I am a Board Certified internist in Denver who specializes in eating disorders, and the Founder & Medical Director of the Gaudiani Clinic which serves the outpatient medical needs of individuals of all ages/genders/body sizes from around the country who have eating disorders. Our doctors are licensed in 46 states among us to provide telemedicine for those not in state. I trained at Harvard, Boston University, and Yale, and I helped run the highest medical stabilization unit in the country for adults with life-threatening anorexia nervosa, the ACUTE center for eating disorders at Denver Health, for 8 years before founding my clinic in 2016. I've published extensively in the peer-reviewed literature as well as written a book and done a great deal of national and international lecturing/teaching.

I write in strong support of SB 176, specifically its provision to remove BMI requirements for insurance coverage decisions for those with eating disorders in higher levels of care. The fact is that a miniscule minority of individuals who restrict calories actually become emaciated. The vast majority of those who restrict will due to protective biology sustain their weight or perhaps even watch it rise. Historically, eating disorder treatment at higher levels of care (HLOC) has been extended to those who met the stereotype of someone with an eating disorder: white, straight, cis, underweight, female, able-bodied, young, and financially resourced. However, data clearly show that the proportion of patients admitting to HLOC around the country increasingly include those with so-called atypical anorexia nervosa (AAN), who have all the same behaviors and fears but don't happen to end up in an emaciated body. Study after study shows that those with AAN (usually in a "normal" or higher BMI) have equally as severe medical complications and psychological distress as those with AN, if not more, with the exception of perhaps having lower rates of low blood sugar and bone density loss. AAN per the DSM5 falls under Other Specified Feeding and Eating Disorders, NOT a matter of nomenclature but vital because many insurance plans explicitly do not cover HLOC for those with OSFED diagnoses, thereby preventing patients with equal medical and psychological compromise from accessing the treatment they need.

BMI cutoffs further deepen this disparity. If we identify BMI levels at which patients may receive a certain intensity of care, we favor those with sterotyped/more privileged features and completely exclude those who qualify for treatment. That exclusion is based on one arbitrary number that has no medical benefit in this field. This excludes someone's 14 year old son who's always been heavier and who develops AAN while trying to get ready for his freshman football season, but is denied HLOC for "normal BMI" despite having lost 30 lbs, counting calories, eating 500 calories a day, feeling dizzy when he stands, and being unable to cease restrictive behaviors in the outpatient setting. It prevents the Black woman with a severe eating disorder who was naturally built to be a higher weight and has now lost weight but isn't "below the BMI threshold" from receiving needed treatment. These people are our neighbors, sisters, brothers, children. It seems theoretical and remote until you are desperate to get your loved one into needed treatment and cannot believe they are being excluded due to BMI.

Furthermore, the most prevalent eating disorder around the world is binge eating disorder. BMI cutoffs prevent those with severe BED who are in larger bodies from receiving the needed HLOC they need to regulate behaviors, get psychological support, and return home to their lives.

In short, I strongly favor removing BMI requirements from eating disorder treatment. It's time to join this century and actually look at the data that matter, not data that were invented for a totally different purpose.

Thank you. Jennifer L. Gaudiani, MD, CEDS-S, FAED

Hello! Thank you in advance for your willingness to read my testimony as a registered dietitian in the field of eating disorders. My name is Mayah Heffler and I have worked in the field of eating disorders for the past 7.5 years, specifically for Eating Recovery Center. I have completed my master's in clinical nutrition and my certification as an Eating Disorder Specialist (CEDS). I currently work at our hospital in Denver, Colorado where we treat patients at the highest levels of care: in-patient, residential, and partial hospitalization. We see patients from across the country, of all ages, and various socioeconomical backgrounds. Despite their differences each case has one thing in common: our patients are struggling and miserable in their lives. I am grateful to work with an interdisciplinary team that supports, guides, and educates patients and their support systems throughout each level of care.

As the dietitian on the team, I monitor weight trends, adjust calories to meet individual energy needs, collaborate with patients on working through food rules and/or anxieties about specific foods, and educate both about the role of nutrition in recovery and impacts of eating disorders on the body. Dietitians are largely responsible for daily calculations related to weight percentages, body mass index (BMI), and calories provided per kilogram to assess appropriateness of our interventions, specifically the meal plans. This information becomes incredibly important to assess for potential medical dangers, discuss progress with patients, and address concerns for any eating disorder behaviors a patient may be engaging in.

