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To:	ETF SMB Board Feedback; Walk, Renee - ETF; Mallow, Eileen K - ETF; Sieg, Tricia - ETF
Cc:	Dougherty, Gary; Tracy Zvenyach; Joe Nadglowski; Catherine Ferguson
Subject:	OAC/ADA Joint Comments re Obesity Care Coverage for GIB Consideration
Date:	Friday, April 28, 2023 4:53:59 PM
Attachments:	042723 Final OAC ADA Letter to WI ETF GIB.docx

Dear Members of the Group Insurance Board,

On behalf of the Obesity Action Coalition (OAC) and the American Diabetes Association (ADA), please see the attached joint comment letter, which urges the Employee Trust Funds' Group Insurance Board to adopt state employee health plan coverage for pharmacotherapy and intensive behavioral therapy (IBT) for the treatment of overweight or obesity.

Should you have any questions or need additional information, please feel free to contact me via email at chris@potomaccurrents.com or ADA Director of State Government Affairs Gary Dougherty at GDougherty@diabetes.org. Thank you.

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April 27, 2023

ATTN: Members of the Group Insurance Board

On behalf of the Obesity Action Coalition (OAC) and the American Diabetes Association (ADA), we urge the Employee Trust Funds' (ETF) Group Insurance Board (GIB) to adopt state employee health plan coverage for pharmacotherapy and intensive behavioral therapy (IBT) for the treatment of overweight or obesity.

While our organizations truly appreciate the positive step that the GIB took to expand coverage of bariatric surgery and required precursor weight management and nutrition services for members with BMI of 35 or greater in 2020, we believe it is critical that state employees have access to all evidence-based treatment tools for obesity.

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 13 types of cancer (which make up 40 percent of all cancers diagnosed).[1] The importance of addressing obesity is further heightened by numerous studies showing that both obesity and diabetes increase the risk for more severe coronavirus disease 2019 (COVID-19) infections.[2] Additionally, obesity contributes to many chronic and costly conditions including sleep apnea and increases the rate of physical injury (including falls, sprains/strains, lower extremity fractures, and joint dislocations) by 48 percent.[3]

In Wisconsin, according to the Department of Health Services, 9 percent of adults have diabetes and 34 percent have prediabetes (higher than normal blood glucose levels).[4] In fact, obesity accounts for up to 53% of new cases of diabetes each year in the United States.[5] Throughout the past decades, the prevalence of obesity has skyrocketed across our country and in Wisconsin – with 41 percent[6] of adults or more than 1.5 million Wisconsinites currently affected by obesity. Wisconsin is among the top five states with the largest differences in obesity prevalence between white and Black adults.[7] The Wisconsin Health Atlas highlights that

[1]Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/obesity/index. Accessed April 26, 2023

[2]Diabetes Care 2023;46(Supplement_1):S128–S139. https://doi.org/10.2337/dc23-S008

[3]Finkelstein EA, Chen H, Prabhu M, Trogdon JG, Corso PS. The relationship between obesity and injuries among U.S. adults. Am J Health Promot. 2007 May-Jun;21(5):460-8. doi: 10.4278/0890-1171-21.5.460. PMID: 17515011.

[4] Wisconsin Department of Health Services, Division of Public Health, Chronic Disease Prevention Program https://www.dhs.wisconsin.gov/diabetes/index.htm. Accessed April 26, 2023

[5] Journal of the American Heart Association. Vol 10, Issue 4 February 2021. "Quantifying the Sex-Race/Ethnicity-Specific Burden of Obesity on Incident Diabetes Mellitus in the United States, 2001 to 2016: MESA and NHANES". https://www.ahajournals.org/doi/full/10.1161/JAHA.120.018799

[6] University of Wisconsin-Madison, Survey of the Health of Wisconsin (SHOW),"*Wisconsin's Obesity Map: Zip Codes Weigh In*", https://show.wisc.edu/wisconsins-obesity-map-the-zip-codes-weigh-in/. Accessed April 26, 2023

[7]Urban Institute, Timothy A. Waidmann, Elaine Waxman, Vincent Pancini, Poonam Gupta, "Obesity Across America," February 2022. https://www.urban.org/research/publication/obesity-across-america. Behavioral Risk Factor Surveillance System, 2018–20.

obesity rates are unevenly distributed across rural and urban communities with individuals living in the ZIP codes on the high end of this spectrum impacted by obesity at four times the rate of those living in the ZIP codes at the opposite end.[8] On average, rural communities are more likely to be impacted by obesity.

