Dear State Leader,

Welcome to the latest installment of the Strategies to Overcome and Prevent (STOP) Obesity Alliance's "Weight and the States" bulletin. Since our last edition, the Supreme Court of the United States issued its ruling on the Affordable Care Act, including allowing individual states the option of expanding Medicaid by changing enrollment requirements. In effect, the Supreme Court decision places even more responsibility for implementing health care reform on the states.

In this bulletin, we attempt to assist state leaders in processing the impact of the Medicaid expansion decision on coverage for obesity prevention and treatment. We look at where states currently stand on Medicaid expansion, what factors are important to states when considering whether or not they will expand eligibility, and current coverage for obesity prevention and treatment in state Medicaid plans.

For many working in health care, policy and government, there remains concern about the availability of prevention and treatment services for obesity, overweight and weight-related chronic disease. And that's worrying given the overwhelming prevalence of obesity in our country and the associated costs and risk factors. Consider that:

- Two-thirds of Americans are overweight or obese[1]
- Half of obesity-attributable medical expenditures are borne by the states and federal government through Medicare and Medicaid[2]
    - Each obese Medicaid beneficiary costs, on average, $1,021 more per year when compared to normal weight beneficiaries[3]
- Obesity is a risk factor for many chronic diseases, such as type 2 diabetes, heart disease, and certain cancers.
- The increased costs associated with obesity and its related chronic diseases have led to huge increases in medical spending, and are challenging already cash-strapped state budgets.[4]

We would be pleased to hear from you on how these issues are affecting you and your state. Please email us at obesity@gwu.edu with questions or find more information at www.stopobesityalliance.org.

Sincerely,

Scott Kahan, M.D., M.P.H.
Director, STOP Obesity Alliance
Faculty, The George Washington University

Review of the Supreme Court Decision on Affordable Care Act and Overview of Reaction from the States

The individual mandate, requiring citizens to purchase health insurance or pay a penalty, and the expansion of Medicaid to cover all non-elderly adults with incomes at or below 138 percent of the Federal Poverty Level (FPL) were two of the most contentious provisions of the Affordable Care Act (ACA). Twenty-six states filed lawsuits challenging the constitutionality of the ACA based on these two provisions. The states contended that the individual mandate was unconstitutional because it was not a reasonable exercise of Congressional Commerce Clause authority granted under the Constitution, and the expansion of Medicaid was unduly coercive and encroached on states' sovereignty. Although the Supreme Court of the United States (SCOTUS) held that the Commerce Clause does not provide authority for the individual mandate, it upheld the requirement under the Spending Clause as a tax. The Court also agreed that forcing states to expand Medicaid eligibility to the extent required under the ACA, by threatening to withhold all Medicaid funds for non-expansion, was in fact coercive. The Court's ruling on Medicaid prevents the Federal government from penalizing states who choose not to expand their Medicaid coverage to 138 of the FPL.

Where States Currently Stand on Medicaid Expansion

States fall into three categories following the Supreme Court's decision:

1. States that planned to proceed with expanding Medicaid regardless of the decision.
2. States that require further guidance from the U.S. Department of Health and Human Services (HHS) on state flexibility to alter Medicaid eligibility while still qualifying for enhanced Federal Medical Assistance Percentages (FMAP) reimbursement.
3. States that view the SCOTUS Medicaid ruling as validation to maintain current eligibility due to budgetary concerns or even to invalidate other Medicaid requirements under the ACA, such as the Maintenance of Effort provision that prevents states from cutting current eligibility prior to January 2014.

The Supreme Court's decision changes very little for states falling into the first category. The federal government will still provide the same FMAP funding for covering the expansion population: 100 percent for the first three years and 90 percent thereafter.

For states falling into the second category, numerous questions remain about how much flexibility HHS is able to or will permit states to tailor their Medicaid programs and eligibility levels to their own needs while still qualifying for federal funds as detailed in the ACA. Several Republican governors sent a letter to HHS Secretary Kathleen Sebelius on July 10, 2012 requesting further guidance on state flexibility in Medicaid. The letter raises important questions, including:

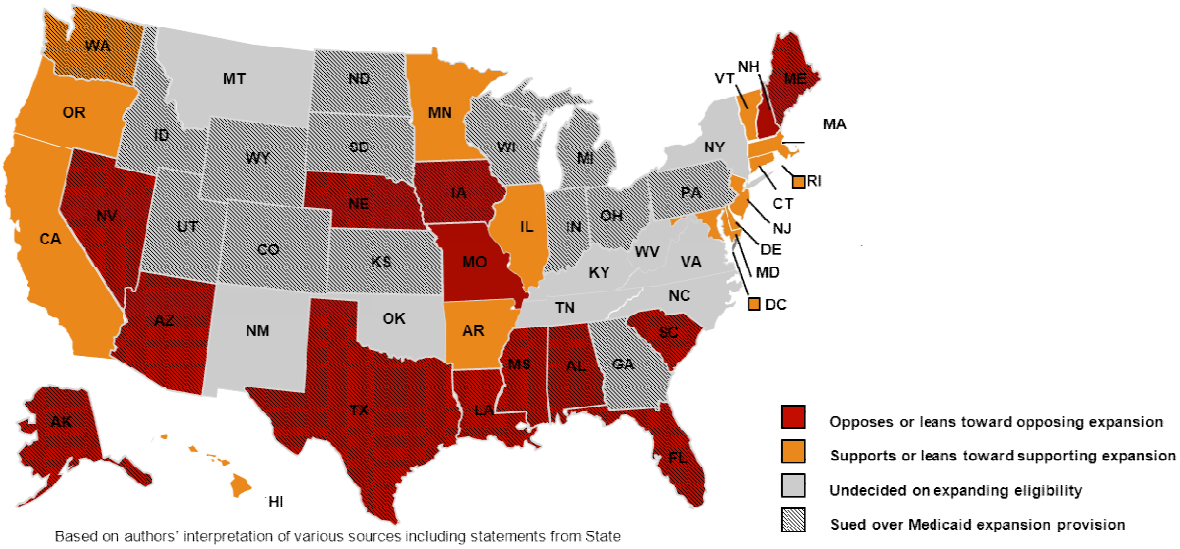
- Will states that opt in have the option of scaling back in future years?
- Will states be able to cut back eligibility if the FMAP changes?

- Can a state participate only partially — for instance, by raising the income cutoff for its program to a level lower than the ceiling envisioned in the law, which is set at 133 percent of the FPL, and still qualify for federal funding?

States falling into the third category have announced intention to challenge additional Medicaid requirements, such as the Maintenance of Effort provision. Although no formal guidance has been issued, Centers for Medicare and Medicaid Services (CMS) officials have stated publicly that, as with any state option under the Medicaid program, states will have the ability to opt in or opt out of the expansion at any time. Unless Congress amends the law, CMS grants a waiver, or courts rule on additional provisions, states must meet all other requirements outlined under the ACA.

To determine where the states stand on the expansion, the STOP Obesity Alliance research team at The George Washington University reviewed statements made by governors, attorneys general, and legislatures in each state. We found that 15 states indicated they definitely will not or are leaning toward not expanding Medicaid eligibility, 14 states are committed to or leaning toward expansion, 22 states are undecided, and only one state (Maine) is beginning to cut its program - as it believes the Supreme Court's decision invalidates HHS' previous Maintenance of Effort provision.

Map 1: Where States Stand on Medicaid Expansion



Based on authors' interpretation of various sources including statements from State Governors, Attorney Generals, and Legislatures

Factors Affecting Where States Stand on Expansion

Many have questioned why states would oppose an expansion where 100 percent of the cost for the first 3 years and 90 percent in additional years is funded by the federal government. Opposition to the expansion appears to occur primarily for two reasons:

1. **Political** - Some states oppose the Medicaid expansion simply as a political act against the ACA as a whole and political opposition to the expansion may further intensify with the approaching elections. The outcome of November elections may have significant ramifications on where states stand on expansion. For example, given the outcome of the presidential election, as well as gubernatorial elections, additional states may change position on the expansion.
2. **Economic** - Some states fear that they simply cannot afford the costs down the road and have stated that even the 10 percent of expansion costs they will be required to pay after 2016 is too burdensome for cash-strapped states. In addition to costs down the road, some states fear that expanding eligibility will have a "woodwork" effect, meaning that millions of people who are already eligible for Medicaid but are not already enrolled will sign up. This effect is significant in some states as it is estimated that there are 6 million uninsured but eligible children and 3.1 million uninsured but eligible parents in the United States.[5] State enrollment levels range between 11 percent and 90 percent of eligible children and parents, meaning that for some states, the woodwork effect is more pronounced.[6] New enrollment under current eligibility levels will be subject to existing Medicaid FMAP reimbursement rates and not the enhanced 100 percent rate for newly eligibles.

