AMERICA'S GROWING PROBLEM: HOW THE PATIENT PROTECTION AND AFFORDABLE CARE ACT FAILED TO GO FAR ENOUGH IN ADDRESSING THE OBESITY EPIDEMIC

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For the last several decades, the United States has been facing an uphill battle against obesity. In addition to constituting a public health crisis, the increasing prevalence of obesity poses serious economic consequences for the United States as health care costs continue to soar. In an attempt to combat this growing problem, Congress included numerous provisions in the Patient Protection and Affordable Care Act aimed at reducing the high rates of obesity in the United States.

This Note argues that the Affordable Care Act could have more effectively addressed the obesity crisis by providing a meaningful financial incentive encouraging the adoption of healthier lifestyles to obese Americans. This Note suggests two ways in which the Affordable Care Act could have incorporated such an incentive: (1) an amendment to section 213 of the Internal Revenue Code and (2) mandatory insurance coverage of weight loss- and health-related expenses.

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I. INTRODUCTION

In merely a quarter of a century, skyrocketing rates of obesity have transformed this once uncommon disease into a public health crisis threatening the American population as greatly as the prevalence of smoking once did.[1] While obesity surely poses a significant health risk, rising rates of the disease also correlate to increasing economic consequences: medical expenses associated with obesity constitute one of the driving forces behind soaring health care costs in the United States,

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[1] Alan S. Go et al., *Heart Disease and Stroke Statistics–2013 Update: A Report from the American Heart Association,* 127 CIRCULATION e6, e59–60, e62 (2012), *available at* http://circ.ahajournals.org/content/127/1/e6.full.pdf.

accounting for one-quarter of all health expenses,[2] with some commentators even going as far as to suggest that rising incidences of obesity are affecting the nation's economic competitiveness on a global scale.[3] In addition to the obvious health concerns raised by obesity, the government needs to address the rising health care costs associated with the disease, which affect not only obese individuals, but also the American public as a whole, by providing an effective means of encouraging the adoption of healthier lifestyles.

Legislation aimed at counteracting drastically increasing rates of obesity in the United States has been on the Congressional calendar since the early 1990s.[4] Since the introduction of the first obesity-related bill, the need for a government response to this expanding problem has increased significantly. As a result, the United States has seen a number of efforts to address this problem at all levels of government, from the proposed sugary drink ban in New York City[5] to First Lady Michelle Obama's "Let's Move!" campaign, which targets childhood obesity.[6] In 2010, Congress enacted the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA"),[7] the primary purpose of which was to provide affordable health insurance coverage for all Americans.[8] Additionally, in an attempt to

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[2] Y. Tony Yang & Len M. Nichols, *Obesity and Health System Reform: Private vs. Public Responsibility,* 39 J.L. MED. & ETHICS 380, 380 (2011).

[3] *Id.* (arguing that "the less fit and less productive U.S. work-force has gradually eroded the nation's industrial competitiveness").

[4] Daniel M. Reach, Article, *Fitness Tax Credits: Costs, Benefits, and Viability,* 7 NW. J. L. & SOC. POL'Y 352, 358 (2012).

[5] *See* Michael M. Grynbaum, *New York Plans to Ban Sale of Big Sizes of Sugary Drinks,* N.Y. TIMES, May 30, 2012, http://www.nytimes.com/2012/05/31/nyregion/bloomberg-plans-a-ban-on-large-sugared-drinks.html?_r=0.

[6] *See generally* Press Release, White House: Office of the First Lady, First Lady Michelle Obama Launches Let's Move: America's Move to Raise a Healthier Generation of Kids (Feb. 9, 2010), *available at* http://www.whitehouse.gov/the-press-office/first-lady-michelle-obama-launches-lets-move-americas-move-raise-a-healthier-genera.

[7] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

[8] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2580 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.").

tackle the growing obesity problem plaguing the United States, Congress included numerous provisions in the Affordable Care Act that seek to decrease the prevalence of obesity in the United States while simultaneously encouraging healthier lifestyles for all Americans. Despite these efforts, however, the Affordable Care Act failed to go far enough.

One of the greatest barriers preventing perhaps a majority of obese Americans from attempting to lose weight is the high cost of health club memberships and weight loss programs.[9] Accordingly, the Affordable Care Act could have more effectively targeted the growing prevalence of obesity by providing a financial incentive to encourage the adoption of overall healthier lifestyles in order to diminish health care costs not only for obese individuals, but also for the American public as a whole.

This Note suggests two ways in which the Affordable Care Act could have provided a financial incentive aimed at spurring weight loss and the adoption of healthier lifestyles, each of which would also serve the Act's underlying purpose of decreasing health care costs. First, Congress could have amended the Internal Revenue Code in order to provide a tax deduction for obese Americans who incur significant medical expenses in an effort to lose weight and remedy their obesity. Rather than provide a meaningful financial incentive through the tax code, however, the Affordable Care Act actually moves a pre-existing financial incentive aimed at encouraging healthier behaviors for obese individuals, section 213 of the Internal Revenue Code, even further out of reach for most Americans.[10] Second, Congress could have mandated insurance coverage of expenses incurred by obese individuals in an attempt to lose weight and adopt a healthier lifestyle, but did not. As a result, the Affordable Care Act failed to adequately address the expanding American obesity epidemic.

Part II of this Note begins with an overview of the U.S. obesity epidemic. Next, Part III explores the various provisions in the Affordable Care Act relating to obesity. Part IV then discusses why the Affordable Care Act should have incorporated a financial incentive encouraging the adoption of healthier lifestyles for obese individuals. Part V proposes two ways in which the Affordable Care Act could have provided such a financial incentive. Finally, Part VI concludes by arguing that the Affordable Care Act failed to go far enough in addressing the obesity

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[9] Arterburn et al., *Insurance Coverage and Incentives for Weight Loss Among Adults with Metabolic Syndrome,* 16 OBESITY 70, 70 (2008).

[10] *See* Patient Protection and Affordable Care Act § 9013, I.R.C. § 213 (Supp. 2013–2014).

epidemic due to the lack of a financial incentive directed at reducing the prevalence of obesity in the United States.

II. THE OBESITY CRISIS CURRENTLY FACING THE UNITED STATES

A. DEFINING OBESITY AND WEIGHING THE STATISTICS

The National Center for Health Statistics ("NCHS"), a part of the Centers for Disease Control and Prevention ("CDC"), classifies any adult with a body mass index ("BMI") greater than or equal to thirty as obese, while adults with a BMI between twenty-five and 29.9 fall under the category of overweight.[11] Among children, the NCHS defines obesity as "a BMI equal to or greater than the age- and sex-specific ninety-fifth percentile of the 2000 CDC growth charts,"[12] while children with a BMI equal to or greater than the eighty-fifth percentile are classified as overweight.[13]

Many factors contribute to an individual becoming obese. In addition to the more obvious causes, such as a lack of energy balance (i.e., consuming more energy than one's body expends) and an inactive lifestyle, the National Health, Lung, and Blood Institute lists the environment in the United States, including large portion sizes, demanding work schedules, and food deserts, hormone disorders, consumption of certain medications, emotional factors, quitting smoking, age, and inadequate sleep as causes of obesity.[14] Moreover, evidence suggests that genetics play a key role in determining whether an individual will develop obesity, with the genetic

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[11] Body mass index is calculated by dividing weight in kilograms by height in meters squared. CYNTHIA L. OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 82, PREVALENCE OF OBESITY IN THE UNITED STATES, 2009–2010, 6 (2012); U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L INST. OF DIABETES & DIGESTIVE & KIDNEY DISEASES, OVERWEIGHT AND OBESITY STATISTICS, 1 (2012), *available at* http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf [hereinafter OVERWEIGHT AND OBESITY STATISTICS].

[12] OGDEN ET AL., *supra* note 11.

[13] OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11.

[14] *What Causes Overweight and Obesity?*, NAT'L HEART, LUNG & BLOOD INST. (July 13, 2012), http://www.nhlbi.nih.gov/health/health-topics/topics/obe/causes.

contribution to obesity being greater than that for other conditions with a strong hereditary link, such as breast cancer and schizophrenia.[15]

Throughout the 1960s and 1970s, the prevalence of obesity in the United States remained relatively stable;[16] however, this changed rapidly beginning in the early 1980s. Between 1980 and 2008, the percentage of American adults classified as obese more than doubled, rising from 13.4% to 34.3%.[17] During this same period, the prevalence of childhood obesity more than tripled, rising from 5% in 1980 to 17% in 2008.[18] When compared to rates from 1973 and 1974, the increase was exponentially higher, despite the relatively small difference in time, with the percentage of obese children being five times higher in 2008–2009 than in 1973–1974.[19]

The dramatic spike in the prevalence of obesity among all sectors of the American population culminated in a total of 78 million American adults falling under the classification of obese between 2009 and 2010, which translates to about 35% of the American population.[20] Furthermore, an additional 33% of the population was overweight between 2007 and 2010.[21] As a whole, this amounts to 73% of American men and 64% of American women being classified as overweight or obese during this recent period.[22]

The statistics are equally as daunting for children. Between 2009 and 2010, 17% of children in the United States were classified as obese, amounting to about 12.5 million children.[23] What is perhaps even more unnerving is that overweight and particularly obese children have a 70%

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[15] Jeffrey M. Friedman, *Modern Science Versus the Stigma of Obesity*, 10 NATURE MED. 563, 563 (2004).

