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Biting the Hands that Feed “the Alligators”: A Case Study in Morbid Obesity Extremes, End-of-Life Care, and Prohibitions on Harming and Accelerating the End of Life

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Biting the Hands that Feed “the Alligators”: A Case Study in Morbid Obesity Extremes, End-of-Life Care, and Prohibitions on Harming and Accelerating the End of Life

Michael J. Malinowski[†]

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Obesity, recognized as a disease in the U.S. and at times as a terminal illness due to associated medical complications, is an American epidemic according to the Centers for Disease Control and Prevention (“CDC”), American Heart Association (“AHA”), and other authorities. More than one third of Americans (39.8% of adults and 18.5% of children) are medically obese. This article focuses on cases of “extreme morbid obesity” (“EMO”)—situations in which death is imminent without aggressive medical interventions, and bariatric surgery is the only treatment option with a realistic possibility of success. Bariatric surgeries themselves are very high risk for EMO patients. Individuals in this state have impeded mobility and are partially, if not entirely, bedridden, highly vulnerable, and dependent upon caregivers who often are enablers feeding their food addictions. The article draws from existing Centers for Medicare and Medicaid Services (“CMS”) and Social Security Administration (“SSA”) policies and procedures for severe obesity treatment and disability benefits. The discussion also encompasses myriad areas in which the law imposes a duty to report on professionals to protect vulnerable individuals from harm from others, and constraints and prohibitions on accelerating the end of life. The article proposes, among other law and policy measures, to introduce an obligation on medical professionals to investigate and report instances of enablement when food addiction has put the lives of individuals at risk of imminent death. The objectives of the proposals are to give providers more leverage to prevent food addiction enablers from impeding treatment and to enable EMO patients to comply with treatment protocols, to save lives and, ironically, to empower enablers to stand firm against the demands of individuals whose lives have been consumed by their food addictions.

I. INTRODUCTION

Dr. Nowzaradan Younan, whose nickname is “Dr. Now,” and his Houston, Texas medical practice, are the subject of The Learning Channel’s (“TLC”) long-running reality television series *My 600-lb Life*.¹ The series illustrates “the lives of ordinary people experiencing extraordinary obesity, and showcase[s] their struggles before, during, and after weight loss surgery.”² Dr. Now, a highly skilled pioneer in laparoscopic surgery with over three decades of experience, is a surgeon who is both compassionate and no-nonsense.³ He specializes in laparoscopic gastric bypass weight-loss surgery on patients who are EMO, meaning individuals with BMIs of 50 or more.⁴ Virtually all patients profiled on the show weigh at least 600 pounds and are “untreatable”—individuals routinely refused treatment due to the surgical and other medical complications associated with their enormous weights.⁵

Dr. Now’s patients portrayed in the series are self-aware to some degree that death is imminent before they commence treatment with him. Most have greatly limited mobility, if any, due to lymphedema attributable to their weights so excessive that, in Dr. Now’s words, they have “elephant legs.”⁶ The threat of imminent death without treatment is undeniable.⁷ With limited if any bariatric surgery options other than Dr. Now, these patients endure financial and logistical barriers, uproot their lives, and travel often hundreds of miles for a Dr. Now intervention.⁸ The journeys to Houston and Dr. Now subject them to added health risks that include heart attacks, strokes, aneurysms, and respiratory failure, and they bear enormous amounts of added pain to make the journeys, often mental as well as physical.⁹ Their goal, bariatric surgery, is itself potentially life threatening for these patients.¹⁰

When they arrive in Houston, Dr. Now confronts patients with the unadulterated truth—direct confirmation that they will die from their addiction if they

¹ See *My 600-lb Life* (TLC television broadcast). For the first season, patients were filmed over a period of seven years, from 2004 to 2011. Starting with the second season, patients were filmed for one year.

² Lisa Swan, *The Untold Truth of My 600-lb Life*, LIST, <http://www.thelist.com/58296/untold-truth-600-lb-life/> [https://perma.cc/Z7UY-5RHZ].

³ See *id.*; *My 600-lb Life*, *supra* note 1.

⁴ The commonly shared rubric for determining obesity, Body Mass Index (“BMI”), is discussed *infra* at notes 23-28 and accompanying text. To define the term EMO for this article, I applied TLC weight baseline for its dozens of patient stories (case studies) aired over the last five seasons, 600 pounds, and accompanied by life-threatening health complications. See generally *My 600-lb Life*, *supra* note 1. This translates to a BMI of 88.6 or higher for an average size man and 103 or higher for an average size woman in the U.S. BMI Calculator, NAT’L INST. HEALTH, https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm [https://perma.cc/LMS6-WK8D].

⁵ See *infra* notes 59-61 and accompanying text; Swan, *supra* note 2. Absent overriding individual patient health considerations, Dr. Now imposes a maximum starting weight limit of 600 pounds; many other providers set limits at substantially lower weights. See *Dr. Now MD: Weight-Loss and Beyond*, DR. NOW MD, <http://dnowmd.com/> [https://perma.cc/2XF9-B7XR]; Swan, *supra* note 2 (“For example, the University of California at San Francisco Medical Center has a weight limit of 450 pounds, due to that being the biggest weight their x-ray machines can measure. Also, the more somebody weighs, the more the risks increase, as with any surgery.”).

⁶ As it progresses, lymphedema causes skin to thicken and harden, and blisters and wart-like growths may develop, in addition to open sores, which often cause excruciating pain. See Christian Nordqvist, *What is Lymphedema?*, MED. NEWS TODAY, <http://www.medicalnewstoday.com/articles/180919.php> [https://perma.cc/D8VS-7W9E] (last updated Dec. 20, 2017).

⁷ See *infra* notes 47-52 and accompanying text.

⁸ See generally *My 600-lb Life*, *supra* note 1; *infra* notes 57-61 and accompanying text (describing the standard treatment protocol for severe obesity and the limitation on treatment options).

⁹ See *infra* notes 47-52 and accompanying text.

¹⁰ See generally discussion *infra* Part II.B.

do not change their eating habits.¹¹ He then imposes a strict diet, typically a daily caloric limit of 1,000-1,200, a jolting deviation from their 10,000+ norms. Dr. Now conditions eligibility for surgery on a substantial weight loss to force his patients to change their eating habits with a stern “or the surgery will not work.”¹² The patients usually are accompanied by their food addiction enablers, the enablement continues even under Dr. Now’s care, treatment is impeded, and episodic drama unfolds.

Dr. Now analogizes addiction to a small pet, which grows with each feeding, only to eventually consume the addict.¹³ Having lived in Louisiana for over 15 years, my take on the analogy is that addiction is an alligator egg. Many of Dr. Now’s patients are trapped in their beds, entangled with scaled behemoths that expose long rows of jagged teeth, yellow eyes focused on the fleshy prize, and ready to chomp. These alligators are larger than the EMO patients, for they have taken over their lives. Yet, episode after episode, the enablers continue unhealthy feedings well aware that those they are “caring for” are on the verge of being consumed by their addictions. Few of Dr. Now’s patients initially meet his weight-loss ultimatums, and Dr. Now has no qualms about confronting the enablers as well as the patients.¹⁴ In some instances, Dr. Now has even hospitalized patients to remove them from their enablers and to control their diets under directly supervised conditions, and enablers still have managed to sneak in food—as the scale faithfully reveals.¹⁵

As a nation, we are, literally, eating ourselves to death.¹⁶ This article focuses on cases of EMO and the caregivers in those situations of near, if not complete, patient dependency and high risk of imminent death, who continue to feed the “addiction alligators.”¹⁷ Through lengthy debate and thoughtful deliberation, Oregon and other states that have enacted end-of-life laws that, while allowing acceleration of the end of life by individuals terminally ill, strictly prohibit anyone, including physicians prescribing the means, from assisting in administering life-ending prescriptions.¹⁸ Although suicide is not criminalized for lack of anyone to prosecute, states prohibit assisting in suicide, and every state in the nation has mandatory reporting requirements to prevent harm to others—from suspected child abuse to elder abuse, and beyond.¹⁹ This article proposes law and policy measures to discourage, if not stop, enablers in cases of extreme food addiction and morbid obesity to the point of imminent death from continuing to feed their “addiction alligators.”

¹¹ Dr. Now elaborated on his patient-interaction philosophy in a May 2017 *People Magazine* interview: “There are times where I think it’s necessary for some tough love and I have to be stern with them. . . . They are the patient because they need help and it’s my job to help them no matter what.” Brittany King, *My 600-Lb. Life Dr. Nowzaradan on Why It’s Difficult for Patients to Keep the Weight Off*, PEOPLE (May 30, 2017, 11:33 AM), <http://people.com/bodies/my-600-lb-life-dr-nowzaradan-why-difficult-patients-keep-weight-off/> [https://perma.cc/3GBT-C8Q4].

¹² Dr. Now explains to his patients in advance that the surgery alone will only keep them from eating a lot at one time, which is why he imposes a surgery prerequisite: patients must lose weight on their own before surgery to adjust their mindsets and lifestyles. *My 600-lb Life: Zsalynn’s Story* (TLC television broadcast Jan 7, 2014).

¹³ *Id.*

¹⁴ See, e.g., *infra* Part III.A.

¹⁵ See *My 600-lb Life: James K’s Story* (TLC television broadcast Mar. 15, 2017); see also *infra* notes 146-47 and accompanying text.

¹⁶ See generally *infra* Part II.A.

¹⁷ See generally *supra* Parts I.

¹⁸ See *infra* notes 179-83 and accompanying text.

¹⁹ See *infra* notes 171-72 and accompanying text.

Part II chronicles the nation's obesity epidemic and treatment options for cases of morbid obesity, and discusses federal health care and disability coverage for EMO cases. Part III delves into the caregiver-enabler situation in more detail by profiling James K's story, one of Dr. Now's patient cases that vividly illustrates how food addiction enablement often impedes treatment of terminally obese patients even when under physician care and with full awareness that death is imminent.²⁰ Part IV draws from areas of developed law and policy to propose measures to protect these vulnerable patients from the addiction enablement that threatens their treatment and lives. These regulatory proposals are introduced to disable enablement—to, in essence, bite the hands that feed the food addiction “alligators.”

II. OBESITY TRENDS, TREATMENTS, AND DISABILITY COVERAGE

America is experiencing an obesity epidemic expanding across the country, as documented by the CDC on a state-by-state basis.²¹ The following discussion begins by presenting the official definitions of obesity and morbid obesity, and addresses this epidemic in more detail. Next, the discussion profiles treatment options and advances with a focus on bariatric surgery—the only treatment option with a realistic possibility for most EMO individuals to overcome their life-threatening obesity and, coupled with lifestyle changes, to control their food addictions.²² The discussion then turns to federal health care and disability coverage for EMO cases, including coverage for personal care assistants (“PCAs”) and bariatric surgery.

A. THE AMERICAN OBESITY EPIDEMIC

The basic screening tool for determining obesity is Body Mass Index (“BMI”), which is the ratio of an individual's height to his or her weight.²³ BMI is an indicator for the level of body fat.²⁴ According to the National Institutes of Health (“NIH”) and CDC, whose rubric generally is followed, obesity is classified into three categories²⁵:

²⁰ *My 600-lb Life: James K's Story*, *supra* note 15. James K's story is discussed *infra* at Part III.A, and similar cases of enablement are discussed *infra* at Part III.B.

²¹ *Adult Obesity Prevalence Maps*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/obesity/data/prevalence-maps.html> (last updated Apr. 10, 2017) (consistent with poverty levels, the rates of obesity are highest in Alabama, Louisiana, Mississippi, and West Virginia, although every state in the nation experiences an obesity rate greater than 20%).

²² See *infra* note 61 and accompanying text.

²³ *Defining Adult Overweight and Obesity*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/obesity/adult/defining.html> [<https://perma.cc/ZAUT-FEBY>] (last updated June 16, 2016). One may calculate his or her own BMI by visiting <http://asmbs.org/calculate-your-bmi/> [<https://perma.cc/SS33-4F3Y>]. Assistance interpreting BMIs is available at *Body Mass Index Table 1*, NAT'L HEART, LUNG & BLOOD INST., https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmi_tbl.htm [<https://perma.cc/7NCM-DNH4>].

²⁴ *Id.*; see Cynthia Ogden et al., *Prevalence of Obesity Among Adults and Youth: United States, 2011-2014*, NAT'L CTR. HEALTH STAT. (2015), <https://www.cdc.gov/nchs/data/databriefs/db219.pdf> [<https://perma.cc/PG99-JDRZ>]. The BMI rubric has been criticized for not considering muscle mass. See *What is Obesity?*, OBESITY SOC'Y, <http://www.obesity.org/obesity/resources/facts-about-obesity/> [<https://perma.cc/9PB8-A7J7>]. However, “most people are not athletes, and for most people, BMI is a very good gauge of their level of body fat.” *Why Use BMI?*, HARV. SCH. PUB. HEALTH, <https://www.hsph.harvard.edu/obesity-prevention-source/obesity-definition/obesity-definition-full-story/> [<https://perma.cc/E6LZ-W543>].

²⁵ *Defining Adult Overweight and Obesity*, *supra* note 23; *The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*, NAT'L HEART, LUNG & BLOOD INST. (Oct. 2000), https://www.nhlbi.nih.gov/files/docs/guidelines/prctgd_c.pdf [<https://perma.cc/3H2M-WPAX>].

- Class 1: BMI of 30 to < 35²⁶
- Class 2: BMI of 35 to < 40²⁷
- Class 3: BMI of 40 or higher. Class 3 obesity is sometimes classified as “extreme” or “severe” obesity.²⁸

“Morbid obesity” is a much more amorphous term. “An individual is considered *morbidly obese* if he or she is 100 pounds over his/her ideal body weight, has a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes.”²⁹

The obesity epidemic is a global problem—nearly 30% of the world’s population, 2.1 billion people, are either overweight or obese, and “[t]he rise in global obesity rates over the last three decades has been substantial and widespread, presenting a major public health epidemic in both the developed and the developing world.”³⁰ The U.S., where the documented obesity epidemic dates some three decades profoundly, is distinguishable: “America leads the world as far as obesity statistics are concerned. In fact, it has become an even bigger threat than coronary heart disease and cancer.”³¹ The rate of obesity increase among U.S. adults slowed and plateaued among children in 2013-2014, only to reach an all-time high in both groups in 2015-2016 (39.8% of adults and 18.5% of children) according to the CDC’s National Center for Health Statistics.³²

²⁶ According to the CDC, the average height for men in the U.S. is five feet, nine inches, and the average height for women is five feet, four inches. See *QuickStats: Mean Weight and Height Among Adults Aged 20--74 Years, by Sex and Survey Period--United States, 1960--2002*, CTRS. DISEASE CONTROL (Aug. 12, 2005), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5431a5.htm> [<https://perma.cc/J7L6-3H3W>]. An average height man (69 inches) with a BMI index of 30 would weigh 203 pounds, whereas an average height woman (64 inches) with a BMI of 30 would weigh 174 pounds. See *Body Mass Index Table 1*, *supra* note 23.

²⁷ An average height man (69 inches) with a BMI index of 35 would weigh 236 pounds, while an average height woman (64 inches) with a BMI of 30 would weigh 204 pounds. *Id.*

²⁸ An average height man (69 inches) with a BMI index of 40 would weigh 270 pounds, and an average height woman (64 inches) with a BMI of 40 would weigh 232 pounds. See *id.*

²⁹ *What is Morbid Obesity?*, UNIV. ROCHESTER MED. CTR.: HIGHLAND HOSP., <https://www.urmc.rochester.edu/highland/bariatric-surgery-center/questions/morbid-obesity.aspx> [<https://perma.cc/CM7B-KMMH>] (emphasis added).

³⁰ Christopher J.L. Murray & Marie Ng, *Nearly One-Third of the World’s Population is Obese or Overweight, New Data Show*, INST. HEALTH MATRIX & EVAL., <http://www.healthdata.org/news-release/nearly-one-third-world%E2%80%99s-population-obese-or-overweight-new-data-show> [<https://perma.cc/M9LB-977N>].

³¹ Sumayah Aamir, *Americans Take Obesity as Seriously as Cancer*, I4U NEWS (Nov. 1, 2016, 1:28 PM), <https://www.i4u.com/2016/11/116911/americans-take-obesity-seriously-cancer> [<https://perma.cc/QZ3B-SDXQ>]; see Maggie Fox, *America’s Obesity Epidemic Hits a New High*, CNBC: HEALTH CARE (June 8, 2016, 8:27 AM), <http://www.cnbc.com/2016/06/07/americas-obesity-epidemic-hits-a-new-high.html> [<https://perma.cc/3VUX-HD8N>] (discussing the increasing prevalence of obesity in America); Amir Khan, *America Tops List of 10 Most Obese Countries*, U.S. NEWS: HEALTH (May 28, 2014, 7:00 PM), <http://health.usnews.com/health-news/health-wellness/articles/2014/05/28/america-tops-list-of-10-most-obese-countries> stating that the US tops the list of the most obese countries in the world); Franco Sassi, *How U.S. Obesity Compares With Other Countries*, PBS: NEWS HOUR (Apr. 11, 2013, 10:54 AM), <http://www.pbs.org/newshour/rundown/how-us-obesity-compares-with-other-countries/> [<https://perma.cc/K2EL-GY8R>] (stating that obesity rates in the U.S. are still on the rise).

