**UNDER SECRETARY OF DEFENSE**
**4000 DEFENSE PENTAGON**
**WASHINGTON, D.C. 20301-4000**

**PERSONNEL AND READINESS**

DEC - 8 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to the House Report 116-442, pages 149-150, accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, requesting a report on Adult Residential Treatment for Eating Disorders, is enclosed.

Eating disorders are a serious condition that have significant medical and psychological effects. Early evidence-based treatment is essential to the long-term health and well-being of all recipients of care. TRICARE covered services for eating disorders include both inpatient and outpatient services: emergency and non-emergency inpatient hospitalization, residential treatment center (RTC) care for children and adolescents up to age 21, partial hospitalization programs, intensive outpatient programs, and outpatient office-based mental health services.

According to a 2021 external assessment, research studying the effectiveness of RTC level of care for eating disorders is currently insufficient and such care is not proven safe and effective for this population. While it may be financially feasible to expand coverage of RTC care for the diagnosis of eating disorders beyond age 21 years, research to date does not support the addition of this level of care to the TRICARE benefit.

Thank you for your continued strong support for our Service members, veterans, and families. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

**UNDER SECRETARY OF DEFENSE**
**4000 DEFENSE PENTAGON**
**WASHINGTON, D.C. 20301-4000**

**PERSONNEL AND READINESS**

DEC - 8 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

# Report to the Committees on Armed Services of the Senate and the House of Representatives

**In Response to: House Report 116-442, Pages 149-150, Accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year (FY) 2021, on**
**Adult Residential Treatment for Eating Disorders**

December 2021

The estimated cost of this report or study for the Department of Defense is approximately $810 in FY 2021. This includes $0 in expenses and $810 in DoD labor.
Generated on 2021May10 RefID: 5-67C633D

## INTRODUCTION

This report is in response to the House Report 116-442, pages 149-150, accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year (FY) 2021, requesting a report on the feasibility of including residential treatment for adults with eating disorders as a TRICARE benefit similar to the Department of Defense actions for residential substance abuse treatment for adults, and the projected cost to the Department, as well as prohibited authorities precluding the Secretary from including this benefit under TRICARE.

## BACKGROUND:

Eating Disorders

Feeding and eating disorders (FEDs) are serious and complex mental health conditions with potentially life threatening complications including, but not limited to, temperature dysregulation, bone degenerative conditions, cardiovascular abnormalities, renal dysfunction, and ultimately, organ failure.[1] According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5),[2] FEDs are defined as a mental illness in which people experience severe disturbances in their eating behaviors and related thoughts and emotions, which can be further classified into the following diagnoses:

- Anorexia Nervosa (AN): AN is characterized by a distorted body image and significantly low body weight due to restriction of energy intake, and intense fear of gaining weight. Individuals with AN will often fail to acknowledge or will deny their low body weight.
- Bulimia Nervosa (BN): BN is characterized by frequent binge eating episodes followed by inappropriate compensatory behaviors to avoid weight gain such as overuse of laxatives or self-induced vomiting. Individuals with BN allow body shape and weight to dictate self-worth.
- Avoidant/Restrictive Food Intake Disorder (ARFID): ARFID is characterized by persistent failure to meet appropriate nutritional and/or energy requirements, despite normal physiologic function, leading to significant weight loss, nutritional deficiency, dependence on enteral feeding or nutritional supplements, or interference of interpersonal relationships.
- Binge-Eating Disorder (BED): BED is characterized by recurring episodes of eating large amounts of food in a short period of time, occurring at least once a week over a 3-month period. Binge eating episodes demonstrate a lack of control and may involve eating too quickly or eating beyond fullness. BED may lead to feelings of guilt, embarrassment, or disgust resulting in efforts to hide the distressing behavior.

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[1] Lindvall Dahlgren C, Wisting L, Rø Ø. Feeding and eating disorders in the DSM-5 era: a systematic review of prevalence rates in non-clinical male and female samples. J Eat Disord. 2017;5:56-56; Peckmezian T, Paxton SJ. A systematic review of outcomes following residential treatment for eating disorders. Eur Eat Disord Rev. 2020;28(3):246-259.

[2] American Psychiatric Association (APA). Feeding and Eating Disorders. In: Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: American Psychiatric Press; 2013.