How Essential Health Benefits (EHBs) Will Impact Medicaid Coverage

States currently must offer services as defined by their Medicaid benchmark plan. Accordant with the ACA, states may still choose a Medicaid benchmark plan from any of the three categories permitted under the Social Security Act:

- Standard Blue Cross Blue Shield PPO plan under FEHBP
- Largest non-Medicaid commercial HMO in the state
- Any generally available state employee plan

However, beginning in 2014, Medicaid benchmark plans must also cover the ten categories stipulated as EHBs.[7] Namely, plans must cover ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorders services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, prevention and wellness and chronic disease management, and pediatric services. States do not have to pick the same "benchmark" plan for commercial plans and the exchange as for Medicaid.

The STOP Obesity Alliance issued recommendations on EHBs in 2011, as well as provided comments to the United States Preventive Services Task Force (USPSTF) and CMS, stating that ***obesity prevention and treatment should be treated as any other medical condition, and not be summarily excluded***. Similarly,

the Alliance has maintained that cost-sharing should not be used as a means to discourage beneficiaries from utilizing obesity-related services.

Medicaid and Obesity

Medicaid beneficiaries not only experience poorer overall health status but also are more likely to be affected by obesity. Obesity rates for Medicaid beneficiaries are approximately 10 percent higher than for individuals otherwise insured.[8] Higher obesity prevalence in this population may contribute to poorer health status as a result of reduced feeling and functioning and the medical consequences of obesity such as diabetes and heart disease.

ACA Targets Obesity Prevention and Treatment[9]

Beyond enumerating the list of EHBs, the ACA stipulates that HHS provide guidance to states on what preventive and obesity-related services are available to Medicaid beneficiaries. In addition, states are required to conduct public awareness campaigns to educate Medicaid beneficiaries on the availability and coverage of obesity-related services and HHS is required to report to Congress every three years on the effectiveness of these efforts, beginning January 1, 2011.The first of these reports is available here.

Public awareness campaigns may have significant impact on increasing access to and use of obesity-related services, since Medicaid is required to cover all services deemed "medically necessary". However, a review of states' current obesity coverage, detailed below, reveals that it is often unclear what coverage states provide for obesity prevention and/or treatment, with states specifically excluding or simply not detailing coverage, which may act as a barrier to beneficiaries seeking and/or receiving care for obesity-related services.

Medicaid-Obesity Coverage Landscape

In 2010, the STOP Obesity Alliance research team at The George Washington University reviewed state fee-for-service Medicaid provider manuals and fee schedules to determine coverage of clinical obesity assessment and management services, pharmaceuticals, and bariatric surgery across the states. For this bulletin, the research team has updated the chart series for 2012. The results show that, for adults, the majority of states are not explicitly providing coverage for obesity prevention and/or treatment and that many states explicitly exclude obesity-related services.

Map 2: State Medicaid Coverage of Obesity Services for Adults in 2012

Source: Divine L, Kahan S, David S, et al. STOP Obesity Alliance. Medicaid Fee-For-Service Treatment Of Obesity Interventions: 50 State & District of Columbia Survey (2012).

Twenty-five states specifically excluded obesity-related drug coverage in 2010 and that number has increased to thirty-four in 2012. Coverage in five states is undeterminable. Twelve states cover obesity drugs, but of these states, ten require prior authorization and/or documentation of previous failed weight loss efforts and eight impose other restrictions, such as losing a specified percent of body weight in a specified time frame to maintain the benefit.

For surgical coverage, a significant majority (44) of state Medicaid programs provided coverage for surgical interventions, while five explicitly excluded coverage. Thirty-six states impose eligibility criteria beyond weight alone and 34 states require prior authorization. Five states specifically exclude bariatric surgery for the treatment of obesity and coverage for two states was undetermined.

Full results of this state-by-state Medicaid survey can be found here. The full survey also explores Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program coverage of obesity-related services, beyond mandated EPSDT levels, coverage of preventive services, coverage of nutritional services, coverage of disease management and education services, and behavioral counseling and therapy.

