Dear State Leader,

Welcome to the second quarterly "Weight and the States" bulletin from the Strategies to Overcome and Prevent (STOP) Obesity Alliance. In this installment, we continue the conversation surrounding essential health benefits (EHB) and the Affordable Care Act (ACA).

In 2011, the Department of Health and Human Services (HHS) made the determination to forgo setting a federal level of EHB requirements in favor of granting tremendous flexibility to state policymakers in deciding what a state can choose to cover, or not cover, when it comes to services that do not clearly fall under one of the 10 broad EHB categories under the ACA.

HHS has signaled, in guidance documents issued in December and January, that it will allow states to pick from 10 different federal and state "benchmark" plans such as the federal employee health benefits plan, state employee health plans and the three largest plans, by enrollment, in each state's small group market. Services covered by the benchmark plan will set the minimum EHB that all small group, non-group and health insurance exchange plans in the state must cover.

Last year, the Alliance convened a Task Force to create federal-level recommendations regarding what should be included for treating obesity and related co-morbidities, which centered on the belief that weight-related interventions should not be treated differently than those for any other health condition.

Due to rising health care costs in general and, specifically, the prevalence and costs of obesity and weight-related chronic diseases at the state level, we examined how states might consider obesity when making the tough decisions about what to include in their respective EHB packages. In this Bulletin, the GW research team reviewed the Task Force federal recommendations and prepared some possible ways for states to move forward based on the work of the Task Force.

We hope this information is helpful to state leaders as you make important decisions regarding health care services in your state. Please email us at obesity@gwu.edu with questions or comments. You can also find more information online at www.stopobesityalliance.org.

Best,

Scott Kahan, M.D., M.P.H.
Director, STOP Obesity Alliance

Background

The Affordable Care Act instructed Secretary Sebelius to require health plans to meet Essential Health Benefit standards by 2014. The Secretary decided to give flexibility to the states by allowing exchanges to determine the benefits package by selecting an existing plan as a "benchmark" for defining the items and services included in its EHB package. States could choose a "benchmark" from among the following health insurance plans:

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national Federal Employee Health Benefit Plan options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

If a state fails to pick a benchmark plan, the largest plan in any of the three largest small group products would be the default.

Small Group "Benchmark" Plans

HHS released a list of the largest three small group products in each state earlier this year. Any one of the top three enrolled small group insurance products may be selected by a state as their "benchmark" plan. The state's EHB must then meet or exceed the coverage of the selected "benchmark" plan.

In the STOP Obesity Alliance's first 2012 "Weight and the States" bulletin, we reviewed coverage of bariatric surgery and weight-loss programs in each of the 153 top-three enrolled small-employer health plans identified by HHS. We found limited coverage of bariatric surgery and practically non-existent coverage of weight-loss programs. There was widely varying coverage within states, for example, one or more state product(s) included bariatric surgery and/or weight-loss programs, while the other(s) did not.

The small group "benchmark" plans are, arguably, the most important in terms of what states are likely to look to when setting their EHBs. These plans are, generally, the least costly to businesses and nearly 90 percent of small group plans already include all services mandated under state laws, meaning the state will not then be subject to picking up the costs of covering services beyond the 10 mandated categories defined by HHS.[1]

Other Potential "Benchmark" Plans

Although unlikely, if a state were to select another "benchmark" plan, coverage of obesity services, while slightly more comprehensive, is still limited.

Among state employee plans, the majority of states do not provide robust coverage across the service continuum from prevention to treatment. However, states are experimenting with incentive programs geared toward behavior modification, while state budgetary concerns challenge providing coverage for obesity treatments. In fact, in a 50-state survey of coverage

for obesity-related treatment, the Alliance research team found that while only a few private small group insurers offer coverage for obesity services, particularly bariatric surgery, more state employee health plans offer coverage. A study by the American Society for Metabolic and Bariatric Surgery found that in 47 out of 50 states, at least one state employee health plan offers coverage of bariatric surgery.[2] States are increasingly realizing there is long-term benefit to covering obesity services such as bariatric surgery but have been much less quick to accept other treatment interventions, such as intensive lifestyle counseling, commercial weight-loss programs, and obesity pharmaceuticals.

Of the top three federal employee health plans, coverage is, generally, more comprehensive than the other "benchmark" plans. For obesity services, all three plans cover bariatric surgery. Consequently, states would likely bear the costs of benefits beyond those mandated by HHS.

Why Do Many State EHB Plans and All of the Top-Three Federal EHB Plans Cover Obesity Services?

