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UNFULFILLED PROMISES: DISCRIMINATION AND THE DENIAL OF ESSENTIAL HEALTH BENEFITS UNDER THE AFFORDABLE CARE ACT

*Jennifer Bennett Shinall**

INTRODUCTION

[S]omeday our grandkids will ask us if there was really a time when America discriminated against people who get sick. Because that is something this law has ended for good.

President Barack Obama, Remarks on the *King v. Burwell* decision by the U.S. Supreme Court (June 25, 2015)¹

When President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law on March 23, 2010, he proclaimed that the Act would provide Americans with “basic security when it comes to their health care.”² According to President Obama, the signing of the Act represented the first step in fulfilling his campaign promise of “affordable, universal healthcare for every single American”³ and the first step in transforming the receipt of health care from a luxury into a “right.”⁴ Achieving this transformation was to be famously realized through the establishment of the Health Insurance Marketplace,⁵ which would offer low-cost plans that would

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1. Remarks on the United States Supreme Court Ruling on the Patient Protection and Affordable Care Act, 2015 DAILY COMP. PRES. DOC. 460, at 1 (June 25, 2015) [hereinafter Obama’s Remarks on the ACA].

2. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, Mar. 23, 2010, N.Y. TIMES, <http://www.nytimes.com/2010/03/24/health/policy/24health.html> (quoting President Barack Obama).

3. See Carlos Lozada, *Obamacare Is Now This President’s Legacy. But It Started Almost on a Whim*, WASH. POST, June 26, 2015, <http://www.washingtonpost.com/news/book-party/wp/2015/06/26/obamacare-is-now-this-presidents-legacy-but-it-started-almost-on-a-whim/> (quoting President Barack Obama, Remarks at the Families USA Conference: The Time Has Come for Universal Health Care (Jan. 25, 2007), reprinted in *Obama’s Speech at Families USA*, WALL. ST. J., Jan. 25, 2007, <http://www.wsj.com/articles/SB116975088437787994>).

4. Obama’s Remarks on the ACA, *supra* note 1, at 1.

5. Of course, at the beginning, implementation of the health exchanges appeared more infamous than famous due to the numerous glitches and problems associated with the healthcare.gov website. See generally Larry Buchanan et al., *How Healthcare.gov Was Supposed To Work and*

provide all “essential health benefits”⁶ to consumers, by ending unjustified rate hiking and common discriminatory insurance practices. Guaranteed essential health benefits under the ACA include mental health treatment, prescription drugs, rehabilitative services, chronic disease management, and pediatric services.⁷ Simultaneously, the ACA prohibits discriminatory health care practices on the basis of race, color, national origin, sex, age, or disability.⁸

Yet, in spite of the ACA’s guarantees, some individuals still endure discriminatory practices in the health insurance marketplace that leave them unable to afford essential health benefits. Among the groups that have thus far fallen victim to the unfulfilled promises of the nondiscrimination and essential health benefit guarantees of the ACA are children with special needs—even though pediatric services are specifically enumerated in the Act as an essential health benefit.⁹ For example, a group of public health scholars recently conducted a state-by-state review of pediatric coverage in benchmark plans, which reflect each state’s determination of the minimum level of coverage necessary to comply with the ACA’s statutory requirements and accompanying Health and Human Services (HHS) regulations.¹⁰ The authors found many notable coverage disparities in state benchmark plan requirements for pediatric care with the most disturbing gaps in coverage experienced by children seeking treatment for autism, hearing impairments, and speech impairments.¹¹

In addition to children with special needs, transgender individuals have also been the subject of popular attention regarding inconsistencies of care in the post-ACA regime. Although the ACA explicitly prohibits sex discrimination,¹² and the HHS has interpreted the prohibition to include discrimination on the basis of gender identity,¹³ the

How It Didn't, N.Y. TIMES, Dec. 2, 2013, <http://www.nytimes.com/interactive/2013/10/13/us/how-the-federal-exchange-is-supposed-to-work-and-how-it-didnt.html> (providing an interactive guide to the marketplace).

6. See generally 42 U.S.C. § 18022 (2012) (defining essential health benefits).

7. *Id.* § 18022(b)(1).

8. *Id.* § 18116(a).

9. *Id.* § 18022(b)(1)(J).

10. Aimee M. Grace et al., *The ACA's Pediatric Essential Health Benefit Has Resulted in a State-by-State Patchwork of Coverage with Exclusions*, 33 HEALTH AFF. 2136 (2014).

11. See *id.* at 2137–41; see also Sara Rosenbaum & Kathleen Noonan, *HHS Proposed Policy on Non-Discrimination: Does It Adequately Protect Children?*, HEALTH AFF.: BLOG (Feb. 19, 2015), <http://healthaffairs.org/blog/2015/02/19/hhs-proposed-policy-on-non-discrimination-does-it-adequately-protect-children/>.

12. 42 U.S.C. § 18116(a).

13. See Memorandum from Andrew Boron, Dir. of Ill. Dep’t of Ins. on Healthcare for Transgender Individuals To All Insurers (July 28, 2014), <http://insurance.illinois.gov/cb/2014/CB2014-10.pdf>; Letter from Leon Rodriguez, Dir., U.S. Dep’t of Health & Human Servs., to Maya Ru-

guaranteed benefits and level of protection that transgender individuals receive vary by state.¹⁴ Not every state benchmark plan currently guarantees coverage of mental health counseling, hormone therapy, or gender reassignment surgery for transgendered individuals, which leads to jurisdiction-based inequities of care.¹⁵ Once again, the unlucky individuals living in less generous states only have the ACA's unfulfilled promises to comfort them.¹⁶

Still, perhaps the largest group of individuals who continue to encounter widespread coverage denials and financial barriers to medical treatment—in spite of the applicable essential health benefits and nondiscrimination guarantees of the ACA—have remained largely unnoticed by both scholars and the media. Six years after the passage of the ACA, many obese individuals remain unable to access any type of medical weight-loss treatment because over one-half of state benchmark plans deny coverage for those treatments.¹⁷ And this wide-

pert, Fed. Policy Dir., Nat'l Ctr. for Lesbian Rights (July 12, 2012), <http://www.scribd.com/doc/102169872/HHS-Response-1557-7-12-12>; Matthew Heinz & Juliet K. Choi, *Enhancing Health Care Protections for LGBT Individuals*, WHITE HOUSE.GOV (Apr. 17, 2014), <https://www.whitehouse.gov/blog/2014/04/17/enhancing-health-care-protections-lgbt-individuals>.

14. See Daphna Stroumsa, *The State of Transgendered Health Care: Policy, Law, and Medical Frameworks*, 104 AM. J. PUB. HEALTH, Mar. 2014, at e31, e34–36.

[C]overage denial based on being transgender as a preexisting condition will be banned under the ACA starting in 2014. To what extent and how promptly these protections will be implemented, and whether they will lead to higher rates of coverage for mental health services, cross-sex hormone therapy, or gender affirmation surgery, remains to be seen. These advances, do not, however, provide an explicit and directed protection of transgender people within the health care system, nor do they address coverage of specific treatments that transgender people may need.

Id. at e34. Even though the Obama administration has recently issued a proposed rule prohibiting health care providers and insurers from discriminating against transgender individuals (see Kimberly Leonard, *Obama Defends Health Rights for Transgender Americans*, U.S. NEWS & WORLD REP. (Sep. 3, 2015), <http://www.usnews.com/news/articles/2015/09/03/obamacare-expands-rights-for-transgender-patients>) health care benefits (and particularly coverage of gender transition procedures) continue to vary widely for these individuals across states. See, e.g., Soumya Karlamangla, *For Transgender People, Getting Healthcare Remains Difficult Despite Obamacare*, L.A. TIMES (Oct. 3, 2015), <http://www.latimes.com/health/la-me-transgender-care-20151004-story.html>.

15. Accord Tara Murtha, *The Problem with Obamacare for Some Transgender Policyholders*, RH REALITY CHECK (Mar. 12, 2014), <http://rhrealitycheck.org/article/2014/03/12/problem-obamacare-transgender-policyholders/> (discussing the systemic marginalization of transgender individuals).

16. Although at least one transgender individual has successfully sued a hospital for gender identity discrimination in violation of Section 1557 of the ACA (42 U.S.C. § 18116), the existence of the suit highlights inequitable care that still exists in some states for many transgender individuals. See *Rumble v. Fairview Health Servs.*, No. 14–CV–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); see also Murtha, *supra* note 15.

17. See OBESITY CARE CONTINUUM, SUMMARY OF OBESITY CARE CONTINUUM (OCC) ADVOCACY EFFORTS (June 2014), <https://asmb.org/wp/uploads/2014/06/Summary-of-OCC-EHB-Advocacy-Efforts.pdf>.

spread lack of coverage has potential repercussions for a tremendous number of individuals living in the United States. Over one-third of the U.S. population is obese, which means they have a body mass index (BMI)¹⁸ of thirty or higher.¹⁹ And, about one in six obese individuals²⁰ is considered morbidly obese, which means they have a BMI of forty or higher.

Obese individuals living in one of the twenty-eight states that do not presently mandate coverage for medical weight-loss treatment are often confronted with an unsolvable financial conundrum as a result.²¹ If their doctor prescribes medical weight-loss treatment but their insurance plan only covers medical treatments mandated by the state benchmark plan, then these obese individuals may be unable to afford to pay out-of-pocket for the prescribed medical weight-loss treatment. Yet, these individuals may simultaneously be unable to afford a more comprehensive insurance plan that goes beyond the state-mandated minimum requirements to cover weight-loss treatments. The inability to access prescribed medical weight-loss treatment can have repercussions that go far beyond the effects on personal appearance. Obesity can contribute to the development of (or exacerbate already existing) coronary heart disease, type 2 diabetes, high blood pressure, high cholesterol, osteoarthritis, gynecological problems, sleep apnea, and other respiratory problems.²²

Of course, the ACA does not provide a right to all physician-prescribed health care;²³ it only provides a right to certain essential health

18. Throughout this Article, weight categories are defined according to BMI, which is calculated using the following equation: Using BMI, individuals are classified as underweight if their BMI is less than 18.5, normal weight (if their BMI is greater than or equal to 18.5 but less than 25.0), overweight (if their BMI is greater than or equal to 25.0 but less than 30.0), obese (if their BMI is greater than or equal to 30.0 but less than 40.0), or morbidly obese (if their BMI is greater than or equal to 40.0). *Obesity: Symptoms*, MAYO CLINIC (June 10, 2015), <http://www.mayoclinic.org/diseases-conditions/obesity/basics/symptoms/con-20014834>.

19. See Cynthia L. Ogden et al., *Prevalence of Childhood and Adult Obesity in the United States, 2011-2012*, 311 J. AM. MED. ASS'N 806, 806 (2014).

20. Morbidly obese individuals comprise approximately 6.6 % of the U.S. population. See R. Sturm & A. Hattori, *Morbid Obesity Rates Continue To Rise Rapidly in the United States*, 37 INT'L J. OBESITY 889, 889 (2013), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3527647/pdf/nihms-405266.pdf>.

21. See OBESITY CARE CONTINUUM, *supra* note 17.

22. See NAT'L INST. OF HEALTH, NO. 98-4083, CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS: THE EVIDENCE REPORT 12-25 (Sept. 1998), http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf.

23. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1464-65 (2001) (discussing the total lack of a right to health care in the United States before the ACA in spite of international laws that recognize health care as a human right); Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUB. HEALTH 1156, 1156-57 (2005); John

benefits and a right to be free from discriminatory health care practices. Thus, both states and insurance companies might argue that the absence of universal medical weight-loss coverage is not an unfulfilled promise of the ACA. To support this argument, they might point to the fact that weight-loss treatments are not specifically enumerated in the Act as an essential health benefit and that the ACA's nondiscrimination provision does not prohibit weight-based discrimination.

But such a narrow reading of the Act ignores the realities of what it means to be obese and ignores other sweeping language within the statute. It ignores the fact that medical professionals—most notably the American Medical Association, the National Institutes of Health, and the Centers for Disease Control and Prevention—consider obesity a chronic disease, and chronic disease management is included on the list of the ACA's enumerated essential health benefits.²⁴ It ignores the fact that federal courts have held that obesity can be a disability, and the ACA explicitly bans disability discrimination in the provision of health care benefits and services.²⁵ Finally, it ignores the fact that obesity has a well-documented disparate impact on women, and the ACA bars sex discrimination.²⁶

As demonstrated by the previously mentioned examples above, many groups have been disappointed, thus far, by the seemingly broad protections of the ACA. The statutory language and federal case law appear to support these individuals, yet residents of some states still find themselves with insurance coverage that is discriminatory and lacks needed essential health benefits. This inequitable situation has arisen because HHS, the federal agency in charge of interpreting the ACA and issuing regulations, has yielded much of its authority to the states. Instead of drafting a uniform plan that enumerates, in detail, the minimum essential health benefits and practices required for compliance with the ACA, HHS has, instead, left this interpretation almost entirely to the states. Each state defines its own benchmark plan based on its own idea of what constitutes an essential health benefit and what is discriminatory under the ACA.²⁷ Sometimes states' inter-

Geyman, *Does the Affordable Care Act Guarantee Healthcare as a Right?* HUFFINGTON POST, (July 6, 2015, 7:43 PM), http://www.huffingtonpost.com/john-geyman/does-the-affordable-care_b_7740156.html (discussing the limitations of the ACA).

24. See *infra* notes 158–74 and accompanying text (discussing the characterization by “major players in the field”).

25. See *infra* notes 186–232 (discussing the ban and decisions in various circuit courts).

26. See *infra* notes 233–73 and accompanying text (discussing the history).

27. In defining a state benchmark plan, some states default to the largest insurance product in the small-group insurance market. See 45 C.F.R. § 156.100(c) (2013). Nonetheless, the default plan takes into account state regulatory requirements for insurance.

pretations of the ACA are reasonable in light of the statutory language and federal case law. And sometimes they are not. These inconsistencies lead to the gaps in insurance coverage previously described.²⁸

To demonstrate the inequity of the current situation, this Article considers, in detail, the case of obese individuals who are arguably the largest group affected by the inconsistencies and coverage gaps that result from allowing states to define their own benchmark plans in accordance with the Act. In Part II, the Article considers the rise in U.S. obesity rates, the nature of obesity as a chronic disease, and the importance of providing access to medical weight-loss treatments.²⁹ Part III reveals the realities of access to weight-loss treatment both before and after the implementation of the ACA.³⁰ Parts IV, V, and VI shift focus, demonstrating why the twenty-eight states that do not cover medical weight-loss treatments in their benchmark plans are in violation of the ACA. Specifically, Part IV argues that medical weight-loss treatment is an essential health benefit as defined by the Act and, thus, should be guaranteed coverage.³¹ Part V explains why failure to cover medical weight-loss treatment violates the ACA's ban on disability discrimination.³² Part VI explains why it also violates the ACA's ban on sex discrimination.³³ Part VII concludes by recommending that HHS draft a national benchmark plan to remedy the inequities in insurance coverage that have arisen from allowing states to define their own benchmark plans.³⁴ Without a uniform standard of coverage as defined by HHS, these coverage inequities will continue to impact not only obese individuals but also many other groups of underserved individuals.