Since our patients at times struggle with transparency related to their illness, having this data and being able to communicate with insurance companies our clinical concerns is imperative. I'd like to briefly share a case that highlights how these objective measures of data are used to advocate for insurance coverage for our patients throughout the treatment process. Please note, the name has been changed to protect patient privacy. Meet Sandy, a 26-year-old female, with a diagnosis of anorexia nervosa-binge eating/purging type. Sandy reported engaging in daily restricting of calories and constant movement due to her active job. The patient's support system expressed patient was also struggling with purging via self-induced vomiting as evidenced by presentation of Russell's sign on both forefingers. Russell's sign is the callusing on the hands due to frequent purging. During my initial assessment patient denied engaging in intentional purging behaviors, suggesting an inconsistency of patient's report (no purging) and objective observations (Russell's sign on both hands). Additionally, Sandy reported a history of sexual assault, PTSD diagnosis, and substance abuse.

Her weight at time of admission was 90.6 lbs. Patient reported a weight history of 130 lbs in 2019, with a weight loss of ~40 lbs over the past two years, approximately 30% of her body weight. Due to Sandy's significantly low weight, 72.5% ideal body weight (IBW), BMI of 15.1 kg/ (m^2), and percent weight loss the team advocated for insurance coverage initially at the in-patient level of care. During the first two weeks at in-patient, patient demonstrated the ability to interrupt eating disorder behaviors and insurance stepped this patient down to the residential level of care despite only gaining ~2 lbs over 2 weeks. Patient was 73.8% IBW and BMI of 15.3 kg/ (m^2). Please understand due to the unique energy needs and metabolism of our patient population it typically requires a significant amount of calories for our patients to gain weight. Due to potentially life threatening complications of re-introducing nutrition it can take several weeks for weight to consistently trend in the positive direction while dietitians are working with patients to increase their oral intake.

Our treatment team advocated these concerns with insurance and emphasized the importance of completing 100% of weight restoration while in treatment. Sandy continued to report minimal urges and consistently interrupted eating disorder behaviors within this level of containment. Due to the lack of behaviors, Sandy appeared on paper ready to step down to an out-patient level of care. However, our treatment team continued to advocate with their insurance company for full weight restoration in treatment to provide Sandy with the best changes at maintaining recovery. She was able to gain a total of ~40 lbs and discharged at 106% IBW with a BMI of 22.1 kg/(m^2) prior to discharge. Without these objective pieces of information, I believe her insurance company likely would have cut her treatment early leading to an increased risk of relapse potentially requiring additional treatment at higher levels of care in the future. I have devoted my professional career to supporting the recovery of patients with eating disorders who come to care in all sizes and shapes. By excluding patients with Anorexia Nervosa in all of its presenting forms, we will inadvertently harm a specific subset of patients in need of treatment and support by decreasing their access to higher levels of care they very much need. I request an amendment to this bill so that ALL forms of Anorexia Nervosa

including Anorexia Nervosa-restricting subtype, Anorexia Nervosa- binge eating/purging subtype and Atypical Anorexia Nervosa all be included. Thank you again for your consideration!

To the members of the committee, my name is Nathalia Trees, MS, RD, CEDRD-S, and I am a certified eating disorder dietitian and nutrition manager at Eating Recovery Center, an eating disorder facility in Denver. I have been in the field for over 11 years treating hundreds of patients and overseeing and managing dietitians for the last 7 years. As a dietitian, we strive to support medical stability through refeeding, weight rehabilitation, and behavior interruption. In my work, I have seen firsthand how insurance providers respond to BMI and ideal body weight outlined in this bill, and while this is a well-intentioned bill, the way it is currently written will have the inadvertent consequence of harming an entire segment of the eating disorder patients we treat. Today I would like to share an example that I think will highlight my concerns:

"Maureen" is a 23 year old female with anorexia nervosa, restrictive subtype. She was recently transferred from an outside hospital whereby she had 7 previous admissions and has previously been with ERC once before. She presents with severe malnutrition including >20% weight loss in 6 months and significant muscular facial wasting despite gaining 10lbs at the outside hospital. Maureen reported feeling great and energy levels had returned to normal. Upon admission, Maureen understood the necessity to gain "some weight" but demonstrated very little insight into the severity of her illness. Maureen's labs were unremarkable as is common with chronically starved patients. Maureen self-reports as type-a, overachiever, and persistent in getting what she wants. Maureen is guarded and superficial about the impact her eating disorder has had on her life and family.

