ As was the case in the courts' reasoning in *Harlick* and *Rea*, there may not be an analogue for anorexia treatment. However, lack of a direct equivalent treatment does not mean those receiving coverage for residential eating disorder treatment will get more significant benefits.

C. Nonquantitative Treatment

Just as in the CMHPA, the MHPAEA does not define medical necessity. However,

¹⁴² Final Rules, *supra* note 69, at 68241 n.4.

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 68246.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ CAL. HEALTH & SAFETY CODE §1374.72(b) (West 2021).

¹⁴⁹ *Id.*

the interim final rules and the final rules outline the intended interpretation of medical necessity through regulations surrounding nonquantitative treatment limitations. Nonquantitative treatment limitations are those that are not expressed numerically but otherwise limited in terms of scope or duration of benefits.¹⁵⁰ First, the interim final rules and the final rules outline the intended implementation of nonquantitative treatment limitations:

(4) Nonquantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.¹⁵¹

The key phrasing is that an insurance plan may not apply a nonquantitative treatment limitation for “mental health or substance use disorder benefits in any classification,” unless the limitations are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.”¹⁵² This means that, typically, an insurance plan may not impose a nonquantitative treatment limitation on mental health benefits in any classification. This phrasing is important because it limits insurance companies’ power to arbitrarily limit mental health coverage. However, an exception to this general rule occurs when an insurance company places nonquantitative treatment limitations on medical/surgical benefits. In this specific scenario, an insurance company can place a nonquantitative treatment limitation on mental health benefits within the same classification as the medical/surgical limitation. Nonquantitative treatment limitations on mental health benefits must be applied in the same manner and no more strictly than the comparable medical/surgical nonquantitative treatment limitations. Thus, parity in application of nonquantitative treatment limitations is the exception to the general rule of no nonquantitative treatment limitations.

The interim final rules list and the final rules sustain medical necessity as the first example of a nonquantitative treatment limitation. Thus, under the MHPAEA, insurance companies cannot make medically necessary limitations for mental illness unless there are equivalent limitations for medical/surgical illness. To elaborate, if someone living with anorexia has a heart attack or stroke, it is obvious that the treatment is medically necessary. The patient may need hospitalization and care at a skilled nursing facility. If a person with anorexia needs medically necessary treatment within the same treatment classification, this treatment must be covered. This means that all medically necessary treatment within the

¹⁵⁰ Interim Final Rules, *supra* note 89, at 5412.

¹⁵¹ *Id.* at 5436.

¹⁵² *Id.*

same classification should be covered for mental illness if it is covered for physical illness. Thus, parity in medically necessary treatment between mental health treatment and medical/surgical treatment is mandated through the interim final rules and the final rules, even though the MHPAEA language does not state this explicitly. Therefore, the MHPAEA and the CMHPA mandate the same type of parity and should be interpreted in the same manner.

VI. INTERPRETATION OF THE MHPAEA

Currently, language of the MHPAEA requiring medical necessity has not been interpreted as expansively as the CMHPA. For instance, in *Kerry v. Anthem Blue Cross Blue Shield*, the plaintiff filed suit because their insurance company denied coverage for residential treatment on a medical necessity basis, even though the plaintiff met medical standards for medically necessary treatment.¹⁵³ In other cases of physical illness, plaintiff alleged the insurance company provided coverage for skilled nursing facilities with no medical necessity basis.¹⁵⁴ In *Kerry*, the defendants motion to dismiss was granted.¹⁵⁵ This decision conflicts with the legislative intent of the MHPAEA. Since the insurance company provided coverage to skilled nursing facilities with no medically necessary restrictions, the insurance company should have provided the same standard for residential treatment of mental illness. Other courts have had similar interpretations of the MHPAEA.¹⁵⁶ For example, in *Michael M. v. Nexsen Pruet Group Medical and Dental Plan*, the plaintiff's insurance company claimed residential treatment for eating disorders was not medically necessary.¹⁵⁷ The plaintiff alleged an improper nonquantitative treatment limitation via medical necessity. The plaintiff's previous treatment facility declared that residential treatment was medically necessary; however, the insurance company decided her treatment was not medically necessary based on their own standards.¹⁵⁸ The court outlined two potential avenues for a MHPAEA violation.¹⁵⁹ The first is a facial challenge of the plan claiming it discriminates against mental health or substance abuse treatments in comparison when compared to medical or surgical benefits.¹⁶⁰ The second is an applied challenge claiming that the same nonquantitative treatment was applied to both medical/surgical benefits and mental health or substance use disorders, but the nonquantitative treatment limitations were not applied in a comparable fashion.¹⁶¹ Unfortunately, both claims were denied by the court.¹⁶²

For the first claim, the parties agree that residential treatment and skilled nursing

¹⁵³ *Kerry W. v. Anthem Blue Cross & Blue Shield*, No. 2:19CV67, 2019 WL 2393802, at *1 (D. Utah June 6, 2019).

