



January 13, 2023

Request for Information on dual eligible population submitted electronically to dualeligibles@cassidy.senate.gov.

Dear Ranking Member Cassidy and Senators Carper, Scott, Warner, Cornyn & Menendez:

On behalf of the Eating Disorders Coalition for Research, Policy & Action (EDC) we thank you for the opportunity to provide information regarding policy solutions to improve coverage for dually eligible enrollees. The EDC is a nonprofit organization comprised of patient and caregiver advocates, treatment providers, advocacy organizations, and academics, aimed to advance the recognition of eating disorders as a public health priority throughout the U.S. By promoting federal support for improved access to care, the EDC seeks to increase the resources available for education, prevention, and improved training, as well as for scientific research on the etiology, prevention, and treatment of eating disorders.

Eating disorders are complex, biologically-based serious mental illnesses that have the second highest mortality rate of any psychiatric illness—with one person losing their life every 52 minutes as a direct result of an eating disorder.¹ Approximately 28.8 million Americans experience a clinically significant eating disorder during their lifetime², affecting individuals of all ages, races, genders, ethnicities, socioeconomic backgrounds, body sizes, and sexual orientations.³

Under the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: DSM-5, eating disorders include the specific disorders of anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder, and other specified feeding or eating disorders.⁴ These disorders are unique in that they co-occur and can lead to several mental health and medical complications. For example, 25% of people experiencing an eating disorder have a co-occurring substance use disorder.⁵ Additionally, eating disorders are associated with a range of medical complications including cardiac disability, starvation, hepatitis, refeeding syndrome, cognitive dysfunction, kidney failure, esophageal cancer, osteoporosis, fractures (hip, back, etc.), hypoglycemic seizures, amenorrhea, infertility, high and low blood pressure, Type II diabetes mellitus, edema (swelling), high cholesterol levels, gall bladder disease,

¹ Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: <https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/>

² Ibid.

³ 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.

⁴ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

⁵ Bahji, A., Mazhar, M. N., Hawken, E., Hudson, C. C., Nadkarni, P., & MacNeil, B. A. (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: a systematic review and meta-analysis. *Psychiatry Research*, 273, 58-66.

decalcification of teeth, severe dehydration, chronically inflamed sore throat, and inflammation and possible rupture of the esophagus.^{6, 7}

When families across the nation do not have affordable and comprehensive insurance coverage that includes mental health and substance use disorder (MH/SUD) treatment at all levels of care, they are unable to access specialized treatment without finding the out-of-pocket means to cover their care. Studies show that when a person with a severe eating disorder like anorexia does not receive comprehensive treatment, 41% of patients will relapse and are two times more likely to end up in the emergency room than someone without an eating disorder.⁸ In turn, eating disorder readmissions amount to \$29.3 million in emergency room visits annually and \$209.7 million for inpatient hospitalizations annually.⁹ Barriers to comprehensive treatment cost the U.S. \$64.7 billion each year with individuals and families shouldering \$23.5 billion, government shouldering \$17.7 billion, and employers shouldering \$16.3 billion respectively.¹⁰

Eating Disorders and Dual Eligible Population

Individuals under age 65 comprise 16% of all Medicare enrollees, however; they represent approximately 42% of enrollees with an eating disorder diagnosis.¹¹ This illustrates the debilitating nature of this psychiatric illness—individuals with eating disorders qualify for Medicare due to disability status.

Among Medicare enrollees, individuals with eating disorders are medically complex with more than half have greater than six comorbid conditions.¹² Enrollees with eating disorders are 2.4 times more likely to be dual eligible for Medicare and Medicaid.¹³ As the RFI stated, the dual eligible population account for a disproportionate degree of spending. Data from 2016 shows Medicare enrollees with an eating disorder diagnosis had more than \$20,000 higher average healthcare expenditure than their counterparts without an eating disorder.¹⁴

However, eating disorders do impact the Medicare population and are particularly serious for this age demographic as inadequate nutrition can result in memory deficits; cognitive decline;

⁶ Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical complications of anorexia nervosa and bulimia. *Am J Med*, 129(1), 30–37.

