NOTE

FOOD FOR THOUGHT: INCREASING ACCESS TO AND COVERAGE OF EATING DISORDER TREATMENT IN NEW YORK STATE BY AMENDING THE DEFINITION OF "SUBSTANCE USE DISORDER"

I. INTRODUCTION

Imagine that you binged[1] for the first time at the age of five years old.[2] For more than thirty-five years, you struggle with binge eating disorder and anorexia nervosa.[3] However, your insurance company provides few in-network specialists and further implements restrictive insurer guidelines, and therefore, you cannot afford the high costs associated with the treatment that you need.[4] Because your eating disorder has gone untreated, your heart eventually becomes too weak to effectively pump blood to the rest of your body and fails.[5] Now, imagine that you are the parent of a teenage girl who is suffering from bulimia nervosa.[6] Your daughter is hospitalized, and she is constantly monitored to ensure that she is not purging.[7] Shockingly, your insurance company only pays for six weeks of your daughter's inpatient care, despite doctors' pleas to your insurance company to extend coverage in this case

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1. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 350-51 (5th ed. 2013) ("An 'episode of binge eating' is defined as eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances.").

2. Chevese Turner, *Mental Health Coverage Needs to Include Eating Disorders*, HILL (May 13, 2019, 3:30 PM), https://thehill.com/opinion/healthcare/443422-mental-health-coverage-needs-to-include-eating-disorders (discussing the author's own struggle with an eating disorder and further discussing recent updates in parity for mental health issues).

3. *Id.*

4. *Id.*

5. *Id.*

6. Scott Pelley, *Denied*, CBS NEWS (Dec. 14, 2014), http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes (interviewing patients, parents of patients, and doctors who have experienced hardships when attempting to obtain or secure insurance coverage with respect to mental health conditions).

7. *Id.*

because your daughter "is[] [not] ready for this."[8] Your daughter begins receiving outpatient treatment, but it is not enough.[9] Her heart fails because she started to purge again, and your daughter dies at the age of fifteen.[10]

Eating disorders, including anorexia nervosa, bulimia nervosa, and binge eating disorder are all mental illnesses currently recognized by the American Psychiatric Association in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").[11] Classification of these conditions has evolved significantly since 1980 when the American Psychiatric Association published the DSM-III.[12] Fortunately, these changes coincided with the establishment of private and public organizations dedicated to serving individuals who suffer from mental illness, including organizations dedicated solely to providing support and resources for those struggling with eating disorders.[13] In addition, social media has helped connect people suffering from mental illness and has helped to undermine the stigma associated with such illness.[14]

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8. *Id.*
9. *Id.*
10. *Id.*
11. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at xxi, xli.
12. *DSM History*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm (last visited Oct. 13, 2021); *Let's Get Real About the History of Eating Disorders*, EATING RECOVERY CTR. (Feb. 24, 2018), https://www.eatingrecoverycenter.com/blog/February-2018/Let's-Get-Real-About-the-History-of-Eating-Disorders. *But see* Shrigopal Goyal et al., *Revisiting Classification of Eating Disorders-toward Diagnostic and Statistical Manual of Mental Disorders-5 and International Statistical Classification of Diseases and Related Health Problems-11*, 34 INDIAN J. PSYCH. MED. 290, 291-93 (2012) (reviewing criticisms of eating disorder classification and highlighting arguments that current classifications are "limit[ed]").
13. *About Us*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/about-us (Sept. 17, 2021); *History*, NAT'L ASS'N ANOREXIA NERVOSA & ASSOCIATED DISORDERS, https://anad.org/about/history (last visited Oct. 13, 2021); *History of F.E.A.S.T.*, F.E.A.S.T., https://www.feast-ed.org/history-of-feast (last visited Oct. 13, 2021); *Our Work*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/about-us/our-work (last visited Oct. 13, 2021). In 1992, Congress established the Substance Abuse and Mental Health Services Administration ("SAMHSA"), a branch of the United States Department of Health and Human Services. *About Us*, *supra*. Thirteen years prior, the National Alliance on Mental Illness, a grassroots mental health organization, was founded. *Who We Are*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-NAMI/Who-We-Are (last visited Oct. 13, 2021). In addition, several organizations exclusively dedicated to increasing awareness and resources with respect to eating disorders are currently operating. *History*, *supra*; *History of F.E.A.S.T.*, *supra*; *Our Work*, *supra*. These organizations include, for example, the National Association of Anorexia Nervosa and Associated Disorders, founded in the 1970s; Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.), founded in 2007; and the National Eating Disorders Association, whose founding date is unclear. *History*, *supra*; *History of F.E.A.S.T.*, *supra*; *Our Work*, *supra*.
14. *See* Colby Itkowitz, *Unwell and Unashamed*, WASH. POST (June 1, 2016), https://www.washingtonpost.com/sf/local/2016/06/01/unwell-and-unashamed. *Contra New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, NAT'L COUNCIL FOR MENTAL WELLBEING (Oct. 10, 2018), https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america.

Approximately thirty million Americans,[15] including two million New Yorkers, suffer from an eating disorder.[16] Yet, despite updated and expanded clinical definitions,[17] increased resources and awareness,[18] and targeted mental health legislation,[19] it is not difficult to find articles arguing that treatment options and insurance coverage are severely inadequate to address the needs of those with a mental illness, including eating disorders.[20] Two critical areas requiring improvement are access to eating disorder treatment services and insurance coverage for such treatment.[21]

This Note discusses the inadequacies surrounding eating disorder treatment options in New York and insufficient insurance coverage, which hamper individuals' ability to receive appropriate care.[22] It concedes that significant improvements have been made, especially with respect to insurance coverage, as a result of federal and state legislation.[23] However, this Note argues that the most promising opportunity to improve access and coverage is to amend the definition of "substance use disorder" in New York so that individuals with mental illnesses related to food can access additional treatment options and receive additional insurance coverage.[24]

Part II of this Note will explain eating disorders from a clinical perspective[25] and will continue by discussing access issues and federal and New York State parity laws, respectively.[26] For the purposes of this Note, parity refers to mental health and substance use disorder benefits that are comparable to medical and surgical benefits provided by an

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15. Vanessa Caceres, *Eating Disorder Statistics*, U.S. NEWS & WORLD REP. (Feb. 14, 2020, 10:14 AM), https://health.usnews.com/conditions/eating-disorder/articles/eating-disorder-statistics.

16. Turner, *supra* note 2.

17. *See supra* note 12 and accompanying text.

18. *See supra* note 13 and accompanying text.

19. *See infra* Part II.C.

20. *See* Guin Becker Bogusz, *Health Insurers Still Don't Adequately Cover Mental Health Treatment*, NAT'L ALL. ON MENTAL ILLNESS (Mar. 13, 2020), https://www.nami.org/Blogs/NAMI-Blog/March-2020/Health-Insurers-Still-Don-t-Adequately-Cover-Mental-Health-Treatment (explaining that inadequate provider networks and unreasonable criteria to qualify for insurance coverage are significant and continuing barriers to care); *New Study Reveals Lack of Access As Root Cause for Mental Health Crisis in America*, *supra* note 14 (stating that Americans perceive "[h]igh [c]ost and [i]nsufficient [i]nsurance [c]overage" and "[l]imited [o]ptions and [l]ong [w]aits" as barriers to mental health treatment); Turner, *supra* note 2 (discussing inadequate insurance coverage for eating disorders specifically).

21. *See infra* Part III.

22. *See infra* Part III.

23. *See infra* Part II.C.

24. *See infra* Part IV.

25. *See infra* Part II.A.

26. *See infra* Part II.B–C.

individual's health insurance policy.[27] Part II will also discuss public and private initiatives that promote eating disorder awareness and provide resources both to individuals suffering from such conditions and to health care providers who treat eating disorders.[28] Part III of this Note will illustrate two fundamental problems with respect to eating disorder treatment in New York State: inadequate access to treatment and services, and inadequate health insurance coverage for these illnesses.[29] This Part will also illustrate the disconnect between parity laws and available treatment options, and the harsh reality of eating disorder treatment.[30] The Note will culminate with Part IV, which builds upon the disconnect articulated in Part III and points to that disconnect in order to justify an amended definition of substance use disorder, allowing individuals with an eating disorder to access additional treatment and health insurance coverage.[31]

II. BACKGROUND: A CLINICAL, LEGISLATIVE, AND ORGANIZATIONAL APPROACH

Part II of this Note begins by discussing the characteristics of eating disorders.[32] It continues by exploring access issues[33] and the history of federal and state parity laws, focusing particularly on what has and has not been achieved with respect to mental health parity.[34] This Part concludes by discussing public and private organizations and their roles in increasing awareness of mental health issues, including eating disorders, and providing resources for those who suffer from these illnesses.[35]

A. Eating Disorder Diagnoses and Common Comorbidities

The most recent edition of the DSM, the DSM-V, defines and analyzes recognized eating disorders.[36] In addition, the DSM-V lists symptoms and patterns of behavior related to each disorder.[37] The definitions and other information contained in the DSM-V serve as the

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27. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet (last visited Oct. 13, 2021).

28. *See infra* Part II.D.

29. *See infra* Part III.

30. *See infra* Part III.

31. *See infra* Part IV.

32. *See infra* Part II.A.

33. *See infra* Part II.B.

34. *See infra* Part II.C.

35. *See infra* Part II.D.

36. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 329-54.

37. *Id.* at 338-39 (listing the diagnostic criteria for anorexia nervosa, for example).

basis for the current definition of eating disorder in New York State's Mental Hygiene Law.[38]

1. What Are Eating Disorders?

The DSM-V classifies eating disorders in an independent category entitled, "Feeding and Eating Disorders," and recognizes eight different disorders within that category.[39] All eight are characterized by a "persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning."[40] The currently recognized disorders are: Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and Unspecified Feeding or Eating Disorder.[41] Of these recognized disorders, anorexia nervosa, bulimia nervosa, and binge eating disorder are the most common among young adults and adults.[42]

The DSM-V's definitions are not only clinically significant,[43] but legally significant as well.[44] Pursuant to New York State's Mental Hygiene Law, an eating disorder includes:

> [C]onditions such as anorexia [], bulimia, and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.[45]

In other words, while New York explicitly references the three most common eating disorders,[46] the state ultimately defers to mental health experts with respect to the identification of eating disorders and accounts

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38. *See* N.Y. MENTAL HYG. LAW § 30.02 (McKinney Supp. 2021).
39. AM. PSYCHIATRIC ASS'N, *supra* note 1, at 329, 353-54.
40. *Id.* at 329.
41. *Id.* at 329, 353-54.
42. *Id.* at 341, 347, 351. Anorexia nervosa is characterized by a "restriction of energy intake relative to requirements" and an "intense fear of gaining weight or of becoming fat . . . even though at a significantly low weight." *Id.* at 338. Bulimia nervosa is characterized by "recurrent episodes of binge eating" and "recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise." *Id.* at 345. Binge eating disorder, similar to bulimia nervosa, is characterized by recurrent binge eating that causes distress. *Id.* at 350. However, binge eating is not marked by "inappropriate compensatory behavior." *Id.*
43. *Id.* at 5 (introducing the manual as a tool for clinicians).
44. *See* N.Y. MENTAL HYG. LAW § 30.02 (McKinney Supp. 2021).
45. *Id.* (emphasis added).
46. *See supra* note 42 and accompanying text.

for future changes in eating disorder diagnoses guidelines through this deference.[47]

2. Eating Disorder Comorbidities

Individuals with eating disorders often suffer from comorbidities,[48] which complicate treatment, as both conditions need to be addressed.[49] For example, a nationally-representative study of adults in the United States, published in 2019, found that eighty-seven percent or more of those diagnosed with anorexia nervosa, bulimia nervosa, and binge eating disorder "met criteria for at least one additional . . . psychiatric disorder."[50] Additionally, a significant percentage of individuals with an eating disorder concurrently struggle with substance use disorders.[51] According to the DSM-V, common comorbid disorders include bipolar, depressive, and anxiety disorders.[52] In order to successfully treat an individual with a comorbidity, health care professionals must address other co-occurring disorders and communicate with members of an individual's treatment team.[53]

47. *See* MENTAL HYG. § 30.02.

