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NOTES

Eating Disorders and Our Youth: Aggressive Action Must be Taken to Ensure Parity

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Abstract

Eating disorders are one of the most common chronic illnesses among adolescents. Yet, our current framework for mental health care provides limited education, access to care, and support for adolescents suffering from this disease. The enactment of key legislation and federal guidance such as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is evidence that there are steps being taken to ensure the removal of barriers to care. However, eating disorders are often overlooked as a category of behavioral disorders. This paper analyzes the current legal and social framework for providing care and support to adolescents suffering from eating disorders. In doing so, it offers recommendations to develop stronger protective and responsive measures to ensure access, support, and care to these individuals.

Keywords: Eating disorders; behavioral disorders; mental health parity; mental health; health care; adolescents

Eating disorders (EDs) are among the deadliest behavioral disorders, second only to opioid overdoses.[1] In a report analyzing the social and economic costs of EDs in the United States of America, Deloitte Access Economics reports that "10,200 deaths each year are the direct result of an [ED]—that's one death every 52 minutes."[2] Among adolescents and young adults, eating disorders are one of the most common chronic illnesses.[3] According to the National Association of Anorexia and Associated Disorders (ANAD):

> 42% of 1st–3rd grade girls want to be thinner; 81% of 10-year-old children are afraid of being fat; 46% of 9–11-year-olds are "sometimes" or "very often" on diets; 35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives; 91% of college-aged women admitted to controlling their weight through dieting.[4]

[1] *Eating Disorder Statistics*, Nat'l Ass'n of Anorexia Nervosa & Associated Disorders, https://anad.org/eating-disorders-statistics/ [https://perma.cc/7ELV-9549] (citing Jon Arcelus et al. *Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies*, 68 Archives of Gen. Psychiatry 724 (2011)).

[2] *Eating Disorder Statistics*, *supra* note 1 (citing 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* i, iv (2020), https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/ [https://perma.cc/H7NS-DJ3G]).

[3] Eleni Lantzouni & Rosheen Grady, *Eating Disorders in Children and Adolescents: A Practical Review and Update for Pediatric Gynecologists*, 34 J. Pediatric Adolescence Gynecology 281, 281 (2021) (citing Rolly M. Ornstein et al. *Distribution of eating disorders in children and adolescents using the proposed DSM-5 criteria for feeding and eating disorders*, 53 J. Adolesc. Health 303, 304 (2013); David S. Rosen, *Identification and management of eating disorders in children and adolescents*, 126 Pediatrics 1240 (2010); Beate Herpertz-Dahlmann, *Adolescent eating disorders: update on definitions, symptomatology, epidemiology, and comorbidity*, 24 Child Adolescent Psychiatry Clinics N. Am. 177 (2015)).

[4] *Eating Disorder Statistics*, *supra* note 1 (citing M. Elizabeth Collins, *Body figure perceptions and preferences among preadolescent children*, 10 Int'l J. of Eating Disorders 199 (1991); Suzanne W. Mcnutt et al., *A longitudinal study of the*

EDs have the highest mortality rate of any psychiatric disorder due to high suicide rates and a confluence of numerous medical issues.[5] Suffering from an ED in adolescence comes with increased risk for growth and development as it can cause puberty delay, intrauterine growth restriction (IUGR), and impair acquisition of bone mass.[6] Each of these health effects has long-term health implications such as increased risks of developing cardiovascular and metabolic disorders.[7] An ED can also cause peptic ulcers, tooth decay, increased risk of heart failure, increased risk of kidney failure, and increased risk of gastric and esophagus rupture.[8]

While EDs manifest in various forms, the most common types include Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorders (BED), and Otherwise Specified, Eating and Feeding Disorders (OS-FED).[9] AN involves severe restrictions on the amount of food consumed[10] while BN consists of "episodic binges" followed by "inappropriate compensatory behaviors."[11] BED is characterized by the same episodic binges that occur in BN, but there is an "absence of inappropriate compensatory behavior."[12] Those suffering from OS-FED do not meet diagnostic criteria for the other categories but still partake in "extremely disturbed" eating habits.[13] Regardless of how the EDs manifest for each individual, studies show that they tend to "result from interactions between genetic and environmental factors at critical time points in development."[14] As much as EDs are influenced by one's individual biology, they can be further influenced by external factors such as distorted images in the media, nutrition habits focusing on calorie counting, and societal pressure to achieve a particular physique or digits on the scale.[15]

The number of individuals, especially children, suffering from EDs has been exacerbated by the COVID-19 pandemic with an increase of 80% in calls to the National Eating Disorders Association helpline since the start of the pandemic.[16] Inpatient and outpatient units in hospitals and specific ED programs are overwhelmed, and the demand for treatment exceeds the capacity of providers to deliver

dietary practices of black and white girls 9 and 10 years old at enrollment: The NHLBI growth and health study, 20 J. of Adolescent Health 27 (1997); A. M. Gustafson-Larson & R. D. Terry, *Weight-related behaviors and concerns of fourth-grade children*, 92 J. Am. Diet Assoc. 818 (1992); Kerri Boutelle et al., *Weight Control Behaviors Among Obese, Overweight, and Nonoverweight Adolescents*, 25 J. of Pediatric Psychol., 531 (2002); Greta Noordenbos et. al., *Characteristics and Treatment of Patients with Chronic Eating Disorders*, 10 J. of Treatment & Prevention, 15 (2002)).

[5]Erin C. Accurso et al., *Adaptation to family-based treatment for Medicaid-insured youth with anorexia nervosa in publicly-funded settings: Protocol for a mixed methods implementation scale-out pilot study*, 9 J. of Eating Disorders 1, 2 (2021).

[6]Canadian Paediatric Society Clinic, *Eating Disorders in adolescents: Principles of diagnosis and treatment*, 3 Paediatric Child Health 189, 190 (1998). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851329/pdf/pch03189.pdf.

[7]Rehana Salam et. al, *Impact of intrauterine growth restriction on long-term health* 17 Current Opinion in Clinical Nutrition & Metabolic Care 249, 249 (2014); Jia Zhu and Yee-Ming Chan, *Adult Consequences of Self-Limited Delayed Puberty* 139 Pediatrics 1,1 (2017).

[8]National Eating Disorders Association, *Fact Sheet on Eating Disorders* (July 10, 2010), https://www.pattymohlercounseling.com/wp-content/uploads/2012/09/NEDA.pdf.

[9]Yael Latzer et. al, *Addressing eating disorders through legislation: The Israeli 'Models' Law'—process, enactment, and dilemmas* 1 Dialogues in Health (2022) 1, 1.

[10]Mayo Clinic, Overview, Anorexia Nervosa (Feb. 20, 2018), https://www.mayoclinic.org/diseases-conditions/anorexia-nervosa/symptoms-causes/syc-20353591 [https://perma.cc/GTM3-ZM3W].

[11]Kathryn Castle & Richard Kreipe, *Bulimia Nervosa*, *in* Pediatric Clinical Advisor 85-86 (Lynn C. Garfunkel et. al. eds., 2d ed. 2007); Nori Geary, *Appetite, in* Encyclopedia of Hum. Behav. 187-198 (V.S. Ramachandran eds., 2d ed. 2012).

[12]C.M. Bulik & J.H. Baker, *Genetics and Human Appearance, in* Encyclopedia of Body Image & Hum. Appearance 453, 458 (Jonathan F. Cash, eds., 2d ed 2012).

[13]Center for Discovery, *OSFED Signs & Symptoms*, https://centerfordiscovery.com/conditions/osfed/#:~:text=Other%20Specified%20Feeding%20and%20Eating,Manual%20(DSM%2DIV) [https://perma.cc/84YJ-N67J].

[14]Lantzouni & Grady, *supra* note 3.

[15]Anne M. Morris & Debra K. Katzman, *The Impact of the Media on Eating Disorders in Children and Adolescents*, 8 Pediatrics & Child Health 287, 287-88 (2003).

[16]Erin C. Accurso et al., *Youth Insured By Medicaid With Restrictive Eating Disorders–Underrecognized and Underresourced,* 175 JAMA Pediatr. 999, 999 (2021); Lisa Damour, *Eating Disorders in Teens Have 'Exploded' in the Pandemic*, N.Y. Times (Apr. 28, 2021), https://www.nytimes.com/2021/04/28/well/family/teens-eating-disorders.html [https://perma.cc/3BAY-T423].

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care.[17] The need for increased access to mental health services for youth and adolescents suffering from EDs is critical – even more so among children in marginalized communities where they are more likely to suffer in silence when dealing with an ED.[18] Prevention and care at a young age is the best method for intercepting downstream harm as individuals with unmet mental health needs face disproportionately high rates of poverty, housing and employment discrimination, and incarceration.[19] While vulnerable communities are more likely to suffer in silence, they are also more likely to be unable to pay for out-of-pocket treatment for mental health services.[20]

"Mental illness … is an abnormality in the body which can result in death if untreated."[21] The best ways to provide care are by expanding coverage, ensuring greater enforcement of coverage by the overseeing federal agencies, and access to care. Part I of this Note will discuss the background of mental health care coverage in the United States leading up to the passage of the passage of various parity legislation and their expansions via the Patient Protection and the Affordable Care Act (ACA) and the current landscape of behavioral health care coverage and thus, ED care.[22] Part II will focus on the implications of our fragmented mental health care "system" and the lack of care provided for youth with EDs. Part III will address more recent action that the federal government is taking because it is important to consider the implications if any legislation successfully passes. Finally, Part IV will take past, present, and pending practices into consideration to provide a roadmap to a more centralized and enforceable system of care via closing coverage gaps, greater enforcement of parity laws, and innovative tactics such as distorted advertising-focused legislation and increased screening and training. Throughout this paper, mental health care will be discussed as a broad field encompassing the specific issue of EDs. Additionally, "children" and "adolescents" will be used interchangeably to encompass the portion of the population harmed. Parity will be defined as the need for payment coverage for mental health care to be comparable to physical health coverage, such that the patients' financial responsibilities, such as copayments and treatment limits, for their mental health services are in 'parity' with that of their physical health services.[23]

Framework of mental health care in the united states

Background of Mental Health Care Legislation in the United States

The evolution of mental health care in the United States has continued to progress in the direction of community-based care since the passage of the Community Mental Health Centers Act of 1963

[17]Damour, *supra* note 16.

