Congress of the United States

Washington, DC 20515

October 28, 2011

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

Dear Secretary Sebelius:

The undersigned members of the New York Congressional delegation are deeply troubled over the August 22nd Notice of Proposed Rule Making (NPRM) issued by the Department of Health and Human Services (HHS), in conjunction with the Labor and Treasury Departments, entitled, "Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials under the Public Health Service Act." At issue is the sample Summary of Benefits and Coverage (SBC) document included in the August 22nd proposed regulations given that the Department specifically enumerates "weight loss programs" and "bariatric surgery" under the "excluded services" section on page 4 of the attached sample SBC.

What concerns us is that the Department is sending contradictory messages regarding health benefits coverage to states and health plans as both work together toward developing their State Health Exchange plans. In addition, it is our fear that this proposed sample SBC, a consumer education document, will enable health plans to continue to deny coverage for so many Americans that are affected by obesity.

For example, in the case of weight loss programs, we are pleased that the Medicare program is proposing to adopt, and define, coverage for intensive behavioral counseling for Medicare beneficiaries affected by obesity. In proposing this step in an August 31, 2011 proposed National Coverage Decision (NCD) memorandum, the Centers for Medicare & Medicaid Services (CMS) outlines 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.

This coverage decision will have a tremendous effect on addressing our country's obesity epidemic and the costs associated with treating obesity-related co-morbidities among Medicare beneficiaries. Medicare's catalytic efforts on this issue could also hopefully encourage commercial health plans to consider expanding their coverage policy to include intensive behavioral intervention for obesity.

While broad coverage for intensive behavioral counseling for obesity is now on the horizon, the same is not true for 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 -- when deemed medically necessary by a physician 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.

Although bariatric surgery is never suggested as a first-line treatment, it is both cost-effective, and more importantly a life saving procedure for those patients affected by severe obesity who have failed all other evidence-based obesity treatments. This is demonstrated by bariatric surgery's profound effect on comorbidities (82% remission of diabetes and similarly good results for other chronic conditions such as hypertension, hyperlipidemia, and sleep apnea) and the cost-effectiveness surrounding bariatric surgery. For example, an Annals of Surgery study found health care costs declined by 70% in the three years following bariatric surgery with numerous medical studies substantiating that surgical intervention can result in over-all cost savings for these patients who required numerous medications, clinic visits, and hospitalizations prior to bariatric surgery.

For these reasons, we question the Department's rationale behind suggesting that weight loss programs be categorized as an excluded service in one of the documents that health exchange plans could use for helping consumers better understand coverage and limitations of certain health care services or benefits. Using such an ambiguous term as "weight loss programs" could easily lead health plans to equally equate evidence-based obesity treatments (EBOT) with weight loss quackery. While quackery should obviously be excluded -- EBOT should not.

Since both the USPSTF and Medicare see the value of evidence-based obesity treatments such as intensive behavioral therapy and bariatric surgery for those affected by obesity, we would appreciate if you could please clarify the Department's reasoning behind these exclusions; and provide any documentation surrounding the decision process.

Sincerely,

Edolphus 'Ed' Towns
Member of Congress

Carolyn Maloney
Member of Congress

Charles Rangel
Member of Congress

Gregory Meeks
Member of Congress

Jerrold Nadler
Member of Congress

Yvette D. Clarke
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