

September 13, 2017

The Honorable Amy Turner
Director, Office of Health Plan Standards and Compliance Assistance [OHPSCA]
Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

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Eating Disorder Coalition of Iowa (EDCI)
The Eating Disorder Foundation
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Dietitians (IFEDD)
Manna Scholarship Fund
McCallum Place Eating Disorder Centers
Moonshadow's Spirit
The National Association of Anorexia
Nervosa and Associated Eating Disorders
Strategic Training Initiative for the Prevention of
Eating Disorders (STRIPED)
Theravive
Wrobel & Smith, PLLP
WVU Disordered Eating Center of Charleston

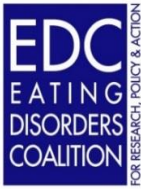
RE: Eating Disorders Coalition-- June 16, 2017 FAQs About MH/SUD Parity Implementation and the 21st Century Cures Act- Eating Disorders and Disclosure Comments

Dear Director Turner,

On behalf of the members of the Eating Disorders Coalition (EDC), we are writing to applaud the President and the corresponding agencies including the Department of Health and Human Services, Department of Labor and Department of Treasury, for providing [FAQs](#) for eating disorder parity and offering the opportunity to provide public comments on mental health parity for eating disorders and disclosure.

The Eating Disorders Coalition is an alliance of eating disorders treatment providers, advocacy organizations, researchers, and families and individuals affected by eating disorders across the nation. Members include trade organizations, law firms specializing in mental health parity compliance, and national patient advocacy organizations. Members include the National Eating Disorders Association (national, based in NY), Residential Eating Disorders Consortium (national), Academy for Eating Disorders (national, based in VA), the Alliance for Eating Disorders Awareness (located in FL), Kantor & Kantor, LLP (located in CA), Wrobel & Smith, PLLP (located in MN), Gail R. Schoenbach FREED Foundation (located in NJ), Binge Eating Disorder Association (national, based in MD), The International Association of Eating Disorders Professionals Foundation (international), International Eating Disorder Action (international), Multi-Service Eating Disorders Association (located in MA), the Eating Disorders Coalition of Iowa (located in IA), Eating Disorders Foundation (located in CO), Eating Disorder FEAST (international, based in WI), International Federation of Eating Disorders Dietitians (international), The National Association of Anorexia and Associated Eating Disorders (national, based in IL), and Harvard University's public health incubator- Strategic Training Initiative for the Prevention of Eating Disorders (located in MA).

Membership also includes eating disorders treatment centers that offer a vast array of treatment levels such as inpatient, residential treatment, partial hospitalization programs, day programs, intensive outpatient programs, and outpatient programs. These treatment center members include: Clementine (located in FL, NY, and OR), Eating Recovery Center (located in CA, CO, IL, OH, SC, TX, and WA), The Emily Program (located in MN, OH, PA, and WA), Monte Nido (located in CA, MA, NY, OR, and PA), Oliver-Pyatt Centers (located in FL), Veritas Collaborative (located in GA, NC, and VA), The Renfrew Center (located in CA, CT, FL, GA, IL, MA, MD, NC, NJ, NY, PA, TN, and TX), Reasons Eating Disorder Center (located in CA), Remuda Ranch (located in AZ), Center for Change (located in UT), Laureate Eating Disorders Program (located in OK), Timberline Knolls (located in IL), Cambridge



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Eating Disorder Center (located in MA and NH), Castlewood Treatment Center (located in AL, CA, and MO), Center for Discovery (located in CA, CT, FL, GA, IL, NJ, NY, OR, TX, VA, and WA), Eating Disorder Center of Denver (located in CO), Mirasol Eating Disorder Recovery Centers (located in AZ), Park Nicollet Melrose Center (located in MN), Rosewood Centers for Eating Disorders (located in AZ), Walden Behavioral Care (located in CT, GA, and MA), Aloria Health (located in WI), Casa Palmera (located in CA), Eating Disorder Therapy LA (located in CA), The Eating Disorders Center at Rogers Memorial Hospital (located in WI), La Ventana Treatment Programs (located in CA), McCallum Place Eating Disorder Centers (located in MO and KS), and West Virginia University's Disordered Eating Center of Charleston (located in WV).