II. OBESITY IN AMERICA: THE EPIC RISE OF A CHRONIC DISEASE

In 2011, a British medical journal, *The Lancet*, referred to the rising obesity rates across the world as a “pandemic.”³⁵ In the United States, the pandemic's global epicenter, obesity rates have tripled over the past two decades. For example, in 1991, only 12% of the U.S. population was obese, and, in 1990, no state had an obesity rate

28. See *supra* notes 9–22 and accompanying text.

29. See *infra* notes 35–106 and accompanying text.

30. See *infra* notes 107–47 and accompanying text.

31. See *infra* notes 148–74 and accompanying text.

32. See *infra* notes 175–232 and accompanying text.

33. See *infra* notes 233–73 and accompanying text.

34. See *infra* notes 274–86 and accompanying text.

35. Editorial, *Urgently Needed: A Framework Convention for Obesity Control*, 378 LANCET 741, 741 (2011).

greater than 15%.³⁶ By 1998, the nationwide obesity rate had dramatically increased to 17.9%, and thirty-seven states had obesity rates greater than 15%.³⁷ Only two years later, in 2000, the statewide obesity rates in twenty-three states exceeded 20%. By 2010, all states had an obesity rate greater than 20%, and twelve states had obesity rates greater than 30%.³⁸ According to the most recent data, one-third of the U.S. adult population is obese, and the nationwide obesity rate currently at 34.9%.³⁹ Given these rapid increases in obesity rates, it is not surprising that researchers commonly refer to this phenomenon as the “obesity pandemic” or the “obesity epidemic.”⁴⁰

Although the obesity epidemic has impacted all individuals living in the United States, its effects have been particularly severe for certain demographic groups. For instance, Asian- and Caucasian-Americans have below-average obesity rates, at 10.8% and 32.6%, respectively. Compare these numbers to the numbers for minority groups, such as Hispanic-Americans, whose current obesity rate is 42.5%, and, stunningly, almost one-half of African-Americans (47.8%) living in the United States are obese.⁴¹ Older individuals are more likely to be obese than their younger counterparts; the current obesity rate for U.S. adults over forty is 39.5% (compared to a 30.3% obesity rate for adults under forty).⁴² Finally, the effects of the obesity epidemic are also disproportionately felt by individuals of a lower socioeconomic status. Individuals with low-education and low-income levels have above average obesity rates.⁴³

Scientists and medical professionals generally agree that this precipitous rise in obesity rates over the past two decades has been detrimental to health in the United States. Health researchers have linked obesity to the development of functional limitations in performing

36. CTRS. FOR DISEASE CONTROL & PREVENTION, *OBESITY TRENDS AMONG U.S. ADULTS BETWEEN 1985 AND 2010* (2010), http://www.cdc.gov/obesity/downloads/obesity_trends_2010.pdf; Ali H. Mokdad et al., *The Spread of the Obesity Epidemic in the United States, 1991-1998*, 282 J. AM. MED. ASS'N 1519, 1520 (1999) (noting that in 1991, 12% of the U.S. population was obese and only four of the participating states had an obesity rate greater than 15%).

37. Mokdad, *supra* note 36, at 1520.

38. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 36.

39. Ogden et al., *supra* note 19, at 809.

40. See, e.g., Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, *The Obesity Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 22, 2011), <http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic.html>.

41. Ogden et al., *supra* note 19, at 811 tbl.4.

42. *Id.* at 813 tbl.6.

43. Charles L. Baum II & Christopher J. Ruhm, *Age, Socioeconomic Status and Obesity Growth*, 28 J. HEALTH ECON. 635, 636 (2009); Charles L. Baum II & Shin-Yi Chou, *The Socio-Economic Causes of Obesity 16-17* (Nat'l Bureau of Econ. Research, Working Paper No. 17423, 2011), <http://www.nber.org/papers/w17423>.

physical tasks—such as standing up from a chair, climbing stairs, getting into a car, running errands, dressing oneself, reaching for a five-pound object, gripping objects, and doing light chores.⁴⁴ Not only does obesity increase an individual's risk of developing musculoskeletal limitations, it also increases the risk of developing more serious diseases. It is widely known that obese individuals face an increased risk of type 2 diabetes, coronary heart disease, high blood pressure, and high cholesterol.⁴⁵ It is less well known that obesity also increases the risk of developing several types of cancer, including gastrointestinal, endometrial, and breast cancers.⁴⁶ Indeed, the health repercussions of obesity are so dire, and the rates of obesity are so high, that a 2013 study attributed 18% of all deaths of U.S. adults between ages forty and eighty-five to obesity.⁴⁷

The medical and scientific communities may concur on the negative effects of the obesity epidemic,⁴⁸ but their opinions are less consonant when it comes to the underlying causes of the epidemic. Section A briefly considers the varying theories for the underlying causes of the obesity epidemic, which leads into Section B's consideration of dieting—or, more specifically, why traditional diets have not worked for the majority of obese individuals.⁴⁹ Section C then evaluates the efficacy of common medical weight-loss treatment programs, demonstrating why the medical and scientific communities agree that medical weight-loss treatments provide the most effective means for obese individuals to lose weight, to keep the weight off in the long run, and to reduce the incidence of other medical conditions and complications that arise from their obesity.⁵⁰

44. See, e.g., Dawn E. Alley & Virginia W. Chang, *The Changing Relationship of Obesity and Disability, 1988–2004*, 298 J. AM. MED. ASS'N 2020, 2021 (2007); Kenneth F. Ferraro et al., *Body Mass Index and Disability in Adulthood: A 20-Year Panel Study*, 92 AM. J. PUB. HEALTH 834, 835 (2002); Andrea L. Hergenroeder et al., *The Influence of Body Mass Index on Self-Report and Performance-Based Measures of Physical Function in Adult Women*, CARDIOPULMONARY PHYSICAL THERAPY J., Sept. 2011, at 11, 13.

45. See, e.g., NAT'L INST. OF HEALTH, MANAGING OVERWEIGHT & OBESITY IN ADULTS: SYSTEMATIC EVIDENCE REVIEW FROM THE OBESITY EXPERT PANEL 1–4 (2013), <http://www.nhlbi.nih.gov/sites/www.nhlbi.nih.gov/files/obesity-evidence-review.pdf>.

46. See Krishnan Bhaskaran et al., *Body-Mass Index and Risk of 22 Specific Cancers: A Population-Based Study of 5.24 Million UK Adults*, 384 LANCET 755, 760–61 (2014).

47. Ryan K. Masters et al., *The Impact of Obesity on US Mortality Levels: The Importance of Age and Cohort Factors in Population Estimates*, 103 AM. J. PUB. HEALTH 1895, 1900 (2013).

48. See *infra* notes 51–66 and accompanying text (discussing theories of the driving forces behind obesity in the United States).

49. See *infra* notes 51–79 and accompanying text.

50. See *infra* notes 80–106 and accompanying text.

A. *War of Words: Theories Behind the Rise in U.S. Obesity Rates*

From medicine to molecular biology, economics to epidemiology, political science to psychology, obesity researchers currently span a vast array of academic disciplines. Perhaps it is not surprising then that these researchers have developed a myriad of theories to explain the rapid increase in obesity rates, given their vastly different research approaches. Popular theories among academics rely on the underlying, widely accepted assumption that weight is solely determined by balancing caloric intake with caloric expenditure.⁵¹

Calorie expenditure theories often emphasize the increase in sedentary behavior among U.S. adults, due to the rise of desk jobs,⁵² increased commuting times,⁵³ and a shift toward less active leisure activities.⁵⁴ Other theories focus on changes in caloric intake rather than calories expended. The most popular theories center on changes in food prices, claiming that U.S. residents have increased their caloric intake over the last few decades⁵⁵ due to the relative decrease in the price of all food⁵⁶ or due to the relative increase in the price of healthy food.⁵⁷ More provocative theories point to the decreased presence of women in the home, leading to the decline of home cooking and family meals.⁵⁸

51. Accord Mayo Clinic Staff, *Counting Calories: Get Back to Weight-Loss Basics*, MAYO CLINIC (Apr. 11, 2015), <http://www.mayoclinic.org/healthy-lifestyle/weight-loss/in-depth/calories/art-20048065> (advising readers that “weight management still comes down to the calories you take in versus those you burn off”).

52. See, e.g., Timothy S. Church et al., *Trends over 5 Decades in U.S. Occupation-Related Physical Activity and Their Associations with Obesity*, PLOS ONE, May 25, 2011, at 1, 4, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019657>.

53. See, e.g., Christine M. Hoehner et al., *Commuting Distance, Cardiorespiratory Fitness, and Metabolic Risk*, 42 AM. J. PREVENTATIVE MED. 571, 574 (2012).

54. Accord Barbara A. Dennison et al., *Television Viewing and Television in Bedroom Associated with Overweight Risk Among Low-Income Preschool Children*, 109 PEDIATRICS 1028, 1032–34 (2002).

55. Recent evidence suggests that individuals living in the United States are beginning to decrease their caloric consumption for the first time in decades. See Margot Sanger-Katz, *Behind a Drop in Calories, A Shift in Cultural Attitudes*, N.Y. TIMES, July 28, 2015, at A3.

56. See Sturm & Hattori, *supra* note 20, at 342–44.

57. See, e.g., Pablo Monsivais & Adam Drewnowski, *The Rising Cost of Low-Energy-Density Foods*, 107 J. AM. DIETETIC ASS'N 2071, 2073–75 (2007); Pablo Monsivais & Adam Drewnowski, *Lower-Energy-Density Diets Are Associated with Higher Monetary Costs per Kilocalorie and Are Consumed by Women of Higher Socioeconomic Status*, 109 J. AM. DIETETIC ASS'N 814, 818 (2009); Mayuree Rao et al., *Do Healthier Foods and Diet Patterns Cost More than Less Healthy Options? A Systematic Review and Meta-Analysis*, BMJ OPEN, Dec. 2013, at 1, 10–12, <http://bmjopen.bmj.com/content/3/12/e004277.full?sid=F40b344f-ef24-4a2d-9c09-59516f35fetc>.

58. Accord MARY EBERSTADT, HOME-ALONE AMERICA: THE HIDDEN TOLL OF DAY CARE, BEHAVIORAL DRUGS, AND OTHER PARENT SUBSTITUTES 39–40 (2004).

Hypotheses to explain the obesity epidemic have arisen outside of academia as well, often tracing their origins to journalists and bestselling books from the popular press. For example, a *New York Times* food columnist, Mark Bittman, has led a very public crusade against processed food and big food companies, blaming them for the country's weight woes.⁵⁹ Other authors have traced the United States' weight problems to the rise of specifically added ingredients in the U.S. food supply: William R. Davis's *Wheat Belly*,⁶⁰ Joseph Mercola's *Sweet Deception* (artificial sweeteners),⁶¹ Michael Moss's *Salt Sugar Fat*,⁶² and Michael Pollman's *The Omnivore's Dilemma* (corn)⁶³ all immediately come to mind. Some of these popular theories have gained traction in the academic world,⁶⁴ whereas others have not.⁶⁵

In sum, researchers have identified many potential contributors to the sharp rise in obesity rates over the last few decades, but they have not yet been able to tease out their relative importance. Perhaps one obesity researcher described the academic consensus best, noting: "There is no one single factor [that causes obesity], but the deck is stacked toward excessive weight gain in our society with the access to high calorie food and engaging sedentary activities in every direction"⁶⁶ Regardless of their preferred theory behind the rise in obesity rates, researchers all seem to be pointing their fingers to outside factors beyond the control of obese individuals, such as changes in envi-

59. See Mark Bittman, Opinion, *Let's Make Food Issues Real*, N.Y. TIMES, May 6, 2015, <http://www.nytimes.com/2015/05/06/opinion/lets-make-food-issues-real.html>; Mark Bittman, *Parasites, Killing Their Host*, N.Y. TIMES, June 18, 2014, at A27; Mark Bittman, *What Causes Weight Gain*, N.Y. TIMES, June 11, 2014, at A23.

60. WILLIAM DAVIS, *WHEAT BELLY: LOSE THE WHEAT, LOSE THE WEIGHT, AND FIND YOUR PATH BACK TO HEALTH* 55–60 (2011).

61. JOSEPH MERCOLA, *SWEET DECEPTION: WHY SPLENDA®, NUTRASWEET®, AND THE FDA MAY BE HAZARDOUS TO YOUR HEALTH* 14–17 (2006).

62. MICHAEL MOSS, *SALT SUGAR FAT: HOW THE FOOD GIANTS HOOKED US* 267–71 (2013).

63. MICHAEL POLLAN, *THE OMNIVORE'S DILEMMA: A NATURAL HISTORY OF FOUR MEALS* 100–08 (2006).

64. See, e.g., Adam Drewnowski, *The Real Contribution of Added Sugars and Fats to Obesity*, 29 EPIDEMIOLOGICAL REV. 160 (2007); Joseph Suez et al., *Artificial Sweeteners Induce Glucose Intolerance by Altering the Gut Microbiota*, 514 NATURE 181 (2014).

65. See, e.g., Jessica R. Biesiekierski et al., *No Effects of Gluten in Patients with Self-Reported Non-Celiac Gluten Sensitivity After Dietary Reduction of Fermentable, Poorly Absorbed, Short-Chain Carbohydrates*, 145 GASTROENTEROLOGY 320 (2013) (finding no positive effects of a gluten-free diet when other known digestive irritants are removed from the diet); Pablo Monsivais et al., *Sugars and Satiety: Does the Type of Sweetener Make a Difference?* 86 AM. J. CLINICAL NUTRITION 116 (2007) (finding no difference in satiety or consumption outcomes when high-fructose corn syrup is consumed versus sugar).

66. Marjorie Connelly, *More Children Are Obese, and More Americans Know It*, N.Y. TIMES, May 13, 2003, <http://www.nytimes.com/2003/05/13/health/more-children-are-obese-and-more-americans-know-it.html> (quoting Dr. Nancy F. Krebs, Chairwoman, American Academy of Pediatrics' Committee on Nutrition).

ronment, business practices, lifestyle, and food supply—they do not seem to be placing much blame on obese individuals for gaining weight.

B. *The Diet Myth*

Although researchers have been careful not to assign all blame for the obesity epidemic on obese individuals themselves, U.S. public opinion is not so forgiving. For example, a 2005 U.S. survey found that 65% of U.S. residents believed that obese people lacked personal willpower, and 62% of respondents thought that obesity was solely the result of an individual's choice to consume unhealthy food.⁶⁷ And, even as obesity becomes more common—affecting an increasingly large percentage of the population—the individual blame appears to be getting stronger. A 2013 U.S. survey asked respondents to categorize food manufacturers, grocery stores, restaurants, government policies, farmers, individuals, and parents as primarily responsible, somewhat responsible, or not responsible for the obesity epidemic. Eighty percent of respondents blamed individuals as primarily responsible for the nationwide rise in obesity rates; 59% of the respondents also primarily blamed parents.⁶⁸ In contrast, only one-half of respondents ascribed any blame to government policies, and less than one-half placed any blame on farmers or grocery stores.⁶⁹

Popular opinion's assignment of most (if not all) blame on individuals unsurprisingly translates into the popular belief that if an obese person wants to lose weight, the remedy is simple: eat less and exercise more. Yet, obesity researchers increasingly agree that the “problem is not really so simple and uncomplicated as it is pictured.”⁷⁰ A 2014 article in the *Journal of the American Medical Association* summarized the research indicating that “[a]ttempts to lower body weight without addressing the biological drivers of weight gain, including the quality of the diet, will inevitably fail for most individuals.”⁷¹ Indeed, approximately 90–95% of individuals who successfully lose weight on

67. J. Eric Oliver & Taeku Lee, *Public Opinion and the Politics of Obesity in America*, 30 J. HEALTH POL. POL'Y & L. 923, 933 (2005).

