

The Affordable Care Act's Impact on Persons with Obesity

Morgan Downey, J.D. and Christopher D.Still, D.O.

Abstract

The Affordable Care Act (ACA) is the most far-reaching health care legislation since the enactment of Medicare and Medicaid in the 1960s. The legislation's principal goals are to increase the number of Americans who have access to health insurance and to control health care costs. As such, the ACA provides significant opportunities to expand and improve care for persons with obesity. For persons with obesity, there are two profound issues at stake. First, will persons with obesity be able to obtain affordable health insurance? Second, will such insurance provide coverage for obesity treatment? This article reviews major features of the ACA in terms of its impact on persons with obesity, as well as broader changes in obesity prevention, research and the health care delivery system.

Table of Contents

1. Introduction
2. Private Insurance Market
 - a. Access
 - b. Preventive Care Services
 - c. Employer Wellness Programs
 - d. Internal and External Appeals
 - e. Cadillac Plans
 - f. Medical Deduction
3. Medicaid Program
4. State Marketplaces
 - a. Essential Health Benefits
5. Restructuring the Health Care System
6. Research
7. Prevention
8. Discussion
9. Conclusion

I. Introduction

In March 2010, Congress enacted the signature legislative accomplishment of President Barack Obama, the Patient Protection and Affordable Care Act, also known as just the Affordable Care Act (ACA) or Obamacare.¹

The major goals of the ACA are two-fold. First, to expand access to health insurance by persons who do not now have coverage due either to health or economic factors. The second is to control health care costs through the inclusion of younger, healthier customers, and structural changes to the health care delivery system.

Many persons, especially those with high Body Mass Index [$\text{weight}(\text{kg})/(\text{height}(\text{m})^2)$] scores, have been unable to obtain any health insurance at all. The lack of insurance can affect one's access to care. In one study, lack of insurance coverage was the predominant reason why patients were not accepted for bariatric surgery.² Another study indicated a rise in the number of patients forgoing bariatric surgery because of insurance denials or unattainable coverage prerequisites.³ Yet another study indicates that the lack of health insurance is the probable reason for the racial disparities in the receipt of bariatric surgery.⁴ Another group of persons with obesity may have insurance but not have coverage for treatments of their obesity. Changes to one's health care coverage under the ACA depends in large part on which market or program a specific individual is in, e.g. has insurance through their employer or pays for an individual plan, is on Medicaid or is uninsured and not eligible for Medicaid. (Other than closing the drug "donut hole", the ACA does not affect the Medicare program.)

2. Private Insurance Market

The majority of Americans, some 170 million, obtain their health insurance through their employer. For persons with obesity who have health insurance coverage through their employers, they may believe that their health insurance will not change. That is not entirely true. (In the ACA, current private health insurance plans are termed "grandfathered". If such plans change, or new plans are created, they are termed "non-grandfathered".) The ACA makes changes in both grandfathered and non-grandfathered private plans, and mostly for the better.

a. Access

In current or grandfathered plans, the ACA will prohibit the use of pre-existing conditions, gender or health status to deny coverage and will remove annual and lifetime caps on reimbursements, effective January 1, 2014.⁵ The importance of this change cannot be overstated. Some 35 states permit obesity to be used for rate adjustments, i.e. persons with obesity may be charged more than their non-obese peers. Two states explicitly permit obesity to be used in eligibility decisions in the individual market.⁶ Rescissions, retroactive denials of coverage, are also prohibited for both grandfathered and non-grandfathered plans.⁷ Nine percent of all rescissions (or cancellations of an existing insurance policy) were based on weight.⁸

b. Preventive Services

Benefits will change with the addition of preventive services. Under regulations issued on July 19 2012, non-grandfathered plans will have to cover, without costs to patients, those preventive services which have received a level A or B recommendation by the U.S. Preventive Services Task Force.⁹ One such recommendation is Intensive Behavioral Therapy for Obesity.¹⁰ The USPSTF found high intensity counseling of 12-26 sessions a year were the most effective. However, a patient might appeal a denial of

more intensive interventions if medically necessary. (See section on Internal and External Appeals, below.) Under regulations issued on July 2, 2013, grandfathered plans will also have to cover these preventive services.¹¹ Thus, employees and those in the individual insurance market will join Medicare beneficiaries (by a prior coverage decision¹²) and Medicaid enrollees in those states opting for additional federal assistance with coverage for Intensive Behavioral Therapy for Obesity.

