STATE OF WISCONSIN
Department of Employee Trust Funds
A. John Voelker
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: April 20, 2022 | Revised: May 20, 2022

To: Group Insurance Board

From: Kimberly Schnurr, Board Liaison
Office of the Secretary

Subject: Board Correspondence

This memo is for informational purposes only. No action is required.

The Department of Employee Trust Funds occasionally receives correspondence on behalf of the Group Insurance Board (Board) regarding proposed or recent changes to the State of Wisconsin Group Health Insurance Program.

Since the February 16, 2022, Board meeting, the following communication(s) have been submitted for the Board's consideration:

1. February 8, 2022 – Email Correspondence – Dental Plan – Dehler
2. February 18, 2022 – Email Correspondence – Sick Leave Conversion Upon Retirement – Zager
3. February 21, 2022 – Email Correspondence – Building Families Act – Gitch
4. April 4, 2022 – Letter Correspondence – Coverage for Erectile Disfunction Treatment – Tetzke
5. April 13, 2022 – Email Correspondence – UHC Reimbursement (COVID Test Kits) – Wilmot
6. April 18, 2022 – Email Correspondence - State Employee health plan coverage of Obesity Care – Gallagher[1]
7. May 1, 2022 – Email Correspondence – Support for Anti-Obesity Therapy Addition to state health insurance formulary – Pabich[1]
8. May 13, 2022 – Email Correspondence – Obesity Medications – Basarich[1]
9. May 13, 2022 – Email Correspondence - Advocating for WETF Coverage of Anti-Obesity Medications and Behavioral Interventions – Hidde[1]
10. May 16, 2022 – Email Correspondence - Please approve anti-obesity medication coverage for state employees – Golden[1]
11. May 16, 2022 – Email Correspondence – Weight Loss Medications – Meade[1]
12. May 16, 2022 – Email Correspondence - OAC and Obesity Community Comments for May 18th GIB Meeting – Gallagher[1]

[1] Presented to Board at time of meeting on May 18, 2022.

Reviewed and approved by Pamela Henning, Assistant Deputy Secretary
Electronically Signed 05/04/2022
Pamela L Henning

Board	Mtg Date	Item #
GIB	5.18.22	10D

13. May 17, 2022 – Email Correspondence – GIB Meeting Comment – Obesity Therapy Coverage – Simpson[1]
14. May 18, 2022 – Email Correspondence – UW Health Comments – Benefit Plan Year 2023 - Schulze[1]

Correspondence for Board consideration is welcome via email to ETFSMBBoardFeedback@etf.wi.gov or U.S. postal mail to Department of Employee Trust Funds, c/o GIB Liaison, P.O. Box 7931, Madison, WI 53707-7931.

Staff will be at the board meeting to answer any questions.

From: Robert Dehler
To: ETF SMB Board Feedback
Subject: Dental Plan
Date: Tuesday, February 8, 2022 1:32:21 PM

Hi,

I read the proposals with respect to changes to the dental plans for 2023. Many state dental programs provided in the benefit package to state employees have a more comprehensive plan than the one WI includes with its health care plans. I think the Board should consider offering a plan that includes crown and root cannel coverage in the basic plan. The costs would be spread out to all members with their health care option: accordingly lowering the costs for all members covered. The Board should price out how much the basic dental plan would increase for the additional coverage. Proper dental health is linked to good overall health and would reduce costs for the all the health care plans offered.

Thanks
Bob Dehler
[redacted]

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February 18, 2022

Robert Dehler [redacted] MID: [redacted]

Dear Mr. Dehler:

Thank you for your February 8, 2022 email to the Department of Employee Trust Funds (ETF) Board Feedback mailbox. In your inquiry, you suggested that the Group Insurance Board (Board) consider adding coverage for crowns and root canals in the Uniform Dental Benefits (UDB).

The UDB provides coverage for dental services that are routine, diagnostic, and preventive in nature. The UDB is only available to members that have their health insurance through ETF.

ETF reviews dental utilization, trends, data, and analytics to help determine possible changes to benefit designs for recommendation to the Board. ETF also receives, reviews, and brings to the Board for consideration pertinent benefit change recommendations made from a variety of other sources including members, legislators, vendors, and other stakeholders. Our recommendations must balance offering robust benefits while maintaining affordable premiums. The Board is also limited under Wis. Stat. § 40.03(6)(c) from changing benefits in a way that cause an increase to overall program costs.

According to Delta Dental, including coverage for crowns and root canals in the UDB would increase the cost by more than 20% for everyone enrolled in the plan when less than 12% of membership utilize that benefit annually. However, ETF and the Board recognize that some members may need additional care; to meet these needs, we have developed supplemental dental options for members.

The supplemental Select Plan and Select Plus Plan are designed to enhance the UDB by offering more robust dental benefits. The plans provide coverage for dental services that are considered major procedures, such as crowns and root canals, that the UDB and Preventive Plan do not cover. Including specialized dental procedures in our two supplemental plans allow members the option to enroll in the plans that provide this enhanced benefit while keeping the UDB premium affordable.

A detailed breakdown of costs, descriptions of the dental procedures covered under the UDB, and information on each of the supplemental plans can be found on ETF's 2022 Dental Insurance webpage.

I hope this information is helpful. If you have further questions, please don't hesitate to contact me or Tom Rasmussen, Dental Program Manager with the Office of Strategic Health Policy, at (608) 266-0994 or tom.rasmussen@etf.wi.gov.

Sincerely,

Eileen Mallow
Director
Office of Strategic Health Policy
(608) 267-0732
eileen.mallow@etf.wi.gov

CC: Tom Rasmussen

From: Zager, Eric P [redacted]
Sent: Tuesday, February 8, 2022 2:25 PM
To: ETF SMB OSHP HELP <ETFSMBOSHPHELP@etf.wi.gov>
Subject: Sick Leave Conversion Upon Retirement

Good afternoon,

I have been trying to pursue this for a while now.

I am interested in changing the sick leave conversion for state employees upon retirement, but really haven't had any response from anyone. So, I'm not sure who to ask or suggest it to.

Currently, upon retirement sick leave can only be converted to pay for health insurance. For an employee that doesn't carry the state health insurance, it seems really unfair.
As an active employee who doesn't carry the state health insurance, it's unfair as well while working. Since the state of WI is paying more for an employee that carries the health insurance than the employee that opts out for the $2000.

My suggestion is this for sick leave conversion upon retirement.

1. Conversion to pay for state health insurance.(Currently the only option)
2. A sick leave conversion payout based on hours and employee's hourly wage.(The State of WI wouldn't even have to match an employee's hours)
3. A sick leave conversion for time in/more length of service based on how many hours an employee has.

I've tried contacting state representatives and other state employees, but have never heard back from one of them.

So, any suggestion would be appreciated.

Thank you for your help.

Sincerely,

Eric Zager [redacted]

From: Zager, Eric P [redacted]
Sent: Wednesday, February 9, 2022 7:44 AM
To: ETF SMB OSHP HELP <ETFSMBOSHPHELP@etf.wi.gov>
Subject: RE: Sick Leave Conversion Upon Retirement

Good morning—

The other point I would like to add is the escrowing of sick leave hours upon retirement.

My current understanding is an employee has to enroll in the State of WI Access Plan and be on it 30 days to escrow the sick leave hours. This makes no sense at all.

Why would I need to be enrolled in the Access Plan just to escrow my sick leave hours? After 25 years plus of State of Wisconsin service the question would be: When would you like to escrow your sick leave hours?

This provision is ridiculous. If an employee retires with 25+ years, it should just be a simple escrow application.

The only answer I receive is: "it's in the statutes." It's time the statutes change. The sick leave statutes are currently very antiquated.

Thank you for your time.

Sincerely,

Eric Zager [redacted]

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February 23, 2022

Eric Zager [redacted] MID: [redacted]

Dear Mr. Zager:

Thank you for your two emails to the Department of Employee Trust Funds (ETF). I appreciate the opportunity to respond. In your first email, you asked if accumulated sick leave could be converted to cash or used like sabbatical to extend an employee's termination date. In your second email, you inquired about why employees who are not insured in the State of Wisconsin Group Health Insurance Program (GHIP) must be insured in the Access Plan for one month prior to termination in order to escrow sick leave credits. I will share the information that I have on each item below. If after your review, you find that you still have questions, please let me know.

Regarding the accumulated sick leave conversion program, the program was designed to help pay the cost of health insurance that is offered by the health plans under contract with the Group Insurance Board (Board) for retired state employees. State law doesn't allow the credits to be used for any other purpose. Because this program is defined in the statutes, ETF and the Department of Administration (DOA) aren't authorized to allow former employees to convert these credits to cash or to use the sick time to extend an employee's termination date.

If credits were cashed out, there is the potential for negative tax consequences for participants. For tax purposes, the current sick leave program is treated like an employer's contribution to the health insurance of its active employees. Any change to the usage of these funds (i.e., to cash them out) could carry substantial tax liabilities for all participants. For example, if participants had the option to receive cash payments, instead of the current contribution toward our employer-sponsored plan, the sick leave payments would require all participants to record this on their income taxes even if only a few individuals chose to receive the payment directly.

In response to your question about using sick leave to extend a person's last date of service, this is not permissible under current law. If the law were changed to permit this, a significant amount of resources would be needed to investigate the ramifications to overall employee compensation, including taxation. Following that, staff would need to draft and propose language for the legislature. Payroll system changes would also be necessary to accommodate the new legal requirements.

Finally, state law requires an employee to be insured in the GHIP prior to termination in order to escrow their sick leave credits. If they are not insured prior to termination, they

forfeit their credits. This is why an employee must, at a minimum, be insured in the Access Plan for one month prior to termination of employment and retirement in order to escrow their sick leave credits.

