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: October 20, 2022

To: Group Insurance Board

From: Renee Walk, Programs & Policy Unit Director
Molly Dunks, Disease Management and Wellness Program Manager
Tricia Sieg, Pharmacy Program Manager
Office of Strategic Health Policy

Subject: Weight Management Analysis

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

Background

Health conditions associated with overweight and obesity are key drivers of cost in the Group Health Insurance Program (GHIP), and the Group Insurance Board (Board) has been asked to add or modify benefits that might address weight as a means to lower cost and improve member health. Weight management is complex, however, and to provide full consideration to benefit change requests, the Board asked the Department of Employee Trust Funds (ETF) to provide a comprehensive review of overweight and obesity, methods to address these issues, and the available evidence related to treatments. The following memo presents a review of many available treatments or approaches to address overweight and obesity that range from lifestyle and behavioral change services to medical services and drugs.

Problem Definition

In adults, weight classification is typically measured using body mass index (BMI). BMI is a ratio of body weight to height. It does not diagnose body fat percentage, disease, or overall health. It is instead a screening tool to compare expected weight based on how tall a person is.[1]

Table 1: BMI and Weight Categories

BMI	Category
<18.5	Underweight
18.5 to <25	Healthy

[1] Centers for Disease Control and Prevention. *Body Mass Index*. Accessed October 3, 2022. https://www.cdc.gov/healthyweight/assessing/bmi/index.html

Eileen K Mallow

Reviewed and approved by Eileen Mallow, Director, Office of Strategic Health Policy
Electronically Signed 10/28/2022

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BMI	Category
25.0 to <30	Overweight
30.0 to <35	Obese, Category 1
35 to <40	Obese, Category 2
40 +	Obese, Category 3

Some people may not be accurately classified within these categories. For example, elite athletes may have a higher body weight relative to their height due to the higher muscle mass that they have built through training. For most people, however, BMI is a good indicator to include with other indicators to monitor overall health.

The proportion of adults with obesity has steadily grown in recent decades. According to the Behavioral Risk Factor Surveillance System (BRFSS) survey of adults in 2021, 33.9% of all Wisconsin adults are now considered obese based on self-reported data. Obesity disproportionately most affects Wisconsin residents of color, and Wisconsin's rate of obesity among Black residents is the highest in the nation[2]; rates are shown in the table below.

Table 2: Obesity Rate by Race, BRFSS 2021

Race	Percent Obese
Asian, Non-Hispanic	15.9%
White, Non-Hispanic	32.5%
Hispanic	35.8%
American Indian/Alaska Native, Non-Hispanic	43.8%
Black, Non-Hispanic	51.8%

As mentioned above, having a BMI that qualifies as overweight or obese does not in itself indicate a particular health status. However, people who are overweight or obese have a higher risk of many serious diseases, including high blood pressure, Type 2 diabetes, coronary artery disease, cancer, body pain, osteoarthritis, mental illness, and stroke.[3] People with overweight or obesity were significantly more likely to suffer worse illness from COVID-19 during the pandemic, even if they were otherwise healthy before infection. This is due to physical changes associated with obesity, including immune deficiency, chronic inflammation, increased blood clotting, and restricted breathing capacity.[4]

Reduced to the simplest explanation, obesity and overweight are caused by an excess of calories consumed over calories used. The body uses calories for a variety of basic

[2] Centers for Disease Control and Prevention. *Adult Obesity Prevalence Maps*. Accessed October 3, 2022. https://www.cdc.gov/obesity/data/prevalence-maps.html
[3] Centers for Disease Control and Prevention. *Health Effects of Overweight and Obesity*. Accessed October 3, 2022. https://www.cdc.gov/healthyweight/effects/index.html
[4] Wadman, M. "Why COVID-29 is more deadly in people with obesity—even if they're young." *Science.* September 8, 2020. https://www.science.org/content/article/why-covid-19-more-deadly-people-obesity-even-if-theyre-young

functions (basal metabolism), such as breathing, repairing cells, and maintaining organ function. The body uses extra calories for other exercise or activity. Calories primarily come from the food a person eats. If a person eats more calories than are needed for basic life functions plus activity, the additional calories will be stored in fat cells for use later. If a person continuously eats more calories than they need each day, those calories will continue to store as fat, and the person will gain weight.