The Centers for Disease Control and Prevention (CDC) finds that two out of three adults are classified as overweight and one out of three as obese. It's estimated that by 2030, half the population will be obese.[3] Obesity is associated with more than 60 chronic diseases and conditions that range from diabetes to cardiovascular disease to sleep apnea, among others. The costs of obesity are enormous, estimated at $190.2 billion a year.[4]

Furthermore, a 2010 report "A Heavy Burden: The Individual Costs of Being Overweight and Obese in the United States" by the STOP Obesity Alliance GW research team found that non-medical costs attributable to obesity are also significant. The average annualized costs, including medical costs, presenteeism, absenteeism, among others, were $4,879 for obese women and $2,646 for obese men. These costs are not just borne by individuals, they also affect businesses and ultimately states.

These costs combined with the health implications of obesity's co-morbidities have led many states and the federal government to cover bariatric surgery, given surgery's profound impact on obesity related co-morbidities such as Type 2 diabetes. Coverage for preventive services and less invasive intervention modalities has been much more restricted.

Why Don't Small Employer Plans Cover Obesity Services?

Large employer, state EHB, and federal EHB plans are increasingly covering obesity services - both bariatric surgery and workplace wellness programs. However, many small business plans have forgone covering these services as plan turnover rates are extremely high in the small group market, making it unlikely that a plan will realize the long-term benefits of treating individuals affected with obesity. Furthermore, given that 38 percent of the costs of obesity are not realized under age 65+, businesses don't bear the full burden of obesity, and taxpayers are left to pick up the costs.[5]

Return on Investment for Obesity Treatment
The decision to provide preventive services and/or treatment for obesity should not be based solely on cost. A "business case" for obesity based solely on cost of treatment ignores the health and quality of life improvements from obesity treatments. For example, although bariatric surgery is cost-saving for individuals with BMI of > 50, it has been shown to be cost-effective for individuals with BMI > 35.[6]

While other obesity interventions, such as wellness programs and intensive lifestyle counseling, have a less clear return on investment (ROI), obesity treatments should not be stigmatized and should be viewed similarly to diabetes and cardiovascular health interventions, for their cost-effectiveness at treating high-risk populations.[7,8]

The Hard Choices
The federal government is increasingly recognizing the evidence supporting the value of providing preventive obesity services, as exemplified by CMS's recent decision to cover obesity screening and counseling for all Medicare beneficiaries. Large, self-employed businesses and state employee plans are also beginning to provide incentives for beneficiaries participating in wellness programs, many of which incorporate weight management components.

In considering options, it may be wise for states to take a longer term view of its population health and the cost-effectiveness of treating obesity when setting their EHBs. States should consider selecting a "benchmark" plan that covers cost-effective evidence-based obesity treatments, like bariatric surgery, counseling, and FDA approved obesity drugs. Treating obesity, even when treatment results in modest weight loss of five to seven percent, has enormous benefit to a person's health, and thus could decrease the long-term costs of treating obesity.

What Can States Do About Obesity Within Essential Health Benefits?
The Alliance convened an EHB Task Force in 2011 to create federal recommendations regarding what should be included for treating obesity and related co-morbidities considering the significance of benefit design to the types of health care services that ultimately will be available to participants through the exchanges. The group's recommendations centered on the belief that obesity and weight-related interventions should not be treated differently than those for any other health condition.

Based on these federal recommendations, the research team at GW has developed the following suggestions that can be applied at the state level.

Overarching Principles
Guiding principles in establishing the coverage provisions of state's EHB package:

- No obesity services should be summarily excluded from the new EHB package coverage requirements under the ACA.
- All evidence-based preventive services should be covered.
- All preventive benefits should be covered by the EHB with no or reduced cost-sharing as articulated in the ACA.
- All evidence-based treatments for obesity should be covered with reasonable cost-sharing.

Recommendation One on the Affordable Care Act Coverage Categories
Treatment for obesity should not be summarily excluded and treatments or services that cross between coverage categories should not be excluded or subject to additional cost sharing as compared to other types of treatments or services.

The following are the essential benefit classes and recommendations for what should be included under the ACA-defined coverage categories.