c. Employer Wellness Programs

Employer wellness programs have grown quickly around the country. Most involve a weight management component of some sort. They are expected to continue to grow in popularity with employers but some employees see them as intrusive. Nevertheless, they are likely to be a major aspect of weight management for the foreseeable future.

In general, the ACA is designed to disconnect one's health status from the ability to access health insurance. However, there is one major exception. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) employers and plans are prohibited from conditioning employee eligibility or premiums on health status, except for "programs of health promotion and disease prevention."¹³ Employers may use tobacco use, body mass index (BMI), or other health factors as long as certain requirements are met. When they are met, employers may assess up to 20% of the individual's health insurance premium for failure to meet the health factor. The ACA amended HIPAA by raising the amount that may be assessed from 20% to 30%. The Secretaries of Labor and Health and Human Services may agree to raise that amount to 50% for tobacco use.¹⁴

However, the final regulations have re-structured employer wellness programs which may make it easier to understand and give employees more rights. The regulation addresses "health-contingent wellness programs" of which there are two types. The first is called an "activity-only wellness program" which require an employee to perform or complete an activity to attain a reward but do not require the individual to attain a specific health metric. The other type of wellness program is called an "outcomes-based wellness program". In these programs, all employees or those who fail a certain health biometric (like a specific Body Mass Index target) incur a penalty or, if they meet the standard, receive a benefit.

Outcomes-based wellness programs must ensure that their program is reasonably designed to promote health or prevent disease; has a reasonable chance of improving the health of, or preventing disease in, participating individuals, is not overtly burdensome; is not a subterfuge for discriminating based on a health factor, and is not overtly suspect in the method chosen to promote health or prevent disease.

The wellness program must also provide a "reasonable alternative." The regulations provide that, a reasonable alternative is what is appropriate "in light of the individual's actual circumstances, as determined to be medically appropriate in the judgment of the individual's personal physician...For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative for the individual cannot be to achieve a BMI of less than 31 on that same date. However, if the if initial standard is to achieve a BMI of less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or a small percentage over a realistic period of time, such as within a year. Second, an individual must be given the opportunity to comply with the

recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request." The regulations require:

- a. If the reasonable alternative is completion of an educational program, the plan must find such a program and make it available and pay for it;
- b. The time commitment required must be reasonable;
- c. If the reasonable alternative is a diet program, the plan is not required to pay for food but must pay for the cost of membership or participation fee; and,
- d. If the individual's personal physician states that a plan is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness.

The regulations state, "The final rules retain the clarification of the proposed regulations and add an additional clarification that an individual's personal physician can make recommendations regarding medical appropriateness that must be accommodated with respect to any plan standard (and is not limited to a situation in which a personal physician disagrees with the specific recommendations of an agent of the plan with respect to an individual)." The regulations go on to note that these decisions are subject to external independent review. (See below "Internal and External Appeals") Significantly, the final regulations declare, "The intention of the Departments in these final regulations is that, regardless of the type of wellness program, every individual participating in the program should be able to receive the full amount of any reward or incentive, regardless of any health factor."¹⁵

Thus, an employee's physician could recommend that the employee receive an anti-obesity pharmaceutical agent or bariatric surgery, if eligible. If that were denied, a review would take place by reviewers external to the employer.