³² See Craig M. Hales et al., *Prevalence of Obesity Among Adults and Youth: United States, 2015-2016*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/nchs/products/databriefs/db288.htm> [<https://perma.cc/4BED-ZU2H>] (last updated Oct. 13, 2017); see also *Adult Obesity Facts*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/obesity/data/adult.html> [<https://perma.cc/EV7B-FSR>] (last updated Sept. 1, 2016) (stating that more than one third of American adults have obesity); Sarah Hedgecock, *Yes, America’s Obesity Rates Are Still (Slowly) Rising*, FORBES (May 27, 2016, 8:00 AM), <https://www.forbes.com/sites/sarahhedgecock/2016/05/27/yes-americas-obesity-rates-are-still-slowly-increasing/#2c946a00d8a> [<https://perma.cc/G4SG-AJM2>] (discussing the increasing obesity rates in the US);

These numbers translate into more than 78 million adults and 13 million children.³³ In comparison, the obesity rate for U.S. adults in 1997 was 19.4%.³⁴ The prognosis for obesity in America's future is bleak: "The Trust for America's Health projects that 44 percent of Americans will be obese by 2030, while the [CDC] projects 42 percent of adults will be."³⁵ According to the Department of Health and Human Services ("DHHS"), which focused on *morbid* obesity in a report issued in 2013, consistent with obesity in general, "morbid obesity rates (at any cutoff point above 40) in the US continue to rise rapidly, although the near exponential growth has noticeably flattened out since 2005."³⁶ DHHS also reported that, in comparison with 1986 data, "[t]he higher the weight groups, the more rapid the rate of growth. The percentage of the population with a BMI over 50 based on reported height and weight has increased more than 10-fold."³⁷ The American Society for Metabolic and Bariatric Surgery ("ASMBS") reports that 15 million Americans are morbidly obese.³⁸

There has been, and continues to be, debate over whether obesity is a disease or lifestyle choice. After much discussion and deliberation among its delegates, the American Medical Association ("AMA") declared obesity a disease in 2013.³⁹ The association adopted a resolution stating: "The suggestion that obesity is not a disease but rather a consequence of a chosen lifestyle exemplified by overeating and/or inactivity is equivalent to suggesting that lung cancer is not a disease because it was brought about by individual choice to smoke cigarettes."⁴⁰ The Obesity Society had reached a similar conclusion in 2008, and the American College of Cardiology and the American Association of Clinical Endocrinologists has endorsed the AMA's resolution.⁴¹ Data that supports a genetic role in obesity often are cited to shore up its disease status. For example, according to the CDC,

Obesity Demographics, LAHEY HOSP. & MED. CTR., http://www.lahey.org/Departments_and_Locations/Departments/Surgical_Weight_Loss_Center/Obesity_Demographics.aspx [https://perma.cc/C6KY-JT8D] (providing obesity demographics for the U.S.); Ogden et al., *supra* note 24; *Understanding the American Obesity Epidemic*, AM. HEART ASS'N, http://www.heart.org/HEARTORG/HealthyLiving/WeightManagement/Obesity/Understanding-the-American-Obesity-Epidemic_UCM_461650_Article.jsp#.WS2WDGjyvIU [https://perma.cc/3F45-89UH] (last updated March 9, 2016) (discussing increases in the U.S. obesity rate between 1962 and 2006).

³³ See *Understanding the American Obesity Epidemic*, *supra* note 32; *Adult Obesity Facts*, *supra* note 32; Hales et al., *supra* note 32; see also Ogden et al., *supra* note 24 (discussing the prevalence of obesity among American adults and children).

³⁴ See Hales et al., *supra* note 32; Brian W. Ward et al., *Early Release of Selected Estimates based on Data from the 2015 National Health Interview Survey*, CTRS. DISEASE CONTROL (May 2016), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201605.pdf> [https://perma.cc/SYA3-GM58].

³⁵ Fox, *supra* note 31.

³⁶ Roland Sturm & Aiko Hattori, *Morbid Obesity Rates Continue to Rise Rapidly in the U.S.*, 37 INT'L J. OBESITY 889, 890 (2013).

³⁷ *Id.* (noting that sample size for this obesity subpopulation is innately smaller).

³⁸ *Fact Sheet: Obesity in America*, AM. SOC'Y METABOLIC & BARIATRIC SURGERY, http://asmbs.org/wp/uploads/2014/07/asmbs_fs_obesity.pdf?newsite07/media/asmbs_fs_obesity.pdf [https://perma.cc/KP9C-R2LW] (last updated June 2010); *Obesity in America*, AM. SOC'Y METABOLIC & BARIATRIC SURGERY (Nov. 2013), <https://asmbs.org/resources/obesity-in-america> [https://perma.cc/8VKP-HZNZ].

³⁹ Kelly Fitzgerald, *Obesity is Now a Disease, the American Medical Association Decides*, MED. NEWS TODAY, <http://www.medicalnewstoday.com/articles/262226.php> [https://perma.cc/695A-DH44] (last updated Aug. 17, 2013).

⁴⁰ *Id.*

⁴¹ *Id.* The AMA debated internally on the matter. After their Council on Science and Public Health studied the issue for over a year, the Association ultimately rejected the conclusion that "obesity should not be classified as a disease because the measure that is used to categorize obesity (body mass index, BMI) is flawed, given that it does not measure overall fat or muscle (lean tissue)." *Id.* See generally *Facts About*

Studies of resemblances and differences among family members, twins, and adoptees offer indirect scientific evidence that a sizable portion of the variation in weight among adults is due to genetic factors. Other studies have compared obese and non-obese people for variation in genes that could influence behaviors (such as a drive to overeat, or a tendency to be sedentary) or metabolism (such as a diminished capacity to use dietary fats as fuel, or an increased tendency to store body fat). These studies have identified variants in several genes that may contribute to obesity by increasing hunger and food intake.⁴²

The U.S. federal government tends to skirt the disease-versus-lifestyle debate by grouping—for example, the CDC uses language such as “chronic diseases and conditions.”⁴³ In 2004, Medicare removed wording from its coverage manual that stated obesity was not a disease.⁴⁴

The AMA’s position and support for it has quieted the debate some, but, in fact, the question is somewhat moot. Whether the “disease” label is stamped on obesity, the fact is that obesity triggers myriad health conditions that are undeniably diseases—a fact recognized globally as well as nationally.⁴⁵ As stated by the World Health Organization (“WHO”) in a 2002 report:

Overweight and obesity are important determinants of health and lead to adverse metabolic changes, including increases in blood pressure, unfavourable cholesterol levels and increased resistance to insulin. They raise the risks of coronary heart disease, stroke, diabetes mellitus, and many forms of cancer. The report shows that obesity is killing about 220 000 men and women a year in the [U.S.] and Canada

Obesity, OBESITY SOC’Y (2016), <http://www.obesity.org/obesity/resources/facts-about-obesity/> [<https://perma.cc/3UXM-E3XP>] (providing public educational materials with background facts and information about obesity).

⁴² *Behavior, Environment, and Genetic Factors All Have a Role in Causing People to be Overweight and Obese*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/genomics/resources/diseases/obesity/index.htm> [<https://perma.cc/5HHP-5R8C>] (last updated May 10, 2013); see *Adult Obesity Causes and Consequences*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/obesity/adult/causes.html> [<https://perma.cc/7979-4MSQ>] (last updated Aug. 29, 2017) (stating that genetics do seem to play a role in development of obesity); *Obesity and Genetics: What We Know, What We Don’t Know, and What It Means*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/genomics/resources/diseases/obesity/obesknow.htm> [<https://perma.cc/8N72-3U84>] (comparing what is known and what remains unknown about the role of genetics in obesity); *Overview: Etiology – Genetic Factors of Overweight and Obesity*, UNIVERSITÉ LAVAL: RESEARCH CHAIR IN OBESITY, <http://www.obesity.ulaval.ca/obesity/generalities/genetic.php> [<https://perma.cc/6LKT-NRLP>] (“Science shows that genetics plays a role in obesity. Genes can directly cause obesity in disorders such as Bardet-Biedl syndrome and Prader-Willi syndrome.”).

⁴³ See, e.g., *Chronic Diseases: The Leading Causes of Death and Disability in the United States*, CTRS. DISEASE CONTROL (Feb. 23, 2016), <https://www.cdc.gov/chronicdisease/overview/index.htm> [<https://perma.cc/2DYW-YBC8>] (“Chronic diseases and conditions . . . are among the most common, costly, and preventable of all health problems.”).

⁴⁴ U.S. DEP’T. HEALTH & HUMAN SERVS., CMS MANUAL SYSTEM PUB. 100-03 MEDICARE NATIONAL COVERAGE DETERMINATIONS, TRANSMITTAL 23 (2004), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R23NCD.pdf> [<https://perma.cc/4ZVA-8E2L>]; see Fitzgeral, *supra* note 39.

⁴⁵ *Adult Obesity Causes and Consequences*, *supra* note 42.

alone, and about 320000 men and women in 20 countries of Western Europe.⁴⁶

Data from multiple and varied sources underscores this point. According to the ASBMS and the Office of the U.S. Surgeon General, “[i]ndividuals who are obese (BMI > 30) have a 50 to 100 percent increased risk of premature death from all causes compared to individuals with a BMI in the range of 20 to 25. An estimated 300,000 deaths a year may be attributable to obesity.”⁴⁷ In fact, “obesity is second only to smoking as a cause of premature death in America.”⁴⁸

Obesity increases one’s risk of developing over 40 health conditions and diseases—all exacerbated by an increased degree of obesity, and many seriously debilitating or life threatening. The list includes: cancers (breast, colon, endometrial, esophageal, gallbladder, kidney, pancreatic, rectal, and thyroid cancers all have been linked to obesity),⁴⁹ diabetes (Type II),⁵⁰ gallstones and other gallbladder diseases, heart disease, high blood pressure (hypertension), high cholesterol, infertility, kidney disease, liver disease, musculoskeletal issues such as orthopedic problems and osteoarthritis (the breakdown of cartilage and bone within a joint), sleep apnea and other breathing problems, and stroke.⁵¹ The CDC adds some sweeping, amorphous, “catch-all” categories—namely body pain and difficulty with physical functioning, low quality of life, mental illness (depression, anxiety, and other mental disorders), and, ultimately, “all causes of death.”⁵²

The myriad health risks associated with obesity, most notably premature death, are exacerbated by its degree.⁵³ As made so vivid by the prevalence and degree

⁴⁶ *World Health Report, Overview: Enemies of Health, Allies of Poverty*, WORLD HEALTH ORG. (2002), <http://www.who.int/whr/2002/overview/en/index1.html> [<https://perma.cc/6MK8-8RZ3>].

⁴⁷ U.S. DEP’T HEALTH & HUMAN SERVS., THE SURGEON GENERAL’S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY 8 (2001), https://www.ncbi.nlm.nih.gov/books/NBK44206/pdf/Bookshelf_NBK44206.pdf [<https://perma.cc/L7AR-BD8L>] [hereinafter “CALL TO ACTION”]. See generally James Greenberg, *Obesity and Early Mortality in the United States*, 21 OBESITY 405 (2013); Ryan Masters, *The Impact of Obesity on US Mortality Levels: The Importance of Age and Cohort Factors in Population Estimates*, 103 AM. J. PUB. HEALTH 1895 (2013).

⁴⁸ Liam Davenport, *Obesity Second Only to Smoking as Cause of Premature Death*, MEDSCAPE (July 24, 2017), <http://www.medscape.com/viewarticle/866096>. See generally *Fact Sheet: Obesity in America*, *supra* note 38.

⁴⁹ “Excess weight and lack of sufficient physical activity causes between 25% to 33% of common cancers in the U.S. and other industrialized nations, according to the International Agency for Research on Cancer.” *Fact Sheet: Obesity in America*, *supra* note 38.

⁵⁰ “Diabetes kills more Americans every year than AIDS and breast cancer combined . . . 85.2% of people with type 2 diabetes are overweight or obese.” *Fast Facts – Data and Statistics about Diabetes*, AM. DIABETES ASS’N (2015), <https://professional.diabetes.org/pel/fast-facts-english-1> [<https://perma.cc/JRV7-6TP5>]; see *Health Risks of Being Overweight*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASES (2012), <https://www.niddk.nih.gov/health-information/weight-management/health-risks-overweight> [<https://perma.cc/23QW-24LC>].

⁵¹ See *Adult Obesity Causes and Consequences*, *supra* note 42; U.S. SOC. SECURITY ADMIN., PROGRAM OPERATIONS MANUAL SYSTEM (POMS) DI 24570.001, <https://secure.ssa.gov/poms.nsf/lnx/0424570001> [<https://perma.cc/LUL2-ARA7>] (last updated Mar. 24, 2017) [hereinafter POMS]; CALL TO ACTION, *supra* note 47, at 8-9; see also *Fact Sheet: Obesity in America*, *supra* note 38; Beth Laurence, *Social Security Disability and Morbid Obesity*, DISABILITYSECRETS, <http://www.disabilitysecrets.com/conditions-page-2-45.html> [<https://perma.cc/HS88-TJ9L>].

⁵² *Adult Obesity Causes and Consequences*, *supra* note 42.

⁵³ Even conservative studies show that moderate obesity may shorten one’s lifespan and lower the quality of life significantly, and extreme obesity exacerbates both. See, e.g., *NIH Study Finds Extreme Obesity May Shorten Life Expectancy Up to 14 Years*, NAT’L INST. HEALTH (July 8, 2014), <https://www.nih.gov/news-events/news-releases/nih-study-finds-extreme-obesity-may-shorten-life-expectancy-14-years> [<https://perma.cc/DRU3-VGQZ>]; *Obesity Could ‘Rob You’ of Twenty Years of Health*, NHS.UK (Dec. 5,

of lymphedema in these individuals,⁵⁴ EMO introduces a whole additional dimension of circulatory, cardio-vascular, musculoskeletal, organ failure, infection (lymphedema alone causes blistering and infection, at times extreme), and other risk factors.⁵⁵

For most EMO individuals, treatment options with meaningful potential for success are limited.⁵⁶ As flashed at the outset of many episodes of the *My 600-lb Life* through the first several seasons, “[e]ach year, hundreds of weight loss operations are performed on patients weighing 600 pounds. Their chances of long-term success are less than five percent.”⁵⁷ The SSA confirms the same: “People with extreme obesity, even with treatment, will generally continue to have obesity. Despite short-term progress, most treatments for obesity do not have a high success rate.”⁵⁸

High-risk bariatric surgery, coupled with core, comprehensive lifestyle changes, and behavior⁵⁹ and trauma therapy,⁶⁰ is the only realistic medical intervention that might enable them to overcome their acute addictions and imminent death—to the extent that they are even eligible for surgery and able to find a surgeon capable and willing to accept them as a patient.⁶¹ Even with medical interventions that include bariatric surgery, the long-term prognosis for EMO patients is precarious. As recognized by the SSA, “[d]espite short-term progress, most treatments for obesity do not have a high success rate.”⁶² Weight-loss success often forces obese individuals to confront

2014), <http://www.nhs.uk/news/2014/12December/Pages/Obesity-could-rob-you-of-20-years-of-health.aspx> [<https://perma.cc/3KBB-577Z>].

⁵⁴ See *supra* note 6 and accompanying text.

⁵⁵ See *supra* note 6; *infra* notes 47-52 and accompanying text.

⁵⁶ That standard course of treatment for obesity begins with the combination of a low-calorie diet, increased physical activity, and behavioral therapy, which achieves weight loss for the majority of obese patients. See *The Practical Guide*, *supra* note 25, at 1. After six months without sufficient responsiveness or in the event of additional health issue risks, providers may introduce pharmacotherapy—primarily sibutramine to suppress appetite and orlistat to inhibit fat absorption from the intestine, each of which have side effects that may exacerbate obesity-related health issues. *Id.* at 3. For individuals not sufficiently responsive to these treatment measures who have a BMI \geq 40, weight-loss surgery is an option. See *infra* note 62 and accompanying text. See generally *Types of Bariatric Surgery*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASE (updated July 2016), <https://www.niddk.nih.gov/health-information/weight-management/bariatric-surgery/types> [<https://perma.cc/6BBK-N2TE>].

⁵⁷ See, e.g., *My 600-lb Life: Chad’s Story* (TLC television broadcast Jan. 20, 2016).

⁵⁸ POMS, *supra* note 51, at 13.

⁵⁹ For CMS coverage of behavioral therapy for obesity treatment protocols, see *infra* notes 61, 75 and accompanying text.