The policy referenced in your email was enacted January 1, 2012 in response to changes in reenrollment requirements under the Health Insurance Portability and Accountability Act (HIPAA). Prior to 2012, employees who weren't insured in the GHIP could enroll at any time; but, outside of a qualified life event, were limited to the Access Plan. Additionally, employees were subject to a waiting period for pre-existing conditions. Consequently, this meant that any employees with pre-existing conditions that enrolled without a life event, would need to wait a set period of time before any claims related to that illness or injury would be payable.

To comply with HIPAA, the Board revised the annual enrollment period to be an open enrollment period. However, this meant that, outside of a life event, retiring employees that were not insured in the GHIP but wanted to escrow their sick leave credits would have to enroll during open enrollment. The Board did not want to alter longstanding policy, so voted to continue to permit employees to be insured for only one month in order to escrow. If the Board hadn't acted, employees who did not enroll during open enrollment or with a life event, they would forfeit their credits or need to extend their termination date.

Some additional information to note here is that employees don't have to terminate their Access Plan coverage after a month. They may continue coverage and change plans during open enrollment. Employees who use this enrollment opportunity are limited to the Access Plan as there is a risk that they may be seeking coverage due to an underlying health issue that could increase claim costs in the GHIP. Some employees retire due to illness. The higher premiums of the Access Plan help to cover this potential, greater claim risk for a brief period of time.

Therefore, if you enroll in the Access Plan and are insured for one month prior to termination, you will be able to cancel that coverage and escrow your sick leave credits. However, this only applies if you have comparable coverage, or other insurance benefits equivalent to the Access Plan (including prescription drug coverage). You must certify this comparable coverage with ETF prior to both escrowing your sick leave credits and, again, if you change that coverage. Then, at a later date, you may unescrow during established time periods, enroll in any health plan, and use the credits to be insured in the GHIP.

Again, thank you for reaching out to ETF with your questions. I hope the information provided in this response is helpful. If you have any further concerns, please don't hesitate to contact me using the information in my signature below. If I'm not available, you're encouraged to reach out to or Arlene Larson, Manager of Federal Health Programs at the Office of Strategic Health Policy, through email, arlene.larson@etf.wi.gov, or phone at (608) 264-6624.

Sincerely,

Brian Stamm
Deputy Director
Office of Strategic Health Policy
(608) 267-4554
brian.stamm@etf.wi.gov

CC: Arlene Larson

From: Kristen Gitch
To: ETF SMB Board Feedback
Subject: Building Families Act
Date: Monday, February 21, 2022 12:38:38 PM

Hello,

Is there a way to find out more about what happened on the 2/16/22 meeting where this was to be addressed?

https://madison.com/news/local/health-med-fit/infertile-couples-support-wisconsin-bill-to-require-fertility-coverage/article_f0b18aca-e4d9-58fa-983c-3e49b5ec6721.html?fbclid=IwAR0o7TRoyvzTQI3Af-yKPY5pjKqAhITF_EifsWWE16-4MOYuoJjCV6CFT68

State coverage urged

Infertility is recognized as a disease by major medical groups, and in 1998 the **U.S. Supreme Court ruled that it is a disability**. More than 172,000 Wisconsin residents are believed to be infertile, according to a letter in November by two UW Health doctors urging the Group Insurance Board, which oversees benefits for state workers, to add coverage of fertility treatments at **its meeting in February**.

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March 11, 2022

Kristen Gitch
[redacted]

Dear Ms. Gitch:

Thank you for your question regarding the discussion of infertility treatment coverage at the February Group Insurance Board (Board) meeting. No changes to coverage were made at the February meeting; below I can provide a bit more detail on how the Board's change process works.

Each February, Employee Trust Funds (ETF) provides the Board with an inventory of all changes that have been requested for consideration for the coming benefit year. The memo presented to the Board is available on our website (https://etf.wi.gov/boards/groupinsurance/2022/02/16/gib7d/direct); infertility coverage is mentioned on page 3.

The Board has an opportunity to ask questions or request other coverage issues be investigated at the February meeting, but no coverage recommendations are made or approved. The Board did not have any specific questions on the infertility coverage concept. ETF will continue analyzing all benefit changes presented in February and will bring recommendations to the Board at their May 18, 2022 meeting.

If you have further questions, please feel free to contact Renee Walk, Lead Policy Advisor, at renee.walk@etf.wi.gov.

Sincerely,

Eileen K Mallow

Eileen Mallow
Director
Office of Strategic Health Policy
(608) 267-0732
eileen.mallow@etf.wi.gov

CC: Renee Walk

Bruce Tetzke
[redacted]
April 2 2022

Group Insurance Board c/o Board Liaison Department of Employee Trust Funds
WEA Trust

To Whom it may concern:

[redacted] I've been trying to find out who to send my concern to and I hope this is the right avenue. My wish is to try to get some type of coverage added to our health insurance for treatment of erectile dysfuntion going forward. This is a growing problem with more and more men affected by this all the time. Maybe it always was a problem, but only now more attention and information have been brought to light over the past years. Whether it would be just for oral meds or coverage for other treatments, *any* type of coverage would be a start that is overdue. ED is a very common problem that is reported to affect as many as 30 million men. It is time to address this and add coverage for this.

Thank you for your time,

Bruce Tetzke

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April 8, 2022

[redacted]

Dear Mr. Tetzke:

Thank you for your letter regarding coverage of erectile dysfunction (ED) medication in the Group Health Insurance Program (GHIP). Below I have shared what our current coverage policy is, the process the Department of Employee Trust Funds (ETF) undertakes every year to review coverage, and what current options might be available to you.

You are correct that the current GHIP does not cover ED drugs. ED drugs are not required to be covered by any current Wisconsin or federal laws, and so these services are not included in the current GHIP pharmacy benefit.

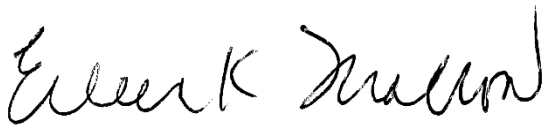
ETF reviews the coverage provided by the GHIP each year. We have just finished our review of services for the coming 2023 plan year and will be presenting our findings to the Group Insurance Board (Board) in May. Unfortunately, we cannot include this request in the review of services for 2023, but we can include it for consideration in future years.

However, ETF is limited under Wisconsin state law regarding which services can be added to the GHIP without a legal mandate. We cannot add any services to the GHIP without proving that those services would reduce costs due to improved health or without reducing coverage in some other part of the program to cover the costs of the new services. This requirement applies to medications, as well.

There are ways members can still save money on ED drugs. When ETF signed the contract with Navitus, the Board's pharmacy benefit manager, in 2017, ETF asked Navitus to create a discount drug list. Members who have a prescription for a non-covered drug can go to an in-network pharmacy; and, if they present their Navitus card, receive Navitus's discount price for that drug. You can find the Navitus Discount Drug List online here: https://etf.benefits.navitus.com. A copy of the list has also been included with this letter. There are also several discount programs outside of the GHIP that may provide larger discounts for ED drugs than those available through the discount list. Services like GoodRx provide discounts for ED drugs for free.

Thank you again for taking time to write to us with your concern. If you have other questions regarding prescription drug coverage, please feel free to reach out to Tricia Sieg, our Pharmacy Program Manager, via email at tricia2.sieg@etf.wi.gov.

Sincerely,



Eileen Mallow, Director, Office of Strategic Health Policy
Department of Employee Trust Funds

Attachment (1)

From: Brian Wilmot
To: ETF SMB Board Feedback
Subject: United Healthcare reimbursement
Date: Wednesday, April 13, 2022 5:23:54 PM

ETF Board,
I was referred to you folks while talking to one of your customer service persons. She was very helpful but was not able to answer my question. My situation is this:

I purchased COVID test kits on December 25, 2021 from a local Walgreen's Pharmacy. UHC told me to fill out a Medical Reimbursement Request Form and include the receipt, which I did on January 29, 2022.
Having not heard back, I talked to UHC on March 16, 2022 as to the status and they said it was denied, for the reason that Wisconsin chose not to participate. This prompted me to call ETF for the rationale, to which I could not get an answer.

So my question to you is: UHC is pointing back to ETF for not providing the reimbursement, Do you really get involved in this level of detail, and choose whether to participate? It seems to me that this significant contract for health care would not require you to deal with this level of minutia.
Granted I purchased the 4 test kits for $101 before the federal government decided to provide them for free. I really expected to be reimbursed.

Thank you in advance for a response.

Brian G. Wilmot
Retired

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April 22, 2022

Brian G. Wilmot
[redacted]

MID: [redacted]

Dear Mr. Wilmot:

Thank you for your April 13, 2022, email to the Group Insurance Board (Board). You expressed concern over the lack of health insurance coverage for COVID-19 at-home test kits that you purchased at Walgreen's pharmacy on December 25, 2021. I appreciate the opportunity to respond as the Deputy Director for the Office of Strategic Health Policy in the Department of Employee Trust Funds (ETF).

Coverage for certain COVID-19 services and supplies, like over-the-counter (OTC) test kits, is established by the federal government. When federal rules are published, affected health plans must comply. At this time, these tests must be covered without participant cost-sharing.

Coverage of OTC test kits is evolving. The Biden-Harris Administration announced on December 2, 2021, that individuals could purchase the OTC tests and get reimbursed later. Starting Saturday, January 15, 2022, the federal government required that insurers of non-Medicare members cover OTC COVID-19 test kits. There was no retroactive coverage for tests purchased before January 15.