Finally, the regulations address the issue of "What happens in year 2?" They note that smoking cessation may take many attempts and maintenance may be a perfectly good outcome. A physician's recommendation of nicotine replacement therapy would constitute a reasonable alternative standard.

d. Internal and External Appeals

Employees with obesity may have had reimbursement for treatments denied by their insurer. In such cases, insurers have appeal processes which are perceived to usually favor the insurer. An important and overlooked change in the ACA are new federal regulations for internal and external appeal processes. Especially in cases of denial of bariatric surgery, these new procedures may be especially helpful.

Under the ACA, all consumers have the right to appeal coverage decisions made by a health insurance company to an outside, independent decision panel, effective January 1, 2014. Plans must comply with existing state laws providing for external reviews or the federal review process.¹⁶

Plans, as of September 23, 2010, must have in effect an internal claims appeal process, provide notice to enrollees of available internal and external appeals process and the availability of consumer assistance,

and allow enrollees to review their files, present evidence and testimony and receive continued coverage pending the outcome.¹⁷

During the rule-making process, the three federal departments involved in implementing the ACA issued rules for group health plans and health plan issuers. In the preamble, they discussed what types of adverse benefit determinations involve “medical judgments” and, therefore, can be appealed. Among those included were: (1) “A plan’s general exclusion of an item or service (such as speech therapy), if the plan covers the item or service in certain circumstances (such as, to aid in the restoration of speech loss or impairment or speech resulting from a medical condition).” (2) “Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the plan’s wellness program.” (3) The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, etc.” As one can see, all three of these areas have application to obesity treatments. In the first case, bariatric surgery is sometimes explicitly excluded in an insurance plan but exceptions may be allowed, such as in life-threatening situations. The second item, the employer wellness program, is discussed above. The third item regarding the USPSTF recommendation implies that participants need not be limited to the time and frequency constraints contained in the recommendation regarding Intensive Behavioral Therapy for Obesity.¹⁸

e. Cadillac Plans

There is another way in which employees who are obese and receive their health insurance through an employer plan may be adversely affected. Starting in 2018, a tax on the ‘excess’ benefit of 40% will be imposed. “Excess” is defined as the cost for health benefits that are more than the annual limit of \$10,200 for self-only coverage and \$27,500 for self, spouse or family coverage. This tax may affect plans which have generous benefits and may include bariatric surgery. Employers may cut back on the benefits in such plans in the next few years to avoid the tax.¹⁹ There is no apparent recourse for employees in this situation.

f. Medical Deduction

Persons with obesity who experience high out-of-pocket medical expenses and are under 65 years of age should be aware that the amount that can be deducted from federal income taxes as a medical deduction is raised under the ACA from unreimbursed costs exceeding 7.5% of adjusted gross income to unreimbursed costs exceeding 10% of AGI starting January 1, 2013.²⁰

3. The Medicaid Program

The Medicaid program is a joint federal-state health program serving low-income families with dependent children and persons who are disabled. Medicaid and the Children’s Health Insurance Program (CHIP) provide acute and long-term health coverage for approximately 40 million children and adults a year.

According to a recent study⁶, all Medicaid programs cover at least one obesity treatment modality. Only 8 states (Delaware, Indiana, Iowa, Louisiana, Minnesota, South Carolina, Virginia, and Wisconsin) cover all three recommended treatments (nutrition counseling, drug therapy, bariatric surgery).

The ACA contains several provisions regarding this population. Section 4004(i) requires the Department of Health and Human Services to provide guidance to the states on preventive and obesity-related services. It also requires states to design public awareness campaigns to inform enrollees on the availability of such services. The ACA makes available \$100 million in demonstration grant funding for projects that offer incentives to Medicaid enrollees to lose weight, control cholesterol, lower blood pressure, control their diabetes or stop their smoking. Effective 2013, the ACA²¹ will give state Medicaid programs enhanced federal matching dollars if they eliminate cost-sharing by enrollees for the use of preventive services that include the USPSTF recommendations, including Intensive Behavioral Therapy for Obesity (see “Preventive Services” above).²²