[18]*Eating Disorder Statistics*, *supra* note 1; Anisa Durham, *Eating Disorders in the Black Community Are More Common Than You Think*, UNC Nutrition Res. Institute (Nov. 10, 2022), https://uncnri.org/2022/11/10/eating-disorders-in-the-black-community-are-more-common-than-you-think/ [https://perma.cc/V9RE-XY36]; University of North Carolina at Chapel Hill: Campus Health, *Diversity in Eating Disorders*, https://campushealth.unc.edu/health-topic/diversity-in-eating-disorders// [https://perma.cc/QC99-G25K] (even while rates of ED are higher among Black individuals than their white counterparts and gay males are "seven times more likely to binge and 12 times more likely to purge than straight males").

[19]Azza Altiraifi & Nicole Rapfogel, *Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis*, Ctr. For Am. Progress (Sept. 10, 2020, 9:05 AM) (citing U.S. Office of Pol'y Development and Rsch., *Rental Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing*, (Washington: U.S. Dep't of Housing and Urban Development, 2017), https://www.huduser.gov/portal/sites/default/files/pdf/MentalDisabilities-FinalPaper.pdf; Jenny Gold, *Adults With Serious Mental Illnesses Face 80% Unemployment*, Kaiser Health News (July 10, 2014), https://khn.org/news/report-adults-with-serious-mental-illnesses-face-80-unemployment/; Liat Ben-Moshe, *Disabling Incarceration: Connecting Disability to Divergent Confinements in the USA*, 39 Critical Socio. 385 (2011)).

[20]*See* Minaa B., *Mental Health Treatment is a Privilege Many People Can't Afford,* Nat'l Alliance on Mental Illness, https://namiiowa.org/mental-health-treatment-privilege-many-people-cant-afford/ [https://perma.cc/9CNX-A3FB].

[21]Jen Sugermeyer, *Eating Disorders (ED), a Global Epidemic, De-stigmatizing ED to Save Lives*, *in* Innovations in Global Mental Health 191, 200 (Samuel O. Opaku, ed., 2021).

[22]Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18001–18122 (2010).

[23]Substance Abuse & Mental Health Serv. Admin., U.S. Dep't of Health & Hum. Servs., Pub. ID SMA16-4971, Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits (2016).

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(CMHCA).[24] Prior to this act, institutionalization of patients triggered human rights violations and poor living conditions.[25] In response, in 1963, President John F. Kennedy proposed a new program under which the federal government would fund community mental-health centers (CMHCs) to take the place of state mental hospitals.[26] The hope was that "reliance on the cold mercy of custodial isolations will be supplanted by the open warmth of community concern and capability."[27] The Community Mental Health Centers Act of 1963 codified deinstitutionalization and allowed for an increase of legislation and treatment focused on quality of life of the patient. This focus has since been a stated goal in healthcare legislation and movements.[28]

In 1965, the Social Security Amendments established Medicaid and Medicare.[29] These federal programs had a positive impact on the expansion of "acute care beds… for psychiatric patients" and led toward a significant reduction in patient state hospital placements.[30] Medicaid became "the single most significant source of support for public mental health systems."[31]

Following in the footsteps of President Kennedy, President Jimmy Carter issued an executive order creating the President's Commission on Mental Health (PCMH) on February 17, 1977.[32] The commission provided a report focusing on its findings of four main issues impacting mental health in the United States: "the delivery of community-based mental health services, financing, the need to expand the general knowledge base, [and] greater efforts [need to] be made to identify strategies that would help prevent mental disorder and disability."[33] In response to the committee and various reports, Congress passed the Mental Health Systems Act in 1980, which focused on providing grants and training programs.[34] However, it soon became clear that the CMHCs did not want to take individuals with "severe" mental health issues.[35] Instead, they focused on the "worried well," leaving many without access to care as the state-based hospitals were slowly closing.[36] This refusal of care allowed the "sickest" patients released from state hospitals to go without treatment.[37]

By 1981, Congress repealed the bulk of CMHC Acts and Mental Health Systems Act.[38] This repeal led to a significant number of individuals relying on this mental health care to become houseless.[39] This prompted action by the federal government to reinstate these programs in other ways, such as through Medicaid and Medicare.[40] The first mental health parity bill, the Equitable Health Care for Severe Mental Illnesses Act of 1992, was introduced to Congress by Senators Pete Domenici and

[24]Community Mental Health Act of 1963, Pub. L. No. 88-164, 77 Stat. 282.

[25]Ellen Sutherland, *Shifting Burdens: The Failures of the Deinstitutionalization Movement From the 1940s to the 1960s in American Society*, 6 Constellations: Univ. of Alberta Student J. 35, 35-36 (2015).

[26]John F. Kennedy, Special Message on mental illness and mental retardation (Feb. 5, 1963), https://www.jfklibrary.org/asset-viewer/archives/JFKPOF/052/JFKPOF-052-012 [https://perma.cc/G7XV-4TJA].

[27]*Id.*

[28]Community Mental Health Act of 1963, *supra* note 24; Blake Erickson, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963*, 13 Am. J. of Psychiatry Residents' J. 6, 6 (2011).

[29]Social Security Amendments of 1965, Pub. L. No. 89-97, 79 State. 286.

[30]Chris Koyanagi, *Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long-Term Care Reform,* the Kaiser Comm'n on medicaid and the Uninsured 1,6 (2007).

[31]*Id.* at 9 (citing Jeffrey A. Buck, *Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services* 54 Psych. Servs. 969, 969 (2003)).

[32]Gerald N. Grob, *Public Pol'y and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health,* 83 Milbank Q. 425, 429 (2005).

[33]*Id.* at 437.

[34]*Id.* at 447; Ramya Sundararaman & C. Stephen Redhead, Cong. Rsch. Serv. RL 33820, The Mental Health Parity Act: A Legislative History 2 (2007); Mental Health Systems Act, 42 U.S.C. §§ 9401–9523.

[35]*See* E. Fuller Torrey, *Fifty Years of Failing America's Mentally Ill,* Wall St. J., (Feb. 4, 2014).

[36]*Id.*

[37]*Id.*

[38]Grob, *supra* note 32, at 449; Pub. L. No. 96-398, 94 Stat. 1609.

[39]Koyanagi, *supra* note 30, at 8.

[40]Grob, *supra* note 32, at 428.

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John Danforth.[41] However, no further action was taken to pursue mental health parity until 1996 when a "scaled-back" version of the previously proposed bill was introduced, the Mental Health Parity Act (MHPA) of 1996.[42] This Act required mental health parity only for "annual and lifetime dollar limits… for group health plans with fifty or more employees that offered mental health benefits."[43] Also, insurance companies were still permitted to "impose other restrictions on mental health coverage such as covering only selected treatments or applying higher cost sharing for mental health crisis, and parity requirements did not extend to substance use disorder" treatment.[44]

Nevertheless, the move from institutionalized care to community care was bolstered by the Supreme Court's 1999 decision in Olmstead.[45] Under Title II of the Americans with Disabilities Act (ADA), "states are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer … is not opposed by the affected individual, and … can be reasonably accommodated."[46] The Court relied on a regulation known as the "integration regulation," which requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[47] They also relied on a regulation called the "reasonable-modifications regulation," which requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability."[48] As a result of these efforts, individuals have avoided unnecessary institutionalization with a move toward a more reasonable community-based method of care.[49]

By 2006, 37 states had their own parity laws in place varying in eligibility, care covered, and the delivery of the use of managed care.[50] It was not until 2008 that the federal government once again took steps to provide insurance coverage and access to care for those suffering from significant mental health challenges and proposed a more comprehensive plan.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted to remedy inequity and discrimination against mental health and substance use disorders in health plans' coverage and payments to mental health professionals.[51] This federal law amended the Employee Retirement Income Security Act (ERISA), which prevented prior laws from requiring employers to cover mental health services, and other federal laws relevant to health insurance benefits, to require "employer-sponsored health plans with more than 50 employees, including self-insured and fully insured plans" to pay for mental health care without disparities in out of pocket costs or payment to providers.[52] While it does not require employer-sponsored health plans to cover mental health care, if the plan does provide coverage, it must be substantially comparable to physical health care.[53] MHPAEA furthered the parity rules set in place by the MHPA and extended them to substance

[41]Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 Milbank Q. 404, 409 (2010); Equitable Health Care for Severe Mental Illnesses Act of 1992, S. 2696, 102nd Cong. (1992).

[42]*Id.* at 409; Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874.

[43]*Id.*

[44]Norah Mulvaney- Day et. al., *Mental Health Parity and Addiction Equity Act and the Use of Outpatient Behavioral Services in the United States, 2005-2016*, 109 Am. J. of Pub. Health 190, 190 (2019).

[45]Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999).

[46]*Id.*

[47]*Id.*; 28 CFR § 35.130(d).

[48]*Id.*; 28 CFR § 35.130(b)(7).

[49]U.S. Dep't of Health & Hum. Servs., *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html [https://perma.cc/V3JE-NXLU].

[50]Barry, *supra note* 41, at 410.

[51]29 U.S.C. § 1185(a); Nat'l Alliance on Mental Illness, *A Long Road Ahead Achieving True Parity in Mental Health and Substance Use Care* 1, 1-2 (2015).

[52]*Id.*; Employee Retirement Income Security Act, 29 U.S.C. §1001-1461).

[53]*See* Kaye Pestaina, *Mental Health Parity at a Crossroads*, Kaiser Fam. Found. (Aug. 18, 2022), https://www.kff.org/private-insurance/issue-brief/mental-health-parity-at-a-crossroads/ [https://perma.cc/D848-XD7K].