68. Jayson L. Lusk & Brenna Ellison, *Who Is To Blame for the Rise in Obesity?*, 68 APPETITE 14, 17, 18 fig.2 (2013).

69. For comparison, 35% of U.S. residents classified food manufacturers as primarily to blame for the obesity epidemic and only 20% classified restaurants as primarily to blame. *Id.*

70. David S. Ludwig & Mark I. Friedman, *Increasing Adiposity: Consequence or Cause of Overeating*, 311 J. AM. MED. ASS'N 2167, 2167 (2014) (quoting *What Causes Obesity?*, 83 J. AM. MED. ASS'N 1003, 1003 (1924)); accord Gary Taubes, *The Science of Obesity: What Do We Really Know About What Makes Us Fat?*, BMY, Apr. 16, 2013, at 1.

71. Ludwig & Friedman, *supra* note 70, at 2167.

a diet will regain the weight within several years.⁷² Even the *Handbook of Obesity*, a research guide written by leading scientists and practitioners, intended to provide “up-to-date coverage of the range of subjects that make up the field of obesity research[,]”⁷³ famously concluded that the long-run results of traditional diets that encourage restricting calories and increasing exercise are “poor and not long-lasting.”⁷⁴

Researchers generally agree that whatever is impeding the long-run success of diets is likely biological in origin, although the exact mechanism remains a source of debate. Some researchers emphasize the nutritional content of most food consumed in the United States, hypothesizing that its nature leads to the buildup of fat within the human body.⁷⁵ Many researchers, however, ascribe to a version of the set-point theory. First advanced by psychologist Richard Nisbett in 1972, this theory emphasizes that every individual has a natural weight, or set point, toward which they gravitate.⁷⁶ Thus, even if an individual successfully loses weight in the short run, in the long run, the individual will naturally return to her set point. The theory has been further bolstered by endocrinology research, which has identified neurological pathways that lead individuals to return to their initial weight regardless of whether their initial weight was above or below normal.⁷⁷

Still, because a few decades is too short of a time period for any kind of evolutionary change in people’s set points, some biologists have explained the obesity epidemic with an addendum to the set-point theory. Instead of natural weight being completely predetermined, many biologists now believe that natural weight is determined

72. Susan C. Wooley & David M. Garner, *Controversies in Management: Dietary Treatments for Obesity Are Ineffective*, 309 *BMJ* 655, 655 (1994).

73. LUDWIG & FRIEDMAN, *HANDBOOK OF OBESITY*, at iii (George A. Bray et al. eds., 1998).

74. See Luc F. Van Gaal, *Dietary Treatment of Obesity*, in *HANDBOOK OF OBESITY*, *supra* note 73, at 875, 876 (“Losing weight is relatively easy, but the maintenance of weight loss may be more distressing . . .”).

75. See, e.g., Ludwig & Friedman, *supra* note 70; Taubes, *supra* note 70, at 3.

76. Richard E. Nisbett, *Hunger, Obesity, and the Ventromedial Hypothalamus*, 79 *PSYCHOL. REV.* 433, 435 (1972). See, for example, Rudolph L. Leibel et al., *Changes in Energy Expenditure Resulting from Altered Body Weight*, 332 *N. ENG. J. MED.* 621, 627 (1995); James A. Levine et al., *Non-Exercise Activity Thermogenesis: The Crouching Tiger Hidden Dragon of Societal Weight Gain*, 26 *ARTERIOSCLER. THROMB. & VAS. BIOL.* 729, 732–35 (2006); and E. A. H. Sims et al., *Endocrine and Metabolic Effects of Experimental Obesity in Man*, 29 *RECENT PROGRESS HORMONE RES.* 457, 463–65 (1973), for more recent laboratory experiments supporting the existence of a biological set point.

77. Roger D. Cone, one leading researcher in this area, identified neurological pathways that contribute to energy homeostasis—in this case, the return to original weight. See Roger D. Cone, *The Central Melanocortin System and Energy Homeostasis*, 10 *TRENDS ENDOCRIN. & METABOLISM* 211, 214–15 (1999).

by the interaction between genes and the environment. Genes determine a person's predisposition toward being heavy; environment determines just how heavy the person becomes.⁷⁸ As one literature review noted: "Genes do not necessarily make people fat[,] but they do make certain people more predisposed to being heavy if environmental conditions are correct."⁷⁹

In general, the scientific and medical research is quite pessimistic regarding the ability of obese individuals to achieve long-term weight loss through traditional dieting methods. Certainly, examples exist of obese individuals who have been able to lose weight and successfully maintain the weight loss without much, or any, rebound. But, the examples are rare. For most obese individuals, another form of treatment is required to achieve sustained, meaningful weight loss. The most popular alternative forms of treatment—and, indeed, the only other existing forms of weight-loss treatment that have been proven effective by scientific studies—are medical in nature and administered under the care of a physician. The next Section examines both the nature and the comparative efficacy of these medical weight-loss treatments.

C. *Medical Weight-Loss Treatment Alternatives*

Physicians currently prescribe two types of weight-loss treatments to obese patients: weight-loss pharmaceuticals and weight-loss surgery. This Section separately considers each method of treatment and compares their methodologies, benefits, risks, efficacies, and costs. Unlike traditional diets, the scientific studies are much more optimistic regarding the ability of obese patients to achieve long-term weight loss using these medical weight-loss options. The increased efficacy, however, comes at a cost, making these treatments out of reach for many individuals whose insurance plans refuse to cover them.

1. *Pharmaceutical Treatments*

The first option for obese individuals seeking weight-loss treatment from a physician is taking a pill. Currently, five prescription weight-loss pills have Federal Drug Administration (FDA) approval in the United States: orlistat, lorcaserin, phentermine-topiramate, naltrex-

78. See ROBERT POOL, *FAT: FIGHTING THE OBESITY EPIDEMIC* 153–55, 167–68 (2001) and ELLEN RUPPEL SHELL, *THE HUNGRY GENE: THE INSIDE STORY OF THE OBESITY INDUSTRY* 170–172 (2002), for reviews of this literature.

79. J. ERIC OLIVER, *FAT POLITICS: THE REAL STORY BEHIND AMERICA'S OBESITY EPIDEMIC* 104 (2006).

one-bupropion, and liraglutide.⁸⁰ Orlistat prevents fat absorption into the body, while the other four drugs target neurological processes that suppress appetite.⁸¹

None of these pills are so-called magic pills; patients on these medications cannot eat whatever they want while being completely inactive and still expect to lose weight. Instead, physicians view the pills as “an adjunct to comprehensive lifestyle management”⁸²—allowing patients who make the commitment to decrease their food intake and increase their activity levels to lose weight in the long-run. The pills also come with adverse side effects. In addition to blocking fat from absorbing into the body, orlistat can prevent good nutrients, such as fat-soluble vitamins, from absorbing.⁸³ All of the medications are (perhaps not surprisingly) associated with negative gastrointestinal symptoms. And, none of the medications are safe for pregnant women.⁸⁴

Current medical guidelines recommend pharmacotherapy for three categories of patients: (1) obese patients (i.e., patients with a BMI = 30); (2) overweight patients with a BMI = 27 and an obesity-related complication, such as type 2 diabetes or sleep apnea; and (3) overweight patients who have been unable to achieve long-term weight loss through lifestyle management alone.⁸⁵ For these patients, the effects of weight-loss drugs are long-term, albeit modest. The drugs are associated with a mean weight loss between four and ten kilograms (approximately nine to twenty-two pounds).⁸⁶ This weight loss is meaningful for patients with BMIs in the high twenties and low thirties for whom twenty pounds can make the difference between being obese and overweight or overweight and normal weight. This weight loss can also make a meaningful difference in the development and treatment of related conditions, such as type 2 diabetes.⁸⁷ Losing twenty pounds is less significant.

Yet given the high costs in the absence of insurance coverage, even the best candidates for pharmaceutical weight-loss treatment may be unable to access this treatment. Orlistat, for example, costs between

80. Caroline M. Apovian et al., *Challenging Obesity: Patient, Provider, and Expert Perspectives on the Roles of Available and Emerging Nonsurgical Therapies*, 23 *OBESITY* S1, S12 (Supp. 2015). However, there are other drugs with the primary purpose of treating another condition (e.g., diabetes) but also can induce a secondary weight-loss effect.

81. *See id.* at S14.

82. *Id.* at S12.

83. *Id.* at S14.

84. *Id.* at S15 tbl.7, S16 tbl.8.

85. *Id.* at S12.

86. *See* George A. Bray & Donna H. Ryan, *Update on Obesity Pharmacotherapy*, 1311 *ANNUALS N.Y. ACAD. SCI.* 1, 2–7 (2014).

87. *See* NAT'L INST. OF HEALTH, *supra* note 45, at 18–19.

\$5.50 and \$6.00 per pill—meaning that a 30-day supply will cost a patient without insurance coverage over \$150 every month. Similarly, one dose of phentermine-topiramate costs approximately \$7.00, running a noncovered patient \$200 every month.⁸⁸ Moreover, these drugs, are intended for long-term use, so even if \$200 is occasionally feasible for a patient, \$2,400 a year in drug expenses may be cost prohibitive. Concerns regarding treatment costs become particularly salient given the composition of the patient population. Recall from the introduction to Part I that obesity disproportionately affects individuals with low income, individuals with low education, and individuals who identify as a minority.⁸⁹

2. *Surgical Treatments*

The second, undoubtedly more drastic, option for obese individuals seeking weight-loss treatment from a physician is surgery. Known as bariatric surgery, several methods of bariatric surgery are currently practiced in the United States to help patients lose weight. These methods include gastric band surgery, gastric bypass surgery, vertical sleeve gastrectomy, and (less commonly) biliopancreatic diversion with a duodenal switch.⁹⁰ Gastric band surgery inserts a saline-filled band around the upper stomach, which reduces the opening for future food intake.⁹¹ A vertical sleeve gastrectomy removes 85% of the stomach to limit future food intake.⁹² Gastric bypass surgery, the most common type of bariatric surgery,⁹³ even more drastically reduces the size of the stomach and reroutes its exit to the middle of the small intestine to limit the future absorption of calories.⁹⁴ Duodenal switch surgery is similar to gastric bypass surgery, although it involves more complex intestinal rerouting, which even more severely restricts the future absorption of calories.⁹⁵

88. Drug price estimates come from drugs.com and are accurate as of March 30, 2016. Orlistat, commonly sold under the label Xenical, costs \$166.55 for thirty capsules. Phentermine-topiramate, commonly sold under the label Qsymia, costs between \$196.61 and \$217.22 for thirty capsules (depending on the dosage).

89. See *supra* notes 41–43 and accompanying text.

90. U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L INST. OF DIABETES & DIGESTIVE & KIDNEY DISEASES, NO. 08-4006, BARIATRIC SURGERY FOR SEVERE OBESITY (June 2011) [hereinafter NIH BARIATRIC SURGERY], http://www.niddk.nih.gov/health-information/health-topics/weight-control/bariatric-surgery-severe-obesity/Documents/Bariatric_Surgery_508.pdf.

91. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, METABOLIC AND BARIATRIC SURGERY 2 (2013), <http://asmbs.org/wp/uploads/2014/05/Metabolic+Bariatric-Surgery.pdf>.

92. *Id.*

93. Approximately 80% of bariatric surgery patients have a gastric bypass. See Ted D. Adams et al., *Long-Term Mortality After Gastric Bypass Surgery*, 357 N. ENG. J. MED. 753, 754 (2007).

94. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, *supra* note 91, at 2.

95. See NIH BARIATRIC SURGERY, *supra* note 90, at 4.

Although bariatric surgery is not a magic cure for obesity, it may be closer than pills. To succeed, patients must commit to decreasing their food intake over the long run; these surgeries simply make that commitment easier. Predictably, the potential negative side effects are also more grave than the side effects of pharmacotherapy or dieting. Complications, such as infections, may occur after any bariatric surgery, although the complication rate is only 4.3%.⁹⁶ Other long-term health effects include problems with malabsorption and development of hernias,⁹⁷ but, again, the overall patient mortality rate remains at 0.1%.⁹⁸

Current medical guidelines recommend bariatric surgery only for: (1) morbidly obese patients (i.e., individuals with a BMI = 40) and (2) obese patients with an obesity-related complication and a BMI = 35.⁹⁹ For these patients, the overall efficacy is remarkable, particularly when compared to the null effects produced by dieting and the small effects produced by pharmacotherapy. Within the first year after surgery, an average gastric bypass patient will lose more than 75% of her excess body weight and will generally maintain at least two-thirds of the surgery-induced weight loss in the long run.¹⁰⁰ Compared to obese patients who use weight-loss drugs, bariatric surgery patients lose, on average, forty-six to sixty-eight pounds more weight.¹⁰¹

Bariatric surgery also has pronounced, positive effects on the patients' weight-related conditions and mortality. Over three-quarters of patients see their diabetes, hypertension, high cholesterol, and sleep apnea either improve or completely dissipate after surgery.¹⁰² And, these effects add up—according to a 2007 *New England Journal of Medicine* study, morbidly obese individuals who had undergone a gastric bypass had a 40% lower mortality rate than similar individuals

96. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, *supra* note 91, at 1 (citing Longitudinal Assessment of Bariatric Surgery (LABS) Consortium, *Perioperative Safety in the Longitudinal Assessment of Bariatric Surgery*, 361 N. ENG. J. MED. 445, 450 (2009)).

97. See NIH BARIATRIC SURGERY, *supra* note 90, at 4–5.

98. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, *supra* note 91, at 1 (citing Yafu Zhao, M.S. & William Encinosa, Ph.D., *Bariatric Surgery Utilization and Outcomes in 1998 and 2004*, *Statistical Brief #23*, AGENCY FOR HEALTHCARE RES. & QUALITY (AHRQ) (Jan. 2007), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb23.jsp>).

99. Note that gastric band surgery is only FDA-approved for obese patients with an obesity-related complication and a BMI \geq 35. See NIH BARIATRIC SURGERY, *supra* note 90, at 1.

100. See Alan C. Wittgrove & G. Wesley Clark, *Laparoscopic Gastric Bypass, Roux-En-Y—500 Patients: Technique and Results, with 3-60 Month Follow-up*, 10 OBESITY SURGERY 233, 235 fig.2, tbl.1 (2000).

101. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, *supra* note 91, at 1.

102. See Viktoria L. Gloy et al., *Bariatric Surgery Versus Non-Surgical Treatment for Obesity: A Systematic Review and Meta-Analysis of Randomised Controlled Trials*, 347 BMJ (2014), <http://www.bmj.com/content/347/bmj.f5934>.

who had not undergone the bypass. The overall mortality rate reduction was largely driven by postoperative declines in the incidence and severity of type 2 diabetes, coronary artery disease, and cancer.¹⁰³

The medical research consistently indicates that bariatric surgery can meaningfully improve both the quality and the duration of morbidly obese individuals' lives. It is not a miracle, yet it offers the possibility of significant, sustainable weight loss and improvement in obesity-related conditions that even weight-loss pharmaceuticals cannot rival. Still, as much as costs impede access to pharmaceutical weight-loss treatment, costs impose an even greater barrier to weight-loss surgery. Few Americans can afford bariatric surgery in the absence of insurance coverage. According to the American Society of Metabolic and Bariatric Surgery (ASMBS), the procedures costs between \$11,500 and \$26,000¹⁰⁴—the price of a new car. Moreover, given that morbidly obese individuals are, on the whole, of a lower-income patient population, these extraordinary costs make the procedure out of reach for many individuals who desire the treatment.¹⁰⁵

The strong empirical evidence that bariatric surgery and weight-loss pharmaceuticals can improve health outcomes for obese patients in a way that dieting cannot—juxtaposed with other, arguably less significant treatments that insurance plans normally cover (the drug Viagra immediately comes to mind)—raises the question: Why do some insurance plans *not* cover these medical weight-loss treatments? Even though the cost of surgery is tremendous, research studies indicate that insurers will recoup their cost outlays within two to four years, due to the reduction in health care costs associated with weight loss.¹⁰⁶

Even though two to four years seem like a relatively short waiting period to recoup costs, from an insurance company's perspective, it is worrisomely long. Because insurance contracts are annually renewed, insurance companies are concerned that covered individuals will change providers within this two-to-four-year period after surgery. (Covered individuals may not change by choice. For instance, so many U.S. employees receive their health insurance through their employer, their employer may elect to change insurance providers shortly after surgery). Thus, insurers are concerned that their com-

103. See Adams et al., *supra* note 93, at 756.

104. See AM. SOC'Y FOR METABOLIC & BARIATRIC SURGERY, *supra* note 91, at 3; see also Leon Salem et al., *Are Bariatric Surgical Outcomes Worth Their Cost? A Systematic Review*, 200 J. AM. COLL. SURGEONS 270, 271 (2005) (estimating the cost effectiveness of surgery).