In 2010, the Centers for Medicare and Medicaid Services (CMS) published an initial core set of pediatric quality measures for voluntary use by Medicaid/CHIP programs. One of the measures is weight assessment and counseling for nutrition and physical activity. A similar set is under development for adults. Similar measures are included in the Medicare and Medicaid Electronic Health Records Incentive Program final regulations.²³

The goal of the ACA to expand access to health insurance is heavily dependent on expansion of the Medicaid program. Under the Supreme Court decision in National Federation of Business v. Sebelius,²⁴ the expansion has to be a voluntary decision by each state. Since then, the expansion has become highly politicized with about only half the states opting for expansion and the others either deciding against expansion or still considering the issue. As of September, 2013, 26 states are expanding Medicaid, 22 states are not and 3 are still debating, according to Kaiser Family Foundation.²⁵

Of the 25 states expanding their Medicaid programs, all provide at least one obesity treatment modality to their Medicaid enrollees. Of the states not expanding or still deciding, five cover all three obesity modalities (Indiana, Louisiana, South Carolina, Virginia and Wisconsin).

Research by Decker et al. estimate the total number of new enrollees in Medicaid to be 14.7 million, (were they all to enroll) most of whom would be childless adults. One-third of eligible new enrollees are obese, less than those currently enrolled in Medicaid, (34.4% and 45.2% respectively). They are also less sedentary but more are smokers. Many more men are included in the newly eligible group than in the existing group of enrollees and they are somewhat younger. According to the authors, “Uninsured adults were less likely than Medicaid enrollees to have diabetes, hypertension or hypercholesterolemia but if they had 1 of these diseases, the disease was more likely uncontrolled or undiagnosed....One-third of potential new Medicaid enrollees are obese, half currently smoke, one-fourth report a functional limitation, and one-fourth report their health as fair or poor – all factors that could require attention from clinicians.²⁶ People who are newly eligible for Medicaid will have benefits, as of January 2014, which include “essential health benefits”.²⁷ As discussed below, essential health benefits will include intensive behavioral counseling of adults for obesity.

Expansion of Medicaid is also controversial in terms of its effect on health outcomes. A study of a previous expansion of the Medicaid population in Oregon showed, over two years, that Medicaid coverage generated no significant improvements in measures of physical health but it did increase the use of health care services, lower rates of depression, raise rates of diagnosed diabetes and reduced financial strain on enrollees. Catastrophic health care costs, mainly out-of-pocket were nearly eliminated. Use of preventive services increased. Medicaid coverage had no significant effect on the prevalence or diagnosis of hypertension or high cholesterol.²⁸ As Medicaid programs and providers prepare to cover more patients in 2013, the Affordable Care Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase above current payment levels is fully funded by the federal government.²⁹

4. State Marketplaces

In addition to expanding Medicaid, the ACA intends to expand access to health insurance by uninsured individuals by the creation of state health marketplaces (formerly called exchanges). The marketplaces come in three varieties: state-administered, joint federal-state run and federally-run. They have been described as an 'Expedia' of health insurance, where one can enter one's age, gender, smoking status, income and be offered a variety of plans (called bronze, silver, gold and platinum {think coach, economy, business, and first class}). An individual can then pick which plan gives them the coverage and cost that is most suitable. The cheapest plans, bronze, will have high out-of-pocket costs and are designed for those who do not expect to have high medical expenses. On the other hand the most costly plans, platinum, will have high premiums but low out of pocket requirements.

What are the health status characteristics of the population expected to enroll in state exchanges/marketplaces? A study undertaken by the Urban Institute looked at the population currently without group insurance and uninsured and whose income is too high to qualify for Medicaid. This population works out to 16.1 million Americans. They are younger and have more males than their insured counterparts. They are somewhat less likely than peers in the employer-insured market to rate their health as excellent or very good but also less likely to report a number of chronic conditions, including high blood pressure, diabetes and heart disease. Interestingly, they are significantly less likely to be obese (23.7% compared to 27.2%) and more likely to smoke (13.7% versus 16.8%). Even so, under this model 3.8 million adults with a BMI ≥ 30 between the ages 19 to 64 will join the health exchanges.³⁰

a. Essential Health Benefits

What benefits will be provided in health insurance plans sold on the exchanges? Under the ACA, there are 10 minimum 'essential health benefits' (EHB) which each plan must provide. They are ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services including oral and vision care.