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use disorder benefits.[54] Though Medicaid and CHIP are not group health plans or issuers of health insurance, there are aspects of the plans that must meet certain MHPAEA requirements as added to the Public Health Service Act (PHS Act).[55] An individual's plan is subject to parity and states must document compliance related to "aggregate lifetime limits, financial requirements, quantitative treatment limitations, non-quantitative treatment limitations (NQTLs), and availability of information" as required by the PHS Act.[56] However, there has been no evidence that the MHPAEA has "substantially improved access to behavioral health for Medicaid and CHIP beneficiaries" as states were only required to make modest changes, "does not require coverage of specific behavioral health services," and is complex to use.[57]

The MHPAEA was developed under the theory of cooperative federalism where state and federal governments should cooperate to administer programs rather than occupy "separate spheres."[58] This structure allows states "great flexibility in designing their program, which leads to variable coverage and benefits across states, which in turn exacerbates disparities in coverage, access to care, and health outcomes."[59] The dynamic of parity laws is both legally and factually complex. This complex structure creates challenges to enforcing parity rights, including but not limited to, lack of congruent enforcement and oversight, lack of consumer and provider knowledge, lack of a private right of action, and NQTLs.[60]

This law was further expanded by the Patient Protection and the Affordable Care Act of 2010 (ACA).[61] The ACA amended MHPAEA to apply to individual and small group plans.[62] Further, mental health and substance abuse care would be required as one of the 10 categories of services individual and small group insurance must cover as "Essential Health Benefits" under the ACA.[63] However, in the process of providing rules for the ACA's essential health benefits for mental health and substance treatment, the Department of Health and Human Services (HHS) "announced a plan allowing each state to choose a benchmark plan from any option existing in the state, most of which limited or excluded eating disorder coverage."[64] Notably, employer-sponsored group health plans are exempt from this ACA requirement and do not have to offer EHB unless they are small group market, fully insured, and non-grandfathered.[65]

The federal statutory foundation created by recent mental health parity acts can be bolstered by stronger centralized enforcement and expansion of requirements, education, and access. These supports

[54]Employee Benefits Security Admin., U.S. Dep't of Labor, Fact Sheet: Mental Health Parity & Addiction Equity Act of 2008 (Jan. 29, 2010), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea.pdf.

[55]Public Health Services Act, Pub. L. No. 78-410, 58 Stat. 682 (1944).

[56]*Id*; Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18390 (March 30, 2016) (amending 42 C.F.R. §§ 438.900, 440.395, 457.496); MACPAC, Advising Congress on Medicaid and CHIP: Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP 1, 1-3 (July 2021).

[57]MACPAC, *supra* note 56, at 4.

[58]*Id.* at 2224 (citing Keith E. Whittington, *Dismantling the Modern State? The Changing Structural Found. of Federalism*, 25 Hastings Const. L.Q. 483, 485 (1998)).

[59]Nicole Huberfeld & Sidney Watson, *Medicaid's Vital Role in Addressing Health and Economic Emergencies,* Assessing Legal Responses to Covid-19, 103, 103 (2020).

[60]*See generally* Caroline V. Lawrence & Blake N. Shultz, *Divide & Conquer? Lessons on Cooperative Federalism from a Decade of Mental-Health Parity Enforcement*, 130 Yale L.J. 2216 (2021).

[61]42 U.S.C. §§ 18001–18122, *supra* note 22.

[62]*Id.*

[63]42 U.S.C. § 18022 (2010); *Essential Health Benefits*, U.S. Ctrs. for Medicare & Medicaid Serv., https://www.healthcare.gov/glossary/essential-health-benefits/ [https://perma.cc/JA3X-Z355].

[64]Sarah Hewitt, *A Time to Heal: Eliminating Barriers to Coverage for Patients with Eating Disorders under the Affordable Care Act,* 31 Minn. J. of L. & Inequality, 411, 414 (2013); Morgan C. Shields, *How Could The 21st Century Cures Act and The Joint Commission Improve Eating Disorder Care?,* Health Aff. (June 28, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20170628.060769/full/ [https://perma.cc/3B3T-QM4Q].

[65]Brian Gilmore, *ACA Essential Health Benefits*, Newfront (Feb. 1, 2020), https://www.newfront.com/blog/aca-essential-health-benefits [https://perma.cc/79YX-SCQ5].

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would create a system that can likely succeed in providing for the mental health care of individuals in the United States.

Structure of Current Mental Health Parity Enforcement

Three federal agencies are responsible for overseeing the MHPAEA at different levels. The Department of Labor's (DOL) Employee Benefit Securities Administration (EBSA) and the Department of Treasury (Treasury) overlap enforcement authority over parity requirements for plans offered by large employers.[66] For regulation of public plans and state enforcement efforts, HHS has primary oversight. Meanwhile, states administer Medicaid and Children's Health Insurance Program (CHIP) plans in conjunction with CMS pursuant to federal statutes and regulations.[67]

Despite MHPAEA requirements, there are overwhelming reports documenting insurance providers' and issuers' lack of compliance with federal laws. Stakeholders asserted that compliance assistance was not enough, prompting Congress to pass the Consolidated Appropriations Act (CAA) allowing HHS and the Treasury to take measures for proactive enforcement.[68] These new tools required plans and issues to provide "comparative analyses of their [NQTLs] upon request and to authorize the Secretaries to determine whether… [they] comply with MHPAEA."[69] NQTLs limit the scope or "duration of benefits for services provided under the plan."[70] In response to the enactment of the CAA, the EBSA created a MHPAEA NQTL Task Force to implement new provisions for insurers and insurance plans.[71]

Further, to ensure equity in the care of patients who suffer from an ED, the Joint Commission for Behavioral Health Care Accreditation Program implemented a set of eleven new standards in 2016; these standards provided for both outpatient and residential ED care.[72] For example, some of the new standards for organizations that provide ED care, treatment, and services focused on respecting the rights of the individual, efficiently exchanging information related to care, treatment, or services with other providers upon transfer or discharge, and creating a plan of care that reflects individual needs, strengths, and preferences.[73]

Beyond federal parity laws via the MHPAEA and expansion through the ACA, states have laws and regulations regarding mental health parity. For example, Massachusetts Mental Health Parity Law (MMHPL) was drafted in the 1999–2000 legislative session and has been updated several times over the years.[74] The MMHPL applies to health plans subject to fully insured and Group Insurance Commission (GIC) plans. Under these plans, the law requires coverage on a nondiscriminatory basis of "biologically based mental disorders" that are listed in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).[75] Biologically based disorders are those caused by "any genetic or psychophysiological

[66]Lawrence, *supra* note 59, at 2224.

[67]*Id.* at 2225.

[68]Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182; U.S. Dep'ts of Labor, Health & Hum. Sers., and Treasury, *2022 MHPAEA Report to Congress on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008* 1, 11 (Jan. 25 2022), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[69]*Id.*

[70]Arizona Dep't of Insurance and Financial Institutions, *What are Non-Quantitative Treatment Limitations (NQTL)?*, https://difi.az.gov/faq/what-are-non-quantitative-treatment-limitations-nqtl [https://perma.cc/CPS5-WB9N].

[71]*2022 MHPAEA Report to Congress supra* note 68.

[72]*See* Lynn Berry, The Joint Comm'n, *Approved: New Requirements for Residential and Outpatient Eating Disorders Programs*, 36 Joint Comm'n Perspectives 1 (2016), https://www.jointcommission.org/-/media/enterprise/tjc/imported-resource-assets/documents/approved_new_req_residential_outpatient_eating_disorderpdf.pdf?db=web&hash=3EA65359BD16E79B472F0F5BE8ECD35E&hash=3EA65359BD16E79B472F0F5BE8ECD35E [https://perma.cc/A9X5-QPU6].

[73]*Id.* at 4.

[74]Sarah Gordon Chiaramida, *Understanding the Mass. and Federal Mental Health Parity Laws*, IV, OnPoint: Health Pol'y Brief 1, 1 (2016) (An Act Relative to Mental Health Benefits, ch. 80, (2000)).

[75]*Id.*

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factors."[76] The most recent edition of the DSM lists 13 biologically based mental disorders: "schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; delirium and dementia; affective disorders; *eating disorders*; post-traumatic stress disorder; substance abuse disorders; and autism."[77]

The plans that most impact children's and adolescents' behavioral health care are Medicaid and the Children's Health Insurance Program (CHIP), which are structured differently within each state, coupled with advancements via the 21st Century Cures Act (Cures Act).[78]

Medicaid and CHIP

When it comes to mental health care for children, Medicaid and CHIP cover "almost half of all U.S. children with special health care needs."[79] Coverage through these federal programs is imperative as these children are "more likely to be low-income, a member of a racial or ethnic minority group, and younger than those children covered by private insurance alone."[80]

Medicaid is a public health care program funded jointly by federal and state governments and administered by states. As of November 2021, 78.9 million Americans received health care coverage through Medicaid.[81] Medicaid is also the "single largest payer for mental health services" in the country.[82] The ACA expanded Medicaid coverage to childless, nonelderly adults "with incomes up to 138% of the Federal Poverty Level" and provided states with an "enhanced federal matching rate" for expanding coverage.[83] Studies show that Medicaid expansion is linked to advancements in "coverage, financial security, and positive health outcomes."[84]

CHIP is available to children in families with low to moderate incomes who do not qualify for Medicaid.[85] The ACA has better positioned CHIP to provide coverage by "expanding coverage in many states and mandating streamlined and modernized eligibility and enrollment systems for all states."[86] Despite these improvements, eligibility and enrollment policies still vary greatly across states, allowing people to fall through the "safety nets" depending on the state in which they reside.[87] Due to the flexibility granted by federal law, some states have CHIP programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches.[88]

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[76]Woo-kyoung Ahn et al., *Mental Health Clinicians' Beliefs About the Biological, Psychological, and Environmental Bases of Mental Disorders,* 33, COGNITIVE SCI.: A MULTIDISCIPLINARY J. 147, 151 (2009).

[77]MASS. GEN. LAWS ch. 175, § 47B (2020).

[78]42 U.S.C. § 1396; CHIP Pub. L. 1140919 129 Stat. 87; 21st Century Cures Act Pub. L. 114-255, 130 Stat. 1033.

[79]Elizabeth Williams & MaryBeth Musumeci, *Children with Special Health Care Needs: Coverage, Affordability, and HCBS Access,* KAISER FAM. FOUND. (Oct. 4, 2021), https://www.kff.org/medicaid/issue-brief/children-with-special-health-care-needs-coverage-affordability-and-hcbs-access/ [https://perma.cc/L7FX-WN3E].

