

August 31, 2016

Dear Mental Health and Substance Use Disorder Parity Task Force:

On behalf of the Eating Disorders Coalition for Research, Policy, and Action, please find our comments to President Obama's Mental Health and Substance Use Disorder Parity Task Force. The Eating Disorders Coalition is a Washington, DC-based nonprofit organization comprised of eating disorder treatment providers, advocacy organizations, and patient advocates across the nation, devoted to improving federal policies to help better the lives of people experiencing eating disorders.

Eating disorders are classified as mental disorders in standard medical manuals including the International Statistical Classification of Diseases and Related Health Problems (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and include specific disorders such as anorexia nervosa, bulimia nervosa, and binge-eating disorder. Eating disorders affect the lives of over 30 million Americans during their lifetimes and are among the most lethal of all psychiatric illnesses. Despite the high prevalence and severity of these mental disorders, persons with eating disorders frequently face remarkable barriers in pursuit of life-saving treatment. These vulnerable citizens are too often the victims of imprudent treatment denials by health insurance companies—casualties of payors' violations of the Paul Wellstone and Pete Domenici Federal Mental Health Parity and Addictions Equity Act of 2008 (Parity Act). Below, we narrate ways that persons with eating disorders—be they adults or children—are affected by Parity Act noncompliance.

A. Mental Health Parity Enforcement Issues for Eating Disorder Benefits

The Parity Act was a groundbreaking piece of legislation aimed at ending ongoing discriminatory practices by insurance companies against those with mental illness and/or addictions. The Act requires fairness—or, as its name implies, parity—between mental health and substance use benefits on the one hand and medical/surgical benefits on the other. The Act was designed to accomplish this goal in three ways.

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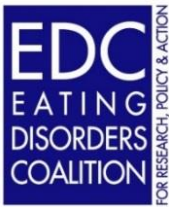
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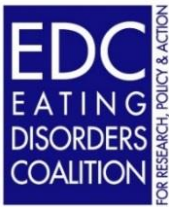
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First, insurance companies cannot apply more restrictive *financial limitations* on mental health and substance use benefits than those applied to medical/surgical benefits on a given plan. Financial limitations include deductibles, copayments, co-insurance and out of pocket expenses.

Second, insurance companies cannot apply more restrictive or separate *treatment limitations* on mental health and substance use benefits compared against limitations applied to medical/surgical benefits on that same plan. Examples of these limitations include limits on the frequency of treatment, the number of visits, or days of coverage.

Finally, the Act precludes insurance companies from applying more restrictive *“nonquantitative” limitations* on mental health and substance use benefits. Nonquantitative limitations include the *processes, strategies and evidentiary standards* used to determine whether coverage is available under an insurance policy. By virtue of the Act’s provisions, insurers may not create standards for mental health benefit utilization differing from those ordinarily found in the medical/surgical benefit utilization. Targeted practices include special medical management techniques such as fail-first provisions, procedures for making medical necessity determinations, standards for determining admissions to networks and reimbursement for in-network providers, and standards for determining usual and customary charges for out-of-network providers.

Some insurance companies seemed to ignore the Parity Act until issuance of the Final Implementing Regulations, which went into effect on January 1, 2015. But even since the publication of these straightforward, clarifying directives, patients and providers have seen fundamental compliance only with the first requirement of the Act – *financial parity*. As to the Act’s expressed requirement that levels of care for mental health/substance use disorders and medical/surgical disorders (e.g., 24-hour care, outpatient visits) be on par in the context of a given plan, policies continue to be written and enacted which exclude 24-hour residential treatment for mental health and substance use disorders. This is a clear violation of the Federal Mental Health Parity Act. For those suffering with eating disorders and their families, this continued noncompliance means that unlawful discrimination continues, treatment remains unavailable, loved ones



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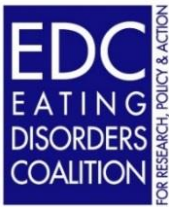
suffer, and, at an alarming and unacceptable rate, persons with treatable illnesses die.

Another example of ongoing parity violation is the alarming increase in denials of treatment of eating disorders for lack of medical necessity. The Parity Act requires insurance companies to apply their medical necessity criteria to mental illness no more stringently than they apply the same criteria to physical illness. Yet some insurance companies are not disclosing their medical management techniques, thwarting the appropriate comparison required by statute.

At the same time, day after day patients and families report that the authorized lengths of stay at residential programs, day treatment programs, and outpatient programs are getting shorter and shorter—very truly receiving inadequate care.