The Centers for Medicare and Medicaid Services (CMS) announced on Thursday, February 3, that they were working to add coverage for Medicare recipients of OTC test kits for COVID-19. On Monday April 4, 2022, CMS announced that people with Medicare Part B can get up to eight free OTC COVID-19 tests each calendar month through the end of the COVID-19 Public Health Emergency. Those with Medicare Part B can get the tests at a participating pharmacy or health care provider. A list of pharmacies who are participating in this program and some frequently asked questions can be found at https://www.medicare.gov/medicare-coronavirus. If you seek out more tests, you should bring your red, white, and blue Medicare card to get the free tests.

We contacted UnitedHealthcare (UHC) to learn more about your interactions with them. They acknowledge that the customer service representative who told you on January 14, 2022, to submit a request for member reimbursement of the tests you purchased in December, made an error. There was no federal coverage for COVID-19 OTC testing kits for Medicare covered individuals at that time. Therefore, the denial that was sent to you on March 12, 2022, was correct.

UHC further stated that when you called on April 11 regarding the new testing kits you received, you were, again, presented with some mistaken information. The customer service representative said the tests were not reimbursable through UHC since Wisconsin wasn't participating in this program at the time. While the representative advised correctly that the tests are not reimbursable through UHC, the representative should have explained that CMS covered

these tests directly through Medicare Part B. This is why these were not reimbursable under your plan.

UHC has provided additional coaching to customer service representatives to emphasize that the tests are covered under Medicare Part B. We regret any inconvenience you experienced with your questions.

I hope this information is helpful. If you have further questions, please contact me or Arlene Larson of my staff at (608) 264-6624 or arlene.larson@etf.wi.gov.

Sincerely,

Brian Stamm
Deputy Director
Office of Strategic Health Policy
(608) 267-4554
brian.stamm@etf.wi.gov

CC: Arlene Larson

From:	Chris Gallagher
To:	ETF SMB Board Feedback
Cc:	Walk, Renee - ETF
Subject:	Obesity Community comments re State Employee health plan coverage of Obesity Care
Date:	Monday, April 18, 2022 8:02:00 AM
Attachments:	041522 Obesity Community Statement to WI GIB re State Employee Coverage.pdf

Dear Members of the Group Insurance Board,

On behalf of the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), Wisconsin Academy of Nutrition and Dietetics (WAND), Obesity Action Coalition (OAC), Obesity Medicine Association (OMA) and The Obesity Society (TOS), we are pleased to send the attached coalition letter — urging the Employee Trust Funds (ETF) and the Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity.

Should you have any questions, please feel free to contact me via email or telephone at [redacted] Thank you.

Chris Gallagher

Chris Gallagher
Washington Policy Advisor
ASMBS, OAC, TOS and OMA
Advocacy Manager
Center for Community Resilience
[redacted]

April 15, 2022

On behalf of the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), Wisconsin Academy of Nutrition and Dietetics (WAND), Obesity Action Coalition (OAC), Obesity Medicine Association (OMA) and The Obesity Society (TOS), we urge the Employee Trust Funds (ETF) and the Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity.

Our groups truly appreciate the positive ETF staff recommendation surrounding bariatric surgery in 2019, which led the GIB to approve coverage of "bariatric surgery and required precursor weight management and nutrition services for members with BMI of 35 or greater" beginning in benefit year 2020. To date, numerous state employees have taken advantage of this new benefit and are now healthier and thriving because of the surgery and accompanying counseling services.

Since WAND, OAC and the ASMBS Wisconsin State Chapter submitted its January 14th comments to the GIB, a major coverage announcement regarding obesity treatment has been issued by the federal government. In a February 17, 2022, carrier letter and subsequent technical guidance, the federal Office of Personnel Management (OPM) released specific instructions for health insurance carriers that administer Federal Employee Health Benefit (FEHB) plans -- "clarifying that FEHB carriers are not allowed to exclude anti-obesity medications from coverage based on a benefit exclusion or a carve out…" and that "FEHB Carriers must have adequate coverage of FDA approved anti-obesity medications (AOMs) on the formulary to meet patient needs and must include their exception process within their proposal."

In issuing this new guidance, OPM is quite clear -- emphasizing that "obesity has long been recognized as a disease in the US that impacts children and adults…" and that "obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer." This new guidance comes eight years after OPM first warned plans that it is not permissible to exclude weight loss drugs from FEHB coverage on the basis that obesity is a "lifestyle" condition and not a medical one or that obesity treatment is "cosmetic."

These definitive statements from OPM should ensure that all federal employees, and their family members, will now have access to comprehensive obesity care. We believe that state employees in Wisconsin deserve the same access and hope that the GIB will support this goal by adopting coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity. Our growing knowledge regarding the complexity of obesity, the tremendous advances in treatment, and the growing recognition of, and support for treating obesity as the chronic disease that it is, clearly make health plans that continue to exclude coverage for evidence-based treatment avenues out of date and out of touch with the current scientific evidence surrounding obesity care.

Should you have any questions or need additional information, please feel free to contact us or Chris Gallagher via email at [redacted] or telephone at [redacted]. Thank you.

From:	SAMANTHA K PABICH
To:	ETF SMB Board Feedback
Subject:	Support for Anti-Obesity Therapy addition to state health insurance formulary
Date:	Sunday, May 1, 2022 8:22:11 AM
Attachments:	Anti-Obesity Therapy Advocacy.pdf Advocacy for antiobesity therapies per the Employee Trust Fund_group document.pdf

To whom it may concern,

These letters have been prepared to provide information in advance of the 5/18/22 ETF meeting to consider addition of anti-obesity therapies to the state health insurance formulary.

Thank you for your time.

Sam Pabich, MD, MPH
Assistant Professor, Endocrinology
she/hers

ATTN: Employee Trust Fund Group Insurance Board

As Wisconsin healthcare professionals and obesity advocates, we urge the Employee Trust Funds (ETF) and the Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity.

Thank you for your consideration.

	Name	Specialty	Email
1	Samantha Pabich, MD, MPH	Endocrinology, Obesity Medicine	[redacted]
2	Luke Funk, MD MPH	Surgery	[redacted]
3	Aaron Carrel, MD	Pediatric Endocrinology	[redacted]
4	Michael Garren, MD	Surgery	[redacted]
5	Jon Gould, MD, MBA	Surgery	[redacted]
6	Compton Kurtz MD	Obesity Medicine, FM	[redacted]
7	David A Harris, MD	Surgery	[redacted]
8	Dawn Belt Davis, MD, PhD	Medicine, Endocrinology	[redacted]
9	Erin Spengler, MD	Hepatology	[redacted]
10	Kathleen Antony,MD	Ob/Gyn	[redacted]
11	Amber Shada, MD	Surgery	[redacted]
12	Anne Lidor, MD, MPH	Surgery	[redacted]
13	Andrew Spiel, MD	Gastroenterology	[redacted]
14	Brittany Galusha, MD	Internal Medicine, Obesity Medicine	[redacted]

15	Brandon Grover, DO	Surgery	[redacted]
16	Dale Schoeller, PhD	Nutritional Sciences	[redacted]
17	Adnan Said, MD,MS	Gastroenterology and Hepatology	[redacted]
18	Cassie Vanderwall, PhD, RDN	Nutrition	[redacted]
19	Becky Kerkenbush, MS, RD-AP, CSG, FAND	Nutrition	[redacted]
20	Brittany Zerbe, MS, RDN, CD	Nutrition	[redacted]
21	Valerie Shurley, MBA, MS, RDN, CD, FAND	Nutrition	[redacted]
22	Jennifer L. Rehm, MD	Pediatric Endocrinology	[redacted]
23	Amy Peterson, MD, MS	Pediatric Preventive Cardiology	[redacted]
24	Madeline Nash, MS, RDN	Nutrition	[redacted]
25	Karen Krchma, RDN CD	Nutrition	[redacted]
26	Christina C Lemon, MS, RDN, CD	Nutrition	[redacted]
27	Magnolia Larson, DO	Family Medicine	[redacted]
28	Raymond F. Georgen, MD	Surgeon	[redacted]
29	Joshua Pfeiffer, MD	Surgeon	[redacted]
30	Christopher Weber, MD	Internal Med, Peds, Obesity Medicine	[redacted]
31	Marisa Pruitt, RD	Nutrition	[redacted]
32	Paige Zimmerman, RD	Nutrition	[redacted]
33	Joan Kortbein, RD, CDCES	Nutrition	[redacted]
34	Sarah Nevsimal, PA-C	Obesity Medicine	[redacted]

35	Natalie Schmit, RD	Nutrition	[redacted]
36	Mariah Wittenberg, RD, CD	Nutrition	[redacted]
37	Afton Koball, PhD, ABPP	Psychology	[redacted]
38	Laura Marchiando MD	Obesity Medicine Family Medicine	[redacted]
39	Christopher Larson PA-C	Surgery	[redacted]
40	Laura Birkel, RD, CD	Nutrition	[redacted]
41	Stephanie Martin, BS, CEP	Exercise Physiology	[redacted]
42	Srividya Kidambi, MD, MS	Endocrinology Obesity Medicine	[redacted]
43	Kristan O'Toole MS RDN CCTD CD	Nutrition	[redacted]
44	Brianne Thornton, MS, RD, CD	Nutrition	[redacted]
45	Kavita Poddar, PhD, RD, CD	Nutrition	[redacted]
46	Mackenzie Burke, MS, RDN, CD	Nutrition	[redacted]
47	Lisa L. Morselli, MD, PhD	Endocrinology Obesity Medicine	[redacted]
48	Tim Logemann MD, FACC, ABOM	Cardiology	[redacted]
49	Ty Carroll, MD	Endocrinology	[redacted]
50	Joseph Regan MD	Surgery	[redacted]
51	Leslie Golden MD,MPH	FM/Obesity Medicine	[redacted]
52	Bradley Javorsky, MD	Endocrinology	[redacted]
53	Maykong Leepalao MD	Surgery	[redacted]
54	Fatima Ahmed, MD	Endocrinology	[redacted]

