NAVIGATING YOUR BENEFITS:
Eating Disorder Insurance Q & A

Health insurance policies can be overwhelming and tricky. There is a lot of different information that varies by policy, and it can be confusing to understand what your plan does and does not cover, how much the cost is per service, etc.

Q: What do all the different payment terms mean?

A: A few different factors go into paying for treatment. Most insurance plans have a **premium**, which is a monthly fee that the patient pays for their insurance plan. Many patients also have an **insurance deductible**, which is a set amount that the patient has to pay out-of-pocket before their insurance benefits kick in. After the deductible is met, patients are typically responsible for a **copay** (a set dollar amount per visit) or **co-insurance** (a set percentage of the total cost of the visit) each time they receive treatment. Many insurance plans also have an **out-of-pocket maximum (OOPM)**, which is a cap on the amount that the patient pays per year in copays and/or co-insurance.

Q: What are common reasons an insurance company denies coverage of eating disorder treatment or payment for services?

A: While there are many reasons a health insurance plan may deny coverage of eating disorder treatment or payment for such services, there are some common reasons you may be experiencing, depending on your plan and the services you are seeking coverage for.

- Level of care (or services) deemed not “medically necessary”
- Not eligible for coverage of services requested under your health plan and/or lack of your plan including a benefit (such as eating disorder residential level of care)
- Failure to attempt treatment a lower level of care prior to requesting coverage for a higher level of care
- Not eligible for coverage of services requested until trying “X” services (generally preferred in-network option or one geographically closer)
- Eating disorders are not an explicitly named “row” of issues covered on your health plan’s Explanation of Benefits (EOB) and therefore quickly dismissed without adequate exploration by the payor
Q: What is the difference between Medicare and Medicaid?

A: Medicaid is a state-run health insurance for people whose income is below a certain level. Medicare is a federally-run health insurance for people above the age of 65 and who have certain qualifying disabilities. Medicaid coverage can vary by state and managed Medicaid plan, while Medicare is accepted in many states regardless of the plan.

Q: What ED treatment do Medicare and Medicaid cover, and why is it so limited?

A: Currently, most Medicare and Medicaid plans limit their coverage of eating disorder treatment to inpatient (hospital-based) and outpatient programs. It’s important, however, to keep in mind that every plan is different and that you should contact your insurance company to verify your benefits and coverage options.

The coverage of eating disorder treatment for those with Medicare and Medicaid is so limited because of how those programs have been designed. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally requires group health plans and health insurance payors to provide mental health or substance use disorder benefits to have equal benefit coverage of mental health diagnoses as medical diagnoses. However, because medical issues are treated either in a hospital or via office visits, the MHPAEA limits mental health coverage to the same treatment options, i.e. inpatient or outpatient. This then excludes any other levels of care that are often required for mental health conditions like eating disorders, including residential, most partial hospitalization programs (unless they are hospital-based), and most intensive outpatient programs (unless they are hospital-based).

Q: How do I know which providers are in-network?

A: In-network providers are those who are “preferred” or covered by your insurance plan. To find who is in your network, it may be easier to call your Member Services number and request a list to be emailed to you, listing in-network providers you are looking for (Therapist, dietitian, psychiatrist, etc.).

These providers may be available on the insurance website when entering your area code in a search tool, and if you are purchasing an insurance plan on the Insurance Marketplace, you can enter your providers in a tool to show which plans match your current providers. Another way to check if your providers take your specific plan is to call your selected provider’s office, and they will inform you if they are in- or out-of-network and provide a benefits check before your scheduled appointment.
Q: My insurance plan does not have any in-network outpatient specialized eating disorder therapists. Is there anything I can do to avoid paying a provider out-of-pocket?

A: Depending on the specific insurance plan, there are likely steps you can take to avoid taking on out-of-pocket costs. Specifically, you will want to follow up with a representative from your insurance company who can let you know whether or not your plan has an option to coordinate a single case agreement (SCA) or special coverage agreements. An SCA is a contract between an insurance company and an out-of-network health care provider for a specific patient that enables the patient to receive in-network coverage for an out-of-network provider for an established period of time. Calling the Member Services number, typically located on the back of your insurance card, will connect you to an insurance representative.

Q: What do I need to do to see a provider out-of-network?

A: If you do need to see a provider who is not in your network or, out-of-network, due to the services you are seeking not being available in-network or in your area, there are additional and different steps you may need to take per your plan’s out-of-network policy.

If your plan has an out-of-network benefit, this will likely be covered by the plan, but this will usually be at a higher deductible and/or co-pay. Often if out-of-network benefits are available, there may be a $4,000 deductible, for in-network services, for example, and a $8,000 deductible for out-of-network. Your in-network copay may be $25 to see your PCP, whereas the out-of-network copay may be $50.