[16] U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE SURGEON GEN., THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION 2010, 2 (2010), *available* at http://www.surgeongeneral.gov/initiatives/healthy-fit-nation/obesityvision2010.pdf [hereinafter THE SURGEON GENERAL'S VISION FOR A HEALTHY AND FIT NATION 2010].

[17] *Id.*

[18] *Id.*

[19] Alan S. Go et al., *supra* note 1, at e60.

[20] OGDEN ET AL., *supra* note 11, at 2.

[21] Go et al., *supra* note 1.

[22] *Id.*

[23] OGDEN ET AL., *supra* note 11, at 2–3.

chance of becoming obese upon adulthood, a risk that rises to 80% if one of the child's parents is overweight or obese.[24]

While the rising rates of obesity appear to be slowing in more recent years,[25] researchers predict that more than 50% of the American population will be obese by 2030.[26] The increasing prevalence of obesity in the United States can likely be attributed to overall greater calorie consumption. Although the average level of physical activity among the population has remained consistent since the 1980s, calorie consumption has increased drastically.[27]

It is a common misconception that obesity is a disease that disproportionately affects the poor.[28] The majority of obese Americans, however, are actually not low-income.[29] Rather, the correlation between obesity and poverty varies according to gender, race, age, and education level.[30] Thus, for example, while higher rates of obesity among non-Hispanic white women correspond to lower-income levels, higher rates of obesity among non-Hispanic African-American men and Mexican-American men actually correspond to higher-income levels.[31] Moreover,

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[24] JENNIFER BISHOP ET AL., ASPE RESEARCH BRIEF: CHILDHOOD OBESITY (Aug. 2005), *available at* http://aspe.hhs.gov/health/reports/child_obesity/index.cfm.

[25] OGDEN ET AL., *supra* note 11, at 1.

[26] Go et al., *supra* note 1, at e61.

[27] David M. Cutler et al., *Why Have Americans Become More Obese?*, 17 J. ECON. PERSPECTIVES 93, 93 (2003) (arguing that the difference in calorie intake can be explained by mass food preparation).

[28] *Relationship Between Poverty and Overweight or Obesity*, FOOD & RES. ACTION CTR., http://frac.org/initiatives/hunger-and-obesity/are-low-income-people-at-greater-risk-for-overweight-or-obesity/ (last visited May 27, 2015).

[29] CYNTHIA OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 50, OBESITY AND SOCIOECONOMIC STATUS IN ADULTS: UNITED STATES, 2005–2008, at 2 (2010); CYNTHIA OGDEN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 51, OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS: UNITED STATES, 2005–2008, at 2 (2010).

[30] Ogden et al., OBESITY AND SOCIOECONOMIC STATUS IN ADULTS, *supra* note 29, at 6.

[31] *Id.* For a more detailed discussion of the intersection between obesity, income level, gender, race, age, and educational level, see *id.* and OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS, *supra* note 29.

any correlation between obesity and income level appears to be decreasing over time[32] as obesity rates increase across all income levels.[33]

B. RELATION TO OTHER HEALTH PROBLEMS

While obesity constitutes a chronic disease in itself,[34] individuals suffering from obesity also face countless associated health risks. Obese adults, as well as some overweight individuals, have a much higher risk of developing other serious medical conditions, such as type 2 diabetes, heart disease, osteoarthritis, liver disease, and certain types of cancer, including breast, colon, endometrial, and kidney cancers, while other associated health risks include high blood pressure and a greater likelihood of suffering from a stroke.[35] Additionally, recent studies suggest that obesity may also correlate to the development of Alzheimer Disease and vascular dementia in some individuals.[36]

Obesity-associated health risks for children are similar to those for adults. Overweight and obese children face an increased probability of developing significant health problems, including certain cardiovascular diseases, such as hypertension, hyperlipidemia and diabetes mellitus, asthma, sleep apnea, and musculoskeletal disorders.[37] Similar to overweight and obese adults, obese children are also at an increased risk of developing some cancers and suffering from a stroke.[38] Moreover, as previously mentioned, overweight and obese children are significantly more likely to become obese adults, which puts them at risk for further health risks later in life.[39] In addition to associated health risks, overweight and obese children are also at a risk of developing certain unhealthy behaviors early on in their lives. These include underachieving school performance, tobacco and alcohol use, and poor dietary habits.[40]

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[32] *Relationship Between Poverty and Overweight or Obesity*, *supra* note 28.

[33] OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN ADULTS, *supra* note 29, at 6; OGDEN ET AL., OBESITY AND SOCIOECONOMIC STATUS IN CHILDREN AND ADOLESCENTS, *supra* note 29, at 4.

[34] *See* Rev. Rul. 2002-19, 2002-1 C.B. 778.

[35] OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 2.

[36] Go et al., *supra* note 1, at e61.

[37] *Id.*

[38] *Id.*

[39] BISHOP ET AL., *supra* note 24.

[40] Go et al., *supra* note 1, at e61.

Perhaps the most alarming obesity-related health risk is that of premature death. Obesity represents one of the foremost causes of premature death in the United States, responsible for one in ten deaths in 2005 according to a study by the Harvard School of Public Health.[41] To put this into perspective, the CDC's Behavioral Risk Factor Surveillance System estimates that the number of quality life years lost due to obesity is equal to or greater than those lost due to smoking. Furthermore, the prevalence of obesity and its effect on both lifespan and quality of life may be beginning to counteract any benefits seen in the United States in terms of life expectancy due to the cessation of smoking.[42]

C. THE COSTS OF OBESITY

While the prevalence of obesity poses a significant public health problem for the United States, the disease also represents a substantial fiscal burden on the country. An obese individual spends roughly 42% more on health care each year than an average individual of a healthy weight, amounting to $1,429 per year.[43] This number reflects 46% higher inpatient costs, 27% additional outpatient visits, and 80% more spent on prescription drugs than the average healthy individual.[44] On a national level, obesity-related expenses accounted for nearly 10% of all medical spending in 2008, which translates to $147 billion in that year alone. If obesity rates continue to rise in alignment with current trends, this number could reach $957 billion in 2030, or about 16–18% of all medical spending.[45]

Heightened health insurance costs tied to obesity account for a noteworthy portion of rising medical spending, in both the private and public sectors. In the private sector, health insurance companies risk-pool both obese and non-obese insureds in formulating insurance rates, which results in higher prices for all insureds, as obesity-related costs are shifted

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[41] Goodarz Danaei et al., *The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors,* PLOS MED., Apr. 28, 2009, *available at* http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000058.

[42] Go et al., *supra* note 1, at e62.

[43] *Id.*

[44] *Id.*

[45] *Id.*

to non-obese insureds,[46] as well as taxpayers through subsidies for employer-sponsored health insurance.[47] While private insureds incur the majority of obesity-related expenditures,[48] the public sector also bears a substantial portion of obesity related costs, with Medicare financing 23% of obesity costs and Medicaid financing 19%.[49] The additional costs incurred by these publicly funded programs are subsequently passed on to American taxpayers.[50]

In addition to its direct relation to health care expenditures, obesity also imposes non-medical costs, particularly on employers. Absenteeism, or a habitual pattern of missing work, and lower productivity attributed to obesity impose a cost of well over $4 billion annually, or about $506 per obese employee per year.[51] According to a 2011 Gallup poll, overweight and obese employers also suffering from other health conditions missed roughly 450 million more days of work than healthy employees, which resulted in $153 billion in absenteeism costs in that year alone.[52] Other costs attributable to obesity include morbidity costs, or income lost from lower productivity, and mortality costs, or the value of future income lost due to diminished lifespan.[53]

Thus, obesity is not merely a public health crisis. Rather, the prevalence of obesity in the United States poses significant economic

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[46] Merav W. Efrat & Rafael Efrat, *Tax Policy and the Obesity Epidemic,* 25 J.L. & HEALTH 233, 245 (2012).

[47] *See* Julia James, *Premium Tax Credits*, HEALTH AFFAIRS, Aug. 1, 2013, at 1–2, *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_97.pdf.

[48] Eric A. Finkelstein et al., *Annual Spending Attributable to Obesity: Payer-And-Service-Specific Estimates*, 28 HEALTH AFFAIRS w822, w829 (2009).

[49] Justice G. Trogdon et al., *State- and Payer-Specific Estimates of Annual Medical Expenditures Attributable to Obesity*, 20 OBESITY 214, 214 (2012).

[50] Efrat & Efrat, *supra* note 46, at 245–46.