In previous communications with the Board, the obesity community has highlighted how since 2013, when the American Medical Association adopted formal policy declaring obesity as a complex and chronic disease and supporting patient access to the full continuum of evidence-based obesity care, numerous federal and state policy organizations have echoed the AMA's position. The American Diabetes Association 2023 Standards of Care further underscore that "obesity is a chronic and often progressive disease with numerous medical, physical, and psychosocial complications, including a substantially increased risk for type 2 diabetes."[9] Similarly, the National Council of Insurance Legislators, National Lieutenant Governors Association, National Hispanic Caucus of State Legislators, the National Black Caucus of State Legislators, the Veterans Heath Administration (VHA) and the Department of Defense (DOD) and the Federal Office of Personnel Management (OPM) have all recognized obesity as a chronic disease and echoed support for addressing this epidemic.

However, some health care programs and policymakers have outdated views that do not align with medical and scientific agreement that the pathology of the disease of obesity is complex. It is related to genetic, psychological, physical, metabolic, neurological, and hormonal impairments. Many still cling to the outdated and discriminatory misconceptions that obesity is a lifestyle choice or a personal failing. Others acknowledge that obesity is a chronic and complex disease, but they believe that it can be addressed solely with robust prevention. These perceptions and attitudes, coupled with bias and stigma, have resulted in health insurance plans taking vastly different approaches in determining what and how obesity treatment services are covered for their members.

Health and Financial Benefits of BMI Reduction

The health benefits of BMI reduction have been extensively and consistently documented. ADA's 2023 Standards of Care reviewed the evidence and demonstrate that obesity management can delay the progression from prediabetes to type 2 diabetes and is highly beneficial in treating type 2 diabetes.[10] In people with type 2 diabetes and have overweight or obesity, modest weight loss clinically improves health including glycemia as well as reduces the need for glucose-lowering medications.[11] Larger weight loss substantially reduces A1C and fasting glucose and has been shown to promote sustained diabetes remission through at least 2 years.[12] Additionally, with greater than 10 percent BMI reduction other significant health

[8]School of Medicine and Public Health, University of Wisconsin-Madison, Wisconsin Health Atlas. Accessed April 26, 2023. https://www.wihealthatlas.org/obesity/place#

[9]Diabetes Care 2023;46(Supplement_1):S128–S139. https://doi.org/10.2337/dc23-S008

[10]Diabetes Care 2023;46(Supplement_1):S128–S139. https://doi.org/10.2337/dc23-S008

[11]Diabetes Care 2023;46(Supplement_1):S128–S139. https://doi.org/10.2337/dc23-S008

[12]Diabetes Care 2023;46(Supplement_1):S128–S139. https://doi.org/10.2337/dc23-S008

benefits can be achieved including reducing osteoarthritis, cardiovascular disease, steatohepatitis and GERD.[13]

The Veterans Health Administration's experience providing access to a comprehensive medical benefit for obesity is relevant. The VA compared the health and total medical cost differences over 6, 12 and 24 months for veterans who participated in its intensive behavioral therapy program (MOVE!) compared to the MOVE! plus anti-obesity medications (AOMs). Veterans treated with AOMs while participating in the MOVE! program had better cardiometabolic indices, greater weight, and BMI reductions, and lower Healthcare Resource Utilization and medical costs compared with participants without AOM treatment. Cardiometabolic endpoints were significantly improved with reduction in systolic and diastolic blood pressure.[14] Similarly, other risk factors including total cholesterol, low-density lipoprotein (LDL) cholesterol, and HbA1c were also documented over 12 and 24 months. Total medical costs were significantly lower in the AOM+MOVE! cohort ($18,182 vs. $20,075; weighted mean annual cost difference: **-$1893** driven primarily by lower inpatient costs. Emergency room costs were also lower for the MOVE! plus AOM cohort.

Effective obesity treatment requires a personalized approach that provides access to obesity care across the continuum of medical care including intensive behavioral therapy, pharmacological treatment, and metabolic surgery.