To end discrimination against individuals and families who seek services for the mental illness of eating disorders, we have advocated for the last two decades in support of parity legislation and the enforcement of corresponding regulations. We are committed to helping this Administration effectively implement and enforce the Mental Health Parity and Addiction Equity Act (MHPAEA), and we submit the below comments and recommendations as outlined in the June 16, 2017 "FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38" and corresponding solicitation for comments.

DISCLOSURE AND TREATMENT FOR EATING DISORDERS, INCLUDING REQUEST FOR COMMENTS

Eating disorders affect over 30 million Americans during their lifetime¹, including people of all ages, races, sizes, sexual orientations, ethnicities, and socioeconomic statuses.² In particular, studies show that eating disorders have a higher prevalence with our military servicemembers and veterans.³ These disorders have the highest mortality rate of any psychiatric illness, and are a serious mental illness.⁴

Eating disorders are complex, biologically-based illnesses including the specific disorders of anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorders (OSFED).⁵ Eating disorders can be successfully treated with interventions at the appropriate durations and levels-of-care, however, only one-third of those with eating disorders receive any medical, psychiatric, and/or therapeutic care.⁶ According to the *American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Eating Disorders*, the best practice for treating eating disorders includes patients, their families, and a comprehensive team of professionals such as social workers, mental health counselors, primary care practitioners, psychiatrists, psychologists, dietitians, art therapists, and other specialty providers.⁷ Successful treatment of eating disorders

¹ Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61(3), 348-358.

² Le Grange, D., Swanson, S. A., Crow, S. J., & Merikangas, K. R. (2012). Eating disorder not otherwise specified presentation in the US population. *International Journal of Eating Disorders*, 45(5), 711-718.

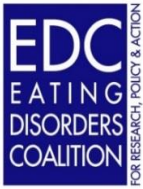
³ Bodell, L. P., Forney, K. J., Keel, P. K., Gutierrez, P. M., & Joiner, T. E., Jr. (2014). Consequences of making weight: a review of eating disorder symptoms and diagnoses in the United States military. *Clinical Psychology: Science and Practice*, 21(4), 398-409.

⁴ Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724-731.

⁵ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C.: American Psychiatric Association.

⁶ American Psychiatric Association. (2006). *Practice guideline for the treatment of patients with eating disorders (3rd ed)*. Washington, DC: American Psychiatric Association.

⁷ American Psychiatric Association. (2006). *Practice guideline for the treatment of patients with eating disorders (3rd ed)*. Washington, DC: American Psychiatric Association.



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may include treatment at all evidence-based levels of care including inpatient, residential treatment⁸, partial hospitalization, day program, intensive outpatient program, and outpatient treatment.⁹

Given the seriousness of eating disorders, we want to first take this opportunity to applaud your efforts in beginning to implement Section 13007 of the 21st Century Cures Act, requiring mental health parity for eating disorders benefits.

As the White House Parity Task Force report noted in its October 31, 2016 report, there is a general lack of awareness of the need for mental health and substance use disorder services, particularly for eating disorders.¹⁰ One listening session highlighted insurance regulators from three states with rural populations, noting the cultural belief that these disorders were not true medical issues, leading to automatic denial of many insurance claims. We regularly see this for eating disorders, with some insurers placing eating disorders under excluded categories related to weight loss, instead of the mental illness as they are designated in the DSM 5.

With this acknowledgement, we submit for your consideration the following comments and recommendations to strengthen enforcement of mental health parity for people affected by eating disorders.