[51] Denise Cohen, Note, *Childhood Obesity: Balancing the Nation's Interest with a Parent's Constitutional Right to Privacy,* 10 CARDOZO PUB. L. POL'Y & ETHICS J. 357, 368 (2012).

[52] Dan Witters & Sangeeta Agrawal, *Unhealthy U.S. Workers' Absenteeism Costs $153 Billion,* GALLUP (Oct. 17, 2011), http://www.gallup.com/poll/150026/unhealthy-workers-absenteeism-costs-153- billion.aspx.

[53] Reach, *supra* note 4, at 354.

consequences, with many of the associated costs being passed on to others, whether it is fellow insureds, taxpayers, or employers.[54]

III. WEIGHT LOSS- AND OBESITY-RELATED PROVISIONS IN THE AFFORDABLE CARE ACT

President Barack Obama signed his seminal health care reform act, the Patient Protection and Affordable Care Act, on March 23, 2010, ushering in a new age in American health care.[55] Having first survived a Supreme Court challenge,[56] many of the provisions of the Act are just beginning to take effect, most notably the individual mandate, which requires all individuals, with certain exclusions, to maintain minimum health insurance coverage beginning in January 2014.[57] While much of the media coverage of the controversial act has surrounded the individual mandate and the rollout of online health insurance exchanges, the Affordable Care Act also contains numerous provisions aimed at addressing the prevalence of obesity in the United States and promoting the adoption of healthier lifestyles. In regard to the obesity epidemic, the relevant provisions of the Affordable Care Act fall into three generalized categories: (1) wellness programs, (2) community grants, and (3) outreach campaigns.

A. WELLNESS PROGRAMS

Wellness programs comprise a recurring theme throughout the Affordable Care Act. In the context of employer-provided wellness

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[54] *But see generally* Colin Hector, *Nudging Towards Nutrition? Soft Paternalism and Obesity-Related Reform*, 67 FOOD & DRUG L.J. 103, 104–08 (2012) (discussing disagreement over labeling obesity as an "epidemic" and the costs of obesity).

[55] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, 30, and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 20, 26, and 42 U.S.C.).

[56] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

[57] Patient Protection and Affordable Care Act § 1501(b), I.R.C. § 5000A(a) (2012).

programs,[58] the ACA defines a wellness program as "a program offered by an employer that is designed to promote health or prevent disease . . ."[59] It further provides that,

> A program complies with [the definition of a wellness program] if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.[60]

The term "wellness program" covers an extensive variety of activities, ranging from employer-funded gym memberships, to diagnostic testing programs, to programs aimed at tobacco addiction, to health education seminars.[61]

In order to encourage employees to participate in wellness programs, the ACA also provides for a range of insurance-based incentives aimed at stirring participation. Perhaps the most prominent incentive offered for participating in a wellness program is a significant discount on health insurance premiums. The ACA currently authorizes employers to discount coverage up to 30% for enrollment in a wellness program;[62] however, the Secretaries of Health and Human Services, Labor, and the Treasury are empowered to raise this to 50% if deemed appropriate.[63] In addition to discounted health care coverage, other qualified incentives include the elimination of co-payments or deductibles.[64]

As the rewards and incentives for work-based wellness programs constitute a significant economic cost on employers, particularly small

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[58] The provisions discussed above relating to employer-provided wellness programs constitute a portion of the Affordable Care Act amending Title III and Part A of Title XXVII of the Public Health Service Act. *See* 42 U.S.C §§ 241 to 280m, 300gg to 300gg-9 (2012).

[59] Patient Protection and Affordable Care Act § 1201(4), 42 U.S.C. § 300gg-4(j)(1)(A) (2012).

[60] *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(3)(B).

[61] *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(2).

[62] *Id.* § 1201(4), 42 U.S.C. § 300gg-4(j)(3)(A).

[63] *Id.*

[64] *Id.*

businesses, the ACA also created a five-year grant program to provide small businesses, those with less than one hundred full-time employees, with the funds necessary to institute a comprehensive wellness program.[65] Under this section, the Secretary of Health and Human Services was allocated $200,000,000 for the five-year period between 2011 and 2015 for disbursement in the form of grants to small businesses. Once approved for a grant, a business must institute a wellness program that embraces four requirements: (1) "[h]ealth awareness initiatives," which are defined to include "health education, preventative screening, and health risk assessments," (2) "[e]fforts to maximize employee engagement," which is meant to stir employee participation in the program, (3) "[i]nitiatives to change unhealthy behaviors and lifestyle choices," which includes "counseling, seminars, online programs, and self-help materials," and (4) "[s]upportive environment efforts," which encompasses "workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health."[66]

Lastly, as a way of providing governmental assistance for employer-provided wellness programs, the Affordable Care Act also directs the Director of the Centers for Disease Control and Prevention to aid employers of all sizes in running their wellness programs.[67] This includes providing technical assistance, as well as helping employers evaluate the success of their programs and offering means of improvement.[68]

Although wellness programs are not limited to the promotion of healthy eating, physical activity, and weight loss, these objectives constitute an essential goal of employer-provided programs.[69] The importance of combatting America's overweight and obesity problem is evidenced both through the language utilized in the sections of the ACA addressing employer-provided wellness programs, such as the explicit mention of healthy eating and physical activity under the provision authorizing grants to small businesses, as well as the theme of obesity

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[65] *Id.* § 10408, 42 U.S.C. § 280*l* note.
[66] *Id.* § 10408, 42 U.S.C. § 280*l* note.
[67] *Id.* § 4303, 42 U.S.C. § 280*l*(1).
[68] *Id.* § 4303, 42 U.S.C. §§ 280*l*(1)–(2).
[69] According to the Harvard School of Public Health, obesity and smoking constitute the two primary targets of employee wellness programs. Larry Hand, *Employer Health Incentives: Employee Wellness Programs Prod Workers to Adopt Healthy Lifestyles,* HARV. SCH. OF PUB. HEALTH MAG., Winter 2009, *available at* http://www.hsph.harvard.edu/news/magazine/winter09healthincentives/.

running throughout the ACA as a whole. Further, in practice, many of the employers instituting wellness programs tie the financial rewards of participation in the program to an employee's success, such as the achievement of losing a certain amount of weight or a decreased BMI.[70]

In addition to employer-provided wellness programs, the Affordable Care Act also authorizes the development of a five-year pilot wellness program for Medicare beneficiaries.[71] More specifically, the ACA directs the Secretary of Health and Human Services to award grants to state and local health departments and Indian tribes for the institution of community-based prevention and wellness programs for individuals between the ages of fifty-five and sixty-four.[72] The ACA divides these programs into several different segments: public health interventions, community preventative screenings, and clinical referral and treatment for chronic diseases.[73] Notably, each of these categories specifically mentions subjects relating to weight loss and obesity. For example, under intervention activities, efforts to improve nutrition and increase physical activity are the first types of activities listed.[74] Moreover, under community prevention screening, each of the diseases for which health screening is recommended, cardiovascular disease, cancer, stroke, and diabetes, is an obesity-related disease. These illnesses are also the key ailments listed under treatment for chronic diseases.[75] In sum, perhaps even more so than employer-provided wellness programs, the pilot program for Medicare wellness programs illustrates how the ACA seeks to conquer obesity.

B. COMMUNITY GRANTS

Community grants represent another manner in which the Affordable Care Act targets obesity. First, section 4201 of the ACA instructs the Secretary of Health and Human Services to award grants to governments at both state and local levels, as well as community-based organizations, "for the implementation, evaluation, and dissemination of

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[70] *See* Matt Lamkin, *Health Care Reform, Wellness Programs and the Erosion of Informed Consent,* 101 KY. L.J. 435, 441 (2012–2013).

[71] Patient Protection and Affordable Care Act § 4202, 42 U.S.C. § 300u-14(a)(1).

[72] *Id.*

[73] *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3).

[74] *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3)(B)(ii).

[75] *Id.* § 4202, 42 U.S.C. § 300u-14(a)(3)(C)(i), (D)(i).

evidence-based community preventative health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming."[76] The Community Transformation Grant program constitutes a part of the broader Prevention and Public Health Fund, also established by the ACA,[77] which represents "the first dedicated federal funding source for prevention and public health programs."[78]

The language of section 4201, such as the mentioning of chronic diseases and secondary conditions, impliedly targets obesity. The focus on obesity is further evidenced by the activities that a grantee may use the awarded funds to implement; such activities include creating healthier school environments through the addition of healthier meals and promoting physical activity, developing programs for individuals of all ages to allow better access to proper nutrition and physical activity, and highlighting healthy menu options at restaurants.[79] Moreover, those receiving grants are expressly prohibited from using the funds to implement activities that could lead to higher incidences of obesity or inactivity, such as video games.[80] The ACA also instructs the entities receiving grants to assess the success of the programs by measuring changes in weight, proper nutrition, and physical activity.[81]

C. OUTREACH CAMPAIGNS

Lastly, the Affordable Care Act orders the institution of education and outreach campaigns aimed at diminishing the prevalence of obesity in the United States. One such campaign requires the Secretary of Health and Human Services to implement "a prevention and health promotion outreach and education campaign to raise public awareness of health improvement

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[76] *Id.* § 4201, 42 U.S.C. § 300u-13(a).