During her admission, Maureen was compliant with her meal plan because she "doesn't like to fail". Maureen denied urges although reported feeling uncomfortable in her body. Maureen's metabolic demands were significant as a result of her malnutrition and she required upwards of 5000 kcals to meet minimum weight restoration goals of 2lbs per week. Maureen was denied IP level of care based on her compliance despite being severely underweight. Maureen left care early because she "felt better" and "insurance agrees". Maureen relapsed quickly not prepared to take on the challenges of completing over 5000 kcals/day. Maureen was hospitalized shortly after leaving due to rapid weight loss and was readmitted to an outside hospital for critically low glucose and complications of severe starvation.

It is evident through Maureen's story and others that patients with eating disorders often hide their use of behaviors and do not disclose struggles. Rooted in their deep fear of gaining weight, these patients will often present "well on paper" to avoid the discomfort in their bodies as they reach their phobic weight thresholds. As a dietitian, I worry this bill could perpetuate this cycle leading to shorten stays and unnecessary hospitalizations especially in those patients with immense shame around reporting urges and behaviors. A person's weight trend, their BMI and establishing their individualized "ideal" body weight serves as an objective criterion that can contribute to establishing an understanding around the medical necessity for treatment. I believe that if we do not utilize these objective standards this could lead to early termination of care, unnecessary hospitalizations, and limit access to higher levels of care especially for those patients who are severely underweight.

I have devoted my professional career to supporting the recovery of patients with eating disorders who come to care in all sizes and shapes. By excluding patients with Anorexia Nervosa in ALL of its presenting forms, we will inadvertently harm a specific subset of patients in need of treatment and support by decreasing their access to higher levels of care.

So, I request an amendment to this bill so that that ALL forms of Anorexia Nervosa be included. Please ADD Anorexia B-P subtype and Atypical Anorexia Nervosa to the diagnoses that are excluded or simply

change the language to read “Anorexia Nervosa” instead of separating out the specific subtype of Anorexia Nervosa – Restricting Subtype.

House Public & Behavioral Health & Human Services
04/27/2023 01:30 PM
SB23-176 Protections For People With An Eating Disorder
Typed Text of Testimony Submitted

Name, Position, Representing	**Typed Text of Testimony**
McKenna Ganz For The Eating Disorder Foundation	My name is McKenna, representing The Eating disorder Foundation, and I am here to support this bill. When people reach out to The Eating Disorder Foundation, they usually start with me, whether it's by phone, by e-mail, or at our office here in Denver. They come in looking for support for themselves in a period of personal crisis, or out of concern for a loved one, and often don't even know where to start. I help direct them to our own non-clinical peer support programs, or help them find appropriate treatment options in the community. You would be AMAZED at how often I hear folks tell me they didn't think they were "sick enough" to get help. We always want to stress that there is NO threshold at which someone is worthy of seeking out help. If food or body image cause distress or impact someone's life, we consider that a good reason to seek out support. Unfortunately, eating disorders are highly stigmatized and misunderstood among the general population as well as the medical community. BMI requirements perpetuate these misconceptions and prevent people from getting appropriate care. Eating disorders can be incredibly dangerous. Unlike many other mental illnesses, they're also accompanied by serious medical complications, which can appear at any weight. When BMI is used to qualify people for care or end treatment prematurely, these issues can be missed – not to mention the negative impacts on quality of life that people experience from eating disorders at all sizes. Our members have been sent away from emergency rooms, doctors offices, or treatment centers without receiving help, told they were not "skinny enough" to have an eating disorder. These folks are now significantly less likely to seek help as their feelings of worthiness and validity were destroyed by the focus on weight as the determining factor for attention. I hear stories like this every day from people who are in constant battles with their own care providers and insurers. I'd also like to close out with some words from one of our members, when it comes to the diet pill aspect of this bill: "In large part due to the encouragement to diet from early adolescence, I developed dangerous disordered eating and bulimia. I

