
HHS Public Forums on EHB

Summary of ASMBS, TOS and OAC Comments During October HHS Public Comment Sessions on Composition of Essential Health Benefits Package

October, 2011

Summary of Comments Made by:
ASMBS President Dr. Robin Blackstone
TOS Advocacy Committee Chair Ted Kyle

Balancing Coverage and Cost:

As HHS seeks to balance coverage and cost in essential benefits, we cannot afford the cost of untreated obesity. Obesity and the chronic diseases that result from untreated obesity are the major drivers of the growth in healthcare costs.

Evidence-based models for treating obesity are abundant. Ken Thorpe recently estimated in Health Affairs that implementing the model proven in the Diabetes Prevention Program and applying it to obesity treatment could save Medicare alone more than \$7 billion.

Evidence-based treatment, ranging from cognitive behavioral therapy to drug treatment to surgical treatment have documented potential to save the costs of untreated obesity. Unfortunately small employer plans too often limit access to surgical treatment, despite the fact that many other plans provide coverage because of the cost saving potential of this treatment.

Medicare, Tricare, 47 State Medicaid Plans, 44 State Employee Plans cover bariatric surgery. Mercer's 2010 National Survey of Employer-Sponsored Health Plans show that bariatric surgery is covered by 40% of plans with <500 employees AND also that the fastest growth in coverage is in small employers (<500) which is growing at 8% annually.

Bias and Discrimination:

Obesity imposes a disproportionate impact on women and racial and ethnic minorities.

Too often, healthcare decisions for people with obesity are based more on shame, blame, and discrimination than medical need and evidence. Studies have documented that bias leads providers and health plans to give people with obesity a lower standard of care. Shockingly, providers often discount or disregard the biological basis for

susceptibility to obesity -- falsely assuming their patients to be lazy, stupid, and non-compliant.

Experiencing bias in healthcare has been shown to discourage people with obesity from seeking care, and has the perverse effect of reinforcing unhealthy behaviors. therefore, HHS must take weight bias into account to protect patients with obesity from discrimination in healthcare, by assuring people can receive evidence-based obesity treatment.

Summary of Comments Made by:

OCC Washington Coordinator Chris Gallagher on behalf of OAC

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.

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. Why are these services carved out for special consideration? Shouldn't they 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 was standing 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. For these reasons, Congress and the President stood up for this special segment of the population.

IOM REPORT: CHAPTER 4 "RESOLVING ACA INTENT"

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 and stand up for those who struggle with obesity as we're sure you will do for those affected by mental illness and addiction.