1. Sub-types of Eating Disorders Coverage

Issue: Despite eating disorders being defined as a mental health condition, specific eating disorders are still being denied coverage while others are not. For example, binge eating disorder—a newly added DSM 5 eating disorder that affects over 3% of the population, avoidant restrictive food intake disorder, and other specified feeding and eating disorder, are often not included in coverage of the disorder, while other eating disorders such as anorexia are included. In discussions with insurance providers, plans will often categorize binge eating disorder treatment, being more common in higher weight individuals, as a “weight loss” treatment and in turn will not cover this sub-type of eating disorders treatment. Mis-categorizing a severe mental illness against industry standards of care is dangerous and leads to increased risk of medical complications and death. Furthermore, this practice represents current stigma and discrimination within some insurance policies, as you would not see the same type of calculated exclusion on the medical surgical side.

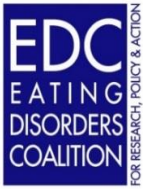
Recommendation: Current mental health parity regulations are unclear on whether an insurance provider can cover a type of mental illness (i.e. eating disorders), but exclude a sub-type of mental illness (i.e. binge eating disorder). In turn, we recommend that you either define eating disorders to include the various types of eating disorders recognized by current medical practice including anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, or Other Specified Feeding or Eating Disorder (OSFED), or cross reference independent standards of current medical practice used within the mental health community such as the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* or the *International Statistical Classification of Diseases and Related Health Programs (ICD-10)*.¹¹

⁸ Brewerton, T. D. & Costin, C. (2011). Treatment results of anorexia nervosa and bulimia nervosa in a residential treatment program. *Eating Disorders*, 19(2), 117-131.

⁹ Koman, S. (n.d). A "continuum of care" approach to eating disorders. *Walden Behavioral Care*. Retrieved from: <http://www.waldenbehavioralcare.com/pdfs/ContinuumOfCare.pdf>.

¹⁰ <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf>

¹¹ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C.: American Psychiatric Association.



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2. Exclusions of Eating Disorders and related Intermediate Level of Services for Eating Disorders, Including Residential Treatment

Coverage of Intermediate Level of Services for Eating Disorders: There is much confusion from both insurers and the courts about how to interpret and apply MHPAEA as it relates to the intermediate level services, including exclusions of residential treatment for eating disorders. Intermediate levels of care have been proven to be evidence-based and effective for treating individuals affected by eating disorders, including day programs¹², intensive outpatient programs¹³, partial hospitalization¹⁴, and residential treatment.¹⁵ For example, one study showed that residential treatment for bulimia nervosa had a 75% success rate over a five year period from treatment.¹⁶ Residential treatment centers for eating disorders abide by very stringent standards of care similar to our nation's hospitals and behavioral health care organizations, being certified by independent, not-for-profit accreditation organizations including The Joint Commission and CARF International.¹⁷ Residential Treatment Centers for eating disorders that are accredited/certified by The Joint Commission and CARF International have strict requirements that do not permit these centers to be group homes, spas, or wilderness treatment. Instead these centers abide by clearly defined requirements for what is considered residential treatment¹⁸ and the pertinent scope of service.¹⁹ Additionally, The Joint Commission and CARF International require that these facilities use evidence-based quality standards that are proven to be effective.²⁰ In turn, these facilities lead to improved outcomes and high patient satisfaction.

¹² Abbate Daga, G., Marzola, E., De-Bacco, C., Buzzichelli, S., Brustolin, A., Campisi, S., . . . Fassino, S. (2015). Day hospital treatment for anorexia nervosa: a 12-month follow-up study. *European Eating Disorders Review*, 23(5), 390-398; Olmsted, M. P., McFarlane, T. L., Trotter, K., & Rockert, W. (2013). Efficacy and intensity of day hospital treatment for eating disorders. *Psychotherapy Research*, 23(3), 277-286.

¹³ Exterkate, C. C., Vriesendorp, P. F., & de Jong, C. A. J. (2009). Body attitudes in patients with eating disorders at presentation and completion of intensive outpatient day treatment; *Eating Behaviors*, 10(1), 16-21. Johnston, J. A. Y., O'Gara, J. S. X., Koman, S. L., Baker, C. W., & Anderson, D. A. (2015). A pilot study of Maudsley family therapy with group dialectical behavior therapy skills training in an intensive outpatient program for adolescent eating disorders. *Journal of Clinical Psychology*, 71(6), 527-543.