⁶⁰ See generally *Swan*, *supra* note 2. See also *My 600-lb Life* *supra* note 1. Many of the patient lives probed in episodes of *My 600-lb Life* attribute food addictions to childhood traumas—from sexual, physical, and mental abuse, to poverty and instability that instilled fixations on food. *Id.* Some patients put on weight to push sexual perpetrators away (for example, Ashley, who allegedly was sexually abused by her uncle, and Laura, who allegedly was molested by an older cousin beginning when she was 5 years old). *Id.*; see, e.g., *My 600-lb Life: Ashley’s Story* (TLC television broadcast Feb. 22, 2012); *My 600-lb Life: Laura’s Story* (TLC television broadcast Mar. 18, 2015). Others eat for self-punishment (for example, Kirsten Perez, who blamed herself for being gang-raped when she was a teen), or for control and comfort in response to uncertainty and chaos. See, e.g., *My 600-lb Life: Kirsten’s Story* (TLC television broadcast Jan. 25, 2017).

⁶¹ “Presently, bariatric surgery is the only available treatment for morbid obesity that consistently achieves and maintains substantial weight loss, decreases the incidence and severity of obesity-related comorbidities, and improves overall quality of life and survival.” James A. Madura & John K. DiBaise, *Quick Fix or Long-Term Cure? Pros and Cons of Bariatric Surgery*, 4 F1000 REP. MED. 19, 20 (2012) (internal citation omitted). A major constraint on treatment, and especially for EMO patients given the added surgical difficulties, is access to surgeons with the requisite skills and who are willing to accept them as patients. *Id.* “From a practical standpoint, given the vast number of individuals that are potential candidates for surgery, there are an insufficient number of surgeons with sufficient expertise in these procedures to perform the necessary operations.” *Id.*

⁶² POMS, *supra* note 51, at 13-14.

underlying traumas that drive their food addictions and relationships that have enabled it.⁶³ Bariatric surgery introduces the possibility of changing EMO from a fatal to a chronic condition, as recognized by the SSA:

Obesity is a life-long disease. Even when treatment has been successful, individuals with obesity generally need to stay in treatment or they will gain weight again. . . . Individuals who have had surgery should receive continuing follow-up care because of health risks related to the surgery. As with other chronic disorders, effective treatment of obesity requires regular medical follow-up.⁶⁴

B. BARIATRIC SURGERY

The bariatric operations performed most frequently in the U.S. to treat obesity are the adjustable gastric band (“the band”), Roux-en-Y (“RNY”), the laparoscopic gastric bypass (“the bypass”), and the gastric sleeve (“the sleeve”).⁶⁵ The appendix to this article provides a table with brief summaries of these procedures and a fifth, the duodenal switch (“the switch”), along with identification of their advantages, disadvantages, and cost estimates presented in a comparative manner. Through increased use over time with favorable outcomes, the three primary bariatric surgery procedures have become familiar and recognized as standard of care more often, with an uptake spike in recent years.⁶⁶ According to ASMBS, an estimated 196,000 patients underwent some form of weight-loss surgery in the U.S. in 2015, compared to 158,000 in 2011—a 24% increase.⁶⁷ Demand and the number of procedures performed are poised to rise:

Despite the invasive nature of bariatric surgery, the initial costs involved, the potential need for re-operation and the long-term consequences requiring lifelong monitoring and medical care, given its success and overall safety record and the burden of obesity and its comorbidities, the number of morbidly obese patients seeking and undergoing bariatric surgery will undoubtedly continue to grow.⁶⁸

⁶³ See generally discussion *infra* Part III.A.

⁶⁴ POMS, *supra* note 51, at 14.

⁶⁵ *Types of Bariatric Surgery*, *supra* note 56.

⁶⁶ Although the first bariatric surgery performed in humans was reported in 1954, meaningful uptake of the procedure did not take place until it was enhanced with laparoscopy, which allows surgery to be performed through small incisions, in the mid-1990s. Madura & DiBaise, *supra* note 61, at 21. A study of a new, non-surgical alternative procedure, endoscopic sleeve gastroplasty (“ESG”), was published in the May issue of the *Journal of Clinical Gastroenterology and Hepatology* and announced in the popular press on June 6, 2017. See John Torres & Parminder Deo, ‘Sewing Machine’ Surgery Helps Weight Loss Without Cutting, NBC NEWS (June 6, 2017, 11:53AM), <http://www.nbcnews.com/health/health-news/sewing-machine-surgery-helps-weight-loss-without-cutting-n768531> [<https://perma.cc/A7G9-M6LC>] (explaining a newly published promising weight-loss procedure that helped people lose body weight and BMI to a substantial degree). According to these reports, rather than a surgical incision, stitches are sewn into the stomach to reduce its size to that of a banana (the popular press referred to the procedure as “sewing machine surgery”). The procedure takes only 40 minutes to perform, and it is done on an out-patient basis. *Id.* The procedure shows promise, but more data and potentially considerably more time are prerequisites for standard of care uptake and insurance coverage. *Id.* Endoscopic sleeve gastroplasty costs the patient \$10,000-\$15,000. *Id.*

⁶⁷ *Estimate of Bariatric Surgery Numbers, 2011-2016*, AM. SOC’Y METABOLIC & BARIATRIC SURGERY, <http://asmbs.org/resources/estimate-of-bariatric-surgery-numbers> [<https://perma.cc/UUX4-6EZN>].

⁶⁸ Madura & DiBaise, *supra* note 61, at 25-26.

The field has evolved in spite of constraints on coverage by insurers, direct and through cumbersome prerequisites difficult to satisfy—leaving many patients to pay for the procedures out of pocket.⁶⁹ In fact, in spite of increased uptake of bariatric surgery as standard of care in recent years, access in the U.S. is limited.⁷⁰ According to an assessment published by ASMBS in 2014, a mere 1% of those in the U.S. who were eligible for bariatric surgery in 2013 actually received it.⁷¹ Although topped by gaps in insurance coverage and costs, other factors that limit true access include shortcomings in provider education about obesity and obesity treatment, insufficient provider competency, and surgery-associated risks, all exacerbated in EMO cases—which chill both patients and providers from undertaking bariatric operations.⁷²

To raise provider competency and insurance coverage in the field of bariatric surgery, ASMBS and the American College of Surgeons (“ACS”) have jointly developed a professional self-regulatory national accreditation and certification program to distinguish bariatric surgery centers that meet their standards, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”).⁷³ A requirement to achieve and maintain certification is an annual surgical volume of 125 cases per institution and, therefore, MBSAQIP accreditation ensures an experiential critical mass. Many insurers have adopted MBSAQIP as a prerequisite for coverage and reimbursement.⁷⁴ Critics argue that MBSAQIP certification “has prevented some otherwise well-qualified small programs from performing or increasing their volume of bariatric surgeries.”⁷⁵ From the patient perspective, while imposing experiential and quality control standards, MBSAQIP accreditation limits supply, inflates costs, and narrows access to bariatric surgeries.⁷⁶

Increased familiarity with bariatric surgery procedures for obesity treatment, the compilation of favorable treatment outcome histories, recognition of the obesity epidemic, the documented health risks to individuals who are obese, the public health implications, and the recognized importance of preventative care for obesity have influenced U.S. federal policy. The U.S. government’s trend is in favor of providing coverage, especially in EMO cases. For example, the Internal Revenue Service has determined that obesity treatments are eligible for tax deductions when diagnosed by a doctor,⁷⁷ and CMS has issued national coverage decisions (“NCDs”) and guidelines for Medicare coverage of obesity treatments, including intensive behavioral therapy under

⁶⁹ See Ayman B. Al Harakeh et al., *Natural History and Metabolic Consequences of Morbid Obesity for Patients Denied Coverage for Bariatric Surgery*, 6 SURGERY OBESITY & RELATED DISEASES 591, 595 (2010) (explaining that a large number of insurers deny coverage for bariatric surgery despite its positive effect on patients).

⁷⁰ See generally Madura & DiBaise, *supra* note 61.

⁷¹ See Jamie Ponce et al., *New Procedure Estimates for Bariatric Surgery: What the Numbers Reveal*, ASMBS: CONNECT (May 2014), <http://connect.asmb.org/may-2014-bariatric-surgery-growth.html> [<https://perma.cc/E7CT-LBMJ>] (explaining only about 1% of adults who are qualified for the bariatric surgery actually underwent the surgery).

⁷² See *id.*; Madura & DiBaise, *supra* note 61, at 23 (listing several factors that limit the availability of bariatric surgery).

⁷³ See *Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program*, AM. COLLEGE SURGEONS, <https://www.facs.org/quality-programs/mbsaqip> [<https://perma.cc/L4YW-8GKJ>].

⁷⁴ See generally Madura & DiBaise, *supra* note 61, at 25 (noting insurers have adopted certification developed by ACS and ASMBS for bariatric surgery coverage).

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ See U.S. DEP’T OF TREASURY, INTERNAL REVENUE SERV., 2016 INSTRUCTIONS FOR SCHEDULE A (FORM 1040), EXAMPLES OF MEDICAL AND DENTAL PAYMENTS YOU CAN DEDUCT A-2 (2016) (includes “[a] weight-loss program as treatment for a specific disease (including obesity) diagnosed by a doctor”).

some circumstances and some bariatric surgery procedures.⁷⁸ Moreover, the NIH established the NIH Obesity Research Task Force in 2003 to engage in a concerted research and physician education effort to accelerate the progress of obesity research, to advance understanding about obesity, and to raise provider awareness and competency in treating obesity.⁷⁹ Moreover, the National Heart Lung and Blood Institute (“NHLBI”) has and continues to fund substantial research to increase understanding of the causes, complications, and treatment of obesity, and NHLBI and other agencies within DHHS have and continue to issue guidelines.⁸⁰ For example, the NHLBI, in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases (“NIDDK”), launched a National Obesity Education Initiative in 1995, which issued practice guidelines and created a treatment algorithm to help break down the steps to diagnose and treat obese patients, and which NHLBI has updated periodically.⁸¹

The primary bariatric surgeries and insurance coverage for them are becoming more frequent.⁸² Even the switch—the most expensive surgery on average, a complicated procedure, and the one with the least amount of experiential data—is covered by insurance, both public and private, under some circumstances.⁸³ However, coverage varies, and at times significantly. “While some insurers may foot the entire

⁷⁸ See CMS MANUAL SYSTEM PUB. 100-03, *supra* note 44, at sec. 100.1 (noting obesity related to certain medical conditions are covered by Medicare); U.S. Dep’t of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity*, CMS.GOV (2013), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8484.pdf> [<https://perma.cc/ZQY3-8CDS>] [hereinafter *Bariatric Surgery for Treatment of Co-Morbid Conditions*]; U.S. Dep’t of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Bariatric Surgery for the Treatment of Morbid Obesity National Coverage Determination, Addition of Laparoscopic Sleeve Gastrectomy (LSG)*, CMS.GOV (2014), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8028.pdf> [<https://perma.cc/53G9-5XE2>] [hereinafter *Bariatric Surgery for the Treatment of Morbid Obesity*]. Medicare covers intense behavioral therapy to treat morbid obesity in many cases, although it did take a step back from broadly mandating coverage. See generally CMS MANUAL SYSTEM PUB. 100-03, *supra* note 44. Also, at this time, CMS is hesitant to reimburse for the sleeve procedure due to the relative (compared with the band and bypass procedures) lack of long-term (> 5 years) follow-up data and a paucity of data in individuals over 65 years of age, as is discussed *infra* note 92. See Madura & DiBaise, *supra* note 61; see also United Healthcare Medicare Advantage Policy Guideline, *Bariatric Surgery for Treatment of Morbid Obesity* (NCD 100.1) (Feb. 8, 2017), https://www.unitedhealthcareonline.com/cmcontent/ProviderII/UHC/en-US/Main%20Menu/Tools%20and%20Resources/Policies%20and%20Protocols/Medicare%20Advantage%20Policy%20Guidelines/Bariatric_Surgery_TX_Morbid_Obesity.pdf [<https://perma.cc/R2K4-8FF8>] (noting some medical condition related obesity treatments are covered by Medicare).

⁷⁹ *NIH Obesity Research Task Force*, NAT’L INST. DIABETES & DIGESTIVE & KIDNEY DISEASES, <https://www.niddk.nih.gov/about-niddk/advisory-coordinating-committees/nih-obesity-research-task-force/Pages/default.aspx> [<https://perma.cc/8NAJ-VKNR>]; see *NHLBI Obesity Research*, NAT’L HEART, LUNG & BLOOD INST. (2016), <https://www.nhlbi.nih.gov/research/resources/obesity/> [<https://perma.cc/K4G2-GCDL>] (explaining NIH established a research task force to accelerate progress in obesity research). Still, given its prevalence and impact on both individual and public health, greater provider education and training in the field of obesity is needed. See Timothy Caulfield, *Obesity, Legal Duties, and the Family Physician*, 53 CAN. FAM. PHYSICIAN 1129, 1130 (2007) (emphasizing that physicians must have sufficient skills, tools and resources to manage health issue of obesity).

⁸⁰ *NHLBI Obesity Research*, *supra* note 79.

⁸¹ See generally *id.*; *The Practical Guide*, *supra* note 25.

⁸² See generally *Weight Loss Surgery Insurance Coverage and Costs*, OBESITY COVERAGE, <http://www.obesitycoverage.com/weight-loss-surgery-insurance-coverage-and-costs/> [<https://perma.cc/RXU8-KKWP>] (explaining currently more insurance companies cover weight-loss surgery than previously).

⁸³ See *Bariatric Surgery Cost in 2017-With or Without Insurance*, BARIATRIC SURGERY SOURCE <http://www.bariatric-surgery-source.com/cost-bariatric-surgery.html> [<https://perma.cc/GU8K-6YSF>] (“With Insurance” chart indicating coverage for the switch procedure).

bill, many public or private insurance companies that cover weight loss surgery will pay 80 percent of what is considered the ‘customary and usual’ for the surgery, as determined by the insurance company.”⁸⁴ True access—largely controlled by the amount of coverage and coverage prerequisites, as well as surgeon competency, availability, and willingness to accept surgery candidates—fluctuates immensely state by state and among insurance providers, and decisions often are very patient-specific.⁸⁵

1. Public Insurance Coverage: Medicare and Medicaid

CMS administers both the Medicare and Medicaid programs, and Medicare coverage decisions often “spill over” to Medicaid to some extent given that the programs are coordinated, providers and private insurers often participate in both, and standard of care transcends the program divisions. Medicare, a federal health insurance program covering those 65 or older and younger individuals with qualifying disabilities and end-stage renal disease,⁸⁶ reimburses for three types of bariatric surgery (the band, bypass, and biliopancreatic diversions with or without the switch component), provided prerequisites are satisfied.⁸⁷ However, there is an administrative (bureaucratic) gap between theoretical coverage and actual coverage (true access). For example, Medicare typically requires candidates to have a BMI of >35 (the high end of Class 2 or greater), be afflicted with at least one obesity-related serious health problem, complete a medically supervised six-month weight-loss program, and be accepted for surgery by a surgeon with sufficient competency who will perform the procedure at a facility certified by MBSAQIP.⁸⁸ The latter means satisfying any additional prerequisites imposed by the surgeon and facility.⁸⁹ Although Medicare does not routinely require a letter of medical necessity from the surgeon, pre-certification, or pre-authorization, surgeons pre-screen for satisfaction of Medicare prerequisites and submit claims. “Some surgeons may ask Medicare patients to sign a contract stating that they will pay for any costs that Medicare does not cover after it processes the claim.”⁹⁰

In contrast with Medicare, Medicaid is a *joint* federal and state program, and in some instances primarily a state program given the level of federal deference, to provide health insurance to qualifying low-income individuals and families.⁹¹ Comprehensive, timely state-by-state compilations of Medicaid coverage for bariatric surgery are lacking—understandably, given the extent of disparity among states. According to a 2010 study, 45 state Medicaid programs covered bariatric surgery to

⁸⁴ Denise Mann & Neil Hatcher, *Weight Loss Surgery Insurance Coverage: How Much Does Weight Loss Surgery Cost?*, CONSUMER GUIDE TO BARIATRIC SURGERY, <http://www.yourbariatricsurgeryguide.com/insurance/> [https://perma.cc/G6UR-UPVW].

⁸⁵ *See generally id.* (noting insurance coverage for weight-loss surgery varies by state and insurance provider).

⁸⁶ *See generally What's Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> [https://perma.cc/Y5AU-4Q6R].

⁸⁷ *See generally* Mann & Hatcher, *supra* note 84.

⁸⁸ For more identification of the “full bouquet” of Medicare prerequisites and more detailed discussion, *see* CMS MANUAL SYSTEM PUB. 100-03, *supra* note 44, at sec. 100.1; *see also* *Bariatric Surgery for Treatment of Co-Morbid Conditions*, *supra* note 78; *Bariatric Surgery for the Treatment of Morbid Obesity*, *supra* note 78.

⁸⁹ Mann & Hatcher, *supra* note 84.

⁹⁰ *Id.*

⁹¹ *See generally Eligibility*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/eligibility/> [https://perma.cc/XSX7-DGGA].

some extent at that time.⁹² However, coverage fluctuates significantly in terms of eligibility criteria and prerequisites, reimbursement rates, and the bundle of associated services included such as counseling and drug therapy.⁹³ All the prerequisites and other variables in Medicare determinations apply and with considerable variation among state Medicaid programs—some offering coverage on par or even more generous than Medicare, while others offer little if any meaningful (true access) coverage.