55	Erin Newkirk, PharmD, CDCES	Endocrinology	[redacted]
56	Kelly Faltersack MS, RDN, LDN, CD	Nutrition	[redacted]
57	Saleem Aman MD	Internal medicine	
58	Akashni Bhasin,MD,	Pediatrics, ABOM	[redacted]
59	Karen Shulman MD	Family Medicine	[redacted]
60	Joseph Regan ,MD	Bariatric surgery	[redacted]
61	Nicole Cvetkovich RN	Bariatric surgery	[redacted]
62	Dianna Malkowski PA-C, RDN	Internal Medicine/ Obesity Medicine	[redacted]
63	Sarah Long, PhD, LP	Psychology	[redacted]
64	Allen Mikhail MD ABOM	Bariatric Surgery/medicine	[redacted]
65	Julie Van Dreser	Patient Experience	[redacted]
66	Jennifer Sulik	Weight Management Program Coordinator Sr	[redacted]
67	Manfred Chiang, MD	Bariatric Surgery	[redacted]
68	Catherine Zellmer PA	Obesity Medicine	[redacted]
69	Julie Heyrman Compernolle	Family Medicine, Integrative Medicine, Obesity Medicine	[redacted]

Dr. Sam Pabich MD, MPH • 600 Highland Ave, Madison WI 53792• [redacted]

May 01, 2022

Employee Trust Funds Board
c/o Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison, WI 53707-7931

Dear Employee Trust Funds Board,

My name is Dr. Sam Pabich. I am an endocrinologist, obesity medicine specialist, and public health expert at University of Wisconsin. I am writing in regard to the Employee Trust Fund's consideration of adding anti-obesity therapies to its formulary.

As you likely know, incidence of obesity has dramatically increased over the past three decades, bringing with it an increase in more than 50 diseases associated with excess body weight. High blood pressure, diabetes, and heart disease are commonly appreciated as "obesity-related", but obesity also increases the risk of cirrhosis, numerous cancers, mood disorders, infections, and lung disease, among so many others. This is thought to be a leading driver in the ever-increasing costs of health care in this country.

Current medical standards focus on individual treatments for obesity-related diseases: there are blood pressure meds for hypertension, statins for dyslipidemia, and insulin for diabetes. But obesity is often *the disease* driving these problems and treating this often treats the rest.

In Wisconsin, survey-based research estimates that 32% of the population had obesity as of 2020 (1). However, data collected from healthcare offices suggests that number is closer to 41% or more (2). Obesity leads to an increase in healthcare spending estimated at more than $1400 per affected individual per year (3), which would translate to $3.3 million spent in Wisconsin annually. Obesity is highly associated with Type 2 Diabetes, which is far costlier still: in 2017, direct medical expenses for diabetes diagnosed in Wisconsin was >$4.1 billion dollars, with an additional $1.4 billion in indirect cost due to lost productivity, etc. (4).

Many still believe that obesity is an individual's own problem and responsibility. In my opinion, when a pathology affects >40% of a population, it hardly seems like an individual problem. But a prevailing dogma dictates that individuals should just be able to work hard on diet and exercise, and then achieve their ideal body weight.

I can tell you, firsthand, that this is not true for many. I have watched patients spend months in nutrition programs, diligently log calories, spend hours per day on exercise, limit themselves to 900 calories per day, and punish themselves for indulging in a single Hershey's kiss, only to lose 5 pounds. I have watched patients painstakingly work to lose 20 pounds, only to regain 10

pounds a few months later though they maintained their healthy habits. I have followed large datasets that demonstrate that nearly 80% of all weight lost is eventually regained (5).

This natural order seems tremendously unfair: why is treating obesity with lifestyle so difficult, when the benefits of weight loss can be so significant? Indeed, losing just 7% of one's body weight can prevent cirrhosis (6); losing ~20 lbs completely cures sleep apnea in about 15% of patients (7), and losing just 8 lbs confers a 35% reduction in the risk that someone will have an acute cardiac event, like a heart attack (8).

These thoughts brought me to the specialty of obesity medicine and knowledge of efficacious pharmaceutical therapies to assist patients with weight loss and prevention of weight regain. I have been treating patients with obesity since 2019. My patients on weight-loss pharmaceuticals have generally lost between 5-20% of their body weight (or about 10-40 lbs on average), which is consistent with nationally-reported data (9-12). As my patients have lost weight, they have come off of numerous medications, including high-priced ones, like insulin.

In the medical system, patients with obesity are more likely to be affected by intrinsic biases (i.e physicians tend to spend less time in visits with patients w/obesity (13) and extrinsic biases (i.e some medical practices ban patients over a certain weight); as a result, patients with the highest risk are dangerously marginalized. Obesity tends to affect all socio-demographics, however, disproportionately affects patients with lower income and education levels, likely related mostly to social factors that affect nutrition. It is tremendously important to not leave these groups behind.

I understand that covering anti-obesity medications can be quite costly. Therefore, I have some cost-effective recommendations for using these meds, garnered largely from my current practices.

- There are two medications that are FDA-approved for long-term weight loss that can be approximated with generically-available medications. It may be less pertinent to cover the brand-name combination pills.
- It may be cost-prohibitive to expand coverage for medications to everyone with overweight/obesity all at once. If this is the case, I would recommend them preferentially for patients who have obesity-related comorbidities.
- It is far easier to maintain a normal weight than it is to lose weight; to avoid further increases in obesity in the population, prevention of excessive weight gain should be emphasized, so as to reduce the need for anti-obesity medication use among the next generation.

Thank you for your consideration of adding coverage of anti-obesity therapies to the state health insurance plan.

Sincerely,

Sam Pabich, MD, MPH
Board Certified in Internal Medicine, Endocrinology, and Obesity Medicine

Works Cited

1. Online BRFSS Database: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2021]. 2. Wisconsin Health Atlas. https://www.wihealthatlas.org/obesity/findings. Accessed 4/10/22.

3. Finkelstein, E. A., Trogdon, J. G., Cohen, J. W., & Dietz, W. (2009). Annual medical spending attributable to obesity: payer-and service-specific estimates. Health affairs, 28(5), w822-w831.

4. Dall, Timothy M., Wenya Yang, Karin Gillespie, Michelle Mocarski, Erin Byrne, Inna Cintina, Kaleigh Beronja, April P. Semilla, William Iacobucci, and Paul F. Hogan. "The economic burden of elevated blood glucose levels in 2017: diagnosed and undiagnosed diabetes, gestational diabetes mellitus, and prediabetes." Diabetes care 42, no. 9 (2019): 1661-1668.

5. Leibel, Rudolph L., Randy J. Seeley, Tamara Darsow, Erika Gebel Berg, Steven R. Smith, and Robert Ratner. "Biologic responses to weight loss and weight regain: report from an American Diabetes Association research symposium." Diabetes 64, no. 7 (2015): 2299-2309.

6. Huang, Mary Ann, Joel K. Greenson, Cewin Chao, Lilian Anderson, Debra Peterman, Jon Jacobson, Dawn Emick, Anna S. Lok, and Hari S. Conjeevaram. "One-year intense nutritional counseling results in histological improvement in patients with nonalcoholic steatohepatitis: a pilot study." The American journal of gastroenterology 100, no. 5 (2005): 1072.

7. Foster, Gary D., Kelley E. Borradaile, Mark H. Sanders, Richard Millman, Gary Zammit, Anne B. Newman, Thomas A. Wadden et al. "A randomized study on the effect of weight loss on obstructive sleep apnea among obese patients with type 2 diabetes: the Sleep AHEAD study." Archives of internal medicine 169, no. 17 (2009): 1619-1626.

8. Sierra-Johnson, Justo, Abel Romero-Corral, Virend K. Somers, Francisco Lopez-Jimenez, Randal J. Thomas, Ray W. Squires, and Thomas G. Allison. "Prognostic importance of weight loss in patients with coronary heart disease regardless of initial body mass index." European Journal of Cardiovascular Prevention & Rehabilitation 15, no. 3 (2008): 336-340.

9. Smith, S. M., Meyer, M., & Trinkley, K. E. (2013). Phentermine/topiramate for the treatment of obesity. Annals of Pharmacotherapy, 47(3), 340-349

10. Billes, Sonja K., Puspha Sinnayah, and Michael A. Cowley. "Naltrexone/bupropion for obesity: an investigational combination pharmacotherapy for weight loss." Pharmacological research 84 (2014): 1-11.

11. Pi-Sunyer, Xavier, Arne Astrup, Ken Fujioka, Frank Greenway, Alfredo Halpern, Michel Krempf, David CW Lau et al. "A randomized, controlled trial of 3.0 mg of liraglutide in weight management." New England Journal of Medicine 373, no. 1 (2015): 11-22.

12. Wadden, Thomas A., Timothy S. Bailey, Liana K. Billings, Melanie Davies, Juan P. Frias, Anna Koroleva, Ildiko Lingvay et al. "Effect of subcutaneous semaglutide vs placebo as an adjunct to intensive behavioral therapy on body weight in adults with overweight or obesity: the STEP 3 randomized clinical trial." Jama 325, no. 14 (2021): 1403-1413.

