

HOLDING INSURANCE COMPANIES ACCOUNTABLE

With only thirteen lawyers and a staff of twelve, Kantor & Kantor is proud to be the largest law firm in the country focusing its practicing on representing individuals whose employer provided health, disability and life benefits have been improperly denied. Since opening our doors in 2004, we have helped over one thousand people recover the benefits to which they are entitled.

This is no easy task. ERISA, which stands for the Employee Retirement Income Security Act of 1974, governs all benefits which an employee gets as a result of employment, such as health insurance. While intended to protect employees, this Act has been interpreted by the courts so as to largely protect insurance companies and has become a morass of confusing regulations and laws which has led one federal court judge to rename it “Everything Ridiculous Invented Since Adam.”

Most importantly, ERISA limits the remedies available to individuals when an insurance company violates its obligations under an insurance policy. This means that the worst that can happen when an insurance company improperly denies a claim is that . . . maybe a year or two later . . . a judge will order that insurance company to pay the benefits it would have had to pay anyway . . . and maybe some fees to the attorney. Insurance companies know this, so when they are deciding whether to pay claims, they can deny valid claims with impunity,

knowing that the likely result is that the patient will just give up, and the worse that happens is that the insurance company will have to pay these claims later, assuming the patient finds a lawyer willing to handle their ERISA lawsuit. Nothing in ERISA makes insurance companies care about the patients whose claims they are considering.

This reality has had a particularly dramatic impact on eating disorder patients, which inspired me several years ago to focus my practice on this population. Let me give you some examples. One of my first cases involved a young woman who started college and came home to tell her parents that she was anorexic. She had coverage through an HMO. The HMO would not allow her to see a medical doctor, as she had already had her yearly physical before she left for school. She finally got an appointment with a psychiatrist, who knew nothing about eating disorders but was happy to prescribe medication, and a psychotherapist, who admitted that the HMO had no eating disorder treatment available but was working on setting up a program. The HMO offered her a once a week drop in group therapy program, but she was the only one who “dropped in.” The woman’s weight was rapidly declining and her mental health was spiraling downward. Her parents took out a second mortgage on their home and paid for treatment at a residential treatment center. Thirty days later she was discharged.

She enrolled in community college, got a part time job, and became involved in her local church.

Her insurance company refused to cover this life saving treatment which allowed this woman to recover and go back to college. I filed an ERISA action in federal court and lost at trial. We filed an appeal with the Ninth Circuit. Nearly five years after she discharged, we won. The Ninth Circuit was appalled that the HMO nearly let this young woman die and offered her only a once a week non-existent group therapy session. We recovered the full cost of the treatment plus interest and attorneys fees.

Let me also tell you about Kim. Kim has had an eating disorder since she was a teenager. She managed, however, to get through nursing school, get married, and have a child. After she miscarried her second child, she relapsed, blaming herself for the miscarriage. She was running 80 miles a week. She ate about 500 calories a day. She weighed 76 pounds. She was in day treatment, but it wasn't working. Her psychiatrist and husband finally convinced her that she needed residential treatment. But as she was packing to leave, her insurance company called, and told her she was not "sick enough" for residential treatment. Somehow, the family scraped together money to send her anyway, borrowing from retirement plans and savings accounts, but as that money was running out, they called me. We submitted a request for independent medical review to the

California Department of Insurance. Unfortunately, the decision ordering the insurance company to pay came the day the money ran out and Kim was on a flight home. There was no convincing her to return. She tried to kill herself three times within the next four months. She now describes herself as a “STEM” – not worth the space, time, effort or money.

And finally, there is Sofia. Sofia was been kicked out of treatment because her health insurance company stopped paying so many times before that she did her own fundraising campaign before she started residential treatment again. Once again, insurance denied before she was ready to discharge. The California Department of Management Health Care ordered the insurance company to pay. That was nearly thirty days ago. They haven't paid yet.

People who have insurance should not have to raise or borrow money to pay for their care, and then worry about their insurance company improperly denying coverage. So, I spend my days helping individuals try to get their insurance companies to honor their legal and contractual obligations. You can imagine how frustrating it is for mentally ill patients and their families, at a time when they are most vulnerable, to discover that the insurance company to whom they have paid premiums for years is refusing to cover the life saving treatment they need or their loved one needs. Even the process of trying to access care is confusing, burdensome, and often humiliating. If you have ever received an Explanation of

Benefits from your insurance company, you might begin to get an idea of what I am talking about. If you really want to start to understand the problem, go home tonight and try to find your health insurance policy and, if you can find it, try to read and understand it. I have been doing this for many years, and I still have to read policies over and over again before I begin to understand them.

But insurance companies understand what their policies say. They understand what claims they are obligated to pay. So why, you may ask, are eating disorder patients having such a hard time getting access to treatment? Why are insurance companies denying coverage for legitimate claims?

The answer is simple: because they can. Because no one is holding them accountable. They are not required to understand eating disorders, they are not required to apply medically accepted criteria in determining whether to cover treatment and they are not required to apply universally accepted criteria so as to provide access to the appropriate level of treatment. The FREED Act will help change this.