[77] *Id.* § 4002, 42 U.S.C. § 330u-11.

[78] Christine Fry et al., *Healthy Reform, Healthy Cities: Using Law and Policy to Reduce Obesity Rates in Underserved Communities,* 40 FORDHAM URB. L.J. 1265, 1285 (2013).

[79] Patient Protection and Affordable Care Act § 4201, 42 U.S.C. § 330u-13(c)(2)(B).

[80] *Id.* § 4201(e), 42 U.S.C. § 330u-13(e).

[81] *Id.* § 4201(c)(4), 42 U.S.C. § 330u-13(c)(4)(A)–(B).

across the life span," allocating $500 million for the campaign.[82] The outreach is to take the form of both a media campaign, as well as a new website providing information on nutrition, regular exercise, and obesity reduction, in addition to several other objectives.[83] When listing the requirements of the campaign, the ACA places healthy living first and foremost, stating that the campaign must "be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers . . . ."[84] The position of nutrition, exercise, and obesity reduction among the first four goals illustrates the importance placed on targeting America's obesity problem in the ACA.

In addition to this national educational campaign, the Affordable Care Act also authorizes the creation of state-sponsored campaigns specifically targeted at preventative and obesity-related services.[85] In consultation with the Secretary of Health and Human Services, states are directed to implement public awareness campaigns in order to educate Medicaid enrollees on preventative and obesity-related services, such as obesity screening and counseling for both children and adults, with a specified goal of reducing obesity among this population, which is more susceptible to developing obesity as a whole.[86] Similarly, the ACA also allocates $25 million for funding the Childhood Obesity Demonstration Project, which seeks to address childhood obesity among low-income children.[87]

In sum, the Affordable Care Act includes many provisions aimed at counteracting increasing rates of obesity in the United States. While several of these provisions, namely employer-sponsored wellness programs, are tied to a financial incentive, the ACA failed to provide a meaningful financial incentive that is available to all Americans, rather

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[82] *Id.* § 4004, 42 U.S.C. § 300u-12(a), (h).
[83] *Id.* § 4004, 42 U.S.C. § 300u-12(c), (d).
[84] *Id.* § 4004, 42 U.S.C. § 300u-12(c)(2)(A).
[85] *Id.* § 4004, 42 U.S.C. § 300u-12(i)(1)–(2).
[86] *Id.*; *see* Go et al., *supra* note 1, at e59.
[87] Patient Protection and Affordable Care Act § 4306, 42 U.S.C. § 1320b-9a(e); *see Childhood Obesity Demonstration Project*, CTR. FOR DISEASE CONTROL & PREVENTION (Apr. 27, 2012), http://www.cdc.gov/obesity/childhood/researchproject.html. The Medicare Access and Chip Reauthorization Act of 2015 amended section 4306 of the ACA to allocate an additional $10 million to the Childhood Obesity Demonstration Project for 2016–2017. Medicare Access and Chip Reauthorization Act of 2015, Pub. L. No. 114-10, § 304, 129 Stat. 87, 158 (to be codified at 42 U.S.C. § 1320b-9a(e)(8)).

than a financial incentive limited to those participating in employer-sponsored wellness programs.

IV. THE CASE FOR A FINANCIAL INCENTIVE

The high cost of gym and health club memberships,[88] nutritional counseling, and weight loss programs[89] presents a significant barrier for obese Americans seeking to lose weight and adopt a more active lifestyle.[90] In order to overcome this financial impediment, the Affordable Care Act could have more effectively addressed the prevalence of obesity in the United States through the inclusion of a financial incentive aimed at spurring weight loss and the adoption of healthier lifestyles among obese individuals.

As a threshold matter, some critics argue that the federal government should not engage itself in the obesity debate, as "obesity should be understood in terms of personal responsibility, and . . . is a consequence of individual choice."[91] The government, however, has long been involved in protecting the health of its citizens,[92] a power that stems from the traditional police powers of the states and the taxing and

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[88] The average monthly cost of a gym membership is $55. Geoff Williams, *The Heavy Price of Losing Weight*, U.S. NEWS (Jan. 2, 2013, 10:10 AM), http://money.usnews.com/money/personal-finance/articles/2013/01/02/the-heavy-price-of-losing-weight.

[89] For example, Weight Watchers costs between $18.95 per month for online-only access and $42.95 per month for in-person meetings, while Nutrisystem costs between $270 and $300 per month. *Id.*

[90] *See* Arterburn et al., *supra* note 9.

[91] Hector, *supra* note 54, at 103 (discussing the two narratives surrounding the obesity debate); *see also* David Adam Friedman, *Public Health Regulation and the Limits of Paternalism*, 46 CONN. L. REV. 1687, 1727 (2014) ("The first question to pose is whether an individual's decisions over time to consume certain foods and remain sedentary comprise a harm that should be corrected.").

[92] Reach, *supra* note 4, at 357.

commerce powers of the federal government.[93] For example, the government played an active role in the fight against tobacco in recent decades, a public health crisis to which obesity often draws comparisons.[94] Furthermore, more than three-quarters of the U.S. population believe that the government should have at least some role in attempting to control the obesity epidemic.[95] Lastly, from an economic standpoint, the obesity crisis has had a significant impact on increasing health care spending, rising insurance costs, and perhaps even the American economy as a whole,[96] which provides even more reason for government involvement.

Studies have continually proven that financial incentives present a viable method of encouraging people to adopt certain behaviors.[97] The use of financial incentives in the weight loss context has proven particularly successful. In a 2007 study conducted by RTI International, a non-profit research organization, and the University of North Carolina at Chapel Hill, researchers found that participants who were monetarily compensated for achieving certain weight loss benchmarks lost more weight than those who received no compensation and those who received slightly less compensation for their weight loss.[98] A more recent study by the Mayo Clinic, the results of which were revealed at an American College of Cardiology conference in March 2013, yielded similar results: employees who were paid monthly for achieving weight loss goals and had to pay a penalty for not losing weight lost more than those who were not provided with any sort of incentive.[99] A third study performed by the University of Washington's Exploratory Center for Obesity Research and the Group Health Center for Health Studies demonstrated that a health insurer-

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[93] *See* Fry et al., *supra* note 78, at 1278–1280 (discussing the power of the government to regulate public health).

[94] *See* Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control,* 47 U.C. DAVIS L. REV. 121, 132-135 (2013).

[95] *Id.*

[96] *See supra* Part II.C.

[97] Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 DUQ. L. REV. 271, 302–03 (2012).

[98] Nanci Hellmich, *Financial Incentives Can Encourage Weight Loss, Research Finds,* USA TODAY, Sept. 11, 2007, http://usatoday30.usatoday.com/news/health/2007-09-10-weightloss-incentives_N.htm.

[99] Nicole Ostrow, *Cash Incentives Help People Lose Weight, Researchers Find,* BLOOMBERG (March 7, 2013, 11:00 AM), http://www.bloomberg.com/news/2013-03-07/cash-incentives-help-people-lose-weight-researchers-find.html.

provided financial incentive tied to weight loss substantially increased interest in participation in a weight management program.[100]

As these studies illustrate, individuals respond to financial enticements aimed at spurring weight loss. A government-sponsored incentive has the greatest potential to meaningfully affect the obesity epidemic, as it would reach the greatest number of people. In other words, a government-provided incentive would be beneficial to all segments of the American public suffering from obesity, particularly to those who do not have the opportunity to engage in employer-sponsored programs. As will be discussed below, providing an incentive designed to spur weight loss and health improvement through the Internal Revenue Code or through mandatory insurance coverage constitutes a viable option for attempting to counteract the obesity problem in the United States.

Moreover, combatting obesity through the implementation of weight loss incentives will likely diminish obesity-related costs, which not only affect obese individuals, but also employers, fellow insureds, and the public as a whole. Obese individuals incur significantly higher health care costs than their healthier counterparts;[101] as a result, obese individuals who take advantage of financial incentives to motivate their own weight loss would likely decrease their own individual health care costs as their weight decreases.[102] Furthermore, decreasing costs associated with obesity will also lessen the burden that is currently transferred to the employers and the co-workers of obese individuals in the form of diminished employee performance, absenteeism, and increased insurance costs.[103] Lastly, obesity poses a significant problem for the American economy, as obesity-associated costs presently constitute roughly 10% of all medical spending, a number that could potentially double in two decades.[104] Were the implementation of a financial incentive targeted at encouraging weight loss and the adoption of healthier lifestyles to accomplish the goal of diminishing obesity-related costs, the resulting decrease in medical spending would benefit the American economy as a whole.