Residential treatment is a critical modality of treatment for eating disorders. Some insurance companies claim not to be in violation of the Parity Act because they exclude residential treatment on the medical surgical side as well. Yet many of these plans cover medical skilled nursing care or physical rehabilitation in 24-hour environments, belying this argument of ‘parity by equal restriction’. Whereas the term ‘residential treatment’ is unique to the treatment disciplines of mental illness and substance use disorders, in concept, this level of care has many siblings in the medical/surgical realm. In *Rea v. Blue Shield*, Justice Jeffrey Johnson (California Court of Appeals) went a step further, noting in his decision that true parity will not be achieved until we recognize that “treatments for mental and physical illnesses can vastly differ in their modality and scope.”¹ This provides an important nuance—even if a particular mental health treatment or level of care has no clear/absolute medical treatment corollary, insurers are not divorced from their responsibility to provide for said treatment.

¹ *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209, 1226, 172 Cal. Rptr. 3d 823, 836 (2014), as modified on denial of reh'g (July 9, 2014), review denied (Sept. 10, 2014)



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In turn, the Eating Disorders Coalition worked with Members of Congress to introduce bipartisan legislation to address these disparities in treatment coverage for persons with eating disorder mental illnesses. Republicans, Democrats, and Independents worked side-by-side in crafting and sponsoring The Anna Westin Act of 2015 (S. 1865 / H.R. 2515), legislation centered on clarifying existing mental health parity language, to ensure that persons with eating disorders would not continue to bear the brunt of an insurer's failure to operate in accordance with the intent of the Parity Act.

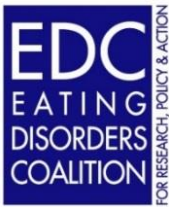
A version of this clarifying language was included within the Helping Families in Mental Health Crisis Act (H.R. 2646)—which passed 422-2 in the US House of Representatives on July 6, 2016—as well as within the Mental Health Reform Act of 2016 (S. 2680), which passed the Senate HELP Committee *unanimously* on March 16th, 2016 and is pending consideration on the Senate floor.

Finally, patients with eating disorders are routinely denied access to dietitians, despite the fact that patients with medical problems, such as diabetes, are allowed such access, often without restriction. This is another violation of the Parity Act. Patients with eating disorders are entitled to access to dietetic care; in fact, recovery may be fully thwarted absent the critical interventions of this clinical discipline.

B. Suggestions on how to improve understanding of parity among key stakeholders such as consumers, families, health care providers, and insurers?

The interim and final rules contain some clear examples on what parity means. These examples should be used with key stakeholders to improve understanding. For example, the interim and final rules contain the following list of non-quantitative treatment limitations:

- medical management techniques like prior authorization;
- medical necessity or medical appropriateness or limitations based on whether a treatment is experimental or investigative;
- formulary design for prescription drugs;



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- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods used to determine usual, customary and reasonable fee charges;
- 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); and
- exclusions based on a failure to complete a course of treatment.
- Network tier design and restrictions based on geographic location [added by final rules]
- Other criteria that limit the scope or duration of benefits for services provided under the plan or policy [added by final rules]

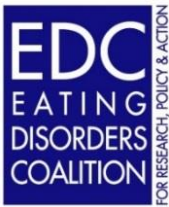
We recommend simple notifications that warn key stake holders to be aware that these nine areas must be applied equally on the mental health side and the medical surgical side.

There are also questions and answers in the interim and final regulations. These should be extracted and circulated to key stakeholders, as they address common factual scenarios faced on a day to day basis.

C. What are some examples of the types of information you commonly see health plans and insurance issuers share with enrollees or providers when coverage for a mental health or substance use disorder benefit is denied?

A frustrating element for treatment providers, consumers and their families is the limited information health plans and insurance companies provide to providers and consumers when coverage for their eating disorders benefit is denied. Oftentimes the information is so limited that both the provider and consumer are not able to determine the exact reason that a benefit was denied- i.e. medical necessity.

Denial letters are confusing and are not tied to the American Psychiatric Association Guideline for the Treatment of Eating Disorders, which is the standard of care in the industry. Even when insurers use their own guidelines, they often do not cite to those guidelines in the denial letters. Often insurers use template denial sentences which are not individualized



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to the patient's condition. Insurers often do not accurately reflect the information provided by the treating experts, and sometimes do not even consult with the experts before making life and death decisions about treatment.