13. Puhl, Rebecca M., Sean M. Phelan, Joseph Nadglowski, and Theodore K. Kyle. "Overcoming weight bias in the management of patients with diabetes and obesity." Clinical Diabetes 34, no. 1 (2016): 44-50

From: John Basarich
To: ETF SMB Board Feedback
Subject: obesity medications
Date: Friday, May 13, 2022 4:14:18 PM

Dear Wisconsin ETF

I would strongly recommend that you approve the coverage of Obesity medications. As a family physician, I see obesity as our #1 chronic health problem. The long term complications of obesity are incredibly costly at a personal and societal level. I am sure that the cumulative costs of obesity and its comorbidities would outweigh the cost of our new obesity medications (such as semaglutide). These medications have significant promise in helping patients lose weight.

Sincerely,
John R Basarich MD

From: Melissa Hidde
To: ETF SMB Board Feedback
Subject: advocating for WETF coverage of anti-obesity medications and behavioral interventions
Date: Friday, May 13, 2022 10:31:44 PM

Dear Sirs and Madams,

I am writing in strong support of full coverage for anti-obesity medications and behavioral interventions As a family physician, I discuss these medications daily with my patients Diet and exercise are always the mainstay of my conversations, however weight loss medications are a powerful tool to help reverse and counteract the hormonal and metabolic changes that come with long-standing obesity

I strongly agree with the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery, the Wisconsin Academy of Nutrition and Dietetics, and the Obesity Action Coalition in advocating for coverage of weight loss drugs

I understand the Board is limited under Wis Stats §40 03(6)(c) from entering into contracts that would increase the cost of the program without concurrent savings elsewhere However there is supporting literature that shows the cost-effectiveness of savings even for a higher cost (up front) medication such as semaglutide

In my medical practice, I have personally seen patients able to wean off medications, improve their productivity at work, and lower the serious complications of obesity through the power of weight loss medications

Here is just one study showing the cost effectiveness of semaglutide

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I urge you to ensure coverage for anti-obesity medications and behavioral interventions

Sincerely,
Dr Melissa Hidde
Green Bay, WI

From: Leslie Golden
To: ETF SMB Board Feedback
Subject: Please approve anti-obesity medication coverage for state employees
Date: Monday, May 16, 2022 8:22:52 AM

Dear members of the Group Insurance Board,

I am writing to you as a person who has struggled with obesity since childhood and as a Family Medicine and Obesity Medicine physician who treats patients in Wisconsin with obesity every day. I am urging you to add insurance coverage for anti-obesity medications (AOMS) to the formulary for state employees.

Obesity is a complex, chronic, progressive disease of abnormal energy regulation that is primarily inherited. It is not a choice, and it is treatable. The treatment of obesity is not willpower or trying harder. Although behavior contributes in part to obesity, the behaviors are driven by abnormal biology. This is supported by the American Medical Association that declared obesity a disease in 2013. Successful treatment of obesity takes a comprehensive approach including focusing nutrition, physical activity, behavior, medications, and surgeries. Only when all these tools are available for our use are we successful. These medications are not experimental. They are FDA-approved medications for the treatment of obesity long term. Treating obesity with these medications is a standard of care. It is not clear to me why any insurance company would separate obesity as a disease that does not merit standard of care treatment. The only idea I can come up with is the inaccurate thought that obesity is a "cosmetic" issue must persist.

I see the benefits of anti-obesity medications every day. I have patients who were once limited to wheelchairs due to severe osteoarthritis that can now ambulate without assistance due to treatment with anti-obesity medications. Patients who were not meeting their diabetic control goals despite hundreds of units of insulin daily that are now off insulin entirely with well controlled blood sugars. However, one of my greatest frustrations are the patients I must face daily who would benefit from evidence-based FDA-approved treatment that is excluded from their insurance plans. They are left to only use lifestyle modification efforts or try to pay out of pocket for obesity care. We know that lifestyle modification results in a weight loss of only 2-5% which is marginally clinically significant. Could you imagine recommending a treatment for cancer with a success rate of 2-5%?

These medications may seem expensive at first glance, but they reduce other expenses. Patients with obesity often have longer and more complicated inpatient hospital stays. Treating obesity reduces the cost of treating the more than 200 medical conditions associated

with this disease. Reducing the costs associated with CPAP for Obstructive Sleep Apnea, joint replacement surgeries for Severe Osteoarthritis, medications and monitoring supplies for Diabetes, medications and interventions for cardiovascular disease. The healthcare costs of an adult with obesity are 150% greater than the cost of an adult without obesity. My colleagues and I are confused many insurance companies exclude anti-obesity medication coverage but are willing to pay the high medical costs associated with diabetes, cardiovascular disease, and cancer that could be prevented by treating obesity first.

In conclusion, I urge you to support adding coverage for FDA-approved anti-obesity medications to the state employee drug formulary. The example has already been set by our state's Medicaid drug formulary that covers AOMs. Our state employees who are struggling with this complex disease should receive the same support and treatment options. Should you have any questions or would like additional information please contact me at [redacted]

Kind Regards,

Leslie M Golden MD MPH
ABOM Diplomate
Watertown Family Practice
Watertown, WI
OMA National Advocacy Committee

From: Jim Meade
To: ETF SMB Board Feedback
Cc: Golden, Leslie
Subject: weight loss medications
Date: Monday, May 16, 2022 10:30:23 AM

Dear Board,

I have read the summary of the consulting firm Segal's recommendations on weight loss drugs. In my professional opinion, the consulting firm was negligent in its duty and did not provide any semblance of a full investigation into weight loss medications and procedures.

Consulting Firm Recommendations: Adding weight loss drugs, such as Wegovy, to the Commercial pharmacy formulary: In late 2021, Navitus's Pharmacy and Therapeutics (P&T) Committee voted to allow Navitus clients the option to add weight loss drugs to formularies. According to Navitus, a small number of their clients have added weight loss drugs to their formulary. The majority of their clients/plans still exclude them. ETF has heard from groups such as the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery, the Wisconsin Academy of Nutrition and Dietetics, and the Obesity Action Coalition requesting weight loss drugs. Segal provided an analysis of adding one drug (Wegovy) to the pharmacy formulary. Segal assumed that 20% of the Board's membership would be interested in weight loss and 3% of those members would be prescribed the drug and found that this would lead to a cost increase of $20 to $30 million a year. As discussed earlier in this memo, the Board is limited under Wis. Stats. §40.03(6)(c) from entering into contracts that would increase the cost of the program without concurrent savings elsewhere, and neither Segal nor ETF was able to determine any projected savings from these drugs at this time. ETF will continue to review literature and cost-benefit analyses on weight-loss drugs as they become available to determine whether these drugs should be added in the future.

1. Wegovy is the only medication they looked at and is the least used medication for weight loss. It is expensive, and there are other medications that can work just as well at a much lower cost.
2. Segal did not look into the cost of obesity on health plans, and even 1 ER visit for hypertension would be the same cost as a year's worth of medications. Wegovy is a diabetes medication, and there are many in the same class that will be used for treating the diabetes that weight loss could have prevented. In the end the Board will incur greater cost because of this lack of foresight.
3. Segal did not look at the long term financial impact of obesity to the plan or to the members
4. As one simple example, Segal did not look at the financial impact of joint replacement caused by obesity.

The current medical standard of practice is to use weight loss medications to address obesity, and denying coverage is not keeping current with accepted medical practice.
Every health plan should be including obesity treatment in their coverage.

James Meade, MD, FAAFP

From:	Chris Gallagher
To:	ETF SMB Board Feedback
Cc:	Joe Nadglowski; Walk, Renee - ETF
Subject:	OAC and Obesity Community Comments for May 18th GIB Meeting
Date:	Monday, May 16, 2022 12:31:57 PM
Attachments:	051622 OAC comments to WI ETF GIB re AOM coverage .pdf

On behalf of the more than 75,000 members of the Obesity Action Coalition (OAC) including the more than 900 in Wisconsin, we would like to present the attached comments expressing our profound disappointment in the State of Wisconsin's Department of Employee Trust Funds (ETF) recommendation to the Group Insurance Board (GIB) that the Board NOT provide state employee coverage for anti-obesity medications (AOMs) for 2023.

We urge the Board to reject the ETF staff recommendation and provide coverage for AOMs to ensure that state employees have access to comprehensive evidence-based treatment options to address this complex and chronic disease.

Should you have any questions, please feel free to contact me via email or phone at [redacted] Thank you.

Chris Gallagher

Chris Gallagher
Washington Policy Advisor
ASMBS, OAC, TOS and OMA
Advocacy Manager
Center for Community Resilience
[redacted]

4511 North Himes Ave., Suite 250
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info@obesityaction.org
www.ObesityAction.org

May 16, 2022,

ATTN: Members of the Group Insurance Board

On behalf of the more than 75,000 members of the Obesity Action Coalition (OAC) including the more than 900 in Wisconsin, we would like to express our profound disappointment in the State of Wisconsin's Department of Employee Trust Funds (ETF) recommendation to the Group Insurance Board (GIB) that the Board NOT provide state employee coverage for anti-obesity medications (AOMs) for 2023.

Throughout the last five years, the OAC has been working closely with the State to educate both ETF staff and GIB members about the complex and chronic nature of obesity and how steps must be taken to both prevent *and* treat this disease. We applauded ETF for its sound approach in 2019 when staff recommended that the GIB provide coverage for bariatric surgery and accompanying intensive behavioral therapy services beginning in 2020.

