



January 31, 2012

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

As a coalition of more than 125,000 individuals, either affected by obesity or healthcare professionals that treat those affected, the Obesity Care Continuum (OCC) appreciates the opportunity to provide comments regarding the Essential Health Benefits Bulletin released by the Department of Health and Human Services (HHS) on December 16, 2011.

As HHS seeks to balance coverage and cost in essential benefits, the OCC implores you to carefully examine the health and cost benefits should HHS choose to designate obesity treatment services as an essential benefit that state health exchange plans must cover under the Affordable Care Act.

Obesity is a multifactorial chronic disease requiring a comprehensive approach to both prevent and treat. Obesity is a major contributor to a large number of preventable deaths in the United States and it carries with it a large number of related conditions such as type 2 diabetes, hypertension, heart disease, certain cancers, sleep apnea and arthritis. Therefore, care should not be seen as simply having the goal of reducing body weight, but should additionally be focused on improving overall health and quality of life.

Obesity and the chronic diseases that result from untreated obesity are the major drivers of the growth in healthcare costs. The CDC estimates that annual medical costs associated with obesity total roughly \$147 billion. Evidence-based treatment, ranging from cognitive behavioral therapy to drug treatment to surgical treatment all have documented potential to significantly reduce the costs of untreated obesity.

Many federal programs such as Medicare, Medicaid, Tricare and the Federal Employees Health Benefits Plan provide coverage for various obesity treatment services. In addition, many medium and large employers have recognized the benefit, both from an economic and quality of life perspective, of providing treatment for their employees and family members who are affected by obesity. Unfortunately, this philosophy has not translated down to the small employer and individual markets, which sadly the Institute of Medicine (IOM) and now HHS believe should represent the scope of covered benefits for the essential health benefit package. In evaluating benefit coverage across markets, HHS stated the following in its December 16th Bulletin:

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information on large employer plans (which account for the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.

There is not yet a national standard for plan reporting of benefits. While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer, and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET) surveys of employer plans, HHS gathered information on employer plan benefits from the IOM's survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans, and information on benefits submitted to HealthCare.gov by small group health insurance issuers.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States.

Current Status of Coverage for Obesity Treatment Services

In light of the above statement from HHS, the OCC believes it is important to note the following regarding the current status of federal, state, and private plan coverage of the three major obesity treatment categories: intensive nutritional and behavioral counseling, pharmaceuticals, and bariatric surgery.

Intensive Nutritional and Behavioral Counseling

Over the last six months, both Medicare and the United States Preventive Services Task Force (USPSTF) have taken significant action toward expanding coverage for intensive behavioral counseling for adults affected by obesity.

On November 29, 2011, the Medicare program finalized a national coverage policy for intensive behavioral counseling for Medicare beneficiaries. In its final National Coverage Decision (NCD) memorandum, the Centers for Medicare & Medicaid Services (CMS) states that:

“The evidence is adequate to conclude that intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals

entitled to benefits under Part A or enrolled under Part B and is recommended with a grade of A or B by the USPSTF.”

The November 29th NCD continues -- outlining a very robust schedule for intensive behavioral therapy that recommends a minimum of 20 counseling sessions over a one-year period. We believe that the Department’s 2010 regulations implementing provisions of the Affordable Care Act (ACA) related to cost sharing and coverage of preventive services were the driving force behind Medicare’s decision to propose expanding coverage for these critical treatment services.

It is also important to note that in the midst of the Medicare coverage process, the USPSTF chose to update its recommendations regarding these critical treatment services. In their October 2011 Draft recommendations, USPSTF recognized “the significant evidence surrounding multicomponent interventions as effective obesity treatment requires a multidisciplinary approach” and the value of a robust schedule of counseling intervention similar to the frequency adopted by Medicare.

These actions by Medicare and the USPSTF will have a tremendous effect on expanding coverage for intensive behavioral intervention in health plans inside and outside of Medicare, respectively.

Bariatric Surgery

The safety and efficacy of bariatric surgery is well documented and a primary reason why many federal and state government health plans provide coverage for surgical intervention for those with severe obesity. Such federal plans include Medicare, the Federal Employees Health Benefit Plan and Tricare. In addition, bariatric surgery is covered as a standard benefit in at least one health plan offered to all state employees in 44 of 50 states and bariatric surgery is also covered in 47 of 50 State Medicaid Plans. It is also important to recognize that bariatric surgery's effect on comorbidities is powerful -- with an 82% remission of diabetes and similarly good results for other chronic conditions such as hypertension, hyperlipidemia, and sleep apnea.

Obesity Drugs

While coverage for intensive behavioral counseling and bariatric surgery is expanding, the same is not true for obesity drugs. There is currently only one approved obesity medication on the market. There are several new drugs that are in the pipeline for FDA review, but we still likely won’t know until the middle of 2012 as to whether or not there will be new drugs coming on the market.

It is the hope of the OCC that approval of these new obesity drugs, combined with clear updated drug approval guidance by FDA, will place pharmaceutical treatment on

the fast track for adoption by federal, state and private health plans as another treatment tool for health care professionals to utilize for those affected by obesity in that category between counseling and surgery.