The circumstances that cause people to become chronically obese, however, are much more complex. On an individual level, "obesity is related to genetic, psychological, physical, metabolic, neurological, and hormonal impairments."[5] Access to and ability to prepare healthy foods may limit the ability of some people to maintain a healthy weight. The places where people live and work can limit physical activity. Chronic stress can increase people's desire to eat more calories while reducing the body's metabolism.[6] Policies that limit the time people have for personal care, such as work or school schedules, can also reduce physical activity and increase the likelihood of people choosing quick, high-calorie foods. This multi-level context for considering health is described by the social-ecological model. It will be important to keep in mind as the Board discusses ways to support members in reducing overweight and obesity.

Figure 1: Social-Ecological Model[7]

[5] Obesity Medicine Association. *Why is Obesity a Disease?* Accessed October 4, 2022. https://obesitymedicine.org/why-is-obesity-a-disease/
[6] Bergland, C. "Why Does Chronic Stress Make Losing Weight More Difficult?" *Psychology Today*. January 8, 2016. https://www.psychologytoday.com/us/blog/the-athletes-way/201601/why-does-chronic-stress-make-losing-weight-more-difficult.
[7] Heise, L., Ellsberg, M., Gottemoeller, M. (1999). "A Social-Ecological Model for Physical Activity." Accessed October 3, 2022. https://blogs.uw.edu/somehm/2017/08/12/social-ecological-model/

Often within this framework, the individual's ability to make change is limited to the individual and interpersonal realms. The organizational, community, and public policy realms define the choices that the individual can contemplate.

While population level surveys are generally representative, it is challenging to specifically quantify the number of members affected by overweight or obesity in the Board's programs. From 2018 to 2022, between 4.43% and 8.58% of the Board's members appeared in the DAISI data warehouse coded as having an obesity diagnosis. Given that the Board's programs do not pay for most services to address weight, it is likely that the diagnosis is under-reported in health insurance claims. According to WebMD, 66% of GHIP members participating in Well Wisconsin have a BMI greater than 25 (Ref. GIB | 05.18.2022 | 8A).

Medical/Clinical Approaches

The United States Preventive Services Task Force (USPSTF) recommends that adults and children be screened for and counseled regarding obesity as a part of routine preventive care. Beyond screening, however, the success of clinical interventions for weight loss can be hard to measure, and weight loss is difficult to maintain long term. According to *UpToDate* (a clinical decision support tool used by providers to make evidence-based care decisions) initial treatment for overweight and obesity in adults includes comprehensive lifestyle intervention, dietary change, exercise, and behavior modification. *UpToDate* references the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Program (DPP) as a successful example of one such intervention, as it focuses not only on weight loss, but on group and individual counseling, and diet and adherence strategies as outcomes.

Continuous monitoring by the provider and patient is necessary for long term success in weight loss programs. In some cases, establishing and monitoring a diet are guided by a registered dietician, who can take into account challenges for patients with other co-occurring conditions or medical needs. For patients who do not necessarily need comprehensive or condition-specific counseling, a primary care provider can be an appropriate counselor.