It is often the case that eating disorder providers or treatment centers will be out-of-network (a frequent and understandable frustration). Eating disorder providers may be out-of-network if your insurance plan does not cover eating disorder services, or there are no specialists available in your area or network.

In these cases, if it is an outpatient provider you are seeking for an eating disorder and they are out-of-network, this will often have to be paid out-of-pocket. Many outpatient providers offer a sliding scale, and you may be able to discuss with them a smaller amount they are willing to bill for your sessions. If an eating disorder treatment center is out-of-network, many plans will allow a Single Case Agreement, a one-time, negotiated contract between provider and insurance payor to set up coverage for your treatment. The amount billed and paid for this service will be discussed ahead of time.
Q: What is pre-authorization and utilization review?

A: A pre-authorization review occurs when your health insurance company reviews a patient’s request for treatment. During the authorization request, your health insurance company will decide whether they are able to cover the requested treatment. A utilization review, typically completed by your treatment facility and/or provider, is a request for continued stay and additional days in treatment. During the utilization review, your insurance company will request information to meet medical necessity criteria according to The Milliman Care Guidelines (“MCG”), a set of health industry best practices, guidelines and diagnostic criteria published by MCG Health for providers and health plans.

Q: What are my options if my health insurance denied pre-authorization for my treatment or covering treatment services already rendered?

A: If your insurance company denies coverage for treatment services, you can submit an appeal for your health insurance to review their decision. The appeal process differs by health insurance company; you can find more information on your health insurance’s appeal process on their website or by calling Member Services. You can find more information about health insurance appeals here and here. If your appeal is denied, you may want to resubmit. If you believe the denial was unfair to the point of being illegal, you should consult an attorney.

Q: How do I submit a Single Case Agreement (SCA)?

A: The process of coordinating a SCA varies by insurance provider. However, since SCAs involve both your insurance and your treatment provider, it is recommended to be in touch with both parties throughout the process so that everyone is on the same page. Read more on starting the SCA process further on in these insurance guides.

Q: Will my health insurance cover treatment expenses from a facility located in a state different from where I live?

A: It depends on your insurance provider. Most insurance providers’ websites have a list of all of their in-network treatment providers, so it’s important to check there before your first treatment appointment.
Q: What is the Mental Health Parity and Addiction Equity Act (MHPAEA)?

A: The MHPAEA is a federal law that was signed in 2008. This law requires that insurance companies provide equivalent coverage for mental health and substance use services that they would for other health services. This law paved the way for in-network mental health coverage. However, it is underenforced. It is also proving insufficient for eating disorder treatment because medical care only includes hospital visits or office visits, while eating disorder treatment also includes residential, PHP, and IOP, which are not included under parity.

**Health Plans that **MUST** follow parity:**
- Group health plans for employers with 51+ employees
- Most group health plans for employers with 50 or fewer employees unless they have been “grandfathered,” which means it was created before the federal parity laws went into effect
- The Federal Employees Health Benefits Program
- Medicaid Managed Care Plans (MCOs)
- State Children’s Health Insurance Programs (S-CHIP)
- Some state and local government health plans
- Any health plans purchased through the Health Insurance Marketplaces
- Most individual and group health plans purchased outside the Health Insurance Marketplaces unless “grandfathered”

**Health plans that do NOT have to follow parity:**
- Medicare (except for Medicare’s cost-sharing for outpatient mental health services do comply with parity)
- Medicaid fee-for-service plans
- “Grandfathered” individual and group health plans that were created and purchased before March 23, 2010.
- Plans who received an exemption based on increase of costs related to parity

The Federal Center for Medicaid and Medicare (CMS) can also enforce parity if states do not enforce the law. If you have concerns that your insurance plan is not following parity, contact the CMS help line.

1-877-267-2323 Ext 6-1565

[Read more on the MHPAEA here](#)
Q: Who can I talk to when I have questions about billing, coverage, etc.?

A: When having questions related to billing or coverage of your insurance plan, it is best to call the Member Services number on the back of your insurance card. Depending on your plan, there may be different Member Services numbers to call, a separate one for medical and one for behavioral health. If you need to reach a separate department, a customer service representative will transfer you to the appropriate department.

Q: How to obtain a copy of my insurance benefits?

A: A copy of your insurance benefits with the plan you have chosen should often be provided to you when you first enroll in your plan. This will often be in the form of a PDF, outlining the covered services, costs, premium, etc. If you do not have a copy of this, try looking on your insurance website, or speaking to your employer’s HR department (if insurance is through work), to obtain a copy. You may also call Member Services to request this document be emailed to you.

Q: My insurance does not cover pre-existing conditions and considers my eating disorder a pre-existing condition. How do I get treatment covered?

A: As of 2014, Obamacare will prohibit insurance companies from excluding anyone with a pre-existing medical condition from coverage. If your insurance companies still reports they will not cover a pre-existing condition, you can seek help from a legal aide or other treatment advocate to assist in fighting for your eating disorder treatment to be covered.