[80]*Id.*

[81]MEDICAID, https://www.medicaid.gov/medicaid/index.html [https://perma.cc/Q6AT-HC2J].

[82]MEDICAID, *Behavioral Health Services*, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html [https://perma.cc/6AZE-2MVX].

[83]KAISER FAM. FOUND., Status of State Medicaid Expansion Decisions (Jul. 21, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/38J5-6HSS] (As of 2022, 39 states and Washington D.C. have adopted Medicaid expansion).

[84]Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021,* KAISER FAM. FOUND. (May 6, 2021), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ [https://perma.cc/QJ75-9BHQ].

[85]*Nat'l Acad. for State Health Pol'y*, Mass. 2019 CHIP Fact Sheet, https://www.nashp.org//wp-content/uploads/2019/12/2019CHIPFactSheet_Massachusetts_Final.pdf.

[86]Huberfeld, *supra* note 59, at 106.

[87]*Id.*

[88]*Key CHIP Design Features*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, https://www.macpac.gov/subtopic/key-design-features/#:~:text=CHIP%20gives%20states%20flexibility%20to,separate%20CHIP%20program%20for%20others [https://perma.cc/P3QD-BSWE].

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The SUPPORT Act in 2018 expanded coverage by requiring CHIP programs to provide behavioral health services to children and pregnant women.[89] Prior to the passage of this act, parity laws applied to CHIP, but states could "get around the requirement by not offering behavioral health services in separate CHIP programs."[90] In March 2020, CMS released a State Health Official Letter to provide guidance to states on implementing the new requirements required in the SUPPORT Act.[91] The letter explicitly states that Section 5022 of the SUPPORT Act requires that "child health and pregnancy related assistance 'include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders.'"[92]

Cures Act

The Cures Act, enacted in 2016, was designed to promote innovation and acceleration in medical product development.[93] The Act also contained key provisions from the Anna Westin Act of 2015, whose namesake passed away in 2000 due to her battle with anorexia.[94] One of the goals of this act was to "improve compliance with MHPAEA by requiring the Departments to solicit feedback from the public on how to improve disclosure of the information required."[95] Another gap that the Cures Act intended to fix was coverage for EDs, which the ACA did not explicitly cover, despite being associated with the highest mortality rates among mental illnesses.[96] Section 13007 of the 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."[97] The Act also called for required ED information to be included on the HHS Office of Women's Health Website and training for health professionals to identify EDs early.[98] The Cures Act marked the first time that Congress passed legislation specifically focused on improving the lives of those suffering from an ED.[99]

Current structure in practice

Despite the piecemeal advancements in federal legislation to promote increased access to mental health care for illnesses such as EDs, the MHPAEA, as mentioned above, has not "substantially improved access

[89]Substance use-disorder prevention that promotes opioid recovery and treatment for patients and communities act, Pub. L. No. 115-271, 132 Stat. 3894; Elisabeth Wright Burak, *Behavioral Health Services in Separate State CHIP Programs: Is Your State in Compliance?*, Geo. Health Pol'y Inst. Ctr. for Children & Fam. (May 29, 2020), https://ccf.georgetown.edu/2020/05/29/behavioral-health-services-in-separate-state-chip-programs-is-your-state-in-compliance/#:~:text=The%20SUPPORT%20Act%2C%20passed%20in,Health%20insurance%20Program%20(CHIP).&text=The%20SHO%20lays%20out%20the,and%20treatment%20states%20should%20detail [https://perma.cc/56EE-K8WT].

[90]Burak, *supra* note 89.

[91]*Id.*; Calder Lynch, *RE: Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children's Health Insurance Program*, 20-002, (Dep't of Health & Human Services March 2, 2020).

[92]Burak, *supra* note 89; Lynch, *supra* note 91.

[93]21st Century Cures Act Pub. L. 114-255, 130 Stat. 1033; U.S. Food & Drug Admin., 21st Century Cures Act (Jan. 31. 2020), https://www.fda.gov/regulatory-information/selected-amendments-fdc-act/21st-century-cures-act [https://perma.cc/ENB2-WEPL].

[94]Press Release, Eating Disorders Coalition, Congress Makes History by Passing First-Ever Eating Disorders Legislation (Dec. 7, 2016); H.R. 2515, 114th Cong. (2015), S. 1865 114th Cong. (2015).

[95]*FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CARES ACT PART 38*, Ctrs. for Medicaid & Medicare Serv. (June 16, 2017), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-38.pdf.

[96]Hewitt, *supra* note 64, at 418.

[97]FAQS ABOUT MENTAL HEALTH, *supra* note 89; 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033.

[98]21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033; Eating Disorders Coalition, *Eating Disorders in the 21st Century Cures Act*, http://eatingdisorderscoalition.org.s208556.gridserver.com/couch/uploads/file/eating-disorders-in-21st-century-cures.pdf

[99]*Id.*

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to behavioral health care for Medicaid and CHIP beneficiaries."[100] While parity laws were enacted to reduce the inequities "between behavioral and physical health services, [they do] not require that payers cover behavioral health services."[101] Further, they are also not required to cover "specific screening tools or treatment modalities" that would likely benefit individuals suffering from an ED.[102] Mental health parity coverage for EDs as actually implemented in the United States is inefficient and children continue to suffer due to lack of access to specific courses of treatment, instability in Medicaid and CHIP coverage, lack of training of educational professionals to support children in schools, the continuing stigma of EDs, and the exacerbation of ED issues due to the pandemic.

Treatment Available for ED Patients

To ensure that children are getting evidence-based care, health researchers, health service institutions, and governments must "join forces to deliver integrated and multidisciplinary actions in mental health, especially in the early steps of the prevention chain."[103] Studies show that family-based treatment (FBT) tends to be "the most effective treatment for adolescents with AN and atypical AN (AAN)".[104] FBT is a "manualized outpatient therapy designed to restore adolescents to health with the support of their parents" with the goal of steady weight loss/gain and empowering autonomous decision making.[105] Parents are responsible for supervising the patient's eating in an environment focusing on empathy and enforcement.[106] The key principles include an "agnostic view" of the illness, a "focus on externalizing the illness from the patient," the therapist taking a "nonauthoritarian therapeutic stance," "empowerment of the parents," and "symptom reduction."[107] Approximately 20% of individuals suffering from AN will require hospitalization and within one year 40% usually require rehospitalization.[108] Studies also show that when this treatment is received within the first three years of illness, there is a higher chance of sustained recovery.[109] Beyond practical effectiveness, outpatient FBT care proves to be the most cost-effective way to treat EDs as it has been shown to "reduce the need for inpatient admission by more than 50%," which saves $9,000 per patient in treatment charges when compared with other specialized outpatient treatment.[110]

However, of the about 60 U.S. clinicians certified in FBT by the Training Institute for Child and Adolescent Eating Disorders, only three are contracted with Medicaid.[111] Two-thirds of these clinicians accept self-payment only, leaving FBT treatment to those who can pay out of pocket.[112] Economically disadvantaged youth have limited access to evidence-based care and FBT implementation has not been tested as widely with low-income and racially and ethnically diverse patients.[113] This gap in access to evidence-based care disproportionately affects youths with public insurance and leaves them "especially

[100]MACPAC, *supra* note 56, at 4.

[101]*Id.*

[102]*Id.*

[103]Marco Colizzi et. al., *Prevention and early intervention in youth and mental health: is it time for a multidisciplinary and trans-diagnostic model for care?,* 12 Int'l J. of Mental Health Sys. 1, 1 (2020).

[104]Accurso, *supra* note 16, at 2.

[105]Renee D. Rienecke, *Family-based treatment of eating disorders in adolescents: current insights,* 8 Adolescent Health, Medicine & Therapeutics 69, 70-71 (2019).

[106]Hannah Sheldon-Sean, *Family-Based Treatment for Eating Disorders*, Child Mind Institute (Sept. 27, 2021), https://childmind.org/article/family-based-treatment-for-eating-disorders/ [https://perma.cc/9ZZZ-AKZ8].

[107]Rienecke *supra* note 105, at 71.

[108]Accurso, *supra* note 5, at 2.

[109]Janet Treasure & Gerald Russell, *The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors*, 199 The British J. of Psychol. 5, 5 (2011).

[110]Accurso, *supra* note 16, at 2.

[111]*Id.* (citing Training Institute for Child and Adolescent Eating Disorders, *Therapists certified in family-based treatment*, http://train2treat4ed.com/certified-therapists-list [https://perma.cc/DW39-GX45]).

[112]Accurso, *supra* note 16, at 2.

[113]Accurso *supra* note 5, at 2.

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vulnerable to hospitalization, and at risk for developing a chronic AN or AAN requiring ongoing, expensive treatment."[114]

Federal Insurance Accessibility for ED Patients

Uninsured Children

Medicaid also leaves many individuals uninsured due to states' refusal to implement Medicaid expansion. In 2019, 2.2 million uninsured individuals were left without health insurance coverage because their income was below the poverty line, which is too low to qualify for coverage in several states.[115] Between 2016-2019, the number of uninsured children in America increased.[116] The rates of uninsured children were highest among Hispanic children, undocumented children, those living in the South, and children in families with lower incomes.[117] In 2018, more than half of uninsured children were eligible for Medicaid or CHIP.[118] Between 2019 and 2020, 873,028 fewer children were enrolled in Medicaid and CHIP, a decrease of 1.9 percent.[119] This decrease in the number of uninsured children is likely due to a variety of reasons, including the policy and political climate shifts that occurred during the Trump administration.[120] CHIP, as it currently exists, is not a permanent part of federal budget plans and therefore, must be reauthorized every few years, allowing it to become a political negotiating tool,[121] as evidenced by Congress allowing CHIP's federal funding to lapse in 2017 and the Trump administration's policy preferences to eliminate $15 billion in federal spending, with $7 billion of those funds being used for CHIP.[122]

Throughout his presidency, President Trump continued to battle against the ACA and attempted to repeal the Act at every level. Some of the changes to Medicaid that were instituted during the Trump years include allowing states "unprecedented authority to require people in poverty to pay premiums for their health care coverage," imposing work requirements, and requiring states to add barriers for Medicaid coverage acceptance (such as requiring additional documentation).[123] Such policy changes

[114]Accurso, *supra* note 16, at 2.