Exercise is also important in weight loss, though less important than calorie reduction.[8] Patients should perform at least 30 minutes of physical activity or more at least five days per week to prevent weight gain. Substantially larger amounts of physical activity appear to be needed to induce weight loss without a calorie-restricted diet, and so it is recommended that patients pair the two versus exercise alone.[9]

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[8] Ehrlicher, S, Chui, T, Clina, J, Ellison, K, Sayer, D. (2022) The Data Behind Popular Diets for Weight Loss. *Medical Clinics of North America.* 106: 5, pp 739-766. https://doi.org/10.1016/j.mcna.2022.05.003

[9] Piercy, K, Troiano, R, Ballard, R, Carlson, S, Fulton, J, Galuska, D, George, S, Olsons, R. (2018). The Physical Activity Guidelines for Americans. *The Journal of the American Medical Association*. 2018;320(19):2020-2028. doi:10.1001/jama.2018.14854

The *UpToDate* summary guidelines on weight loss note that, "…the body appears to have a 'set point' of adipose tissue mass, and strategies that assume the effective treatment of obesity is only a matter of an individual's 'willpower' may lead to repeated failure due to the body's tendency to revert to its set point." Subsequent treatment discussed includes drug therapy (covered later in this memo), devices, and bariatric surgery. The guidelines specifically do not recommend liposuction, dietary supplements, or acupuncture.

"Devices" referenced above include gastric bands or balloon systems, electrical vagus nerve stimulators, gastric emptying systems, and hydrogels. These treatments are typically not covered by insurance plans, nor are they recommended as treatment unless a patient cannot tolerate alternatives.

The GHIP's medical coverage currently does not cover most of the above services beyond the screening and counseling done in a primary care provider's office unless those services are intended to prepare a patient for bariatric surgery. The Board added coverage of bariatric surgery in 2020 (Ref. GIB | 05.15.22 | 8C). Bariatric surgery is covered under the GHIP for members with a BMI of 35 or greater, and health plans may impose pre-surgical criteria before a surgery is covered such as nutritional or behavioral counseling. Bariatric surgery is becoming a more common coverage in commercial insurance policies, and Medicare now covers bariatric surgery.

ETF has presented one report in February of 2022 (Ref. GIB | 02.16.22 | 7A), monitoring the current utilization and cost of those surgeries in the GHIP. Typically, the Board cannot add benefits to the GHIP that would increase the cost of the program unless statutorily required or unless savings are found elsewhere in the program. Following several years of review and consideration, ETF recommended that the Board add coverage given the available evidence that the costs of the bariatric surgeries themselves were typically recouped by resulting patient health improvements over the following two years. 427 of the Board's members in total have had a bariatric surgery for obesity since the benefit began. So far in 2022, 102 members have had a bariatric surgery as of May, trending upwards from 273 members in all of 2021 and 145 in 2020 when the benefit began. The number of members receiving the surgery has increased in the last year, likely because more members who were eligible have been completing prerequisites for the surgery, as well as delays in elective surgeries due to COVID. It is still too early to state any outcomes for members who have had a bariatric surgery since the benefit was added in 2020.

Pharmaceutical Approaches

Currently, the Board does not cover any weight-loss drugs, also known as weight-loss pharmaceuticals or pharmacotherapy, that are taken for the sole purpose of losing weight. The Board last examined the coverage of weight-loss pharmacotherapy at its June 30, 2022, meeting (Ref. GIB | 06.30.22 | 4).

Navitus Health Solutions (Navitus) the Board's pharmacy benefits manager (PBM) allows commercial, Health Insurance Exchange, and Medicaid clients to opt into adding weight-loss drugs. Navitus estimates that between 12.5% and 15% of their Commercial and Exchange clients have added weight-loss drug coverage.

Navitus's clients who offer Medicare Part D coverage, such as the Board, cannot add weight-loss drugs to their Part D formularies. 42 U.S.C. §1395W-102 excludes the Centers for Medicare and Medicaid Services (CMS), which creates the Medicare Part D drug formulary, from including coverage for weight-loss drugs.

Navitus currently has four drugs that can be added to a client's commercial formulary.

The drugs in the subsections below have been approved by the United States Food and Drug Administration (FDA) for adults with a BMI of 27 or higher and at least one weight-related medical issue, or for patients with BMI of 30 or higher regardless of other health issues.