105. See *supra* notes 41–43.

106. Pierre-Yves Crémieux et al., *A Study on the Economic Impact of Bariatric Surgery*, 14 AM. J. MANAGED CARE 589, 589, 592, 594 (2008).

pany will pay for the surgery, but another insurance company will reap all of the benefits.

In many ways, the coverage issue presents a common collective action problem in which all insurance providers would be better off in the long run if they all covered bariatric surgery, but they might be harmed if some insurers decide to shirk and decline to provide coverage. This reasoning provided a sufficient justification for the insurance companies to decline covering medical weight-loss treatments—that is, until the passage of the ACA changed the rules.

III. HEALTH INSURANCE ROADBLOCKS TO WEIGHT-LOSS TREATMENT

Part II of this Article explored both why obesity rates have risen over the last few decades and why physicians recommend medical weight-loss treatments to so many of their obese patients.¹⁰⁷ This Part shifts focus, examining why so many obese individuals who wish to comply with their physicians' recommendations are unable to access the necessary care in spite of presently applicable federal statutory protections.¹⁰⁸

The precise number of obese individuals who wish to receive medical weight-loss treatment but are unable to receive the treatment due to cost constraints is unknown. But, the numbers that are known are quite telling. According to the ASMBS, approximately 18 million patients in the United States are currently eligible for bariatric surgery. Yet, only 160,000 patients underwent the procedure in 2013.¹⁰⁹ Moreover, the annual number of patients undergoing bariatric surgery has remained very similar over the past decade despite the fact that obesity rates (and, thus, the eligible patient population) have continued to rise.¹¹⁰

Anecdotal evidence tells the story behind these numbers. Physicians recount numerous stories of patients who desired medical weight-loss treatment but could not afford it. Indeed, the problem is so widespread that the Associated Press posted an article in 2014 proclaiming: "Few eligible patients can get weight-loss surgery."¹¹¹ The problem is that weight-loss treatment coverage has traditionally re-

107. See *supra* notes 35–106 and accompanying text.

108. See *infra* notes 109–47 and accompanying text.

109. Associated Press, *Few Eligible Patients Can Get Weight-Loss Surgery*, FOX NEWS (Feb. 14, 2014), <http://www.foxnews.com/health/2014/02/14/few-eligible-patients-can-get-weight-loss-surgery/>.

110. *Id.*

111. *Id.*

quired the purchase of a special insurance rider—it has not been part of a standard insurance policy.¹¹² Of course, most health insurance is purchased by employers not individuals,¹¹³ and nearly two-thirds of employers elect not to spend the money on the additional coverage.¹¹⁴

Compounding the pervasive lack of insurance coverage is the fact that the procedure can still be cost-prohibitive for the few individuals who are covered. Insurance riders often only pay for 50% of the cost of weight-loss treatment, so even after help from insurance, bariatric surgery patients may, nonetheless, be stuck with a \$10,000 bill.¹¹⁵ Finally, denials of coverage are frequent. Before covering weight-loss treatments, insurance companies require much more extensive documentation than mere proof that an individual is obese. Common requirements include: documentation of obesity for a five-year period, a year of psychological counseling, a year of supervised dieting, and proof of prior, failed attempts to lose weight without medical treatment.¹¹⁶ Insurance companies are notoriously strict with these requirements because many patients will give up due to frustration and the inability to complete the necessary requirements. According to one bariatric surgeon, the number of doctor's appointments needed to qualify for insurance coverage of bariatric surgery leads "[h]alf of the people I see [to] drop out because they can't commit to time away from their jobs."¹¹⁷

Historically, obese employees who desired medical weight-loss treatment but were barred from accessing this treatment due to cost did not have any legal recourse. Currently in the United States, there is no federally mandated right to all physician-prescribed health care.¹¹⁸ In fact, prior to the ACA, the only people who had a right to health care, regardless of their ability to pay, were patients requiring emergency care. The Emergency Medical Treatment and Active La-

112. See PAM DAVIS, WHAT TO DO WHEN YOU'RE DENIED (BARIATRIC)WEIGHT-LOSS SURGERY, <http://www.obesityaction.org/wp-content/uploads/Bariatric-Surgery-Denial.pdf>.

113. See *Number of Americans Obtaining Health Insurance Through an Employer Declines Steadily Since 2000*, ROBERT WOOD JOHNSON FOUND. (Apr. 11, 2013), <http://www.rwjf.org/en/library/articles-and-news/2013/04/number-of-americans-obtaining-health-insurance-through-an-employ.html>. Certainly, the importance of employer-provided health plans may diminish in the post-ACA regime.

114. See Associated Press, *supra* note 109.

115. See *id.*

116. See DAVIS, *supra* note 112, at 3; Associated Press, *supra* note 109.

117. See Associated Press, *supra* note 109 (quoting Dr. Carson Liu, bariatric surgeon).

118. See Geyman, *supra* note 23. But see Rebecca E. Zietlow, *Democratic Constitutionalism and the Affordable Care Act*, 72 OHIO ST. L.J. 1367, 1388–89 (2011) (arguing that the ACA “recognizes a fundamental right to health care in the United States” but acknowledging that there are weaknesses in the argument).

bor Act¹¹⁹ requires all hospitals that accept Medicare to determine whether individuals presenting themselves for emergency treatment actually require said treatments, and, if so, to provide these individuals with sufficient treatment to stabilize their condition.¹²⁰ The federal government also provides extensive health insurance benefits to the poor,¹²¹ elderly,¹²² and veterans,¹²³ but even these programs do not guarantee a right to all physician-prescribed health care. With the exception of these limited carve-outs, health care guarantees have been virtually nonexistent in the United States—until the implementation of the ACA.

Although the ACA does not establish a right to all physician-prescribed health care, it professes to make substantial progress toward this goal. Two key provisions of the ACA are critical to this progression. First, the ACA's nondiscrimination provision, 42 U.S.C. § 18116, guarantees the following:

an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.¹²⁴

In simpler terms, the ACA's nondiscrimination provision prohibits discrimination in health care provisions and health care coverage on the basis of race, color, or national origin (prohibited by Title VI), sex (prohibited by Title IX), age, or disability (prohibited by the Rehabilitation Act, 29 U.S.C. § 794). By its plain language, the prohibition extends to essentially all entities in the health care domain because it would be difficult to find a health care provider, hospital, insurer, or insurance exchange that does *not* receive federal funds. Nonetheless, the provision recognizes that the realities of implementation might require the HHS Secretary to issue regulations.¹²⁵

119. See Pub. L. No. 99-272, § 9121, 100 Stat. 164, 164–67 (codified as amended at 42 U.S.C. § 1395dd (2012)).

120. 42 U.S.C. § 1395dd.

121. *Id.* § 1396(b)(2)(B).

122. See *id.* § 1395.

123. See 38 U.S.C. §§ 1701–54 (2012).

124. 42 U.S.C. § 18116(a) (citations omitted).

125. *Id.* § 18116(c).

Second, the ACA requires health insurance plans to provide, at a minimum, an “essential health benefits package.”¹²⁶ Section 18022(b)(1) mandates that the essential package contain:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventative and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.¹²⁷

The statute defers to (and, indeed, requires) the HHS Secretary to precisely define what treatments fall within the scope of these ten categories; however, the statute does offer the Secretary interpretive guidance in 42 U.S.C. § 18022(b)(4). Among its directives are requirements that the Secretary “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life”¹²⁸ and “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.”¹²⁹

In the face of these directives, the obvious course of action for HHS would have been to devise its own list of treatments that would be required for insurance plans to comply with the ACA. Instead, HHS punted; rather than exercise its direct authority to determine what kinds of treatments and health care practices were essential and non-discriminatory, HHS yielded its authority to the states. In its final regulations, HHS merely restates the ten categories of essential health benefits without elaboration.¹³⁰ It then directed the individual states to select a “base-benchmark plan”—a plan that, in the state’s opinion, meets the essential health benefit and nondiscrimination require-

126. *Id.* § 18021(a)(1)(B).

127. *Id.* § 18022(b)(1).

128. *Id.* § 18022(b)(4)(B).

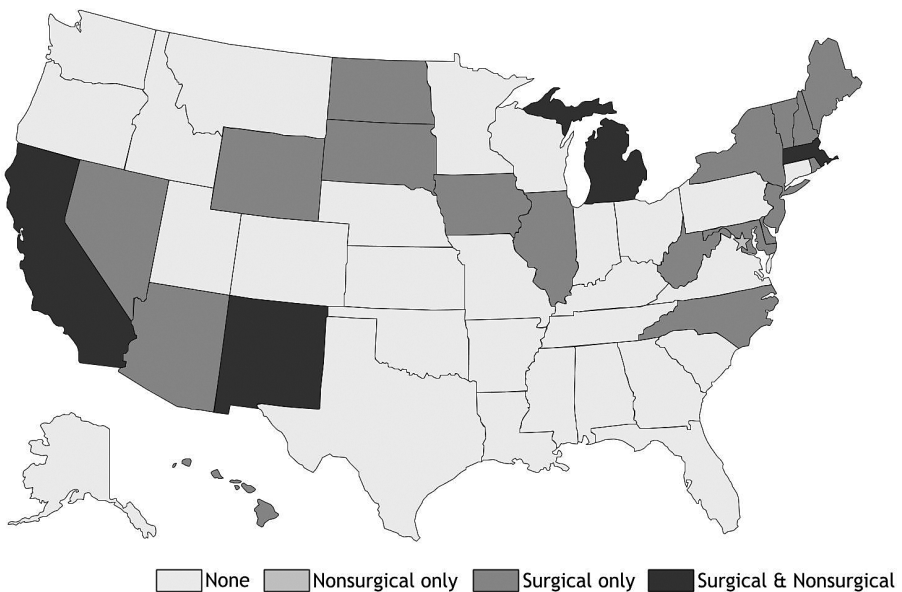
129. *Id.* § 18022(b)(4)(C).

130. *See* 45 C.F.R. § 156.110(a) (2014).

ments.¹³¹ Once selected, this plan sets the minimum requirements for plans offered through the state insurance health exchanges. The state benchmark also becomes the guidepost for other insurance plans offered throughout the state, even for those not offered through the insurance health exchange.¹³²

The practical results of HHS's punting its authority to the states are inconsistency and uncertainty. Conditions considered to be an essential health benefit in one state may not be covered in the state next door. Although some regional trends are apparent (Southern states, for example, have been noticeably stingy in their determination of essential health benefits), the inconsistencies are not always regional in nature.¹³³ Figure 1, which compares the state-by-state determination of whether medical weight-loss treatment constitutes an essential health benefit under the ACA, illustrates this point.

FIGURE 1. COVERAGE OF MEDICAL WEIGHT LOSS TREATMENTS IN STATE BENCHMARK PLANS¹³⁴



131. *Id.* § 156.100. If a state fails to select a base-benchmark plan, the default benchmark plan is the largest plan in the small-group insurance market, which takes into account state regulatory requirements regarding mandatory coverage of specific health conditions. *See id.* § 156.100(c).

132. *See id.* §§ 156.100–.110.

133. *See OBESITY CARE CONTINUUM, supra* note 17.

134. This figure was originally developed by the Obesity Care Continuum for its 2014 report. *See id.*

Figure 1 demonstrates that in some areas of the country, moving over the border can make a tremendous difference in access to weight-loss treatments. For instance, Chicago-area residents who choose to live in a Northwest Indiana suburb are far more likely to face access problems to medical weight-loss treatment than are residents who live in Illinois. The Illinois state benchmark plan covers bariatric surgery, which means that insured individuals throughout the state enjoy this coverage as a core benefit.¹³⁵ In contrast, the Indiana benchmark plan, covers nothing related to weight loss.¹³⁶ The state-by-state discrepancies are even more pronounced in the Washington D.C. metropolitan area. Residents of D.C. enjoy coverage of nonsurgical weight-loss programs as a core benefit,¹³⁷ but residents of Maryland are only covered for surgical weight-loss programs.¹³⁸ Residents of Virginia, on the other hand, are not covered for any medical weight-loss treatments through the state benchmark plan.¹³⁹

The state-by-state determinations regarding medical weight-loss treatments necessarily related to the proportion of the state's population that is obese. True, medical weight-loss treatments are generally not part of the state benchmark plans in the southern states, which is the region where obesity rates are highest.¹⁴⁰ At first glance, this pattern may lead observers to suspect that states may be interpreting the meaning of an essential health benefit (at least with respect to medical weight-loss treatment) purely based on cost concerns.¹⁴¹ Yet many states with an obesity rate over 30% cover at least one form of medical weight-loss treatment in their benchmark plans—including Delaware, Iowa, Michigan, North Dakota, and West Virginia.¹⁴² In fact,

135. The only insured individuals who will not be covered for bariatric surgery are those who qualify for and have elected to purchase catastrophic coverage. *CTRS. FOR MEDICARE & MEDICAID SERS., ILLINOIS EHB BENCHMARK PLAN*, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/illinois-ehb-benchmark-plan.pdf>. Only individuals under age thirty and individuals with a “hardship exemption” (usually related to the inability to pay) are eligible for catastrophic coverage. See *Catastrophic Health Plans*, *OBAMACARE FACTS*, <http://obamacarefacts.com/health-insurance/catastrophic-plans/> (last visited Jan. 14, 2016).

136. See *OBESITY CARE CONTINUUM*, *supra* note 17.

137. See *id.*

138. See *id.*

139. See *id.*

140. See generally *OBESITY CARE CONTINUUM*, *supra* note 17 (showing availability of surgery); *Data, Trends and Maps*, *CTRS. FOR DISEASE CONTROL & PREVENTION*, <http://www.cdc.gov/obesity/data/prevalence-maps.html> (last visited Feb. 19, 2016) (depicting self-reported obesity).

141. States with high obesity rates might be concerned about the costliness of covering weight-loss treatment in the benchmark plan when such a large percentage of their population is already obese.