OPM Guidance re Obesity Coverage under the Federal Employees Health Benefits Program

In particular, we recommend the GIB follow the comprehensive coverage model outlined by Office of Personnel Management (OPM) for Federal Employees Health Benefits (FEHB) program carriers beginning this year, where OPM states, regarding AOM coverage, that:

> *As per "Carrier Letter 2022-03, OPM FEHB Carriers are not allowed to exclude anti-obesity medications from coverage based on a benefit exclusion or a carve out. Carrier Letter 2022-02 outlines the requirements for Non-Discriminatory Formulary Design, namely, that a non-discriminatory formulary design does not have cost or access barriers imposed by disease or condition.*
>
> *FEHB Carriers must have adequate coverage of FDA approved anti-obesity medications on the formulary to meet patient needs and must make available their exception process to members. Carriers must cover at least one anti-obesity drug from the GLP-1 class for weight loss and cover at least 2 additional oral anti-obesity drug options. As new anti-obesity drugs are approved by the FDA, OPM expects Carriers to evaluate and update their coverage of anti-obesity drugs. Carriers should provide access to a range of obesity drugs on the formulary to satisfy OPM's requirement in Carrier Letter 2022-02 that Carriers must ensure non-discriminatory access to safe, clinically appropriate drug*

[13]Garvey WT, Mechanick JI, Brett EM, et al. American Associations of Clinical Endocrinologists (AACE) and American College of Endocrinology Comprehensive Clinical Practice Guidelines for Medicare Care of Patients with Obesity. *Endocr Pract*. 2016;22 Suppl 3:1-203. doi:10.4158/EP161365.GL

[14]W. Timothy Garvey, Mu Cheng, Abhilasha Ramasamy, B. Gabriel Smolarz, Suna Park, Neela Kumar, Nina Kim, Maral DerSarkissian, Rachel H. Bhak, Mei Sheng Duh, Melody Wu, Shawn Hansen, and Yinong Young-Xu, Clinical and Cost Benefits of Anti-Obesity Medication for US Veterans Participating in the MOVE! Weight Management ProgramPopulation Health Management Vol 26, No 1, 2023. DOI: 10.1089/pop.2022.0227

therapy for members with chronic conditions. This includes drug therapies indicated for adolescents aged 12 years and older."

Regarding preventive care, OPM also states that "FEHB Carriers must cover the full scope of required preventive services recommendations as outlined in Carrier Letter 2019-01. Specific to obesity, this means the benefit includes screening and, if referred, the multicomponent, family centered programs that are part of intensive behavioral interventions." In short, OPM's coverage policies surrounding IBT, AOMs and metabolic and bariatric surgery are a road map for how health plan coverage *should be* for obesity treatment.

USPSTF-Mandated Preventive Care Services

As highlighted above, non-grandfathered health plans must provide **both** obesity screening and intensive behavioral therapy services for those diagnosed with obesity. This is policy is clear under the Affordable Care Act (ACA).[15] The Group Health Insurance Program (GHIP) complies with the screening component of the obesity benefit, but then precludes any type of intensive behavioral therapy.

The USPSTF's September 18, 2018 Final Recommendation Statement entitled, "Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions," recommends that adults diagnosed with obesity (BMI ≥30) must "be offered or referred to intensive, multicomponent behavioral interventions."[16] The evidence report that accompanies the Task Force's recommendation defines both the frequency and intensity of these interventions as:

- 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.

Unfortunately, the October 20, 2022, ETF Memo to the Board states on page 5 that "the GHIP's medical coverage currently does not cover most of the services (comprehensive lifestyle intervention, dietary change, exercise, and behavior modification) 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 exclusionary language governing obesity/weight management services (outside of bariatric surgery services), preclude primary care providers from delivering services required under the law. This position could put GHIP's coverage policy in violation of the ACA requirements.

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[15]U.S. Preventive Services Task Force, Appendix I. Congressional Mandate Establishing the U.S. Preventive Services Task Force. U.S. Preventive Services Task Force. April 2019. https://uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/procedure-manual/procedure-manual-appendix-i

[16]U.S. Preventive Services Task Force, "Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions." September 2018. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions

Pharmacotherapy

There was much discussion regarding potential utilization and cost numbers associated with AOM coverage that occurred during last year's meetings. ETF focused on the final evidence report on treatments for obesity management, which was released on October 20, 2022, by the Institute for Clinical and Economic Review (ICER).