Saxenda
Saxenda (*liraglutide*) is an appetite suppressant that is injected via a prefilled pen into the layer of skin directly below the epidermis. It is on Level 2 of Navitus's commercial formulary; a member would pay 20% of the cost with a $50 maximum. The wholesale acquisition cost (WAC) per 30-day dose is $1,349. Saxenda carries an FDA black box warning (indicating serious and sometimes life-threatening risk) for C-cell thyroid tumors. Other side effects include diarrhea, acute pancreatitis, constipation, acute gallbladder disease, vomiting, hypoglycemia, nausea, increased heart rate, suicidal ideation, renal impairment, and hypersensitivity.

Contrave
Contrave (*naltrexone/bupropion*) is an extended-release, orally administered appetite suppressant. It is a Level 2 drug with a quantity limit on Navitus's commercial formulary. The WAC for a 30-day dose is $625. Contrave carries an FDA black box warning for suicidality. Other side effects include constipation, neuropsychiatric adverse events, dizziness, seizure, headache, opioid use, nausea, increased heart rate and blood pressure, hypoglycemia, allergic reactions, angle-closure glaucoma, liver toxicity, and mania.

Qsymia
Qsymia (*phentermine/topiramate*) is a Level IV controlled substance capsule appetite suppressant. A person taking Qsymia must also have a reduced-calorie diet and increased physical activity. Brand name Qsymia is a Level 2 drug on the Navitus formulary, and generic phentermine is Level 1 but only covered for short-term (90-day) usage. The WAC for the drug is $200 per 30-day dose. Qsymia does not have any black box warnings, but side effects listed include embryo-fetal toxicity, dizziness, increased heart rate, headache, suicidal ideation, dry mouth, myopia/angle closure glaucoma, constipation, mood/sleep disorders, lab abnormalities, cognitive impairment,

hypokalemia, metabolic acidosis, hypothermia, creatinine increase, kidney stones, hypoglycemia, renal/hepatic impairments, hypotension, and seizures.

Wegovy

Wegovy (*semaglutide*) is a once-weekly, self-injected drug, and the newest entrant to the weight loss drug marketplace. A person taking Wegovy must also have a reduced-calorie diet and increased physical activity. Of the 96 Navitus clients who cover Wegovy, they all have placed the drug on Level 2. The WAC cost per 30-day dose of the drug is $1,349. Like Saxenda, Wegovy has a black box warning for C-cell thyroid cancer. Other side effects include suicidal ideation, acute pancreatitis, increased heart rate, acute gallbladder disease, diabetic retinopathy, hypoglycemia, hypersensitivity, and acute kidney injury.

When covered, all four weight loss drugs require prior authorization (PA) by Navitus before a prescription can be filled. The PA form requires the patient's BMI and baseline weight and lists the criteria that are required to be on the drug. The prescriber must indicate they have counseled the patient on realistic expectations of weight loss, a need for continued calorie reduction and exercise, the chronic nature of weight-loss pharmacotherapy, and the safety concerns and common tolerability concerns with the drug. A prescriber must resubmit a PA every year and include the patient's weight when the drug was first prescribed and their current weight. This is required to demonstrate that there is weight loss or maintained a weight loss of greater than or equal to 5% of the patient's body weight from when the drug was first prescribed.

On May 19, 2022, the FDA approved tizepatide, which will have the brand name Mounjaro, for Type 2 diabetes. According to numerous media reports, the approval of Mounjaro will be important competition for weight-loss drugs like Wegovy.