2. Private Insurance Coverage

In theory, most major insurance companies typically cover band, bypass, and sleeve surgeries at least partially *when both a primary care physician and weight-loss surgeon document sufficiently that the surgery is medically necessary*.⁹⁴ Some states require specific coverage,⁹⁵ and the Affordable Care Act (“ACA”), though an ongoing target for major reform if not repeal, “made many changes and provided guidelines for weight loss surgery that required certain insurance companies to provide coverage for those insured.”⁹⁶

However, reality is that private insurers impose a weighty burden of proof on claimants and their physicians. Shifting from severe obesity (Class 3) to obesity in general (Classes 1 and 2),⁹⁷ “[n]early two-thirds of employer-sponsored health plans do not cover bariatric surgery. More than half the State Health Exchanges under the Affordable Care Act currently exclude bariatric surgery as a covered benefit.”⁹⁸ In addition, coverage is policy-specific (not insurance carrier specific) in most cases, some exclude most or all of these procedures, preconditions as well as implementation policies

⁹² Jennifer S. Lee et al., *Coverage of Obesity Treatment: A State-by-State Analysis of Medicaid and State Insurance Laws*, 125 PUB. HEALTH REP. 596, 599 (2010).

⁹³ See *id.*; see also Mann & Hatcher, *supra* note 84; FAQ—*Medicare and Medicaid, Does Medicare and Medicaid Cover Weight Loss Surgery?*, WEIGHT LOSS SURGERY FOUND. AM., <http://www.wlsfa.org/looking-for-help/how-to-apply-for-a-grant/faq-medicare-medicaid/> [<https://perma.cc/ST58-RPMY>].

⁹⁴ Letters of medical necessity from both a patient’s weight-loss surgeon and primary care physician should include:

- [The patient’s] height, weight history and BMI
- A detailed description of [the patient’s] obesity-related health conditions, including records of treatment. Such conditions may include high blood pressure, diabetes, heart and blood vessel disease, sleep apnea, gastroesophageal reflux, arthritis and high cholesterol.
- [The patient’s] current medications
- A detailed description of how the obesity affects [the patient’s] daily activities
- A detailed history of past dieting efforts. A number of insurers now require detailed documentation of participation in a physician-supervised diet plan. Most require the submission of at least six months’ worth of office notes from the supervising doctor.
- A history of exercise programs, along with gym membership documentation

Mann & Hatcher, *supra* note 84. Many insurers require a nutritional consultation and psychological evaluation and, if required, individuals should obtain these through a referral from their surgeon, and both the primary care physician and surgeon should incorporate them into their submissions. *Id.*

⁹⁵ See *Weight Loss Surgery Insurance Coverage and Costs*, *supra* note 82; Mann & Hatcher, *supra* note 84.

⁹⁶ Nanci Hellmich, *Obamacare Requires Most Insurers to Tackle Obesity*, USA TODAY (July 4, 2013, 8:00 AM), <https://www.usatoday.com/story/news/nation/2013/07/04/obesity-disease-insurance-coverage/2447217/> [<https://perma.cc/H4BY-CRNR>].

⁹⁷ See *supra* notes 25-28 and accompanying text.

⁹⁸ Ponce, *supra* note 71.

and practices vary, and many insurers charge a premium increase consistent with the scope of coverage for weight-loss surgery.⁹⁹ The bariatric surgery medical policy and prerequisites of Anthem Blue Cross Blue Shield (“Anthem”), which spans across much of the nation’s Anthem’s private insurance entities, provides an illustrative example.¹⁰⁰

Even when coverage does exist, due to documentation requirements and a patient-specific approach to coverage decision-making, the reimbursement process usually is cumbersome and laborious, and it is common for patients to have to reapply multiple times and to exhaust insurance companies’ mandatory appeals processes.¹⁰¹ Bariatric surgery procedures encompass a cluster of costs, including follow-on therapies and surgeries essential to combat the underlying addiction and to achieve overall successful patient outcomes—costs that will be incurred by the patient in whole or in part.¹⁰² Perversely, when coverage is possible, obesity severity and insurance coverage are directly related. Food addicts are most likely to realize and maximize bariatric surgery coverage (reimbursement) by allowing their addictions to spin out of control—by amassing weight and exacerbating related health care afflictions as much as possible.

Fortunately, physicians and surgeons who specialize in the field are accustomed to coverage gaps and denials, have experience working with specific insurance carriers, and have staff who will provide strategic and technical guidance. Also, many directly offer payment plans and, if not, are able to identify finance companies they have relationships and experience working with.¹⁰³

C. DISABILITY COVERAGE FOR OBESITY

Morbidly obese individuals are candidates for health care, living expenses, and other benefits under Title II (the Social Security Disability Insurance program, “SSDI”) and Title XVI (the Supplemental Security Income program, “SSI”) of the Social Security Act—the largest and primary federal programs that provide benefits to individuals with disabilities.¹⁰⁴ Other federal and state programs complement SSDI and SSI, and qualifying for SSDI and SSI benefits may make benefits through other programs available—from the federal Medicare and Medicaid programs to the

⁹⁹ See *Weight Loss Surgery Insurance Coverage and Costs*, *supra* note 82; Mann & Hutcher, *supra* note 84.

¹⁰⁰ See generally *Bariatric Surgery and Other Treatments for Clinically Severe Obesity*, ANTHEM (Sept. 27, 2017), https://www.anthem.com/medicalpolicies/policies/mp_pw_a053317.htm [<https://perma.cc/5FJX-3P2Y>].

¹⁰¹ Hellmich, *supra* note 96; Mann & Hutcher, *supra* note 84.

¹⁰² See *infra* note 214. See also Mann & Hutcher, *supra* note 84; Hellmich, *supra* note 96.

¹⁰³ Mann & Hutcher, *supra* note 84.

¹⁰⁴ Social Security Act of 1935, Title II, 42 U.S.C. §§ 401-433 (2016); Social Security Act of 1935, Title XVI, 42 U.S.C. §§ 1381-1383f (2016). See U.S. SOC. SEC. ADMIN., *supra* note 51; SSR 83-20, 1983 WL 31249 (Jan. 1, 1983). See also Beth Laurence, *Does Medicare or Medicaid Come with Disability?*, NOLO, <https://www.nolo.com/legal-encyclopedia/does-medicare-medicaid-come-with-social-security-ssi-disability-benefits.html> [<https://perma.cc/K2E3-PMPT>]; Laurence, *supra* note 51; *Obesity and Social Security Disability*, DISABILITY BENEFITS HELP, <http://www.disability-benefits-help.org/disabling-conditions/obesity-and-social-security-disability> [<https://perma.cc/MG3V-HMHA>]; *Supplemental Security Income (SSI)*, HEALTHCARE.GOV, <https://www.healthcare.gov/people-with-disabilities/ssi-and-medicaid/> [<https://perma.cc/J4FN-AEFQ>]; *Benefits for People With Disabilities*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/> [<https://perma.cc/APR8-VRJJ>]; *National Average Wage Index* (2016), SOC. SECURITY ADMIN., <https://www.ssa.gov/OACT/COLA/AWI.html> [<https://perma.cc/EYU9-79ER>]; *SSI Federal Payment Amounts For 2018*, SOC. SECURITY ADMIN., <https://www.ssa.gov/OACT/COLA/SSI.html> [<https://perma.cc/8VBR-EZKJ>].

Supplemental Nutritional Assistance Program (“SNAP”), which provides food stamps.¹⁰⁵

States vary immensely in terms of the complementary benefits they provide (in content, quantity, and scope), eligibility, preconditions, and their application and determination processes. A notable example is compensation for PCAs, which most states provide to some extent through home care programs serviced by agencies.¹⁰⁶ While some state programs explicitly compensate spouses and other family members for providing care to individuals with disabilities, the majority explicitly prohibit family members to serve as paid caregivers except in unusual and limited circumstances.¹⁰⁷

Although SSA administers both SSDI and SSI, and both programs provide benefits to individuals with disabilities who qualify based upon SSA criteria,¹⁰⁸ the programs are readily distinguishable in fundamental ways.¹⁰⁹ SSDI provides benefits to individuals and some of their family members when they have worked long enough, paid Social Security taxes, and satisfy the other qualifying criteria—which center on SSA determinations that they have disabilities that significantly impede or prevent their ability to work.¹¹⁰ In contrast, SSI provides benefits to individuals similarly afflicted by disabilities but based upon financial need.¹¹¹ Given this distinction, some recipients of disability benefits are able to draw concurrently from both programs.¹¹²

Ideally, those with disabilities are able to access benefits by matching the SSA’s Blue Book list of medical conditions that qualify.¹¹³ Although the Blue Book does not list obesity as an independently qualifying condition for disability benefits, SSA’s Manual is directly responsive to recognition of obesity as a potential disability based upon a litany of obesity-related limitations and health conditions, and it provides

¹⁰⁵ *Obesity and Social Security Disability*, *supra* note 104. *See generally Supplemental Nutrition Assistance Program (SNAP)*, U.S. DEP’T OF AGRIC. (Jan. 30, 2017), <https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap> [<https://perma.cc/54SH-M4HC>].

¹⁰⁶ *See generally* AM. ELDER CARE RESEARCH ORG., *State by State Guide to Medicaid’s Home Care Benefits*, PAYING FOR SENIOR CARE (May 2017), <https://www.payingforseniorcare.com/medicaid-waivers/home-care.html> [<https://perma.cc/6HH8-G3ET>]; Helga Niesz & Peter Martino, *States that Allow Family Members to Act as Personal Care Assistants*, CONN. GEN. ASSEMBLY (Feb. 21, 2003), <https://www.cga.ct.gov/2003/rpt/2003-R-0040.htm> [<https://perma.cc/3HSC-SJHD>].

¹⁰⁷ According to the Connecticut General Assembly based on its 2003 state survey,

States that allow relatives to be caregivers often do so through a “consumer-directed option,” either as part of the home care program or as a separate program, whereby consumers can choose and hire their own personal care attendant or assistant (PCA). PCAs may be certain relatives, but not usually the spouse, parent of a minor child or legally liable relative (except in 12 purely state-funded programs that do not have any limits on who can be a PCA and do not use Medicaid money). . . . Most states do not require any particular training for a family member who acts as a PCA in the consumer-directed option but leave it up to the clients to do any necessary training.

Niesz & Martino, *supra* note 106.

¹⁰⁸ POMS, *supra* note 51 (“How do we evaluate obesity in assessing residual functional capacity in adults . . . ?”).

¹⁰⁹ *See generally Benefits for People with Disabilities*, *supra* note 104.

¹¹⁰ *Id.*

¹¹¹ *See generally id.*; POMS, *supra* note 51; *Supplemental Security Income*, *supra* note 104.

¹¹² Laurence, *Medicare or Medicaid?*, *supra* note 104.

¹¹³ Listing of Impairments, 20 C.F.R. pt. 404, subpt. P., app. 1 (2002); *see* 20 C.F.R. §§ 404.1569, 416.969; *Disability Evaluation Under Social Security*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/professionals/bluebook/> [<https://perma.cc/5W6S-C3EW>].

guidance to qualify.¹¹⁴ Processing of SSA disability claims typically originates at the local and state level—namely in SSA field offices and Disability Determination Services (“DDSs”), which are state agencies.¹¹⁵ The process places an evidentiary burden on claimants and their health care providers, which is case-specific and often proves challenging, laborious, time-consuming, and frustrating.¹¹⁶ However, claimants are entitled to appeal unfavorable determinations to a DDS or an administrative law judge in SSA’s Office of Disability Adjudication and Review.¹¹⁷

EMO individuals are very strong candidates for SSA and state disability benefits given the prevalence and degree of associated immobility and health conditions on the SSA’s disability listings. The scope of SSA’s inquiry is expansive: “[SSA] will . . . find that a listing is met if there is an impairment that, in combination with obesity, meets the requirements of a listing.”¹¹⁸ Also,

[SSA has] added paragraphs to the prefaces of the musculoskeletal, respiratory, and cardiovascular body system listings that provide guidance about the potential effects obesity has in causing or contributing to impairments in those body systems. . . . The paragraphs state that [SSA] consider[s] obesity to be a medically determinable impairment and remind adjudicators to consider its effects when evaluating disability. The provisions also remind adjudicators that the combined effects of obesity with other impairments [may] be greater than the effects of each of the impairments considered separately.¹¹⁹

People with disabilities approved for SSDI benefits receive Medicare health insurance, while those approved for SSI benefits receive Medicaid health insurance.¹²⁰ However, SSDI and SSI claims take time for approval and, although there is no waiting period for SSI recipients to receive Medicaid in most states, SSDI recipients are not eligible to receive Medicare benefits for two years from their date of entitlement.¹²¹ Therefore, people often apply for SSDI, SSI, and Medicaid simultaneously and find themselves with concurrent benefits, which necessitates sorting out health insurance coverage, beginning with their local Social Security office.¹²² As discussed previously, both Medicare and Medicaid coverage trigger potential coverage for bariatric surgery, but realizing that potential is a separate, case-specific, and health care provider-intensive process.¹²³

¹¹⁴ See generally POMS, *supra* note 51.

¹¹⁵ *Disability Determination Process*, SOC. SECURITY ADMIN., <https://www.ssa.gov/disability/determination.htm> [<https://perma.cc/MUH2-N2SY>].

¹¹⁶ See generally *id.*; Laurence, *Medicare or Medicaid?*, *supra* note 104; Laurence, *Morbid Obesity*, *supra* note 51; *Obesity and Social Security Disability*, *supra* note 104; Facts About Morbid Obesity and Filing for Disability, SOC. SECURITY DISABILITY RESOURCE CTR., <http://www.ssdrc.com/ssd-morbid-obesity.html> [<https://perma.cc/27AQ-Q5XT>].

¹¹⁷ *Hearings and Appeals*, SOC. SECURITY ADMIN., https://www.ssa.gov/appeals/about_odar.html [<https://perma.cc/B42Y-PHRP>].

¹¹⁸ POMS, *supra* note 51.

¹¹⁹ *Id.* at SSR 02-1p.

¹²⁰ See generally Laurence, *Medicare or Medicaid?*, *supra* note 104; *Benefits for People With Disabilities*, *supra* note 104.

¹²¹ See generally Laurence, *Medicare or Medicaid?*, *supra* note 104; *Benefits for People With Disabilities*, *supra* note 104.

¹²² See generally Laurence, *Medicare or Medicaid?*, *supra* note 104.

¹²³ See generally discussion *supra* Part II.B.1.

III. CAREGIVERS WHO FEED THE “ALLIGATORS”

“Families can either be enablers or encouragers. Having a supportive family for patients on a weight loss journey is an important component to their success. . . . If they don’t have that, it’s almost impossible for them to be successful in the long term, unless they remove those people from their environment. So they either have to change their dynamic with those enablers or separate from them if they want to succeed.”

— Dr. Nowzaradan Younan¹²⁴

The dozens of EMO patient stories documented and aired throughout the last five seasons of *My 600-lb Life* share some palpable common themes. One is Dr. Now’s professional capabilities, his compassion for his patients, and his dedication to treat them. Another is the chokehold of addiction on human life, even when confronted by health misery and imminent death. In fact, the common-denominator story line is individuals overcoming addiction that has devoured vast amounts of health and quality from their lives to regain control over daily life, longevity, and independence. Food addiction enablement by family members and other caregivers is yet another common theme and, at times, one more exasperating than the addiction itself. Most of the patients profiled are immobile to a significant extent, if not entirely bedridden,¹²⁵ wrestle with chronic and often excruciating pain¹²⁶ and humiliation,¹²⁷ grapple with clusters of life-debilitating and life-threatening health conditions, and depend, at times wholly, upon others for their daily survival—and to feed the food addictions that jeopardize it. Even Dr. Now occasionally has walked away from patients he could not help due to, in addition to the patients themselves not adhering to his treatment protocols, enabler interference with his attempts to treat them.¹²⁸ James K is one of these patients.¹²⁹ His story, relayed below, vividly illustrates the problem of addiction enablement by caregivers prevalent in, and to varying degrees innate to, the lives of EMO patients.

A. JAMES K’S STORY

James K is a Kentucky native who was 46 years old when TLC documented his story.¹³⁰ James weighs 790+ pounds at the outset of the episode. As his story begins, James has been entirely bedridden for nearly three years—to the point of being unable to stand and barely able to move.¹³¹ His massive legs are encased by balloon-like deposits of fat seamed by thick folds of skin, covered by a layer of contiguous bumps, blisters and open sores subject to infection caused by extremely advanced

¹²⁴ King, *supra* note 11.

¹²⁵ See generally Swan, *supra* note 2.

¹²⁶ *Id.* (“None of the people on the show are elderly or terminally ill, yet they feel some sort of physical pain from the moment they get up in the morning, until they go to sleep at night. Some can’t even walk across the room without pain.”)

¹²⁷ *Id.* (“The show has really humiliating bathroom scenes. . . . Maybe the most embarrassing instance was in an episode featuring Nicole Lewis, whose story aired in 2017. . . . She got so big, she couldn’t fit in the shower. So she had to be hosed-off like an animal outside on the porch.”).

¹²⁸ King, *supra* note 11.

¹²⁹ *My 600-lb Life: James K’s Story*, *supra* note 15.