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[100] Arterburn et al., *supra* note 9, at 70, 74.

[101] Reach, *supra* note 4, at 354–55.

[102] *See id.* at 355 (stating that "an obese person incurs 42% more in medical costs than someone of normal weight").

[103] *See* Yang & Nichols, *supra* note 2, at 380, 383.

[104] Go et al., *supra* note 1, at e62.

V. TWO WAYS IN WHICH THE AFFORDABLE CARE ACT COULD HAVE INCORPORATED A FINANCIAL INCENTIVE

In including the aforementioned provisions in the Affordable Care Act, Congress recognized the significance of the consequences obesity poses for the United States in terms of the effect on public health, as well as economically. The Affordable Care Act failed to go one step further, however, and draw on other provisions in the act in order to provide a meaningful financial incentive to obese individuals to counteract the increasing prevalence of obesity in the United States. This could have been accomplished in one of two ways. First, Congress could have amended the Internal Revenue Code to provide a blanket deduction for obesity-related medical expenses. Second, Congress could have mandated insurance coverage of obesity-related expenses.

A. AMENDMENT TO SECTION 213 OF THE INTERNAL REVENUE CODE

Section 213 of the Internal Revenue Code, the medical expenses deduction, allows a taxpayer to deduct certain medical expenses that exceed a threshold amount.[105] For qualified individuals, section 213 allows for the deduction of obesity-related expenses.[106] The Affordable Care Act, however, increased the minimum threshold for claiming this deduction,[107] thus rendering it useless for most taxpayers. In alignment with the numerous obesity-related provisions in the act, the Affordable Care Act could have eliminated this threshold requirement for qualified individuals undertaking significant obesity-related expenses in order to provide an incentive aimed at combatting the obesity crisis.

This section will proceed as follows: (1) a brief survey of tax-based alternatives for addressing the obesity epidemic, (2) a history and overview of the medical expenses deduction, (3) an analysis of the intersection of the Affordable Care Act and the medical expenses deduction, and (4) a proposal for how the Affordable Care Act could have provided a financial incentive by amending section 213.

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[105] *See* I.R.C. § 213 (Supp. 2013–2014).
[106] *See infra* Part V.A.2.ii–iii.
[107] Patient Protection and Affordable Care Act § 9013, I.R.C. § 213.

1. Survey of Tax-Based Alternatives

As a preeminent health concern for the United States, proposals for how to combat the ever-increasing obesity problem, many of which are tax-based, are abundant. These include sin taxes, fitness tax credits, and tax credits for all weight loss-related expenses.

A "sin" tax, sometimes referred to as a "fat tax," imposes a type of excise tax on unhealthy foods in order to deter the consumer from purchasing such foods.[108] Similar to cigarette taxes, a food sin tax increases the cost of foods deemed unhealthy, such as soda and other foods high in sugar.[109] Sin taxes have received great attention in recent years, with thirty-four states having already placed a sales tax on soda.[110] Sin taxes are subject to harsh criticism by consumers due to the governmental intrusion on personal autonomy and the disparate impact on low-income consumers, as well as by manufacturers.[111] Furthermore, there is little evidence that these taxes have any substantial of impact on weight loss or curbing obesity.[112]

A system of fitness tax credits represents a second tax-based alternative to address the obesity crisis. This proposal advocates for the adoption of a new tax credit, the Americans in Shape Tax Credit, modeled after a program already in place in Canada, which would provide a tax credit of up to $1,000 for fitness expenses and would be coupled with government-provided awareness about healthier lifestyles.[113] One of the significant advantages of a fitness tax credit is the benefit to low-income taxpayers, who may not otherwise be able to afford fitness expenses.[114] However, the fitness tax credit plan fails to go far enough, both by ignoring other weight loss expenses, namely the cost of enrolling in a weight loss program, which can be significantly more expensive than a health club membership.

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[108] *See* Reach, *supra* note 4, at 360.

[109] *Id.*

[110] *Id.*

[111] *See id.*

[112] *Id.* For a critique of sin taxes, see Katherine Pratt, *A Constructive Critique of Public Health Arguments for Antiobesity Soda Taxes and Food Taxes,* 87 TUL. L. REV. 73 (2012).

[113] Reach, *supra* note 4, at 364-65.

[114] *See id.*

Similar to the fitness tax credit, another recently proposed alternative for combatting the obesity epidemic recommends a Public Health Tax Credit. Under this proposal, obese and overweight taxpayers would be reimbursed via a tax credit for all weight loss-related expenses.[115] Of the three discussed alternatives, the Public Health Tax Credit, which in a way implicitly builds on the Americans in Shape Tax Credit, represents the most advantageous proposal as it provides the most direct benefit to taxpayers of all income levels and does not directly penalize consumers for their dietary choices.

2. The Medical Expenses Deduction

The 77th United States Congress enacted what is commonly referred to as the medical expenses deduction as part of the Revenue Act of 1942.[116] In over seventy years and fifteen revisions, the actual overall language of section 213, formerly section 23, of the Internal Revenue Code ("the Code"), has changed little. The minor textual amendments to this section, particularly the recent enactment of the Affordable Care Act, however, have dramatically altered the substantive impact of the deduction by altering both the floor for claiming the deduction, as well as the cap on the maximum deductible amount.

a. History of the medical expenses deduction

The Roosevelt administration introduced the medical expenses deduction in the midst of the Second World War as part of legislation the President referred to as "the greatest tax bill in American history."[117] At the time of the enactment of the deduction, expenses for medical care, defined as expenses incurred for the "diagnosis, cure, mitigation, treatment, or prevention of disease,"[118] not otherwise compensated for by insurance were

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[115] Lauren Ridley, Comment, *Our Taxes Get a Diet: The Code Attacks the Overweight & Obesity Epidemic,* 85 TEMP. L. REV. 951, 996–97 (2013).

[116] Revenue Act of 1942 § 127, I.R.C. § 23 (1942).

[117] Kelly Phillips Erb, *Deduct This: The History of the Medical Expenses Deduction,* FORBES (June 20, 2011, 8:25 AM), http://www.forbes.com/sites/kellyphillipserb/2011/06/20/deduct-this-the-history-of-the-medical-expenses-deduction/.

[118] Revenue Act of 1942 § 127, I.R.C. § 23.

deductible so long as they exceeded 5% of net income.[119] The deduction was subject to a cap of $2,500 for those filing a joint return and heads of households and $1,250 for single taxpayers.[120] According to Representative John Carl Hinshaw, a Republican from California, the underlying purpose of this tax deduction was to provide financial assistance for those incurring "unusual outlays for medical purposes," not common medical expenses.[121] Given that the deduction was enacted in the midst of World War II, it is likely that Congress intended for it to primarily benefit wounded soldiers returning from overseas.[122]

The first noteworthy revision to the medical expenses deduction occurred when the 83rd Congress enacted the Internal Revenue Code of 1954. The 1954 version of the Code lowered the minimum threshold for claiming the medical expenses deduction, now section 213, to 3% of adjusted gross income.[123] Additionally, the 1954 revision more than doubled the cap for the amount of deductible medical expenses, which rose to $5,000 for single taxpayers and $10,000 for those filing a joint tax return.[124] The cap on the deduction, however, was eliminated shortly thereafter in the 1960s.[125] The 1954 version of the medical expenses deduction prevails as perhaps the most favorable for taxpayers, as the 3% threshold remains the lowest percentage of adjusted gross income for claiming the deduction and the cap on the total amount of expenses capable of being deducted was reasonably high, especially when considering the $5,000–10,000 cap in light of inflation.

During Ronald Reagan's tenure as president, the medical expenses deduction received several amendments as part of the President's multiple tax reforms. The Tax Equity and Fiscal Responsibility Act of 1982

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[119] *Id.*; Letter from George J. Blaine, Deputy Assoc. Chief Counsel of Income Tax & Accounting of the I.R.S. 1 (December 29, 2006), *available at* http://www.irs.gov/pub/irs-wd/06-0088.pdf [hereinafter Blaine].

[120] Revenue Act of 1942 § 127, I.R.C. § 23.

[121] Blaine, *supra* note 119 (quoting statement of Congressman Hinshaw, 88 CONG. REC. 8569 (1942)).

[122] Erb, *supra* note 117.

[123] Internal Revenue Code of 1954 § 213, I.R.C. § 213 (1954). Although the Revenue Act of 1942 set the floor for claiming the deduction at 5% of net income, this was changed to 5% of adjusted gross income in 1944. *See* Ridley, *supra* note 115, at 955.

[124] Internal Revenue Code of 1954 § 213, I.R.C. § 213.