- Pica: Pica is characterized by persistent and compulsive eating of nonfood substances lacking any nutritional value. A common comorbidity of pica is obsessive-compulsive disorder.
- Rumination Disorder (RD): RD is characterized by repeated regurgitation, both voluntary and involuntary, of food in a 1-month period or more. In some cases, regurgitated food is rechewed, reswallowed, or spit out.
- Other Specified FED (OSFED): Individuals with OSFED present with signs and symptoms similar to other FEDs, including AN, BN, and BED; however, full diagnostic criteria are not met.
- Unspecified FED (UFED): Individuals with UFED present with signs and symptoms similar to other FEDs but lack adequate clinical history to determine a more specific FED diagnosis. A UFED diagnosis is typically reassigned given additional relevant information.

FEDs can be challenging to treat as treatment pathways are not well defined and rely largely on the individual diagnosis and accompanying symptoms. Generally, FEDs are difficult to address on an individual level and require the support and organization of a multidisciplinary team of experts. Treatment for FEDs are generally delivered on a continuum of care starting with outpatient treatments attempted prior to progression to more intense treatment options. Treatment plans may incorporate a variety of components such as psychotherapy, nutrition education, medical monitoring, and medications. In addition, treatment regimens may also seek to address comorbidities contributing to or caused by the FED. Ultimately, managing a FED requires long-term commitment and maintenance from the patient and the support of family and a collaborative team of experts.[3]

The prevalence of FEDs has been estimated to range anywhere from 2 percent to 13.5 percent on a global level. In the United States, it has been estimated that 30 million Americans will experience a FED at some point in their lifetime, contributing to an economic cost of nearly $65 billion annually.[4]

Patients with FED typically present with a persistent disturbance of eating that impairs health or psychosocial functioning. Physical manifestations will vary according to the specific diagnosis but may include significantly low or high body weight, dental problems, dry skin and hair, brittle nails, fine hair on the body (lanugo), swelling around salivary glands, and cuts and/or calluses across the top of finger joints (due to induced vomiting). Physiologic symptoms may

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[3] Herzog DB, Eddy KT. Eating disorders: What are the risks? J Am Acad Child Adolesc Psychiatry. 2009;48(8):782-783; Yager J, Devlin MJ, Halmi KA, et al. Guideline watch (August 2012): practice guideline for the treatment of patients with eating disorders, third edition. FOCUS. 2014:12(4);416-431; Friedman K, Ramirez AL, Murray SB, et al. A narrative review of outcome studies for residential and partial hospital-based treatment of eating disorders. Eur Eat Disord Rev. 2016;24(4):263-276; Waller G. Treatment protocols for eating disorders: Clinicians' attitudes, concerns, adherence and difficulties delivering evidence-based psychological interventions. Curr Psychiatry Rep. 2016;18(4):36; National Institute for Health and Care Excellence (NICE). Eating disorders: recognition and treatment. NICE Clinical Guideline No. NG69. London, UK: National Institute for Health and Care Excellence; 2019; See Peckmezian et al, 2020 above.

[4] Galmiche M, Déchelotte P, Lambert G, Tavolacci MP. Prevalence of eating disorders over the 2000-2018 period: a systematic literature review. Am J Clin Nutr. 2019;109(5):1402-1413.

include amenorrhea, gastrointestinal dysfunction, and abnormal laboratory findings, such as anemia or low thyroid and hormone levels.[5]

Diagnosis of a FED relies on physician physical and psychological assessment and must agree with the diagnostic criteria detailed in the DSM-5.[6] The DSM-5 recognizes eight mutually exclusive FED diagnoses including pica, RD, avoidant/restrictive food intake disorder, AN, BN, BED, OSFED, and UFED.

The exact cause of FED is difficult to pinpoint as it encompasses a range of diagnoses with varying development pathways. It is important to note that FEDs can occur in anyone; however, certain factors can elevate the likelihood of developing a FED including:[7]

- Family history of FED
- Young age
- Female sex
- Early feeding or undereating problems
- Psychological and emotional health, such as:
  - Thin-ideal internalization
  - Body dissatisfaction
  - Other mental health diagnoses
  - Impaired interpersonal functioning
  - Negative affect

Prevalence of Eating Disorders in the Military Health System

Various research studies and articles have reported a range of estimates about the number of TRICARE beneficiaries, including Service members, who are diagnosed with an eating disorder. According to FY 2019 private sector and direct care claims data, there were 12,140 TRICARE beneficiaries between the ages of 11 and 65+ with a diagnosis of an eating disorder (3,387 beneficiaries ages 11-20, and 8,753 beneficiaries ages 21-65+).