¹³⁰ *Id.*

¹³¹ *Id.*

lymphedema¹³² and cellulitis,¹³³ which constantly ooze fluids. James requires constant, extensive care, much of which is impossible for Lisa, his girlfriend and full-time caregiver, to attend to alone due to James's physical enormity and pain from simple touch and movement. Lisa has pulled Baily, their daughter, out of high school to tend to James full-time as well.¹³⁴ Hygiene is a constant battle given the threat of infection posed by the lymphedema and cellulitis. From the outset, James self-professes that death is imminent—that he probably only has a few months to live. The episode opens with a voiceover narrated by James: “When just being alive becomes the greatest burden in your life, it is time to look for anything that can save you.”

Viewers learn that James's weight remained steady until his father married a woman with four children of her own, and food became scarce. When food was available, James indulged and experienced a euphoria of comfort, safety, and control. Food addiction rooted, and steady weight gain became a fixture in his life. As an adult, James attributes the stress of not being able to be openly and fully involved in his children's lives (Lisa was a married neighbor, and their children did not know he was their father) as a factor that contributed to his steady weight gain during this time. James's weight reached around 540 pounds when he turned 30. Although Lisa separated from her husband when James was 32 and he then could openly be a father to his biological children, he kept amassing more weight. At the age of 42, James fell and seriously damaged his ankle. Bed rest for recovery morphed into a chronic state of being bedridden and amassing yet more weight. In James's words, “I'm not even sure if it ever healed because that's the last time I put weight on it.”

Although imprisoned in his bed by his EMO, James controls his surroundings and those in it by crying out about his pain and bellowing, at times barking, commands from his pillows. He becomes verbally hostile when they are not met—especially when his demands pertain to food. James dictates the contents of grocery store runs, which Lisa and Bailey dutifully make, deliver, prepare, and serve in between constantly catering to James's voluminous and relentless needs.

¹³² See *supra* note 6.

¹³³ See generally *Cellulitis*, HEALTHLINE, <http://www.healthline.com/health/cellulitis#overview1> [<https://perma.cc/94BH-KBCT>]. Cellulitis is bacterial skin infection, which causes swelling, pain to the touch, and leaking sores. *Id.* The infection, which usually starts in the legs, spreads rapidly throughout the body and face. *Id.* Without proper treatment, cellulitis may become life-threatening. *Id.*

¹³⁴ *My 600-lb Life: James K's Story*, *supra* note 15. The next few pages will recount James K's episode of *My 600-lb Life*. All quotes from the show are attributable to note 15.



Figure 1: James after becoming bedridden from his accident (Photo Credit: TLC).¹³⁵

Both Lisa and Bailey resent the situation, and they are self-aware and guilt-ridden over their roles as enablers. Bailey relays to the camera, “I should not have to be a caretaker for my dad” and “I always feel guilty, because we always keep giving into him.” Lisa is emotionally and physically spent:

I worry about James because every year it seems like he gains twenty or thirty more pounds. It’s breaking my heart, and I can’t, I can’t really take it much longer. But he is bedridden, so I am an enabler. I bought this food and I carry the food to him, but I do not know how to stop. . . . If I take him something healthy, then we argue . . . because [the food he demands] is his comfort zone.

Lisa caps off her draining days ordering fast food—lots of it. Nevertheless, James, Lisa, and Bailey all repeatedly acknowledge the obvious: James will die soon without an effective medical intervention. James pleads into the camera, “[m]e dying in this bed one night—it’s not an if, it’s a when.”

James and Lisa research and exhaust treatment options, which brings them to one—a bariatric surgery performed by Dr. Now. James’s health situation and their precarious financial means make a trip to Houston for an initial screening impossible, so Dr. Now agrees to a Skype meeting. Consistent with the surgeon he is, Dr. Now ‘cuts to the chase’ during the face time by identifying Lisa as James’s primary enabler and addressing her directly: “Lisa, being bedridden and super obese is very dangerous. So I want you to stop enabling him. Do you understand me?” After receiving an immediate “Yes, sir” from Lisa, Dr. Now delivers his prognosis to James with ringing clarity: “It’s just a matter of time when one simple thing pushes your body over the limit and you die. So, the only chance you’ve got is weight-loss surgery.” Dr. Now launches treatment by

¹³⁵ Jeryl Lippe, ‘My 600-Lb Life’ Star James K. Before and After: Inside His Weight Loss Journey, IN TOUCH (Nov. 30, 2017, 4:41 pm), <http://www.intouchweekly.com/posts/my-600-lb-life-james-k-before-and-after-127951/photos/christina-phillips-600-lb-life-238610> [<https://perma.cc/WP9J-QXGY>].

emailing a prescribed diet of 1,200 calories per day, a regimen of upper body exercise, and a promise to approve James for bariatric surgery if he arrives in Houston with his weight reduced to 600 pounds, provided no other medical issues must be resolved.

James's health condition prohibits travel to Houston without emergency medical service ("EMS") staff, and James and Lisa have no means to cover the \$10,000+ expense. The couple and Dr. Now grapple for weeks with James's insurer, which includes correspondence from Dr. Now emphasizing that the situation is a matter of life and death, only to receive denials. Desperate, the couple set up an online fundraising page and reach out to the local news to raise awareness, only to draw a little over \$300.00 in donations. James responds to the disappointment by further indulging in food—for example, steak with fat because "fat makes it taste good." Ultimately, James's father, after suffering a stroke in front of him while visiting, refinances his home to make the travel possible, and James and Lisa depart for Houston.

Upon their arrival, Dr. Now meets them at the designated hospital, checks James's vitals, and observes that he has lost no weight over the four months since he prescribed the weight-loss diet. When Dr. Now asks James how his eating habits have been since he spoke with him last, James, without hesitation, responds "much better." In fact, he weighs 735 pounds—135 pounds above the projected weight-loss target based on the diet Dr. Now prescribed months before.

After delivering a testimonial into the camera ("James needs to take responsibility for his behavior. . . . But the majority of this all falls on his girlfriend, who has been enabling him"), Dr. Now pulls Lisa aside and confronts the problem:

DR. NOW: "Let me explain the situation to you. James is not going to survive much longer and, since I have been working with you two, he has not lost any weight, and he's worse off now."

LISA: "We are just going to just have to stick to the plan of making the change . . ." [DR. NOW INTERRUPTS HER]

DR. NOW: "There is no *we*, it's *you*. There's *no we*. *It's you!* You are bringing him the food. *You* are helping him to kill him[self]. . . . So why are you doing that?"

LISA: "Because if I do not bring it to him, I will pay hell all the rest of the day."

DR. NOW: "How [in] hell is he going to raise hell in the bed?"

LISA: "If we don't give him what he wants . . ." [DR. NOW INTERRUPTS HER]

DR. NOW: "He can scream all he wants to. *Don't tell me that!* You are the one that got him in this bed, and *you* are the one making his life miserable right now."

LISA: "I've been trying to get him out of that bed . . ." [DR. NOW INTERRUPTS HER]

DR. NOW: "No you're not. If you did, last time I talked to you, you would have changed his diet. . . . This is a miserable lifestyle. . . . And *you* got him into this shape, and you are blaming everybody and him. . . . Look, if you all don't change the diet right now, he's going to go back to Kentucky."

James admits to Dr. Now that, when Lisa and Bailey do not bring him food, he yells, argues, and “gets bad.” With his patience tested, Dr. Now asks James, “Why did you come to Houston? We don’t have a miracle for you.” When James responds, “Well, I have to eat something,” Dr. Now corrects him: “You *don’t* have to eat something. You have 800 pounds of food in you!”

Dr. Now admits James to the hospital. When he visits him the next morning, he decides to give James a second chance. Dr. Now keeps James there for a month on a supervised 800 calorie-per-day diet to get his weight loss started, and James loses 50 pounds to reach a weight of 685. Dr. Now releases him with an ultimatum to lose 85 pounds over the next two months. James professes fundamental change: “I am determined to do this. I *have* to succeed. Because, if I don’t, I’m losing my last chance to get help from the only place I can. . . . I know I am on borrowed time right now.”

Soon after, James experiences congestive heart failure, to which his immediate response is, “I know this may be my last chance. I cannot afford to wait any longer.” But then his thinking and behavior shifts into “[a]ll that stress [from the heart failure episode] is making it hard to resist my cravings.” When a tire blows out on Lisa’s van, the couple conclude that they cannot afford to replace it and, instead, forego transportation and live off of take-out food deliveries. During this time, the couple cancel multiple appointments with Dr. Now. At one point, James rejects Lisa’s offer of fish or shrimp and demands Chinese food. Lisa obliges, joins him, and cautions him to “save room for dessert”—a supersized slice of cheesecake. James shares his mindset in a testimonial: “Life is meant to enjoy. So I just need to find a balance between what I enjoy and what I need to do. . . . Hope I get approved next time I see the doctor, and he sees how far I’ve come.” Later, he declares, “I’m excited to show him my progress and get approved for weight loss surgery,” but adds that he cannot commit to surgery until Lisa sorts out her car situation and they have paid their bills. In James’s words, “[s]o surgery is the last thing we all need to deal with right now.” Lisa shares her sentiments as well:

Physically and mentally, I am *worn out*. . . . I feel trapped because I cannot leave . . . and sometimes I don’t want to stay. . . . Sometimes I feel like, as soon as he starts to walk, I’ll be gone. . . . Why am I wasting my life . . . to help somebody that doesn’t appreciate me? . . . [CRYING] I cannot take it. I do not know what to do, because I am stuck.

Four months since James’s last appointment with several scheduled and cancelled in between, Dr. Now drives to his apartment to find out what is going on. Although James says that he “feels looser,” Dr. Now readily assesses that James has not lost much weight, and he asks Lisa to summarize a typical day’s diet for James. Lisa lies. She declares a breakfast of two eggs, two pieces of turkey bacon or sausage, no lunch, and four ounces of meat and a salad for dinner. Dr. Now challenges them and puts James back in the hospital for a weigh-in.

The scale speaks: James weighs 843+ pounds—108 pounds over his last weigh-in. While the two nervously wait for Dr. Now’s arrival, James doubts the accuracy of the scale, and both express surprise and hope that Dr. Now will give them yet another chance. Dr. Now moves directly to the weigh-in result: “All right James. You are 844 pounds, so we both finally are on the same page that you are not sticking to the diet. You have gained weight.” Lisa pipes in to intervene: “We slipped a few times because we had car trouble, we did not have a way to get food, so we had to order food in. . . .” After calling Lisa delusional, Dr. Now responds, “[i]t does not matter what you say. The

scale . . . tell[s] me what I need to know. If you continue like that, I do not think you are going to live to the end of the year.” When James tries to put blame on Dr. Now for not providing enough resources such as physical therapy, Dr. Now cuts him off with, “[w]e are talking about your food. [We are] not talking about anything else.” As James rambles about needing to retrain his body from eating cheeseburgers, Dr. Now interjects:

You gained a hundred pounds . . . are you are saying that it is not your fault? That you had to retrain your body? Seriously? You are eating yourself to death, and you do not want to quit that. And that’s your responsibility. Nobody else’s in here. You got yourself in this bed. . . . You’ve been overeating, she’s been bringing it to you, and then you come here and say, “maybe we slipped a couple times.” You really think you can lie your way out of this? . . . I mean this is just mind-boggling. [DR. NOW LOOKS TO LISA] Why won’t you stop overfeeding him?

Lisa attempts to prevent Dr. Now from giving up on them: “I don’t know what the issue is. I know, like I said, that he has cheated some, but I will not bring him anything else.” Dr. Now corrects her—“It’s not *some*. It’s every day, and every hour, and every meal.” Dr. Now then turns back to James: “What do you expect us to do for you? *Tell me*. . . . Are you going to stay in your bed until you die?” When James responds, “start eating right,” Dr. Now interjects, “why haven’t you done it up to this point? [You] might as well go back home.” Lisa pleads—“You are one of the best doctors in this world. We cannot lose you.”

Dr. Now, though exasperated, contemplates, and then hesitantly decides to give James yet another chance—his third. With the reasoning that there is no chance for James if he sends him home, and with the hope that he might be able to get James on track one more time and jump start successful treatment, Dr. Now admits James into the hospital again and puts him back on a medically supervised 800-calories-per-day diet. The hospital stay works. James weight drops from 843+ pounds to 786. Dr. Now discharges James with a clear mandate to lose 100 pounds over the next two months, and then makes another testimonial: “We always have hope for every patient, but he either chooses to do this, or he chooses to die.”

Two months later, James returns to Dr. Now’s clinic for another weigh-in. After cordially greeting James and Lisa, Dr. Now announces James’s weight: 788 pounds—a gain of two pounds. He then advises the couple to return to Kentucky over Lisa’s pleading, but offers that, if James shows up again under 600 pounds, he will treat him. He walks away without scheduling another appointment, which resonates with the couple. Dr. Now provides a concluding testimonial: “Excuses, lies—until [that] stops, no other stage of the program will help him. Until then, James is done. . . . Once [James] loses 300 pounds, I’ll see him.”

The episode picks up with coverage of James and Lisa in their apartment. The couple is determined to stay in Houston and to continue trying. James, speaking from a place of denial, anger, and defiance, exclaims, “[Dr. Now] fired my ass up!” However, when Lisa then asks him if he would like to exercise, James responds that he does not feel like it at the moment.

B. EMO ENABLEMENT “‘TIL DEATH DO US PART”

James’s story is representative of the dozens documented by TLC in which “caregiver” enablement threatens the effectiveness of treatment interventions and patient lives—lives already jeopardized by the obesity and addiction these caregivers

are feeding. Absent an overriding metabolic or other physiological health condition, it simply is not feasible for one to consume enough food to reach and then maintain EMO status for any extended period of time without enablers:

Everybody on *My 600-lb Life* has at least one enabler, if not more, bringing them the food. You might think they would simply stop bringing them fast food, or going to the grocery store and buying a cart full of junk, but it's not so simple.

In some instances, the obese participants will make their caretakers' lives miserable by hollering and throwing fits until they get what they want. In other cases, the enablers are also heavy, albeit not as heavy, and they don't want to change their own diets. In other cases, the enablers seem to want to be in a caretaker role.¹³⁶

Although most EMO patients' expansive needs necessitate adult primary caregivers, often children are not spared.¹³⁷ Typically, primary enablers are EMO patients' parents, siblings, or significant others.¹³⁸ They also are directly, fully informed observers of EMO patients' physical and mental pain, overwhelming dependency, and daily struggles to remain alive and cope with misery, humiliation, and dire health prognoses. In fact, beyond observers, they are active participants. Motivations abound. For example, Lisa, who also is obese and partakes in James's dietary choices, readily admits that she is wasting her life, and that it would be a lot easier to just walk away.¹³⁹ James weighed hundreds of pounds less than his approximately 800-pound high when they began their relationship years before.¹⁴⁰

In contrast to Lisa, numerous other spouses and partners *do* walk away from the EMO patients they enable, but because these patients *do* adhere to treatment and lose weight. Laura Perez, Christina Phillips, and Zsalyann Whitworth are notable examples.

At the outset of her TLC story, Laura weighed 594 pounds at the age of 42, was diabetic, confined to a wheelchair, and relied on an oxygen tank to breathe.¹⁴¹ She depended on her husband Joey and mother Carmen to survive. Upon examining Laura, Dr. Now declared, "she is physically in one of the worst shapes I have ever seen."¹⁴² In the middle of an attempted gastric bypass surgery, he discovered that Laura's liver and spleen were far too large for that procedure, so he performed his only other option, a

¹³⁶ Swan, *supra* note 2.

¹³⁷ *Id.* ("Of the dozens of examples of children 'parented' into EMO enablement documented by TLC, one of the most extreme and troubling involves Marla McCants' [sic] children. Marla unabashedly consumed junk food at a weight of 800 pounds, and even cooked fried chicken in bed—from which she ordered her three children to bring her food.")

¹³⁸ See Marilia Schteleben, 'My 600-lb Life' Dr. Now Blames Obesity, Weight-Loss Fail on Enabling Care-Givers, BLASTINGNEWS (June 20, 2017), <http://us.blastingnews.com/showbiz-tv/2017/06/my-600-lb-life-dr-now-blames-obesity-weight-loss-fail-on-enabling-caregivers-001788341.html> [<https://perma.cc/QP3Z-R6C9>].

¹³⁹ *My 600-lb Life: James K's Story*, *supra* note 15.

¹⁴⁰ *Id.*

¹⁴¹ *My 600-lb Life: Laura's Story* (TLC television broadcast Mar. 18, 2015); Naomi Greenaway, *Obese Woman Who Lost 300lbs Says Her Marriage Nearly Collapsed After her Husband Felt 'Pushed Out' When He No Longer Needed to Shower, Dress and Feed Her*, Daily Mail (May 12, 2016, updated June 1, 2017), <http://www.dailymail.co.uk/femail/article-3586460/Obese-woman-says-marriage-nearly-ended-dropped-300lbs.html> [<https://perma.cc/NT2G-YRP3>].

¹⁴² *Id.*

gastrectomy, and removed 80% of her stomach.¹⁴³ Ultimately, Laura lost over 300 hundred pounds and, with it, her marriage.