48. Tomoko Udo & Carlos M. Grilo, *Psychiatric and Medical Correlates of DSM-5 Eating Disorders in a Nationally Representative Sample of Adults in the United States*, 52 INT'L J. EATING DISORDERS 42, 44-45, 47-48 (2019). It does not appear that there is a universally accepted definition of "comorbidity" in medical literature. *See* Jose M. Valderas et al., *Defining Comorbidity: Implications for Understanding Health and Health Services*, 7 ANNALS FAM. MED. 357, 358 (2009). However, varied definitions of the word share a "single core concept" which is "the presence of more than [one] distinct condition in an individual." *Id.* Merriam-Webster's Dictionary defines "comorbid" as "existing simultaneously with and usually independently of another medical condition." *Comorbid*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/comorbid (last visited Oct. 13, 2021). For the purposes of this Note, "comorbidity" refers to the simultaneous presence of at least two conditions in an individual. *See* Valderas et al., *supra*.

49. *Anxiety, Depression, & Obsessive Compulsive Disorder*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/anxiety-depression-obsessive-compulsive-disorder (last visited Oct. 13, 2021) (listing comorbidities that commonly occur simultaneously with eating disorders and treatment options for such conditions).

50. Udo & Grilo, *supra* note 48, at 44.

51. Lauren Muhlheim, *Eating Disorders and Substance Abuse*, VERYWELLMIND, https://www.verywellmind.com/eating-disorders-and-substance-abuse-4585199 (Mar. 18, 2019). According to one article published in 2019, the rate of co-occurrence ranges from seventeen to forty-six percent. *Id.*

52. AM. PSYCHIATRIC ASS'N, *supra* note 1, at 344-45, 349-50, 353.

53. Kirsten Haglund, *Common Comorbidities of Eating Disorders*, EATING DISORDER HOPE, https://www.eatingdisorderhope.com/blog/common-co-morbidities-of-eating-disorders (Feb. 24, 2016).

B. Access to Treatment

American mental health services are woefully insufficient to meet the needs of those who require treatment but lack access or the ability to find care.[54] Studies have demonstrated that access and availability issues operate as barriers to receiving treatment.[55] Financial considerations are among the most frequently cited concerns, however, non-financial concerns have been cited as well.[56] For example, studies have found that individuals' attempts to receive treatment have been hampered by a lack of "readily available or convenient therapy programs."[57] Distance from treatment has also been cited as a barrier,[58] as there are "few inpatient and intensive outpatient eating disorder treatment centers across the country," and the few existing treatment centers operate primarily in metropolitan areas.[59] Access to care is critical because effective, available treatment helps "reduce [] the burden of suffering" among those with an eating disorder.[60]

C. History of Mental Health Parity Laws

As mentioned above, parity is achieved when insurance coverage of mental health conditions and substance use disorders is comparable to insurance coverage of medical conditions, such as diabetes.[61] Parity laws have affected significant change in the health insurance industry by requiring insurance companies to adhere to new mental health and

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54. *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, *supra* note 14.

55. *See* Pamela Regan et al., *Initial Treatment Seeking from Professional Health Care Providers for Eating Disorders: A Review and Synthesis of Potential Barriers to and Facilitators of "First Contact"*, 50 INT'L J. EATING DISORDERS 190, 206-07 (2017).

56. *See id.*; Carly Thompson & Sinyoung Park, *Barriers to Access and Utilization of Eating Disorder Treatment Among Women*, 19 ARCHIVES WOMEN'S MENTAL HEALTH 753, 757 (2016); Anne E. Becker et al., *A Qualitative Study of Perceived Social Barriers to Care for Eating Disorders: Perspectives from Ethnically Diverse Health Care Consumers*, 43 INT'L J. EATING DISORDERS 633, 643 (2010).

57. Regan et al., *supra* note 55, at 207.

58. *See supra* note 56 and accompanying text.

59. Thompson & Park, *supra* note 56, at 755; Becker et al., *supra* note 56, at 642-43.

60. Fary M. Cachelin & Ruth H. Striegel-Moore, *Help Seeking and Barriers to Treatment in a Community Sample of Mexican American and European American Women with Eating Disorders*, 39 INT'L J. EATING DISORDERS 154, 154 (2006).

61. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27; *see What Is Mental Health Parity?*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Your-Journey/Individuals-with-Mental-Illness/Understanding-Health-Insurance/What-is-Mental-Health-Parity (last visited Oct. 13, 2021).

substance use disorder coverage mandates.[62] Both federal[63] and state governments,[64] including New York, have enacted such laws.[65]

Congress's first success in enacting a parity law occurred approximately twenty-five years ago, with the passage of the Mental Health Parity Act of 1996 ("MHPA").[66] The MHPA was ultimately a symbolic piece of legislation due to its limited scope.[67] For example, pursuant to the MHPA, large group health plans that provided mental health benefits were required to apply the same "lifetime and annual dollar limits" to both mental health and medical and surgical benefits.[68] However, the MHPA did not address visit limitations and high cost-sharing.[69] In order to adhere to the new "dollar limits," insurers further restricted the number of covered hospital and outpatient visits—undermining the MHPA's intended impact.[70] While the MHPA's impact was limited, it was credited with "heightening the profile of the parity issue."[71] The law successfully encouraged states to pass their own parity laws and by 2006, thirty-seven states had enacted similar statutes.[72]

1. New York State Parity Law

In 2006, New York State enacted Timothy's Law in an effort to provide New Yorkers with increased coverage for those suffering from mental illnesses.[73] The law stated that:

> Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care *shall* provide, as part of such policy, broad based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the coverage provided for other health conditions[.][74]

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62. *See, e.g.*, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.
63. *See id.*
64. *Issue Brief: Parity*, MENTAL HEALTH AM., https://www.mhanational.org/issues/issue-brief-parity (last visited Oct. 13, 2021).
65. 2006 N.Y. Sess. Laws 1465-71 (McKinney) (enacting Timothy's Law).
66. Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 409-10 (2010).
67. *Id.* at 410.
68. *Id.* at 409.
69. *Id.*
70. *Id.* at 409-10.
71. *Id.* at 410.
72. *Id.*
73. 2006 N.Y. Sess. Laws 1465 (McKinney).
74. *Id.* at 1466 (emphasis added).

The law further mandated that policies cover both inpatient and outpatient treatment for a minimum number of days and required comparable inpatient coverage for "biologically based mental illness" (such as bulimia nervosa and anorexia nervosa) as compared to inpatient medical coverage.[75] For example, Timothy's Law required group insurance policies to provide members no less than thirty days of inpatient mental health benefits and twenty days of outpatient mental health benefits per calendar year.[76] However, the legislature struck from the law the minimum number of days that insurers were required to cover.[77] Currently, Sections 3221, 3216, and 4303 of New York State's Insurance Law state that limitations related to the "number of visits" or "days of coverage" are prohibited where the limitations would be "more restrictive" than the same limitations on medical and surgical benefits.[78] The justification for Timothy's Law, to "prevent the unfair treatment of persons who suffer such [mental, emotional, or nervous] illnesses and help ensure their successful, complete recovery," is arguably undermined by the elimination of the minimum requirements mentioned above.[79]

2. Federal Parity Laws

Since 1996, Congress has enacted legislation that expands upon the foundation laid by the MHPA and limits insurers' ability to circumvent new parity mandates.[80] The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") and the Patient Protection and Affordable Care Act of 2010 ("ACA") resulted in substantive changes to federal mental health law.[81] In many ways, these two acts have helped to achieve what the MHPA failed to accomplish.[82]

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75. *Id.* However, coverage of biologically based mental illness did not automatically apply to small employers. *See id.* at 1467. In 2019, the legislature amended the law to require insurers to cover the treatment of "mental health conditions" rather than the treatment of "mental, nervous or emotional disorders or ailments" and "biologically based mental illness." 2019 N.Y. Sess. Laws 474-75, 480-82 (McKinney). According to Timothy's Law, insurers defined what constituted a mental, nervous, or emotional disorder. 2006 N.Y. Sess. Laws at 1470. The current law defines "mental health condition[s]" as those "defined in the [most recent DSM]" or another recognized standard. 2019 N.Y. Sess. Laws 475, 482; N.Y. INS. LAW § 3221(l)(5)(A), (l)(5)(E)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 3216(i)(35)(E)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(g)(6)(D) (McKinney 2021).

76. 2006 N.Y. Sess. Laws at 1466.

77. 2019 N.Y. Sess. Laws at 474, 481.

78. N.Y. INS. LAW § 3221(l)(5)(C), (l)(5)(E)(iii) (McKinney Supp. 2021); N.Y. INS. LAW § 3216(i)(35)(C), (i)(35)(E)(iii) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(g)(4)(C) (McKinney 2021).

79. 2006 N.Y. Sess. Laws 2198-99 (McKinney) (providing the justification for Timothy's Law).

80. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

81. *See infra* Part II.C.2.a–b.

82. *See infra* Part II.C.2.a–b.

a. The Mental Health Parity and Addiction Equity Act of 2008

According to the Centers for Medicare and Medicaid Services, the MHPAEA "generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder [] benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits."[83] Benefit limitations addressed by the MHPAEA are both quantitative[84] and non-quantitative.[85] Quantitative treatment limitations relate to numerical limitations, such as the number of doctor's visits covered by insurance, while non-quantitative treatment limitations relate to non-numerical limitations, including those limiting "the scope or duration of benefits for services."[86] Such non-quantitative limitations would include preauthorization requirements, for example.[87] Eliminating these limitations reduces the number of restrictions that insurers are permitted to utilize with respect to mental health and substance use disorder benefits.[88] Other key MHPAEA provisions include: coverage for out-of-network mental health and substance use disorder benefits and a ban on "separate cost-sharing requirements" that apply to mental health and substance use disorder benefits only.[89] In 2017, the United States Department of Labor ("DOL") published responses to frequently asked questions regarding the MHPAEA.[90] In that publication, the DOL stated that eating disorders are considered "mental health conditions" for the purposes of the MHPAEA and thus treatment of these disorders is subject to the provisions discussed above.[91]

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83. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

84. *Id.*

85. *Id.*; *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) That Require Additional Analysis to Determine Mental Health Parity Compliance*, U.S. DEP'T LABOR, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf (last visited Oct. 13, 2021).

86. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

87. *Id.*

88. *See Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) That Require Additional Analysis to Determine Mental Health Parity Compliance*, *supra* note 85; *see also* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68240 (Nov. 13, 2013) (requiring "parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage"). The final rule applies to "individual health insurance coverage" as well, as a result of the enactment of the Patient Protection and Affordable Care Act of 2010 ("ACA"). *Id.*; *see infra* Part II.C.2.b.

89. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

90. *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38*, U.S. DEP'T LABOR, at 1 (June 16, 2017), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf.

91. *Id.* at 4-5.