[125] Erb, *supra* note 117.

reinstated the 5% minimum for claiming the deduction,[126] while the noteworthy Tax Reform Act of 1986 again increased the threshold to 7.5%.[127] The 7.5% floor remained in place until the enactment of the Affordable Care Act in 2010.[128] According to Senate reports detailing the legislative history behind the 1986 reforms, Congress intended only those medical expenses constituting a considerable amount of a taxpayer's income, which would perhaps diminish the taxpayer's ability to pay his taxes, to qualify for the deduction.[129] Additionally, Congress also sought to decrease the percentage of Americans claiming the medical expense deduction, allegedly to remove the burden of record keeping off of the taxpayers, but more likely for the principal reason of decreasing the need for the Internal Revenue Service to analyze smaller claims.[130]

b. Evolution of Interpretation

In regard to weight loss expenses, the Internal Revenue Service's ("IRS") interpretation as to what qualifies for the deduction represents the most significant aspect of the history of the medical expenses deduction. The IRS first considered the deduction of weight loss-related expenses in 1955 with Revenue Ruling 55-261, concluding that "fees paid to a health institute where the taxpayer takes exercise, rubdowns, etc., are held to be a personal expense, deduction for which is prohibited by section 24(a)(1) [now section 262] of the Code."[131] The agency further held, however, that certain expenses could qualify for the deduction if the treatment was prescribed by a physician as necessary for the "alleviation of a physical or mental defect or illness."[132] Given the relatively low rates of obesity at the time of this decision,[133] the IRS's reluctance to allow a deduction for

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[126] Tax Equity and Fiscal Responsibility Act of 1982 § 202, I.R.C. § 213 (1982).

[127] Tax Reform Act of 1986 § 133, I.R.C. § 213 (1988).

[128] For a more detailed history of the medical expenses deduction, see Erb, *supra* note 117, and Ridley, *supra* note 115.

[129] Blaine, *supra* note 119 (citing S. REP. NO. 99-313, at 59 (1986)).

[130] Blaine, *supra* note 119.

[131] Rev. Rul. 55-261, 1955-1 C.B. 307.

[132] *Id.*

[133] In the 1950s, 9.7% of American adults were obese. Beverly Bird, *How Much Have Obesity Rates Risen Since 1950?*, LIVESTRONG (Aug. 16, 2013), http://www.livestrong.com/article/384722-how-much-have-obesity-rates-risen-since-1950/.

weight loss-related expenses is not surprising. Moreover, Revenue Ruling 55-261 was a narrow decision in that it was limited to the consideration of exercise-related expenses, rather than weight loss-related expenses as a whole. This can likely be attributed to the fact that the extensive weight loss programs presently offered were, for the most part, non-existent in the 1950s.

The IRS did not discuss the issue of the deductibility of weight loss expenses again until nearly twenty-five years later in 1979. The agency held that "[t]he cost of an individual's participation in a weight reduction program that is not for the purpose of curing any specific ailment or disease, but for the purpose of improving the individual's appearance, health, and sense of well being, is not deductible as a medical expense."[134] Thus, any expenses incurred for reasons other than for the treatment of a disease were held to be personal and therefore not deductible under section 262 of the Code.

In addressing weight loss expenses generally, Revenue Ruling 79-151 broadened the scope of the prior revenue ruling, which only pertained to exercise expenses, while also maintaining the distinction that any expenses undertaken for the purpose of weight loss, whether via exercise or another program, were only deductible if for the treatment of a disease, which did not include obesity. The stipulation that expenses had to be undertaken for the treatment of a disease in order to claim the deduction relates back to section 213's definition of medical care, which limits the availability of the deduction to expenses incurred in connection with a specific disease.[135]

The IRS issued its most recent decision regarding weight loss expenses in 2002. In Revenue Ruling 2002-19, the agency made a marked change in its interpretation of section 213, holding that,

> [u]ncompensated amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases (including obesity) diagnosed by a physician are expenses for medical care that are deductible under § 213, subject to the limitations of that section. The cost of purchasing diet food items is not deductible under § 213.[136]

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[134] Rev. Rul. 79-151, 1979-1 C.B. 116.
[135] I.R.C. § 213(d)(1)(A) (2012).
[136] Rev. Rul. 2002-19, 2002-1 C.B. 778.

In its decision, the IRS specifically addressed the World Health Organization's recognition of obesity as a disease in 1997, as well as the classification of obesity as a chronic disease by the National Heart, Lung, and Blood Institute in 1998;[137] these classifications were thus impliedly a principal motivating factor in the decision. Moreover, the 2002 ruling clarified that obesity would not have been considered a disease for the purposes of the deduction in prior years, including in the IRS's decisions in its earlier rulings.

c. The Medical Expense Deduction in Practice Prior to the Affordable Care Act

Prior to the implementation of the Affordable Care Act, the applicable section of which went into effect in 2013 (the revision of section 213), a taxpayer could deduct eligible medical and dental expenses incurred by the taxpayer, his spouse, and any dependents so long as he satisfied several conditions: (1) the expenses directly or proximately related to the "diagnosis, cure mitigation, treatment, or prevention of disease" or "the purpose of affecting some structure or function of the body,"[138] (2) the primary purpose of each expense incurred was primarily for the treatment or prevention of a physical or mental illness, (3) the expenses were incurred within the applicable taxable year, (4) insurance had not reimbursed the taxpayer for the expenses, (5) the total expenses claimed equaled or exceeded 7.5% of the taxpayer's adjusted gross income, and (6) the taxpayer itemized his deductions.[139]

In general, expenses for weight loss programs qualify for the deduction so long as the taxpayer has been diagnosed with a disease for which weight loss is recommended as a treatment.[140] This includes obesity, as well as obesity-associated diseases, such as heart disease or type 2 diabetes; an individual does not have to be diagnosed with obesity itself as well as an obesity-related disease in order to deduct expenses for a weight

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[137] *Id.*

[138] Havey v. Comm'r, 12 T. C. 409, 413 (1949).

[139] I.R.C. § 213; *see also* I.R.S. PUB. 502: MEDICAL AND DENTAL EXPENSES 2–3 (2012).

[140] I.R.S. PUB. 502, *supra* note 139, at 15.

loss program.[141] Obese individuals, as well as those with other physician-diagnosed diseases for which weight loss is prescribed as treatment, may also deduct the cost of any physician-prescribed medications used for weight loss.[142] It does not appear that a taxpayer may claim the deduction if he is classified as overweight, but not obese, even though a weight loss program for an individual in this situation could seemingly qualify as "prevention of disease" as defined by section 213.[143]

There are numerous limitations, however, on which categories of expenses associated with weight loss are deductible. Regardless of whether weight loss is recommended for an individual, the cost of a gym or health club membership is not deductible, nor is the cost of special dietary food, as this substitutes for the food that the individual would still consume otherwise.[144] The extent to which the cost of special dietary food exceeds the price of a normal diet, however, may qualify for the deduction.[145]

In regard to obesity, the main taxpayers who benefit from the medical expenses deduction are those who undergo bariatric surgery, the all-encompassing term for weight loss surgical procedures.[146] This markedly limits the availability of the deduction, as bariatric surgery is generally only available for severely or morbidly obese individuals, or individuals with a BMI of forty or higher, which translates to just over 6% of American adults as of 2009–2010, not all of whom can afford the expensive procedure.[147] There are also further limitations on qualifying for the surgery, such as age restrictions and evidence of prior attempts of adopting a healthier lifestyle.[148] Once an individual even qualifies for bariatric surgery, the price can range from as low as $12,000 to upwards of

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[141] *Weight Loss Programs May Be Tax Deductible,* DUKE DIET & FITNESS CTR. (June 28, 2011), http://www.dukehealth.org/services/diet_and_fitness/about/news/weight_loss_programs_may_be_tax_deductible.

[142] I.R.C. § 213(b) (2012).

[143] *Id.*

[144] I.R.S. PUB. 502, *supra* note 139, at 15–17.

[145] *Id.* at 15; *see* Ridley, *supra* note 115, at 963, 996–97.

[146] Connie Farrow, *IRS Allows Tax Deduction for Doctor-Approved Weight-Loss*, USA TODAY, Mar. 1, 2004, http://usatoday30.usatoday.com/money/perfi/taxes/ 2004-03-01-weightloss_x.htm.

[147] *Information on Bariatric Surgery*, U.S. NEWS: HEALTH (Jan. 28, 2010), http://health.usnews.com/health-conditions/heart-health/information-on-bariatric-surgery#2; OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 1–2.

[148] *Information on Bariatric Surgery*, *supra* note 147, at 1–2.

$35,000, with only select insurers offering coverage for the procedure.[149] Thus, although the price of weight loss surgery would undoubtedly qualify most taxpayers for the deduction under section 213 if not covered by insurance, due to the low number of taxpayers even eligible for the surgery, the availability of the deduction is extremely limited in this context.