State mandates are in force but not those that mandate specific providers or which define dependents. Of concern here is that CMS has established for each state a 'benchmark plan' as a model for other plans

to use. The Obesity Care Continuum has provided a very helpful analysis of each state's benchmark plan and obesity treatment modalities.³¹

Coverage of approved pharmaceutical products for the treatment of obesity is problematic. The final regulations require coverage of either one or more drugs from each class (as listed in the U.S. Pharmacopeia Model Guidelines or the 'benchmark' plan the state as selected as its model plan. Most benchmark plans do not include FDA approved drugs for weight loss (e.g. orlistat, phentermine, lorcaserin). The U.S. Pharmacopeia Model Guidelines do not have a category of drugs for weight loss or appetite suppressants even though the FDA does.³² The regulations do provide that "a plan offering EHB (essential health benefits) have procedures in place to ensure that enrollees have access to clinically appropriate drugs that are prescribed by a provider but are not included on the plan's drug list which is generally consistent with private plan practice today."³³ The regulations stress that an issuer "does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, or present or predicted disability, degree of medical dependency, quality of life or other health conditions."³⁴ Appeals of adverse decisions may be required to obtain the necessary coverage.

Interestingly, the Association of Managed Care Pharmacy (AMCP) requested guidance from HHS regarding the USPSTF recommendation for the use of aspirin as a preventive service for a reduction in myocardial infarctions. Aspirin is widely available over the counter. AMCP asked whether group plans and health insurance issuers were now required to pay for OTC aspirin. HHS said yes when prescribed by a provider.³⁵

On October 1, 2013 state health marketplaces start to facilitate the sale of health insurance plans to millions of persons who are currently uninsured. The major question is how many will sign up and are they healthy or sick. If mainly healthy, their addition to health insurance plans can have the effect of lowering health insurance premiums (a major goal of the legislation) as this population will not be major users of health care services. On the other hand, if many have chronic illnesses and are high users of health care services, health insurance premiums may rise.

5. Restructuring the Health Care Delivery System

As mentioned earlier, one of the goals of the ACA was to achieve cost savings in the health care system through structural reforms. Several different efforts are underway. In the Medicare program, a system of 'value-based purchasing' is being introduced giving hospitals financial incentives based on quality of care related to measures such as heart attacks, heart failure, surgical care, health-care associated infections and patient satisfaction.³⁶

Physicians are being given incentives to join "Accountable Care Organizations" (ACOs). ACOs are integrated health care delivery systems composed of hospitals, physician practices, delivering coordinated care for Medicare beneficiaries.³⁷

The term "medical home" refers to a concept³⁸ (not a physical facility) which includes many health service domains and financing coordination a spectrum of acute and long term services to persons with

complex medical needs in a manner to lower health care costs, improve compliance with treatment recommendations, increase quality, reduce disparities, achieve better outcomes, and, lower utilization rates.

One change to Medicaid in the ACA may be especially useful to persons with obesity. It creates an optional Medicaid benefit.³⁹ for states to establish “Health Homes” to coordinate care for people with Medicaid who have chronic conditions. Health Homes are for people on Medicaid who have 2 or more chronic conditions, have one chronic condition and are at risk for a second, have one serious and persistent mental health condition. Chronic conditions include mental health, substance abuse, asthma, diabetes, heart disease and being overweight (BMI >25). Health Homes are intended to integrate and coordinate all primary, acute, behavioral health and long-term services in support of the whole person.⁴⁰

