

**America's Health
Insurance Plans**

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September 12, 2017

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, D.C. 20710

Centers for Medicare & Medicaid Services
Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Internal Revenue Service
U.S. Department of Treasury
1500 Pennsylvania Ave., NW
Washington, D.C. 20220

Re: FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38; Treatment for Eating Disorders, Including Request for Comments

Submitted electronically via e-ohpsca-mhpaea-eating-disorders@dol.gov

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is writing on behalf of our members in response to the request for comments from the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) regarding the recently issued FAQ on Treatment for Eating Disorders. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

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We appreciate the continuing federal efforts to provide guidance on implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Our members have worked diligently to ensure compliance with parity requirements – involving clinical and administrative personnel across both medical and behavioral departments to promote understanding and implementation of parity rules. Beyond parity, our members have been leaders in pioneering innovative programs focused on ensuring that patients have affordable access to quality, evidence-based treatments, emphasizing proactive identification and outreach as well as coordination and integration of services.

In addition, health plans have been strong proponents of transparency and are committed to making information available to consumers that is useful in helping them understand their benefits and make informed decisions regarding their care. The Departments have issued FAQ guidance pertaining to disclosure obligations under the MHPAEA for medical necessity determinations with respect to MH/SUD benefits. Health plans have been meeting those obligations under MHPAEA for the past several years and will continue to provide the necessary disclosures to members and clinicians when there are requests or appeals.

We welcome the opportunity to provide comments on the recently issued FAQ regarding parity's application to eating disorders.

Section 3007 of the Cures Act requires that if a group health plan or a health insurance issuer provides coverage for eating disorder benefits, the group health plan or issuer must provide the benefits consistent with the requirements of MHPAEA. The recently issued FAQ reiterates this requirement, making clear that eating disorders are mental health conditions and MHPAEA applies to any benefits a plan or issuer may offer for treatment of an eating disorder.

We appreciate the Departments' ongoing efforts to make guidance available on implementation of MHPAEA and encourage the Departments to take steps to consolidate and streamline all MHPAEA guidance into a single source so health plans can ensure they are complying with the agencies' interpretations of all the statutes and regulations. Currently, health plans must search through a myriad of documents, including multiple FAQs, scattered across multiple agency websites, resulting in increased burden and inefficiency.

With respect to the treatment of eating disorders, health plans are committed to providing members with access to quality, evidence-based and affordable treatments and that parity is appropriately applied. Multiple challenges persist in identifying and treating these very serious and complex conditions that should be taken into consideration regarding how the MHPAEA requirements apply to eating disorders.

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Based on generally recognized independent standards of current medical practice, excessively rigid parity implementation will create impediments to seamless care for people suffering from conditions that are treated in multiple settings by a variety of specialists, including practitioners with qualifications outside of the MH/SUD field. At a minimum, improved attention to the complexity described below will facilitate understanding by affected individuals, their families and regulators of the importance of seamless care.

Challenges include the following:

- Eating disorders can be difficult to diagnose, as there are many factors contributing simultaneously. According to the American Academy of Child and Adolescent Psychiatry (AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders: [http://www.jaacap.com/article/S0890-8567\(15\)00070-2/pdf](http://www.jaacap.com/article/S0890-8567(15)00070-2/pdf)), appropriate evaluation of a possible eating disorder in children and adolescents includes consideration of a host of conditions (note that there is variation in the differential diagnosis depending on the specific eating disorder type) outside of the MH/SUD domain. If defined too broadly, eating disorders could encompass conditions not included in the DSM-5 or ICD-10 as eating disorder diagnoses.
- Eating disorders are associated with complications that are outside of the MH/SUD domain. Therefore, physicians will often test potassium levels, BMI, blood counts, and serum magnesium. Testing can also include urinalysis, a thyroid scan ECG, immune function testing, bone density testing, and checking estradiol levels (or testosterone levels in men). These tests are all medical/surgical tests, not behavioral health tests. Values outside of the expected range will often be addressed by specialists outside of the MH/SUD field, thus requiring coordination between medical specialists regardless of specialty. Monitoring notable laboratory findings will also require coordination. Further regulation can create barriers to seamless coordination of patient care.
- Co-occurring non-MH/SUD conditions, a wide range of diagnoses, and limited evidence to support a single treatment approach add to the challenges of treatment. For example, physical and laboratory findings (see above) can reveal life-threatening non-MH/SUD complications or co-occurring conditions that necessitate assessment and treatment outside of MH/SUD in facilities such as intensive care units, medical-surgical beds. Physical rehabilitation may be required in inpatient and Skilled Nursing Facility (SNF) settings. Treatment could involve procedures such as placement of a feeding tube in some instances, a medical procedure that is

not unique to eating disorders. Additionally, there are a wide range of diagnoses, and the severity can and should determine treatment pathways. Lastly, the evidence base for effective treatments for eating disorders is less developed in some cases than for medical/surgical care. The National Institute of Mental Health, for example, has noted that specific treatments for chronic eating disorders “have not yet been identified.” Overall, eating disorders require a comprehensive care team, including physicians, mental health services, nutritional therapy, and a variety of specialists, and coordination across these providers and potentially different care settings can prove challenging.

- A quality measurement infrastructure that is less developed than that for medical/surgical care, and the resulting lack of readily available information on the quality of behavioral health clinicians and facilities, means effective treatments can be difficult to identify. Accordingly, health plans should have the flexibility to choose the types of providers and programs they include in their MH/SUD benefits.
 - For example, while residential treatment centers are often utilized for MH/SUD conditions, including eating disorders, there is a great deal of ambiguity and wide variation in the quality and regulatory oversight within the current landscape of residential treatment centers. As a result, loose definitions (e.g., residential facilities may include wilderness therapy programs, ranches, and boot camps, etc.), an undefined scope of service, and often very long duration treatment options that can isolate the patient from family support and involvement in treatment plans, create challenges for improved outcomes, continuity and coordination of care, and patient satisfaction.¹
 - The lack of widespread adoption of certification/accreditation standards for behavioral health facilities (for examples, see The Joint Commission: https://www.jointcommission.org/assets/1/6/Approved_New_Req_Residential_Outpatient_Eating_Disorder.pdf) adds to the difficulty in identifying effective facilities.

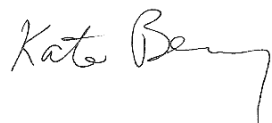
Health plans will continue to pioneer innovative MH/SUD programs, advance transparency of information regarding MH/SUD benefits, and promote parity across medical/surgical and MH/SUD benefits.

¹ Marketing Residential Treatment Programs for Eating Disorders: A Call for Transparency 67:6, March 2016.

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We look forward to working with the Departments on these efforts and appreciate your consideration of our comments. Please be in touch with questions.

Sincerely,

A handwritten signature in cursive script that reads "Kate Berry". The signature is written in black ink and is positioned to the left of the typed name and title.

Kate Berry
Senior Vice President