The stories I hear every day are similar. A patient is in residential treatment because her doctor, her therapist, her dietician – all of whom specialize in treating eating disorders – believe that it is medically necessary to treat her at that level of care. Perhaps she is restricting so much that her health is at risk. It takes her two

hours to finish lunch, but with the care and guidance of the clinical team, she eats enough calories to satisfy them. She is still trying to water load before weigh-ins, must be watched when she uses the bathroom to make sure she does not purge, and has to sleep with her door open to make she does not get up in the middle of the night to exercise. She is on wheelchair restriction some of the time because she is trying to constantly move to burn the normal amount of calories her treatment team is requiring her to eat. With the team's expertise and guidance, she is slowly gaining some weight and, because she is no longer as malnourished, is beginning to be able to deal with the severe psychological and psychiatric issues which underlie her disease. Her family begins to see a glimpse of the person she once was, and she begins to feel like maybe there is hope, maybe she has worth, maybe she can create a life without her eating disorder

But a mere two weeks into treatment, her insurance company decides that the treatment is no longer medically necessary. How does this happen? Insurance companies refuse to recognize that effective treatment of an eating disorder takes time. Instead of allowing medical professionals to make medical decisions about treatment, the insurance companies require the providers to repeatedly call to get authorization to treat her for more days, often two, or three or four days at a time. Thus, instead of spending time treating patients, providers are on the phone with insurance companies.

The providers, of course, are intimately familiar with the patient. They are able to give the insurance company detailed information about the specific patient, the course of her disease and treatment, the reasons why continued treatment is medically necessary, and the medical and psychological challenges she faces. This is done over the phone, sometimes to a lay person, who takes notes and gives those notes to a doctor, or sometimes directly to a doctor. These calls typically last between ten and thirty minutes.

In that short period of time, the insurance company representative – without ever having met the patient or looked at her medical records – makes a life and death decision, denying coverage for treatment. After all, they say, she is eating, right? She has gained weight, she is no longer restricting, or purging. She says she is feeling better. She is improving. Certainly she can continue her treatment on an outpatient basis. The insurance company ignores the fact, of course, that she is only eating because her treatment team sits with her, offering therapy through her tears and her anxiety, so that she is able to eat. She is only no longer purging because she is supervised twenty-four hours a days. She is feeling better because for the first time is God knows how long she is not malnourished. She cannot do this on her own.

Moreover, in reaching their hasty conclusion, each insurance company creates and applies its own guidelines which it says defines when each level of care

is medically necessary. Some insurers have strict weight requirements. Some require patients to “fail” at lower levels of care before they are allowed to access higher levels of care. Some insurers will not cover eating disorder patients who they deem to be “chronic.” Could you imagine if we treated our physically ill this way? Would we allow an insurer to tell a diabetic who could not lose weight or comply with a certain meal plan that we would not pay for her insulin because she has allowed herself to become “chronic”? Would we ever tell a patient who had a heart attack and suddenly needed bypass surgery that she needed to try medication first?

The FREED Act will put an end to these practices, by requiring each insurer to follow the universally accepted criteria as set forth in the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Eating Disorders. This provision will make it much easier for providers to get claims paid and for insureds to convince the courts that their claims should have been paid.

Another problem is that insurance companies also often consult with doctors who are completely uninformed about eating disorders and their treatment. I have had an insurance company doctor tell me in a deposition that eating disorders do not exist unless the patient’s jaw is broken. I have seen notes from insurance company doctors who seem to believe that failure to eat is a choice rather than a disease. I have read insurance company notes claiming that the family of an eating

disorder patient will “just have to deal” with the patient’s behavior at home because she has had “too much” treatment. And I have seen countless denial letters from insurance companies which contend that the patient was not “motivated” to recover and therefore was not entitled to benefits. And then, to add insult to injury, insurers end all of their letters by saying that they are not making decisions about treatment, only about coverage. Who are they kidding? Who of us can afford health care treatment without accessing our insurance benefits?

The research initiatives, establishment of the Research Consortiums that will provide training and fund research, as well as the training of all health professionals contemplated by the FREED Act will be instrumental in reversing this trend in the conduct of insurance companies. These provisions will assure that all health professionals are better educated about eating disorders, so that these types of uninformed, unscientific denials of access to care do not continue. I applaud the drafters for the inclusion of these provisions.

In closing, I want to thank you for this opportunity to speak to you today. And let me leave you with a thought I paraphrased from Warren Buffet. "Let's say that it was 24 hours before you were born, and a genie appeared and said, 'What I'm going to do is let you set the rules of the society into which you will be born. You can set the economic rules and the social rules, and whatever rules you set will apply during your lifetime and your children's lifetimes.' And you'll say, 'Well,

that's nice, but what's the catch?' And the genie says, 'Here's the catch. You don't know if you're going to be born rich or poor, white or black, male or female, able-bodied or infirm, mentally well or mentally ill.” Or as Mahatma Ghandi said, "A nation's greatness is measured by how it treats its weakest members."

It is time to hold insurance companies accountable. Instead of them setting their erroneous rules that prioritize money over lives – we need to set the rules and put the value of human life at the top of the list. Congress can do that by passing the FREED Act. We urge your support.