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 5.

¹⁵⁶ See *Anne M. v. United Behav. Health*, No. 2:18-CV-808 TS, 2019 WL 1989644 (May 6, 2019); *Smith v. U.S. Off. of Pers. Mgmt.*, 80 F. Supp. 3d 575 (E.D. Pa. 2014).

¹⁵⁷ *Michael M. v. Nexsen Pruet Grp. Med. and Dental Plan*, No. 18-cv-00873, 2021 WL 1026383 at *10 (D.S.C. March 17, 2021).

¹⁵⁸ *Id.* at *3.

¹⁵⁹ *Id.* at *10.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.* at *15.

facilities are comparable institutions.¹⁶³ The nonquantitative treatment limitation is applicable when the insurance company decides if residential treatment is medically necessary. However, the plaintiff claimed that there was a violation of the MHPAEA due to a difference in definition of residential treatment facility and skilled nursing facility.¹⁶⁴ The court determined that the plan criteria was not more stringent for admission for a residential treatment facility than that of a skilled nursing facility.¹⁶⁵ This interpretation fails to incorporate the legislature's intent of providing the same treatment of residential treatment facilities and skilled nursing facilities. Under the plan, a residential treatment facility has to meet six separate qualifications:

1. Maintain permanent and full-time facilities for bed care of resident patients, and
2. Have the services of a Psychiatrist (Addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated; and
3. Have a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7); and
4. Keep a daily medical record for each patient; and
5. Primarily provide a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
6. Operate lawfully as a residential treatment center in the area where it is located.¹⁶⁶

Meanwhile, a skilled nursing facility only needed to be certified and licensed by an appropriate agency.¹⁶⁷ This is an inherently unequal standard. Residential treatment clearly has a more restrictive qualifications as compared to skilled nursing facilities. Although the parties stipulated that residential treatment and skilled nursing facilities are analogous, this difference in standards exemplifies that they are in fact not analogous. If the court wanted to be consistent with legislative intent, it should have found that the nonquantitative treatment limitation of medical necessity on residential treatment was more restrictive than that for medical/surgical benefits at a skilled nursing facility.

In the second claim, the plan denied plaintiff's coverage at a residential treatment center based on medical necessity and a requirement for acute behaviors and symptoms.¹⁶⁸ The insurance company manual lists four criteria to evaluate admission into a skilled nursing facility for medically necessary treatment:

¹⁶³ *Id.* at *11.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at *12.

¹⁶⁶ *Id.* at *11.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at *13.

1. The member has an illness severe enough to require constant or frequent skilled nursing care on a 24-hour basis that cannot be safely, efficiently, or effectively provided in a home environment or outpatient basis; and/or
2. The member is currently receiving inpatient hospital care, inpatient sub-acute care, or home skilled nurse visits exceeding 2 or more visits per day; and/or
3. The admission to a skilled nursing facility will take the place of an admission to or continued stay at a hospital or sub-acute facility; and/or
4. There is an expectation of sufficient improvement in the member's condition within a reasonable period of time that would permit the member to be discharged home.¹⁶⁹

However, between each of the four listed criteria, there is “and/or,” indicating that only one of the four criteria needs to be met to be admitted to a skilled nursing facility for medically necessary treatment.¹⁷⁰ Only the first of the four criteria relate to the severity of symptoms or illness; the other three do not. The fourth provision is a broad catchall option, and a wide variety of conditions could be argued to meet it.¹⁷¹

However, residential treatment has no such standard and is entirely based on acute severity and the need for 24-hour care. The court reasoned that because both standards “require” 24-hour care, there is a comparable application.¹⁷² On the other hand, the phrasing of the skilled nursing facility included “and/or,” meaning that 24-hour care was not a requirement.¹⁷³ Therefore, this was an unequal application. Basing the entire admission of residential on severity of illness and need for acute physical care is an unequal nonquantitative treatment limitation. Instead, the MHPAEA should be read as the CMHPA to recognize that there may not be an analogous treatment for mental and physical health.