⁷ Thornton, L. M., Watson, H. J., Jangmo, A., Welch, E., Wiklund, C., von Hausswolff-Juhlin, Y., . . . Bulik, C. M. (2017). Binge-eating disorder in the Swedish national registers: somatic comorbidity. *Int J Eat Disord*, 50(1), 58-65.

⁸ Tackling Relapse Among Anorexia Nervosa Patients. (2013). *Eating Disorders Review*, 24, 9-11.; Yafu Zhao, M., & Encinosa, W., Ph.D. (2011, September). An Update on Hospitalizations for Eating Disorders, 1999 to 2009. Retrieved from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.jsp>

⁹ Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: <https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/>.

¹⁰ Ibid.

¹¹ Presskreischer, R., Steinglass, J. E., & Anderson, K. E. (2022). Eating disorders in the U.S. Medicare population. *The International journal of eating disorders*, 55(3), 362–371. <https://doi.org/10.1002/eat.23676>

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

decubitus ulcers; impaired healing of sores, wounds, or infections; and dizziness, disorientation, and falls, which can initiate a cascade of pathophysiological events leading to a 30% to 40% mortality rate.¹⁵ What makes this population particularly challenging is that although the symptomatology of eating disorders in older Americans is the same for younger populations, weight loss may signal an undiagnosed medical illness or may be the result of a known medical condition and/or its pharmacologic treatment, which can delay a formal diagnosis.¹⁶

Policy Recommendations & Considerations to Improve Dual Eligible Coverage

- i. *Passage of the Nutrition Counseling Aiding Recovery for Eating Disorders Act (Nutrition CARE Act, S. 584, 117th Congress)*

Comprehensive treatment of eating disorders requires a multidisciplinary team of health care providers including a physician, psychiatrist, therapist, and dietitian. Importantly, the dietitian is the only healthcare provider that assesses the patient cognitively and physically. It is not uncommon that nutrition intervention is neglected in the course of eating disorders treatment as there is an erroneous assumption that disordered eating behaviors is a secondary feature of the illness and the behaviors will correct themselves once the patient has received the necessary psychotherapy.¹⁷

However, it is critical to acknowledge medical stabilization and nutritional rehabilitation are the most important determinants of short-term outcomes and are essential for the advancement of mental health interventions.¹⁸ Further, the American Psychiatric Association and the National Institute for Clinical Excellence specify clearly the first goal of treatment for anorexia nervosa is weight restoration.¹⁹ Nutrition counseling guides patients in identifying problematic behaviors and setting realistic and achievable nutrition related goals to support clients in making behavior changes. Nutrition education includes conversations about discrepancies between knowledge, beliefs and behaviors, ultimately empowering the patient to normalize eating and make healthier decisions. Studies support that nutritional interventions along with psychological and psychiatric treatment are effective to improve eating behaviors and to normalize BMI and body composition.²⁰

Currently, Medicare does not cover medical nutrition therapy for individual with eating disorders. The bipartisan, bicameral Nutrition CARE Act would provide Medicare Part B coverage for medical nutrition therapy for individuals with an eating disorder at the same coverage levels

¹⁵ Dudrick, Stanley. (2013). Older Clients and Eating Disorders. *Today's Dietitian*, 15:11, 44.

¹⁶ Peat, Christine; Peyerl, Naomi; and Muehlenkamp, Jennifer. (2010). *Body Image and Eating Disorders in Older Adults: A Review*. *The Journal of General Psychology*, 135:4, 343-358.

¹⁷ Hart, S., Russell, J. and Abraham, S. (2011). Nutrition and dietetic practice in eating disorder management. *Journal of Human Nutrition and Dietetics*, 24, 144-153.

¹⁸ Rosen, David. (2010). Clinical Report—Identification and Management of Eating Disorders in Children and Adolescents. *American Academy of Pediatrics*, 126:6.

¹⁹ Marzola, E., Nasser, J., Hashim, S., Pei-an, B., and Kaye, W. (2013). Nutritional rehabilitation in anorexia nervosa: review of the literature and implications for treatment. *BMC Psychiatry*, 13:290.

