Resolution 26-310

Modernizing Medical Necessity Criteria for Eating Disorder Treatment and Reimbursement

FMA Medical Student Section

Whereas, Eating disorders have the second-highest mortality rate of any mental illness, with an estimated 10,200 deaths annually in the United States;[1] and

Whereas, Fewer than 6% of individuals with eating disorders are medically classified as "underweight," yet current insurance reimbursement models frequently utilize Body Mass Index (BMI) as a primary gatekeeper for intensive levels of care (Residential, Partial Hospitalization, and Intensive Outpatient);[2-4] and

Whereas, The divide between inpatient medical care and mental health care can be a source of confusion with regards to coverage for treatment of eating disorders;[5] and

Whereas, Only 25% of eating disorder treatment centers accepted Medicaid across 45 states and the District of Columbia;[6] and

Whereas, Weight history was independently associated with markers of malnutrition in hospitalized patients with restrictive eating disorders;[2,7] and

Whereas, Individuals with "Atypical Anorexia Nervosa," defined as those who meet all clinical criteria for Anorexia Nervosa but remain within or above a "normal" BMI of 18.5 to 24.9, exhibit the same physiological instabilities as those with low BMI, including bradycardia, hypotension, electrolyte derangements, and suicidal ideation;[7-9] and

Whereas, A study of young adults found that eating disorder diagnoses are delayed by an average of nine months for patients who were previously classified as "overweight" or "obese" compared to those who were never in those weight categories, often because rapid weight loss was initially praised by providers;[10] and

Whereas, Significant and rapid weight loss in individuals of any starting BMI is a primary driver of medical complications, including bone density loss, cardiac arrhythmias, and severe malnutrition, yet these patients are routinely denied insurance coverage for higher levels of care because they have not yet reached an "underweight" BMI;[11] and

Whereas, The Academy for Eating Disorders (AED) clinical guidelines state that body weight is not a reliable proxy for medical stability, yet current insurance practices that mandate a "low BMI" for coverage create an unequal barrier to care compared to medical/surgical treatments;[12] and

Whereas, Over-reliance on BMI as a measure of health facilitates weight stigma in clinical settings, leading up to 74% of patients in larger bodies to report bias from their physicians, which correlates with healthcare avoidance and worse clinical outcomes;[13] therefore, be it

RESOLVED, That the Florida Medical Association (FMA) supports the use of comprehensive clinical indicators, including rate of weight loss, vital sign stability, metabolic status, and other evidence-based measures, rather than body mass index (BMI) alone, when determining medical necessity for

eating disorder treatment by public and private insurers, while recognizing that treatment decisions should ultimately be guided by the treating physician's clinical judgment and individualized assessment of the patient; and be it further

RESOLVED, That the Florida Medical Association (FMA) encourage the incorporation of education regarding malnutrition, eating disorders across the weight spectrum, and the effects of weight stigma into physician training programs.

Fiscal Note:

Description	Amount	Budget Narrative
100 Staff hours	$20,000	Can be accomplished with current staff
Total	$20,000	$0 added to the operating budget

Fiscal notes are an estimate of the cost to implement a given Resolution. All Resolutions that are adopted by the House of Delegates will be referred to the FMA Committee on Finance and Appropriations for fiscal consideration.

Reference Committee: III – Legislation and Miscellaneous

References:

1. National Association of Anorexia Nervosa and Associated Disorders. Eating disorder statistics. ANAD. Accessed May 22, 2024. https://anad.org/learning-library/eating-disorder-statistic/
2. Garber AK, Cheng J, Accurso EC, et al. Weight Loss and Illness Severity in Adolescents With Atypical Anorexia Nervosa. Pediatrics. 2019;144(6):e20192339. doi:10.1542/peds.2019-2339
3. Brennan C, Illingworth S, Cini E, Bhakta D. Medical instability in typical and atypical adolescent anorexia nervosa: a systematic review and meta-analysis. J Eat Disord. 2023;11(1):58. Published 2023 Apr 6. doi:10.1186/s40337-023-00779-y
4. National Alliance for Eating Disorders. Insurance and paying for treatment. Accessed May 22, 2024. https://www.allianceforeatingdisorders.com/insurance-and-paying-for-treatment/
5. Accurso EC, Buckelew SM, Snowden LR. Youth Insured By Medicaid With Restrictive Eating Disorders-Underrecognized and Underresourced. JAMA Pediatr. 2021;175(10):999-1000. doi:10.1001/jamapediatrics.2021.2081
6. Welch R, Rao T, Karakus M, Scott E, Doreson A, Ghose SS. State-Level Analysis of Access to Intensive Eating Disorder Care for Medicaid Beneficiaries. Psychiatr Serv. 2026;77(3):209-216. doi:10.1176/appi.ps.20250233

7. Whitelaw M, Lee KJ, Gilbertson H, Sawyer SM. Predictors of Complications in Anorexia Nervosa and Atypical Anorexia Nervosa: Degree of Underweight or Extent and Recency of Weight Loss?. J Adolesc Health. 2018;63(6):717-723. doi:10.1016/j.jadohealth.2018.08.019
8. Hornberger LL, Lane MA; COMMITTEE ON ADOLESCENCE. Identification and Management of Eating Disorders in Children and Adolescents. Pediatrics. 2021;147(1):e2020040279. doi:10.1542/peds.2020-040279
9. Attia E, Walsh BT. Eating Disorders: A Review. JAMA. 2025;333(14):1242–1252. doi:10.1001/jama.2025.0132
10. AMA J Ethics. 2023;25(7):E540-544. doi: 10.1001/amajethics.2023.540.
11. Vo M, Golden N. Medical complications and management of atypical anorexia nervosa. J Eat Disord. 2022;10(1):196. Published 2022 Dec 16. doi:10.1186/s40337-022-00720-9
12. Academy for Eating Disorders. About eating disorders. Accessed April 30, 2026. https://www.aedweb.org/resources/about-eating-disorders
13. Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. Obes Rev. 2015;16(4):319-326. doi:10.1111/obr.12266

Relevant FMA Policies:

P 300.009 INCREASE IN MEDICAID REIMBURSEMENT RATES

The Florida Medical Association supports an increase in Medicaid reimbursement rates to meet at least the Medicare reimbursement levels for all physicians; and further will work with state government to make Medicaid a viable program and to pay physicians in a timely fashion. (BOG July 2000) (Reaffirmed HOD 2009) (Reaffirmed HOD 2017) (Reaffirmed Motion 06-19-14, BOG October 2019) (Reaffirmed HOD 2025)

P 300.010 PEDIATRIC MEDICAID PRESCRIBING

The Florida Medical Association supports exploring the Florida Pediatric Society's legislative proposal to restructure the Florida Medicaid Pharmaceutical and Therapeutics Committee so that pediatric Medicaid prescribing issues can be addressed in an appropriate manner. (BOG October 2005) (Reaffirmed HOD 2013) (Reaffirmed HOD 2023)

P 380.009 MENTAL HEALTH CARE IN THE PRIMARY CARE SETTING

The Florida Medical Association seeks legislation requiring parity coverage and reimbursement for treatment of mental illnesses, thereby allowing all physicians and their patients to approach these illnesses as they would any other medical problem. (Res 00-6, HOD 2000) (Reaffirmed Res 03-3, H

Relevant AMA Policies:

Eating Disorders H-150.965

Our American Medical Association adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as obesity.

Our AMA asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them.

Our AMA encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy abnormal eating behaviors, dieting, and weight restrictive behaviors in children and adolescents and to offer education and appropriate referral of adolescents and their families for evidence-based and culturally-informed interventional counseling.

Our AMA participates in this effort by consulting with appropriate, culturally-informed educational and counseling materials pertaining to unhealthy abnormal eating behaviors, dieting, and weight restrictive behaviors.