

STOP Obesity Alliance's Essential Health Benefits Task Force Essential Health Benefits Recommendations

Under the Patient Protection and Affordable Care Act (ACA), the Secretary of Health and Human Services (HHS) is required to establish a minimum standard of coverage, or “essential health benefits” package, that must be included as of 2014 by all qualified health plans offered through Health Insurance Exchanges established under Section 1302 of the ACA as well as through insurers in individual and small group markets. The ACA also sets forth a series of broad benefit classes that the Secretary’s definition of essential benefits must include. To help in this effort, the Secretary has asked for assistance from the Institute of Medicine (IOM). The IOM has established a Committee on the Determination of Essential Health Benefits to develop the framework for establishing the essential health benefits package and is expected to issue its report by the end of September 2011.

The STOP Obesity Alliance’s Essential Benefits Task Force has developed consensus recommendations to help inform the Secretary and the IOM regarding treatments for obesity and related co-morbidities that should be considered essential health benefits and covered by all non-grandfathered qualified health plans. At the root of these recommendations is the belief that obesity and weight-related interventions should not be treated differently than any other health condition.

In the process of developing a set of principles of coverage for obesity-related services, participating members of the Alliance’s Essential Health Benefits Task Force reviewed current federal evidence-based guidelines relating to the recommendation of services to be provided to patients with overweight and obesity by physicians and physician extenders, and how they relate to coverage requirements under the ACA. Based on the evidence, the Task Force has developed a set of overarching principles detailed below, as well as more specific recommendations of types of services that should be covered under each of the 10 categories of essential benefits.

Overarching Principles

- 1. As the guiding principle in establishing the coverage provisions of the essential health benefits package, the Task Force recommends that no obesity services be summarily excluded from the new essential health benefits package coverage requirements under the ACA.*
- 2. The Task Force recommends that all evidence-based preventive services be covered.*
- 3. The Task Force recommends that all preventive benefits be covered by the essential benefits package with no or reduced cost-sharing as articulated in the ACA.*
- 4. The Task Force recommends that all evidence-based treatments for obesity should be covered with reasonable cost-sharing.*

Task Force Essential Health Benefits Recommendations

1. ACA Coverage Categories

The following are the essential benefit classes and the Task Force’s recommendations for what should be included under the ACA-defined coverage categories. The Task Force recommends that treatment for obesity should not be summarily excluded and that treatments or services that cross between coverage categories should not be excluded or subject to additional cost sharing as compared to other types of treatments or services.

- a. **Ambulatory Patient Services:** For example, the Task Force believes a physician who consults with a patient with obesity regarding treatment should be able to bill and be reimbursed for that consultation in the same manner that a physician treating a patient with diabetes is allowed to bill and receive reimbursement for a consultation.
- b. **Emergency Services:** The Task Force believes no person with obesity or a related co-morbidity should be treated differently in cases of emergency. All patients should be treated equally in terms of their needs.
- c. **Hospitalization:** The Task Force recommends hospitalizations for obesity treatment be covered.
- d. **Maternity & Newborn Care:** The Task Force recommends coverage for screenings, counseling, and other necessary services to encourage an expectant mother to maintain a healthy weight. Breastfeeding consultations and other related services should also be covered, in accordance with the IOM's Recommendations for Preventive Health Care Services for Women.
- e. **Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment:** Research shows a significant overlap between obesity and mental health and substance abuse disorders. Specifically, there is a strong link between obesity and depression—one study demonstrated that depression likely plays a role in the development of physical health problems, such as cardiovascular disease, through its association with weight gain and increased abdominal obesity over time.¹ Therefore, the Task Force believes mental health services should be covered for people with obesity.
- f. **Prescription Drugs:** The Task Force believes all drugs for the treatment of obesity approved by the U.S. Food and Drug Administration (FDA) should be covered.
- g. **Rehabilitative and Habilitative Services and Devices:** Due to significant overlap between persons with disabilities and persons with obesity, the Task Force believes rehabilitative and habilitative services and devices should be covered.
- h. **Laboratory Services:** The Task Force recommends routine labs/screenings, including, but not limited to A1C, blood glucose, and lipid levels be covered. Additionally, the Task Force recommends coverage of genetic testing, which may serve the purpose of more accurately matching the most effective treatment for obesity and other related conditions to an individual in the future.
- i. **Preventive and Wellness Services and Chronic Disease Management:** The Task Force recommends all evidence-based preventive services and chronic disease management for obesity and related co-morbidities be included in this category with no or reduced cost-sharing.
- j. **Pediatric Services, including Oral and Vision Care:** The Task Force recommends aggressive interventions around overweight and obesity be included in this essential benefit category.

2. Evidence Base for Obesity-Related Prevention and Treatment Services

The Task Force believes that at a minimum the recommendations from the following two organizations should be used for the evidence base for obesity and obesity-related chronic disease prevention, treatment, and management.

U.S. Preventive Services Task Force (USPSTF) Recommendations for Obesity Treatment

The Task Force agrees that the USPSTF recommendations with an “A” or “B” rating should be covered as a minimum under the essential health benefits package.

The following is the current USPSTF recommendation of primary and preventive services for adults with obesity:

The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

Rating: B recommendation²

National Heart, Lung, and Blood Institute (NHLBI) Recommendations for Obesity Treatment

The Task Force believes NHLBI evidence-based recommendations for the treatment of obesity should be considered as essential health benefits.

NHLBI recommends treating obesity based on evidence from randomized controlled trials that show that weight loss not only helps control diseases, but may also reduce the likelihood of developing those diseases. Specifically, the NHLBI recommends the following interventions for weight loss and weight management³:

Physical Activity
Dietary Therapy
Pharmacotherapy
Combined Therapy, and
Weight Loss Surgery.

3. Cost Sharing for Obesity-Related Services

The Task Force recommends that no evidence-based treatments for obesity should be excluded from coverage and that such services have cost sharing that is no greater than that which is required by other comparable treatments.

There are often blanket exclusions placed on the coverage of weight-loss treatments. Where there is coverage, often the cost sharing requirements for the intervention are much higher than for comparable interventions to prevent or treat non-obesity related diseases or conditions. For example, studies indicate bariatric surgery produces significant improvements in both the short- and long-term, but despite the benefits of surgical intervention, and the NHLBI recommendations less than two percent of eligible patients undergo bariatric surgery each year in the United States.⁴

¹Needham B, Epel E, Adler N, Kiefe C. Trajectories of Change in Obesity and Symptoms of Depression: The CARDIA Study. *American Journal of Public Health*. 2010;100(6):1040-1046.

²U.S. Preventive Services Task Force. Screening for Obesity in Adults. Recommendations and Rationale. November 2003. <http://www.uspreventiveservicestaskforce.org/3rduspstf/obesity/obesrr.htm>.

³National Heart, Lung, and Blood Institute. <http://www.nhlbi.nih.gov/about/org/mission.htm>.

⁴Brolin R. Bariatric Surgery and Long-term Control of Morbid Obesity. *JAMA*. 2002–288(22); 2793-2796.