Even though the MHPAEA built upon the foundation laid by the MHPA, its scope is still limited.[92] Large group health plans and insurers are not required to provide mental health and substance use disorder benefits under the law.[93] Instead, the MHPAEA's provisions govern group plans and insurers that "*choose to include* [these] benefits in their benefits package."[94] Fortunately, a significant percentage of the population received these types of benefits[95] through large group health plans in 2008,[96] and therefore, the MHPAEA's protections shielded many Americans from insurers attempting to subvert parity laws.[97]

Research indicates that employers have altered their insurance plans in order to comply with the MHPAEA's provisions.[98] However, the law included several exceptions and exclusions that hampered its ability to make substantial change throughout the entire health insurance market.[99] In 2010, the passage of the ACA extended MHPAEA protections to additional types of insurance plans, greatly expanding mental health and substance use disorder benefits available to the insured.[100]

92. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

93. *Id.*

94. *Id.* (emphasis added).

95. *See Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/statedata (last visited Oct. 13, 2021) (in the text box, enter "Health Insurance Coverage of the Total Population"; select the result with the same name; then, under "Timeframe" select "2008") (showing that more than half of the population received health insurance through group plans in 2008); Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, HEALTH AFFS., Sept.–Oct. 2003, at 127, 128-29 (citing a study conducted by Kaiser/Health Research and Educational Trust finding that "98[%] of workers with employer-sponsored health insurance had coverage for mental health care in 2002," a rate that is consistent with a 2000 study conducted by the United States Bureau of Labor Statistics).

96. *See* Chris Gaetano, *More Americans Work at Big Firms Than Small Ones*, N.Y. STATE SOC'Y CERTIFIED PUB. ACCTS. (Apr. 7, 2017), https://www.nysscpa.org/news/publications/the-trusted-professional/article/more-americans-work-at-big-firms-than-small-ones-040717 (stating that in the wake of the 2008 economic crisis, more than sixty percent of the working population was employed at firms with over one hundred employees).

97. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27. Until the passage of the Mental Health Parity and Addition Equity Act ("MHPAEA"), substance use disorder benefits were not included in federal parity law. *Id*.

98. *See* Eric Goplerud, *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, U.S. DEP'T HEALTH & HUM. SERVS. (Oct. 31, 2013), https://aspe.hhs.gov/report/consistency-large-employer-and-group-health-plan-benefits-requirements-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act-2008.

99. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27. For example, "[s]elf-insured non-[f]ederal governmental plans that have [fifty] or fewer employees; [s]elf-insured small private employers that have [fifty] or fewer employees; . . . and [l]arge, self-funded non-[f]ederal governmental employers that opt-out of the [act's] requirements" are excepted from the MHPAEA's provisions. *Id.*

100. *See infra* Part II.C.2.b.

b. The Patient Protection and Affordable Care Act of 2010

The most comprehensive health reform of the last two generations, the ACA, "significantly changed the landscape of U.S. health policy."[101] Pursuant to the ACA, some insurers must now provide an "essential benefits package" which includes coverage for mental health and substance use disorder services.[102] In addition, parity is required, as insurance coverage for these services must be comparable to the coverage that an insurance company provides for medical and surgical benefits.[103]

Such parity was achieved, in part, when the MHPAEA was enacted.[104] The ACA's essential benefits package extended existing MHPAEA parity requirements to small group health plans and individual health insurance coverage.[105] Although the MHPAEA included eating disorder treatment as a mental health benefit,[106] the Department of Health and Human Services, pursuant to the power bestowed upon it by the ACA, "left 'the definition of a required "mental health service" to the discretion of the states,'"[107] half of which now specifically provide some coverage of eating disorders as mental health conditions.[108]

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101. BARRY R. FURROW ET AL., HEALTH LAW 533 (8th ed. 2018).

102. *Id.* at 549; *see* Kirsten Beronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, U.S. DEP'T HEALTH & HUM. SERVS. (Feb. 19, 2013), https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans. The package was novel because prior to the enactment of the ACA, the federal government had never, save for a few exceptions, required private insurance plans to cover specific benefits. FURROW ET AL., *supra* note 101, at 549.

103. *See* Beronio et al., *supra* note 102.

104. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27.

105. *Id.* Notably, however, the ACA's essential benefits package provision does not apply to large group or self-insured plans. FURROW ET AL., *supra* note 101, at 549.

106. *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38*, *supra* note 90, at 4-5.

107. Sarah Hewitt, *A Time to Heal: Eliminating Barriers to Coverage for Patients with Eating Disorders Under the Affordable Care Act*, 31 L. & INEQ. 411, 425-26 (2013).

108. MKS, *Improving Coverage for Eating Disorders: A Long, Slow Process*, EATING DISORDERS REV. (2016), https://eatingdisordersreview.com/improving-coverage-for-eating-disorders-a-long-slow-process. Other provisions of the ACA benefitted individuals with eating disorders as well. *See* MKS, *supra*; *Obamacare and the Benefits for Those in Eating Disorder Treatment*, EMILY PROGRAM (Oct. 4, 2013), https://www.emilyprogram.com/blog/obamacare-and-the-benefits-for-those-in-eating-disorder-treatment (showing a re-post from the Cleveland Center for Eating Disorders ("CCED") blog archives). For example, because eating disorders often begin during adolescence, the extended period of coverage (until age twenty-six) affords many the resources they need to treat their illnesses for a longer period of time under a parent's insurance coverage. *MKS*, *supra*; *Obamacare and the Benefits for Those in Eating Disorder Treatment*, *supra*. Additionally, insurers are no longer permitted to deny coverage to those with pre-existing conditions, including eating disorders. *MKS*, *supra*; *Obamacare and the Benefits for Those in Eating Disorder Treatment*, *supra*. Relatedly, consumer insurance rates are lower, as those with eating disorders are no longer members of a "high-risk pool" which generally resulted in high

D. Federal Agencies and Non-profit Organizations

Federal agencies and non-profit organizations offer a number of resources to individuals with eating disorders, whether directly or indirectly.[109] Additionally, these entities fund eating disorder research initiatives and focus on training practitioners who may encounter patients with an eating disorder.[110] The following is a sampling of these entities.[111]

1. The Substance Abuse and Mental Health Services Administration

In the early 1990s, Congress established the Substance Abuse and Mental Health Services Administration ("SAMHSA" or the "Administration"), a branch of the United States Department of Health and Human Services.[112] The Administration's goal is to "reduce the impact of substance abuse and mental illness on America's communities" by "advanc[ing] . . . prevention, treatment, and recovery services in order to improve individual, community, and public health."[113] SAMHSA is a comprehensive public entity that provides mental health and substance use disorder resources—such as information regarding treatment locations—to those suffering from mental illness or substance use disorders, provides funding opportunities to combat these illnesses,[114] and conducts research and collects data to assess mental health treatment services.[115]

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insurance rates for the insured. *Obamacare and the Benefits for Those in Eating Disorder Treatment*, *supra*.

109. *See SAMHSA Announces Up to $3.75 Million in Funding to Enhance Training Efforts to Address Eating Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (July 18, 2018), https://www.samhsa.gov/newsroom/press-announcements/201807180130; *Our Mission*, NAT'L CTR. EXCELLENCE FOR EATING DISORDERS, https://www.nceedus.org (last visited Oct. 13, 2021); *Help & Support*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/help-support (last visited Oct. 13, 2021).

110. *See infra* Part II.D.1–2.

111. *See infra* Part II.D.1–2.

112. *About Us*, *supra* note 13.

113. *Who We Are*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/about-us/who-we-are (May 5, 2021).

114. *See Frequently Asked Questions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/about-us/frequently-asked-questions (July 29, 2021).

115. *See, e.g.*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL MENTAL HEALTH SERVICES SURVEY (N-MHSS): 2019 at 3 (2019) (reporting on information collected from public and private facilities that treat individuals suffering from mental illness regarding the services that these facilities provide).

In 2018, the Administration announced that $3.75 million in funding would be available over five years for the establishment of a "center of excellence for training on the treatment of eating disorders."[116] "[P]ublic and private non-profit entities" in the United States were eligible to apply for a grant.[117] That year, the Administration founded the National Center of Excellence for Eating Disorders ("NCEED").[118] NCEED seeks to "advance education and training of healthcare providers and to promote public awareness of eating disorders and eating disorder treatment" with the goal of "ensur[ing] that all individuals with eating disorders are identified, treated, and supported in recovery."[119] Doctors tend to receive few hours of training with respect to eating disorders, making SAMHSA and the NCEED's resources important for diagnosticians and other mental health practitioners.[120]

SAMHSA also manages and supports the Interdepartmental Serious Mental Illness Coordinating Committee ("ISMICC").[121] Members of the ISMICC include, for example: the Secretary of the Department of Health and Human Services, the Attorney General, the Secretary of Housing and Urban Development, the Administrator for Medicare and Medicaid Services, and members of the public who have personal experience combatting serious mental illness, as well as professionals who treat serious mental illness.[122] The ISMICC was established in accordance with the 21st Century Cures Act, and is tasked with researching mental illness and the effects of federal programs on public health.[123] Notably, one of the ISMICC's non-federal members tasked with such duties is Johanna Kandel, the founder and Chief Executive Officer of the Alliance for Eating Disorders Awareness.[124] While these initiatives related to

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116. *SAMHSA Announces Up to $3.75 Million in Funding to Enhance Training Efforts to Address Eating Disorders*, *supra* note 109.

117. *Id.* SAMHSA's intent was to award one $750,000 grant each year for five years, totaling $3.75 million. *Id.*

118. *Our Mission*, *supra* note 109.

119. *Id.*

120. *See* Fauzia Mahr et al., *A National Survey of Eating Disorder Training*, 48 INT'L J. EATING DISORDERS 443, 445 (2015) (finding that surveyed internal medicine programs provided an average of 1.94 hours of didactic teaching, while surveyed pediatric programs provided an average of 5.25 hours of didactic teaching).

121. *Interdepartmental Serious Mental Illness Coordinating Committee Charter*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/about-us/advisory-councils/ismicc/committee-charter (July 26, 2021).

122. *Id.*

123. *Id.*

124. *Interdepartmental Serious Mental Illness Coordinating Committee Roster*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/about-us/advisory-councils/ismicc/committee-roster (Sept. 28, 2020).

eating disorders are important, the impacts of these initiatives are inherently limited.[125]

2. Eating Disorder Organizations

In addition to government-run and government-sponsored entities, there are several private organizations exclusively dedicated to increasing awareness of eating disorders and providing resources to those affected by them.[126] These organizations disseminate both educational[127] and treatment information to the public.[128] For example, the National Eating Disorders Association ("NEDA") advances a comprehensive approach to combating eating disorders by offering myriad resources[129] and advertising several fundraising opportunities.[130] Visitors to the organization's website can interact with a screening tool, which "can help determine if it[] [is] time to seek professional help" or use the organization's provider database to locate eating disorder practitioners in their area.[131] NEDA also awards research grants through its Feeding Hope Fund for Clinical Research, which are funded by donations,[132] and each year, NEDA organizes "NEDA Walks" which raise funds for "eating disorder education, prevention, and support, as well as advocacy and research initiatives."[133]

Other eating disorder advocacy groups include: Project HEAL, Families Empowered and Supporting Treatment of Eating Disorders, the Alliance for Eating Disorders Awareness, the National Association of Anorexia Nervosa and Associated Disorders, and the Eating Disorders

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125. *See SAMHSA Announces Up to $3.75 Million in Funding to Enhance Training Efforts to Address Eating Disorders*, *supra* note 109 (stating that the short-term grant program will fund a "national hub" pertaining to eating disorders); *Interdepartmental Serious Mental Illness Coordinating Committee Charter*, *supra* note 121 (stating that the Committee is tasked with "evaluat[ing] [] the effect [that] federal programs related to serious mental illness have on public health" and subsequently making "recommendations for actions that agencies can take to better coordinate the administration of mental health services").