VII. SUGGESTIONS FOR THE FUTURE

More research is needed to understand the most effective method to treat anorexia. Right now, the research is exceptionally limited. Studies with varied controls and variables should be conducted at all levels of mental health treatment facilities. Further research should be conducted as to the comparison and efficacy of treatments traditionally used for physical illness when applied to mental illnesses. After all, a broken leg does not need the same treatment as severe anorexia, but both conditions deserve the same quality of treatment.

Given current knowledge and understanding, residential treatment can be medically necessary and effective for severe anorexics. If future studies uncover a better treatment, the same analysis applied to residential treatment in this Note should be applied to new treatments. Additionally, more research should be done to determine whether utilizing BMI

¹⁶⁹ *Id.* at *14.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

as a standard for eating disorder treatment is beneficial. BMI is a dated practice, and likely does not measure the “severity” of an eating disorder accurately. However, not everyone who requires eating disorder treatment has the same low BMI. Just because someone is within the “normal” BMI range does not mean they are physically or mentally healthy.

In order to abide by the legislative intentions of parity, medical necessity in the MHPAEA should be read broadly to include residential treatment for severe anorexics. Residential anorexia treatment is medically necessary and should be determined by the patient’s practitioner, despite an insurance plan’s classification. Anorexia has several fatal consequences and should be analyzed under the same medical necessity standard as physical illnesses.

In 2020, California amended the CMHPA to be even broader. The *Harlick* and *Rea* courts both ruled that residential treatment must be covered under the CMHPA prior to the 2020 amendment.¹⁷⁴ However, after these seminal cases, insurance companies in California continued to argue that the original CMHPA does not require medically necessary residential treatment for mental health disorders.¹⁷⁵ The 2020 amendment to the CMHPA eliminates this argument by clarifying that insurers must cover all intermediate levels of care, including residential treatment for mental health disorders.¹⁷⁶ The relevant language of the 2020 amendment is as follows:

The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following . . . (2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.¹⁷⁷

This is a step in the right direction. Statutory interpretation in line with what is written in this Note would be sufficient. Overall, in an ideal world, Congress would amend the MHPAEA to explicitly require treatment for all mental illnesses. Although, this is probably an unrealistic goal at the present time, as it is very difficult to get Congress to amend statutes. A more reasonable suggestion would be for Congress to amend the MHPAEA to overtly define what medical necessity means.

CONCLUSION

Annually, eating disorders cost the United States economy an average of 64.7 billion dollars.¹⁷⁸ 48.6 billion dollars of this amount was due to lost productivity (reduced productivity at work, loss of earnings due to mortality, and reduced workforce participation).¹⁷⁹ This amount could be significantly reduced if patients received proper treatment the first time, resulting in a reduction of subsequent costly treatments. In 2018–

¹⁷⁴ Elizabeth Hopkins, *Kantor & Kantor, LLP Helps Make the California Mental Health Parity Act the Most Protective in the Nation*, CAL. INS. LAW. BLOG (Oct. 2, 2020), <https://www.californiainsurancelawyerblog.com/kantor-kantor-llp-helps-make-the-california-mental-parity-act-the-most-protective-mental-health-parity-law-in-the-nation/>.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ CAL. HEALTH & SAFETY CODE § 1374.72 (West 2021).

¹⁷⁸ DELOITTE ACCESS ECON., *supra* note 33.

¹⁷⁹ *Id.*

2019, the estimated annual cost because of lost productivity from deaths associated with eating disorders was \$8.8 billion.

Courts have embraced the underlying notion of parity and have interpreted the CMHPA broadly to expand coverage for mental healthcare. The language of the CMHPA and the MHPAEA differ slightly in terms of their explicit language. Although, through the interim final rules and the final rules, the MHPAEA ultimately mandates the same type of parity as the CMHPA; parity between medically necessary mental health treatment and medical/surgical treatment. Thus, the CMHPA and the MHPAEA should be interpreted the same as they aim to achieve the same goal. All mental illnesses should be treated the same as physical illnesses, but given the severity of anorexia, equal treatment is essential. In order to meet the legislature's intent of parity between mental health treatment and medical/surgical treatment, the MHPAEA should be read broadly to include residential treatment as medically necessary in severe cases of anorexia.