142. See *OBESITY CARE CONTINUUM*, *supra* note 17; *Data, Trends and Maps*, *supra* note 140.

West Virginia, has the highest obesity rate in the nation (35.7%)¹⁴³ and, nonetheless, provides coverage for bariatric surgery in its benchmark plan.¹⁴⁴ Stingy benchmark plans in the South more likely derive from general political animosity toward the ACA rather than cost concerns or legitimate differences in interpretation of the federal statutory language.¹⁴⁵

Regardless of states' underlying motivations, they have arrived at very different interpretations of which treatments are required by the ACA as Figure 1 makes clear. The result, at least for obese individuals, is a patchwork of incongruous interpretations of what is compulsory for state benchmark plans, resulting in inconsistent insurance coverage for medical weight-loss treatment across the states. Currently, twenty-two states include bariatric surgery as a core benefit in their benchmark plans, and only five states (plus Washington D.C.) include nonsurgical weight-loss treatments as a core benefit.¹⁴⁶ Twenty-eight states provide nothing, even though at least one-fifth (and often a much greater proportion) of their populations are obese.¹⁴⁷ The next three Parts explain why the twenty-eight states that presently deny coverage for any type of medical weight-loss treatment in their benchmark plans are in violation of the ACA's statutory provisions and closely examine the language and relevant case law associated with the Act's relevant statutory provisions.

IV. UNFULFILLED PROMISES OF ESSENTIAL HEALTH BENEFITS

Part III explained the origin of state-by-state discrepancies in medical weight-loss coverage, yet it raises a powerful follow-up question: Which states have it right?¹⁴⁸ Are the states that fail to cover medical weight-loss treatments in their benchmark plans in violation of the ACA? Or, are the states that provide coverage for these treatments going beyond the statutory requirements of the Act? Part IV takes up

143. *Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory*, CTRS. FOR DISEASE CONTROL & PREVENTION (2014), <http://www.cdc.gov/obesity/data/table-adults.html>

144. OBESITY CARE CONTINUUM, *supra* note 17.

145. For popular discussions of the political opposition to the ACA in Southern states, see Glen Browder, *Exploring Southern States' Opposition to Obamacare*, HUFFINGTON POST, http://www.huffingtonpost.com/glen-browder/obamacare-opposition-southern-states_b_5050813.html (last updated May 28, 2014, 5:59 AM); and Sarah Varney, *How Obamacare Went South in Mississippi*, ATLANTIC (Nov. 4, 2014), <http://www.theatlantic.com/health/archive/2014/11/how-obamacare-went-south-in-mississippi/382313/>.

146. OBESITY CARE CONTINUUM, *supra* note 17.

147. Colorado has the lowest statewide obesity rate at 21.3%. See *Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory*, *supra* note 143.

148. See *supra* notes 109–47.

this question by specifically examining the ACA's guarantee of essential health benefit coverage under 42 U.S.C. § 18022.¹⁴⁹

Section 18022(b)(1)(I) mandates insurance coverage of “[p]reventative and wellness services and chronic disease management.”¹⁵⁰ Consequently, if obesity is properly characterized as a “chronic disease,” then the ACA requires health plans to cover some form of treatment to manage it. But, is obesity properly characterized as a chronic disease or as something else? The most logical way of answering this question would be to look to the definition of “chronic disease” within the ACA and then use this definition to decide whether obesity fits within the statutory definition. The problem is that Congress never defined “chronic disease” within the statute.¹⁵¹ The omission of this key definition is particularly notable because Title IV of the Act is dedicated entirely to the “prevention of chronic disease and improving public health.”¹⁵²

In the years since the ACA's passage, HHS has not filled in this statutory gap by promulgating a rule that defines this term. As a result, defining “chronic disease” requires turning elsewhere. When Congress fails to define a key term within a statute, courts generally look to the term's “ordinary meaning.”¹⁵³ One of the first places that courts look to determine the ordinary meaning of a term is the dictionary.¹⁵⁴ The *Oxford English Dictionary* defines a disease as a “condition of the body” or “a departure from the state of health”;¹⁵⁵ it defines chronic disease as a disease that is “[l]asting a long time, long-continued, lingering, inveterate.”¹⁵⁶ Given the scientific research documenting obesity's role in the development of musculoskeletal conditions, sleep apnea, diabetes, heart disease, and even cancer, it is easy to argue that obesity (particularly severe or morbid obesity) represents a departure from the state of health. In other words, obesity is a disease. Moreover, recalling the scientific research discussed in Section II.A—which consistently, but pessimistically, concluded that as many as 95% of obese individuals who tried to achieve long-term

149. *See infra* 150–72.

150. 42 U.S.C. § 18022(b)(1)(I) (2012).

151. A definition of the term “chronic disease” is noticeably absent from all of the definition sections within (or referenced by) the ACA, including §§ 18024, 18111, and 300gg-91.

152. Pub. L. No. 111-148, § 4001–4402, 124 Stat. 538, 538–588.

153. *See, e.g., Taniguchi v. Kan Pac. Saipan, Ltd.*, 132 S. Ct. 1997, 2002 (2012) (citing *Asgrow Seed Co. v. Winterboer*, 513 U.S. 179, 187 (1995)) (“When terms used in a statute are undefined, we give them their ordinary meaning.”).

154. *See id.* at 2002.

155. *Disease*, OXFORD ENGLISH DICTIONARY (online ed. 2015).

156. *Chronic Disease*, OXFORD ENGLISH DICTIONARY (online ed. 2015).

weight loss without medical help would fail¹⁵⁷—it is easy to argue that obesity is a disease that is long continued, lingering, and inveterate. In other words, obesity is a chronic disease.

And, in fact, the major players in the medical field agree with this characterization of obesity as a chronic disease. In 2013, the American Medical Association (AMA) formally adopted a policy “recogniz[ing] obesity as a disease requiring a range of medical interventions to advance obesity treatment and prevention.”¹⁵⁸ Other medical organizations that have characterized obesity as a chronic disease include the National Institutes of Health (NIH),¹⁵⁹ the Centers for Disease Control and Prevention (CDC),¹⁶⁰ the World Health Organization,¹⁶¹ and the American Heart Association.¹⁶² The NIH and CDC’s characterizations are particularly noteworthy because both agencies are divisions of HHS, the umbrella agency in charge of issuing regulations on the ACA.

The dictionary definition of chronic disease, the characterization within the medical profession, and the usage within HHS all point to the same conclusion: obesity is a chronic disease. As mentioned, 42 U.S.C. § 18022(b)(1)(I) mandates that health plans cover management of chronic diseases, yet obesity treatments are noticeably absent from the list of covered treatments in the benchmark plans of twenty-eight states.¹⁶³ By wholly excluding all medical weight-loss treatments from their benchmark plans, these states have ignored the ordinary meaning of the term chronic disease and, thus, have failed to provide

157. See, e.g., Wooley & Garner, *supra* note 72.

158. *AMA Adopts New Policies on Second Day of Voting at Annual Meeting*, AM. MED. ASS’N (June 18, 2013), <http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-18-new-ama-policies-annual-meeting.page>.

159. See, e.g., *Genetic Influence in the Development of Overweight and Obesity, Guidelines on Overweight an Obesity*, NAT’L HEART, LUNG & BLOOD INST. (1998) http://www.nhlbi.nih.gov/guidelines/obesity/e_txtbk/ratnl/25.htm (describing obesity as “a complex multifactorial chronic disease”).

160. *Chronic Diseases: The Leading Causes of Death and Disability in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 18, 2015), <http://www.cdc.gov/chronicdisease/overview/> (characterizing obesity as a chronic disease that is one of the leading causes of death in the United States).

161. See *Controlling the Global Obesity Epidemic*, WORLD HEALTH ORG. (2003), <http://www.who.int/nutrition/topics/obesity/en/> (noting that “obesity is predominantly a ‘social and environmental disease’”); see also *FAO/WHO Launch Expert Report on Diet, Nutrition, and Prevention of Chronic Diseases*, WORLD HEALTH ORG. (Apr. 23, 2003), <http://www.who.int/mediacentre/news/releases/2003/pr32/en/> (characterizing obesity as well as cardiovascular disease, cancer, and diabetes as “chronic diseases”).

162. *Treating Obesity as a Disease*, AM. HEART ASS’N. (Aug. 18, 2015), http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/Obesity/Treating-Obesity-as-a-Disease_UCM_459557_Article.jsp.

163. OBESITY CARE CONTINUUM, *supra* note 17.

their citizens with all of the essential health benefits guaranteed by the ACA.

Of course, some might contest that obesity is not properly characterized as a disease because, arguably, not all obese individuals are unhealthy. The “Health at Every Size” movement abounds with anecdotal evidence of obese individuals who eat healthy, regularly work out regularly, and have low cholesterol.¹⁶⁴ Nevertheless, the data discussed in Section I.A indicate that these individuals are the exception not the rule. Moreover, to the extent that obesity causes other chronic diseases, medical weight-loss treatment can have profound effects on the management of these related diseases. A meta-analysis in the *Journal of the American Medical Association* concluded that after bariatric surgery, 76.8% of obese patients with type 2 diabetes saw their diabetes completely go into remission; another 11.2% saw improvement in their diabetes. And, no one genuinely objects to diabetes being labeled as a chronic disease.¹⁶⁵

Still, others might argue that obesity is not properly characterized as a disease because it is self-inflicted. Proponents of this blame-the-patient argument might contest that society should not reward (and the government should not subsidize treatment coverage for) a condition that results from a lack of self-control. There are several problems with this argument. One problem is that, as discussed in Section II.A, researchers are still uncertain about the precise causes of obesity, but they generally agree that obesity is, in some part, the result of changing environmental and social (i.e., not wholly individual) factors.¹⁶⁶ Yet, even if it were true that an individual becomes obese purely because she lacks self-control, Section II.B illustrates that obesity has a profound biological effect on the body, so even if a person wants to lose weight, it becomes nearly impossible to do so.¹⁶⁷ Finally, this argument ignores the fact that the ACA explicitly covers treatment of other self-inflicted diseases. No one seriously disputes coverage of lung cancer and liver cancer treatments, even though these diseases are common results of smoking and excessive drinking.¹⁶⁸ The argu-

164. See generally LINDA BACON, *HEALTH AT EVERY SIZE* (2008) (arguing that death by fat is a myth); LINDA BACON & LUCY APHRAMOR, *BODY RESPECT: WHAT CONVENTIONAL HEALTH BOOKS GET WRONG, LEAVE OUT, AND JUST PLAIN FAIL TO UNDERSTAND ABOUT WEIGHT 13–17* (2014) (noting that overweight people are shown to live longer than people who are “normal”).

165. See Henry Buchwald et al., *Bariatric Surgery: A Systematic Review and Meta-Analysis*, 292 *J. AM. MED. ASS'N* 1724, 1724, 1729 (2004).

166. See *supra* notes 51–66 and accompanying text.

167. See *supra* notes 67–79 and accompanying text.

168. See *Liver Cancer*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/livercancer.html> (lasted updated Nov. 20, 2015) (“Risk factors for primary liver cancer include . . . [h]eavy alcohol

ment also ignores the language of § 18022(b)(1)(E), which explicitly guarantees coverage of “substance use disorder services, including behavioral health treatment” as an essential health benefit in insurance plans.

The exclusion of obesity treatment from state benchmark plans becomes particularly discordant with the plain language of 42 U.S.C. § 18022 after considering the interpretive guidance that Congress provides the Secretary of HHS in §§ 18022(b)(4)(B)–(D).¹⁶⁹ In “defining the essential health benefits[,]” Congress directed HHS to “take into account the health care needs of diverse segments of the population, including women, children, [and] persons with disabilities.”¹⁷⁰ The statutory language further directed HHS “not to make coverage decisions . . . or design benefits in ways that discriminate against individuals because of their . . . disability.”¹⁷¹ Additionally, HHS is directed to “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of . . . the individuals’ present or predicted disability.”¹⁷² If obesity is properly characterized as a disability, then failure to cover medical treatments for obesity goes against the interpretive guidance provided in § 18022(b)(4). Similarly, if obesity has a particularly negative impact on a referenced, special-status group, such as women, then, again, the failure to cover medical weight-loss treatments appears out of alignment with the interpretive guidance. Part V takes up the issue of obesity and disability,¹⁷³ and Part VI focuses on obesity and women.¹⁷⁴

V. UNFULFILLED PROMISES OF DISABILITY NONDISCRIMINATION

One of the ACA’s core guarantees is that individuals will enjoy insurance coverage for essential health benefits, including chronic disease management. Part IV demonstrated how obese individuals are being denied this core guarantee in the states that do not cover medical weight-loss treatments in their benchmark plans.¹⁷⁵ This Part turns to examine another core guarantee of the ACA, nondiscrimination and, in particular, the implications of the core guarantee of disability

use.”); *Lung Cancer–Patient Version*, NAT’L CANCER INST., <http://www.cancer.gov/types/lung> (last visited Jan. 19, 2016) (“Tobacco smoking is the most common cause of lung cancer.”).

169. See 42 U.S.C. §§ 18022(b)(4)(B)–(D) (2012).

170. *Id.* § 18022(b)(4)(C).

171. *Id.* § 18022(b)(4)(B).

172. *Id.* § 18022(b)(4)(D).

173. See *infra* notes 175–232 and accompanying text.

174. See *infra* notes 233–73 and accompanying text.

175. See *supra* notes 148–74 and accompanying text.

nondiscrimination for state benchmark plans that deny coverage of medical weight-loss treatments for obese individuals.¹⁷⁶

Recall from Part III that 42 U.S.C. § 18116(a) protects individuals from being “excluded from participation in, . . . denied the benefits of, or . . . subjected to discrimination” in “any health program or activity.”¹⁷⁷ In 2013, HHS issued a request for information regarding discrimination in healthcare, indicating their intent to issue a proposed rule interpreting Section 18116.¹⁷⁸ The agency received over 150 comments, many of which asked the agency to clarify whether certain groups would be specifically protected and what it meant for a health plan to discriminate.¹⁷⁹ The resulting rule that HHS proposed is relatively unhelpful in answering any of these questions because it merely provides: “An issuer does not provide EHB [essential health benefits] if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”¹⁸⁰ Consequently, courts and state policy makers have little more to guide them than the plain language of § 18116 when attempting to comply with this section of the Act.

Fortunately, the plain language of § 18116 is more instructive than it may appear on its face. Instead of explicitly listing each protected class under the ACA, Congress listed a series of civil rights acts.¹⁸¹ By referencing these acts, Congress clarified that any type of discrimination made illegal by the listed acts would also be illegal under the ACA. Congress thus incorporated the meaning of discrimination from other statutes—as derived by legislation, court decisions, and regulations—into the ACA. As a result, to determine whether a specific health care practice constitutes discrimination under the ACA, courts and policy makers must evaluate whether the practice would

176. See *infra* notes 177–232 and accompanying text.

177. 42 U.S.C. § 18116(a).

178. Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities, 78 Fed. Reg. 46,558, 46,559–60 (proposed Aug. 1, 2013) (to be codified at 45 C.F.R. § 156.125 (A) (2013)).

179. See Nondiscrimination in Health Programs or Activities, REGULATIONS.GOV, <http://www.regulations.gov/#!docketDetail;D=HHS-OCR-2013-0007> (last visited Apr. 3, 2106) (162 comments received); see, e.g., ADAM KARPATI, N.Y.C. DEP’T HEALTH & MENTAL HYGIENE, HHS REQUEST FOR INFORMATION (RFI) REGARDING NONDISCRIMINATION IN CERTAIN HEALTH PROGRAMS OR ACTIVITIES (Sept. 26, 2013); SUSAN PILCH, NAT’L CMTY. PHARMACISTS ASS’N, 1557 REQUEST FOR INFORMATION—RIN 0945-AA02—NONDISCRIMINATION IN CERTAIN HEALTH PROGRAMS OF ACTIVITIES (Sept. 30, 2013).

180. 45 C.F.R. § 156.125(a).

181. 42 U.S.C. § 18116(a).

constitute discrimination in the context of any one of the listed civil rights acts.