Despite the high expense of enrolling in a weight loss program, few taxpayers take advantage of the medical expenses deduction.[150] This can perhaps be attributed to the high floor for claiming the deduction, as well as taxpayer unawareness about the availability of the deduction. Notwithstanding the cause of the underuse of the deduction, it appears that Congress' intent with the 1986 reforms has been realized.[151]

d. Amendment to Section 213 under the Affordable Care Act

The Affordable Care Act constitutes the latest amendment to the medical expenses deduction, again increasing the floor for claiming the deduction.[152] The section now reads, "There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent . . . to the extent that such expenses exceed 10 percent of adjusted gross income."[153] The Act thus raises the minimum threshold for utilizing the deduction by 2.5% beginning in 2013; taxpayers over sixty-five, however, are exempt from the increase through 2016.[154] The increase, or rather the revenue gained from increasing the minimum for claiming the deduction, was implemented in part to help subsidize the ACA,[155] which also explains why the increase was included in a piece of health reform legislation, rather than a revenue act.

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[149] *Id.*

[150] Erb, *supra* note 117.

[151] *See* Blaine, *supra* note 119, at 1 ("The Congress wanted to reduce the number of tax returns claiming deductions for medical expenses . . . .").

[152] Patient Protection and Affordable Care Act § 9013, I.R.C. § 213 (Supp. 2013–2014).

[153] I.R.C. § 213(a).

[154] *Id.* § 213(f).

[155] Kelly Phillips Erb, *Tax Breaks for Medical Expenses Under ObamaCare,* FORBES (Nov. 26, 2012, 11:54 AM), http://www.forbes.com/sites/kellyphillipserb/2012/11/26/tax-breaks-for-medical-expenses-under-obamacare/.

e. The Affordable Care Act, the Medical Expenses Deduction, and Tax Policy

The Affordable Care Act and tax policy are forever intertwined since the Supreme Court's decision in *National Federation of Independent Business v. Sebelius,* in which Chief Justice John Roberts proclaimed the penalty imposed on those individuals who fail to purchase health insurance to be a tax.[156] In regard to tax benefits for weight loss expenses, this decision raises an interesting question: if the federal government can tax an individual for failing to purchase health insurance, why should the government not provide taxpayers with a tax break for engaging in behavior that will presumably decrease their health care costs? The motivation behind the Affordable Care Act, at least in part, was to improve access to health care and lower health insurance costs.[157] By choosing to expend a portion of their income on weight loss expenses, some taxpayers contribute to lower health insurance costs in another way, as reducing rates of obesity will likely lead to lower insurance costs in the aggregate.[158] Thus, it is puzzling that the Affordable Care Act renders a tax benefit for these individuals more unattainable by amending section 213 when such individuals are actually contributing to the achievement of one of the underlying purposes of the ACA.

3. Proposed Amendment to Section 213

By increasing the threshold for claiming the medical expenses deduction to 10% of adjusted gross income, the Affordable Care Act further limited the number of taxpayers eligible for claiming the deduction, rendering it largely unavailable for the average taxpayer. In amending the medical expenses deduction in this manner, Congress effectively eliminated a pre-existing benefit for obese taxpayers. In order to have provided an incentive for undertaking weight loss and health improvement expenses for obese individuals, and in alignment with the provisions in the ACA aimed at counteracting the increasing prevalence of obesity in the

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[156] Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2600 (2012).

[157] *See* Alicia Ouellette, *Health Reform and the Supreme Court: The ACA Survives the Battle of the Broccoli and Fortifies Itself Against Future Fatal Attack*, 76 ALB. L. REV. 87, 90–91 (2012–2013).

[158] *See* Lamkin, *supra* note 70, at 449.

United States, Congress could have amended section 213 to eliminate the threshold for claiming the deduction, as well as to expand the categories of eligible expenses.

First, Congress could have eliminated the floor for the claiming the medical expenses deduction in order to incentivize taxpayers to undertake obesity-related expenses.[159] Such an amendment would render the deduction available for all obese taxpayers, as well as all individuals with physician-diagnosed diseases for which weight loss is recommended as treatment.

Second, the category of weight loss-associated expenses that qualifies for the deduction could have been expanded. Currently, only certain expenses are eligible for the deduction, namely formal weight loss programs.[160] This does not include the most obvious tool for spurring weight loss: a gym or health club membership.[161] Similar to eliminating the threshold for claiming the deduction, expanding the category of deductible expenses would increase access to the deduction, especially for low-income taxpayers who may not be able to otherwise afford a weight loss program.

Additionally, expanding the deduction to cover the cost of certain foods would further benefit taxpayers.[162] Currently, the cost of diet food is generally not deductible; only to the extent that it exceeds the cost of a normal diet does it potentially qualify.[163] By preventing the increased cost of a nutritious diet from being eligible for deduction, the IRS ignores the fact that healthy foods generally constitute a much higher expense than the unhealthy alternatives that typically contribute to obesity.[164] In order to encourage healthier consumption, the ACA could have provided that, in addition to the increased cost of special dietary foods, the amount that a healthy diet generally exceeds the cost of an unhealthy one qualifies for the

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[159] The legislative history of the Affordable Care Act reveals that at least one Congressional leader, Representative Paul Broun of Georgia, advocated for eliminating the floor for claiming the medical expenses deduction, although his proposal was not limited to obesity-related expenses. This proposal was defeated in the Committee on Rules. H.R. REP. NO. 111-148 pt. 6, at 14 (2010).

[160] I.R.S. PUB. 502, *supra* note 139.

[161] *Id.*

[162] For an argument in support of the deductibility of diet foods, see Ryan A. Bailey, *Obesity and the Internal Revenue Code: Deducting Costs of Diet Food Items Incorporated in Physician-Prescribed Weight-Loss Programs*, 13 DEPAUL J. HEALTH CARE L. 377, 386 (2011).

[163] Rev. Rul. 2002-19, 2002-1 C.B. 778.

[164] *See* Reach, *supra* note 4, at 360.

deduction. This would, of course, require substantiation by the taxpayer of the expenses incurred for healthier foods in comparison with the cost of his or her formerly unhealthy diet.

In order for these amendments to have a meaningful effect, it is important to note that any proposed amendment to section 213 would necessarily have to be accompanied by increased awareness about the availability of the deduction, as the deduction is not widely utilized, which can perhaps be attributed to a lack of awareness, as well as the high threshold for claiming the deduction.[165]

There are several reasons for which amending section 213 in the proposed manner represents the most viable in which Congress could have provided a tax-based incentive for encouraging healthier behavior in the Affordable Care Act. First, altering the deduction presents the most feasible means of addressing obesity through the tax code, particularly in light of the fact that the Affordable Care Act actually amended section 213. Furthermore, rather than introducing a new benefit, such a refundable tax credits for fitness- or weight loss-related expenses, a revision of section 213 would amend a deduction already in place.

Additionally, amending section 213 to eliminate the threshold for claiming the deduction and to expand eligible expenses has the potential to decrease administrative costs associated with the medical expenses deduction, as it would reduce the amount of time spent by the IRS determining which expenses qualify for the deduction.[166] In contrast, a tax credit could potentially increase administrative costs due to the added burden of issuing the credit to each qualified taxpayer.

Finally, an expanded deduction poses less potential for abuse than a refundable tax credit. According to Senator Orrin Hatch, a member of the Senate Finance Committee, refundable tax credits are highly susceptible to abuse and fraud, with the risk of fraud rising with the desirability of the credit; for example, the Earned Income Tax Credit is far too often a target for abuse, as it provides an appealing benefit, especially for lower-income taxpayers who may not be subject to federal taxes at all.[167] A recent report by the Associated Press revealed that, over the past decade, the IRS issued

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[165] *See* Erb, *supra* note 117 (noting that roughly 6% of taxpayers claimed the medical expenses deduction in 2001).

[166] *See* Associated Press, *IRS Paid More than $110 Billion in Improper Tax Credits,* FOX NEWS (Oct. 22, 2013), http://www.foxnews.com/politics/2013/10/22/irs-paid-more-than-110-billion-in-improper-tax-credits/.

[167] *Id.*

over $110 billion in improper refundable tax credits.[168] Although any tax credit received for the reimbursement of fitness or weight loss program expenses would likely be significantly less than most current available tax credits, such as the Earned Income Tax Credit, a potential credit for these expenses would still pose potential for abuse due to the tangible benefit received, i.e., a cash reimbursement for expenses paid during the taxable year. In contrast, an expanded deduction seemingly would not be as susceptible to abuse, as the deduction would lower taxable income rather than provide the taxpayer with a cash refund.

The historical roots of what is now section 213 of the Internal Revenue Code lie in Congressional desire to ease the burden of taxpayers who incur exceptional health costs. This section, however, has lost most of its impact and functionality over the last several decades, as the deduction has become unattainable for the vast majority of Americans due to the high threshold for claiming the deduction, as well as judicially imposed limits on which expenses are eligible for the deduction. For this reason, eliminating the threshold for claiming the deduction and expanding the categories of expenses which qualify for the deduction under the Affordable Care Act, in conjunction with increased taxpayer awareness, could have placed this financial benefit back in the hands of more taxpayers, while also encouraging them to take charge of their health.

