From the STOP Obesity Alliance

Weight and the States
A Policy Research Bulletin

Winter 2013

Dear State Leader,

We're excited to share with you the next edition of our "Weight and the States" bulletin. In this installment of our bulletin, we discuss our recent research on state-by-state Medicaid coverage of obesity treatments.

The Strategies to Overcome and Prevent (STOP) Obesity Alliance first analyzed Medicaid coverage of obesity prevention and treatment in 2010, finding near-universal coverage of bariatric surgery but limited coverage of obesity medications. As much has changed since then – including FDA approval of two new obesity medications, declaration of obesity as a chronic disease by the American Medical Association, publication of several new obesity treatment guidelines, and generally increasing recognition of the impact of obesity on health care status and medical expenditures – we decided to reassess coverage of obesity treatment modalities using the most up-to-date data from 2013. Our findings will be published in early 2014. In this bulletin, we'll summarize the general policies around medical and bariatric surgery coverage.

Specifically, we found that coverage of obesity pharmaceuticals continues to be limited, while coverage of bariatric surgery remained a near universal standard. To date:

- Just 12 states cover obesity medications
- 38 states explicitly exclude obesity medications
- 47 states cover bariatric surgery
- 4 states explicitly exclude bariatric surgery

States should have interest in obesity treatment modalities, as each obese Medicaid beneficiary costs, on average, $1,021 more per year than normal weight beneficiaries.[1]

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

Sincerely,

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Overview of Medicaid and Its Beneficiaries[2,3]

Current Medicaid Beneficiaries and Eligibility

In general, Medicaid serves low-income women and children and provides long-term care for the elderly and persons with disabilities. Medicaid covers approximately:

- 31 million children, including 8 million children in the Children's Health Insurance Program (CHIP), up to age 19;
- 11 million non-elderly, low-income parents or caretaker relatives, pregnant women, and other non-disabled adults;
- 8.8 million non-elderly disabled adults, 4.6 million low-income elderly adults—the majority of whom are dual Medicaid-Medicare beneficiaries; and
- 3.7 million adults with disabilities.

As of January 2012, all states covered children younger than age 19, up to at least 100% of the Federal Poverty Level (FPL) and many provide coverage beyond this level. Coverage for adults is much more limited. Prior to the enactment of the Affordable Care Act (ACA), non-elderly adults without dependent children were ineligible for Medicaid unless the state covered them under a waiver. Income eligibility for parents ranges from as low as 11% of FPL to 200%. There are no minimum federal eligibility standards for non-disabled adults without dependent children. Consequently, 33 states limit Medicaid eligibility to 100% of FPL or below and 17 states limit eligibility to 50% of FPL or below; just 9 states provide full Medicaid benefits to adults.[4]

The ACA would have required states to expand Medicaid eligibility to all individuals at or below 138% of the FPL as of January 1, 2014. However, the Supreme Court's ruling in 2012 made Medicaid expansion optional.[5] To date, just 25 states and the District of Columbia have elected to expand the eligibility level. The majority of individuals who will gain coverage under the expansion are low-income and uninsured and many have significant health problems. For example, one in four is in fair or poor health and three in four are overweight or obese.[6]

Medicaid and Obesity

Medicaid beneficiaries have poorer overall health status and are more likely to have obesity. Obesity rates are approximately 10% higher in Medicaid beneficiaries than in individuals otherwise insured.[7] Higher obesity prevalence in this population may contribute to poorer health status due to medical consequences of obesity, including glucose intolerance, diabetes, heart disease, sleep apnea, arthritis, mobility limitations, and others.