[115]Jennifer Sullivan et. al., *To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap,* Center on Budget & Pol'y Priorities (Oct. 4, 2021), https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap [https://perma.cc/NZU3-MRVV]; Kaiser Fam. Found., *supra* note 70 (Eleven states have not fully adopted the ACA Medicaid expansion: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, and Wyoming).

[116]Katherine Keisler-Starkey & Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019,* U.S. Dep't of Commerce (Sept. 2020), https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf; *The State of America's Children 2021*, Children's Defense Fund, https://www.childrensdefense.org/state-of-americas-children/soac-2021-child-health/ [https://perma.cc/7XDU-5GEL].

[117]Joan Akler and Alexandra Corcoran, *Children's Uninsured Rates Rises by Largest Annual Jump in More Than a Decade,* Geo. Univ. Health Pol'y Inst. Ctr. for Child. & Families (2020), https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.

[118]Jennifer M. Haley et. al., *Progress in Children's Coverage Continued to Stall Out in 2018*, Urb. Inst. (Oct. 1, 2020), https://www.urban.org/research/publication/progress-childrens-coverage-continued-stall-out-2018 [https://perma.cc/UGV6-8LE9].

[119]https://www.medicaid.gov/chip/downloads/fy-2020-childrens-enrollment-report.pdf.

[120]Phil Galewitz, *Number of U.S. Kids Who Don't Have Health Insurance is on the Rise,* NPR (Nov. 29, 2019), https://www.npr.org/sections/health-shots/2018/11/29/671666280/number-of-u-s-kids-who-dont-have-health-insurance-is-on-the-rise [https://perma.cc/PP8X-JYM9] (citing Joan Alker & Olivia Pham, *Nation's Progress on Children's Health Coverage Reverses Course*, Geo. Health Pol'y Inst. Ctr. for Children & Families (2018)).

[121]Joyce Frieden, *Everybody Loves CHIP, So Why Isn't It Permanently Funded?,* MedPage Today (April 18, 2022), https://www.medpagetoday.com/publichealthpolicy/healthpolicy/98249 [https://perma.cc/QP3F-6JKS].

[122]Phil Galewitz, *4 Takeaways From Trump's Plan To Rescind CHIP Funding,* Kaiser Health News (May 8, 2018), https://khn.org/news/4-takeaways-from-trumps-plan-to-rescind-chip-funding/ [https://perma.cc/M49N-2F4A]; Phil Galewitz, *With CHIP in Limbo, Here Are 5 Takeaways On The Congressional Impasse,* Kaiser Health News (Dec. 1, 2017), https://khn.org/news/with-chip-in-limbo-here-are-5-takeaways-on-the-congressional-impasse/ [https://perma.cc/89G5-DRHJ].

[123]Ctr. on Budget & Pol'y Priorities, *Trump administration's Harmful Changes to Medicaid* (2020), https://www.cbpp.org/sites/default/files/atoms/files/6-12-19health.pdf.

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caused many individuals to avoid or disenroll themselves and their children from the Medicaid/CHIP system.[124]

Insured Children

Despite these harsh measures, there are already additional barriers in place to access CHIP behavioral health services such as NQTLs, transparency in requirements, and lack of clarity in how to report violations.[125] For example, as of July 2021, three states had yet to meet their requirement to "provide documentation of compliance with parity" to the public and post it on their Medicaid website.[126]

Other issues involve the lack of individual entitlement and use of waiting periods. One way for children and adolescents on public health care to receive ED treatments is to provide for express and continuous eligibility and remove all waiting periods. While the CHIP waiting period used by some states used to be as long as twelve months, the ACA limited the length to a maximum of ninety days.[127] The waiting period, even at ninety days, hinders individuals' access to proper health care, leaving them vulnerable. A five-year waiting period applies for immigrant children and pregnant women.[128] Ten states (CA, IL, MA, NY, OR, WA, NJ, CT, VT, and ME) and the District of Columbia "currently use or plan to use state-only funds to cover income-eligible children in Medicaid/CHIP who are otherwise ineligible due to immigration status."[129] Once again, vulnerable populations are more likely to not address their EDs and as such, the added barrier of waiting periods could lead to detrimental and even fatal outcomes for these individuals, especially children.[130]

Further, both public and private insurance limit funding available to patients in need. For example, Georgia Medicaid refused a treatment program for an individual suffering from AN because the state deemed it "a luxury that taxpayers should not be forced to endure."[131] Private insurers may even require a patient to arrive at a residential treatment for in-person evaluation before authorizing treatment, despite the fact that that there are fewer than 1,500 residential beds available across the country.[132] Once evaluated and authorized for residential treatment, the insurance can still deny coverage at any point, before or during the treatment, based on "ongoing utilization review" processes.[133] The health insurance providers, not the physicians themselves, are dictating care and treatment for those suffering with EDs

[124]Ricardo Alonso-Zaldivar, *Rise in health uninsured may be linked to immigrants' fears*, AP News (Sept. 15, 2019), https://apnews.com/article/health-census-2020-ap-top-news-politics-business-4f2a8639b841406880f4d61cd253a77d [https://perma.cc/D93Q-3HLV].

[125]MACPAC, *supra* note 56.

[126]*Id.*

[127]Gary W. Reinbold, *State Medicaid and CHIP options and child insurance outcomes: an investigation of 83 state options with state-level panel data,* 13 World Med. & Health Pol'y 436, 437 (2021).

[128]*Huberfeld*, *supra* note 59, at 107.

[129]*Covering All Kids in 2022: 13,000 Children Shouldn't Have to Wait Another Year*, The Commonwealth Inst. (Jan. 26, 2022), https://thecommonwealthinstitute.org/the-half-sheet/covering-all-kids-in-2022-13000-children-shouldnt-have-to-wait-another-year/ [https://perma.cc/J3ZF-HG3J].

[130]*Eating Disorder Statistics*, *supra* note 1.

[131]Elizabeth Koh, *Medicaid patient with anorexia struggles to get treatment,* Miami Herald (May 29, 2018), https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi3-eXOmN77AhVMLFkFHaFAChIQFnoECAcQAQ&url=https%3A%2F%2Fwww.miamiherald.com%2Fnews%2Fhealth-care%2Farticle211743659.html&usg=AOvVaw10YOPso_JKoFqM20dfzcCW [https://perma.cc/4LQV-UT6B].

[132]Deb Gordon, *Despite Progress, Patients Still Struggle with Insurance Coverage For Eating Disorder Treatment,* Forbes (Feb. 26, 2021), https://www.forbes.com/sites/debgordon/2021/02/26/despite-progress-patients-still-struggle-with-insurance-coverage-for-eating-disorder-treatment/?sh=68d9ec8122b8 [https://perma.cc/N6NE-26W2] (citing 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* i, 39 (2020), https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/ [https://perma.cc/7TF3-T465]).

[133]Gordon, *supra* note 132.

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via their purse strings, deeming recommended treatment not "medically necessary."[134] Behavioral health providers are five times as likely as other providers to be outside of a patients' insurance network.[135] The 2022 MHPAEA Report to Congress reported that thirty health insurance plans and issuers were out of compliance with parity laws in 2021.[136] Insurers are ignoring evidence-based treatment recommendations from physicians and working around parity laws.[137]

Stigma and Schools

Another issue giving rise to this lack of ED care is the long-existing stigma surrounding the disease in the United States. "Stigma is defined as the cooccurrence of 'labelling, stereotyping, separation, status loss and discrimination' in a 'power situation that allows them.'"[138] EDs have been described as a "silent killer" since cultural acceptance and understanding of the disease are deficient.[139] While EDs are a "biologically influenced medical illness," there is a common misperception that they are a lifestyle choice.[140] Research on ED stigma tends to suggest that compared to other mental disorders, EDs are controllable "e.g., caused by a lack of self-discipline." [141] As such, studies show that "individuals with EDs are held more responsible for their conditions than individuals with other mental disorders."[142] Today, the financial costs of EDs in the United States, a nation with over 300 million residents, are over $60 billion dollars a year.[143]

Such stigma is exacerbated by school, where adolescents in the United States spend most of their time. These institutions tend to create a space that can lead to negative self-image and body dysmorphia through practices such as weighing students, discussing caloric and fat content in food in a negative manner, and comparing athletic ability.[144] While all these activities are meant to have an inherently positive benefit, the communication of such acts are not always expressed in the most sensitive way for a highly impressionable population. Additionally, school counselors are not typically trained to provide ED therapy or care. Educators, staff, and counselors are in positions of distinct advantage to be able to recognize symptoms of EDs and to teach positive body image, however, there seems to be a lack of training, education, and discussion about such programming due to stigma surrounding the topic.

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[134]Kirsten Swanson & Joe Augustine, *Wrongfully denied: Minnesotans fighting mental illness denied coverage from insurance providers,* KSTP (updated Jan. 27, 2022), https://kstp.com/5-investigates/wrongfully-denied-minnesotans-fighting-mental-illness-denied-coverage-from-insurance-providers/ [https://perma.cc/M2F3-JV6R] (In Minnesota, a 12-year old was diagnosed with anorexia and her health insurance provider determined that her recommended in-patient treatment was not "medically necessary." A teenager sent to the emergency room by her psychiatrist because of ED was denied coverage because her insurer asserted she simply needed "hydration.").

[135]Alex Ruoff, *Biden's Call for Mental Health Coverage Sparks Legislative Push*, Bloomberg Law (Mar. 15, 2022), https://www.bloomberglaw.com/product/blaw/bloomberglawnews/employee-benefits/BNA%200000017f-75b8-d06a-ab7f-f7bfd8d50001?bwid=0000017f-75b8-d06a-ab7f-f7bfd8d50001 [https://perma.cc/52UY-FTLG].

[136]*Id.*; 2022 MHPAEA Report to Congress, *supra* note 71, at 14.

[137]Ruoff, *supra* note 127.