B. MANDATORY INSURANCE COVERAGE

Increased access to affordable health care for all Americans represents perhaps the principal and most notable purpose underlying the Affordable Care Act. Requiring all Americans to purchase health insurance by January 2014, and imposing a federal tax on those who do not, the ACA seeks an ideal of a fully insured population, with a particular emphasis on providing insurance for those who could not previously afford it. While increased access to affordable health care is a feat within itself, this expansion in the percentage of insured Americans also presented a valuable opportunity to address the obesity epidemic. While the Affordable Care Act does mandate insurance coverage of preventative services, the act could have mandated

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[168] *Id.*; *see also IRS Goes after Tax Credit Fraud and Identity Theft,* CLIFTON LARSON ALLEN (Nov. 21, 2012), http://www.claconnect.com/Tax-Watch/IRS-Goes-After-Tax-Credit-Fraud-Identity-Theft.aspx (highlighting examples of recent tax credit abuse).

coverage of all obesity-related expenditures in order to provide an incentive aimed at counteracting obesity.

1. Survey of Insurance-Based Alternatives

In addition to the numerous tax-based proposals for how to combat the obesity crisis, a number of proposals focus on mandating insurance coverage of certain obesity-related expenses.

One insurance-centered alternative advocates for increased insurance coverage of bariatric surgery.[169] Prior to providing coverage for bariatric surgery, many insurers require that an individual satisfy several conditions. Generally, not only must a primary care physician recommend that an individual undergo bariatric surgery, an individual must provide documented proof from his or her primary care physician that the individual has failed to lose weight under a medically supervised dietary program.[170] Moreover, some insurance companies require that bariatric surgery be medically necessary before providing coverage.[171] Noting that the Affordable Care Act failed to require insurance coverage of bariatric surgery, this proposal argues that the federal government should mandate coverage of bariatric surgery for individuals with a BMI of thirty or greater in accordance with FDA recommendations in order to increase overall health and diminish health care costs.[172]

A second proposal suggests that public and private health insurance providers should provide coverage for gym or health club memberships, as well as nutrition counseling, in order to encourage physical activity and the adoption of healthier lifestyles.[173] This proposal, however, does not go as far as to suggest that the government require health insurers to provide such coverage.

Each of these proposals targets a specific type of obesity-related expense. In order to reach the largest number of individuals and have the most meaningful impact, the Affordable Care Act could have mandated

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[169] Jessica A. Nardulli, Commentary, *The Road to Health is a Battle Hard Fought: Support for Requiring Coverage of Bariatric Surgery for an Expanded Group of Qualified Individuals*, 33 J. LEGAL MED. 399, 414–15 (2012).

[170] *Id.* at 410.

[171] *Id.*

[172] *Id.* at 414–15.

[173] Deena Patel, Note, *Are We Too Darned Fat? Trying to Prevent and Treat Obesity with Health Care Reform*, 8 QUINNIPIAC HEALTH L.J. 141, 152–54 (2004).

insurance coverage for all obesity-related expenses, including bariatric surgery and the cost of a gym or health club membership.

2. Mandatory Insurance Coverage of All Obesity-Related Expenses

Section 1001 of the Affordable Care Act, an amendment to the Public Health Service Act, obligates health insurers to provide coverage for preventative services recommended by the United States Preventative Services Task Force without imposing cost-sharing on their insureds;[174] this includes BMI screening and other obesity-related services.[175] While this requirement is certainly a step in the right direction, the ACA falls short of increasing insureds' access to weight loss programs and services by failing to require insurers to provide coverage for weight loss- and health-related expenses incurred by obese individuals.

Congress missed a vital opportunity to institute an insurance-based solution for conquering the obesity crisis with the Affordable Care Act for several reasons. First and foremost, the mandatory coverage provision of the ACA, which went into effect on January 1, 2014,[176] will, in theory, drastically increase the number of Americans with health insurance, with a large number of new insureds being low-income individuals who could not previously afford insurance. As such, requiring health insurers to provide full coverage[177] for weight loss- and health-related expenses incurred by obese individuals could potentially have a considerable impact on the obesity epidemic, as it would increase the number of obese individuals with access to the means to lose weight and adopt healthier lifestyles.

Moreover, mandatory insurance coverage for obesity-related expenses also constitutes a financial incentive, which, as previously

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[174] Patient Protection and Affordable Care Act § 1001(5), 42 U.S.C. § 300gg-13(a)(5) (2012).

[175] Wiley, *supra* note 94, at 152.

[176] Patient Protection and Affordable Care Act § 1501(b), I.R.C. § 5000A(a) (2012).

[177] Many health insurers provide coverage for gym or health club memberships. For example, UnitedHealthcare, through its Fitness Reimbursement Program, offers a $20 reimbursement for every month an insured goes to the gym or health club at least twelve times. *Fitness Reimbursement Program*, UNITEDHEALTHCARE, http://uhctogether.com/uhcwellness/16181.html (last visited May 27, 2015).

discussed, is proven to positively affect human behavior.[178] Studies have demonstrated that insurance incentives in particular can help to encourage weight loss. For example, the University of Washington's Exploratory Center for Obesity Research, in conjunction with the Group Health Center for Health Studies, published a study focusing on overweight and obese adults suffering from metabolic syndrome[179] in 2008, which revealed that a hypothetical proposal increasing insurance coverage for weight management programs from 10% to 100% dramatically increased interest in participation in such a program.[180] The researchers further postulated that, while providing full insurance coverage to obese individuals for enrollment in a weight loss program would temporarily increase health care costs, such coverage could lead to decreased medical spending in the long run due to a reduction in obesity-related costs.[181] Thus, this study[182] strongly supports the proposition that mandatory insurance coverage of weight loss expenses has the potential to become an effective tool in the battle against obesity.

Furthermore, mandating insurers to provide coverage of obesity-related expenses also solves one problem raised by solely amending section 213 to provide a financial incentive for inspiring weight loss: some individuals, including a substantial of Americans affected by obesity, are not subject to federal income taxes. Insurance coverage of these expenses would insure that all Americans are provided with a financial incentive encouraging weight loss, rather than just taxpayers. Moreover, the language of section 213 prevents a double benefit from occurring in this context, meaning that taxpayers can only deduct expenses not covered by insurance.[183]

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[178] *See supra* Part IV.

[179] "Metabolic syndrome" is defined as "a constellation of weight-related risk factors (elevated blood pressure, elevated waist circumference, and elevated levels of lipoprotein cholesterol levels; and reduced high-density lipoprotein cholesterol levels) affecting 24% of US adults." Arterburn et al., *supra* note 9, at 71.

[180] *Id.* at 70.

[181] *Id.*

[182] The study also found that a majority of adults, specifically 76% of women and 57% of men, supported the institution of a health insurer-provided financial incentive program through which insurers would pay participants for achieving certain weight loss goals, with 41% of study participants stating that they believed that such a program would motivate them to lose weight. *Id.* at 73.

[183] I.R.C. § 213(a) (Supp. 2013–2014).

In sum, while Congress now requires insurers to cover, with no co-pay, preventative services aimed at diminishing the prevalence of obesity in the United States, it stops short of mandating coverage for expenses incurred by obese Americans who seek to lose weight and shed the label of obese. While mandatory coverage of weight loss-driven expenses would certainly be costly for insurance providers at the outset, if this tactic accomplished the desired result, decreasing the percentage of Americans suffering from obesity, health care costs would likely decrease as obesity rates decline.[184] As a result, mandated coverage of these expenses could potentially benefit insurers in the long run.

VI. CONCLUSION

In recent decades, obesity has gone from affecting less than 15% of the population in the 1960s to a major health crisis credited with causing 112,000 premature deaths in 2000.[185] Not only does obesity pose a major public health concern, but the prevalence of this chronic disease in the United States has caused skyrocketing medical spending and increased health insurance costs, which affect both obese individuals and the rest of the population alike.[186] Although Congress made strides towards combatting this public health crisis with the Patient Protection and Affordable Care Act, the act could have more effectively targeted the escalating prevalence of obesity by providing a financial incentive to encourage weight loss and the adoption of overall healthier lifestyles.

Drawing on other provisions included in the act, the Affordable Care Act could have provided a financial incentive in one of two ways. First, rather than increasing the floor for claiming the medical expenses deduction, the Affordable Care Act could have amended section 213 of the Internal Revenue Code to eliminate the threshold for claiming a deduction for obesity-related expenses, as well as expand the categories of expenses eligible for the deduction. Second, Congress could have mandated health insurance coverage of weight loss- and health-related expenses incurred by obese individuals. Although in no way an exhaustive list of ways in which the Affordable Care Act could have provided a financial incentive, the implementation of such an incentive would have provided a meaningful

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[184] *See supra* notes 101–04 and accompanying text.

[185] OVERWEIGHT AND OBESITY STATISTICS, *supra* note 11, at 4; Go et al., *supra* note 1, at e61.

[186] *See supra* Part II.C.

means of addressing the obesity epidemic, which continues to pose dire consequences on public health, as well as the American economy.