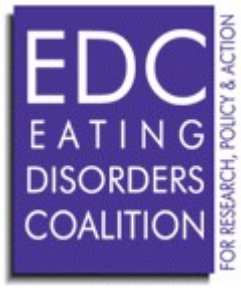

May 27, 2009

Internal Revenue Service
U.S. Department of the Treasury

Employee Benefits Security Administration
U.S. Department of Labor

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 74 Fed. Reg.19155 et seq.)

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

To the Departments:

The Eating Disorders Coalition for Research, Policy & Action (EDC) welcomes the opportunity to respond to the request for information as you begin the rulemaking process on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In this letter we first underscore the importance of considering regulatory language that ensures eating disorders coverage is not specifically excluded. Second, we offer answers to a number of the specific questions as requested.

The statutory language of the MHPAEA should prevent an employer from evading the spirit of its parity requirement by creating new, additional, or other restrictions for mental health/substance use benefits. Thus, we urge that a central consideration in regulatory implementation be clear guidance that prohibits employers and insurance companies from specifically excluding eating disorders coverage.

Eating disorders are complex biopsychosocial illnesses with the highest mortality and morbidity rate of any psychiatric diagnosis. They are the third most common serious illness affecting adolescent females, after diabetes and asthma. According to the newest genetics research, more than 50% of all of the factors that cause eating disorders are inherited. This heritability rate is comparable to what has been found among

other illnesses like schizophrenia and bipolar disorder both of which are commonly included in coverage without dispute.

When eating disorders treatment is cut short due to insurance limitations, recovery is temporary or partial which leads to a revolving door phenomenon with people returning for treatment over and over again. This trend increases the overall cost of care and threatens lives. Between 1985 & 1998 readmissions of eating disorders patients have increased steadily as length of stay has become briefer and weight at discharge has been lower (Halmi et al., 2000). Shorter periods of treatment for eating disorders are associated with less successful outcomes (Commerford, Licino, & Halmi, 1997). Yet relative to other accepted medical interventions, the treatment of eating disorders when done adequately and comprehensively are cost-effective and, in fact, quite reasonable (Crow and Nyman, 2004).

Lastly, when done well, treatment works. In one study where patients were followed for 5-10 years, approximately half of the sample had recovered, 25% improved with some residual symptoms, and only 25% remained ill or died (Garfinkle, 1995).

In summary, comprehensive eating disorders treatment is financially a sound investment and most importantly, in keeping with the spirit of mental health parity, leads to improved health outcomes.

Now we address the following questions posed in the request for information.

Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?

> The answer is different for every single insurance plan available, so this is difficult to answer. We do know that there are unequal restrictions on mental benefits versus medical benefits. An example is seen in the coverage of nutrition therapy. Most insurance companies currently cover nutritional visits for someone who is diagnosed with obesity and/or diabetes. However, people with eating disorders do not get nutritional visits covered or if they do it is for a handful of visits (like a maximum of three). This makes the financial burden of recovery for those diagnosed with eating disorders higher and threatens recovery. Since eating disorders are illnesses with serious medical and nutritional consequences, nutritional rehabilitation is a critical aspect of successful recovery requiring regular follow-up for months or years.

What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

> Clarification is necessary regarding when state laws are to be preempted or not. It is particularly important that stronger state laws that specifically enumerate the coverage of eating disorders either explicitly or through general parity laws (they include all mental illnesses in the DSM-IV) remain in effect and are not trumped by the federal law.

What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder

benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

> Information regarding reasons for denial is very difficult to obtain by the consumer. Typically when a consumer calls to request coverage they speak with a "plan specialist" who details benefit coverage in a “Swiss Cheese method” where they receive an overview of coverage but much of the critical information is missing. The consumer must then call multiple times to try and fill in the 'holes'. It is not unusual to call insurance companies and speak with five different people trying to obtain their definitions of "medical necessity” and receive five different answers. It is nearly impossible for the consumer to get a hard copy of these definitions. Oftentimes the standard response is, "That is not something I have access to." We know of families who have tired for more than two years to obtain definitions of coverage.
>
> The consistent failure to provide adequate information to consumers produces stress and dissuades people from seeking much needed treatment. In addition, failure to provide clear and direct access to this information has resulted in bankruptcy for some of those seeking treatment yet they believed their benefits were quoted to them correctly. Later they found out that they were not provided accurate information and complete full disclosure of their benefits.

To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

> Definition of out-of-network varies from plan to plan and in some cases, within the plan, out-of-network coverage varies from diagnosis to diagnosis. Out-of-network coverage is typically much less in both dollar amount and in days covered. A major treatment limitation in relation to eating disorders is out-of- network coverage even when the only treatment available is out-of-network. For example, Michigan does not have a specialized eating disorders treatment center and insurance plans do not cover treatment outside of the state. A person who needs specialized care cannot receive it due to this restriction.

Thank you for consideration of our views in your rule making process. We look forward to supporting you further in the next steps of your implementation of this vital law.

Sincerely,

Jeanine C. Cogan, Ph.D., Policy Director
Eating Disorders Coalition for Research, Policy & Action