Laura, who attributes her childhood weight gain to sexual abuse by a cousin,¹⁴⁴ had met Joey when she was 18 and weighed about 300 hundred pounds—the amount of weight she ultimately lost under Dr. Now’s care. Joey was attracted to Laura’s obesity, but encouraged her to seek treatment from Dr. Now. However, as her weight declined after surgery, Joey became increasingly distant and resentful because he felt, in his words, “pushed out.” Despite overcoming Laura’s near death due to pneumonia following her surgery and a concerted effort at relationship counseling, their relationship became a casualty to Laura reaching her weight goal and saving her life. Laura reflected, “I thought if I lost the weight, then I would start to get happy, but it has really just been bringing everything to the surface, and I don’t want to run from it anymore.”¹⁴⁵

Christina, like Laura, met her husband Zach when she was 18 years old and EMO at nearly 700 pounds.¹⁴⁶ She had turned 22 by the time TLC began documenting her story, had not left her house in two years, and was wholly dependent upon full-time care from Zach and her mother for daily survival. When Christina lost only four pounds after a month-long hospital stay under Dr. Now’s controlled hospital diet, his initial suspicions that Zach and Christina’s mother would sabotage her weight loss proved true—in this case by sneaking food into the hospital. As Christina “white knuckled” adhering to her diet, her family indulged in unhealthy eating in front of her. For example, they discussed enjoying waffles for breakfast the next morning while savoring biscuits as Christina sat at the dinner table. Ultimately, Christina’s mother stopped enabling her food addiction and Christina lost over 500 pounds—but also lost her husband.¹⁴⁷

Joey, Zack, and enablers like them do not want their EMO significant others to lose the weight that is destroying the quality and longevity of their lives. Weight-loss threatens their control and a state of co-dependency, which often constitute addictions as well. Moreover, some partner enablers are sexually attracted to severe obesity, such as Laura’s and Christine’s, and it may even constitute an all-out fetish that drives and sustains a relationship—as was true in the marriage of Zsalynn and Gareth Whitworth.¹⁴⁸

Gareth Whitworth was one of many men with an obesity fetish (self-proclaimed “fat admirers”) drawn to Zsalynn during a global “fat girl rock star” (Zsalynn’s own words) era in her life.¹⁴⁹ Zsalynn had attained that status by becoming extremely active in the National Association to Advance Fat Acceptance and visually present in its events media, in addition to posting photos of herself clad in lingerie on obesity fetish internet sites.¹⁵⁰ Zsalynn enjoyed a comfortable lifestyle, global travel, and partying financed by admirers.¹⁵¹ Gareth, on a mission to find and marry an obese woman, discovered Zsalynn online, and they married and had a child.¹⁵²

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ See *My 600-lb Life: Christina’s Story* (TLC television broadcast Feb. 4, 2014); see also Swan, *supra* note 2.

¹⁴⁷ *Id.*

¹⁴⁸ See Annabel F. Elliott, ‘Our Husbands Only Loved Us When We Were Fat’: Two My 600-lb Life Stars Lose Half their Body Weight - Along with Their Unsupportive Spouses, DAILY MAIL (Jan. 8, 2015), <http://www.dailymail.co.uk/femail/article-2902609/Our-husbands-loved-fat-Two-600-lb-Life-stars-lose-half-body-weight-unsupportive-spouses.html> [https://perma.cc/XGT3-DUPX].

¹⁴⁹ *My 600-lb Life: Zsalynn’s Story* (TLC television broadcast).

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

When TLC introduced Zsalyann's story to its *My 600-lb Life* viewers, her life was in a very different place. At the age of 42 and weighing 597 pounds, Zsalyann's health had plummeted to the point where she could barely stand, and she had become a recluse enduring a chronic state of misery.¹⁵³ She spent her days watching television and napping from the confines of her home, and observing others chaperone and enjoy activities with Hannah, her young daughter.¹⁵⁴ Zsalyann was hyper-aware that she could die at any time from a heart attack or stroke and leave Hannah both devastated and motherless, and Zsalyann was also guilt-ridden that she was depleting the quality of Hannah's childhood.

Zsalyann embraced Dr. Now's treatment intervention and chose her daughter over her addiction—and her marriage. Although Gareth initially shared Zsalyann's fear that her weight would leave Hannah motherless and devastated, he balked when she actually pursued treatment.¹⁵⁵ On the way home from Zsalyann's weight-loss surgery, Gareth drove them through a fast food takeout restaurant, and he had no qualms about informing Zsalyann that he found the slimmer version of her unattractive—even repulsive.¹⁵⁶ Gareth's belligerence and abuse escalated as Zsalyann's weight decreased. At one point, he barked, "I'm not buying you a salad. If you want to eat grass, you can go in the garden and graze."¹⁵⁷ He even suggested that she had deceived him—telling her that he thought he had married "a fat, happy woman, not a fat miserable one."¹⁵⁸ Even Hannah told Zsalyann that she should leave Gareth, and eventually she did. She also lost 316 pounds.¹⁵⁹

Money is another motive that must be considered. Although the burden to realize federal and state disability benefits on EMO patients and their providers is often cumbersome and frustrating, they are strong candidates.¹⁶⁰ Moreover, even with weight-loss success, benefits continue because the SSA recognizes that bariatric surgery is accompanied by related health risks that necessitate follow-up care over time.¹⁶¹ The SSA classifies severe obesity as a life-long disease, and encourages patients to remain in treatment to make long-term weight-loss success possible.¹⁶²

Another money consideration is that EMO's full-time caregivers often are candidates for PCA benefits under federal and state programs.¹⁶³ When traditional, legal marriages under state law are an impediment to realize and optimize benefits, avoiding the institution makes financial sense. Potential instances include an EMO patient who has dependent children and is able to represent that he or she is the sole supporter, and to overcome prohibitions on caregiver compensation to spouses.¹⁶⁴ TLC does not substantially address EMO dependence on government program benefits in its patient stories beyond health insurance coverage limitations, such as the refusal by James's insurer to cover his medically supervised travel to Houston. Lisa and James, and Laura

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ See *supra* notes 113-19 and accompanying text.

¹⁶¹ POMS, *supra* note 51, at 14 ("How do we evaluate failure to follow prescribed treatment in obesity cases?"); see *supra* note 64 and accompanying text.

¹⁶² POMS, *supra* note 51, at 14; see *supra* note 64 and accompanying text.

¹⁶³ See *supra* note 106 and accompanying text.

¹⁶⁴ See *supra* notes 106-7 and accompanying text

and Joey were involved in live-in partner relationships for decades without legally formalizing them through traditional marriages. In both situations, the EMO patients were unable to work, and their live-in partners provided full-time care, and so were unable to work outside the home as well. When food addicts' obesity is the primary source of income, their full-time caregivers, and dependents in some cases (for example, James's daughter Bailey), their control over their enablers (including what, when, and how much to eat) is fed as well.

Material assets are another monetary factor that could influence enablement, whether conscious or not. Patients on disability could maintain life insurance policies acquired prior to that status or perhaps provided by others. Financial support from an EMO patient's extended family or friends, perhaps withheld during their lives to maximize disability benefits, could become available to EMO patients' caregivers upon their deaths.¹⁶⁵

IV. LAW AND POLICY PROPOSALS TO DISABLE ENABLEMENT

The extent to which the U.S. government and the medical profession have documented and recognized obesity as a national epidemic bestows upon both federal and state government substantial discretion to intervene to protect public health and safety under their police powers and the doctrine of *parens patriae*.¹⁶⁶ SSA, CMS, state governments, and private insurers have demonstrated a trend in favor of responsiveness to the dire health consequences of obesity.¹⁶⁷ This responsiveness is recognition of the prevalence and scope of the U.S. obesity epidemic, the accumulation of persuasive data on the physical and mental health detriments associated with obesity, and advances in bariatric weight-loss surgery. Familiarity with the leading bariatric surgery procedures and documentation of effectiveness have elevated their presence in standard of care, and recognition as the final realistic option for most EMO patients.¹⁶⁸

Given that substantial, reliable data makes it beyond dispute that severe obesity causes and exacerbates myriad health conditions and disability in the lives of hundreds of thousands of people.¹⁶⁹ Accordingly, U.S. federal and state law and policy supportive of treatment interventions is both desirable and laudable. Similarly, law and policy should protect and maximize returns on investments in the treatment of severe obesity and the lives of those afflicted with it, especially in an age of unmanageable health care costs, aggressive health care rationing, zero-sum decision-making over health care finance dollars, and myriad proposals to cut health care-related benefits and coverages substantially.¹⁷⁰

¹⁶⁵ *My 600-lb Life: Penny's Story* (TLC television broadcast Jan. 21, 2014).

¹⁶⁶ See generally discussion *supra* Part II.A. Federal police powers are based in the Commerce Clause, Art. 1, sec. 8, cl. 3, and state police powers are grounded in the state reservation of power and rights to them under the Tenth Amendment to the U.S. The Constitutional checks on these powers, requiring government interventions to be sufficiently compelling, are due process under the Fourteenth Amendment (check on federal government) and Fifth Amendment (check on state government), and individual rights under the First Amendment. See SANDRA H. JOHNSON ET AL., *BIOETHICS AND LAW IN A NUTSHELL*, 273-77, 280-85 (2d ed. 2006).

¹⁶⁷ See generally discussion *supra* Part II.

¹⁶⁸ See *supra* note 61 and accompanying text.

¹⁶⁹ See *supra* notes 45-52 and accompanying text.

¹⁷⁰ See, e.g., Alison Kodjak & Rob Stein, *Medical Research, Health Care Face Deep Cuts in Trump Budget*, NPR (May 23, 2017), <http://www.npr.org/sections/health-shots/2017/05/23/529654114/medical-research-health-care-face-deep-cuts-in-trump-budget> [https://perma.cc/8LUT-ESQT].

As illustrated throughout this article, EMO patients' addictions and resulting health conditions render them vulnerable. Regulatory reform to maximize the effectiveness of treatment interventions by disabling EMO patients' addiction enablers is essential.

A. PRECEDENT FOR PREEMPTING DEATH BY ENABLEMENT

There is broad U.S. federal and state law obligating medical and other professionals to report instances when the health and well-being of vulnerable individuals, such as children and the elderly, are in jeopardy.¹⁷¹ Many of these statutes require reporting of just suspicions of abuse and neglect, and some require "anyone" or "all persons" to report.¹⁷²

States have considerable discretion to place conditions on the licenses they grant individuals to practice medicine within their jurisdictions, and those conditions often include reporting requirements to promote compelling state interests such as protection of the health and wellbeing of their citizens. For example, many states have imposed broad mandates that require medical professionals to report any diagnoses of conditions in licensed drivers that *could* impair their ability to operate a motor vehicle safely.¹⁷³ Under Pennsylvania law, for instance,

[a]ll physicians, podiatrists, chiropractors, physician assistants, certified registered nurse practitioners and other persons authorized to diagnose or treat disorders and disabilities defined by the Medical Advisory Board shall report to the department, in writing, the full name, date of birth and address of every person over 15 years of age diagnosed as having any specified disorder or disability within ten days.¹⁷⁴

States have even empowered coroners to commit individuals involuntarily to treatment centers when they have addiction and other mental health issues that pose a danger to themselves or others.¹⁷⁵ These situations, often triggered by the reporting obligations of treating medical professionals, include individuals engaged in self-mutilation (cutting) and individuals addicted to the legal substance of alcohol.¹⁷⁶

¹⁷¹ See, e.g., The Victims of Child Abuse Act of 1990, 18 U.S.C. § 3509 (1990); *Mandatory Child Abuse Reporting*, 0030 SURVEYS 13 (2016) (a survey of state laws imposing a mandatory duty to report child abuse and neglect); *Physical and Financial Abuse of the Elderly*, 0080 SURVEYS 1 (2016) (a survey of state laws protecting the elderly and, in some instances, other vulnerable adults).

¹⁷² See, e.g., Ind. Code § 31-33-5-1 (2013). For a history of mandatory reporting laws in the context of child abuse, see Megan M. Smith, Note, *Causing Conflict: Indiana's Mandatory Reporting Laws in the Context of Juvenile Defense*, 11 IND. HEALTH L. REV. 439, 444-46 (2014).

¹⁷³ Donald Redelmeier, Vikram Vinkatesh & Matthew Stanbrook, *Mandatory Reporting by Physicians of Patients Potentially Unfit to Drive*, OPEN MED (2008).

¹⁷⁴ 75 PA. CONS. STAT. § 1518 (2017).

¹⁷⁵ *State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Treatment*, TREATMENT ADVOCACY CENTER (Oct. 2014), http://www.treatmentadvocacycenter.org/storage/documents/Standards_-_The_Text_-_June_2011.pdf [https://perma.cc/YU9Q-DXVR]. Involuntary admissions to treatment centers is not a practical solution for EMO patients given limited facilities with the capability to provide their inpatient care. Beyond general facility staffing, many physicians do not have the professional training necessary for treatment interventions of these patients or desire to assume the associated patient health care risks. See *supra* notes 5, 61 and accompanying text.

¹⁷⁶ See generally *State Standards for Assisted Treatment*, *supra* note 175.

Food addicts who become EMO patients, who are recognized as disabled under federal and state law, and who depend on caregivers for daily existence as they grapple with their addictions, are a highly vulnerable population. The standard of care definition of “terminally ill” is life expectancy of six months or less without expectation of treatment success.¹⁷⁷ The life-jeopardizing health conditions associated with EMO and the bleak rate of treatment success at least approximate the definition and satisfy it unquestionably in many cases.¹⁷⁸

The vigorous national and state debates over end-of-life decision-making have generated legislation and crystalized guidance over the roles of medical professionals, other caregivers, family, and friends, in end-of-life situations.¹⁷⁹ Safety provisions in Oregon’s pioneering Death With Dignity legislation are consistent with prohibitions on assisted suicide and maintaining social faith in the medical profession as givers of care, promoters of health, and sustainers of life.¹⁸⁰ Most notably, under Oregon’s law and similar legislation enacted by other states, only one who is terminally ill, competent, and *capable of self-administering* the lethal prescriptions may carry out the act.¹⁸¹ The application of this provision was witnessed by millions through the story of Brittany Maynard, a young woman with terminal brain cancer who relocated to Oregon to control

¹⁷⁷ CMS has adopted the standard for the purposes of hospice care benefits under Medicare. See Certification of Terminal Illness, 42 C.F.R. § 418.22(b) (2012) (requiring two physicians to certify that the patient’s prognosis is six months of life or less); CMS, MEDICARE BENEFIT POLICY MANUAL, CMS PUB. 100-02, Chap. 9, sec. 10 (Rev. 209, May 8, 2015), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf> [<https://perma.cc/H6WY-MQW3>]. See generally Kathleen Tschantz Unroe & Diane E. Meier, *Palliative Care and Hospice: Opportunities to Improve Care for the Sickest Patients*, 25 NOTRE DAME J.L. ETHICS & PUB. POL’Y 413 (2011).

¹⁷⁸ See *supra* notes 46-52, 58 and accompanying text.

¹⁷⁹ See DEATH WITH DIGNITY NAT’L CTR., <https://www.deathwithdignity.org/> [<https://perma.cc/N9UK-MMFU>].

¹⁸⁰ Oregon Health Authority, *Death with Dignity Act Requirements*, OREGON.GOV, <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/requirements.pdf> [<https://perma.cc/5QGB-X9K8>]. In sum, patients “must be:

- An adult (18 years of age or older),
- A resident of Oregon
- Capable (defined as able to make and communicate health care decisions), and
- Diagnosed with a terminal illness that will lead to death within six months.”

Id. In addition,

- The patient must make two oral requests to his or her physician, separated by at least 15 days.
- The patient must provide a written request to his or her physician, signed in the presence of two witnesses.
- The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.
- The prescribing physician and a consulting physician must determine whether the patient is capable.
- If either physician believes the patient’s judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.
- The prescribing physician must inform the patient of feasible alternatives to DWDA, including comfort care, hospice care, and pain control.
- The prescribing physician must request, but may not require, the patient to notify his or her next-of-kin of the prescription request.

Id. (emphasis added).

¹⁸¹ See generally *id.*

the end of her life. Brittany, who shared her experience with the public via YouTube to raise awareness, had to time the end of her life while she was competent and capable of self-administering her legal yet lethal prescription—while the option was still available to her—though accompanied through the ordeal by family and friends.¹⁸² Her final day and self-administered death were relayed by her husband afterwards.¹⁸³

An obvious distinction between most EMO patients and those terminally ill who qualify to control the end of their lives under death with dignity laws is that, for most, there remains some possibility of a medical intervention that could extend their lives beyond six months. However, though not an immediately lethal prescription, food is a lethal substance in EMO patients' lives—lives they share with, and maintain at the mercy of, their “addiction alligators.” It is one made available and administered—purchased, prepared, and served—in part or in whole through caregiver enablers. The fact that there is some chance for treatment intervention in most EMO patients' lives, not to mention the number of citizens directly impacted, actually makes state interest in intervening to contain their addiction enablers arguably even more compelling. Caregiver enablers such as James's girlfriend Lisa disregard medical reality, EMO patients' often dire health care circumstances, and medical provider prognoses and orders—the means to treat them and to fend off preventable, premature death—without legal repercussion. Given EMO patients' vulnerabilities, regulatory standards should more effectively them from additional suffering, the loss of quality of life, and the premature loss of life itself.