[138]Rachel Baffsky, *Eating Disorders in Australia: a commentary on the need to address stigma* 8 J. of Eating Disorders 1, 1 (citing Bruce G. Link, *Conceptualizing Stigma*, 27 Annu. Rev. Sociol 363, 367 (2001)).

[139]Sugermeyer, *supra* note 21, at 192.

[140]*Id.*

[141]Nicole Thörel et al., *Differential Stigmatization in the Context of Eating Disorders: Less Blame Might Come at the Price of Greater Social Rejection*, 6 Stigma & Health 100, 101 (citing Daria Ebneter & Janet Latner, *Stigmatizing Attitudes Differ Across Mental Health Disorders. A Comparison of Stigma Across Eating Disorders, Obesity, and Major Depressive Disorder,* 201 J. Nervous & Mental Disease 281 (2013)).

[142]*Id.* (citing Arthur Crisp, *Stigmatization of and discrimination against people with eating disorders including a report of two nationwide studies,* 13 European Eating Disorders Rev. 147 (2005)).

[143]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*, 1, 55 (2020).

[144]Suggestions for eating disorder education in schools, GenPsych (Oct. 17, 2020) https://www.genpsych.com/post/suggestions-for-eating-disorder-education-in-schools [https://perma.cc/27ZN-RHG8].

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The COVID-19 Pandemic

It is important to reiterate that unmet mental health needs have been exacerbated by the COVID-19 pandemic.[145] Studies have shown that individuals with preexisting mental health conditions are at increased risk of hospitalization and death from COVID-19.[146] The pandemic transformed the lives of people with EDs in particular by limiting available coping mechanisms (mostly social supports that allowed for distraction, guidance, and reinforcement), changing the types of treatment available (no longer face-to-face), and those suffering reached out for help far less.[147] In many households the pandemic heightened food insecurities with research showing that "compared to teenagers whose families have enough food, those in homes where food is scarce are more likely to fast, to skip meals, and to abuse laxatives and diuretics with the aim of controlling their weight."[148]

The exacerbation and increased number of EDs since the beginning of the pandemic will likely result in practitioners seeing an influx of new patients and patients whose EDs went untreated and have now created long-term detrimental harm.[149] The convergence of these public health crises should trigger both great concern and a strong response.

Federal changes already in motion

While the Biden-Harris administration has not enforced many of the Trump-era policies, it will take more than executive action to ensure adequate behavioral health care for those suffering from EDs. President Biden has signaled that his administration has plans to strengthen enforcement of mental health parity laws, ensuring removal of "inequitable barriers," most recently reiterated during his State of the Union.[150] Through the American Rescue Plan Act (ARPA), Congress has laid the groundwork by providing critical investments to expand access to mental health care services, expanding eligibility for the ACA's financial help toward health insurance market premiums (further expanded by the Inflation Reduction Act until 2025[151]), and dedicating $160 billion to school districts, colleges, and universities to address mental health needs of students.[152]

The White House announced a mental health strategy which focuses on strengthening system capacity, connecting more individuals to care, and creating a continuum of support.[153] Some actions include investing $700 million in programs that provide "training, access to scholarships, and loan repayment to mental health and substance use disorder clinicians committed to practicing in rural and

[145]Roberto Mezzina et al., *Mental health at the age of coronavirus: time for change*, 55 Soc. Psychol. & Psychol. Epidemiology 965, 967 (2020).

[146]Jennifer Sullivan et. al., *To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap,* Ctr. on Budget & Pol'y Priorities (Oct. 4, 2021), https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap [https://perma.cc/524G-YVFZ]; Felicia Ceban et al., "Association Between Mood Disorders and Risk of COVID-19 Infection, Hospitalization, and Death: A Systematic Review and Meta-analysis," *JAMA Psychiatry*, July 28, 2021, https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2782453 [https://perma.cc/8H4K-4BUB].

[147]Ashleigh N. Shields et. al., *Understanding the conversation around COVID-19 and eating disorders: A thematic analysis of Reddit* 10 J. of Eating Disorders 1, 2 (2022).

[148]Damour, *supra* note 16.

[149]*Id.* at 11.

[150]Ruoff, *supra* note 135; White House Press Release, Fact Sheet: President Biden to Announce Strategy to Address our national mental health crisis, as part of unity agenda in his first state of the union (Mar. 1, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/ [https://perma.cc/JVR3-QE5A]; White House Press Release, Fact Sheet: In State of the union, President Biden to Outline Vision to Advance Progress on Unity Agenda in Year Ahead (Feb. 07, 2023), https://www.whitehouse.gov/briefing-room/statements-releases/2023/02/07/fact-sheet-in-state-of-the-union-president-biden-to-outline-vision-to-advance-progress-on-unity-agenda-in-year-ahead/ [https://perma.cc/JHU6-PUXC].

[151]Inflation Reduction Act of 2022, Pub. L. 117-169, 136 Stat. 1818.

[152]White House Press Release, *supra* note 150; American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.

[153]*Id.*

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other underserved communities," creation of a national certification program for peer specialists, granting funds to expand Certified Community Behavioral Health Clinics (CCBHCs), and investing $5 million in research.[154] The policy also established a '988' crisis response line creating a national network of local crisis centers to answer calls for individuals seeking help during a behavioral health emergency.[155] This 3-digit number was formerly known as the National Suicide Prevention Lifeline and was a 10-digit number with much less funding, and fewer resources, than the new hotline.[156] When the hotline launched in mid-July 2022, the crisis line saw a 27% increase in calls, texts, and chats.[157]

Most notably, the policy preferences of this administration differ from those of the previous administration as President Biden's 2023 budget includes a proposal to strengthen the MHPAEA, calling for all health plans to "cover robust behavioral health services with an adequate network of providers, including three behavioral health visits each year without cost-sharing."[158] The budget also authorizes the Secretaries of HHS, Labor, and Treasury to "regulate behavioral health network adequacy, and to issue regulations on a standard for parity in reimbursement rates."[159] To further enforcement, $125 million will be provided to states to enforce mental health and parity requirements.[160] Finally, the 2023 budget "eliminates the ability of self-insured non-federal governmental plans to opt out of these provisions."[161]

Further, the Bipartisan Safer Communities Act is a national investment in the safety of America's school children, including funds to help schools hire more school-based mental health professionals.[162] This funding is allocated to the Mental Health Service Professional (MHSP) Demonstration Grant Program with a goal to create a strong foundation for increased entrance into the mental health profession, supporting school districts in hiring these providers in high-need districts.[163] Additionally, the School-Based Mental Health (SBMH) Services Grant Program was developed as a competitive program that incentivizes states and school districts to increase mental health providers in their schools.[164] The U.S. Secretary of HHS and U.S. Secretary of Education sent a letter on July 29, 2022, to governors across the country to highlight federal resources available to advance mental health care coverage throughout schools.[165]

Congressional concern of increasing rates of EDs has spurred the proposal of several bipartisan bills. One bipartisan measure would require Medical Nutrition Therapy (MNT) to be a covered benefit for those suffering from an ED under Medicare Part B.[166] The Eating Disorders Coalition (EDC) applauded

[154] *Id.*

[155] *Id.*

[156] SAMHSA, Lifeline Timeline, https://www.samhsa.gov/find-help/988/lifeline-timeline [https://perma.cc/FR5B-XWD3].

[157] Heather Saunders, *Taking a Look at 988 Suicide & Crisis Lifeline Data, One Month After Launch*, Kaiser Fam. Found. (Oct. 17, 2022), https://www.kff.org/other/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-data-one-month-after-launch/ [https://perma.cc/4QPB-3JZY].

[158] White House Press Release, *supra* note 150.

[159] U.S. Dep't of Health & Human Services, Fiscal Year 2023: Budget in Brief, 1, 103.

[160] *Id.*

[161] *Id.*

[162] Bipartisan Safer Communities Act, Pub. L. 117-159, 136 Stat. 1313; White House Press Release, Fact Sheet: Biden-Harris administration announces two new actions to address youth mental health crisis (Jul. 29, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/29/fact-sheet-biden-harris-administration-announces-two-new-actions-to-address-youth-mental-health-crisis/ [https://perma.cc/UME7-G2TU].

[163] *Id.*; Press Release, U.S. Dep't of Ed., Hundreds of Millions of Dollars in Funds to Increase the Number of School-Based Mental Health Providers (Oct. 3, 2022), https://www.ed.gov/news/press-releases/hundreds-millions-dollars-funds-increase-number-school-based-mental-health-providers-schools-provided-through-bipartisan-safer-communities-act [https://perma.cc/EM39-DUXM].

[164] *Id.*

[165] Dep't of Education, Key Policy Letters Signed by the Education Secretary or Deputy Secretary, https://www2.ed.gov/policy/gen/guid/secletter/220729.html?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term= [https://perma.cc/XPU6-HXG2].

[166] Nutrition CARE Act of 2021, S. 584, 117th Cong. (2021); H.R. 3711, 116th Cong. (2019); Press Release, Eating Disorders Coalition, EDC Applauds the Reintroduction of the Nutrition CARE Act in the House & Senate (Mar. 3, 2021), http://eatingdisorderscoalition.org.s208556.gridserver.com/couch/uploads/file/edc-nutrition-care-reintroduction-press-release.pdf.

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such efforts for the need to fill a "critical gap in eating disorders treatment coverage to ensure individuals have the resources they need on their journey toward recovery."[167]

Focused on youth and prevention measures for EDs, Congresswoman Vicky Hartzler, Representative Kathy Manning, Senator Amy Klobuchar, and Senator Cynthia Lummis have introduced a bill focused on updating existing law for local school wellness programs to incorporate mental health resources.[168] This act strives to amend the Richard B. Russell National School Lunch Act which in 1946, created the National School Lunch Program (NSLP) to provide free or reduced lunch to qualifying students.[169] Such a program will go beyond promoting physical fitness and nutrition to incorporate language into school policies that focuses on disordered eating as well.[170]

Additionally, Senators Klobuchar, Shelley Moore Capito, Tammy Baldwin (D-Wis.), and Thom Tillis proposed the Anna Westin Legacy Act, a $5 million dollar authorization per year for 2023-2027 for the Center of Excellence for Eating Disorders to continue training, intervention, and treatment.[171] Representative Doris Matsui has introduced a related bill in the House.[172] The Center of Excellence for Eating Disorders, based out of University of North Carolina Chapel Hill, provides world-renowned care for those suffering from an ED. The authorization of the funds is imperative to this organization run on grants and donations. The center accepts most insurance plans and treatment includes a care team consisting of psychologists, nurses, psychiatrists, social workers, recreational therapists, and dietitians.[173] The work being done at the center shows the rigor and compassion needed to combat this disease on an exceptional scale. Given the current state of divisive politics, the impact of the bipartisan efforts is a testament to the dire state and importance of ED care and prevention in the United States.