Following this positive step toward providing comprehensive coverage, we are obviously troubled by the failure of ETF to support coverage for AOMs for the 2023 plan year. We are roughly a decade removed from the Food & Drug Administration (FDA) approving the first of many new AOMs, enabling patients and their providers the ability to take advantage of another critical treatment tool. Currently, 24 states have taken steps to expand care by providing coverage for anti-obesity medications for their state employees, with several additional states in the planning process.

Most troubling are the cost and utilization assumptions made by Segal that ETF are using for their recommendation – predicting a 3% utilization rate and annual cost of $20-30 million. AOM utilization and real-world data from neighboring state employee health benefits plans, including Minnesota and Michigan, in addition to data from Wisconsin Medicaid, demonstrate that when access to AOMs is available, utilization has historically tended to remain below 1% for patients with obesity. Although Wisconsin Medicaid has provided AOM access to patients through a prior authorization process for more than 4 years, prescribing of AOM therapy remains below the national average (<1%). Given this low utilization of AOMs, it is likely the cost of treatment associated with covering the AOM class would be far less than the anticipated $20 - $30 million annual cost identified by Segal in their analysis – especially since Segal is basing these cost figures on one single branded drug as opposed to the entire class of United States Pharmacopeia recognized anti-obesity agents, many of which are generics and significantly lower in cost. By comparison, the following data shows approximate one year of AOM cost for the identified entity:

- Minnesota State Employees - $2M (50,000 lives)
- Michigan State Employees - $2.7M (67,000 lives)
- Wisconsin Medicaid - $7.9M (1.1 million lives)

OAC also takes exception with the belief that "neither Segal nor ETF was able to determine any projected savings from these drugs at this time… and that … ETF will continue to review literature and cost-benefit analyses on weight-loss drugs as they become available to determine whether these drugs should be added in the future." As obesity is a leading contributor to rising health care costs in the United States[1], we respectfully challenge the comment regarding the inability to determine any projected savings from AOM therapy at this time and would encourage a review of the extensive evidence showing improvement in outcomes and comorbidities seen when patients improve their obesity status.

[1] Economic value of nonsurgical weight loss in adults with obesity J Manag Care Spec Pharm. 2021;27(1):37-50

Finally, OAC is concerned that comments made by the obesity community to ETF and GIB earlier this year appear not to be in the official record as letters dated January 14, 2022 and April 15, 2022 are nowhere to be found under the "Board Correspondence" section of the agenda for the upcoming May 18th meeting or previous February 16th meeting. Therefore, we ask that the following two comment letters also be entered into the record.

In closing, we urge the Board to reject the ETF staff recommendation and provide coverage for AOMs to ensure that state employees have access to comprehensive evidence-based treatment options to address this complex and chronic disease.

Sincerely,

Joe Nadglowski, OAC President and CEO

April 15, 2022

On behalf of the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery (ASMBS), Wisconsin Academy of Nutrition and Dietetics (WAND), Obesity Action Coalition (OAC), Obesity Medicine Association (OMA) and The Obesity Society (TOS), we urge the Employee Trust Funds (ETF) and the Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity.

Our groups truly appreciate the positive ETF staff recommendation surrounding bariatric surgery in 2019, which led the GIB to approve coverage of "bariatric surgery and required precursor weight management and nutrition services for members with BMI of 35 or greater" beginning in benefit year 2020. To date, numerous state employees have taken advantage of this new benefit and are now healthier and thriving because of the surgery and accompanying counseling services.

Since WAND, OAC and the ASMBS Wisconsin State Chapter submitted its January 14th comments to the GIB, a major coverage announcement regarding obesity treatment has been issued by the federal government. In a February 17, 2022, carrier letter and subsequent technical guidance, the federal Office of Personnel Management (OPM) released specific instructions for health insurance carriers that administer Federal Employee Health Benefit (FEHB) plans -- "clarifying that FEHB carriers are not allowed to exclude anti-obesity medications from coverage based on a benefit exclusion or a carve out…" and that "FEHB Carriers must have adequate coverage of FDA approved anti-obesity medications (AOMs) on the formulary to meet patient needs and must include their exception process within their proposal."

In issuing this new guidance, OPM is quite clear -- emphasizing that "obesity has long been recognized as a disease in the US that impacts children and adults…" and that "obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and certain types of cancer." This new guidance comes eight years after OPM first warned plans that it is not permissible to exclude weight loss drugs from FEHB coverage on the basis that obesity is a "lifestyle" condition and not a medical one or that obesity treatment is "cosmetic."

These definitive statements from OPM should ensure that all federal employees, and their family members, will now have access to comprehensive obesity care. We believe that state employees in Wisconsin deserve the same access and hope that the GIB will support this goal by adopting coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity. Our growing knowledge regarding the complexity of obesity, the tremendous advances in treatment, and the growing recognition of, and support for treating obesity as the chronic disease that it is, clearly make health plans that continue to exclude coverage for evidence-based treatment avenues out of date and out of touch with the current scientific evidence surrounding obesity care.

Should you have any questions or need additional information, please feel free to contact us or Chris Gallagher via email at [redacted] or telephone at [redacted]. Thank you.

January 14, 2022

On behalf of the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery, Wisconsin Academy of Nutrition and Dietetics and the Obesity Action Coalition, we urge the Employee Trust Funds (ETF) and the Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and medical nutrition therapy (aka nutrition counseling) for the treatment of overweight or obesity.

Our groups truly appreciate the positive ETF staff recommendation surrounding bariatric surgery in 2019, which led the GIB to approve coverage of "bariatric surgery and required precursor weight management and nutrition services for members with BMI of 35 or greater" beginning in benefit year 2020. To date, numerous state employees have taken advantage of this new benefit and are now healthier and thriving because of the surgery and accompanying counseling services.

Obesity, COVID-19 and Communities of Color

While these benefit additions in 2020 have been critical for state employees who wish to address their obesity and severe obesity, thousands of other state workers with overweight or obesity, who do not have a BMI of 35 or above, remain without covered options to treat their obesity, such as pharmacotherapy or robust medical nutrition therapy (MNT) services. The inability for state employees to access comprehensive obesity treatment services is especially alarming given the COVID-19 pandemic and obesity being a significant risk factor for serious cases of the virus -- tripling the rate of hospitalization and increasing the risk for death for affected individuals.

In addition to being an epidemic, obesity is also a critical health equity issue! Nationwide and in Wisconsin, obesity disproportionately impacts Black and Latinx individuals. An analysis of UW Health patient data found that 50% of Black adults and 40% of Latinx adults are living with obesity, compared to 36% of White adults. The devastating effect of obesity was laid bare during the COVID-19 pandemic, as Black and Latinx adults in our state were twice as likely to be hospitalized compared with white adults. Rural areas in Wisconsin also have higher obesity rates than urban and suburban areas, increasing the risk of poor health outcomes for rural communities.

For these reasons, the ETF and GIB should take action to address coverage gaps in obesity care services in the state employee health plan surrounding Food and Drug Administration (FDA) - approved anti-obesity medications (AOMs) and MNT services.

Pharmacotherapy

In December of 2021, the Navitus Pharmacy & Therapeutics (P&T) Committee for ETF completed a clinical review of pharmacotherapy options available to treat obesity and the P&T Committee designated the anti-obesity medication class in general as a "may add." This means their customers, including ETF, should work with their PBM account manager to add coverage for this category if they so desire.

We are hopeful that the GIB will act on this recommendation to ensure that state employees have the same access to the broad scope of obesity drugs -- including both generic and branded products that are currently available to Wisconsin Medicaid recipients. It is also important to note that the neighboring states of Michigan and Minnesota provide state employee coverage for obesity drugs as well as the growing momentum in Iowa to secure drug coverage in that state employee plan.

Many of the aforementioned AOMs represent significant medical advances in this space that have taken place during the last ten years. These new drugs and many others that are progressing through the FDA's approval process show great promise for helping millions of Americans address their overweight or obesity. For example, the FDA recently approved Wegovy, where clinical trials for the drug demonstrated that nearly half of the patients on the drug lost 15 percent of their total body weight. Other obesity medications in the agency's approval pipeline will likely match, or even exceed the results of Wegovy.

Providing coverage for obesity drugs is also good policy and is supported by a number of organizations representing key state policy stakeholders. For example, in 2015, the National Council of Insurance Legislators that represents legislators who chair Insurance Committees in state legislatures across the country adopted its first ever disease-specific policy statement – urging Medicaid, state employee and state health exchange plans to update their benefit structures "to improve access to, and coverage of treatments for obesity such as pharmacotherapy and bariatric surgery."

In 2018, the National Lieutenant Governors Association went on record supporting efforts to reduce obesity stigma and support access to obesity treatment options for state employees and other publicly funded healthcare programs. And late last year, the National Hispanic Caucus of State Legislators and National Black Caucus of State Legislators adopted formal policy recognizing that "health inequities in communities of color have led to a disproportionate impact of COVID-19 and that states must address the high rates of obesity to improve the health of racial minorities and prepare for the next public health epidemic…..and ensure that their constituents, including those using Medicaid, have access to the full continuum of treatment options for obesity."

Our growing knowledge regarding the complexity of obesity, the tremendous advances in treatment, and the growing recognition of, and support for treating obesity as the chronic disease that it is, clearly make health plans that continue to exclude coverage for FDA-approved obesity drugs out of date and out of touch with the current scientific evidence surrounding these new pharmaceutical treatments.

ACA-Mandated Preventive Care Services: Screening for Obesity and Referral for Behavioral Interventions

Under Section 2713 of the Affordable Care Act (ACA), non-grandfathered health plans must cover evidence-based preventive care services for adults that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), an independent panel of clinicians and scientists commissioned by the Agency for Healthcare Research and Quality. An "A" or "B" letter grade indicates that the panel finds there is high certainty that the services have a substantial or moderate net benefit. The services required to be covered without cost-sharing include screening for depression, diabetes, cholesterol, various cancers, HIV and sexually transmitted infections, as well as screening and counseling for obesity.