6. Research

The ACA established the Patient Centered Outcomes Research Institute (PCORI) as an independent, non-profit research organization to fund research to give patients and caregivers information needed to make healthcare decisions. Specifically, the legislation states PCORI’s purpose is, “To assist patients, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations,” “Improved Patient Decisions about Bariatric Surgery,” “A Toolbox Approach to Obesity Treatment in Primary Care.” On April 16, 2013, PCORI conducted a workshop on Obesity Treatment Options in Diverse Populations which made a number of recommendations for further research in the areas of communication, primary care, intervention models, alternative delivery sites, training, and, comparison of treatment options.⁴¹

7. Prevention

The ACA creates a National Prevention Strategy and Action Plan. The 2011 National Prevention Strategy stresses healthy eating and active living, among other priorities and strategies. One key indicator is a 10% reduction in adult and child obesity by 2021.⁴² The ACA also created the Prevention and Public Health Fund to provide expanded and sustained investments in prevention and public health, including community and clinical prevention initiatives.⁴³ One such grant was to the Centers for Disease Control and Prevention for early childhood obesity prevention. The Fund was originally allocated \$21 billion from FY 2010 to FY2022. Fund has been cut or reallocated by nearly 1/3 reducing amount allocated to \$14.5 million.⁴⁴

In addition, the ACA created Community Transformation Grants. These grants are designed to enable communities to design and implement sustainable, community-living programs that prevent chronic disease. Current project are expected to improve health of more than 4 out of 10 citizens, about 130 million Americans.⁴⁵

The ACA also included a requirement that all food outlets with 20 or more locations, including chain restaurants, bakeries, grocery stores, convenience stores and coffee chains, to clearly post the caloric

content of standard menu items. Companies with 20 or more food or beverage vending machines would have similar requirements.⁴⁶ Other nutritional information, such as salt content, total carbohydrates, sugars, fibers and protein, would be available on request. On July 23, 2010, the Food and Drug Administration (FDA) issued guidelines for companies to voluntarily register to post caloric information pending final regulations.⁴⁷ Proposed final regulations were issued for public comment on April 6 2011.⁴⁸ Under the proposed regulations, movie theatres, airplanes, bowling alleys, stadiums and hotels would be exempt on the basis that selling food is not their primary business. The FDA has not taken any further action.

8. Discussion

The Affordable Care Act, in addition to being complex, has, as of this time, modest public support, strong political opposition, a mixed reaction by state governments and a patchwork of reactions by businesses and unions and other interests. It will be some time before the written policies are implemented. Even then, further changes by regulation, legislation, litigation, politics or economics will occur. Two major factors will affect the future of the ACA. First, will newly insured participants in the marketplaces be generally healthy or have complex, chronic diseases? Will they join at all or wait and incur the modest penalty for not participating? If a large number of people who do join have complex diseases, costs may rise and make the program less affordable. The second major factor will be is there an adequate supply of physicians and health care professionals to handle the expected increases in the insured population? While the ACA does try to address this expected shortage, especially in primary care, it remains to be seen if additional Americans with insurance will increase the burdens on physician practices, hospitals and other providers.⁴⁹

9. Conclusion

The Affordable Care Act's major impact on persons with obesity is quite historic. Assuming that 34% of the 170 million adults with employer-based health insurance are obese, starting January 1, 2014 57.8 million adults with obesity will be protected from losing coverage due to pre-existing conditions, have no annual or lifetime caps, a right to external, independent review of denied claims, rights in employer wellness programs and a new benefit, intensive behavioral counseling for obesity. An estimated five million persons with a BMI >30 may enroll in Medicaid and be eligible for intensive behavioral counseling for obesity, if all those eligible enrolled. The same is true for an estimated 3.8 million American adults under the age of 65 with obesity eligible to enroll in the state exchanges. In state exchanges, a strong non-discrimination provision based on "benefit-design" appears to provide the legal foundation to expand coverage of drugs for the treatment of obesity and bariatric surgery. In short, an estimated 66.6 million Americans with obesity will have new protections, rights and benefits on January 1, 2015.