126. *E.g.*, *History*, *supra* note 13; *History of F.E.A.S.T.*, *supra* note 13; *Our Work*, *supra* note 13.

127. *E.g.*, *Types of Eating Disorders*, F.E.A.S.T., https://www.feast-ed.org/types-of-eating-disorders (last visited Oct. 13, 2021).

128. *E.g.*, *Treatment*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/treatment (last visited Oct. 13, 2021).

129. *Help & Support*, *supra* note 109.

130. *Other Ways to Give*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/other-ways-give (last visited Oct. 13, 2021).

131. *Help & Support*, *supra* note 109.

132. *Grant Announcement: 2021 Feeding Hope Fund for Clinical Research Grant Program*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/grant-announcement (last visited Oct. 13, 2021).

133. *About NEDA Walks*, NAT'L EATING DISORDERS ASS'N, https://nedawalk.org/about (last visited Oct. 13, 2021).

Coalition.[134] Some of these organizations are similar to NEDA in their comprehensive approach to addressing and combating eating disorders,[135] while other organizations, such as Project HEAL[136] and the Eating Disorders Coalition serve the community by focusing on a single objective.[137] While the missions and visions of these organizations differ, they share a common goal—to ardently support men and women who battle these potentially life-threating conditions.[138] However, they do not (and cannot) provide care.[139] As a result, like SAMHSA, these organizations are limited in their ability to facilitate positive clinical outcomes.[140]

III. THE MENTAL HEALTH MIRAGE

To those thirsty for change, parity laws may appear to be an oasis of mental health reform.[141] Sadly, their thirst will not be quenched because parity for those with eating disorders has not been achieved.[142] Part III of this Note discusses two primary issues with respect to eating disorder treatment in New York.[143] Subpart A addresses inadequate

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134. Lauren Muhlheim, *Leading Eating Disorder Charities and Organizations*, VERYWELL MIND (Feb. 17, 2020), https://www.verywellmind.com/leading-eating-disorder-charities-and-organizations-4145389.

135. *Id.*

136. *Id.*; *How Treatment Access Support Works*, PROJECT HEAL, https://www.theprojectheal.org/apply-for-support (last visited Oct. 13, 2021). For example, Project HEAL's primary goal is to increase individuals' access to treatment by offering financial assistance and maximizing individuals' existing insurance coverage. *See How Treatment Access Support Works*, *supra*.

137. Muhlheim, *supra* note 134; *Mission & Goals*, EATING DISORDERS COAL., https://www.eatingdisorderscoalition.org/inner_template/about_us/mission-and-goals.html (last visited Oct. 13, 2021). The Eating Disorders Coalition focuses on a macro approach, advocating for federal legislative action that will "increase resources for education, prevention, and improved training" as well as "increase funding and support for scientific research" related to eating disorders. *Mission & Goals*, *supra*.

138. *See* Muhlheim, *supra* note 134.

139. *See id.*

140. *See id.* (emphasizing the advocacy and fundraising aspects of these organizations).

141. *See The Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 27 (describing the significant changes in mental health coverage that occurred as a result of the enactment of the MHPAEA); FURROW ET AL., *supra* note 101, at 549 (discussing novel changes to the health insurance market as a result of the enactment of the ACA, including mandated coverage of mental health and substance use disorders). Prior to the enactment of these laws, mental health legislation was largely symbolic. Barry et al., *supra* note 66, at 410.

142. *See* Ali Shana, *Mental Health Parity in the US: Have We Made Any Real Progress?*, PSYCHIATRIC TIMES (June 17, 2020), https://www.psychiatrictimes.com/view/mental-health-parity-in-the-us-have-we-made-any-real-progress (citing a 2019 report that found "continued and increased disparities between behavioral health care and physical health care coverage, indicating possible evidence of noncompliant insurance practices" and citing successful parity lawsuits against insurers, as well as settlements with insurers who were accused of violating parity laws).

143. *See infra* Part III.A–B.

access to eating disorder treatment services,[144] while Subpart B addresses inadequate insurance coverage for treatment.[145]

A. *Inadequate Access to Eating Disorder Services and Resources*

The State of New York has explicitly admitted that access to eating disorder treatment is fraught with problems.[146] Despite acknowledging the existence of "numerous" providers with eating disorder treatment expertise, the New York State Legislature found that "there is no generally accessible, comprehensive system for responding to [eating] disorders."[147] As a result, treatment is "fragmented and incomplete."[148] In response to these concerns, New York State established an allegedly "sufficient" number of eating disorder treatment locations throughout the state.[149] These facilities, known as Comprehensive Care Centers for Eating Disorders ("CCCEDs"), can be found in Metropolitan New York, Northeastern New York, and Western New York.[150]

CCCEDs consist of hospital and medical center affiliations within each of the three regions of the state.[151] By establishing affiliations, each CCCED can treat more patients than an independent center can treat.[152] While the CCCEDs are located in different regions,[153] the participating hospitals within each are in close proximity to one another.[154] The areas

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144. *See infra* Part III.A.
145. *See infra* Part III.B.
146. N.Y. MENTAL HYG. LAW § 30.01 (McKinney Supp. 2021).
147. *Id.*
148. *Id.*
149. N.Y. MENTAL HYG. LAW § 30.05(a) (McKinney Supp. 2021); *Comprehensive Care Centers for Eating Disorders in New York State*, N.Y. STATE DEP'T HEALTH, https://www.health.ny.gov/diseases/chronic/eating_disorders/comprehensive_care_centers.htm (Aug. 2009).
150. *Comprehensive Care Centers for Eating Disorders in New York State*, *supra* note 149. The Western New York Comprehensive Care Center for Eating Disorders ("CCCED") includes the University of Rochester and Golisano Children's Hospital. *Id.* The Northeastern CCCED includes Albany Medical Center and Four Winds Hospital. *Id.* The Metropolitan CCCED includes New York Presbyterian Hospital, New York Psychiatric Center, and Schneider's Children's Hospital, *id.*, which was renamed in 2010 and is now known as "the Steven and Alexandra Cohen Children's Medical Center of New York." Jennifer Barrios, *New Name for Schneider Children's Hospital*, NEWSDAY, https://www.newsday.com/long-island/nassau/new-name-for-schneider-children-s-hospital-1.1828787 (Mar. 24, 2010, 10:03 PM). While these CCCEDs are composed of partnerships between or among medical facilities, suggesting increased access, they are each referred to as a single unit in the three regions. *Comprehensive Care Centers for Eating Disorders in New York State*, *supra* note 149.
151. *See Comprehensive Care Centers for Eating Disorders in New York State*, *supra* note 149.
152. *See id.*
153. *See id.*
154. *See* Driving Directions from University of Rochester School of Nursing to Golisano Children's Hospital, GOOGLE MAPS, https://www.google.com/maps (click on "Directions"; then search starting point field for "255 Crittenden Boulevard, Rochester" and search destination for "601 Elmwood Avenue, Rochester") (stating that the driving distance between the two locations is 0.1 miles); Driving Directions from CCCED of Northwestern New York at Albany Medical Center

where the participating hospitals are located are densely populated[155] and are therefore more likely to have a greater eating disordered population, making the centers' locations a facially reasonable choice.[156] But eating disorders do not discriminate by geographic region.[157] Thus, individuals who live even one hour away from a center experience "barriers" to care, undermining the scope and reach of CCCEDs.[158]

CCCEDs and health care providers with "expertise in eating disorder treatment"[159] are not the only treatment providers capable of assisting this community.[160] The New York State Office of Mental Health has established licensing standards for residential facilities that provide treatment to those with eating disorders in the state as part of its "Community Residence for Eating Disorders Integrated Treatment Program" ("CREDIT").[161] There are currently five CREDIT-licensed facilities in the state.[162] Hospitals provide eating disorder services as well.[163] For example, Stony Brook University Hospital's Adolescent Medicine Division employs a multidisciplinary team that conducts both

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to Four Winds Saratoga, GOOGLE MAPS, https://www.google.com/maps (click on "Directions"; then search starting point field for "25 Hackett Boulevard, Albany" and search destination for "30 Crescent Avenue, Saratoga Springs") (stating that the driving distance between the two locations is 34.8 miles); Driving Directions from the Eating Disorders Clinic at Columbia University to Cohen Children's Medical Center, GOOGLE MAPS, https://www.google.com/maps (click on "Directions"; then search starting point field for "269-01 76th Avenue, Queens" and search destination for "1051 Riverside Drive, New York") (stating that the driving distance between the two locations is 18.8 miles).

155. Victoria Simpson, *The Biggest Cities in New York State*, WORLDATLAS (Aug. 28, 2020), https://www.worldatlas.com/articles/the-10-biggest-cities-in-new-york-state.html.

156. *See* Joshua Breslau et al., *Are Mental Disorders More Common in Urban Than Rural Areas of the United States?*, 56 J. PSYCHIATRIC RSCH. 50, 51-53 (2014). The rate of serious mental illness, while statistically significant, is not substantially different between urban and rural areas. *Id.* at 53 fig. 2 (finding that the prevalence of serious mental illness in large metropolitan areas is 2.1%, while the prevalence of such illnesses in rural areas is 3.2%, a 1.1% difference). However, because urban areas have larger populations, the number of individuals who have a serious mental illness is higher in urban areas than in rural areas. *See id.* at 51-53.

157. *See id.* at 53 (finding that individuals suffer from mental illness in both urban and rural areas).

158. Sara Heath, *Key Barriers Limiting Patient Access to Mental Healthcare*, PATIENT ENGAGEMENT HIT (Aug. 7, 2019), https://patientengagementhit.com/news/key-barriers-limiting-patient-access-to-mental-healthcare.

159. N.Y. MENTAL HYG. LAW § 30.01 (McKinney Supp. 2021).

160. *See infra* notes 161-66.

161. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 594.1(b) (2020).

162. *Find a Mental Health Program*, N.Y. STATE OFF. MENTAL HEALTH, https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages&PortalPath=/shared/Mental%20Health%20Program%20Directory/_portal/Mental%20Health%20Program%20Directory&page=Advanced%20Search&Action=Navigate (last visited Oct. 13, 2021) (select "Advanced Search"; select "Residential" under "Program Category"; then select "Community Residence for Eating Disorder Integrated Treatment Program" under "Program Type").