The EBSA has "primary enforcement jurisdiction over MHPAE for approximately two million group health plans covering roughly 136.5 million Americans."[174] The enactment of the CAA has allowed the EBSA to implement a framework with more rigorous requirements, including creating the Task Force which oversees implementation of new provisions and evaluates investigations for comparative analysis and determining compliance.[175] The increase in staffing and training to complete these investigations has led to increased access for millions of Americans. One instance of diligent NQTL comparative analysis led to a health insurance issuer amending its nutritional counseling coverage to include ED conditions, positively impacting 1.2 million participants.[176]

For non-federal governmental health plans and states with no authority to enforce the MHPAEA, HHS has primary enforcement authority.[177] As of December 3, 2021, CMS was able to identify forty-five instances of non-compliance across fifteen comparative analysis reviews.[178] One CMS determination

[167]Eating Disorders Coalition, *supra* note 166.

[168]Improving Mental Health and Wellness in Schools Act, S.2930, 117th Cong. (2021); Improving Mental Health in Schools Act, H.R. 5526, 117th Cong. (2021); Press Release, Vicky Hartzler, Congresswoman, Hartzler, Manning, Klobuchar, Lummis Introduce bipartisan, Bicameral Legislation to Improve Mental Health Resources in Schools (Oct. 15, 2021), https://www.klobuchar.senate.gov/public/index.cfm/2021/10/klobuchar-lummis-manning-hartzler-introduce-bipartisan-bicameral-legislation-to-improve-mental-health-resources-in-schools [https://perma.cc/WTC8-8UFW].

[169]Richard B. Russell National School Lunch Act, Pub. L. 79-396, 60 Stat. 230 (as amended through Further Consolidated Appropriation Act, Pub. L. 116-94 133, Stat. 2534 (2019).

[170]*Id.*

[171]Anna Westin Legacy Act, S. 3686, 117th Cong. (2022); Press Release, Baldwin, Klobuchar, Capito, Tillis Introduce Bipartisan Legislation to Support Eating Disorder Diagnosis and Treatment (Feb. 17, 2022), https://www.baldwin.senate.gov/news/press-releases/baldwin-klobuchar-capito-tillis-introduce-bipartisan-legislation-to-support-eating-disorder-diagnosis-and-treatment [https://perma.cc/BM9C-Y9J2].

[172]Anna Westin Legacy Act, H.R. 7249, 117th Cong. (2022).

[173]University of North Carolina School of Medicine, Ctr. of Excellence for Eating Disorders, https://www.med.unc.edu/psych/eatingdisorders/patient-care/ [https://perma.cc/2Y2G-2UM8].

[174]2022 MHPAEA Report to Congress *supra* note 68, at 7.

[175]*Id.* at 11, 13.

[176]*Id.* at 22.

[177]Lawrence, *supra* note 54, at 2224; MHPAEA Report to Congress *supra* note 68, at 25-26.

[178]MHPAEA Report to Congress *supra* note 68, at 32.

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letter led to an issuer revising continued-stay and discharge criteria that no longer limited demonstrable progress or improved condition for the enrollee.[179] A recommitment to the goals of the MHPAEA are demonstrated through the EBSA's and HHS' commitment to investigations and corrective actions. However, the Departments agree that to reach maximum enforcement of the law, more must be done.[180] While these improvements will hopefully strengthen access to care, it is important to note that none of the aforementioned bills in Congress have since been passed and the challenges associated with MHPAEA compliance are still vast. Nevertheless, increased calls to action to address this growing crisis will hopefully bolster awareness and lead to increased care for those suffering and those at risk.

Changes to care for youth with EDs

At a more "drastic level," starting from "scratch" and creating a comprehensive and centralized system of health insurance at the federal level that focuses on removing existing limits to access for children's health insurance would be helpful to care for youth suffering with EDs, but likely unworkable.[181] While completely reconstructing the current system may be impractical to achieve, updating our current system will require great efforts. These efforts should focus on access to treatment through adequate programming, payment, and legislative efforts and increased education.

Access to Care

When it comes to treatment, access to care is one of the greatest barriers for children and young adolescents suffering from EDs. Removing waiting periods and increasing treatment centers in underserved communities will drastically change the system of care. Studies show that setting a maximum waiting period for CHIP, which required many states to shorten their previous waiting period, resulted in an improvement in child insurance outcomes.[182] Additionally, since 2009 a number of states have removed the five-year waiting period for immigrant children resulting in a "1.6% increase in the child means-tested public insurance rate."[183] A continued effort to reduce and ultimately remove this barrier of waiting periods will lead to increased access to care for children to receive the supports they need.

More than one-third of Americans live in "Mental Health Professional Shortage Areas" which are "communities that have fewer mental health providers than the minimum their level of population would need." [184] Increase in access through telehealth would be beneficial to those in rural communities where there are few or no mental health providers nearby. Allowing for telehealth reduces physical distance to services and costs related to caretakers and patients taking time off from work or school and traveling long distances to seek treatment.[185] However, lack of access to residential care exacerbates the issue for those needing more extensive treatment than can be provided via telehealth. Additionally, the use of telehealth for individuals who are returning from residential care or who are not placed in residential care is dependent upon access to high-speed internet connection, which is not readily available for "up to 10% of individuals" in the United States, technological literacy, and privacy in the

[179] *Id.* at 34.

[180] *Id.* at 31.

[181] Joan C. Alker et. al., *Children's Health Insurance Coverage: Progress, Problems, And Priorities For 2021 And Beyond,* 39 Health Aff. 1743, 1748 (2020); *See generally* Medicare For All Act of 2019, H.R. 1384, 116th Cong. (2019) (available at https://www.congress.gov/116/bills/hr1384/BILLS-116hr1384ih.pdf); Medicare For All Act of 2019, S. 1129, 116th Cong. (2019) (available at https://www. congress.gov/bill/116th-congress/senate-bill/1129/text).

[182] Reinbold *surpa* note 127, at 445.

[183] *Id.*

[184] White House Press Release, *supra* note 150.

[185] Rosmary Ros-DeMarize, et al., *Pediatric behavioral telehealth in the age of COVID-19: Brief evidence review and practice considerations* 51 Current Problems in Pediatric & Adolescent Health Care 1, 7 (2021).

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home.[186] Increasing care facilities and access to online care services is pivotal to combatting the epidemic of EDs.

Further, protecting and expanding coverage via Medicaid and CHIP would allow for a powerful foundation to further assert a need for expanded ED care. CHIP is currently authorized through 2027. However, a provision included in the Build Back Better Act to make CHIP a permanent federal budget item and expansion provisions aimed at eliminating the coverage gap plaguing Medicaid in a dozen states, were removed from the Act that actually passed.[187] The ARPA, which passed in 2021, expanded eligibility provisions which allowed 400,000 individuals to gain Medicaid coverage allowing those with coverage to avoid increases in premium costs.[188]

Strengthening our current mental health parity will require strict agency enforcement to ensure that insurance companies comply with mental health parity regulations to provide the care for those in need. Insurance companies who stop paying for residential behavioral health care too early puts children and their parents in vulnerable positions. Parents and guardians are "faced with paying tens of thousands of dollars … or pulling [the child] out early, possibly endangering [their] recovery," when insurance companies deny care coverage.[189] Due to this complicated structure of health insurance and mental health parity laws, enforcement has clearly not been centralized or powerful enough. Passage of the CAA, which was passed to provide greater enforcement power to Departments, resulted in issuance of hundreds of letters requesting comparative analyses to investigate their NQTLs. However, despite this call to action, plans and insurers delayed providing their analyses by the approved deadline and submitted analyses were incomplete and insufficient.[190] Further, despite new requirements to address difficulties in determining MHPAEA NQTL compliance, challenges remain. The EBSA believes that there are a variety of tools that can be used to strengthen the enforcement including, but not limited to, providing the DOL the authority to "assess civil monetary penalties for parity violations," providing for permanent expansion to telehealth and remote care access, and amending definitions in the MHPAEA to ensure an "objective and uniform" definition based in "nationally recognized standards."[191]

Prevention through Legislation and Education

One solution which can promote prevention and even further promote aggressive legislative action to care for those with EDs, is education about EDs. Studies have shown that individuals believe that those suffering with an ED are attempting to "garner attention from others," lack self-control, and are ultimately "responsible for their disorder."[192] Therefore, increased education to the general population may combat the stigma surrounding the diseases.[193] Further, increasing awareness will not just destigmatize this illness and promote those suffering to seek help, but may also lead to earlier detection and referral by others.[194] Such increased awareness would hopefully lead to increased legislative action that will remove barriers to access for treatment for EDs and lead to a decline in ED prevalence and therefore, mortality rates.

[186]*Id.* at 7-8; Accuroso *supra* note 8, at 8.

[187]Inflation Reduction Act, *surpa* note 143; *see also* Build back Better Act, H.R.5376, 117th Cong. (2022); American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.; Frieden, *supra* note 112.

[188]Timothy S. Jost, *How the Build Back Better Bill Would Improve Affordable Care Act Coverage,* The Commonwealth Fund Blog (Jan. 19, 2022), https://www.commonwealthfund.org/blog/2022/how-build-back-better-bill-would-improve-affordable-care-act-coverage [https://perma.cc/HV3H-U7YZ]; American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.

[189]*See* Ruoff, *supra* note 135 (Joseph Feldman faced this hard choice when Blue Cross Blue Shield stopped paying for his daughters' residential care, resulting in a lawsuit that "won't solve this problem").