¹⁴ Friedman, K., Ramirez, A., Murray, S. B., Anderson, L. K., Cusack, A., Boutelle, K. N., & Kaye, W. H. (2016). A narrative review of outcome studies for residential and partial hospital-based treatment of eating disorders. *European Eating Disorders Review*, 24(4), 263-276; Ornstein, R. M., Lane-Loney, S. E., & Hollenbeak, C. S. (2012). Clinical outcomes of a novel, family-centered partial hospitalization program for young patients with eating disorders. *Eating and Weight Disorders*, 17(3), e170-177.

¹⁵ Delinsky, S. S., St Germain, S. A., Thomas, J. J., Craigen, K. E., Fagley, W. H., Weigel, T., . . . Becker, A. E. (2010). Naturalistic study of course, effectiveness, and predictors of outcome among female adolescents in residential treatment for eating disorders. *Eating and Weight Disorders*, 15(3), e127-135; Twohig, M. P., Bluett, E. J., Cullum, J. L., Mitchell, P. R., Powers, P. S., Lensegraven-Benson, T., & Quakenbush-Roberts, B. (2016). Effectiveness and clinical response rates of a residential eating disorders facility. *Eating Disorders*, 24(3), 224-239.

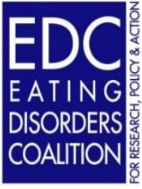
¹⁶ Brewerton, T. D., & Costin, C. (2011). Long-term Outcome of Residential Treatment for Anorexia Nervosa and Bulimia Nervosa. *Eating Disorders*, 19(2), 132-144. doi:10.1080/10640266.2011.551632

¹⁷ . The Joint Commission (n.d.). Retrieved from <https://www.jointcommission.org/>; CARF International (n.d.). CARF accreditation focuses on quality, results. Retrieved from <http://www.carf.org/home/>

¹⁸ The Joint Commission provided new requirements for residential and outpatient eating disorders programs effective July 1, 2016, including addressing assessments; plan of care, treatment or service; outcomes assessment; data to be collected and analyzed; transitions of care; components of care, treatment or services; roles of key staff and other clinicians; supervision of individuals served; family involvement; marketing materials and insurance information; and organization policies. (*Approved: New Requirements for Residential and Outpatient Eating Disorders Programs*, Joint Commission Perspectives®, January 2016, Volume 36, Issue 1). For example, The Joint Commission Standard CTS.04.02.29 requires multidisciplinary care, treatment or service team that consists of, "A licensed clinician with experience and/or training in treating eating disorders; A doctor of medicine or osteopathy with experience and/or training in treating eating disorders either on staff or available to the team 24 hours a day, 7 days a week. If individuals served are under the age of 13, the MD or DO is a pediatrician. If the MD or DO is not on staff, an advanced practice nurse with experience and/or training in treating eating disorders and licensed to prescribe medications is on staff.; a psychiatrist or clinical psychologist with experience and/or training in treating eating disorders, either on staff or available to the 24 hours a day, 7 days a week; a registered dietitian; a registered nurse, unless there is an advanced practice nurse on staff."

¹⁹ For example, The Joint Commission Standards CTS.03.01.03 (C 26) requires that, "The plan of care, treatment or services specifies a diagnosis based on the current Diagnostic and Statistical Manual (DSM) and/or the current edition of the International Classification of Diseases (ICD). Additionally, The Joint Commission Standards CTS.03.01.03 (C 27) requires that, "The plan of care, treatment, or services provides for sufficient nutritional rehabilitation to support regular and consistent weight when indicated (including expected rates of controlled weight gain of at least one pound per week) and/or measurable improvement in eating behaviors (for example, restricting, binge eating, and purging)."

²⁰ For example, The Joint Commission Standards CTS.04.02.16 (2) states, "For organizations that provide eating disorders care, treatment, or services: The organization is knowledgeable about evidence-based guidelines for treatment of individuals with eating disorders, such as the American Psychiatric Association Eating Disorder Treatment Guidelines, the Guidelines of the British National Institute for Clinical Excellence (NICE Guidelines), or the American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders."