A June 4, 2022, article in the New England Journal of Medicine reported on a 72-week weight reduction trial of Mounjaro. The study, supported by Mounjaro's manufacturer Eli Lily, found that 85.1% of people taking 5 milligrams (mg) once a week saw a 5% weight reduction. 88.9% of those taking 10mg of the drug saw a 5% weight reduction and 90.9% of those taking 15mg of the drug saw a 5% weight reduction. Only 34.5% of participants who took placebo saw a 5% weight reduction.[10] It should be noted that all participants in the study were required to attend regular lifestyle counseling sessions to help participants in the study adhere to requirements like balanced meals and at least 150 minutes of physical activity per week. There are currently three additional weight-loss studies being conducted on Mounjaro. It is expected to go to the FDA for approval as a weight-loss drug in the next two years.

In comparison, Wegovy's 68-week study of the drug was administered weekly at 0.25mg for the first four weeks. The dose was then increased every four weeks to reach

[10] Jastreboff, A. M., Aronne, L. J., Ahmad, N. N., Wharton, S., connery, L., Alves, B., . . . Stefanski, A. (2022). Tirzepatide Once Weekly for the Treatment of Obesity. *The New England Journal of Medicine*. https://www.nejm.org/doi/10.1056/NEJMoa2206038

the maintenance dose of 2.4mg by week 16. Participants received individual counseling sessions every four weeks to help them stay with the reduced-calorie diet and 150 minutes per week physical activity requirement of the study. At the end of the study, 86.4% of the participants who had taken the drug had a 5% or less body-weight reduction versus only 31.5% of those who took the placebo. Of the participants, 69.1% had a 10% or less body weight reduction.[11]

Contrave, Saxenda, and Qsymia all had studies conducted that lasted 56 weeks. The effects of taking weight-loss drugs for multiple years are unknown or studies are currently being conducted. These studies aim to answer the question of whether weight regain may occur over time despite continued therapy, if maintaining weight loss is viable under the drug, and what are both the good and bad health effects of taking weight-loss drugs for a long duration. The timelines and release dates of the information from these ongoing studies are unknown.

Wegovy and Saxenda cost significantly more than any other weight loss drugs on the market. Wegovy is also sold in different injection pens for different indications such as Type 2 diabetes, and the pens sold for obesity were 51% more expensive than those sold for other indications.[12]

If approved, Mounjaro will compete most directly with Wegovy for market share. The biggest difference found between Wegovy and Mounjaro, besides the possibility of a lower price when introduced as a weight-loss drug and more weight-loss by participants in Mounjaro's study as compared to Wegovy, is the amount of the drug a member needs to take. When Wegovy was introduced as a way to treat Type 2 diabetes, it was taken in a much lower dose than what is needed when taken for weight loss. In initial weight-loss studies of Mounjaro people are losing weight on the same dosage of the drug as when taken for Type 2 diabetes.

On March 3, 2022, The Institute for Clinical and Economic Review (ICER), began an in-depth review of pharmaceutical treatments for obesity management. ICER's review examined all four weight-loss drugs available through Navitus including Saxenda, Wegovy, Qsymia, and Contrave.

ICER's Treatments Obesity Management: Effectiveness and Value presentation at a public meeting on September 16, 2022, found that all four weight-loss drugs available through Navitus improved one-year weight loss outcomes as compared to standard lifestyle management. Wegovy (*semaglutide*) and Saxenda (*liraglutide*) have shown to improve patients standard blood pressure and blood sugar. The best chance of weight loss appears to be with semaglutide and phentermine/topiramate with semaglutide

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[11] Wilding, J. P., Batterham, R. L., Calanna, S., Davies, M., Van Gaal, L. F., Lingvay, I, Yokote, K. (2021). Once-Weekly Semaglutide in Adults with Overweigth or Obesity. *The New England Journal of Medicine*. https://www.nejm.org/doi/full/10.1056/NEJMoa2032183

[12] ConscienHealth. (2022, May 19). *FDA Approves "An Important Advance," Tirzepatide*. Retrieved from ConscienHealth: https://conscienhealth.org/2022/05/fda-approves-an-important-advance-tirzepatide

providing the best chance for a person to achieve 20% weight loss.[13] The ICER review was silent on longer-term health outcomes; as discussed with the Board in ETF's reviews of bariatric surgery coverage, the health outcomes of weight loss can take time to manifest.