With regard to obesity, the most obvious type of discrimination that might be implicated by the ACA's nondiscrimination provision is disability discrimination. Section 18116 prohibits disability discrimination through its reference to a provision of the Rehabilitation Act of 1973 (Rehabilitation Act).¹⁸² That section provides:

No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.¹⁸³

The ACA's reference to 29 U.S.C. § 794 implies that any condition that is considered a disability under § 794 will also be a disability for the purposes of § 18116. The Rehabilitation Act defines what it means to be disabled in the same manner as the Americans with Disabilities Act of 1990 (ADA),¹⁸⁴ which provides:

The term "disability" means, with respect to an individual—

- (A) a physical or mental impairment that substantially limits one or more major life activities of such individual;
- (B) a record of such an impairment; or
- (C) being regarded as having such an impairment¹⁸⁵

Thus, any individual who meets this definition of disability under the ADA and the Rehabilitation Act will also, by incorporation, meet the definition of disability under 42 U.S.C. § 18116. Congress did not explicitly list conditions that qualified as disabilities under these acts but, rather, elected to take a more flexible approach in defining what it means to be disabled under federal law. Accordingly, determining whether obesity is a disability for purposes of the ACA requires examining how courts and federal agencies have viewed disability claims by obese individuals under the ADA and the Rehabilitation Act. The next Section takes up this precise task.

182. *Id.*

183. *Id.* See generally Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794(a) (2012)).

184. See 29 U.S.C. § 705(20)(B) ("[T]he term 'individual with a disability' means, for purposes of . . . subchapter[] . . . V [which contains § 794] . . . , any person who has a disability as defined in section 12102 of title 42."). See generally Americans with Disabilities Act of 1990, Pub. L. No. 101-336, § 3, 104 Stat. 327, 330 (codified as amended at 42 U.S.C. § 12102(1) (2012)).

185. 42 U.S.C. § 12102(1).

A. *The Meaning of Disability Discrimination Under Federal Law*

As obesity rates have risen in the United States, so has the amount of litigation over whether obesity is a disability for purposes of the ADA and Rehabilitation Act. The early federal court and agency decisions on this issue largely answered this question in the negative, but recent Congressional amendments have caused them to reverse course. The first published case addressing the issue of obesity as a disability came in 1993 from the U.S. Court of Appeals for the First Circuit: *Cook v. Department of Mental Health, Retardation & Hospitals*.¹⁸⁶ In *Cook*, the court upheld a jury award of \$100,000 to a job applicant after the Rhode Island Department of Mental Health refused to rehire the plaintiff, Bonnie Cook, as an institutional attendant because she was morbidly obese.¹⁸⁷ Cook, who had always been morbidly obese, had previously held this position twice, voluntarily leaving both times with an exemplary employment record.¹⁸⁸ In reaching its decision, the First Circuit placed particular importance on the fact that Cook's obesity arose from an underlying physiological condition. The court emphasized the evidence presented at trial indicating that Cook would have to deal with a dysfunctional metabolism for the rest of her life no matter how much weight she lost.¹⁸⁹ Cook could not "simply lose weight and rid herself of any concomitant disability";¹⁹⁰ therefore, the jury appropriately concluded that Cook was disabled for purposes of the ADA.

The First Circuit appeared to have opened the door for coverage of obese employees in *Cook*, but other federal courts did nothing but close this door in the years immediately following. U.S. Courts of Appeals for the Second, Sixth, and Eleventh Circuits all distinguished or disagreed with *Cook* over the course of the next decade. For example, in *Andrews*,¹⁹¹ the Sixth Circuit found that Ohio State Highway Patrol officers who failed to meet the weight limits set by the Highway Patrol Fitness Program were not disabled for purposes of the ADA.¹⁹² In reaching this decision, the court asserted that "a mere physical characteristic does not, without more, equal a physiological disorder" and concluded that holding otherwise "would . . . debase [the] high purpose [of] the statutory protections available to those truly handi-

186. 10 F.3d 17, 23 (1st Cir. 1993).

187. *Id.* at 20–21, 28.

188. *Id.* at 20.

189. *Id.* at 24.

190. *Id.* at 23.

191. 104 F.3d 803 (6th Cir. 1997).

192. *Id.* at 810.

capped.”¹⁹³ To distinguish its holding from *Cook*, the court pointed out that the *Cook* plaintiff had presented expert testimony that her morbid obesity arose from a physiological impairment of her metabolism.¹⁹⁴ Nine years later, in *EEOC v. Watkins Motor Lines, Inc.*, the Sixth Circuit reaffirmed the *Andrews* decision.¹⁹⁵

The Second and Eleventh Circuits were also less generous to obese plaintiffs in their early decisions. In *Francis v. City of Meriden*,¹⁹⁶ the Second Circuit declined to recognize that a firefighter, who failed to meet the department weight standard and refused to take a body fat or fitness test, was disabled for purposes of the ADA.¹⁹⁷ The Second Circuit agreed with the Sixth Circuit that physical characteristics that do not arise from a physiological condition were not impairments under the statute.¹⁹⁸ In *Greenberg v. Bellsouth Telecommunications, Inc.*,¹⁹⁹ which was brought by an obese telephone lineman who suffered from additional physiological conditions—including diabetes, hypertension, and hypothyroidism—did not end well for the plaintiff.²⁰⁰ In *Greenberg*, the Eleventh Circuit held that the plaintiff was not disabled for purposes of the ADA because, in spite of the evidence demonstrating his poor health, the plaintiff failed to demonstrate that he was “unable to work in a broad class of jobs.”²⁰¹

Yet, these unfavorable federal court rulings largely reversed course in 2008. In that year, Congress passed the ADA Amendments Act of 2008 (ADAAA)²⁰² in response to the restrictive decisions that federal courts had been making with regard to all plaintiffs claiming a disability under the acts (not just obese plaintiffs).²⁰³ The ADAAA clarified

193. *Id.* (alterations in original) (quoting *Forrisi v. Bowen*, 794 F.2d 931, 934 (4th Cir. 1986)).

194. *Id.* at 809 (citing *Cook*, 10 F.3d 17).

195. 463 F.3d 436 (6th Cir. 2006). The court held that “to constitute an ADA impairment, a person’s obesity, even morbid obesity, must be the result of a physiological condition.” *Id.* at 443.

196. 129 F.3d 281 (2d Cir. 1997).

197. *Id.* at 282–83, 87.

198. *Id.* at 285.

199. 498 F.3d 1258 (11th Cir. 2007).

200. *Id.* at 1259–60, 1265.

201. *Id.* at 1264 (quoting *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 491 (1991)).

202. Pub. L. No. 110-325, 122 Stat. 3553 (codified as amended in scattered sections of 42 U.S.C.).

203. In passing the ADAAA, Congress specifically reversed four restrictive and very influential U.S. Supreme Court decisions from the turn of the millennium. *See id.* §§ 2(b)(4)–(5). The first three decisions, nicknamed the “*Sutton* trilogy,” consisted of *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555 (1999), *Murphy v. United Parcel Service, Inc.*, 527 U.S. 516 (1999), and *Sutton v. United Air Lines*, 527 U.S. 471 (1999). Decided together on June 22, 1999, the three cases severely limited the definition of disability under the original version of the ADA by holding that an individual was not disabled if corrective measures could ameliorate the individual’s condition. *See Albertson’s*, 527 U.S. at 565; *Murphy*, 527 U.S. at 517–21; *Sutton*, 527 U.S. at

Congress's intent that the ADA (and, by incorporation, the Rehabilitation Act) would encompass a broad range of health conditions. Along these lines, the ADAAA expressly instructed federal courts to construe the definition of disability in these acts "in favor of broad coverage of individuals under this chapter, to the maximum extent permitted."²⁰⁴

Congress's instructions have markedly impacted the ADA and Rehabilitation Act decisions of federal courts over the past six years. In *Lowe v. American Eurocopter, LLC*,²⁰⁵ a Mississippi district court denied summary judgment to an employer who argued that obesity could never be a disability for purposes of the ADA, concluding: "Based on the substantial expansion of the ADA by the ADAAA, Defendant's assertion that Plaintiff's weight cannot be considered a disability is misplaced."²⁰⁶ Another district court in Louisiana similarly found that a plaintiff's obesity was a disability because it substantially limited her breathing, which was a major life activity.²⁰⁷ Moreover, a recent case from a Missouri district court also agreed that obesity claims under the ADA will fare much better in the post-ADAAA regime.²⁰⁸ The district court in *Whittaker v. America's Car Mart, Inc.* agreed that the pre-ADAAA case law, which required "obesity . . . [to be] related to an underlying physiological disorder or condition [This requirement was] based on the more restrictive approach that was applied before Congress passed the [ADAAA]."²⁰⁹

Similar to federal courts, the Equal Employment Opportunity Commission (EEOC), the agency charged with enforcing the ADA and Rehabilitation Act, has reversed course on the issue of obesity. The

582–831. The fourth case, *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, decided in 2002, even more severely limited the definition of disability under the original ADA by holding that "the central inquiry must be whether the claimant is unable to perform the variety of tasks central to most people's daily lives, not whether the claimant is unable to perform the tasks associated with her specific job." 534 U.S. 184, 200–01 (2002). According to this decision, a plaintiff would not be disabled for purposes of the ADA—even if her impairment substantially limited her ability to do her job—unless her impairment also substantially limited her ability to function in daily life.

204. 42 U.S.C. § 12102(4)(1)(A) (2012).

205. No. 1:10CV24-A-D, 2010 WL 5232523 (N.D. Miss. Dec. 16, 2010).

206. *Id.* at *8.

207. *Melson v. Chetofield*, No. 08-3683, 2009 WL 537457, at *3 (E.D. La. Mar. 4, 2009). In spite of the district court's finding that the plaintiff was disabled for the purposes of the ADA, the court ultimately dismissed the plaintiff's case for failure to state a claim because she failed to demonstrate in her pleading that she had either experienced an adverse employment action or endured a hostile work environment due to her disability. *Id.* at *6–7.

208. *Whittaker v. Am.'s Car Mart, Inc.*, No. 1:13CV108 SNLJ, 2014 WL 1648816, at *2 (E.D. Mo. Apr. 24, 2014).

209. *Id.*

agency's prior guidance stated that obesity would only be a covered disability under the ADA in "rare circumstances."²¹⁰ However, the current guidance has no mention of this language.²¹¹ The EEOC's definition of severe obesity roughly equates to the medical definition of morbid obesity (a BMI of forty or more).

In addition to revising its compliance guidelines, the EEOC has also filed two successful ADA lawsuits involving morbidly obese plaintiffs following the passage of the ADAAA. In September 2010, the EEOC filed its first obesity-related public interest suit, *EEOC v. Resources for Human Development, Inc.*²¹² The plaintiff, Lisa Harrison, who was morbidly obese, had been terminated from her job at a New Orleans residential treatment facility despite an excellent performance record.²¹³ In contrast to the pre-ADAAA decisions, here, the district court denied the employer's motion for summary judgment, finding that Harrison's "severe obesity . . . [was] clearly an impairment."²¹⁴ Before the case could go to trial, Harrison's employer settled with the EEOC for \$125,000.²¹⁵

The EEOC filed its second public interest suit, *EEOC v. BAE Systems, Inc.*,²¹⁶ in September 2011. The case arose after a Houston employer, BAE Systems, terminated a morbidly obese employee, Ronald Kratz, because of his weight.²¹⁷ Although Kratz weighed approximately 450 pounds at hiring and 680 pounds at termination, Kratz was

210. Appendix to Part 1630—Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. § 1630 app. § 1630.2(j) (2003).

211. See Appendix to Part 1630—Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. § 1630 app. § 1630.2(j) (2013).

212. 827 F. Supp. 2d 688 (E.D. La. 2011).

213. *Id.* at 690. The plaintiff in this case weighed over 400 pounds at the time of her hiring and weighed 527 pounds at the time of her termination. *Id.*

214. *Id.* at 694. Reflecting the sea change since Congress enacted the ADAAA, the court explicitly held that the EEOC did not need to prove the underlying physiological basis of the plaintiff's obesity in order to gain the protection of the ADA. *Id.*

215. Press Release, U.S. Equal Emp't Opportunity Comm'n, Resources for Human Development Settles EEOC Disability Suit for \$125,000 (Apr. 10, 2012), <http://www.eeoc.gov/eeoc/newsroom/release/4-10-12a.cfm>.

216. No. 4:11-cv-03497 (S.D. Tex., Sept. 27, 2011); Press Release, U.S. Equal Emp't Opportunity Comm'n, BAE Systems Subsidiary To Pay \$55,000 To Settle EEOC Disability Discrimination Suit (July 24, 2012), http://s3.amazonaws.com/fcmd/documents/documents/000/002/698/original/bae-systems-kratz_july-2012-update_eeocpr.pdf?1423021272.

217. L.M. Sixel, *Feds Sue Company for Firing 600-Pound Worker*, HOUSTON CHRON., <http://www.chron.com/default/article/Feds-sue-company-for-firing-600-pound-worker-2191655.php> (last updated Sept. 28, 2011, 12:29 AM); L.M. Sixel, *Fired Obese Worker Will Get \$55,000*, HOUSTON CHRON. [hereinafter Sixel, *Fired Worker*], <http://www.chron.com/default/article/Fired-obese-worker-will-get-55-000-3732044.php> (last updated July 25, 2012, 9:03 AM); L.M. Sixel, *Man Fired at 680 Pounds Says Weight Didn't Hurt His Work*, HOUSTON CHRON., <http://www.chron.com/default/article/Man-fired-at-680-pounds-says-weight-didn-t-hurt-2193407.php> (last updated Sept. 29, 2011, 12:10 AM).

able to perform the essential functions of his job throughout his employment. Before the district court could rule on any motions (but after the favorable *Resources for Human Development* decision and settlement), BAE Systems settled the suit with the EEOC for \$55,000.²¹⁸

In sum, although some courts were initially hesitant to recognize obesity as a disability for purposes of the ADA and the Rehabilitation Act, that hesitance is waning in the years since the passage of the ADAAA—at least for morbidly obese individuals. Indeed, it is easy to see how obesity, particularly in its most severe form, fits within the statutory definition. As discussed in Part II, obesity often leads to the development of musculoskeletal conditions, sleep apnea, diabetes, heart disease, and other diseases.²¹⁹ To the extent that obesity (or a secondary condition caused by obesity) substantially interferes with major life activities, such as walking, standing, breathing, or sleeping, obesity clearly falls within the statutory definition of disability under 42 U.S.C. § 12102(1)(A).

Even when obesity does not interfere with major life activities, obesity easily falls under the “regarded as” substantially limited definition in 42 U.S.C. § 12102(1)(C).²²⁰ Recall the EEOC case of Ronald Kratz, for example, in which Kratz was terminated because of his weight despite the fact that he could perform the essential functions of his job. Although he was not substantially limited in a major life activity, his employer regarded him as substantially limited, which qualified Kratz as disabled for purposes of the ADA and Rehabilitation Act.²²¹ In the post-ADAAA regime, morbidly obese individuals, as well as obese individuals who have developed a secondary condition caused by their weight, can make a strong case that they are disabled under federal disability law.