B. REGULATORY MECHANISMS TO MANAGE EMO ENABLERS

The following law-policy proposals strive to elevate medical provider controls over EMO enablers by building upon existing insurance coverage and disability decision-making that requires substantial input from medical providers.¹⁸⁴ The discussion introduces proposals to check caregiver enablement in EMO cases, albeit once proven true, with the potential to encompass other cases of severe obesity, and perhaps other forms of life-threatening addiction.¹⁸⁵ Developing law and policy in this

¹⁸² See Compassion Choices, *A New Video for My Friends*, YOUTUBE (Oct. 29, 2014), <https://www.youtube.com/watch?v=1HXXH0Zb2QI> [<https://perma.cc/3ECR-UGD2>].

¹⁸³ See generally, Nicole Weisensee Egan, *Brittany Maynard's Final Hours: Husband Dan Diaz Says She 'Knew It Was Time'*, PEOPLE (Oct. 25, 2016), <http://people.com/celebrity/brittany-maynards-final-hours-husband-dan-diaz-says-she-knew-it-was-time/> [<https://perma.cc/S9K4-L6XW>]; *The Meredith Vieira Show* (NBCUniversal television broadcast Jan. 14, 2015) (Dan Diaz discussing his wife's, Brittany Maynard, final moments before ending her own life through “Death-With-Dignity”).

¹⁸⁴ See, e.g., *supra* notes 88-89, 93, 116 and accompanying text.

¹⁸⁵ If one focuses on addiction, another comparison that comes to mind is the liability of associates of drug addicts who provide the ‘final fix,’ resulting in overdoses—but in this case the medium is controlled substances, an antonym to food given its legal availability. Nevertheless, while addictions to substances other than food leading to EMO are beyond the scope of this article, opiate addiction in the U.S., like food addiction causing obesity, is an epidemic. See Laura Santhanam, *Here's What Trump's New Executive Order Means for Opioid Addiction*, PBS NEWS HOUR (Mar. 29, 2017), <http://www.pbs.org/newshour/rundown/heres-trumps-new-executive-order-means-opioid-addiction/> [<https://perma.cc/D85V-Y4AC>]. According to the CDC, Opioids (including prescription opioids and heroin) killed more than 33,000 people in 2015, more than any year on record. *Opioid Overdose*, CTRS. DISEASE CONTROL, <https://www.cdc.gov/drugoverdose/index.html> [<https://perma.cc/N8CH-XBDT>] (last updated Apr. 16, 2017). CMS has recently summarized the dilemma. See generally, *Opioid Misuse Strategy*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 5, 2017), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf> [<https://perma.cc/YNB4-AWAJ>]. Similar to food addiction, CMS covers the costs of treatment for opioid addiction when eligibility requirements are satisfied, and there is an ongoing oversight and progress component to monitor treatment compliance. See generally *Federal Guidelines for Opioid*

area could also introduce another deterrent to some enablers—potential civil liability under the doctrine of wrongful death.¹⁸⁶

1. Modification of CMS Criteria

Favorable CMS coverage decision-making, which is evidence-based, necessitates health care provider involvement, and this is especially true for procedures with intrinsic levels of significant risk, components of innovation, and unpredictable treatment outcomes.¹⁸⁷ The basic CMS prerequisites for coverage of bariatric surgery for EMO patients mandate health care provider supervision of a six-month weight-loss program, a qualified surgeon's acceptance of the patient for surgery, and a MBSAQIP-certified facility's agreement to serve as the site for the surgery—accompanied by a range of patient-specific medical professional evaluations.¹⁸⁸ Dr. Now is often the “surgeon of last resort” for the EMO patients he treats because bariatric surgeons and surgical facilities rigorously prescreen EMO candidates for satisfaction of both CMS prerequisites and their own.¹⁸⁹ Standard of care, which emphasizes patient-centered medicine and prioritizes safety, demands that medical providers define each patient's specific medical complications and risks with a heightened level of caution.¹⁹⁰

As Dr. Now routinely reminds his patients, scales do not lie. Moreover, scales do make enforcement of patient-specific enabler inquiries and monitoring achievable. The impact of the enabler variable on treatment outcomes and the quality and sustainability of EMO patient lives make these indicators essential for maximizing EMO treatment outcomes, health care decision-making, and health care cost effectiveness.

Treatment Programs, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (2015), <http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf> [<https://perma.cc/B5LG-37WP>]; *Paying for Rehab with Medicaid and Medicare*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.addictioncenter.com/rehab-questions/medicaid-and-medicare/> [<https://perma.cc/BA5S-NSFS>] (last updated Jan. 10, 2017). The Trump Administration has formed a commission by Executive Order to respond to and counter what it has declared a national public health emergency, and the chair has expressly recognized addiction as a disease. *See* Santhanam, *supra* note 185.

¹⁸⁶ This civil liability cause of action recently drew national attention with a \$36 million judgment against Nick Gordon for the wrongful death of Bobbi Kristina Brown, daughter of the late Whitney Houston, in a wrongful death action brought by her family. *See* Ryan Dennis & Maria Puente, *Judge Orders Nick Gordon to Pay \$36 Million to Bobbi Kristina's Family*, USA TODAY, <https://www.usatoday.com/story/life/music/2016/11/17/judge-orders-nick-gordon-pay-36-million-bobbi-kristinas-family/94041640/> [<https://perma.cc/5623-N6YC>] (last updated Nov. 18, 2016). The cause of action drew much national attention years before when the families of the late Ronald Goldman and Nicole Brown Simpson brought a victorious wrongful death action against O.J. Simpson based on allegations of double murder. *See generally*, Matt Gutman et al., *Ron Goldman's Family Speaks Out 20 Years After 'Empty' Victory in O.J. Simpson Civil Suit*, ABC NEWS (Feb. 3, 2017), <http://abcnews.go.com/US/ron-goldmans-family-speaks-20-years-empty-victory/story?id=45233200> [<https://perma.cc/WUA7-VYSH>].

¹⁸⁷ As explained by CMS, “Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). . . . In some cases, CMS' [sic] own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).” *Medicare Coverage Determination Process*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/> [<https://perma.cc/7ZNA-GWEW>] (last updated Apr. 8, 2015).

¹⁸⁸ *See supra* notes 88-89 and accompanying text.

¹⁸⁹ *See supra* notes 5, 61, 89 and accompanying text.

¹⁹⁰ *See generally*, INST. OF MED., COMM. ON THE QUALITY OF HEALTH CARE IN AM., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001); U.S. DEP'T OF HEALTH & HUMAN SERVS. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES (Ronda G. Hughes, ed., 2008), <https://www.ncbi.nlm.nih.gov/books/NBK2681/> [<https://perma.cc/6Q7W-FQP3>].

CMS should modify its policies and procedures to require health care providers to directly address the issue of enablement. Specifically, CMS should compel medical providers to directly investigate and report EMO enablers. CMS should condition eligibility for coverage on identifying existing enablers, containing them, and monitoring the enablement factor through periodic inquiries and reporting as a precondition for coverage, and ongoing coverage moving forward. The only substantial administrative complexity introduced by the proposed enabler impact assessments (“EIAs”) would be for instances in which EMO patients assert that they have maintained or increased their weights on their own—in other words, assertions of food addiction without enablement. Such assertions would be readily dismissible for EMO individuals with limited or no mobility who are heavily dependent upon full-time caretakers. At the very least, caretakers in these situations would be privy to deviations from treatment plans and food addiction enablement by others.

The burden on benefit claimants to meet coverage criteria is entrenched in CMS programs, as are medical provider assessments of relevant variables such as mobility, the overall state of a patient’s health, and life function capabilities.¹⁹¹ Any additional burden imposed on medical providers by a focused inquiry directed to assess the feasibility of non-enablement during defined evaluation periods would be workable. Moreover, the burden would be offset by the promise of substantially increasing treatment effectiveness and outcomes—in other words, furthering the delivery of care objective of improving and saving lives. In such instances, requisite documentation—for example, of takeout food and grocery delivery self-orchestrated by the EMO patient—would suffice. EIAs would bestow medical providers with more control over the treatments they prescribe and render. In many situations in which EMO food addicts bully enablers, EIAs would empower them to resist their demands. The most beneficial impact of the proposed EIA component might be to create an accountability and deterrent effect on both EMO patients and their enablers, in part by infusing a needed dose of reality into their dire health care situations.

Accordingly, CMS and MBSAQIP guidelines, policies, and practices should expressly demand full assessment of the enabler situation, EIAs, for each individual patient. CMS and MBSAQIP should work the proposed EIA component into their existing policies and procedures, which they could accomplish in most instances through simple add-ons. Consider, for example, the existing CMS weight-loss program prerequisite for bariatric surgery. Mandatory medical supervision and program content should include a patient-specific inquiry at the outset to assess and identify enablers, both actual and potential, who pose a direct threat to the program’s success. The programs themselves should include an enabler education component executed at least partially in the EMO patient’s presence. When a weight-loss program failure necessitates the further intervention of bariatric surgery, the report to CMS should include an EIA based upon the specific facts gathered, and the EIA should be shared with the patient and any enabler identified with an opportunity to raise challenges. This notice would give all involved an opportunity to refine identification and assessment of actual enabler impact and promote case-specific accuracy. Again, CMS programs already place the burden of proof on benefit applicants and recipients, and this added burden is more than justified given the potential to improve treatment outcomes and EMO patient lives—perhaps even save them.

The intention of this proposal is to advance the health, quality, and longevity of the lives of EMO patients—certainly not to add to the bureaucratic burden already

¹⁹¹ See generally POMS, *supra* note 51.

placed on them in a manner that impedes access to meaningful treatment intervention. EMO individuals have no choice but to seek medical intervention unless they opt to perpetuate the health care and quality of life situations their addictions have created, with avoidable premature death looming. Regulatory intervention to contain enablers is necessary to overcome the situations EMO patients' food addictions have created.

The proposed approach should be implemented to avoid lost opportunities to intervene with medical effectiveness, and especially for instances when time is of the essence. Patients who fail the prerequisite weight-loss programs due to enabler involvement should be granted another CMS-covered opportunity to succeed—albeit with the consequence that any bariatric surgery intervention will be delayed yet another six months, the time necessary to complete the familiar prerequisite weight-loss program.¹⁹² CMS policies and practices also should be modified to reflect the medical practice of Dr. Now, which is consistent with the SSA's recognition that severe obesity requires fundamental lifestyle changes.¹⁹³ For EMO patients who satisfy the weight-loss program prerequisite with measured success, access to bariatric surgery interventions should be increased (in some instances, present policy promotes failures for access), for they will have demonstrated the lifestyle changes essential for long-term success with the surgery. Ultimately, depending upon how profound the enabler variable proves to be, the proposed law and policy modifications could ease the existing overall burden on EMO patients by drastically improving EMO bariatric surgery intervention outcomes, and alleviate suspicions and reservations that impede granting coverage.

On a macro-level, the proposed EIAs would introduce an opportunity to stretch limited health care resources to accomplish the most good—to potentially reach more EMO patients with more resources by eliminating wasted treatment, time, and patient life along the way by editing medical interventions made futile by not addressing a recognized and fixable problem. Health care finance reality is the high likelihood that CMS and SSA resources are going to become more scarce in the near future given proposed cuts to Medicaid and the SSA supported by the Trump Administration and others, including many states.¹⁹⁴ The proposed change to CMS law and policy also could affect much broader change. CMS law and policy influences standard of care profoundly given the extent to which health care providers and private insurers participate in the Medicare and Medicaid programs. In most cases, private insurers, such as Anthem, place medical provider documentation burdens on EMO patients for bariatric surgery and other treatments on par with, if not greater than, CMS, so their uptake of the EIA requirement would be likely.¹⁹⁵

2. Modification of Disability Benefits Criteria

CMS health care benefits and SSA disability benefits under its SSDI and SSI programs are interwoven: disability benefits under the latter trigger health care benefits

¹⁹² See *supra* notes 56, 88 and accompanying text.

¹⁹³ See *supra* note 12 and accompanying text. See generally POMS, *supra* note 51.

¹⁹⁴ See generally Kodjak & Stein, *supra* note 170; Michael Martin, *Federal Medicaid Funding Cuts Under Senate Health Care Bill Puts Pressure on States*, NPR (June 24, 2017), <http://www.npr.org/2017/06/24/534248643/federal-medicare-funding-cuts-under-senate-health-care-bill-puts-pressure-on-sta> [<https://perma.cc/XNF5-K6YL>].

¹⁹⁵ See generally *Bariatric Surgery and Other Treatments*, *supra* note 100 (listing seven required documents patients or their physicians must provide to private insurers before surgery may be authorized).

under the former.¹⁹⁶ Qualifying for SSDI and SSI also triggers eligibility for other federal and state programs, including programs that provide compensation for PCAs.¹⁹⁷

SSA disability benefits span beyond health care to cover living and other expenses, and for qualifying dependents in addition to those deemed eligible based upon their severe obesity and related health conditions.¹⁹⁸ Given the scope of benefits at issue, EIAs in SSA disability determinations and ongoing SSA oversight of benefits could prove a profound influence. In fact, EIAs in initial eligibility decision-making could provide an intervention that preempts an individual's food addiction, obesity, and obesity-related health conditions from progressing to EMO status. Rather than tied to specific procedures, SSA oversight of disability benefits is comprehensive and ongoing, as would be its oversight of enablement through periodic EIAs—especially given the SSA's recognition that obesity requires continuation of treatment beyond initial weight-loss milestones.¹⁹⁹ Moreover, similar to CMS's influence on private health insurers, SSA adoption of EIAs in its eligibility criteria, policies, and procedures could influence private insurers who provide disability benefits that encompass living expenses to do the same—thereby broadening the scope of impact beyond SSA beneficiaries.

3. A Health Care Provider Reporting Obligation

As discussed above, federal and state governments, other regulatory bodies, and professional organizations have imposed reporting obligations on medical and other professionals increasingly over the last several decades—particularly to promote interventions to prevent individuals from harming themselves or others, and to protect vulnerable persons from identifiable, preventable harms.²⁰⁰ Beyond case-specific interventions, awareness of the existence of reporting obligations itself has the potential to modify behavior meaningfully, provided the consequences for violating them and committing the underlying offenses are sufficient and enforced.

To maximize enforcement, treatment effectiveness, and the deterrence effect of EIAs, CMS and SSA should accompany EIAs with an obligation on all medical professionals servicing their beneficiaries to report instances of EMO enablement under defined circumstances. Rather than incidents, required reportings should include patterns of enablement on the part of individuals identified as enablers or potential enablers and documented over a designated period of time. The timeframe should be long enough between weigh-ins to meaningfully measure projected weight losses consistent with medically supervised dietary, lifestyle, and other prescribed changes. When the lives of EMO individuals are at risk of imminent death and time is of the essence, reporting to CMS and SSA should be obligatory for patterns of enablement measured at approximately 30 days. The period should be extended to perhaps 60 days in all other instances when evidence suggests that food addiction enablement seriously impedes a prescribed and medically supervised weight-loss treatment protocol.

The consequences of addiction enablement in violation of treatment protocols must include refusals to grant benefits and suspensions of benefits pending a cure of the violation. However, the means to cure the situation, including dietary and nutrition education and counseling, should be provided for a time period long enough to be effective—as determined case-by-case based upon input from supervising medical

¹⁹⁶ See *supra* notes 105, 120 and accompanying text; POMS, *supra* note 51.

¹⁹⁷ See *supra* notes 105-06 and accompanying text.

¹⁹⁸ See generally *Benefits for People with Disabilities*, *supra* note 104.

¹⁹⁹ See *supra* note 64 and accompanying text; POMS, *supra* note 51, at 14.

²⁰⁰ See *supra* notes 171-6 and accompanying text.

professionals. Federal and state programs that compensate or otherwise provide benefits to enablers, such as PCAs and dependents of EMO patients, should immediately suspend those benefits in a similar manner and with a similar means to cure—a program of intense education and counseling that includes the identified enablers.