TRICARE Benefits Coverage for Eating Disorders

The TRICARE Basic benefit provides medically or psychologically necessary and appropriate services in accordance with statute (10 U.S.C. Chapter 55) and regulation (32 CFR Part 199). Further guidance is provided in the TRICARE manuals, which are then executed through the TRICARE contracts. In addition to the requirement that TRICARE benefit services must be medically or psychologically necessary and appropriate, TRICARE health care must also be proven safe and effective, via the reliable evidence standards. Evidence is reviewed and

[5] NICE, 2017

[6] See note 2 above

[7] See Herzog and Eddy, 2009 above; Hilbert A, Pike KM, Goldschmidt AB, et al. Risk factors across the eating disorders. Psychiatry Res. 2014;220(1-2):500-506; Stice E, Gau JM, Rohde P, Shaw H. Risk factors that predict future onset of each dsm-5 eating disorder: Predictive specificity in high-risk adolescent females. J Abnorm Psychol. 2017;126(1):38-51; Mayhew AJ, Pigeyre M, Couturier J, Meyre D. An evolutionary genetic perspective of eating disorders. Neuroendocrinology. 2018;106(3):292-306.

a coverage determination is presented to Director, Defense Health Agency (DHA) for final approval. For covered services, only TRICARE authorized providers practicing within the scope of their license may diagnose and provide treatment.

Per statute and regulation, TRICARE covered services for FEDs include both inpatient and outpatient services: emergency and non-emergency inpatient hospitalization, residential treatment center (RTC) care for children and adolescents up to age 21, partial hospitalization programs, intensive outpatient programs, and outpatient office-based mental health services.

Feasibility of Including Residential Treatment Center Care for Adults with Eating Disorders

To determine if RTC care for adults with FEDs should be considered as safe and effective, proven medical care, the first step is to review the literature. An external review of the literature for RTCs for eating disorders in adults was conducted. The analysis found that RTCs for treatment of adults with FEDs are associated with improvements in eating disorder-related outcomes between program admission and discharge. However, it is unclear whether these improvements are clinically meaningful due to inadequate reporting and lack of published accepted thresholds for minimal thresholds of clinical improvement. Further, the external review found that there is relatively little information on actual health status outcomes. Data are missing on laboratory nutritional outcomes, quality of life, and readmission, and are extremely minimal on calorie intake and relapse.

The external review found that patients diagnosed with anorexia had weight gain on average that may be large enough to be clinically meaningful. However, reporting on follow-up is extremely limited and lacks insight into relapse or readmission; accordingly, the sustainability of these gains is therefore unclear. This, coupled with very limited post-discharge follow-up, makes drawing firm evidence-based conclusions about the durability of RTC care impossible at this time.

No adverse events or other safety concerns for RTCs for adults with FEDs were reported.

There is a lack of evidence comparing RTCs with alternative treatment options. Accordingly, the current evidence does not inform whether outcomes observed with RTC care are better, worse, or the same as treatment administered in less intensive settings. Evidence from studies comparing RTCs with other approaches to eating disorder treatment are needed to inform relative efficacy and safety.

Research is needed to identify prognostic factors associated with treatment success, to inform optimal patient selection for RTC care. Such research could also inform which program factors are most suitable for which patients. The evidence base identified in this review was composed predominantly based upon samples of White/Caucasian women in early adulthood with anorexia or bulimia. Its generalizability to adults with other demographic characteristics or other types of FEDs is unclear.

Research is also needed to identify specific components of RTC care associated with program success. In particular, determining what durations of stay in RTC care are associated

with adequate benefit to merit discharge, and how length of stay relates to durability of treatment effect, would be very informative. Understanding how to optimize RTC care and determine the minimum needed duration of stay is particularly important given how costly and disruptive residential treatment is.

The external review found that the overall quality of the evidence base by diagnostic groups and outcomes were low to very low. Despite the fact that improvements in eating disorder outcomes were reported consistently across studies, not all studies determined whether the improvements were statistically significant, and whether the improvements achieved levels that were clinically important overall could not be established due to reporting issues.

Additionally, the quality of the individual studies were all rated as very poor to poor quality. Limitations included incomplete reporting, lack of power or statistical analyses, retrospective or unclear study design, lack of reporting clinical outcomes other than psychosocial instruments for many studies, and lack of follow-up past discharge. Importantly, many study samples were highly selected and/or subject to considerable loss to attrition, limiting the generalizability of these findings to all patients at admission.