However, ICER's presentation concluded that "Long-term weight management with semaglutide or liraglutide was not cost effective given commonly accepted willingness-to-pay thresholds." That same presentation found that drug phentermine/topiramate with the addition of lifestyle modifications was cost effective.[13]

Lifestyle Approaches

The Board's wellness and disease management program vendor, WebMD, offers a variety of tools and resources to support GHIP subscribers and spouses with making and sustaining lifestyle changes to support weight management. Examples include one-on-one health coaching, educational content and articles, wellness challenges, Well Wisconsin Radio podcast, fitness videos, healthy recipes, and a digital program called Daily Habits which provides daily support to encourage positive habits. Participants can choose to focus on weight management specifically, or other areas that can impact weight (e.g., nutrition, physical activity, stress management, and sleep). WebMD continues to evaluate ways to support participants with reaching their well-being goals and are currently working on developing additional products such as group coaching, a program they plan to make available to clients as an add-on program beginning next year.

More intensive weight management program support is also available through WebMD. WebMD (StayWell) piloted a program called Ignite in 2017 and 2018 for 50 participants in each year. It was a group-based coaching program that lasted 12 weeks and included an activity tracker and wireless scale. The Board approved adding the program for up to 200 participants beginning in 2020 with a cost of approximately $115,000 or $.09 per employee per month in the wellness administration fee (Ref. GIB | 08.21.19 | 5C).

When WebMD acquired StayWell, the 12-week group-based weight management program was discontinued. Therefore, longer term analysis on this program has not been completed. Instead, WebMD had an intensive weight management program called Positively Me. Positively Me is a year-long, one-on-one intensive coaching program focused on weight management that is based off the DPP. The DPP is a year-long program focused on lifestyle behavior changes that support weight loss, in order to reduce a member's risk of diabetes. Positively Me does not include an activity tracker or digital scale which results in a lower cost per person than the previous Ignite program. Therefore, more people have been able to participate in the program while remaining within the $115,000 budget starting in 2021.

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[13] Institute for Clinical and Economic Review (2022, September 16). Treatments for Obesity Management: Effectiveness and Value [PowerPoint slides]. https://icer.org/wp-content/uploads/2022/03/ICER_Obesity_Evidence_Presentation.pdf

Attachment A includes more information about Positively Me, results from 2021 participants, and year-to-date results for 2022 participants. 40–50% of participants reported improvements in weekly exercise and fruit and vegetable intake, and approximately 51% of participants lost weight, with the average weight loss being 8–10 pounds per person. For comparison, average weight loss among individuals who engaged in health coaching lost approximately 2.5 pounds. Additionally, WebMD is in the early stages of piloting DPP virtually with select employer groups and is awaiting CDC recognition as an approved provider.

Other States' Approaches

Staff requested information from State and Local Government Benefits Association (SALGBA) members in August 2022 to learn about their efforts with wellness and medical weight management. 10 SALGBA members replied, including Alabama Local Government Health Insurance, Albuquerque, Florida, Hawaii, Kansas, Midwest Public Risk (Missouri and Kansas), Minnesota, Nevada, North Carolina, and Tennessee. Nine of the 10 offer some type of lifestyle or wellness support ranging from weight loss team challenges to coaching, DPP, gym memberships or discounts, educational programs, webinars, and obesity and overweight care disease management. Many do not measure outcomes or impact of their lifestyle or wellness support programs. Those that do measure outcomes are seeing positive results related to self-reported activity or nutrition and biometric health values.