[190]2022 MHPAEA Report, *supra* note 68, at 51.

[191]2022 MHPAEA Report, *supra* note 68, at 53.

[192]Lisa Brelet et al., *Stigmatization toward People with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder: A Scoping Review*, 13 Nutrients 1, 14 (2021).

[193]*Id.* at 17.

[194]Margarita Sala, *Race, Ethnicity, and Eating Disorders Recognition by Peers,* 21 Eat Disord., 1, 8 (2013).

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"Prevention or early recognition in the school system is critical because of the high rate of medical and psychiatric comorbidities, including the risk of suicide."[195] This educational push will likely be most impactful if administered via schools, hopefully becoming a campaign funded through a federal government regulatory agency such as the Center for Disease Control and Prevention ("CDC").[196] Creating programs to bring awareness to EDs must be careful not to "glamorize … symptomatology and/or teach adolescents disordered strategies."[197] Successful strategies may range from prevention programs for students which are aimed to "induce cognitive dissonance with respect to thin-ideal standard" through small-group interactive activities and discussions[198] and prevention programming for parents focused on creating a "nurturing family environment."[199] The push for legislation such as the Improving Mental Health and Wellness in Schools Act is evidence enough that action needs to be taken on a national stage to protect impressionable minds.[200] Changing the language in the policies is the first step, but enacting the strategies to enforce it will take greater change and pressure on schools.

Early intervention is defined as "early detection of disease followed by stage-specific or proportionate intervention, for as long as necessary and effective."[201] In ED research there is increased evidence that "the illness changes over time, with maladaptive eating and weight control behaviors becoming gradually more automatic and entrenched."[202] Early intervention prevents children and young adolescents from increased risk of a life-threatening disease as it may worsen over time without proper care and treatment. The continuation of an ED can lead to a myriad of psychiatric and physical co-morbidities.[203] Early intervention and education allow individuals to become more aware of what may be happening to their bodies and minds. One of the biggest issues with this disease is having people recognize that they, in fact, have a life-threatening disease. Teaching those who encounter children and young adolescents of the warning signs of an ED adds another level of protection for individuals to be able to seek treatment. Studies point to "school-based identification" as more "promising and more acceptable to young people who are at a risk of developing an eating disorder."[204] School counselors are in a unique and advantageous setting to be able to identify the existence of a child suffering from an ED – they observe the student daily in a variety of settings.[205] Monitoring can even be done by ensuring that ED screening questions are included in standardized mental health assessments.[206] Additionally, ensuring that teachers and staff are engaged in positive talk regarding nutrition and body language is crucial as impressionable young minds may cling to the wrong ideals about nutrition and weight in health or

[195]Dara Puryear, *Raising Awareness of Eating Disorders in the High School System: A Community Program Project,* Master of Science in Nursing Theses & Projects 1, 2 (2020).

[196]*See* Tips from Former Smokers, https://www.cdc.gov/tobacco/campaign/tips/about/index.html; see also Heads Up https://www.cdc.gov/headsup/index.html [https://perma.cc/TS3D-MELT].

[197]Juleen K. Buser, The School Counselor's Role in Addressing Eating Disorder Symptomatology Among Adolescents, Vistas 1, 9 (2012), https://www.counseling.org/docs/default-source/vistas/the-school-counselor-s-role-in-addressing-eating-disorder.pdf?sfvrsn=12 [https://perma.cc/G7QN-RHNK].

[198]Carolyn Black Becker et al., *Reducing self-objectification: are dissonance-based methods a possible approach?* 1 J. of Eating Disorders 1, 3 (2013).

[199]Buser, *supra* note 197.

[200]Improving Mental Health and Wellness in Schools Act, S.2930, 117th Cong. (2021); Improving Mental Health in Schools Act, H.R. 5526, 117th Cong. (2021); Press Release, *supra* note 140.

[201]Michaela Flynn et. al., *Assessing the impact of first episode rapid early intervention for eating disorders on duration of untreated eating disorder: a multi-centre quasi-experimental study,* 29 Euro. Eating Disorders 458, 459 (2021).

[202]*Id.*

[203]JI Hudson et al., *The prevalence and correlates of eating disorders in the national comorbidity survey replication.* 61 Biological Psychiatry 348, 348 (2007); Andrea B. Goldschmidt et. al, *Shared risk factors for mood-, eating-, and weight-related health outcomes* 35 Health Psychol. 245, 245 (2016).

[204]Buser, *supra* note 191, at 1 (citing Laura Currin & Ulrike Schmidt, *A critical analysis of the utility of an early intervention approach in the eating disorders*, 14 J. of Mental Health 611, 620 (2009)).

[205]Buser *supra* note 197, at 2.

[206]Accurso, *supra* note 16, at 1–2.

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physical education classes.[207] Therefore, introducing a health campaign that educates and increases awareness of EDs is important to "enhance early detection and referral."[208]

It is also interesting to consider if changes to this media exposure can be done through legislation and the impact it would have. According to social comparison theory, one's view of their own self-worth is dependent upon processes of social comparison with others who are "similar, close, and viewed as attractive."[209] As such, exposure to media that displays photos altered by technological means and promotes thin-ideal internalization and gender role expectations can distort one's view of body image and negatively impact their self-worth.[210] The rise in the wave of EDs was "first recognized in first-world countries where there was greater access to media."[211] This is an issue that can be addressed in schools via adequate teaching and reinforcement of healthy eating and body image practices. Thus, one strategy to combat the prevalence of EDs in adolescents is to remove some influential triggering factors – images on adolescent accessible media. Israel was the first country to tackle the problem of these "unrealistic and unhealthy images in the media" via legislation.[212] The law passed in 2013 forbids the appearance of underweight models (BMI of 18.5 or below) in commercial advertising and on any advertising photo that has used a "graphic editing program" to distort the model's image.[213] There must be clear notice of that fact.[214]

This law, while it has numerous limitations, was the first to formally recognize that EDs are a "dangerous social phenomenon" that needs to be addressed in the "public sphere."[215] While the Federal Trade Commission (FTC) monitors truthful advertising in the United States, it has been slow to act on technologically distorted images relating to body size and legislative acts to specifically address altered imaging in advertisements have yet to pass Congress.[216] Creating a law broad enough to encompass restrictions on distorted images which perpetuate unrealistic and unhealthy body images and nutrition would likely prove difficult given the political climate and the lack of urgency from legislators to address this issue.

Conclusion

"Breaking the stigma around eating disorders will save lives."[217] The idea that EDs are a "choice" or a "phase" will continue to cause individuals to suffer, many times in silence, until it is too late. Efforts to discuss the impact of EDs will bring awareness at community and individual levels, and hopefully, prompt more aggressive lawmaking at the federal level to create more comprehensive and enforceable plans to prevent, diagnose, and treat individuals suffering with an ED.

Nevertheless, an important question to keep in mind while attempting to achieve mental health parity, is whether it is practical and productive for mental health care to be equivalent to that of physical health care. Mental health differs from physical health in several ways, including the length and sort of treatments necessary. Some argue that equating mental health to physical health will not lead to parity because of their inherent differences.[218] Thus, the differences require an entirely separate system to

[207] *Buser,* supra note 19, at 8.

[208] Sala, *supra* note 186 at 8.

[209] Lon Festinger, *A Theory of Social Comparison Processes* (1954); Latzer, *supra* note 9, at 2.

[210] Latzer, *supra* note 9, at 2.

[211] Sugermeyer, *supra* note 21, at 193 (citing Jacquelyn Ekern, *The rise of eating disorders in developing countries*, 2017, https://www.eatingdisorderhope.com/blog/eating-disorders-developing-countries [https://perma.cc/JZ8J-8NFC]).

[212] Latzer, *supra* note 9, at 2; The Law for Restricting Weight in the Modeling Industry, 557-2012. (Isr.).

[213] Latzer, *supra* note 9, at 2.

[214] Latzer, *supra* note 9, at 2.

[215] Galya Hidelsheimer & Hemda Gur-Arie, *Just Modeling? The Modeling Industry, Eating Disorders, and the Law* 8 Int'l J. of Feminist Approaches to Bioethics 103, 129 (2015).

[216] Truth in Advertising Act of 2016, H.R. 4445, 114th Cong. (2016).

[217] Sugermeyer, *supra* note 21, at 200.

[218] Joni Roach, *Discrimination and Mental Illness: Codified in Federal Law and Continued by Agency Interpretation*, 269 Mich. St. L. Rev 215, 310 (2016).

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provide mental health treatment. Additionally, it is important to recognize that there must be a concerted effort for equity via treatment, education, and legislation throughout this push to address EDs in the United States as individuals from marginalized racial and ethnic populations are systematically underrepresented within the ED field. Without being intentional about how we address ED issues, there is a risk of perpetuating the "myth that EDs only affect White, Westernized, cisgender women."[219] Creating a successful system to combat EDs requires increased attention to social determinants of health and the impact on vulnerable populations.

In sum, it is evident that our current parity laws are not doing enough to treat mental health care and are in fact, far from providing parity. While it may be difficult (and impractical giving the political climate) to create an entirely new system, it will likely be just as difficult to update our current one to create proper rules and regulations to treat behavioral health issues that are pervasive yet overlooked in our current system, such as EDs. The Biden administration's commitment to expanding mental health care and improving parity laws is a step in the right direction, but EDs are often left behind when discussing behavioral health as a general area. Focused education to counteract the impact of EDs early on will prove impactful and substantial to helping those that suffer, and those who support them. "The speed to which these goals can be achieved is greater when more are committed to a cause."[220] By developing an information-based campaign or educational programming to be administered in schools, there will be greater awareness and recognition to combat this disease. Focusing on increasing coverage for ED treatment will require a much more focused and specialized effort on the part of individuals, communities, physicians, and legislators. Once the illness is recognized, providing access to care is the only way to combat this disease. Without proper recognition, treatment, and supports, lives will continue to be lost.

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[219]Neha J. Goel MS et al., *Accountability in promoting representation of historically marginalized racial and ethnic populations in the eating disorders field: A call to action* 55 Int'l J. of Eating Disorders 463, 467 (2022).

[220]Sugermeyer, *supra* note 21, at 198.

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