163. *See, e.g.*, *Pediatric Specialties—Adolescent Medicine*, STONY BROOK CHILD.'S, https://www.stonybrookchildrens.org/specialties-services/pediatric-specialties/Adolescent-Medicine/services (last visited Oct. 13, 2021); *Eating Disorders Program (The Outlook at Westchester)*, WEILL CORNELL MED. PSYCHIATRY, https://psychiatry.weill.cornell.edu/eating-disorders-program-outlook-westchester (last visited Oct. 13, 2021).

inpatient and outpatient consultations to provide comprehensive primary care to adolescents with eating disorders.[164] Additionally, a collaborative program operated by New York Presbyterian Hospital, Weill Cornell Medical College, and Columbia University College—The Outlook at Westchester—operates an inpatient eating disorder program that serves both adolescents and adults.[165] Mather Hospital, located on Long Island, operates an eating disorder program that includes partial hospital treatment and intensive outpatient treatment as well.[166]

Despite the existence of these treatment options, the needs of the mentally ill are not always met.[167] This includes the needs of those who suffer from eating disorders.[168] For example, New Yorkers in the Long Island region have been placed on waiting lists for weeks or months before accessing treatment.[169] Waiting lists are created, in part, due to a shortage of mental health providers—a problem that permeates the state's mental health care industry.[170] The shortage is a result of low reimbursement rates for psychiatrists, psychologists, and therapists.[171] These low reimbursement rates have led medical students to pursue other specialties, resulting in fewer mental health specialists.[172]

1. Logistical Barriers to Treatment

Even in metropolitan areas, like New York, where mental health resources are more readily available,[173] "logistical barriers" may impede an individual's choice of providers, undermining access.[174] Lack of transportation is a logistical barrier.[175] So is distance, where a provider is too far away from the individual seeking treatment.[176] These logistical

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164. *Pediatric Specialties—Adolescent Medicine*, *supra* note 163.

165. *Eating Disorders Program (The Outlook at Westchester)*, *supra* note 163.

166. *Eating Disorders Program*, MATHER HOSP. NORTHWELL HEALTH, https://www.matherhospital.org/care-treatment/behavioral-health/eating-disorders-program (last visited Oct. 13, 2021).

167. David Reich-Hale, *Shortage of Mental Health Providers Can Leave Patients Waiting Months*, NEWSDAY, https://www.newsday.com/business/mental-health-care-access-1.29347148 (Apr. 4, 2019, 6:00 AM).

168. *See id.*

169. *Id.*

170. *Id.* In 2012, the New York State Department of Labor projected that a thirty percent increase in the number of mental health therapists would be necessary to meet demand from 2012 to 2022. *Id.*

171. *Id.*

172. *Id.*

173. *See* Thompson & Park, *supra* note 56, at 755; Simpson, *supra* note 155.

174. Kathleen T. Call et al., *Barriers to Care in an Ethnically Diverse Publicly Insured Population: Is Health Care Reform Enough?*, 52 MED. CARE 720, 721, 723-24 (2014) (studying barriers to receiving health care in Minnesota and finding that barriers to care were "unacceptably high").

175. *Id.*

176. Thompson & Park, *supra* note 56, at 757.

barriers leave patients with few or no choices in providers.[177] As such, their access to treatment options are inadequate.[178] What happens if you dislike the only remaining provider in your area?[179] Your access to services is undermined.[180]

"Access" means, or should mean, that a person can obtain the treatment that she needs.[181] If a practitioner specializes in eating disorder treatment in an individual's area, the patient technically has "access" to needed care.[182] But, arguably, "needed care" is care which will lead to a positive outcome (or increase the probability of a positive outcome).[183] With respect to eating disorders, a positive physician-patient relationship is one critical factor affecting the probability of recovery.[184] True "access" for those with eating disorders would afford individuals the opportunity to subscribe to a program where they can establish a positive relationship with providers.[185] If a patient is unable to choose between two or more providers, and is unable to see a doctor that she prefers, the patient arguably does not have access to needed care.[186]

Unfortunately, the concept of access described above is difficult to satisfy—even in New York (with the exception, perhaps, of New York City)—due to "logistical barriers."[187] For example, Long Island is home to few comprehensive eating disorder treatment programs.[188] An adult

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177. *See id.*; Call et al., *supra* note 174, at 723-24.

178. *See* Call et al., *supra* note 174, at 723-24; Thompson & Park, *supra* note 56, at 757.

179. *See* William Lewis, *What Is the Iron Triangle of Health Care?*, MEDIUM: MORE HEALTH (May 18, 2017), https://medium.com/more-health/what-is-the-iron-triangle-of-health-care-9ce6f5276077 (arguing that a patient is unlikely to visit a doctor that he or she dislikes, even if that doctor is the only accessible provider); *see also* FURROW ET AL., *supra* note 101, at 508 ("In many rural areas, as well as urban areas with highly concentrated markets, provider choice is limited further by a lack of competition and viable alternatives.").

180. Lewis, *supra* note 179; *see* Call et al., *supra* note 174, at 722-23 tbls. 1 & 2 (finding that 62.6% of the study's respondents experienced "access barriers" to care, which included the inability to see a "preferred doctor").

181. Lewis, *supra* note 179; *see* FURROW ET AL., *supra* note 101, at 357 ("Access to health care depends on finding providers who are willing and able to treat you.").

182. *See* Lewis, *supra* note 179.

183. *See Stages of Recovery*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/stages-recovery (last visited Oct. 13, 2021) (emphasizing that recovery relies in part, on the existence of a "treatment team" that works with the individual and his or her family). There are five Stages of Change that occur during the recovery process. *Id.* These stages are: the pre-contemplation stage; the contemplation stage; the preparation stage; the action stage; and the maintenance/relapse stage. *Id.* In particular, the action stage is critical insofar as abiding by the treatment team's recommendations is "essential" to the success of this stage, and ultimately the success of recovery. *Id.*

184. Lewis, *supra* note 179; *Stages of Recovery*, *supra* note 183 (emphasizing that "[t]rusting the treatment team . . . is essential to making the Action Stage successful").

185. *See* Lewis, *supra* note 179.

186. *See id.*; Call et al., *supra* note 174, at 722 tbl. 1 (categorizing an inability to see a "preferred doctor" as an "access barrier" to care).

187. Call et al., *supra* note 174, at 721; *see* Reich-Hale, *supra* note 167.

188. *See, e.g.*, *Pediatric Specialties—Adolescent Medicine*, *supra* note 163; *Eating Disorders Program*, *supra* note 166; *Find a Mental Health Program*, *supra* note 162 (listing two licensed

who lives in eastern Suffolk County and is seeking comprehensive outpatient treatment, but who does not have the time or resources to travel in excess of one hour, may have no option but to seek treatment at Mather Hospital.[189] If the patient does not like the program or its providers, and thus cannot form positive relationships that could aid in her recovery process, then she has limited access, at best, to the services that she needs.[190]

New York's densely populated areas are home to a larger number of practitioners and programs.[191] However, even those living in urban areas may struggle to access a provider due to "logistical barriers" and a lack of choice.[192] For those fortunate enough to access a handful of practitioners or programs, insurance companies may not cover local treatment options, which can further limit access to services or make treatment unavailable for financial reasons.[193]

B. Inadequate Coverage for Eating Disorder Treatment

Despite the passage of state and federal parity laws,[194] obtaining treatment coverage for an eating disorder can be a hard-fought battle.[195]

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eating disorder programs located on Long Island). While the operation of four comprehensive eating disorder programs in Nassau and Suffolk counties may seem substantial, individuals do not necessarily have access to all four of these programs, minimizing the seemingly robust presence of such programs. *See Pediatric Specialties—Adolescent Medicine*, *supra* note 163 (explaining that the Adolescent Medicine Division only serves individuals ages twelve through twenty-five); *Program Details: Center for Discovery*, *Hamptons LLC*, N.Y. STATE OFF. MENTAL HEALTH, https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages&PortalPath=/shared/Mental%20Health%20Program%20Directory/_portal/Mental%20Health%20Program%20Directory&page=Advanced%20Search&Action=Navigate (last visited Oct. 13, 2021) (select "Residential" under "Program Category"; select "Community Residence for Eating Disorder Integrated Treatment Program" under "Program Type"; click apply; then click on "Center for Discovery, Hamptons Adol Eating Disorder Program") (stating that the residential program only serves up to eight adolescents); *Program Details: Eating Disorder Treatment of New York, LLC*, N.Y. STATE OFF. MENTAL HEALTH, https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages&PortalPath=/shared/Mental%20Health%20Program%20Directory/_portal/Mental%20Health%20Program%20Directory&page=Advanced%20Search&Action=Navigate (last visited Oct. 13, 2021) (select "Residential" under "Program Category"; select "Community Residence for Eating Disorder Integrated Treatment Program" under "Program Type"; click apply; then click on "Monte Nido Glen Cove") (stating that the residential program only serves up to eleven adults).

189. *See Eating Disorders Program*, *supra* note 166.

190. *See* Lewis, *supra* note 179.

191. *See, e.g.*, *Find a Mental Health Program*, *supra* note 162 (noting that there are five residential eating disorder programs licensed by the state's Department of Mental Health, four of which are clustered in the downstate region near New York City); *see also* Thompson & Park, *supra* note 56, at 755.

192. *See* Reich-Hale, *supra* note 167; Call et al., *supra* note 174, at 721.

193. *See infra* Part III.B.

194. *See supra* Part II.C.

195. *See* Rachel Teicher, *What You Should Know About Insurance Coverage and Eating Disorder Treatment*, EATING DISORDER HOPE, https://www.eatingdisorderhope.com/treatment-for-eating-disorders/special-issues/payment/fighting-insurance-companies-to-pay-for-eating-disorder-treatment (Aug. 24, 2020).

Health insurance plans attempt to limit eating disorder coverage by treating mental illness and physical illness differently, and by setting strict coverage criteria.[196] Without comprehensive insurance coverage, "adequate treatment often proves unaffordable," causing some to endure significant financial stress.[197]

Historically, the New York State Legislature has recognized the existence of inadequate insurance coverage for those suffering from eating disorders.[198] In its legislative findings, with respect to Section 30.01 of the state's Mental Hygiene Law, which mandated the development of CCCEDs, the legislature acknowledged that insurance coverage for those with eating disorders is "usually fragmented . . . leaving citizens with insufficient coverage for essential services[.]"[199] Without proper coverage, individuals risk "incomplete treatment, relapse, deterioration and potential death."[200]

Despite the establishment of CCCEDs pursuant to the Mental Hygiene Law,[201] and the passage of both state and federal parity laws,[202] insurance coverage has remained a significant barrier to receiving eating disorder treatment in New York State.[203] In 2013, the Office of the New York Attorney General ("NYAG") launched investigations into several health insurance companies due to "an abundance of consumer complaints" regarding "health plans' coverage of behavioral health treatment."[204] Eventually, after finding that the insurers violated parity laws, the NYAG entered into settlements requiring the insurers to rectify their violations.[205] Some of these settlements specifically addressed

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196. Hewitt, *supra* note 107, at 417, 425-26 (arguing that the Department of Health and Human Services' decision to allow each state to determine what services were to be included in its essential health benefits package afforded states the opportunity to "continue letting health insurance companies deny or limit [eating disorder] coverage").

197. *Id.* at 418. Sometimes, individuals face bankruptcy as a result of treatment-related expenses. *Id.*

198. *See* N.Y. MENTAL HYG. LAW § 30.01 (McKinney Supp. 2021); *Metropolitan Comprehensive Care Center for Eating Disorders (CCCED)*, COLUM. UNIV. DEP'T PSYCHIATRY, https://www.columbiapsychiatry.org/join-study/research-clinics/eating-disorders-clinic/metropolitan-comprehensive-care-center-eating (last visited Oct. 13, 2021) (stating that the CCCED legislation was introduced in 2003).

199. MENTAL HYG. § 30.01.

200. *Id.*

201. *See Comprehensive Care Centers for Eating Disorders in New York State*, *supra* note 149 (showing the CCCED's in New York State).

202. *See supra* Part II.C.

203. *See* N.Y. STATE OFF. OF THE ATT'Y GEN., MENTAL HEALTH PARITY: ENFORCEMENT BY THE NEW YORK STATE OFFICE OF THE ATTORNEY GENERAL 3-5 (2018) (discussing insurance company parity violations in New York which deprived insured individuals' coverage for mental health services).