The Public Health Service (PHS) Act and federal regulations also allow plans to use "reasonable medical management" techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent it is not specified in a recommendation or guideline. While there is no formal regulatory definition or parameters for reasonable medical management, medical management techniques are typically used by plans to control cost and utilization of care or comparable drug use. For example, plans can impose limits on number of visits or tests if unspecified by a recommendation, cover only generics or selected brands of pharmaceuticals, or require prior authorization to acquire a preferred brand drug.

On October 23, 2015, the Tri-Agencies (The Departments of Health and Human Services, Labor, and Treasury) issued "Frequently Asked Questions (FAQs)" guidance regarding weight management services, which highlighted how health plan use of "reasonable medical management" techniques has raised many questions about how plans should implement the preventive services policy specific to obesity. In its guidance, the Tri-Agencies highlighted how the 2012 USPSTF recommendation "specifies that intensive, multicomponent behavioral interventions include, for example, the following:

- Group and individual sessions of high intensity (12 to 26 sessions in a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes."

Despite the Tri-Agencies guidance and two subsequent updates to the Task Force's recommendations regarding obesity, we have found that many health plans provide coverage for few if any sessions that would be considered high intensity.

For example, the essential health benefits (EHB) benchmark plan for Wisconsin state health exchange (UnitedHealthcare Insurance Company, Choice Plus), includes the following language under the Exclusions & Limitations section under the subheading of "Physical Appearance" of the certificate of coverage: "Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded." The plan also excludes "any product dispensed for the purpose of appetite suppression or weight loss" or "surgical and non-surgical treatment of obesity." While the preventive care services section of the plan document does state there is coverage for "evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force," we found no mention of the USPSTF recommended benefit for obesity screening and referral for counseling services. One could argue that the plan does cover MNT for obesity/overweight, in that it's exclusion for MNT/nutrition counseling notes it "does not apply to medical nutrition education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional"

We also note that the state employee health plan's certificate of coverage outlining the Uniform Benefits (UB) offered under the Group Health Insurance Program (GHIP) covers nutrition counseling by a registered dietitian nutritionist (RDN), however it excludes "weight loss programs including dietary and nutritional treatment in connection with obesity unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the Health Plan…or any diet control program, treatment, or supply for weight reduction unless prescribed for the purposes of meeting authorization requirements to undergo bariatric surgery, as determined by the Health Plan." While the UB certificate for the GHIP does mention coverage for USPSTF preventive care services, the plan document is silent regarding obesity screening and referral for behavioral interventions as a covered preventive care service.

Benefits and Savings Associated with Comprehensive Obesity Treatment

As the ETF and GIB review adding coverage for pharmacotherapy as well as ensuring that state employees affected by obesity have equal access to mandated preventive care services, we urge them to follow the same forward-thinking approach that was used for evaluating coverage for bariatric surgery in 2019. For example, the April 14, 2019, ETF memo to the GIB regarding 2020 benefit changes, which made the following points:

1. "Obesity is the most prevalent health condition in the ETF population"
2. "Calculating return on investment for bariatric surgery is challenging, due to the complexity of obesity as a medical condition. Several studies indicate that bariatric surgery is cost effective. One study estimated that the cost of a bariatric surgery could be recovered in full in approximately 30 months"
3. "The GHIP's relatively stable membership lends particularly well to being able to recoup these costs."

We were pleased that ETF and the GIB recognized the benefits of providing bariatric surgery coverage when they stressed both the stable membership of the GHIP and the two to three-year return on investment (ROI) associated with surgical intervention. The decision to also require coverage for the "precursor weight management and nutrition services" demonstrates that the ETF and GIB are truly committed to ensuring that bariatric surgery patients have appropriate tools to achieve the best outcomes for addressing their obesity.

Adding coverage for AOMs and ensuring robust MNT services as envisioned by the USPSTF for state employees affected by obesity will afford patients with a broad range of evidence-based treatment tools to address this complex and chronic disease at an earlier stage – possibly avoiding bariatric surgery. The latest round of FDA-approved and pending obesity drugs can also be an alternative for those who may not be ready or comfortable with surgical intervention. However, for those with severe obesity and ideal candidates for bariatric surgery, accompanying drug coverage would ensure even better outcomes for those individuals who may begin to suffer weight regain.

Expanding coverage for MNT services by removing the exclusion for obesity/overweight and designing coverage that aligns with the Tri-Agencies' guidance provides patients the opportunity to engage with RDNs who offers cost-effective, quality care that fosters patient and provider satisfaction while improving patient outcomes. Research has shown that for every $1 invested in an RDN-led lifestyle modification program for obesity/overweight, there has been a nearly $15 return.[1] Several studies have shown that medical nutrition therapy (MNT) provided by RDNs improves clinical outcomes, reduces costs, decreases medication usage, and reduces hospital admissions by 9.5% for individuals with obesity and other weight-related chronic diseases.[2]

The US Preventive Services Task Force (USPSTF), American Heart Association, American College of Cardiology, and The Obesity Society all agree that intensive nutrition counseling provided by clinicians, including RDNs, should be recommended for adults with overweight or obesity (BMI<35) with chronic disease.[3] For weight loss in adults with overweight or obesity, at least 14 MNT encounters (either individual or group) over a period of at least 6 months are recommended. These "high-frequency, comprehensive" weight loss interventions result in weight loss of 5-7% of initial weight which is significant in improving the biochemical landscape. At minimum monthly MNT encounters over a period of at least 1 year are also recommended to maintain weight lost.[4]

In conclusion, we are hopeful that the ETF and GIB will take action to address these gaps in critical treatment avenues for state employees affected by obesity. Should you have any questions or need additional information, please feel free to contact us or Chris Gallagher at [redacted]

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1 Wolf AM, Crowther JQ, Nadler JL, Bovbjerg VE. The return on investment of a lifestyle intervention: The ICAN Program. Paper presented at: American Diabetes Association 69th Scientific Sessions (169-OR); June 7, 2009; New Orleans, LA.

2 Medical nutrition therapy (MNT) systematic review (2009). Academy of Nutrition and Dietetics Evidence Analysis Library. http://www.andeal.org/topic.cfm?menu=3949.
Johnson R; The Lewin Group. What does it tell us, and why does it matter? J Am Diet Assoc. 1999;99:426-427.

3 Registered dietitians: your nutrition experts [brochure]. Academy of Nutrition and Dietetics; 2013.
http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/patient%20care/registered_dietitians_your_nutrition_experts ashx.

4 Adult Weight Management Guideline (2014) Academy of Nutrition and Dietetics Evidence Analysis Library
https//www andeal org/template cfm?template=guide summary& key=4326

From:	Elizabeth Simpson
To:	ETF SMB Board Feedback
Subject:	GIB Meeting Comment - Obesity Therapy Coverage
Date:	Tuesday, May 17, 2022 3:30:06 PM
Attachments:	AfPA WI GIB Comment - Obesity Treatment.pdf

Good afternoon,

I'm reaching out on behalf of the Alliance for Patient Access with a comment letter in support of coverage for nutritional therapy and pharmacotherapy for the treatment of obesity. Please find our letter attached and let me know if you have any questions.

Best,
Elizabeth Simpson

Elizabeth (Hale) Simpson, MPA
Health Advocacy Manager
[redacted]
P: [redacted]

AfPA | Alliance for Patient Access

May 17, 2022

Submitted Electronically
Group Insurance Board
c/o Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison, WI 53707-7931

Re: Support for State Employee Health Plan Coverage for the Treatment of Overweight and Obesity

Dear Chairman Day:

Thank you for the opportunity to provide comment regarding proposed changes to the Group Insurance Board's pharmacy benefit program in advance of the May 18th, 2022 Group Insurance Board meeting. We want to extend our appreciation of the Employee Trust Funds' positive recommendation of inclusion of bariatric surgery for state employees in 2019. I am writing today to express concern about another facet of treatment for obesity and to encourage you to take a broader approach to coverage for obesity care.

On behalf of the Alliance for Patient Access, I am writing to convey support for the proposed inclusion of obesity pharmacotherapies to the commercial pharmacy formulary for the State Employee Health Plan. We are concerned that the current exclusion of coverage for anti-obesity medications (AOMs) and medical nutrition therapy (MNT), or nutrition counseling, has a detrimental impact on patient-centered care for those living with obesity in Wisconsin, and we urge you to consider inclusion to ensure we can address Wisconsin's obesity challenges.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the physician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA's Obesity Initiative is a network of policy-minded clinicians focused on the specific needs of patients living with obesity.

