Obesity Action Coalition

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October 21, 2011

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

Dear Secretary Sebelius:

The more than 33,000 patient advocates of Obesity Action Coalition (OAC) are deeply troubled over the August 22, 2011 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."

The OAC is a national 501(c)3 non-profit organization dedicated to giving a voice to individuals affected by obesity through education, advocacy and support. One of the major core beliefs of the OAC is that the negative stigma associated with obesity must be eradicated as this stigma greatly hinders efforts to recognize obesity as a disease and extend to it the same benefits as any other disease state. For these reasons, we are deeply troubled that the sample Summary of Benefits and Coverage (SBC) document included in the NPRM negatively targets obesity treatment services by specifically enumerating "weight loss programs" and "bariatric surgery" under the "excluded services" section on page four of the sample SBC document.

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 overweight or 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 many believe should represent the scope of covered benefits for the essential health benefit package that HHS must now formulate in the wake of the recent Institute of Medicine's (IOM) Consensus Report entitled, "Essential Health Benefits: Balancing Coverage and Cost."

The OAC questions some of the private health plan documents that the IOM chose to include in its report to illustrate examples of benefits currently offered in the small employer market. These documents show little or no coverage for obesity treatment services and perpetuate 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.

In addition, we are disappointed by the IOM's suggestion that these types of small employer plans should be used as the template for the typical benefit design for the targeted state health exchange plan population. However, in making this

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statement, IOM did include language in its report about the necessity of protecting special categories of services due to "shortcomings in current coverage."

"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)."

While the OAC would have preferred to have "obesity treatment services" listed as one such "protected category of service" in the benefit package, we do believe that, at a minimum, these critical services should be clearly enumerated under the "chronic disease management" section of the EHB package. Certainly, we would argue that it would be a tragic setback for societal acceptance of treating obesity should HHS suggest that treatment services such as evidence-based weight-loss programs and bariatric surgery be considered as traditional services that health plans should exclude.

Treating or addressing obesity among those already affected by obesity is difficult. This is clearly demonstrated by the more than 34 percent 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 – we often urge policymakers to go back in time 20 years ago to the coverage situation facing the millions of Americans affected by mental illness or addiction. After decades of intense advocacy efforts by the mental health and substance abuse communities, Congress and the President chose to specify these services in the EHB 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.

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,

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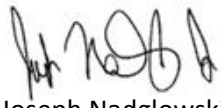
with the advancements in modern medicine and an open mind by policymakers, we can reverse this trend. We urge HHS to use its wide discretionary powers in defining the benefit package and stand up for those who struggle with obesity as we're sure you will do for those affected by mental illness and addiction.

If this is not possible, the OAC implores HHS to, at a minimum, "first, do no harm" by finalizing such a flawed sample Summary of Benefits and Coverage document in the August 22, 2011 NPRM. Final approval of a "consumer education" document that is clearly prejudicial toward such a vast population of Americans is not only contradictory to past and recent federal coverage policy decisions surrounding obesity treatment, but could easily be viewed as violating the Affordable Care Act provisions regarding discrimination against individuals because of their age, disability status or expected length of life.

Again, the OAC appreciates the opportunity to provide comments regarding this critical issue. Should you have any questions, please don't hesitate to contact me. Thank you.

Sincerely,



Joseph Nadglowski
OAC President and CEO

Appendix A-2 Sample Completed SBC (Individual Health Insurance Coverage)

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium?	**$481** monthly	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	**$2,500** person / **$7,500** family. Doesn't apply to preventive care.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes; **$300** for pharmacy expenses.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,500** person / **$7,500** family.	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating for providers in their network.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

OMB Control Numbers 1545-XXXX, 1210-XXXX, and 0938-XXXX (expires XX/XX/XXXX)

Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What It Costs

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | Plan Type: PPO

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is $1,000 and you've met your deductible, your co-insurance payment of 20% would be $200. If you haven't met any of the deductible and it's at least $1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit	40% co-insurance	none
	Specialist visit	$50 co-pay/visit	40% co-insurance	none
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	none
	Preventive care/screening/immunization	$0	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	0% co-insurance	40% co-insurance	none
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions	Generic drugs	$10 co-pay (retail), $10 co-pay (mail order)	40% co-insurance	Covers up to a 30-day supply (retail prescription), 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)	40% co-insurance	none
	Non-preferred brand drugs	40% co-insurance (retail and mail order)	60% co-insurance	none
	Specialty drugs (e.g., chemotherapy)	0% co-insurance		none

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Insurance Company 1: PPO Plan 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	40% co-insurance	none
	Physician/surgeon fees	0% co-insurance	40% co-insurance	none
If you need immediate medical attention	Emergency room services	0% co-insurance	40% co-insurance	none
	Emergency medical transportation	0% co-insurance	40% co-insurance	none
	Urgent care	0% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-insurance	40% co-insurance	none
	Physician/surgeon fee	0% co-insurance	40% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% co-insurance	40% co-insurance	After 8 visits, not covered.
	Mental/Behavioral health inpatient services	0% co-insurance	40% co-insurance	none
	Substance use disorder outpatient services	0% co-insurance	40% co-insurance	none
	Substance use disorder inpatient services	0% co-insurance	40% co-insurance	none
If you become pregnant	Prenatal and postnatal care	Not Covered	Not Covered	none
	Delivery and all inpatient services	Not Covered	Not Covered	none
If you have a recovery or other special health need	Home health care	0% co-insurance	40% co-insurance	none
	Rehabilitation services	0% co-insurance	40% co-insurance	none
	Habilitation services	0% co-insurance	40% co-insurance	none
	Skilled nursing care	0% co-insurance	40% co-insurance	none
	Durable medical equipment	0% co-insurance	40% co-insurance	none
	Hospital service	0% co-insurance	40% co-insurance	none
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Routine hearing tests
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxxx.com.
- An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxx.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Insurance Company 1: PPO Plan 1

Coverage Examples

Policy Period: 1/1/2011 – 12/31/2011
Coverage for: Individual + Spouse | **Plan Type:** PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much insurance protection you might get from different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $10,000
- **Plan pays** $0
- **You pay** $10,000 (maternity is not covered, so you pay 100%)

Sample care costs:

First office visit	$100
Radiology	$300
Laboratory tests	$200
Routine obstetric care	$2,000
Hospital charges (mother)	$4,100
Hospital charges (baby)	$1,900
Anesthesia	$1,000
Circumcision	$200
Vaccines, other preventive	$200
Total	**$10,000**

You pay:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$10,000
Total	**$10,000**

Treating breast cancer
(lumpectomy, chemotherapy, radiation)

- **Amount owed to providers:** $98,000
- **Plan pays** $94,800
- **You pay** $3,200

Sample care costs:

Office visits & procedures	$4,000
Radiology	$4,000
Laboratory tests	$2,400
Hospital charges	$3,300
Inpatient medical care	$200
Outpatient surgery	$3,400
Chemotherapy	$64,000
Radiation therapy	$13,000
Prostheses (wig)	$500
Pharmacy	$2,000
Mental health	$1,200
Total	**$98,000**

You pay:

Deductibles	$2,500
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$500
Total	**$3,200**

Managing diabetes
(routine maintenance of existing condition)

- **Amount owed to providers:** $7,800
- **Plan pays** $6,800
- **You pay** $1,000

Sample care costs:

Office visits & procedures	$960
Laboratory tests	$300
Medical equipment & supplies	$40
Pharmacy	$6,500
Total	**$7,800**

You pay:

Deductibles	$300
Co-pays	$260
Co-insurance	$400
Limits or exclusions	$40
Total	**$1,000**

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.
If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services (HHS), and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same policy period.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for these conditions could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.