A major challenge exists in motivating and educating primary care practitioners to provide counseling on obesity or appropriate referral to their patients with obesity. The advent of the American Board of Obesity Medicine anticipates the ultimate recognition of obesity medicine as a medical specialty which can give the field the value and visibility it deserves.⁵⁰

The major omission is both partial expansion of Medicaid (at this time) because half of the states seem to have opted out but more so because of the poor coverage of obesity treatments under the current Medicaid program. Expanding the number of states which provide comprehensive obesity treatment alternatives and which adjust their reimbursement rates to make the provision of services realistic is necessary next step to assure access to safe and effective treatments of obesity and to reduce racial and socioeconomic disparities. Removal of the limitation in the Medicaid and Medicare statutes on the provision of drugs for weight loss approved by the FDA in those two programs is long overdue and can provide physicians and their patients with additional tools to use in fighting obesity.

Author Affiliations:

Morgan Downey J.D. Editor & Publisher, Downey Obesity Report, Washington, D.C.

Christopher O. Still, D.O., Director, Geisinger Obesity Institute, Danville, PA.

The authors received no honorarium or payments in connection with the writing of this article.

FOOTNOTES

Glossary

CFR Code of Federal Regulations

FR Federal Register

P.L. Public Law

U.S. United States (Official reporter of Supreme Court decisions)

1. P.L. 111-148, as amended, Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (hereinafter "ACA")
2. Tsuda S, Barrios, L, Schneider B, Jones DB, Factors affecting rejection of bariatric patients from an academic weight loss program, *Surg Obes Relat Dis*, 2009 Mar-Apr;5(2):199-202. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/19136316>, accessed Oct.1, 2013)
3. Sadhasivam S, Larson CJ, Lambert PJ, Mathiason, MA, Kothari SN, Refusals, denials, and patient choice: reasons prospective patients do not undergo bariatric surgery, *Surg Obes Relat Dis* 2007 Sep-Oct;3(5):531-5. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/17903773> accessed Oct. 1, 2013)
4. Mainous AG, Johnson SP, Saxena SK, Wright RU, Inpatient bariatric surgery among eligible black and white men and women in the United States, 1999-2010, *Am J. Gastroenterol* 2013 Aug;108(8):1218-23. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/23912399> accessed Sept. 19, 2013)

5. 75 FR 37187, June 28, 2010 <https://www.federalregister.gov/articles/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual>
6. Lee, JS, Sheer, JLO, Lopez, N, Rosenbaum, S, Coverage of Obesity Treatment: A state-by-state analysis of Medicaid and State Insurance Laws, Public Health Reports, 2010, July-Aug, 125(4): 596-604. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/20597460>, accessed Oct. 1, 2013)
7. <https://www.aetna.com/health-reform-connection/questions-answers/rescissions.html>
8. National Association of Insurance Commissioners, Data Call Rescissions, Dec.2, 2009
9. 75 FR 137:41726 et seq. <http://www.gpo.gov/fdsys/pkg/FR-2010-07-19/pdf/2010-17242.pdf>
10. See <http://www.uspreventiveservicestaskforce.org/uspstf/uspsobes.htm>.
11. 78 FR 39869, July 2, 2013, (<https://www.federalregister.gov/articles/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act>, (accessed Sept. 14, 2013).
12. <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253>, (accessed Sept. 30, 2013)
13. P.L. 104-191
14. ACA §1201
15. 26 CFR Part 54, (<http://www.regulations.gov#!documentDetail;D=IRS-2012-0047-0003>, (accessed September 10, 2013).
16. ACA §1001
17. <http://www.hhs.gov/cciio/regulations/consumerappeals/>) For information on consumer assistance, see Families USA <http://www.familiesusa.org/resources/resources-for-consumers/consumer-assistance-programs-resource-center/>; State Maps of federal consumer assistance grantees available at <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.
18. <https://www.federalregister.gov/articles/2011/06/24/2011-15890/group-health-plans-and-health-insurance-issuers-rules-relating-to-internal-claims-and-appeals-and>
19. <https://www.aetna.com/health-reform-connection/questions-answers/excise-tax.html>
20. <http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses>
21. ACA §4106