Four of the respondents reported offering medical/clinical benefits as follows:

1. Alabama Local Government Health Insurance: 50% coverage for surgical bariatric surgery; 80% coverage for physician supervised weight management and nutrition counseling up to $150 per year.
2. Minnesota: Diabetes self-management training and education, including medical nutrition therapy; weight loss program if medically necessary; bariatric surgery; mental health and registered dietician services for eating disorders.
3. Nevada: Office visits, lab tests, nutrition counseling covered at 100%; meal replacement therapy covered at 50% or $50/month; travel benefit for bariatric surgery.
4. Tennessee: Medically necessary surgery.

On May 24, 2020, ETF posed questions to the SALGBA list serve regarding coverage of weight loss drugs. Those questions and states' responses can be found on page three of the memo prepared for the Board's June 30, 2022, that examined coverage of weight-loss pharmacotherapy (Ref. GIB | 06.30.22 | 4).

Additional Related Benefits

Health savings accounts (HSAs) and flexible spending accounts (FSAs) can be used to pay for prescribed weight management-related costs that may not be covered by insurance. GHIP members can use their HSAs and FSAs to pay for or reimburse themselves for these costs. Members need to include a letter of medical necessity with their weight loss expense reimbursement request. Optum Financial reported 27

expense claims totaling $6,285.38 January through September 21, 2022, and 97 expense claims totaling $18,522.31 in 2021. It should be noted, though, that these costs can be difficult to track since there is no specific payment code established, and so these numbers may be undercounts.

Some studies have found that home-delivered meals, specifically those that can be tailored to people with medical needs such as assistance with weight loss or diabetes have shown promise in helping to combat those diagnoses.[14] Healthy home meal delivery can be done by a private sector company online or through a person's health insurer or a public program like Meals-on-Wheels. Costs for private plans can vary from $11 per serving per meal with free shipping to $190 per person for five days of meals with an additional $20 shipping cost.[15]

Some private sector employers have taken to offering onsite weight management meetings, such as Weight Watchers, to assist employees with losing weight. Along with these meetings, employers have created gyms to work out in, and employee personal trainers to work with employees. They may have cafeterias that only offer low-calorie options and vending machines that only have healthy items, or that offer healthy eating options at a substantially decreased price.[16] While these employer-driven approaches have had some success in the workplace, research is still needed on how to assist employees in the new virtual workplace where many employees are not in the office five days a week or 40 hours a week, but work from home or various non-conventional workplaces. In addition, the Board and ETF do not serve as the employer for the vast majority of the GHIP population; the GHIP can support employers in programming, but workplace programs are ultimately up to the employer to administer.

2022 ICER Report

On October 20, 2022, ICER published its Final Evidence Report and Policy Recommendations on Treatments for Obesity Management (ICER Report). The report includes recommendations regarding payer coverage.[17]

ICER recommends changing the BMI thresholds currently used. Currently, the National Health System in England requires a higher BMI for weight loss drug coverage than what the FDA recommends for patients in the United States. ICER points out that BMI may not always be an accurate guide to evaluating a person's need to be prescribed a weight-loss drug. Guidelines should consider exceptions based on racial and ethnic groups whose general BMI threshold does not accurately reflect underlying risks for

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[14] Berkowitz, Seth, et al. "Meal Delivery Programs Reduce the Use of Costly health Care in Dually eligible Medicare and Medicaid Beneficiaries." *Health Affairs*, 37, 4, 2018 April, page 535-541. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0999

[15] Godio, Mili (2022, September 6). *8 best meal delivery services in 2022, according to experts.* NBC News. https://www.nbcnews.com/select/shopping/best-meal-kit-delivery-services-ncna1287814

[16] Okie, Susan, M.D. "*The Employer as Health Coach." The New England Journal of Medicine*, 357, 15, 2007, October, pages 1465-1469 https://www.nejm.org/doi/full/10.1056/NEJMp078152

[17] Institute for Clinical and Economic Review. (2022, October 20). Treatments for Obesity Management: Final Policy Recommendations for New England Comparative Effectiveness Public Advisory Council

future complications from obesity and possible additional risk factors. ICER points out that not all patients who would be best served taking a weight-loss drug have a BMI that fits into any current BMI perimeters.