	abused over-the-counter diet pills for decades. This has been a lifelong struggle for me and I still have anxiety around food, body image, feeling full. I am turning 60 this year. I fear for children who will suffer the same or similar consequences I did.”
Brittany Athmer For themself	I am a mental health psychiatric nurse practitioner with my DNP at ED Care, a clinic that specializes in PHP and IOP level of care for individuals with eating disorders. Time after time, I have had to have heartbreaking conversations with patients that their insurance is stepping them down because their BMI makes them "normal weight", and therefore not in need of treatment. These patients reported feeling invalidated and more often than not took this as proof that they were "not sick enough" and spiraled even further into their eating disorder. Just this week, I had a patient who has suffered with an eating disorder since fifth grade admit that after learning insurance was stepping her down to IOP, she felt it meant that she was "not that sick" and "shouldn't really be that worried". I am her psychiatrist, and I have watched her slip back into behaviors ever since she was stepped down to IOP. The doctor in the "doc to doc" that I participated in to advocate for more php was largely fixated on the fact that her BMI was in the normal weight range, even though she was engaging in behaviors daily. Walsh, Hagan, and Lockwood (2022) completed a systematic review of studied that compared clinical characteristics of individuals with atypical anorexia compared to those with anorexia nervosa and/or healthy controls. The results found that the level of eating disorder-specific psychopathology in individuals with atypical anorexia was as high or even higher than individuals with anorexia nervosa. The only difference between atypical anorexia nervosa and typical anorexia nervosa is BMI. To be diagnosed with anorexia nervosa, you must have a BMI that is below 18.5. By this logic, a patient could go to bed one night with atypical anorexia, and wake up the next morning with typical anorexia due to natural fluctuations in weight and nothing at all with the severity of their illness or behaviors. In eating disorder treatment, we teach patients that they are more than what they weigh, how invalidating is it then, when patients are denied treatment BECAUSE OF THEIR WEIGHT? Additionally, patients who weight restore need the support of higher levels of care to cope with the high amounts of distress that come with adjusting to their new body.
Lalita Akers For themself	I am currently a psychiatric provider and the chief medical officer at EDCare Denver. We serve patients at the partial hospital and intensive outpatient level. I whole-heartedly believe that the BMI metric should be completely removed from requirements regarding eating disorder treatment and coverage. I have worked with numerous patients who are unable to access the care that is required secondary to not meeting BMI requirements. When I am working with patients who require peer to peer for insurance coverage, often the provider will ignore much of the information presented if the patient's BMI is normal or higher. This does not make sense as anorexia nervosa is the only eating disorder in which weight is considered. There are myriad

	eating disorder diagnoses and presentations --- and untreated eating disorders lead to significant medical and mental health consequences. Relying on BMI as an indicator for the severity of illness harms patients struggling with an eating disorder in normal or larger body frames. There are multiple other factors which can determine the severity of an eating disorder, as well as the appropriate level of care to include non-weight related vital signs, lab work, eating patterns, psychological factors, comorbid medical/mental health conditions and degree of functionality. Recently, I was working with a patient with binge eating disorder. The patient received only several weeks of care, and their insurance stopped covering their care due to the patient being "normal-weighted." This patient was still experiencing irregular eating patterns, significant eating disorder thoughts as well as concurrent mental health conditions, which were exacerbated by the un-treated eating disorder. The provider refused to listen to further details about this clinical case due to the BMI weight standard. In my opinion, the BMI requirement discriminates against patients who are not underweight and restricts care to many patients in our community. All eating disorders are highly co-morbid with significant mental health illness such as depression, anxiety and even suicidality. Many of my patients feel that they have to prove they are "sick enough" to deserve care. By removing the antiquated BMI standard, we will allow patients to access the care they need to recover.