Additionally, a review of coverage policies (commercial and Centers for Medicare and Medicaid (CMS)) described inconsistent benefit provisions or no coverage at all:

- CMS - No CMS National Coverage Determination of RTC care for adults was identified.
- Of six commercial plans reviewed, no medical coverage policy was identified for four plans, one plan defined specific criteria for RTC level of care, and one plan identified inpatient treatment under special circumstances.

DHA also completed a utilization and cost estimate for RTCs for adults with FEDs. Since there is no current coverage provision for RTCs for adults with FEDs, several assumptions were made. To estimate the number of adults who might access RTC care, an examination of the percentage of adolescents diagnosed with FEDs by gender who used RTC care in FY 2019 was completed. Because of career, family and financial resources, the estimate adjusted adolescent use rates downward based upon the age of the adult and the availability of TRICARE-approved RTCs for treating FEDs across states with the largest populations and applied these use rates to the population of adults diagnosed with FEDs. It is uncertain whether this will under- or over-estimate actual RTC adult use.

It was found that the total number of adolescents between the ages of 11 and 20 who used the RTC level of care was approximately two percent. In the absence of academic literature regarding exclusively adult RTC use (for above age 21) for FEDs, the estimate developed a method to adjust the observed RTC use rates for adolescents in order to estimate potential use rates for adults. Based upon this review of available information, it was concluded that overall potential use rates for adults should be lower than the rates observed for TRICARE children and adolescents, particularly for older adults. Six references regarding relative adult demand for

RTCs to treat FEDs were identified.[8] In summary, these references conclude that due to the pressures of career, family, financial resources and home life, adults have a difficult time carving out time to seek FED treatment and making it a priority. This becomes increasingly true as patients get older. Based on FY 2019 data, it was estimated that 107 eligible TRICARE adult beneficiaries above the age of 21 would use the RTC level of care.

The four key drivers of costs are the number of adult TRICARE beneficiaries with clinically diagnosed FEDs who want to participate in RTC treatment, the availability of RTCs within a state that will treat adults for FEDs, the average length of stay for these RTC users, and the average allowed TRICARE treatment cost per participant per day. Using these key drivers, it was estimated that total costs (both health care and administrative) would total $18.22 million over a 4-year period.

## CONCLUSION

FEDs are a serious condition that have significant medical and psychological effects. Early evidence-based treatment is essential to the long-term health and well-being of all recipients of care. TRICARE covers the full scope of medically and psychologically necessary and appropriate, evidence-based treatment under the current coverage provisions. TRICARE covers psychiatric RTC level of care for only children and adolescents ages 21 and under. Notably, RTC care for ages 21 and over is not industry standard. According to the external health technology review research studying the effectiveness of RTC level of care for this diagnosis of FEDs is currently insufficient and is not proven safe and effective according to statute and regulation for this population.

While it may be financially feasible to expand coverage of RTC care for the diagnosis of FEDs beyond age 21 years, research to date does not support the addition of this level of care to the TRICARE benefit. Should research advance to warrant such a change, the Secretary of Defense already has the authority to issue regulations to add new providers and benefits when the care would be medically necessary and appropriate, as well as proven safe and effective. Should the Department determine that the care is supported by reliable evidence, the Secretary of Defense may issue regulations to modify the definition of an RTC and to expand the benefit under existing authorities.

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[8] Pietrangelo, Ann, "Eating Disorders Plaguing Older Women," Healthline Health News, January 10, 2018, accessed October 4, 2018 at www.healthline.com/health-news/eating-disorders-plaguing-older-women; Samuel, K.L., et al., "Disordered Eating, Eating Disorders, and Body Image in Midlife and Older Women," Current Psychiatry Reports, 2019; 21(70): 1-9; Schaeffer, J. Elder Eating Disorders: Surprising New Challenges. Today's Geriatric Medicine. 2009. Available online at:http://www.todaysgeriatricmedicine.com/news/exclusive_0409_03.shtml; Sharratt, A. Why Women in their 40s are Falling Through the Cracks When it Comes to Eating Disorders, Best Health Canada, 2018. Available online at:https://www.besthealthmag.ca/best-you/health/anorexia-recovery/; Enos, G. A., "Dynamics differ for older women with eating disorders," Institute for the Advancement of Behavioral Healthcare Addiction Professional. 2016. Available online at:https://www.addictionpro.com/article/dynamics-differ-older-women-eating-disorders; Cytrynbum, P., "Anorexia and Aging: Is There a Silent Crisis of Eating Disorders in Older Women?," Global Action on Aging, 2012. Available online at:http://globalag.igc.org/health/us/2012/Older%20women%20anorexia.html