22. <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-002.pdf> (accessed Sept. 18, 2013)
23. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-Obesity.html>. (accessed September 18, 2013).
24. 567 U.S. __ (2012)
25. Status of State Medicaid expansion, <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> accessed Sept. 30, 2013 Additional info at http://www.urban.org/health_policy/health_care_reform/map.cfm.
26. Decker, SL, Kostova D, Kenney GM, Long SK, Health Status, Risk Factors, and Medical Conditions Among Persons Enrolled in Medicaid vs Uninsured Low-Income Adults Potentially Eligible for Medicaid under the Affordable Care Act. JAMA, 2013; 309(24):2579-2586. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/23793267>)
27. <https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit#h-14>
28. Baicke K, Taubman SL, Allen HL, et al, The Oregon Experiment – Effects of Medicaid on Clinical Outcomes, NEJM 2013, May 2;368(18) 1713-22. (PubMed: <http://www.ncbi.nlm.nih.gov/pubmed/?term=the+oregon+experiment+the+effects+of+Medicaid+on+clinical+outcomes>)
29. <http://medicaid.gov/AffordableCareAct/Provisions/Provider-Payments.html>
30. Blumberg LJ, Holahan, Health Status of Exchange Enrollees: Putting Rate Shock in Perspective. Urban Institute, July 2013, <http://www.urban.org/UploadedPDF/412859-Health-Status-of-Exchange-Enrollees-Putting-Rate-Shock-in-Perspective.pdf>, (accessed Sept. 11, 2013)
31. Gallagher, C, Summary of Obesity Treatment State Benchmark Plan Coverage <http://www.obesityaction.org/wp-content/uploads/1212-OCC-Summary-of-Obesity-Treatment-State-Benchmark-Plan-Coverage.pdf>, (accessed September 18, 2013)
32. <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/default.htm>
33. 45 CFR §156.125 <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf> (accessed Oct. 3, 2013)
34. 45 CFR §122 <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf> (accessed Oct. 3, 2013)

35. <http://amcp.org/WorkArea/DownloadAsset.aspx?id=16173>
36. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf
37. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco>
38. For background, <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>. (accessed Sept. 18, 2013.)
39. Social Security Act §1945
40. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>, (accessed Sept. 11, 2013.)
41. <http://pcori.org/assets/PCORI-Obesity-Treatment-Options-Workshop-TopTopics-041613.pdf>. (accessed Sept. 11, 2013.)
42. National Prevention Council, National Prevention Strategy, Washington, D.C.: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011. <http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf> At p. 56, (accessed September 4, 2013)
43. <http://www.hhs.gov/open/recordsandreports/prevention/>(accessed Oct. 3, 2013)
44. Trust for America's Health, *F as in Fat How Obesity Threatens America's Future*, 2013, at p.52
45. July 2013 Update National Prevention Strategy, p. 8. See <http://www.cdc.gov/communitytransformation/> State and grants amounts at <http://www.cdc.gov/communitytransformation/pdf/ctg-factsheet.pdf> (accessed Oct. 3, 2013)
46. ACA §4205.
47. 75 FR 141, July 23, 2010:43182-43184 <http://www.gpo.gov/fdsys/pkg/FR-2010-07-23/html/2010-18123.htm>(accessed Oct. 3, 2013)
48. 76 FR 66; April 6,2011; 19192 et seq. For further info, see FDA, Menu & Vending Machines Labeling Requirements at <http://www.fda.gov/food/ingredientspackaginglabeling/labelingnutrition/ucm217762.htm>,(accessed Sept. 12, 2013).
49. Whitcomb ME, Commentary: Meeting future medical needs: a perfect storm on the horizon, *Acad Med.* 2011 Dec;86(12):1490-1, (PubMed:<http://www.ncbi.nlm.nih.gov.proxyau.wrlc.org/pubmed/22130260>, (accessed Sept. 12, 2013).
50. <http://abom.org/> (accessed Sept. 20, 2013)