Obesity Coverage Outside of Medicaid

Obesity is increasingly recognized as a complex multi-factorial chronic condition, requiring access to and coverage for intensive prevention and intervention services. The United States Preventive Services Task Force (USPSTF) recently issued a recommendation that all primary care physicians should screen patients for obesity and to refer obese patients to intensive, multi-component behavioral interventions to improve their condition. The recommendation has been given a B grade meaning "there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial".[10]

Medicare regulations allow for flexibility in determining what preventive services are covered because of provisions which allow the Secretary of HHS to determine whether a previously unstipulated service is reasonable and necessary for the prevention or early detection of an illness or disability or if a Grade A or B recommendation is issued by the USPSTF for the service.[11]

In response to the USPSTF recommendation, CMS issued a National Coverage Determination which, as of November 2011, reimburses physicians for providing intensive behavioral interventions for Medicare beneficiaries with or at risk for obesity.

The USPSTF and Medicare National Coverage Determination decisions reflect two significant advances in payors covering obesity prevention and treatment services.

The Bottom Line

While CMS officials have indicated that it will likely take "several months" for states to decide whether they want to expand their Medicaid program in 2014, the federal government needs to issue guidance

to support states in determining how to proceed in evaluating the value of the Medicaid expansion and provide information on implementation issues, such as a timeline.

Cash-strapped states face tough decisions when it comes to the Medicaid expansion. The federal government offers large incentives to expand (e.g. enhanced FMAP rates for the expansion population and state subsidies for providing care to individuals who otherwise would go to the state-based exchanges), as well as disincentives for not expanding (e.g. reductions in disproportionate share hospital payments to cover uncompensated care costs). States will need to carefully balance these factors.

When it comes to selecting a Medicaid benchmark plan that is compliant with the EHB coverage categories, states may consider a plan that follows the Alliance's recommendations on EHBs, which does not summarily exclude obesity prevention and/or treatment. Similarly, all obesity-related services for which there is adequate evidence of benefit (e.g. screening and behavioral counseling[12]) should be covered as they would be for any other condition (e.g. behavioral interventions for tobacco cessation or alcohol abuse). Plans should clearly specify which obesity-related services are covered, for which populations they are covered (e.g. BMI$\geq$25 with co-morbidities, BMI$\geq$30, etc.) and any other coverage issues (e.g. prior authorization required, cost-sharing arrangements, etc.). Selecting this type of plan could ensure that appropriate access to treatments that help people address and reduce their weight-related health problems are available.

Resources

[1] Flegal, KM, Carroll, MD, Ogden, CL, Curtin, LR. Prevalence and Trends in Obesity Among US Adults, 1999–2008. *Journal of the American Medical Association.* 2010; 235–241.

[2] Sherry B, Blanck HM, Galuska DA, Pan L, Dietz WH. Vital Signs: State-Specific Obesity Prevalence Among Adults – United States, 2009. Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, August 3, 2010, 59 (Early Release);1-5.

[3] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: Payer-and service-specific estimates. Health Affairs. September/October 2009;28(5):w822-w831. doi: 10.1377/hlthaff.28.5.w822.

[4] Flegal KM, Graubard BI, Williamson DF, Gail MH. Excess Deaths Associated With Underweight, Overweight, and Obesity. *JAMA* 2005; 293: 1861-1867. Available at http://jama.ama-assn.org/content/293/15/1861.short

[5] Kaiser Commission on Medicaid and the Uninsured. Issue Paper: Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?. Feb 2007; 7613.

[6] Kaiser Commission on Medicaid and the Uninsured.

[7] HealthAffairs Blog. Implementing Health Reform: Essential Health Benefits And Medical Loss Ratios. Available at: http://healthaffairs.org/blog/2012/02/18/implementing-health-reform-essential-health-benefits-and-medical-loss-ratios/. February 18, 2012.

[8] Finkelstein EA, Fiebelkorn IC, Wang G. National medical spending attributable to overweight and obesity: How much, and who's paying? *Health Aff (Millwood)*. 2003;Suppl Web Exclusives:W3-219-26.

[9] Section 4004(i) of the Affordable Care Act (P.L. 111-148)

[10] Grade Definitions" U.S. Preventive Services Task Force. Available at: http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm#brec

[11] "Decision Memo for Intensive Behavior Therapy for Obesity (CAG-00423N)". Centers for Medicare and Medicaid. Available at: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253&.

[12] As evidenced by recent USPSTF screening and behavioral counseling referral recommendation and CMS behavioral counseling NCD (links provided above)