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For example, an adolescent woman from Pennsylvania discussed that she was in and out of intensive outpatient treatment and outpatient treatment for years. Upon changing her insurance plan, she was finally approved to receive treatment at a residential treatment facility, at which time she spent five weeks at the facility to the point of complete recovery. She has now been successfully discharged, keeps up with regular outpatient treatment, and began her freshman year at a local university. In discussions with her, she believes she would never have been in this state of recovery or be starting college if it was not for her successful treatment at a higher level of care.

Despite the effectiveness and stringent criteria, we often see insurance companies excluding residential treatment for eating disorders, arguing that under the Interim Rules such exclusions are permissible. While the Final Rules clarified the Interim Rules, specifically addressing the scope of services and providing additional illustrative examples, “one of which precludes coverage plans from excluding mental health coverage for a particular treatment setting, i.e., a residential care facility.” *Id.* at * 6 (citing 78 Fed. Reg. 68246), we still see some courts and plans arguing that the Interim Rules govern and in turn allow the exclusion of residential treatment. Moreover, this exclusion and Interim Rules interpretation is unlawful based on the plain language of the Act. Under 29 U.S.C.A. § 1185a (3) (A) (ii) (emphasis added):

(3) Financial requirements and treatment limitations

(A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

* * *

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and *there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.*

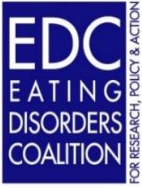
As the plain language of MHPAEA acknowledges that treatment between the medical and surgical benefits may not look exactly like treatment for mental health and substance use disorder benefits, there must not be a separate treatment limitation only for mental health and substance use disorder benefits.

The other issue of note is the attacks insurance companies and plans are levying against application of the Act and the Rules. We are still seeing attacks based on *Chevron U.S.A. Inc. v. Natural Resources Defense Counsel Inc.*, 467 U.S. 837, 843-44 (1984) (where agency has not properly interpreted a statute, court will not give effect to agency interpretation). Some insurers also maintain that if the language of the exclusion appears to apply on the medical/surgical side, it is a proper exclusion, even though it is common knowledge that residential treatment only applies to mental health conditions. We are very concerned that many people affected by eating disorders are being told that these exclusions are still valid, and those suffering and are being discouraged from pursuing much needed care and potentially costing lives.

Recommendation: We recommend the following to strengthen enforcement for intermediate level of services for eating disorders:

(1) Provide regulatory clarification that the Final Rules apply from the start of mental health parity implementation and not upon their issuance. Further, this same clarification must specify that the Interim Rule is now a legal nullity and should be not applied, in any circumstances, to coverage decisions of any kind.

(2) Amending existing Final Rules regulations to include both the “Treatment for Eating Disorders” FAQs issued on June 16, 2017. To ensure that enforcement for eating disorders benefits is clarified and followed by plans, we recommend amending the following:



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Under 29 CFR §2590.712 (a); 45 CFR §146.136 (a); 26 CFR §54.9812-1 (a)- *Mental Health Benefits*, insert the following from the FAQs: “The Departments’ regulations implementing MHPAEA define “mental health benefits” as benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Eating disorders are mental health conditions and therefore treatment of an eating disorder is a “mental health benefit” within the meaning of that term as defined by MHPAEA.”²¹

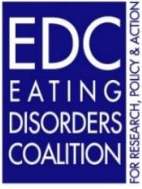
(3) Issue guidance for courts to help in their determinations of mental health parity coverage for intermediate level services. The following contain examples of good analysis of an improper exclusion under MHPAEA:

- *A.F. v. Providence Health Plan*, 35 Supp. 3d 1298 (D. Or. 2014), which concerned an exclusion for Applied Behavioral Analysis treatment for autism. The ERISA plan at issue contained an exclusion for mental health services “related to developmental disabilities, developmental delays or learning disabilities.” *Id.* at 1302-3. Plaintiff argued that this exclusion violated the Act because it was a treatment limitation that applied only to mental conditions. Providence responded with two arguments. First it argued that the exclusion was not a treatment limitation because it was not in the nature of a quantitative limitation. The court correctly responded that the Rules also included nonquantitative limitations. *Id.* at 1314-15. Providence also argued that MHPAEA does not mandate coverage of any specific benefit of a condition, but merely requires that if a certain service or treatment is covered, it must be covered equally for medical and mental health conditions. *Id.* at 1315. The court’s response was: “Providence would be free under the Federal Parity Act not to cover autism. But after Providence chooses to cover autism, any limitation on services for autism must be applied with parity. Because Providence does cover autism, it cannot use the Developmental Disability Exclusion to deny coverage of ABA therapy because it is a “separate treatment limitation” that applies only to mental health disorders.” *Id.* at 1315.

- *N.F. v. Sinclair Services Co.*, 158 F. Supp.3d 1239 (D. Utah 2016) is another example for an exclusion for residential treatment. The self-funded ERISA plan added the exclusion was effective January 1, 2013, even though benefits for residential treatment were provided in 2012. *Id.* at 1245. The plan argued that the residential exclusion did not violate MHPAEA because it applied across the board, regardless of whether the services were for medical/surgical conditions or mental health/substance abuse conditions. *Id.* at 1261. Plaintiff countered that residential treatment is only provided for mental health/substance abuse conditions, and, since the plan provided coverage for skilled nursing for medical/surgical conditions, the exclusion violated the Act. *Ibid.*

The court began its analysis by stating that “the parties seemingly agree that the residential treatment exclusion is a nonquantitative treatment limitation.” *Ibid.* The court concluded that the residential treatment exclusion “runs afoul of the clear and unambiguous language of the Parity Act’s second requirement” that there be no separate treatment limitations applicable only with respect to mental health benefits. *Id.* at 1261-2. The court stated, “To be sure, the Parity Act does not require plans to provide mental health or substance use disorder benefits at all. But once a plan does provide such benefits, the plan must do so on a level that is on par with the benefits it provides for medical and surgical benefits. And once provided, the Parity Act

²¹ <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf>



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prohibits imposing treatment limitations applicable only to mental health benefits. Further, although the Administrator argues that the exclusion applies across the board, there is no evidence to suggest that coverage for residential treatment would have been available for medical or surgical conditions but for the exclusion. Without evidence to that effect, the Administrator's argument that it would have also denied residential treatment benefits for medical or surgical conditions under the exclusion is illusory." *Id.* at 1262.

- In *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 753 (N.D. Ill. 2015), the plan excluded residential treatment. Defendant argued that the Interim and Final Rules went beyond the text of the statute by adding NQTLs. Per the defendant, the statute's definition of "treatment limitations" contains three examples: "frequency of treatment," "number of visits," and "days of coverage" and then the additional phrase, "other similar limits." 29 U.S.C. § 1185a (a) (3) (B) (iii). According to defendant, these specific examples indicate that the additional phrase "other similar limits," only applies to limitations that are also numerical in nature. The court rejected this argument by stating, "The practical effect of the RTC exclusion is that Jane Doe receives fewer hours (or days) of coverage for medically necessary nursing care than, for example, an elderly person would receive to rehabilitate a broken hip. Essentially, HCSC argues that the issuer's characterization of the limitation is controlling. This is not the only reasonable interpretation of the phrase "other similar limits," and it is arguably at odds with the statute's purpose to achieve coverage parity whenever a plan offers both mental-health and medical/surgical benefits." *Craft* at 754.

(4) Issue guidance to payers on up-to-date evidence-based quality standards and accreditation/certification requirements for treating eating disorders

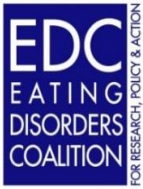
- As we understand it may be difficult for payers to stay up-to-date on evidence-based quality standards and accreditation/certification requirements for unique and complex diseases like eating disorders, we encourage the agencies to provide further guidance on the current evidence-based industry standards of care, and certification/accreditation standards for treating eating disorders, to ensure that payers are informed of the most up-to-date treatment science and industry accreditation/certifications. Particularly we recommend providing specific accreditation guidance for The Joint Commission and CARF within your recommendations as well as industry standards of care in guidance on evidence-based quality standards.