204. *Id.*

205. *Id.* As of 2018, each insurance company was compliant with the provisions of its agreement with the New York Attorney General ("NYAG"). *Id.* at 5-8.

parity violations with respect to insurers' failure to cover eating disorder-related services.[206]

In 2014, the NYAG announced that it reached a settlement with Cigna Corporation, after an investigation revealed that the company had wrongfully denied hundreds of nutritional counseling claims for those with eating disorders.[207] During the investigation, the NYAG discovered that Cigna was limiting coverage for nutritional counseling for those with behavioral health issues.[208] However, Cigna was not limiting coverage for patients with non-behavioral health issues.[209] This violation affected approximately fifty downstate Cigna members, causing members to pay out-of-pocket for critical eating disorder treatment.[210]

In 2016, the NYAG announced another settlement with a different insurer.[211] An investigation of Healthnow New York uncovered wrongful denials of thousands of claims, which totaled more than $1.6 million.[212] Specifically, Healthnow New York denied claims for coverage of outpatient psychotherapy *and* for coverage of nutritional counseling for eating disorder patients.[213] Healthnow's policy, prior to the settlement, required patients to receive preauthorization for all outpatient behavioral health visits after the first twenty visits per year and excluded coverage of nutritional counseling for patients with eating disorders.[214] The same limitations were not generally found with respect to outpatient medical services, indicating violations of both state and federal parity law,[215] similar to the Cigna matter that was settled in 2014.[216]

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206. *Id.* at 4-5.

207. *A.G. Schneiderman Announces Settlement with Health Care Insurer for Wrongfully Denying Mental Health Treatment Claims*, N.Y. STATE OFF. ATT'Y GEN. (Jan. 15, 2014), https://ag.ny.gov/press-release/2014/ag-schneiderman-announces-settlement-health-care-insurer-wrongfully-denying.

208. *Id.*

209. *Id.*

210. *Id.*

211. *A.G. Schneiderman Announces Settlement with Healthnow New York Over Wrongful Denial of $1.6 Million in Outpatient Mental Health Treatment and Ensures Coverage for Nutritional Counseling for Patients with Eating Disorders*, N.Y. STATE OFF. ATT'Y GEN. (Aug. 22, 2016), https://ag.ny.gov/press-release/2016/ag-schneiderman-announces-settlement-healthnow-new-york-over-wrongful-denial-16.

212. *Id.*

213. *Id.*

214. *Id.*

215. *See id.*

216. *A.G. Schneiderman Announces Settlement with Health Care Insurer for Wrongfully Denying Mental Health Treatment Claims*, *supra* note 207.

In addition to the NYAG's investigations, the legislature itself recently acknowledged the inadequacy of insurance coverage.[217] In 2019, New York State Senator Alessandra Biaggi sponsored Senate Bill 3101 ("S.3101"), an act that would "close[] a gap" in insurance coverage for eating disorders by "requiring insurance companies to provide full coverage for all the aspects of eating disorders treatment."[218] The Sponsor's Memorandum associated with S.3101 acknowledged existing barriers to treatment, stating that "[d]espite mental health parity laws, many insurance companies continue to deny coverage for an eating disorder, often times because they do not have a solid understanding of what kind of care a patient requires in order to reach full recovery."[219] Accordingly, S.3101, if enacted, would have "help[ed] ensure New York residents have access to adequate healthcare coverage for eating disorders."[220] The bill received overwhelming support from both the New York State Senate[221] and Assembly when a vote was taken in 2019.[222] S.3101 passed,[223] but unfortunately, former Governor Andrew Cuomo vetoed the bill.[224]

IV. FOOD IS A SUBSTANCE TOO!

Part IV of this Note begins by discussing the similarities between substance use disorders and eating disorders.[225] This Part continues by proposing an amended definition of "substance use disorder" in various sections of New York State law and regulations,[226] and discusses the

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217. *See* S3101, 2019-2020 Leg., Reg. Sess. (N.Y. 2019), https://www.nysenate.gov/legislation/bills/2019/s3101 (including the Sponsor's Memorandum, which provides the purpose of and justification for the bill).

218. *Id.*

219. *Id.*

220. *Id.*

221. *See id.* The Senate passed the bill by a vote of 53-8. *Id.* (displaying the State Senate's voting record with respect to the bill).

222. A01619, 2019-2020 Assemb., Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A01619&term=2019&Summary=Y&Floor%26nbspVotes=Y (select "Summary," "Floor Votes," and "Text") (displaying the State Assembly's voting record with respect to the bill). The Assembly passed the bill by a vote of 131-5. *Id.*

223. *See supra* notes 221-22.

224. *See* N.Y. S3101. However, in 2019, the legislature amended the state's insurance law. *See* 2019 N.Y. Sess. Laws 474-75, 480-82 (McKinney). The amended law requires insurers to cover the treatment of "mental health conditions" as defined by the DSM, rather than "mental, nervous or emotional disorders or ailments" as defined by the insurer's policy. *Id.*; N.Y. INS. LAW § 3221(l)(5)(A), (l)(5)(E)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 3216(i)(35)(E)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(g) (McKinney 2021). Despite the 2019 amendments, which arguably extend coverage to those with eating disorders, the Sponsor's Memorandum and voting results associated with S.3101 are evidence that the legislature has recently recognized the continuing inadequacy of coverage despite the existence of parity laws in the state. *See* N.Y. S3101; N.Y. A01619.

225. *See infra* Part IV.A.

226. See *infra* Part IV.B.

impact of those proposed amendments.[227] As discussed below, the amended and expanded definitions will provide individuals with eating disorders access to existing addiction services and additional insurance coverage options.[228] This Part concludes by identifying and addressing concerns related to the proposed amendments.[229]

A. The Link to Substance Use

According to the DSM-V, substance use disorders are characterized by (i) impaired control; (ii) social impairment; (iii) risky use; and (iv) pharmacological criteria.[230] "Impaired control" criteria focus on the following: the individual's use of the substance (the amount and period of time used); the individual's inability to "cut down" on substance use; the time that the individual spends obtaining, using, or recovering from the substance; and the individual's "intense desire or urge" for the substance.[231] New York State's Mental Hygiene Law defines substance use disorder, in part, as "[the] recurrent use of alcohol and/or legal or illegal drugs causing clinical and functionally significant impairment to the individual's physical and mental health, or the welfare of others."[232] It is clear, according to the DSM-V and the State of the New York, that eating disorders are not currently considered substance use disorders.[233] While the neurobiology of substance addiction is not identical to the neurobiology of eating disorders, there are similar "addictive" and "compulsive" aspects common to both disorders.[234] The similarities between the two types of disorders could result in the characterization of eating disorders as a substance use disorder, as defined in New York State law.[235]

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227. *See infra* Part IV.B.1.

228. *See infra* Part IV.B.1.

229. *See infra* Part IV.C.

230. AM. PSYCHIATRIC ASS'N, *supra* note 1, at 483.

231. *Id.*

232. N.Y. MENTAL HYG. LAW § 1.03(56) (McKinney 2020). The remainder of the definition is as follows: "Unless otherwise provided, for the purposes of this chapter the term substance use disorder shall mean and include alcoholism, alcohol abuse, drug abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence." *Id.* A substance, for the purposes of this definition, includes controlled substances, *id.* § 1.03(39)(i), and inhalants, *id.* § 1.03(39)(ii); N.Y. PUB. HEALTH LAW § 3380 (McKinney 2018). MENTAL HYG. § 1.03(39)(i)–(ii). The definition of "substance" also includes any substance (excluding alcohol and tobacco), which has "the capability of causing physical and/or psychological dependence." MENTAL HYG. § 1.03(39)(iii).

233. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 329 (asserting that while some individuals with eating disorders report experiencing symptoms associated with substance use disorders, "the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood"); MENTAL HYG. § 1.03(39), (56).

234. Ella Quittner, *Are Eating Disorders a Form of Substance Abuse?*, HEALTH, https://www.health.com/condition/bulimia/are-eating-disorders-a-form-of-substance-abuse (Oct. 22, 2011).

235. *See infra* notes 236-51 and accompanying text.

However, it is important to note that eating disorders differ from each other.[236] Unlike bulimia nervosa and binge eating disorder, one of the main characteristics of anorexia nervosa is "semi-starvation"—not an addiction to a substance, like food.[237] It is, in fact, the opposite.[238] An article published in 2011 stated that the "relentlessness with which individuals with anorexia nervosa pursue starvation despite profound negative physical, emotional, and social consequences is similar to the maladaptive cycle seen in individuals with addiction."[239] For example, individuals with anorexia nervosa exhibit behaviors similar to those with substance use disorders by "narrowing their behavioral repertoire so that weight loss, restricting food intake, and excessive exercise interfere with other activities."[240] Often, individuals with an addiction behave similarly—by "forgo[ing] activities and responsibilities for the sake of seeking out and consuming drugs of abuse."[241]

Bulimia nervosa, characterized by binging and purging,[242] is also similar to substance use disorders.[243] Both bulimia nervosa and substance use disorders focus on the consumption of substances.[244] According to one doctor who suffered from bulimia nervosa, "[t]he thoughts driving [his] disordered behaviors closely resembled the thoughts driving the behavior of a substance abuser."[245] In his experience, he engaged in a "'problematic pattern' of behavior 'leading

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236. *See infra* notes 237-51 and accompanying text.

237. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 338-39, 341; *Food*, BRITANNICA, https://www.britannica.com/topic/food (last visited Oct. 13, 2021) (stating that food is a "substance consisting essentially of protein, carbohydrate, fat, and other nutrients").

238. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 338-39 (listing the criteria used to diagnose an individual with anorexia nervosa).

239. Nicole C. Barbarich-Marsteller et al., *Does Anorexia Nervosa Resemble an Addiction?*, HHS PUB. ACCESS: AUTHOR MANUSCRIPT 3 (May 20, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4438277/pdf/nihms-375893.pdf.

240. *Id.* at 4. Anorexia resembles substance use disorders in other ways as well. *Id.* ("Moreover, individuals with anorexia nervosa often engage in dietary restriction as a mechanism for modulating anxiety and dysphoric mood, in much the same way individuals with substance abuse modulate mood with drug use. When food intake in anorexia nervosa does occur, anxiety increases in a similar manner to anxiety often reported during periods of drug abstinence, e.g. withdrawal.").

241. *Id.* However, there are "critical differences" between anorexia nervosa and substance use disorders. *Id.* First, individuals with substance use disorders seek instant gratification from their consumption of addictive substances, while individuals with anorexia nervosa seek both the immediate and long-term effects associated with dieting and starvation. *Id.* Second, individuals with anorexia nervosa are encouraged to continue their behavior as a result of society's obsession with thinness. *Id.* However, individuals with substance use disorders do not receive "positive reinforcement." *Id.* Instead, they are looked down upon for their failure to comply with societal norms. *Id.*

242. AM. PSYCHIATRIC ASS'N, *supra* note 1, at 345-46.

243. *See* Sumati Gupta, *Is Bulimia Like a Drug Addiction?*, PSYCH. TODAY (June 22, 2012), https://www.psychologytoday.com/us/blog/emotional-eating/201206/is-bulimia-drug-addiction.