Such obligatory reporting requirements imposed by CMS and SSA would grant medical providers like Dr. Now much needed leverage over both EMO patients and their enablers given the benefit consequences. The potential for mandatory reporting programs to elevate patient care is illustrated by one of Dr. Now’s patient case studies, Steven’s story.²⁰¹

Steven’s father delivered him into Dr. Now’s care in Houston when he was over 700 pounds at the age of 33 by financing transportation from Rhode Island to Houston via a medically-staffed recreational vehicle.²⁰² Steven was noncompliant with Dr. Now’s program to the point of gaining over 100 pounds while under his care for over a year.²⁰³ During his treatment, Steven’s father engaged in long-distance enablement by ordering Steven pizza deliveries, and Steven developed an addiction to pain medications.²⁰⁴ The pain medication addiction, along with the food addiction, continued after Dr. Now suspended Steven from the weight-loss program and he failed a drug addiction program.²⁰⁵ Steven engaged in calling 911 for emergency room care, and shopped Houston’s emergency rooms to obtain 39 prescription pain medications from 17 different doctors, totaling thousands of pain medication tablets.²⁰⁶ As observed by Dr. Now, the emergency room system “can be easily abused if you know how to do it”—especially if one is EMO, with severe lymphedema, and who lands in an emergency room with a “fresh” set of physicians to receive complaints of pain.²⁰⁷ Dr. Now was able to intervene on Steven’s pain medication addiction by complying with and utilizing the Texas Prescription Drug Monitoring Program (“PMP”).²⁰⁸ The program forbids individuals from receiving pain medication from more than one doctor, and Steven had exhausted lifetime hospital privileges for admission.²⁰⁹ As Dr. Now informed Steven, once entered into the Texas-wide data bank, he would be arrested if he attempted another hospital admission.²¹⁰

In some situations, the obligatory reporting would grant caretaker enablers incentive and leverage needed to refuse the demands of EMO patients, and give the latter added incentive to adhere to treatment protocols. Especially for enablers who reside with EMO individuals and who share their financial means, these measures would position them better to refuse their food addict’s demands. While the purview of CMS and SSA oversight is largely limited to the benefits they administer, over time, professional bodies and state legislatures might bolster both enabler reporting requirements and the

²⁰¹ *My 600-lb Life: Steven & Justin—Part I* (TLC television broadcast Mar. 29, 2017); *My 600-lb Life: Steven & Justin—Part II* (TLC television broadcast Apr. 5, 2017).

²⁰² *Steven & Justin—Part I*, *supra* note 201.

²⁰³ *Id.*; *Steven & Justin—Part II*, *supra* note 201.

²⁰⁴ *Steven & Justin—Part I*, *supra* note 201.

²⁰⁵ *Steven & Justin—Part II*, *supra* note 201.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.* For information about the program, see *Texas Prescription Monitoring Program*, TEX. ST. BOARD OF PHARMACY (Sept. 1, 2017), <http://www.pharmacy.texas.gov/PMP/> [<https://perma.cc/56YM-B2BQ>]; Krista R. Crockett, *Prescription Monitoring Program—Now Available Online*, TEX. MED. LIABILITY TR., <https://www.tmlt.org/tmlt/tmlt-resources/newscenter/blog/2012/Prescription-monitoring-program-now-available-online.html> [<https://perma.cc/7H44-85BY>].

²⁰⁹ *Steven & Justin—Part II*, *supra* note 201.

²¹⁰ *Id.*

consequences of violating them. By adopting the EIA regulatory approach and obligatory reporting, organizations such as the ASMBS, AMA, AHA, and the ACS—all of which have directly addressed treatment of severe obesity, as discussed throughout this article—could evolve EIAs into the standard of care in a timely manner.²¹¹

V. CONCLUSION

A common observation is that food addiction, unlike addiction to alcohol or pills, is more difficult for the addict to conquer because we all have to eat to survive. This article has proposed law and policy reforms to check enablers and hold them accountable when food addiction consumes individuals to the point of becoming EMO. It is not the intention of this article to chill food addicts from seeking medical care but, rather, to better position them to overcome their addiction beasts, health care ailments, and the risk of imminent death. As illustrated by the dozens of Dr. Now's patient stories relayed by *My 600-lb Life*, EMO patients and their enablers depart for Houston, or any other road to survival and recovery, with recognition that food addiction is going to take their lives and with every intention to overcome it.

There is broad, long-standing precedent for obligating medical and other professionals to report instances when the health of individuals is in jeopardy—from child abuse, to elder abuse, and beyond.²¹² There also is ample precedent to prevent individuals from accelerating the end of others' lives.²¹³ Along these lines, this article has proposed measures tied to federal and state health care and disability program benefits to contain food addict enablers in EMO cases, and the introduction of an obligation on medical providers to report enablers when food addiction reaches an EMO state. Although an imposition on health care providers, this measure would actually provide them with a means to block enabler interference with treatment, to better position their patients to beat addiction, which drains quality from their patients' lives, and threatens premature death—ultimately saving more lives. Such a measure might also better position enablers to stand firm against their addicts' demands, especially given that scales do not lie and would disclose violations. The obligation to report would be a means to check the enablers of EMO food addicts—a means to bite the hands of those who feed the alligators.

²¹¹ See, e.g., *supra* notes 39-40, 73 and accompanying text (discussing the AMA's adoption of a policy regarding obesity "disease" status and the ASMBS and ACS's joint development of the MBSAQIP self-regulation, national accreditation, and certification program).

²¹² See *supra* notes 171-2 and accompanying text.

²¹³ See *supra* notes 179-83 and accompanying text.

APPENDIX

Primary Bariatric Operations Performed in the U.S. (2015 Use)²¹⁴

Procedure and % of Total	Advantages	Disadvantages	Cost ²¹⁵ (approx.)
<p>Adjustable Gastric Band (5.7%): A ring with an inner inflatable band is implanted around the top of the stomach to divide the stomach in two, and to form a small pouch. The band is filled with saline solution to create a fullness sensation after consuming small amounts of food.</p> <p>Those with a BMI of 30-35 (BMI Class 1) are candidates,</p>	<p>The least invasive of the three principal procedures (there is no stomach cutting or stapling), the band is adjustable to accommodate each patient.</p> <p>The band also is readily reversible and removable once the patient reaches the weight goal.</p>	<p>The band generally induces less weight loss than alternative procedures.</p> <p>Often, frequent follow-up visits are necessary to adjust the band, and some patients are unable to adapt to it.</p> <p>The procedure is associated with high failure rates and reoperation rates (10-20%) due to a need to adjust the band and band slippage, band erosion, esophageal dilatation,</p>	\$14,500

²¹⁴ *Bariatric Surgery Procedures*, AM. SOC'Y METABOLIC & BARIATRIC SURGERY (2017), <https://asmbs.org/patients/bariatric-surgery-procedures> [https://perma.cc/X74J-YNKF]; *Cost Range of a Gastric Bypass Revision*, BARIATRIC SURGERY SOURCE, <http://www.bariatric-surgery-source.com/cost-range-of-a-gastric-bypass-revision.html> [https://perma.cc/48YC-ADMC] (last modified May 5, 2016); *Estimate of Bariatric Surgery Numbers*, *supra* note 67; *Types of Bariatric Surgery*, *supra* note 56.; Madura & DiBaise, *supra* note 61; *see Bariatric Surgery Cost in 2017*, *supra* note 83; *Bariatric Surgery for the Treatment of Morbid Obesity*, *supra* note 78; *Weight Loss Surgery Insurance Coverage and Costs*, *supra* note 82; Denise Mann, *Duodenal Switch Surgery Cost*, CONSUMER GUIDE TO BARIATRIC SURGERY, <http://www.yourbariatricsurgeryguide.com/duodenal-switch-cost/> [https://perma.cc/NE75-QAP9]; Mann & Hatcher, *supra* note 84. A surgery-alternative procedure, ESG, was announced in the popular press on June 6, 2017, but ESG is in the nascent stage of introduction into obesity treatment. *See supra* note 66 (discussing ESG).

²¹⁵ The overall cost of bariatric surgery encompasses:

anesthesia, the hospital facility and the surgeon's fee. There will also likely be additional costs after surgery, including those associated with diet and fitness plans, behavioral modification therapy and nutritional supplements. And the weight loss surgery is likely not the last surgery you will undergo. After weight loss surgery, many people want additional body contouring surgeries to remove excess skin, lift sagging body areas, improve loose muscles or treat fat deposits. Some of these additional procedures could include a facelift, breast augmentation, breast lift, abdominoplasty or liposuction.

Mann & Hatcher, *supra* note 84. Costs vary at times significantly among providers, as does insurance coverage. Surgery fees, overhead, and demand tend to be higher in urban areas, which raise costs charged for the procedures. *See id.* According to one source, with full insurance coverage and provided prerequisites are met, the patient out-of-pocket costs of each of the surgery procedures profiled may be reduced to \$3,500.00. *Bariatric Surgery Cost in 2017*, *supra* note 83. When core costs are combined with unforeseen and incidental costs, they often escalate substantially. *See generally* Gary Weiss, *The True Cost of my Weight-Loss Surgery*, TIME (Jan. 31, 2014), <http://time.com/money/2795119/the-true-cost-of-my-weight-loss-surgery/> [https://perma.cc/NW2D-KXJW].

Procedure and % of Total	Advantages	Disadvantages	Cost ²¹⁵ (approx.)
<p>provided other qualifications are satisfied. EMO patients typically are not candidates for this procedure.</p>	<p>Recovery is relatively fast, and requires a shorter hospital stay than the bypass procedure.</p> <p>This surgery introduces a low risk of mortality.</p> <p>Long-term metabolic and nutritional complications are uncommon.</p> <p>The intestine is unchanged, and this procedure introduces the lowest chance of causing a vitamin shortage.</p>	<p>leakage, incision/port infection, and weight-loss failure.</p> <p>Other risk factors include bleeding, reflux, pouch stretching, and development of blood clots in the patient's lungs.</p> <p>The percentage of patients who have their bands in place after 10 years may be as low as 54%.</p>	
<p>RNY Gastric Bypass (23.1%): A surgeon staples the patient's stomach to reduce its size to the length of the patient's gastrointestinal tract. Reduction of stomach size creates a sense of fullness, and bypassing the full stomach reduces the calories absorbed.</p> <p>Rerouting the food stream produces changes in gut hormones that promote satiety, suppress hunger, and</p>	<p>This procedure has the largest experiential use base, which has raised provider competency and patient access.</p> <p>Bypass surgery is associated with a high likelihood of success in obesity patients.</p> <p>Patients who opt for the bypass realize greater weight loss than patients who opt for the gastric band. Most patients</p>	<p>Of the three primary bariatric procedures, the bypass is the most complex, which raises susceptibility to complications, requires a longer hospital stay, and raises the needed surgeon technical skill level.</p> <p>Specifically, this operation requires advanced laparoscopic surgical skills with a learning curve of approximately 100 cases, which impacts access and cost.</p>	<p>\$23,000</p>

Procedure and % of Total	Advantages	Disadvantages	Cost²¹⁵ (approx.)
<p>reverse one of the primary mechanisms by which obesity induces type 2 diabetes.</p> <p>Those with a BMI of 30-35 (Class 1) are baseline candidates, provided other qualifications are satisfied.</p>	<p>experience a 65% weight loss, 50-60% experience weight loss beyond their surgery targets, and over 85% initially lose 50% of their excess weight and maintain that weight loss.</p> <p>No objects are placed in the patient's body.</p>	<p>The bypass introduces a higher chance of surgery-related problems than the gastric band.</p> <p>The bypass also introduces a higher chance of vitamin shortage issues than both the band and sleeve.</p> <p>The long-term failure rate is approximately 10-15%, due to issues that include fat malabsorption, protein-energy malnutrition, and micronutrient deficiencies (primarily vitamin B12, iron, calcium, and folate), but these are not common and typically manageable with oral supplements.</p> <p>This procedure requires adherence to dietary recommendations, life-long vitamin/mineral supplements, and follow-up compliance.</p> <p>Although possible if medically necessary, the procedure is difficult to reverse.</p>	
<p>Gastric Sleeve (53.8%): A surgeon cuts and removes 70-80% of a patient's stomach, leaving only a banana-shaped section—a pouch—</p>	<p>This procedure is simpler than the bypass and requires only a short hospital stay (approximately two days).</p>	<p>Given the relative novelty of the procedure, long-term data is not as plentiful as with the band and bypass procedures.</p> <p>The gastric sleeve is not reversible, and there is a higher earlier (surgery-</p>	\$14,900

Procedure and % of Total	Advantages	Disadvantages	Cost²¹⁵ (approx.)
<p>closed with staples (which resembles a sleeve, and hence the name).</p> <p>Similar to the band and bypass surgeries, the sleeve reduces the amount of food that can fit in the patient’s stomach to create a sense of fullness sooner. In addition to this physical change, the procedure triggers favorable changes in gut hormones which suppress hunger, reduce appetite, and increase satiety.</p> <p>Although introduced much more recently than the band and bypass alternatives, as of 2013, the sleeve procedure outnumbered the band procedure at a ratio of three to one.</p> <p>According to NIH, those with a BMI of >40 are candidates, provided other qualifications are satisfied, though other indicators suggest those with BMIs of 30-35 are baseline candidates (in sync with the band and bypass).</p>	<p>Nevertheless, according to available data, sleeve surgery achieves weight loss comparable to bypass with maintenance, and greater weight loss than the band. Patients typically lose 30-50% of their excess weight during the first year after surgery, and >50% over 3-5+ years.</p> <p>No foreign objects (medical devices) are inserted.</p> <p>The food stream is not bypassed or rerouted. Given that the digestive tract is not changed, digestion happens naturally. This approach enables patients to consume a greater variety of foods than after bypass surgery, and there is no risk of “dumping syndrome” (when food not fully digested is dumped into the small intestine).</p>	<p>related) complication rate when compared with the band.</p> <p>Given that the patient’s food stream is not bypassed or rerouted, diet is especially important to achieve targeted weight loss.</p> <p>Associated risks include: acid reflux, anemia, bleeding, breaks in the staple line, formation of gallbladder stones, hernia at the port (small holes used for the surgery) sites, incision infections, long-term vitamin and mineral deficiencies, sleeve leaks, need for additional surgery, stomach pouch stretching, stomach pouch ulcers, and stricture of the stomach.</p>	

Procedure and % of Total	Advantages	Disadvantages	Cost ²¹⁵ (approx.)
<p>Patients who have illnesses that prevent other surgery options, such as anemia and Crohn's disease, may be candidates for the sleeve procedure.</p>			
<p>Duodenal Switch (.6%): The switch is an extension of another procedure, the biliopancreatic diversion, and the two often are grouped as a treatment option.²¹⁶</p> <p>The surgery is twofold. First, a portion of the stomach is removed to create a tubular stomach pouch—very similar to the sleeve procedure. Next, a large portion of the small intestine is bypassed—similar to the bypass procedure.</p> <p>When the patient eats, food goes through the pouch and empties directly into the last segment of the small intestine. Roughly three-fourths of the small intestine is bypassed by the food stream.</p>	<p>The switch results in the greatest reported weight loss—loss of 60-70% of excess weight at 5-years following surgery.</p> <p>Eventually, patients are able to eat “normal” meals.</p> <p>This procedure is the most effective for combatting diabetes.</p>	<p>Although use was first reported in 1998, the switch procedure is yet to reach a point of critical mass utilization. The complexity of the procedure and associated risks continue to dissuade surgeons and patients from utilizing it. Accordingly, experiential data is limited and unreliable compared with data for the alternative bariatric procedures.</p> <p>The switch is the most technically challenging of the surgeries profiled and introduces higher rates of complications and mortality.</p> <p>Nevertheless, the rate of long-term weight loss and overall obesity treatment is only marginally higher than the other procedures.</p> <p>The procedure requires a longer hospital stay than the band and sleeve procedures, and over the long-term, requires patient compliance with</p>	<p>\$20,000-\$30,000</p>

²¹⁶ For information about both procedures, see *Biliopancreatic Diversion and Biliopancreatic Diversion with Duodenal Switch*, WEBMD (Feb. 20, 2015), <http://www.webmd.com/diet/obesity/biliopancreatic-diversion-1920> [https://perma.cc/GCX8-LKE7].

Procedure and % of Total	Advantages	Disadvantages	Cost ²¹⁵ (approx.)
<p>Similar to the bypass and sleeve, the switch affects guts hormones in a manner that impacts hunger and satiety as well as blood sugar control. Specifically, the procedure reduces fat absorption >70+ and changes gut hormones to reduce appetite and increase satiety.</p> <p>The switch procedure derives weight loss benefit mostly from promoting malabsorption, but sleeve gastrectomy also creates some degree of restriction of food intake.</p> <p>Initially, similar to the other surgeries described above, the switch procedure reduces the amount of food consumed. Over time, however, this effect lessens. Eventually, patients are able to consume nearly normal amounts of food.</p> <p>Due to associated risk factors, candidates for this surgery typically have a BMI of >50 who have exhausted</p>		<p>follow-up visits and dietary and vitamin supplements guidelines.</p> <p>There is a significant long-term risk of potentially severe nutritional deficiencies—e.g., of protein, iron, calcium, zinc, micronutrients (needed for growth and development), and fat-soluble vitamins such as vitamin D. These deficiencies may cause malnutrition, fat malabsorption, and developmental irregularities.</p>	

Procedure and % of Total	Advantages	Disadvantages	Cost²¹⁵ (approx.)
other weight-loss options.			
Revisions (13.6%): There are primarily 5 options, which may or may not be applicable for a given patient case:(1) shrink the stoma (artificial opening) by injection, (2) reduce the stomach by creating internal folds, (3) convert to lap band surgery, (4) lengthen the intestine section primarily for food intake (roux limb), or (5) convert to a duodenal switch.	Varied	Varied	\$20,000-\$30,000
Other (3.2%)²¹⁷	N/A	N/A	N/A

²¹⁷ “Other” includes the gastric balloon, AspireAssist, and vBloc Therapy treatments. *See Bariatric Surgery Cost in 2017*, *supra* note 83. However, these alternatives stray from standard of care for obesity treatment, which limits both availability and insurance coverage. *Cf. id.*