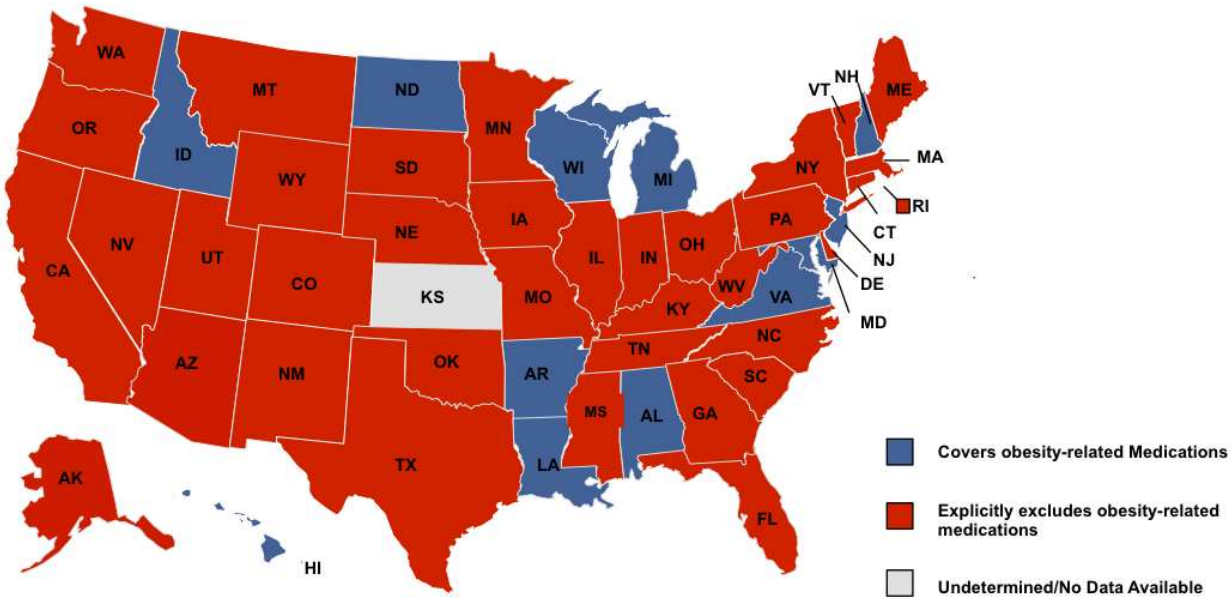
Medicaid-Obesity Coverage Landscape

In 2010, the STOP Obesity Alliance and George Washington University School of Public Health and Health Services reviewed state fee-for-service Medicaid provider manuals and fee schedules to determine coverage of clinical obesity assessment and management services, medications, and bariatric surgery. We recently reassessed this coverage using updated provider manuals, fee schedules, and drug formularies available between September 1 and November 9, 2013. The

updated analysis shows that for adults the majority of states are not explicitly providing coverage for obesity prevention and treatment, and many states explicitly exclude obesity-related services.

Coverage of Obesity Medications

Map 1: State Medicaid Coverage of Obesity Medications for Adults in 2013



Only 12 states – Alabama, Arkansas, Hawaii, Idaho, Louisiana, Maryland, Michigan, North Dakota, New Hampshire, New Jersey, Virginia, and Wisconsin – cover obesity medications. Thirty-eight states explicitly exclude obesity medications. Coverage was indeterminable for one state (Kansas).

Among the 12 states that do cover obesity medications, 11 explicitly require prior authorization. Specific prior authorization criteria varied widely. Common prior authorization requirements include documentation of body mass index (BMI) or BMI plus obesity-related comorbidities, documentation of prior medically-supervised weight loss ranging from six months to two years. Five states (Alabama, Hawaii, North Dakota, Virginia, and Wisconsin) require that certain weight-loss benchmarks be met over a specified timeframe in order to continue medication coverage once started.

We also used drug formularies to explore coverage of specific obesity medications that have been FDA approved for long term use:

Xenical (orlistat): Seven states – Alabama, Hawaii, Idaho, Michigan, North Dakota, Virginia, and Wisconsin – cover Xenical with a prior authorization. Four states – Arkansas, Connecticut, Louisiana, and New Hampshire – do not have Xenical listed on the preferred drug list (PDL) or

prior authorization list but claim drugs not on the PDL will be covered with documented medical necessity and prior authorization. One state – Maryland – does not cover Xenical.