244. *Id.*

245. Spencer Hansen, *Conceptualizing Bulimia as Addiction: A Resident's Personal Experience*, AM. J. PSYCHIATRY: RESIDENTS' J., Aug. 2016, at 6, 7.

to clinically significant impairment and distress.'"[246] He spent "a great deal of time" in pursuit of his food-related behaviors and suffered "'persistent or recurrent social or interpersonal problems caused or exacerbated by the effects' of [his] eating disorder."[247] Like drugs and other substances, food can be "experienced as [a] craving[] that often become[s] associated with certain places or situations."[248] In addition, tolerance and withdrawal, which are often associated with substance use disorders, can be experienced by individuals with bulimia nervosa.[249] Positive mood shifts, which reinforce behaviors and a loss of control occurring after consumption of the substance (either food or other addictive substances), further link the two.[250] Ultimately, both bulimia nervosa and substance use disorders manifest in addictive tendencies and behaviors.[251]

The similarities between these two types of disorders—substance use and eating—support including eating disorders within the definition of substance use disorder.[252] If eating disorders did not include addictive behaviors, then including them within the legal definition of substance use disorders would not be reasonable.[253] However, there are similarities—as stated above[254]—and therefore, it is reasonable to include eating disorders within the category of substance use disorders as proposed below.[255]

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246. *Id.* at 6.
247. *Id.*
248. Gupta, *supra* note 243.
249. *Id.*
250. *Id.*
251. *See id.*
252. *See supra* notes 234-51 and accompanying text (arguing that eating disorders are addictions related to food, a substance); *OASAS Provider and Program Search*, N.Y. STATE OFF. ADDICTION SERVS. & SUPPORTS, https://webapps.oasas.ny.gov/providerDirectory/index.cfm?search_type=2 (last visited Oct. 13, 2021) (indicating that both chemical dependence programs and problem gambling are considered "addictions" addressed by the state's Office of Addiction Services and Supports, despite their differences).
253. *See* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 292, 483 (characterizing dissociative and substance use disorders as distinct categories of disorders, neither of which is subsumed into the other). For example, dissociative identity disorder shares no common diagnostic criteria with substance use disorders and therefore is not considered a substance use disorder. *See id.* A diagnosis of alcohol use disorder, in contrast, occurs when an individual satisfies diagnostic criteria similar to other substance use disorders. *See id.* at 483, 490-91. While the DSM-V distinguishes substance use disorders and feeding and eating disorders, it does acknowledge that there may be a "resemblance" between eating disorders and substance use disorders. *Id.* at 329.
254. *See supra* notes 234-51 and accompanying text.
255. *See infra* Part IV.B.

B. Re-Defining "Substance Use Disorder" in New York

Current New York State law does not observe one definition of "substance use disorder."[256] Title 14 of the New York Code of Rules and Regulations ("NYCRR") defines substance use disorder as:

> [T]he misuse of, dependence on, or addiction to alcohol and/or legal or illegal drugs leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others and shall include alcoholism, alcohol abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence.[257]

However, Sections 3216, 3221 and 4303 of New York State's Insurance Law state that substance use disorder:

> [S]hall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.[258]

These definitions apply in different settings.[259] For example, the definition of substance use disorder in Title 14 of the NYCRR applies to facilities that provide substance use disorder services,[260] while the definition in the state's insurance laws applies to health insurance policies.[261] While nuances exist, each definition generally refers to the use of a substance that results in harm to the user.[262] Despite the general similarities among the definitions, each must be changed in order to address inadequate access to and coverage for treatment.[263]

Remedying the access issue requires an amendment to the definition of substance use disorder in Title 14 of the NYCRR.[264] In

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256. *Compare* N.Y. INS. LAW § 3221(l)(6)(F)(iv) (McKinney Supp. 2021), *with* N.Y. COMP. CODES R. & REGS. tit. 14, § 810.4(m) (2020).

257. Tit. 14, § 810.4(m).

258. INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); N.Y. INS. LAW § 3216(i)(30)(F)(iv), (i)(31)(G)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(k)(6)(D), (l)(7)(D) (McKinney 2021).

259. *See infra* text accompanying notes 260-61.

260. N.Y. COMP. CODES R. & REGS. tit. 14, § 810.3 (2020).

261. INS. § 3221(a); INS. § 4303(a); *see* INS. § 3216(c).

262. *See* tit. 14, § 810.4(m); INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D); AM. PSYCHIATRIC ASS'N, *supra* note 1, at 483-84 (mentioning social, physical, and psychological problems that can accompany substance use). As stated above, another definition is "[the] recurrent use of alcohol and/or legal or illegal drugs causing clinical and functionally significant impairment to the individual's physical and mental health, or the welfare of others." *See supra* note 232.

263. *See infra* notes 264, 268 and accompanying text.

264. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 810.1 (2020). If this section is not amended, certified substance use disorder service providers will not be able to provide services to individuals with eating disorders, as the definition of substance use disorder does not include eating disorders. *See* tit. 14, § 810.1; tit. 14, § 810.4(m).

order to bring eating disorders within the purview of Title 14, the new definition should read as follows:

> [T]he misuse of, dependence on, or addiction to alcohol [*, food,*] and/or legal or illegal drugs leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others and shall include alcoholism, alcohol abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence.[265] *The misuse of, dependence on, or addiction to food brings within the purview of this definition eating disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.*[266]

This amended definition would permit facilities that provide substance use disorder services to treat those with eating disorders, in addition to those struggling with substance use disorders.[267]

Remedying the coverage issue requires an amendment to New York State Insurance Law, which establishes coverage standards for health insurance policies.[268] The Insurance Law definitions should be amended to read as follows:

> '[S]ubstance use disorder' shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.[269] *"Substance use disorder" shall also include eating disorders, as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.*[270]

Adding the italicized language to both definitions is justifiable as it reflects existing language in the law which the legislature has already approved.[271] As an additional benefit, this language allows the law to

265. *See* tit. 14, § 810.4(m).

266. Tit. 14, § 810.4(m); INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D); *see* AM. PSYCHIATRIC ASS'N, *supra* note 1, at 329 (stating that eating disorders are "characterized by a persistent disturbance of eating or eating-related behavior").

267. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 810.3 (2020).

268. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D). If these sections defining substance use disorder are not amended, those with eating disorders will not be entitled to any coverage under the state's substance use disorder parity laws. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

269. INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

270. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

271. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

remain up-to-date with medical diagnostic practices and therefore does not require amendments to account for future updates made to the DSM.[272] Through these changes, the legislature will make a policy decision in favor of assisting those with eating disorders, while deferring to the medical community's expertise in the area of diagnostics and treatment.[273]

1. How Will This Help?

Amending the definition of substance use disorders will ultimately provide *additional* resources to those suffering from these illnesses.[274] With respect to access, if New York amends Title 14 of the NYCRR to include the proposed language, facilities in the state that have a certificate to provide substance use disorder services will be able to treat individuals who suffer from eating disorders.[275] The additional number of facilities where individuals could now seek treatment is significant.[276] For example, the Commissioner of the Office of Addiction Services and Supports ("OASAS") has certified over 700 programs throughout the State of New York, including residential and outpatient programs, that currently treat individuals with substance use disorders.[277] For comparison, there are three CCCEDs[278] and five residential centers in New York State that treat individuals with eating disorders, according to the State's website.[279]

By supplementing the definition of "substance use disorder" to include eating disorders, group health insurance policies offering "major

272. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

273. *See* INS. § 3221(l)(6)(F)(iv), (l)(7)(G)(iv); INS. § 3216(i)(30)(F)(iv), (i)(31)(G)(iv); INS. § 4303(k)(6)(D), (l)(7)(D).

274. *See infra* notes 275-88 and accompanying text.

275. *See* N.Y. COMP. CODES R. & REGS. tit. 14, § 810.1 (2020); N.Y. COMP. CODES R. & REGS. tit. 14, § 810.4(m) (2020).

276. *Compare OASAS Provider and Program Search*, *supra* note 252 (select "Chemical Dependence Treatment Programs" under "Program Type" and select "Statewide Search" under "Provider Location") (listing over seven hundred programs throughout the state that provide services to those with substance use issues), *with supra* Part III.A (discussing the limited number of CCCEDs and Community Residence for Eating Disorders Integrated Treatment ("CREDIT") programs providing services to those with eating disorders). Chemical dependence treatment programs are also referred to as substance use disorder treatment programs. *See Treatment*, N.Y. STATE OFF. ADDICTION SERVS. & SUPPORTS, https://oasas.ny.gov/treatment (last visited Oct. 13, 2021). The "Program Lookup" section, which states that an individual can search for substance use disorder programs, links the website user to the Office of Addiction Services and Supports ("OASAS") Provider and Program Search, which uses the phrase "chemical dependence treatment programs" in lieu of "substance use disorder treatment programs." *Id.*

277. *See OASAS Provider and Program Search*, *supra* note 252 (select "Chemical Dependence Treatment Programs" under "Program Type" and select "Statewide Search" under "Provider Location").

278. *Comprehensive Care Centers for Eating Disorders in New York State*, *supra* note 149.

279. *Find a Mental Health Program*, *supra* note 162.

medical or similar comprehensive coverage" would be required to cover both inpatient and outpatient treatment for eating disorders under the law.[280] Further, insurers would be barred from applying financial requirements or treatment limitations for inpatient or outpatient services that are more restrictive than the requirements and limitations that apply to an insured's medical and surgical benefits.[281] Prohibited financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses,[282] while prohibited treatment limitations include limits "on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment."[283]

Insurance coverage for substance use disorder treatment, like coverage for mental health disorder treatment, is not always easy to obtain.[284] Parity is the law, but is not necessarily achieved in practice.[285] Therefore, simple amendments to insurance laws, while they may have an impact on paper, may not have an impact in practice.[286] However,

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280. N.Y. INS. LAW § 3221(l)(6)(A), (l)(7)(A) (McKinney Supp. 2021); N.Y. INS. LAW § 3216(i)(30)(A), (i)(31)(A) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(k)(1), (l)(1) (McKinney 2021). Additionally, insurers that offer group health insurance coverage and provide hospital coverage would be required to cover inpatient treatment for substance use disorders under the law. INS. § 3221(l)(6)(A); INS. § 3216(i)(30)(A); INS. § 4303(k)(1). The language of Sections 3221(l)(7)(A), 3216(i)(31)(A), and 4303(l)(1) differ slightly. *Compare* INS. § 3221(l)(6)(A), INS. § 3216(i)(30)(A), INS. § 4303(k)(1) (requiring each policy that provides "hospital, major medical, or similar comprehensive coverage" to provide inpatient coverage), *with* INS. § 3221(l)(7)(A), INS. § 3216(i)(31)(A), INS. § 4303(l)(1) (requiring each policy that provides "medical, major medical or similar comprehensive type coverage" to provide outpatient coverage). Many insured individuals fall under the protection of this law because many New Yorkers receive comprehensive coverage. *See Comprehensive Coverage*, HEALTHINSURANCE.ORG, https://www.healthinsurance.org/glossary/comprehensive-coverage (last visited Oct. 13, 2021) (stating that most employer-provided health plans, Medicaid plans, and Medicare plans provide individuals with comprehensive coverage); *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/statedata (last visited Oct. 13, 2021) (enter "Health Insurance Coverage of the Total Population" in the text box; select the result with the same name; then, under "Timeframe," select "2019") (showing that 49.8%, 25.7%, and 13.0% of New Yorkers receive health insurance through their employer, Medicaid, and Medicare, respectively). *But see Mental Health and Substance Use Disorder Coverage Covered by New York Protections*, N.Y. STATE DEP'T FIN. SERVS., https://www.dfs.ny.gov/consumers/health_insurance/new_york_health_insurance_policies__programs/mh_sud (last visited Oct. 13, 2021) (explaining that the State's protections do not apply when an employer elects to self-fund group coverage and, further, that different rules apply with respect to Medicare coverage).