Honorable members of this committee, my name is Katie Ney, and I am a Registered Dietitian who has worked at the inpatient, residential and partial hospitalization levels of care for over four years. I currently hold an eight-person caseload at the highest level of eating disorder inpatient care on the intensive treatment unit at Eating Recovery Center in Denver. My job is to support the nutritional stabilization and rehabilitation of my patients. This includes monitoring their labs, vitals, daily weights, daily nutrition intake and recommending the correct caloric needs and delivery of their nutrition (solid food, supplements and/or enteral feedings). This is to meet their nutrition needs, often which coincides with weight restoration. Due to the hypermetabolic status during the refeeding process, my patients have needed upwards of 5,000 kcals/day which would objectively be nearly impossible for these patients to adhere to outside of 24-hour care. The reason for this is not just the fear of food that many of my patients have, but also the ability to condense this number of kcals into a volume that, while still physically challenging, is tolerable day after day. This is done with an individualized meal plan that can include, but not limited to, a combination of nutrient and calorie dense foods and oral supplements. In addition to oral nutrition, many of my patients require tube feedings to meet their calorie needs for wt. restoration. Tube feeding and the refeeding process require 24-hour oversight, thus only appropriate and available at higher levels of care. While I support the removal of BMI as an objective unit for insurance companies to dictate levels of care, in cases where my patients are otherwise stable (labs, vitals, completing their meal plan), if they remain at a low body weight in a hypermetabolic state, a lower level of care will do them a disservice as it could limit their nutrition options (no tube feeds) and create an environment with less medical oversight, which could be dangerous. This will lead to patient harm and the likelihood of the insurance company or self-paying family to spend more in medical costs as the patient will likely be stepped back up to a higher LOC to fully weight restore OR be discharged home prematurely and significantly increase their chance of relapse.

This is a deidentified case of a recent patient at Eating Recover Center on the intensive treatment unit:

Cassie is a 27-year-old female with AN-BP. Cassie is 68" tall and admitted at 110 lbs., which is 79% IBW. The patient has a history of multiple treatment admissions with limited sustained recovery. The patient transferred from an inpatient hospital and continued their current meal plan of 2600 kcals/day. The patient was completing their meal plan 100% with the use of solid food and supplements. Over the next 11 weeks at the inpatient level of care, the patient continued to complete their meal plan 100% and accept calorie increases to this meal plan. In the first several weeks, the patient did not engage in eating disorder behaviors such as excessive movement, restriction or purging. The patient was placed on 1:1 bathroom protocol, used a body movement tracker and room searches were completed as part of program routine. Despite the containment of 24-hour care, completing 100% of meal plan, within-normal-limits labs and vitals, the patient struggled to meet wt. restoration goals. The patient was agreeable to nutrition support via a nasogastric feeding tube. The patient denied any secretive ED behaviors.

The meal plan was increased on average 300-400 kcals every 3-5 days, until eventually bringing the patient to a meal plan of 6,610 kcals/day which was 124 kcals/kg of actual body weight of 116.8 lbs. in their 9th week of treatment. For reference, most patients require 75-100 kcals/kg actual body weight to consistently meet their weekly weight restoration goal of 3-4 lbs./week. In my four years, I have only needed to exceed 100 kcals/kg for wt. restoration with less than five patients, many of which were males who were nearly or over 70". The team suspected that Cassie was struggling with secretive eating disorder behaviors but were otherwise frustrated and perplexed with the patient's extremely high meal

plan requirements. In the patient's 6th week of care, large bags of intentional vomit were found hidden in the patient's wardrobe. This behavior continued over the last half of the patient's inpatient stay. Multiple, large bags of vomit were hidden in the patient's room, on her person, in the community room and in the spa. As a result of this purging, the patient did not full weight restore and ultimately discharged from treatment at 112.6 lbs., only 2 lbs. over their admission weight. This patient has since re-admitted two more times.

Without the use of the patient's low body weight data, it is highly likely that this patient would have been recommended for a lower level of care and their purging behaviors and lack of full weight restoration would not have been resolved. This would have led to a significantly underweight human purging a large daily amount putting them at risk of significant and serious fluid and electrolyte shifts which can be fatal. It is my opinion that if BMI is not utilized in a patient's care, especially and specifically in low body weighted patients who otherwise show up "perfect on paper", this will lead to harmful limitations on patient's access to higher levels of care and increased rates of relapse.

I have devoted my professional career to supporting the recovery of patients with eating disorders who come to care in all sizes and shapes. By excluding patients with Anorexia Nervosa in ALL its presenting forms, we will inadvertently harm a specific subset of patients in need of treatment and support by decreasing their access to higher levels of care.

Therefore, I request an amendment to this bill so that that ALL forms of Anorexia Nervosa be included. Please ADD Anorexia B-P subtype and Atypical Anorexia Nervosa to the diagnoses that are excluded or simply change the language to read "Anorexia Nervosa" instead of separating out the specific subtype of Anorexia Nervosa – Restricting Subtype.