- **Ambulatory Patient Services:** For example, a physician who consults with a patient with obesity regarding treatment should be able to bill and be reimbursed for that consultation in the same manner that a physician treating a patient with diabetes is allowed to bill and receive reimbursement for a consultation.
- **Emergency Services:** No person with obesity or a related co-morbidity should be treated differently in cases of emergency. All patients should be treated equally in terms of their needs.
- **Hospitalization:** Hospitalizations for obesity treatment should be covered.
- **Maternity & Newborn Care:** Screenings, counseling, and other necessary services to encourage an expectant mother to maintain a healthy weight should be covered. Breastfeeding consultations and other related services should also be covered, in accordance with the IOM's Recommendations for Preventive Health Care Services for Women.
- **Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment:** Research shows a significant overlap between obesity and mental health and substance abuse disorders. Specifically, there is a strong link between obesity and depression—one study demonstrated that depression likely plays a role in the development of physical health problems, such as cardiovascular disease, through its association with weight gain and increased abdominal obesity over time.[1] Therefore, mental health services should be covered for people with obesity.
- **Prescription Drugs:** All drugs for the treatment of obesity approved by the U.S. Food and Drug Administration (FDA) should be covered.
- **Rehabilitative and Habilitative Services and Devices:** Due to significant overlap between persons with disabilities and persons with obesity, rehabilitative and habilitative services and devices should be covered.

- **Laboratory Services:** Routine labs/screenings, including, but not limited to A1C, blood glucose, and lipid levels should be covered. Additionally, coverage is recommended of genetic testing, which may serve the purpose of more accurately matching the most effective treatment for obesity and other related conditions to an individual in the future.
- **Preventive and Wellness Services and Chronic Disease Management:** All evidence-based preventive services and chronic disease management for obesity and related co-morbidities be included in this category with no or reduced cost-sharing.
- **Pediatric Services, including Oral and Vision Care:** Aggressive interventions around overweight and obesity should be included in this essential benefit category.

Recommendation Two on the Evidence Base for Obesity-Related Prevention and Treatment Services

At a minimum, the recommendations from the following two organizations should be used for the evidence base for obesity and obesity-related chronic disease prevention, treatment, and management: U.S. Preventive Services Task Force (USPSTF) and National Heart, Lung, and Blood Institute (NHLBI).

<u>USPSTF Recommendations for Obesity Treatment</u>

- *USPSTF recommendations with an "A" or "B" rating should be covered as a minimum under the essential health benefits package.*
    - The following is the current USPSTF recommendation of primary and preventive services for adults with obesity:
        - *The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Rating: B recommendation*[2]

<u>NHLBI Recommendations for Obesity Treatment</u>

- *NHLBI evidence-based recommendations for the treatment of obesity should be considered as essential health benefits.*
    - NHLBI recommends treating obesity based on evidence from randomized controlled trials that show that weight loss not only helps control diseases, but may also reduce the likelihood of developing those diseases. Specifically, the NHLBI recommends the following interventions for weight loss and weight management[3]:
        - Physical Activity
        - Dietary Therapy
        - Pharmacotherapy
        - Combined Therapy
        - Weight Loss Surgery

Recommendation Three on Cost Sharing for Obesity-Related Services

No evidence-based treatments for obesity should be excluded from coverage and that such services have cost sharing that is no greater than that which is required by other comparable treatments.

- There are often blanket exclusions placed on the coverage of weight-loss treatments. Where there is coverage, often the cost sharing requirements for the intervention are much higher than for comparable interventions to prevent or treat non-obesity related diseases or conditions. For example, studies indicate bariatric surgery produces significant improvements in both the short- and long-term, but despite the benefits of surgical intervention, and the NHLBI recommendations less than two percent of eligible patients undergo bariatric surgery each year in the United States.[4]

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[1] National Association of Health Underwriters. 2012. "Small Employer Plan Coverage".
[2] Obesity Action Coalition. 2012. "Comments to HHS Secretary Sebelius". Available at: http://www.obesityaction.org/wp-content/uploads/OCC-Comments-on-HHS.pdf
[3] Wang C, McPherson K, Marsh T, Gortmaker S, Brown M. 2011. Health and economic burden of the projected obesity trends in the USA and the UK. *The Lancet*. 378:815-825.
[4] IOM (Institute of Medicine). 2012. Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation.
[5] Trogdon J. RTI. 2009. "Obesity: The Business Case for Intervention".
[6] Chang S, Stoll CRT, Colditz GA. 2011. Cost-effectiveness of bariatric surgery: Should it be universally available? *Maturitas*. 69(3):230-238.
[7] Russell LB. 2009. Preventing chronic disease: An important investment, but Don't count on cost savings. *Health Affairs*. 28(1):42-45.
[8] Trogdon. 2009.