As noted on page 8 of ETF's October 20, 2022 memorandum, "ICER 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 providing the best chance for a person to achieve 20% weight loss."

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." ICER also stated that the "health-benefit price benchmark range for semaglutide is $7,500 to $9,800 per year; this would require a discount from the wholesale acquisition cost of 44-57%." Given that rebates generally range from 25-50%, it is more likely that the actual cost of AOMs could be much lower. For example, a 2022 financial report from Morgan Stanley suggests dramatic price decreases could occur in the next few years. As the Veterans Affairs' experience demonstrates that while the cost of certain categories could increase, the total medical cost per individual decreases by as much as $1893 per patient as BMI reduces and health improves.[17] Key cardiometabolic indicators improve, including the potential for reduced glucose lower medications and emergency room and inpatient expenditures also decline.

Additionally, there are many studies that point to extremely low utilization rates for obesity treatment such as only 1% of eligible individuals receiving intensive behavioral therapy or bariatric surgery. And while past studies of AOM utilization[18] hover around 1% as well, current trends in utilization are more likely in the 2-4% range as reflected in the recent VA experience.[19] Low utilization of obesity medical treatment has been consistently documented with only 3.4 percent of adults with obesity seeking health professional help for weight reduction.[20] These barriers to obesity care include individual perceptions, lack of medical diagnosis which are further hampered by health care provider discomfort and time-constraints.[21] Of those who sought medical support or obesity only 24% scheduled a follow-up visit to an initial weight-

[17] W. Timothy Garvey, Mu Cheng, Abhilasha Ramasamy, B. Gabriel Smolarz, Suna Park, Neela Kumar, Nina Kim, Maral DerSarkissian, Rachel H. Bhak, Mei Sheng Duh, Melody Wu, Shawn Hansen, and Yinong Young-Xu, Clinical and Cost Benefits of Anti-Obesity Medication for US Veterans Participating in the MOVE! Weight Management ProgramPopulation Health Management Vol 26, No 1, 2023. DOI: 10.1089/pop.2022.0227

[18] Joanna MacEwan, Hong Kan, Kevin Chiu, Jiat Ling Poon, Shraddha Shinde, Nadia N. Ahmad, "Antiobesity Medication Use Among Overweight and Obese Adults in the United States: 2015–2018" VOLUME 27, ISSUE 11, P1139-1148, July 11, 2021.https://doi.org/10.1016/j.eprac.2021.07.004

[19]W. Timothy Garvey, Mu Cheng, Abhilasha Ramasamy, B. Gabriel Smolarz, Suna Park, Neela Kumar, Nina Kim, Maral DerSarkissian, Rachel H. Bhak, Mei Sheng Duh, Melody Wu, Shawn Hansen, and Yinong Young-Xu, Clinical and Cost Benefits of Anti-Obesity Medication for US Veterans Participating in the MOVE! Weight Management ProgramPopulation Health Management Vol 26, No 1, 2023. DOI: 10.1089/pop.2022.0227

[20]Stokes A, Collins JM, Grant BF, Hsiao CW, Johnston SS, Ammann EM, Berry KM, Tong C, Scamuffa RF. Prevalence and Determinants of Engagement with Obesity Care in the United States. Obesity (Silver Spring). 2018 May;26(5):814-818. doi: 10.1002/oby.22173. Epub 2018 Apr 6. PMID: 29626388; PMCID: PMC5947584

[21]Ibid. Stokes A, Collins JM, Grant BF, Hsiao CW, Johnston SS, Ammann EM, Berry KM, Tong C, Scamuffa RF.

related conversation.[22] Furthermore, another study highlights that the average time that individuals remain on AOMs is 81 days.

In conclusion, we are hopeful that the ETF and GIB will take action to address these gaps in critical obesity treatment for state employees. Should you have any questions or need additional information, please feel free to contact OAC Public Policy Consultant Chris Gallagher at chris@potomaccurrents.com or ADA Director of State Government Affairs Gary Dougherty at GDougherty@diabetes.org.

[22]Ibid. Stokes A, Collins JM, Grant BF, Hsiao CW, Johnston SS, Ammann EM, Berry KM, Tong C, Scamuffa RF.