Obesity Prevalence

Obesity is a disease that affects 32% of Wisconsinites, according to the Wisconsin Department of Health Services.[1] Data suggests that this is an issue that is not being addressed effectively; a 2016 Wisconsin Overweight and Obesity fact sheet cites that 32% of Wisconsinites were obese.[2] Obesity is not an insular disease; we know that it is related to a host of other diseases including certain cancers, heart disease, stroke, and type 2 diabetes.[3] These diseases are among the leading causes of both preventable and premature death. Furthermore, obesity is also expensive; the estimated annual cost of obesity in the

[1] Chronic disease prevention program maps and Data. Wisconsin Department of Health Services. (2022, May 4). Retrieved May 17, 2022, from https://www.dhs.wisconsin.gov/disease/data-chronic htm
[2] Overweight and obesity in Wisconsin. (n.d.). Retrieved May 17, 2022, from https://www.dhs.wisconsin.gov/publications/p01274.pdf
[3] Centers for Disease Control and Prevention. (2022, April 8). Consequences of obesity. Centers for Disease Control and Prevention. Retrieved May 17, 2022, from https://www.cdc.gov/obesity/basics/consequences.html

United States in 2008 was $147 billion and because prevalence has increased since that year, it can be assumed that costs have in tandem.[4]

In the context of the present day, obesity creates a higher risk of severe illness from COVID-19 and having obesity may triple the risk of hospitalization due to COVID-19.[5] Obesity can create increased difficulty with COVID-19 because of decreased lung capacity and it may even cause difficulty with ventilation.[6]

Treatment Options

In recent years, several therapies have been approved by the FDA for the treatment of obesity, meant to be used in conjunction with lifestyle changes. These medications have shown benefit to patients in clinical trials as well as now, in clinical practice.

These medications work in different ways in the body, all purposed for weight loss. According to the NIH, orlistat works in the gut to reduce the amount of fat absorbed from food; phentermine-topiramate may create a feeling of fullness sooner; bupropion- naltrexone may decrease feelings of hunger or make one feel full sooner; and liraglutide and semaglutide mimic GLP-1 and target areas of the brain that regulate appetite and eating.[7]

The CDC describes MNT as "a nutrition-based treatment provided by a registered dietitian nutritionist."[8] It is supported by a wide body of research; one study showed a $15 return for every $1 invested in registered dietician nutritionist-led lifestyle modification programs.[9] It is important to note that research shows that MNT is most successful for patients when used in tandem with another form of treatment, including pharmacological treatment.[10] For this reason, we urge expansion of coverage to include both MNT services and AOMs for Wisconsinites living with obesity.

Access to Care

Aside from the cost to an individual's health, obesity has enormous costs for society as a whole. As previously stated, obesity is related to several chronic and potentially fatal diseases. Addressing obesity has the potential to positively impact levels of these diseases in Wisconsin. On the micro level, Wisconsin will benefit from lower obesity rates in several ways. One study found that in 2015, 12.71% of all medical

[4] Ibid.
[5] Centers for Disease Control and Prevention. (2022, February 17). Obesity, race/ethnicity, and Covid-19. Centers for Disease Control and Prevention. Retrieved May 17, 2022, from https://www.cdc.gov/obesity/data/obesity-and-covid-19 html
[6] Ibid.
[7] U.S. Department of Health and Human Services. (n.d.). Prescription medications to treat overweight & obesity. National Institute of Diabetes and Digestive and Kidney Diseases. Retrieved May 17, 2022, from https://www.niddk nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity
[8] Centers for Disease Control and Prevention. (2021, February 1). Medical nutrition therapy. Centers for Disease Control and Prevention. Retrieved May 17, 2022, from https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medical-nutrition-therapy.html
[9] Wolf AM, Crowther JQ, Nadler JL, Bovbjerg VE. The return on investment of a lifestyle intervention: The ICAN Program. Paper presented at: American Diabetes Association 69th Scientific Sessions (169-OR); June 7, 2009; New Orleans, LA.
[10] Wharton, S., Lau, D. C., Vallis, M., Sharma, A. M., Biertho, L., Campbell-Scherer, D., ... & Wicklum, S. (2020). Obesity in adults: a clinical practice guideline. *Cmaj*, *192*(31), E875-E891.

expenditures in Wisconsin were associated with obesity.[11] Aside from being expensive, obesity causes absenteeism from work at higher levels than among individuals without obesity.[12] Specifically in Wisconsin, individuals with obesity recorded job absenteeism from illness or injury at a 138.8% higher rate than those without obesity.[13] This rate increases as weight increases.[14] This absenteeism causes a per employee yearly productivity loss ranging between $271 and $542 (in 2017 dollars).[15] Therefore, addressing obesity would have tremendous value in supporting both employee health and productivity. Of relevance, the study yielding this data recommends that employers choose health plans that cover treatments for obesity.[16]

Despite the value of these therapies to providers, patients, and employers, we are very concerned that that the existing ban on coverage for AOMs and MNT is outdated and severely limits access to appropriate, FDA-approved therapies, as state employees may not be able to afford obesity therapies without commercial pharmacy formulary inclusion. This creates challenges for patients and their clinicians and results in fewer treatment options for obesity patients. Placing barriers between patients and the therapies that their healthcare provider prescribes interferes with patient care and undermines the primacy of the physician-patient relationship, a relationship that serves as the backbone of our healthcare system. For obesity patients who are at higher risk of developing other deadly and preventable diseases, access to all appropriate medications is particularly important.

For this reason, we urge you to include broader coverage of obesity therapies for state employees. Doing so will allow access to medical therapies for obesity, providing more opportunities for a patient-centered care approach, one that allows for tailored treatment of each patient and their individual disease management needs. A patient-centered approach focuses on the ability to change course as needed and allows patients the opportunity to access innovative medications that could drastically improve their quality of life.

Conclusion

On behalf of the Alliance for Patient Access, we urge you to support inclusion of obesity therapies in Commercial pharmacy formulary for the state-sponsored employee health plan. Doing so will support timely access to appropriate care for those with obesity and support a patient-centered system of care.

Thank you for your consideration. If we can answer any questions or provide further information, please contact us at [redacted] or [redacted]

[11] Adam Biener, John Cawley, Chad Meyerhoefer, The Impact of Obesity on Medical Care Costs and Labor Market Outcomes in the US, *Clinical Chemistry*, Volume 64, Issue 1, 1 January 2018, Pages 108–117, https://doi.org/10.1373/clinchem.2017.272450

[12] Cawley, John PhD; Biener, Adam PhD; Meyerhoefer, Chad PhD; Ding, Yuchen PhD; Zvenyach, Tracy PhD, NP; Smolarz, B. Gabriel MD, MS; Ramasamy, Abhilasha MS Job Absenteeism Costs of Obesity in the United States, Journal of Occupational and Environmental Medicine: July 2021 - Volume 63 - Issue 7 - p 565-573 doi: 10.1097/JOM.0000000000002198

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

Sincerely,

Josie Cooper
Executive Director
Alliance for Patient Access

Alliance for Patient Access
2020 K St NW, Suite 505
Washington, DC 20006

From: Schulze, Connie R
To: ETF SMB Board Feedback
Cc: Sieg, Tricia - ETF; Schulze, Connie R; Temple, Jack D
Subject: UW Health Comments -- Benefit Plan Year 2023
Date: Wednesday, May 18, 2022 7:49:21 AM
Attachments: Letter--GIB--May 2022 JDT Signature.pdf

To Whom it May Concern. Please find attached a letter from Jack Temple, Senior Director of Pharmacy Services for UW Health that is relative to the changes proposed for benefit plan year 2023. Thank you for your consideration. I am happy to field any questions you might have about the attached.

Connie Schulze
Director, Government Affairs
UW Health & UW School of Medicine and Public Health
Madison, WI
PHONE: [redacted] (mobile)
EMAIL: [redacted]

UWHealth

May 18, 2022

Group Insurance Board
c/o Board Liaison
Department of Employee Trust Funds
PO Box 7931 Madison, WI 53707-7931
Sent via email transmittal to BoardFeedback@etf.wi.gov

Dear Members of the Group Insurance Board:

I write with regard to the health and pharmacy benefit changes you will be asked to approve for plan year 2023 when you meet today. I understand you will be voting on several recommendations and while we respect the ETF staff who have spent months researching various proposals, we want to articulate our hesitation to proceed with the recommendation made on page 4 of this memo. Specifically, please consider the potential negative impact implementing a "clear bagging" program applied to UW Health's specialty pharmacy for Tier 4 medications (omitting oncology medications) might have. We prefer the current approach for the following reasons:

1) Continuity of Care – Dispensing a patient specific medication from hospital or health system's own pharmacy on a common electronic health care record, ensures patient continuity of care and regulatory compliance.
2) Patient Safety – Drugs that arrive from retail specialty pharmacies may not be streamlined for in-house pharmacy systems and can be incompatible with in-house equipment to deliver the infusion. Product waste can be higher.
3) Compliance Concerns – Billing compliance processes to ensure patients are not double-billed for medications.
4) Higher operating costs – Labor, overhead, regulatory requirements, and risk management expense are not accounted for in historical rates for medication administration fees.

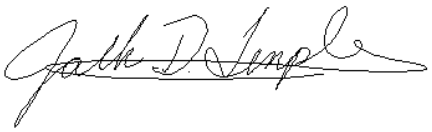
UW Health will need to evaluate the impact of continued willingness to provide uncompensated patient care due to payers' and PBMs' requirements to use bagged medication. We will need to determine if the payer and/or PBM changes to mandate Tier 4 bagged medications are in accordance with the existing contract terms and the reimbursement impact, as Tier 4 medications shift from the medical benefit to the pharmacy benefit.

Furthermore, we are concerned a clear bagging program might negatively impact patients we serve through a joint operating agreement with UPH-Meriter. The joint operating agreement (JOA) we have had in place for four years has allowed our health systems to address long-standing capacity concerns, support the financial viability of both systems, and share innovative approaches to care and treatment that benefit patients from throughout Dane County. Regarding the recommendation before you, it's important to note UPH-Meriter does not have a specialty pharmacy equipped to provide medications through a clear bagging option. Therefore, we would

want some assurances UPH-Meriter patients would continue to be served by the UW Health specialty pharmacy under this proposal, which would be appropriate given the JOA.

Thank you for your consideration.

Sincerely,



Jack Temple, MS, PharmD
Senior Director
Pharmacy Services