Given these positive steps toward expanding coverage for obesity treatments, the OCC is deeply concerned that HHS is signaling to the states that adopting benefit plans currently in the small plan market would satisfy the intent of the Affordable Care Act regarding establishment of a uniform EHB package. As previously stated, small market plans tend to not provide coverage for obesity treatment services partly due to upfront costs associated with some treatment avenues and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

Treating or addressing obesity among those already affected by obesity is difficult. This is clearly demonstrated by the more than 34% of Americans who are currently affected by obesity. However challenging though, efforts must be made to both prevent and treat obesity at all stages and in all age groups.

Unfortunately, the disease of obesity is the last acceptable form of discrimination in today's society. Individuals affected by obesity are stigmatized in healthcare, education, employment and mass media. Those affected by obesity have also been the target of acts of negative stigma such as IQ testing requirements for those seeking obesity treatment, illustrated depictions on national billboards comparing an individual affected by obesity to a whale and much more. These instances of stigma only further hinder efforts to raise awareness of this disease and provide it with the respect it deserves and needs.

To better understand the situation of those affected by obesity -- who often find themselves without access to any form of covered obesity treatment -- one need only look toward the improving coverage landscape for treating those affected by mental illness or addiction.

Why are mental health and substance abuse services specifically mentioned as a covered category of services under the health care reform law, but not obesity related services? Why are these other services carved out for special consideration? Shouldn't they all fall under the broad essential benefit categories of hospitalization, ambulatory care, prescription drugs, or chronic disease management?

They're clearly enumerated because of the pervasive discrimination and stigma that was, and still continues today, to be associated with mental illness and addiction. Treating obesity is deserving of the same consideration as treating mental illness.

Those seeking obesity treatment face the same societal hurdles facing those impacted by mental illness and substance use.

Unfortunately, those affected by obesity find themselves where the mental health community stood 20 years ago. It took years, decades if you will, of tireless lobbying by the mental health community to educate not only policymakers but more importantly their peers in the medical community -- some of which still scoff at those who struggle with mental illness or addiction as weak or defective

Despite these strides through legislative victories such as the mental health parity law, coverage for mental illness and substance abuse still lags far behind coverage of these services in federal, state, and large health plans. For these reasons, Congress stood up for this special segment of the population, which the IOM highlighted in chapter four of its report regarding congressional intent and the Affordable Care Act:

10 CATEGORIES OF CARE VERSUS TYPICAL

The 10 categories of care designated in Section 1302 for inclusion in the essential health benefit package are a mix of condition-specific care (maternity and newborn care), types of services (laboratory services), facility-based care (hospitalization), and age-based services (pediatric services): Consequently, some categories overlap; for example, if maternity care was not a separate category, those services could be classified among the others.

Congress, however, sought to remediate what it saw as shortcomings in current coverage by pulling out certain categories to ensure that they were covered, such as maternity services, mental health and substance abuse disorder services, and habilitative services. Habilitative services are distinct from rehabilitation, in that it is designed to help a person first attain a particular function, versus restoring a function. As was remarked during one of the committee's workshops, a separate listing of mental health and substance abuse disorder services would not be required if parity had truly been achieved. Others noted that coverage of maternity care has frequently not been a standard offering in the individual market; instead, until the ACA requirement goes into effect, it must be purchased as an additional policy rider that is frequently "expensive and limited in scope" (NWLC, 2008).

Today, 93 million Americans are affected by obesity! For the first time in history, America's children are being diagnosed with type 2 diabetes, hypertension and are said to have a shorter life-expectancy than that of their parents. Thankfully, with the advancements in modern medicine and an open mind by policymakers, we can reverse this trend. We urge HHS to use its wide discretionary powers in defining the benefit package to ensure that those who struggle with obesity have access to the full

continuum of care -- consistent with diagnosis and treatment coverage policy for other chronic diseases.

Endorsement of the status quo, which is basically what HHS is suggesting by giving its approval to states to adopt a small market plan approach to benefit setting, will have chilling effects on both future and current coverage of obesity treatment services. It would be a tragic setback for societal acceptance of treating obesity should HHS suggest that evidence-based treatment services such as nutritional and behavioral counseling, FDA-approved obesity drugs, and bariatric surgery be considered as traditional services that health plans could exclude.

Should you have questions or need additional information, please feel free to contact us through Chris Gallagher, OCC Washington Coordinator at 571-235-6475 or via email at chris@potomaccurrents.com. Thank you.

Sincerely,



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With a combined membership of over 125,000 healthcare professionals and patient advocates, the Obesity Care Continuum is dedicated to promoting access to, and coverage of, the continuum of care surrounding the treatment of overweight and obesity. The OCC also challenges weight bias and stigma oriented policies – whenever and wherever they occur. The OCC is a coalition of the Obesity Action Coalition (OAC), the Obesity Society (TOS), the Academy of Nutrition and Dietetics (AND), and the American Society for Metabolic and Bariatric Surgery (ASMBS)