281. INS. § 3221(l)(6)(A), (l)(7)(A); INS. § 3216(i)(30)(A), (i)(31)(A); INS. § 4303(k)(1), (l)(1).

282. INS. § 3221(l)(6)(F)(i), (l)(7)(G)(i); INS. § 3216(i)(30)(F)(i), (i)(31)(G)(i); INS. § 4303(k)(6)(A), (l)(7)(A).

283. INS. § 3221(l)(6)(F)(iii), (l)(7)(G)(iii); INS. § 3216(i)(30)(F)(iii), (i)(31)(G)(iii); INS. § 4303(k)(6)(C), (l)(7)(C).

284. *See* Patrick J. Kennedy, *Mental Health and Addiction Care Are Poorly Covered by Insurance Networks*, STAT (Dec. 10, 2019), https://www.statnews.com/2019/12/10/mental-health-addiction-care-poorly-covered-by-insurance-networks.

285. *Id.*

286. *See id.*

amending the definition of substance use disorder in New York State's Insurance Law, at a minimum, provides an avenue for individuals to appeal coverage denials, arguing that they are entitled to substance use disorder benefits.[287] If the current definition is not amended, these individuals will be unable to argue that they are entitled to such benefits.[288]

C. *An Imperfect Solution*

Unfortunately, this solution will not resolve all of the underlying issues that arise with respect to access and coverage.[289] As stated above, for example, some insurance companies have failed to comply with parity laws.[290] Other issues, such as insurers' tendency to deny coverage[291] and the lack of appropriate providers in substance abuse treatment centers, are explored below.[292]

1. "Medical Necessity" Will Still Be Necessary

This Note does not address the frequent problem that many insureds face: coverage denials on the basis of so-called "medical necessity."[293] In New York State, insurers are required to cover "the diagnosis and medically necessary treatment of a mental health condition or substance use disorder."[294] However, insurance companies are the arbiters of what is considered "medically necessary."[295] Insurers may deny coverage in an attempt to save money, making it difficult to secure critically important treatment for those with illnesses like substance use or eating disorders.[296] For example, a study conducted by the Congressional Budget Office found that private insurance companies pay "13% to 14% less for mental health care than Medicare does."[297]

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287. *See Mental Health and Substance Use Disorder Coverage Covered by New York Protections*, *supra* note 280.

288. *See id.*; *supra* note 233 and accompanying text (arguing that eating disorders are not currently considered substance use disorders).

289. *See infra* Part IV.C.1–2.

290. Kennedy, *supra* note 284.

291. *See infra* Part IV.C.1.

292. *See infra* Part IV.C.2.

293. David Lazarus, *Column: When Your Insurer Denies a Valid Claim Because of "Lack of Medical Necessity"*, L.A. TIMES (Jan. 23, 2018, 3:00 AM), https://www.latimes.com/business/lazarus/la-fi-lazarus-healthcare-claim-denials-20180123-story.html.

294. *Mental Health and Substance Use Disorder Coverage Covered by New York Protections*, *supra* note 280.

295. *Id.*

296. *See* Lazarus, *supra* note 293.

297. Graison Dangor, *'Mental Health Parity' Is Still an Elusive Goal in U.S. Insurance Coverage*, NPR (June 7, 2019, 5:00 AM), https://www.npr.org/sections/health-

In 2019, health insurance members in New York filed over 58,000 internal appeals[298] with their insurance companies.[299] These appeals included claims that coverage was denied on the basis that the requested treatment was not medically necessary.[300] While concerns about health insurance denials are apparent, there is hope for those struggling with mental illness and substance use disorders.[301] Of the over 58,000 New Yorkers who filed internal appeals, over forty percent saw their initial denials reversed.[302] Further, commercial health insurance companies reversed seventy-seven percent of the initial decisions that formed the basis of their internal appeals.[303]

2. Substance Use Treatment Centers Are Not Equipped to Treat Eating Disorders

According to the OASAS, substance use treatment centers do not provide treatment for eating disorders.[304] This is not surprising, as eating disorders are not currently considered substance use disorders under New York State laws and regulations.[305] However, including treatment for eating disorders at substance use treatment facilities may not be complex because eating disorders can be considered an addiction[306] and because the types of therapy used to treat both disorders overlap.[307]

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shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage.

298. *See* N.Y. STATE DEP'T OF FIN. SERVS., NEW YORK CONSUMER GUIDE TO HEALTH INSURERS 15-18 (2020), https://www.dfs.ny.gov/system/files/documents/2020/09/cg_health_insurers_2020.pdf. According to the New York State Department of Financial Services, an internal appeal "occurs when a member or provider asks a health insurance company to reconsider its refusal to pay for a medical service that the health insurance company considers experimental, investigational, not medically necessary, a clinical trial or a treatment for a rare disease." *Id.* at 14.

299. *Id.* at 15-18.

300. *Id.* at 14.

301. *See* Lazarus, *supra* note 293; N.Y. STATE DEP'T OF FIN. SERVS., *supra* note 298, at 15-18.

302. N.Y. STATE DEP'T OF FIN. SERVS., *supra* note 298, at 15-16.

303. *Id.* at 17-18.

304. *See Types of Treatment*, N.Y. STATE OFF. ADDICTION SERVS. & SUPPORTS, https://oasas.ny.gov/treatment/types (last visited Oct. 13, 2021). OASAS identifies five treatment options: crisis services, inpatient rehabilitation, outpatient rehabilitation, opioid treatment, and residential services. *Id.* When describing these options, OASAS refers specifically to alcohol and other substances. *Id.* Chapter XXI of Title 14 of the NYCRR, which governs OASAS, defines substance use disorder, in part, as the "misuse of, dependence on, or addiction to alcohol and/or legal or illegal drugs," foreclosing the possibility that the types of treatment above address eating disorders. N.Y. COMP. CODES R. & REGS. tit. 14, § 800.3(q) (2020).

305. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 14, § 810.4(m) (2020); N.Y. INS. LAW § 3221(l)(6)(F)(iv), (l)(7)(G)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 3216(i)(30)(F)(iv), (i)(31)(G)(iv) (McKinney Supp. 2021); N.Y. INS. LAW § 4303(k)(6)(D), (l)(7)(D) (McKinney 2021); N.Y. MENTAL HYG. LAW § 1.03(56) (McKinney 2020).

306. *See supra* Part IV.A.

307. *See infra* notes 308-11 and accompanying text.

While the 12-Step Program used by both Alcoholics Anonymous and Narcotics Anonymous is a popular treatment method,[308] it is not the sole therapy used to treat addiction.[309] For example, Cognitive Behavioral and Dialectal Behavioral therapies can be used to treat individuals with substance use disorders.[310] These therapies are used to treat individuals with eating disorders, as well.[311] Therefore, facilities that utilize these types of therapies could cater to those with either disorder.[312]

Despite the overlap in therapeutic treatment options,[313] nutritional counseling is an important aspect of eating disorder treatment[314] which is not critically important to the treatment of substance use disorders, as registered dietitian nutritionists are not typically utilized in substance use disorder treatment centers.[315] However, including nutritional counseling services onsite at treatment centers may benefit individuals with both eating disorders and substance use disorders, thus encouraging centers to employ this type of professional.[316] For example, studies have shown that individuals who are addicted to a substance or who are in recovery tend to favor a high-sugar or high-fat diet and tend to use caffeine and nicotine—which can lead to "unhealthy patterns of weight changes."[317] Therefore, providing nutritional counseling at substance use treatment centers may benefit a significant portion of the treatment-seeking population.[318]

Including these services and providing for the treatment of eating disorders at substance use treatment centers would not require an overhaul of a center's operations.[319] As stated above, the same types of therapy can be used to treat both eating disorders and substance use disorders, which would allow individuals with eating disorders to

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308. *12 Step Programs: 12 Steps to Recovery for Drug & Alcohol Treatment*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/rehab-guide/12-step (Aug. 4, 2021) (stating that according to SAMHSA, the 12-Step model is used at approximately seventy-four percent of treatment centers and citing additional treatment options including counseling and therapy).

309. Leah Miller, *Substance Abuse Treatment & Types of Addiction Therapy*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/therapy-treatment (Oct. 15, 2021).

310. *Id.*

311. *Types of Psychotherapy*, NAT'L EATING DISORDERS ASS'N, https://www.nationaleatingdisorders.org/treatment/types-psychotherapy (last visited Oct. 13, 2021).

312. *See id.*; Miller, *supra* note 309.

313. *See supra* notes 310-12 and accompanying text.

314. *A.G. Schneiderman Announces Settlement with Healthnow New York Over Wrongful Denial of $1.6 Million in Outpatient Mental Health Treatment and Ensures Coverage for Nutritional Counseling for Patients with Eating Disorders*, *supra* note 211.

315. *See* David A. Wiss et al., *Registered Dietitian Nutritionists in Substance Use Disorder Treatment Centers*, 118 J. ACAD. NUTRITION & DIETETICS 2217, 2217 (2018) (stating that registered nurse dietitians are "scarce" in substance use disorder treatment centers).

316. *See id.* at 2217-19.

317. *Id.* at 2217-18.

318. *See id.* at 2217-19.

319. *See id.* at 2218-19.

integrate into existing therapy sessions offered at substance use treatment centers.[320] Therefore, equipping a center to treat eating disorders would likely only require the addition of a registered dietician nutritionist or a like professional and the assignment of a physical location at the center where the professional could meet with individuals seeking treatment.[321]

V. CONCLUSION

Unfortunately, millions of people "have to do battle" to get the help that they need.[322] It is clear that both the New York State Legislature and Congress have attempted to make significant progress with respect to mental health parity.[323] While some progress has been made, it is equally clear that legislators' lofty goals have gone unrealized.[324] In New York, individuals with eating disorders struggle to obtain the care they need.[325]

The solution proposed above—including eating disorders within the definition of substance use disorders in New York State's laws and regulations—is controversial insofar as it links the disorders in a way that is not typically recognized in the medical profession.[326] However, the focus of this Note is neither diagnostic nor clinical.[327] Instead, the focus is institutional and financial—as this Note ultimately seeks to increase the number of opportunities to receive medical help.[328] If the proposed changes are implemented, medical experts will continue to be the arbiters of diagnostics and proper treatment in the field of mental health.[329]

This solution will not resolve every problem regarding access to and insurance coverage for treatment.[330] However, it would make available new avenues for help that have been and continue to be blocked.[331] First, this solution will provide those with eating disorders the opportunity to receive help closer to home and have a choice in the location of their treatment.[332] Second, this solution has the potential to

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320. *See supra* text accompanying notes 310-12.
321. *See* Wiss et al., *supra* note 315, at 2218-19.
322. Lazarus, *supra* note 293.
323. *See supra* Part II.
324. *See supra* Part III.
325. *See supra* Part III.
326. *See supra* note 233 and accompanying text.
327. *See supra* Parts III–IV (emphasizing financial and accessibility issues).
328. *See supra* Parts III–IV.
329. *See supra* text accompanying notes 266, 270 (proposing amendments that ultimately defer to the DSM and the medical community).
330. *See supra* Part IV.C.
331. *See supra* Part IV.
332. *See supra* Part IV.

decrease the financial burden that too often accompanies treatment.[333] Now, imagine that you binged for the first time at the age of five and as an adult, you continue to struggle with an eating disorder.[334] You would want any additional opportunity available, however small, to become well—right?[335]

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333. *See supra* Part IV.

334. *See* Turner, *supra* note 2.

335. *See id.*

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