3. In-Person Pre-Authorization Examination Requirement for Eating Disorders

On October 27, 2016, the Department of Labor issued FAQs describing that [pre-authorization examination for medical necessity](#) cannot be more stringent of a requirement for MH/SUD than medical surgical side, for example requiring an in-person pre-authorization examination for MH/SUD and phone examination for med/surg. However, despite these clear FAQs, we are still seeing plans requiring in-person authorization for higher levels of care; while the same requirements are not required on the medical surgical side, and instead allow a local provider to authorize treatment.

For example, recently an adult male from Minnesota had to travel three hours to have his pre-authorization assessment. He drove to the assessment, spent the night in the area the night before, and then after the face-to-face assessment, had to "keep himself busy" at a coffee shop until an authorization was given from his insurance plan.

Given that the number of specialized eating disorders treatment centers providing intermediate levels of care are limited in the United States, this is a very large problem because it requires ill patients to travel long distances, sometimes even flying across the nation, to receive in-person



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pre-authorization for treatment before actually authorizing the treatment. This is a huge financial burden to patients and their families and a direct violation of mental health parity.

Recommendation: We recommend providing regulatory guidance that pre-authorization examinations for eating disorders be permitted by the local provider, or for self-refer patients, allow examinations to occur telephonic or virtually by the specialty intermediate level of care provider.

4. Fail-First Policies for Eating Disorders

Issue: Throughout the eating disorders community, we hear numerous stories of fail-first policies. These policies require that an eating disorder patient fail at a lower level of care before a higher level of care will be authorized. Fail-first policies are prohibited under the purview of MHPAEA, however in both the appeals process and court cases, it is currently unclear who, the insurance plan or patient, has the burden of proof to demonstrate that a fail-first policy does or does not exist on the medical surgical side. Due to the lack of disclosure from many plans, proving a noncompliant fail-first policy is extremely difficult for even the most seasoned attorneys.

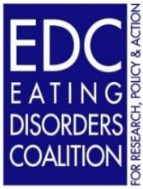
A recent example in Seattle was the case of a young woman seeking residential treatment. Her insurance required her to go into a partial hospitalization program (PHP) before residential treatment would be considered as an option for authorization. She went into PHP, but did poorly and felt like she was not able to progress. She left treatment entirely as a result, and the severity of her disorder heightened.

Recommendation: Given the disclosure issues still occurring within the industry, we recommend clarifying in regulation that the burden of proof lies on the issuer to prove that there was or was not a fail-first policy within the corresponding medical surgical side.

5. Utilization Review Process and Disclosure for Eating Disorders

Issue: The MHPAEA Final Rules state that when your processes, strategies, and evidentiary standards are not the same on the medical surgical side as the mental health and substance use disorder side, these standards are noncompliant.²² In practice, the utilization review process between the medical surgical side and MH/SUD side are often very different given the complexity of treating MH/SUD and difference in disclosure. Often there will be no utilization review or minimal utilization review on the medical surgical side, while having an extensive required review on the MH/SUD. Additionally, the utilization review is often used more on the MH/SUD side over the med/surg due to a lack of disclosure of Medical Guidelines for MH/SUD in comparison to med/surgical. For example, some Medical Guidelines are very clear that certain illnesses/treatments are not covered, like bone marrow cancer, and drills down into specifics. However, the MH/SUD guidelines are not disclosed or available to doctors.