B. Denial of Coverage as a Form of Disability Discrimination

Of course, more is required than proving the existence of a disability to allege a violation of the ACA. Under 42 U.S.C. § 18116, alleging this type of violation requires proof that an individual was: (1) “excluded from participation in, . . . denied the benefits of, or . . . subjected to discrimination under[] any health program or activity; or

218. Sixel, *Fired Worker*, *supra* note 217.

219. See *supra* notes 44–47 and accompanying text.

220. See 42 U.S.C. § 12102(1)(C) (2012).

221. See *supra* notes 217–218 and accompanying text (discussing the details of the EEOC’s lawsuit).

excluded (2) “on the ground” of disability.²²² As mentioned in Section A, HHS’s proposed rule on nondiscrimination does not provide any guidance on what it means for a health plan to exclude, deny benefits to, or discriminate against an individual.²²³ Nonetheless, in November 2014, HHS released a Notice of Benefit and Payment Parameters for 2016, which provided some insight behind the proposed rules. Within its commentary on §156.125, HHS made the following warning to insurers:

We also caution issuers to avoid discouraging enrollment of individuals with chronic health needs. For example, if an issuer refuses to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, we believe that, absent an appropriate reason for such refusal, such a plan design effectively discriminates against, or discourages enrollment by, individuals who would benefit from such innovative therapeutic options. As another example, if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions.²²⁴

This language clarifies the agency’s understanding that discrimination under the ACA includes any action taken by the states, or insurers, that will tend to “discourage enrollment by” individuals with “chronic health needs” or individuals who are a member of another protected group.²²⁵ Actions by insurers that tend to discourage enrollment by these individuals include refusal to cover “effective . . . innovative therapeutic options” and “plac[ing] . . . all drugs that treat a specific condition on the highest cost tiers.”²²⁶ Meanwhile, obese individuals in twenty-eight states face treatment by insurers that is much worse than HHS’s examples. For them, the problem is not that insurers refuse to cover the most innovative therapies or that they offer only limited coverage of drugs that treat obesity, the problem is that insurers refuse to cover any therapies at all.

To the extent that states and insurers might try to offer an “appropriate reason”²²⁷ for refusing to cover medical weight-loss treatments for obese individuals, they might complain that treatment coverage

222. 42 U.S.C. § 18116.

223. See *supra* notes 186–218 and accompanying text.

224. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,674, 70,723 (proposed Nov. 26, 2014) (to be codified in scattered parts of 45 C.F.R.).

225. *Id.*

226. *Id.*

227. *Id.*

costs will be unsustainable, particularly in states with high obesity rates. But this argument loses credibility after considering that two of the states with the highest obesity rates in the nation, Michigan and West Virginia, cover medical weight-loss treatments in their state benchmark plans. The argument is even harder to justify given the research demonstrating the cost savings that insurers enjoy after an obese patient completes medical weight-loss treatment due to an overall improvement in the patient's health.²²⁸

After reading HHS's guidance on nondiscrimination, it is difficult to draw any other conclusion but the following: denial of medical weight-loss treatment is impermissibly discriminatory under the ACA. HHS's examples regarding denial of treatment for chronic health needs speak directly to the issues faced by many obese individuals. Nonetheless, even ignoring the agency's guidance, a denial of medical weight-loss treatment still appears to directly conflict with the ACA's statutory language. Section 18116 of the ACA prohibits health plans from "den[ying] . . . benefits" to individuals "on the ground" of disability as that term is defined within the Rehabilitation Act.²²⁹ Health plans in twenty-eight states are currently denying any medical weight-loss treatment benefits to obese individuals who could benefit from them.²³⁰ And, as Section A discussed, obesity—at least in its most severe forms, when medical weight-loss treatments can be most beneficial—is now recognized by federal courts as a disability for purposes of the Rehabilitation Act. Thus, the state benchmark plans that refuse to cover weight-loss treatments deny benefits to obese individuals on the basis of their disability and, as a result, violate § 18116.

In addition to violating § 18116, states that do not cover medical weight-loss treatments in their benchmark plans run afoul of 42 U.S.C. §§ 18022(4)(B)–(D).²³¹ Recall from Part III that in these Sections, Congress offers interpretive guidance in how to construe the term "essential health benefit." Among other things, Congress instructs that essential health benefits should "take into account the health care needs of . . . persons with disabilities" and "not . . . discriminate against individuals because of their . . . disability."²³² Here, again, states that do not cover medical weight-loss treatments in their benchmark plans appear to go directly against Congress's wishes. Because

228. See, e.g., Crémieux et al., *supra* note 106, at 590–91 (finding that the health care cost savings associated with improved health after bariatric surgery will offset the initial cost of the procedure in two to four years).

229. 42 U.S.C. § 18116 (2012).

230. OBESITY CARE CONTINUUM, *supra* note 17.

231. See generally 42 U.S.C. §§ 18022(4)(B)–(D).

232. *Id.* §§ 18022(4)(B)–(C).

the ACA takes its definition of disability from the Rehabilitation Act, then, by incorporation, obesity (particularly severe or morbid obesity) should be considered a disability for purposes of the ACA. By failing to include weight-loss treatment as an essential health benefit, states do not take into account—indeed, they do not even acknowledge—the health care needs of persons who are legally disabled.

VI. UNFULFILLED PROMISES OF SEX NONDISCRIMINATION

State benchmark plans' failure to cover medical weight-loss treatments on the basis of a disability represents a classic case of disparate treatment discrimination. In a disparate treatment discrimination case, "liability depends on whether the protected trait . . . actually motivated the . . . decision."²³³ "The ultimate question" in a disparate treatment case, according to the U.S. Supreme Court, "is whether the [accused] intentionally discriminated."²³⁴ In the argument presented above in Part V, by choosing a benchmark plan that wholly excluded treatment for a medical condition (obesity), states (and insurers within these states) intentionally treated a class of legally disabled individuals differently than they treated everyone else.²³⁵ Thus, states disparately treat, and discriminate against the disabled, contrary to Congress's directives.

This Part considers a second type of discrimination: disparate impact. Disparate impact discrimination consists of "practices that are not intended to discriminate but in fact have a disproportionately adverse effect" on a protected group.²³⁶ Specifically, this Part examines the disproportionately adverse effects that obesity has on women and how these effects implicate the nondiscrimination provision of the ACA.²³⁷ Section A discusses research on the disparate impact that obesity has on sex,²³⁸ and Section B explores the scenarios in which federal law prohibits disparate impact discrimination.²³⁹ Section C specifically considers whether disparate impact discrimination is prohibited under the ACA and whether states' refusals to cover medical weight-loss treatment in their benchmark plans rise to the level of disparate impact discrimination against women.²⁴⁰

233. *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 141 (2000) (quoting *Hazen Paper Co. v. Biggins*, 507 U.S. 604, 610 (1993)).

234. *Id.* at 146.

235. *See supra* notes 223–232 and accompanying text.

236. *Ricci v. DeStefano*, 557 U.S. 557, 577 (2009).

237. *See infra* notes 241–73 and accompanying text.

238. *See infra* notes 241–48 and accompanying text.

239. *See infra* notes 249–62 and accompanying text.

240. *See infra* notes 263–73 and accompanying text.

A. *Weight as a Woman's Issue*

The realities of being an obese woman are much harsher than the realities of being an obese man. Indeed, academic research from multiple disciplines have confirmed that weight can impede a woman's success in almost every aspect of her life, yet it does not create the same barriers for men. As early as 1979, with the publication of Susie Orbach's book, *Fat is a Feminist Issue*, psychology researchers have recognized that weight has a particularly negative effect on women. For instance, a 2004 study found that obese women had a lower quality of life than obese men, reporting higher levels of social distress in public.²⁴¹ Another study from 2010 asked participants to evaluate political candidates and found that subjects were quite critical of obese female candidates but not of obese male candidates.²⁴² Still, another study from 2011, which questioned adolescents about their attitudes on weight, similarly revealed disturbing, gender-based conclusions: the male and female subjects made statements such as, "[I would] rather be a fat guy than a fat girl" and "[i]t's more normal for guys to be overweight."²⁴³

The disparate effects of weight on women go far beyond psychological measures. Empirical research over the past two decades has consistently demonstrated that obesity has grave social and economic consequences for women that it does not have for men. Demographic and labor market data reveal that obese women marry spouses with lower levels of education and lower earnings than the spouses of nonobese women.²⁴⁴ Further, obese women cannot compensate for their spouses' lower income in the labor market; studies examining how obese women fare in employment are even more pessimistic. For example, a 2004 empirical study, reported that obese women earn lower wages than nonobese women even after accounting for differences in education, demographics, and socioeconomic status; no effect was pre-

241. See Marney A. White et al., *Gender, Race, and Obesity-Related Quality of Life at Extreme Levels of Obesity*, 12 *OBESITY RES.* 949, 951–54 (2004).

242. See Beth J. Miller & Jennifer D. Lundgren, *An Experimental Study of the Role of Weight Bias in Candidate Evaluation*, 18 *OBESITY* 712, 715 (2010).

243. Nicole L. Taylor, "Guys She's Humongous!": *Gender and Weight-Based Teasing in Adolescence*, 26 *J. ADOLESCENT RES.* 178, 187 (2011).

244. See, e.g., Pierre-André Chiappori et al., *Fatter Attraction: Anthropometric and Socioeconomic Matching on the Marriage Market*, 120 *J. POL. ECON.* 659, 662 (2012) (citing Susan L. Averett et al., *For Better or Worse: Relationship Status and Body Mass Index*, 6 *ECON. & HUM. BIOLOGY* 330, 348 (2008); Susan Averett & Sanders Korenman, *The Economic Reality of the Beauty Myth*, 31 *J. HUM. RESOURCES* 304, 314–18, 326 (1996); and Sankar Mukhopadhyay, *Do Women Value Marriage More? The Effect of Obesity on Cohabitation and Marriage in the USA*, 6 *REV. ECON. HOUSEHOLD* 111, 118–24 (2008)).

sent for obese men.²⁴⁵ Along these lines, a very recent study examined differences in the occupational characteristics of obese and non-obese employees and found that employers exclude obese women, but not obese men, from jobs that require interaction with customers and with the public.²⁴⁶ Exclusion from these jobs is particularly detrimental to obese women because, on average, public interaction occupations are high paying and have pleasant working conditions. As a result, the study found that obese women were forced to take the few jobs available to them—jobs that often required physical labor, had poor working conditions, and were low paying.²⁴⁷

The above studies reveal that living with obesity is a much different experience for women than it is for men. Obese women face economic, social, and psychological barriers not encountered by obese men. As a result, medical weight-loss treatment has more to offer women than men; not only does this treatment offer the chance to escape the negative health effects associated with the disease, but, for women, it also offers the chance to escape the negative economic, social, and psychological effects of the disease. In other words, denying insurance coverage for medical weight-loss treatment to obese individuals has a disparate impact on women. This disparate impact may extend beyond the economic, social, and psychological arenas; recent medical evidence suggests that the disparate impact of denying treatment may also extend to the health arena. Three different studies from the past six years have all concluded that bariatric surgery reduces subsequent obesity-related cancer risk in women more than it does in men.²⁴⁸ Once again, the evidence indicates that women have a lot more to gain from access to medical weight-loss treatment—and a lot more to lose from denial of coverage. Considering this disparate impact on women, the next two Sections take up the question of whether this situation presents a cognizable claim of discrimination under federal law and, specifically, under the ACA.

245. See John Cawley, *The Impact of Obesity on Wages*, 39 J. HUM. RESOURCES 451, 451–52 (2004).

246. See Jennifer Bennett Shinall, *Distaste or Disability? Evaluating the Legal Framework for Protecting Obese Workers*, 37 BERKELEY J. EMP. & LAB. 5 (forthcoming 2016) (manuscript at 5).

247. See *id.* (manuscript at 39).

248. See Ted D. Adams et al., *Cancer Incidence and Mortality After Gastric Bypass Surgery*, 17 OBESITY 796, 801–02 (2009); Lars Sjöström et al., *Effects of Bariatric Surgery on Cancer Incidence in Obese Patients in Sweden (Swedish Obese Subjects Study): A Prospective, Controlled Intervention Trial*, 10 LANCET ONCOLOGY 653, 657–60 (2009); Xiang-wu Yang et al., *Effects of Bariatric Surgery on Incidence of Obesity-Related Cancers: A Meta-Analysis*, 21 MED. SCI. MONITOR 1350, 1355 (2015).

B. The Meaning of Sex Discrimination Under Federal Law

When the term “discrimination” appears in any federal statute, it always encompasses the idea of disparate treatment. Disparate treatment is arguably the “ordinary meaning”²⁴⁹ of the word “discrimination” in the English language. The Oxford English Dictionary defines discrimination as “[t]he action of perceiving, noting, or making a distinction between things[.]” which implies the presence of intent.²⁵⁰ Nonetheless, courts have recognized disparate impact—which does not require proof of intent—as a form of discrimination under some federal statutes, but not all. The U.S. Supreme Court first endorsed the theory of disparate impact as a form of federally prohibited discrimination in *Griggs v. Duke Power Co.*,²⁵¹ a 1971 case brought under Title VII of the 1964 Civil Rights Act. In striking down a neutral job requirement that had the effect of excluding African-Americans, the Court recognized that the term discrimination “proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation.”²⁵²

Forty years later, the Court still recognizes the disparate impact theory as cognizable in Title VII discrimination cases.²⁵³ The Court has been less generous with other statutes: for instance, the Court has prohibited individuals from bringing a private right of action for disparate impact under Title VI of the 1964 Civil Rights Act.²⁵⁴ Even though Title VI, which prohibits discrimination on the basis of race, color, or national origin in federally funded programs, arises from the same Act as Title VII,²⁵⁵ the Court has asserted that congressional intent regarding the scope of the two titles was different.²⁵⁶ The Court has also refused to recognize disparate impact claims in Equal Protection cases, holding that discriminatory intent is required to rise to the level

249. See *Taniguchi v. Kan Pac. Saipan, Ltd.*, 132 S. Ct. 1997, 2002 (2012).

250. *Discrimination*, OXFORD ENGLISH DICTIONARY (online ed. 2016).

251. 401 U.S. 424 (1971).

252. *Id.* at 431.

253. *E.g.*, *Ricci v. DeStefano*, 557 U.S. 557, 577 (2009) (“Title VII prohibits both intentional discrimination (known as ‘disparate treatment’) as well as, in some cases, practices that are not intended to discriminate but in fact have a disproportionately adverse effect on minorities (known as ‘disparate impact’).”). Although Title VII did not explicitly include a disparate impact theory within its statutory language at the time that *Griggs* was decided in 1971, Congress explicitly added prohibitions against disparate impact discrimination into Title VII with the Civil Rights Act of 1991. See Civil Rights Act of 1991, Pub. L. No. 102-166, § 105, 105 Stat. 1071, 1074–75 (codified as amended at 42 U.S.C. § 2000e-2(k)(1)(A) (2012)).

254. See, *e.g.*, *Alexander v. Sandoval*, 532 U.S. 275, 285–89 (2001).

255. Compare 42 U.S.C. § 2000d; with 42 U.S.C. § 2000e-2.

256. See, *e.g.*, *Alexander*, 532 U.S. at 280–81; *Guardians Ass’n v. Civil Serv. Comm’n of N.Y.C.*, 463 U.S. 582, 617 (1983) (“Title VI’s proscription of racial discrimination is coextensive with the Equal Protection Clause.”).

of a constitutional violation.²⁵⁷ Nonetheless, the Court has explicitly recognized disparate impact claims as cognizable in discrimination claims brought under many other nondiscrimination statutes, including the Age Discrimination in Employment Act (ADEA),²⁵⁸ the Fair Housing Act (FHA),²⁵⁹ and the ADA.²⁶⁰

With the Court's prior decisions in mind, the question at hand becomes whether the ACA's nondiscrimination provision should be interpreted in line with the ADEA, FHA, and the ADA—or whether it should be interpreted more strictly, in line with the Equal Protection Clause. In other words, does the ACA's prohibition of discrimination in health plans encompass coverage decisions that lack the intent to discriminate? As discussed in Part V, the statutory language of 42 U.S.C. § 18116 is completely unhelpful in this regard because it does not provide any definition of the term “discrimination.”²⁶¹ Moreover, the HHS regulations and guidance have not filled in this obvious and important gap. In the absence of any obvious direction by Congress or HHS, a more careful study of the ACA's statutory language is required to determine whether Congress left any hints as to the intended meaning of the term discrimination. The next Section is devoted to this study.²⁶²

C. Denial of Coverage as a Form of Sex Discrimination

Determining whether the ACA's nondiscrimination provision prohibits disparate impact discrimination requires revisiting the language of 42 U.S.C. § 18116 once again. In § 18116(a), sex discrimination is prohibited in health plans via a reference to Title IX of the Education Amendments of 1972.²⁶³ Congress could have more simply stated that sex discrimination was prohibited in health care, but, instead, Congress chose to reference Title IX. Consequently, under the same argument made in Part IV, Congress incorporated the meaning of sex

257. See, e.g., *Washington v. Davis*, 426 U.S. 229, 239 (1976) (“[O]ur cases have not embraced the proposition that a law or other official act, without regard to whether it reflects a racially discriminatory purpose, is unconstitutional solely because it has a racially disproportionate impact.”).