²⁰ Ruiz-Prieto, Inmaculada, Bolanos-Rios, Patricia and Jauregui-Lobera, Ignacio. (2013). Diet Choice in weight-restored patients with eating disorders; progressive autonomy by nutritional education. *Nutricion Hospitalaria*, 28:5, 1725-1731.



currently provided for individuals with diabetes or ESRD. This is a critical gap in eating disorders care as seeking treatment outside of Medicare is cost-prohibitive—especially for the dual eligible population.

ii. *Provide Medicare coverage and parity enforcement across all levels of care*

The *Consolidated Appropriations Act of 2023* (P.L. 117-328) provided historic coverage for intensive outpatient treatment for mental health conditions under Medicare.²¹ In order to ensure this population receives the care they need; Medicare coverage needs to also extend to residential treatment for mental health conditions. Without explicit Medicare coverage for residential care for mental health conditions, a dual eligible with an eating disorder either forgoes treatment and their condition worsens to the extent they're admitted to inpatient, or they seek treatment at a lower level of care that is not necessarily compatible with the level of care they need.

As Medicare historically sets the tone for what services other public health insurance and commercial insurance covers and reimburses for, Medicare inadequacies have been replicated within TRICARE and the commercial market. This patchwork system continues to be a disservice for individuals and families with eating disorders. Although beyond the scope of this particular RFI, we encourage the U.S. Senate to examine dual eligibles within the TRICARE and Medicaid space given the complexity for enrollees and their families to navigate between the two systems of care.

Given Medicare does not have to comply with federal parity law, individuals and families with mental health and substance use disorders continue to receive discriminatory care. However, the EDC was heartened to see Senators Booker (D-NJ) and Braun (R-IN) and McGovern (D-MA) and the late Walorski (R-IN) successfully pushed for the White House to host a conference addressing food, nutrition, hunger, and health. Subsequently, the conference was held last fall and the administration released the White House National Strategy on Hunger, Nutrition, and Health.²² This strategy includes expanding Medicare and Medicaid beneficiaries' access to nutrition and obesity counseling to enrollees with additional conditions. Further, the strategy also calls to increase consistency in access and coverage of health care services and requests DOL, HHS and Treasury to clarify how mental health parity protections apply to coverage related to nutritional counseling for eating disorders to ensure coverage is not being inappropriately limited.

Conclusion

Access to quality, comprehensive, and affordable care that includes mental health and substance use disorder treatment is of critical importance to the work of the EDC and a key pillar for successful health outcomes for our community and the nation. We thank you for your leadership

²¹ See page 3743 <https://www.appropriations.senate.gov/imo/media/doc/JRQ121922.PDF>

²² See pages 17-18 <https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf>



in exploring ways to improve coverage for dual eligible Americans. We look forward to continuing to work with you on this important issue.

Sincerely,

Academy for Eating Disorders

Accanto Health

Alsana

ANAD (Anorexia Nervosa & Associated Disorders)

Academy of Nutrition & Dietetics

Be Real

Cambridge Eating Disorder Center

CarMax

Center for Change

Center for Discovery

Donahue Family Foundation

Eating Disorder Hope

Eating Disorders Coalition of Iowa

Eating Disorders Foundation

Eating Recovery Center

EDCare

EQUIP

Farrington Specialty Consulting

Galen Hope

International Association for Eating Disorders Professionals (iaedp)

International Federation of Eating Disorder Dietitians (IFEDD)

Laureate Eating Disorders Program

McCallum Place

Monte Nido & Affiliates

Montecatini

Moonshadow



Multi Service Eating Disorders Association Inc.

National Alliance for Eating Disorders

National Eating Disorders Association

National Center of Excellence for Eating Disorders (NCEED)

Project Heal

REDC Consortium

Rogers Behavioral Health

Stay Strong Virginia

Strategic Training Initiative for the Prevention of Eating Disorders (STRIPED)

SunCloud Health

The Renfrew Centers

Timberline Knolls

WithAll

Within Health

Wrobel & Smith