One example includes a young woman in Minnesota who was requesting 14 additional days of residential eating disorders treatment, per the medical determination from her treatment team. During the insurance review discussion with her treatment team, the treatment team explained the reasons outlined in the documentation, including the patient needing to restore approximately 15 pounds to reach the bottom end of her goal weight range. The insurance reviewer questioned the goal weight range, as he had previously on this case, despite the range being set from the patient's growth charts and multiple other markers of success not being attained, including a recent incident of self-harm. The insurance reviewer responded that a doctor needed to review this claim, since the patient had been in residential treatment for six weeks. The treatment team requested a meeting with the doctor reviewing the claim to see if he had any questions before a



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decision was made. An additional week was authorized, but they needed a peer-to-peer conversation to do anything further. After a few days had passed and minimal updates had been communicated to the treatment team, the insurance representative stated that the doctors on the treatment team offer to discuss the treatment with the reviewing doctor was not sufficient, as the reviewing doctor would only communicate with an MD and not a PhD. The treatment team then offered an MD on the treatment team to speak with, however, scheduling had not worked out for communicating with the doctor reviewing the request, and consequentially the patient was denied additional time in residential treatment.

Recommendation:

- While there is currently an ERISA regulation stating that an insurance plan may offer Medical Guidelines upon request²³, in practice it has become an empty offer as plans do not willingly disclose this information claiming it is proprietary. We recommend providing additional regulation, requiring that medical guidelines and medical necessity criteria be automatically provided to providers and patients' agents upon request.
- We applaud the Department of Labor's 1,515 investigations of mental health parity noncompliance, resulting in 171 cited cases of noncompliance between October 2010 to October 2016.²⁴ However, being on the ground with consumers, providers, and representatives, we know that there are at minimum 171 instance of noncompliance for eating disorders parity every year. Currently, one of the largest barriers is that consumers do not know their rights under current law, and there are limited outlets to help hold plans accountable. We encourage the further enactment of a consumer protection portal that can be used by consumers, providers and representatives to submit mental health parity noncompliance complaints. The 2016 BETA tested version was a good start; however, we encourage the enactment of an enforcement mechanism like the Consumer Financial Protection Bureau, as well as public service announcements to help consumers understand their rights under mental health parity.

6. Insurance Reviewers Lack Expertise to Make Utilization Determinations

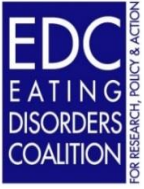
Issue: Another issue that we often see is with a plan's utilization review doctor's qualification to conduct the review. Some insurers only require its utilization review doctor be "board certified", have five years of practice in the last ten years, and have an unrestricted and active license in one state. Their reviewers can have a general behavioral health background, but there is no requirement that they have experience or knowledge about the treatment of eating disorders. In turn, you are having a doctor who has no experience or knowledge of treating an eating disorder and has never examined the patient, denying treatment coverage, while at the same time having a specialized eating disorders doctors working with the patient strongly recommending a continuation of treatment. In turn, how can a utilization reviewer provide a non-biased basis for the industry standard of care, if they were never trained in the industry standard of care.

An example occurred last year for a fourteen-year-old boy suffering from bulimia nervosa in North Carolina. The reviewer denied partial hospitalization care because the boy, "should be vomiting at least five times a week to need that much care." Industry standards of care do not designate a certain number of purging per week to evaluate what level of care is needed for a person affected by bulimia nervosa.

Recommendation: We recommend providing requirements that insurance reviewers receive some type of continuing education for the diseases/disorders areas in which they are reviewing. The continuing education should be evidence-based and utilize industry standards of care for medical practice of that disease/disorder.

²³ 29 CFR § 2560.03-1(g)(1)(v)(A)

²⁴ <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf>



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7. Expedited Resolution of Parity Challenges

Issue: Patients are in a strict disadvantage when they challenge plans' parity compliance, as the patient must make the decision to continue with the doctor-recommend treatment, potentially leading to a high cost if they lose the parity challenge, or to not take the treatment due to the fear of not being repaid by their plan. In turn, it often takes patients years before they are ever reimbursed for the parity noncompliance, when it was the plan that was in violation. This high risk often leads many patients to not challenge denials and/or not receive treatment they need.

Recommendation: We recommend creating a new policy that if a challenge to a plan with a specific limitation violates parity, the insurance company should have to pay for the treatment while the appeal is pending. In turn, this process should be expedited, so that both parties do not have to wait to go through the ERISA litigation.