258. See, e.g., *Smith v. City of Jackson, Miss.*, 544 U.S. 228, 240 (2005) (finding that the disparate impact theory is not categorically unavailable under the ADEA).

259. See *Tex. Dep't of Hous. & Cmty. Affairs*, 135 S. Ct. 2507, 2525 (2015) (“[D]isparate-impact claims are cognizable under the Fair Housing Act . . .”).

260. See, e.g., *Raytheon Co. v. Hernandez*, 540 U.S. 44, 53 (2003) (“Both disparate-treatment and disparate-impact claims are cognizable under the ADA.”).

261. See *supra* notes 178–232 and accompanying text.

262. See *infra* notes 263–73 and accompanying text.

263. See 42 U.S.C. § 18116(a) (2012); Education Amendments of 1972, Pub. L. No. 92-318, § 901, 86 Stat. 235, 373 (codified as amended at 20 U.S.C. § 1681(a) (2012)).

discrimination from Title IX into the ACA. As a result, if Title IX prohibits disparate impact discrimination on the basis of sex, then so should the ACA.

Congress passed Title IX after a series of lawsuits brought to light the pervasive bias against women working in higher education.²⁶⁴ Since its passage, however, the Act has become most well known for its positive impact on the funding of girls' sports programs.²⁶⁵ The Act provides the following: "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance"²⁶⁶ The statutory language itself is not helpful in determining whether disparate impact is a cognizable theory under the statute; indeed, the phrase "be excluded from participation in, be denied the benefits of, or be subjected to discrimination" is precisely the same language used by the nondiscrimination provision of the ACA in 42 U.S.C. § 18116(a).²⁶⁷ The legislative history is also unhelpful. Title IX's passage was clearly motivated by the existence of intentional discrimination, but so was Title VII of the 1964 Civil Rights Act, and it recognizes the disparate impact theory.

The U.S. Supreme Court has never considered whether disparate impact is a cognizable theory of discrimination under Title IX. Nonetheless, the federal courts that have considered the question have answered it in the affirmative.²⁶⁸ The Title IX regulations issued by the U.S. Department of Education seem to embrace the disparate impact theory because they prohibit educational institutions from "administer[ing] or operat[ing] any test or other criterion for admission which has a *disproportionately adverse effect* on persons on the basis of sex."²⁶⁹ In its legal manual, the U.S. Department of Justice recog-

264. U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIV., TITLE IX LEGAL MANUAL 16–17 (Jan. 11, 2001) [hereinafter TITLE IX MANUAL], <http://www.justice.gov/crt/about/cor/coord/ixlegal.pdf>.

265. See, e.g., Steve Wulf, *Title IX: 37 Words that Changed Everything*, ESPN (Apr. 29, 2012), <http://espn.go.com/espnw/title-ix/article/7722632/37-words-changed-everything> (acknowledging the impact of the statute on women's collegiate sports).

266. 20 U.S.C. § 1681(a).

267. See 42 U.S.C. § 18116(a).

268. See, e.g., *Jeldness v. Pearce*, 30 F.3d 1220, 1231 (9th Cir 1994) (finding that intent was not required to violate Title IX); *Roberts v. Colo. State Bd. of Agric.*, 998 F.2d 824, 832–33 (10th Cir. 1993) (holding that disparate impact is a cognizable theory of liability under Title IX because Title VII of the 1964 Civil Rights Act is "the most appropriate analogue when defining Title IX's substantive standards," and that "Title VII does not require proof of overt discrimination").

269. 34 C.F.R. § 106.21(b)(2) (2015) (emphasis added).

nized that disparate impact sex discrimination claims may be brought under Title IX.²⁷⁰

Assuming that the U.S. Supreme Court would agree with the weight of the authority from lower courts and agencies, then disparate impact is a cognizable theory of sex discrimination under Title IX. And, if disparate impact is a cognizable theory of sex discrimination under Title IX, then, by incorporation, it should also be a cognizable theory of sex discrimination under § 18116 of the ACA.²⁷¹ Using the evidence presented in Part V.A, obese women have an argument that insurance plans' denials of medical weight-loss treatment coverage have a disparate impact on their psychological, social, economic, and physical well-being. By reducing obese women's access to medical weight-loss treatment, states and insurers inhibit obese women—but not obese men—in virtually every aspect of their lives. In response to such an argument by obese women, states and insurance companies might try to assert the defense that the cost of providing this coverage is unsustainable and, as such, denying this coverage is a business necessity for insurance companies. This potential defense is quite weak, however, given the empirical evidence that medical weight-loss treatments eventually lead to cost savings for insurers.²⁷² As a result, the failure of twenty-eight state benchmark plans to cover medical weight-loss treatment appears to give rise to liability for sex-based discrimination under 42 U.S.C. § 18116 based on the disparate impact caused by the denial of benefits. This liability exists in addition to any liability for disability discrimination under § 18116.

Finally, in addition to liability under § 18116, the failure to cover medical weight-loss treatments appears to run afoul of 42 U.S.C. § 18022(4)(C). As discussed in Part IV, Congress directed HHS to “take into account the health care needs of diverse segments of the population, including women,” when determining what constitutes an essential health benefit under the ACA.²⁷³ Because obesity (and, hence, failure to receive medical treatment for obesity) has such a dis-

270. See TITLE IX MANUAL, *supra* note 264, at 63 (discussing the disparate impact theory of discrimination under Title IX).

271. Recent scholarship on the ACA's nondiscrimination provision agrees that the § 18116, by incorporation from Title IX, includes liability for disparate impact discrimination on the basis of sex. See Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 YALE L. J. 2470, 2491–93 (2015) (“Section 1557 incorporates the private right of action for disparate treatment and disparate impact claims provided in Title IX.”).

272. See, e.g., Crémieux et al., *supra* note 106, at 53–54 (finding that the health care cost savings associated with improved health after bariatric surgery will offset the initial cost of the procedure in two to four years).

273. See 42 U.S.C. § 18022(4)(C); *supra* notes 151–72 and accompanying text.

parate impact on women, state benchmark plans that exclude medical weight-loss treatments from their list of covered treatments appear to go directly against Congress's wishes. In sum, the conclusion drawn by twenty-eight states that the ACA does not require coverage of medical weight-loss treatments flies in the face of the Act's requirements of nondiscrimination on the basis of sex, disability, and guaranteed essential health benefits. Yet, twenty-eight states are currently getting away with interpreting the ACA in this manner. How are these states getting away with it—better still, *why* is HHS letting them get away with it? The final Part focuses on precisely this question.

VII. CONCLUSION: A CALL TO ACTION FOR FEDERAL FULFILLMENT

The ACA makes grandiose promises of sweeping reform in the health care system with the stated goal of ensuring “that in this country the security of health care is not a privilege for a fortunate few.”²⁷⁴ To achieve this goal, the statute extensively relies on HHS to enforce these grandiose promises—so frequently that the Act references the HHS Secretary more than 3,000 times within its provisions.²⁷⁵ And, although HHS has already issued many regulations in the six years since the ACA's passage, most notably the contraception coverage mandate²⁷⁶ and the Patient's Bill of Rights,²⁷⁷ HHS has largely dodged its responsibility to regulate and provide guidance on two of the ACA's core provisions, essential health benefits and nondiscrimination. By deferring to the states to precisely decide what these terms mean, HHS allows states to have the final word on which treatments and conditions must be covered by health plans.

The result is inconsistency of health plan coverage across the states. As this Article has pointed out, obese individuals in twenty-eight states endure inequities of coverage without any good explanation other than that their state did not deem medical weight-loss treatment important or worthwhile enough to include in its benchmark plan.²⁷⁸ The result is a patchwork system of complete coverage, some coverage, and no coverage across states without any logic or reason behind it. The inequities of such a patchwork system become particularly ap-

274. Remarks on the Patient Protection and Affordable Care Act, 2013 DAILY COMP. PRES. DOC. 716, at 6 (Oct. 21, 2013).

275. TEVI TROY, HUDSON INST. “THE SECRETARY SHALL” HOW THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT WILL AFFECT DOCTORS 2 (May 2012), <http://www.hudson.org/content/researchattachments/attachment/1034/secshalltroy—052212web.pdf>.

276. See 45 C.F.R. § 147.130(a)(1)(iv) (2015).

277. See *id.* § 147.136.

278. OBESITY CARE CONTINUUM, *supra* note 17.

parent for individuals who live in metropolitan areas that encompass more than one state. Obese individuals who work in New York City, for example, are guaranteed coverage for bariatric surgery if they choose to live in the city or a New Jersey suburb, but, if they choose to live in a Connecticut suburb, they are out of luck.²⁷⁹

These interstate inconsistencies are more than just annoying or inconvenient; they are at odds with the plain language of the ACA. In the case of obesity, state benchmark plans' continued failure to guarantee coverage of medical weight-loss treatments conflicts with the ACA's directives not to discriminate on the basis of disability (42 U.S.C. § 18116(a)), not to discriminate on the basis of sex (42 U.S.C. § 18116(a)), and not to withhold benefits for the management of chronic disease (42 U.S.C. § 18022(b)(1)(I)). Nonetheless, twenty-eight states continue to get away with not providing coverage for medical weight-loss treatment without any recourse from HHS.

This Article focused on the example of obesity, principally because of the injustices that have arisen from HHS's punting its regulatory authority to the states are so obvious. Here is a situation in which a disease affects one-third of the United States, medically effective treatments for the disease exist, and federal law guarantees insurance coverage of these treatments, yet only one-half of the affected population enjoys the supposed coverage. More troubling is the fact that obesity is not an anomaly. In fact, individuals with a wide range of other conditions face exactly the same situation as obese individuals. This Article's Introduction mentioned the frustrations faced by parents of children with special needs, whose state of residence may determine whether their children are covered by insurance for the medically effective treatments they need or whether lack of coverage renders the treatments financially out of reach.²⁸⁰

Even for parents of children without special needs, the ACA has failed to live up to its explicit promises in some states. Section 18022(b)(1)(J) of the ACA expressly guarantees that insurance plans will cover “[p]ediatric services, including oral and vision care” as an essential health benefit, using language that could not be any clearer.²⁸¹ Nonetheless, a report prepared by research fellows at the Georgetown University Health Policy Institute revealed that as of October 2014, thirty states neither required the purchase of pediatric dental coverage nor issued any guidance for insurers on pediatric den-

279. *Id.*

280. See Rosenbaum & Noonan, *supra* note 11.

281. 42 U.S.C. § 18022(b)(1)(J) (2012).

tal coverage.²⁸² According to the report, a similar situation has arisen for individuals in need of rehabilitative services. Even though these services are guaranteed coverage in § 18022(b)(1)(G), the lack of a state policy on these services renders the reality of coverage uncertain for individuals in eleven states.²⁸³

All of these inconsistencies in coverage, which still exist six years after passage in spite of the guarantees of the ACA, raise the same question: Why does HHS continue to allow the states to define their own benchmark plans? As long as states are allowed to select their own benchmark plans, inconsistencies in insurance coverage will continue to arise between states. States will continue to disagree about what is required under the essential health benefits and nondiscrimination guarantees of the ACA—sometimes because of differences in statutory interpretation and sometimes because of differences in politics. Regardless of states' underlying motivations, in the absence of more specific federal regulations and stronger federal enforcement, situations will continue to arise in which residents of one state enjoy drastically better ACA-mandated insurance coverage than residents of a neighboring state.

As complicated as navigating the differences in state benchmark plans has become, the problem has a simple solution: HHS should cease deferring to the states and establish its own federal benchmark plan. The plan would designate the minimum level of coverage necessary for insurance plans to comply with the ACA. The plan would also list the treatments that must be covered under the essential health benefit and nondiscrimination provisions of the Act. Certainly, crafting this plan and ensuring that it complied with the many provisions of the ACA would be time-consuming for HHS, although not necessarily any more time consuming than what HHS is already asking the states to do.

One time-saving possibility for HHS would be to select the lowest-coverage insurance plan offered to federal employees as the federal benchmark plan. States (and insurance companies within the states) could then use that plan's handbook to determine which treatments and conditions must be covered in other insurance plans. Whether HHS pursued this time-saving strategy or developed a benchmark plan from scratch, in subsequent years, HHS would have the authority

282. JUSTIN GIOVANNELLI ET AL., COMMONWEALTH FUND, IMPLEMENTING THE ACA'S ESSENTIAL HEALTH BENEFITS REQUIREMENTS 5 exh.5 (2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/oct/1783_giovanelli_implementing_aca_essential_hlt_benefits_rb.pdf.

283. *See id.* at 4 exh.4.

to amend the plan based on new developments from court decisions and from medical treatments. And, if individual state laws required more extensive insurance coverage guarantees than provided by the federal benchmark plan, states would still be able to develop their own benchmark plans that guaranteed the minimum federal benchmark plan coverage supplemented by the additional coverage required by state law.²⁸⁴

The passage of the ACA is a source of great pride for President Barack Obama's Administration, and the President undoubtedly hopes that the ACA will be his greatest legacy.²⁸⁵ As a result, it is difficult to understand why, under his administration, HHS has relinquished its rulemaking authority to the states regarding the core guarantees of the Act. For the individuals living in states in which promised essential health benefits have not yet become a reality, HHS has offered a glimmer of hope. In 2012, the agency released a bulletin stating that it would "revisit" its approach of allowing states to define required insurance benefits for the 2016 plan year.²⁸⁶ Whether HHS will follow through on this assurance remains uncertain—so far, there are no signs of HHS making any changes, even though 2016 has arrived. What is certain is that until the agency follows through on this assurance, many of the ACA's core promises will remain unfulfilled.

284. For instance, Massachusetts law, requires insurance coverage for abortion treatment, which is not required under the ACA. See Patrick Whelan, *Abortion Rates and Universal Health Care*, 362 N. ENG. J. MED. e45(1) (2010), for a discussion of the Massachusetts health care law, which famously implemented "universal" health care four years before the passage of the ACA.

285. For a discussion of the ACA and the legacy of the Obama administration, see Michael D. Shear, *Obama Gains Vindication and Secures Legacy with Health Care Ruling*, N.Y. TIMES, June 25, 2015, http://www.nytimes.com/2015/06/26/us/politics/obama-supreme-court-aca-ruling-health-care.html?_r=0.

286. U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICARE SERVS., FREQUENTLY ASKED QUESTIONS ON ESSENTIAL BENEFITS BULLETIN (Feb. 17, 2012), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.