Recently, a large insurer in Iowa provided written authorization to families for treatment at the residential level of care. After the family member finished their treatment, families got letters stating that the care was not authorized and would not be paid for. Denial letters included reasons for denial as lack of medical necessity, despite prior authorization based on medical necessity, and incomplete documentation, despite thorough documentation submitted to the company. Families are left with enormous bills that they believed would be covered by their insurance company.

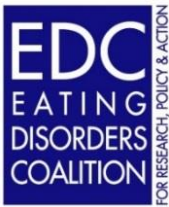
D. When health plans provide parity compliance-related information, how easy or hard is it for consumers and providers to understand? Do consumers and providers know how to act on this information?

In our experience, information on parity compliance has been nearly impossible for consumers to get from insurance companies.

E. What additional tools, guidance or other strategies are needed to improve the information made available to consumers and providers and their understanding of how to act on it?

Medical necessity:

The place providers run into the most trouble is the accessibility of the medical necessity standards that insurance companies use. Difficulties arise when providers and reviewers disagree on interpretation of medical necessity. What occurs is that the providers will be working in-person with the consumer and their family and the provider believes it is the best interest of a consumer to receive a particular level of care. However, upon discussion with the health plan reviewer, who has never met or interacted with the consumer and their family, the reviewer believes it is in the best interest of the consumer to not receive that level of care. While this doesn't always happen, it is particularly distressing when it does. The provider is then left to tell the consumer and family, "We believe you need this level of care, yet your insurance company disagrees and will



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not authorize the care. You can choose to have your loved one in this level of care at your own expense."

In turn, we would recommend creating a systemized medical necessity criteria that can be used universally by both provider and reviewer, in turn ensuring that both clinician providers and reviewers are working off of the same requirements.

"Chronicity":

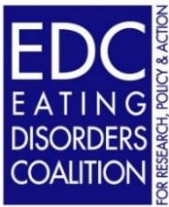
Some insurance companies speak often about "chronic" eating disorders, despite the fact that there is no standard in the field of eating disorders that defines "chronic". There is no agreed upon definition and no treatment guidelines that say that providers should definitively treat those with an eating disorder for a long time period differently than those with a short time of illness. In this way, there are some insurance companies that are essentially creating a requirement to determine something that cannot be determined.

Anecdotally, we have had clients who have been told at the age of 17, after having anorexia for under 2 years, that they are "chronic" and treatment should focus on helping them adapt to this chronic illness and facilitate return to "baseline level of functioning" at this "chronic" place rather than providing coverage for treatment that would support and facilitate full recovery, which we know to be possible.

We recommend addressing chronicity standards to create a uniform standard for all providers, reviewers, and health plans to use.

F. What are some best practices used by health plans and insurance issuers to share information with enrollees and their providers regarding the following topics: medical necessity criteria, why coverage is denied, how these policies are comparable to policies for coverage of medical/surgical benefits, and transparency in how the non-quantitative treatment limits in the coverage are designed and implemented?

Medical necessity criteria used by insurance companies are often only available online and are often difficult to locate. When providers ask



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insurance company representatives to explain the criteria, they are often unable or unwilling to do so. Enrollers can try to access the criteria online, but the criteria are confusing and often impossible to meet.

As explained above, denial letters are confusing and are not tied to the standard of care in the community or insurance company criteria.

Consumers are not getting any information about how non-quantitative treatment limits in coverage are designed and implemented.

G. What are some best practices used by state insurance commissioners to ensure the health plans and policies issued in their states are in compliance with parity?

In New York, the State Attorney General has been diligent in assuring compliance with parity by instituting enforcement actions against various insurance companies and third party administrators.

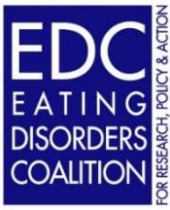
H. What additional actions could be taken to improve responsiveness to concerns regarding non-compliance with parity requirements, both on the part of insurance issuers and on the part of regulators?

A clear path for families to contact regulators and voice concerns regarding non-compliance with parity requirements should be put in place.

In addition, a commission of experts should be convened to conduct random audits of insurance company denials to assure compliance with parity. This commission should consist of persons knowledgeable about parity requirements. The audits should start immediately and should encompass all major insurance companies and third party administrators.

I. Conclusion

Thank you for your consideration of our comments as you work towards improving compliance with the Mental Health Parity Act. We welcome the opportunity to discuss how parity non-compliance affects our community at length, and encourage you to reach out to the Eating Disorders Coalition Policy Director, Katrina Velasquez at kvelasquez@eatingdisorderscoalition.org for further discussion.



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Johanna Kandel
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Addendum attached