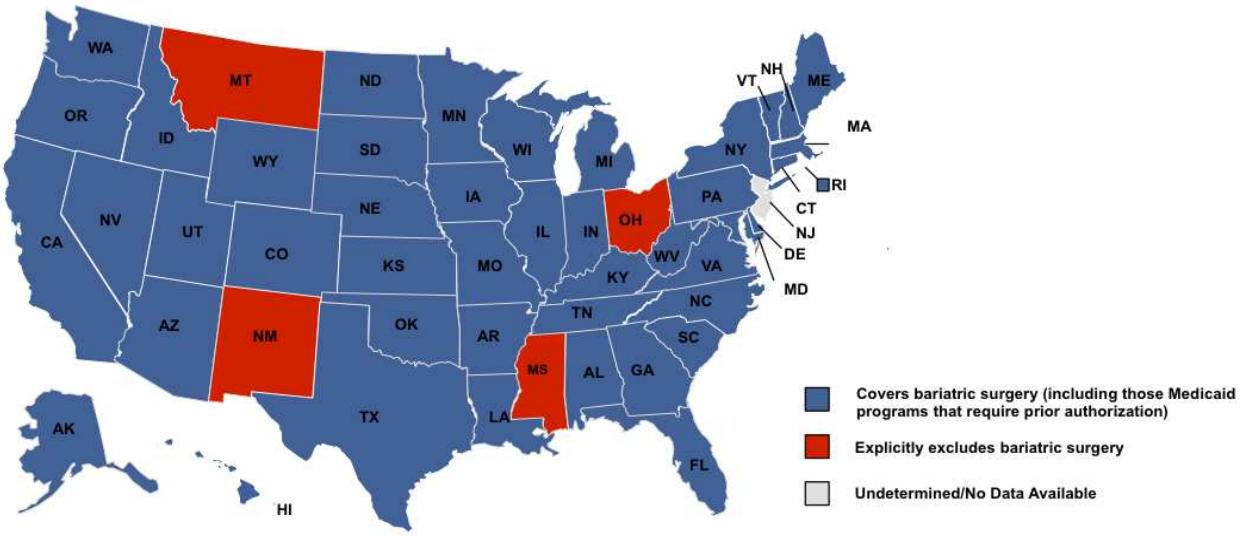
Qsymia (phentermine and topiramate extended-release): One state – Wisconsin – covers Qsymia with a prior authorization. Six states – Arkansas, Connecticut, Hawaii, Idaho, Louisiana, and New Hampshire – did not have Qsymia on the PDL or prior authorization list but claim drugs not on the PDL will be covered with documented medical necessity and prior authorization. Four states – Alabama, Maryland, Michigan, and North Dakota – do not cover Qsymia. One state – Virginia – had indeterminable coverage.

Belviq (lorcaserin): Two states – Maryland and Wisconsin – cover Belviq with a prior authorization. Seven states – Arkansas, Connecticut, Hawaii, Idaho, Louisiana, Michigan, and New Hampshire – did not have Belviq on the PDL or prior authorization list but claim drugs not on the PDL will be covered with documented medical necessity and prior authorization. Two states – Alabama and North Dakota – do not cover Belviq. One state – Virginia – had indeterminable coverage.

Most states appear to cover the two new obesity drugs (Qsymia and Belviq) when medically necessary and prior authorized. However, provider uncertainty around reimbursement and the lack of knowledge about what prior authorization details are required under standard non-formulary drug prior authorization may act as barriers to beneficiary utilization.

Coverage of Bariatric Surgery

Map 2: State Medicaid Coverage of Bariatric Surgery for Adults in 2013



Nearly all states (46) and the District of Columbia cover bariatric surgery. Among the states that cover bariatric surgery, prior authorization was explicitly required by all but four states (Colorado, Connecticut, Georgia, New York, and Tennessee). Four states (New Mexico,

Mississippi, Montana, and Ohio) explicitly exclude bariatric surgery. New Jersey had indeterminable coverage.

Comparison of 2013 Coverage and 2010 Coverage

Between 2010 and 2013, 13 additional states began to explicitly exclude obesity medication coverage, bringing the total to 38 states. This is surprising, given the FDA's approval of two new obesity medications in 2012. Additionally, New Jersey updated its policy to specify that it will only cover lipase inhibitors, an older obesity medication that is now available over-the-counter, effectively excluding the two newly approved medications.

For bariatric surgery, two additional states now covers bariatric surgery, bringing the total to 47 states. However, two additional states explicitly excluded bariatric surgery, bringing the total to four states.

Conclusion

Providers would benefit from clarity around which patients are appropriate for consideration of obesity medications and bariatric surgery and under what circumstances such treatments will be reimbursed. Further, all obesity-related services for which there is adequate evidence of benefit (e.g., screening and behavioral counseling[8]) should be covered in a similar fashion 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, and denote any specific coverage requirements (e.g., prior authorization, cost-sharing arrangements). Most state Medicaid agencies have latitude to update their provider manuals to include guidance on appropriate evidence- and/or consensus-based guidelines.

Resources

[1] 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.
[2] Kaiser Commission on Medicaid and the Uninsured. Key facts: Where Are The States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults. Jul 2012;7993-02.
[3] Kaiser Focus on Health Reform. Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries. Aug 2010;8092.
[4] Kaiser Commission on Medicaid and the Uninsured. Key facts: How will the Medicaid expansion for adults impact eligibility and coverage? Jul 2012;8338.
[5] National Federation Of Independent Business et al. v. Sebelius, Secretary Of Health And Human Services, et al, 567 US (2012). Available at: http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf
[6] Chang, T., and M. Davis. "Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Medicaid Beneficiaries." *Annals of family medicine* 11.5 (2013): 406-11.
[7] 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.
[8] As evidenced by recent USPSTF screening and behavioral counseling referral recommendation and CMS behavioral counseling NCD (links provided above)