ICER recommends payers not require individuals who are prescribed weight-loss drugs have any ongoing enrollment in a lifestyle management program, such as exercise or nutrition. Prescribers making patients aware of diet and exercise recommendations is all that is needed according to ICER. This policy recommendation notes "that it does not serve the interests of most individuals who have a long history of attempting to lose weight to require that they enroll in a new weight loss program just to qualify for coverage with an obesity medication."

ICER's policy recommendations also advise payers to consider adding step therapy requirements for weight-loss drugs. Step therapy is the requirement that an individual try different, sometimes less expensive, drugs other than what is prescribed. If those drugs are effective for the individual, then they remain on that drug. If the alternative drug does not work, they can "step up" and try another drug or in most cases the drug that was originally prescribed.

ICER's policy recommendations also include recommendation for weight-loss drug manufacturers. The recommendations for manufacturers include:

- Setting prices that will foster affordability and good access for all patients
- Establishing patient assistance programs
- Initiating long-term studies examining the benefits and harms of long-term use of weight-loss drugs
- Conducting research comparing real-world treatment options and effectiveness.

Legal Limitations

As is often discussed with the Board when reviewing benefit changes, the Board is limited from signing contracts that would modify or expand benefits of the GHIP by Wis. Stats. § 40.03(6)(c). The exceptions to this are in cases where coverage is required by law (for example, mandatory coverages resulting from the Affordable Care Act), or if the changes approved would either maintain or reduce premium costs. The statutory language also exempts wellness and disease management programs from the cost limiting language. The limits for non-wellness offerings are irrespective of medical necessity or appropriateness of a treatment, and often have the unfortunate effect of limiting the Board's ability to be responsive to member coverage requests.

Internal Revenue Service (IRS) rules also impact incentives that are often used to encourage wellness and disease management program participation. Services that qualify as a medical expense under 26 U.S. Code § 213(d) are exempt from taxation. However, any wellness-related incentive, including discounts, reimbursements, fitness memberships or meals are considered taxable income. ETF relies on vendors in the GHIP to report all wellness incentive payments that do not qualify as a 213(d) medical expense for tax reporting purposes.

To reduce complex administrative burden and likelihood of error, the Board approved prohibiting non-Medicare Advantage health plans from offering wellness incentives to GHIP members beginning in 2021 (Ref. GIB | 05.13.20 | 5A). Future benefit changes to support weight management that do not qualify as a medical expense should include an analysis regarding tax reporting.

Next Steps

There remain opportunities to evaluate the impact of current program benefits on weight management within and across the wellness, medical, and pharmacy benefits. ETF recently approved new file specifications on program participation for the Well Wisconsin vendor(s) to submit to Merative. The longer-term vision includes expanding this file to health plans so that a comprehensive evaluation can be completed on the various program benefits that are not sent via claims data (e.g., coaching, challenges, DPP) that are available to support members with managing their health and releasing excess weight. Then, staff and the Board will be able to determine which program benefits under medical, pharmacy, and wellness are the most effective and drive toward those more consistently across health plans or program vendors. In addition, ETF will continue to monitor and report on the health and cost outcomes of the bariatric surgery benefit longer term for the Board's members, as well as developments in weight management pharmaceuticals and their associated costs.

As approved by the Board, ETF staff are currently reviewing vendor proposals for the Well Wisconsin program beginning in 2024 (Ref. GIB | 08.18.21 | 6). Services like what is currently available via WebMD for weight management is a contract requirement included in the RFP; however, vendors have the opportunity to propose additional services. The Board will learn more about the evaluation committee's recommendation and vendor's services at the February 2023 Board meeting.

Staff will be available at the Board meeting to answer any questions.

Attachment A: Positively Me Report (Confidential)