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**BROADENING COVERAGE TO COMBAT
THE OBESITY EPIDEMIC: A TOOLKIT FOR
STATE INNOVATION**

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GLOSSARY

ACA	Patient Protection and Affordable Care Act: federal health care reform law enacted in March 2010
AOM	Anti-Obesity Medication; pharmacological agents altering one of the fundamental metabolic processes of the human body
CMS	The federal Centers for Medicaid & Medicare Services; administers the nation's major healthcare programs including Medicare, Medicaid, children's health insurance program, and the state and federal health insurance marketplaces (exchanges)
EHB	Essential Health Benefits: a set of ten categories of benefits, defined under the Affordable Care Act of 2010, that must be covered by individually purchased health insurance and plans in small-group markets both inside and outside of health insurance marketplaces
EHB benchmark plan	The plan that each state uses to define essential health benefits within that state for individual/family and small group plans
Exchange/Marketplace	Online shopping and enrollment service for medical insurance, the goal of which is to provide one-stop shopping and to facilitate plan comparison
HHS	U.S. Department of Health and Human Services; principal federal agency overseeing major health programs including CMS, NIH, and CDC
Individually purchased health insurance	Coverage that is purchased directly by an individual as opposed to obtaining it through an employer or from a government-run program
Large group insurance	Group medical insurance that covers an employer or association with 51 or more employees
Obesity	Abnormal or excessive fat accumulation that presents a risk to health; a serious chronic disease that has emerged as a major national health challenge in the last few decades
Reinsurance	System protecting insurers from very high claims, typically involving a third-party reimbursing a portion of an insurance company's qualifying claims once they pass a certain amount; by reducing uncertainty in the market, reinsurance has been shown to lower premiums and increase insurer competition in individual health insurance market
Risk Adjustment	A statistical process that considers the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs; used in Medicare Advantage as well as ACA-compliant individual and small group health insurance markets
Section 1332 Waivers	Also called State Innovation Waiver; federal waiver allowing states to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA such as guaranteed issue
Self-insured plan	Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims; the employer may contract with a third-party administrator to carry out some or all health insurance functions
Small group insurance	Medical insurance purchased by businesses with 50 or fewer full-time employees, to provide health coverage for the employees and their families

EXECUTIVE SUMMARY

Today, over 42 percent of Americans have obesity. Experts predict that fully half of Americans will have obesity by the end of this decade. Rather than a character flaw or just “needing to shed a few pounds,” obesity is a serious, chronic medical condition with linkages to many of the top causes of death in this country, including heart disease, stroke, diabetes, and cancer.

The costs of obesity are high and growing. A recent study found that healthcare costs for people with obesity are about \$3,500 higher each year than those with normal weight. When the indirect costs of obesity are included, including negative labor market outcomes like absenteeism, the total economic costs of obesity are staggering, estimated at nearly \$1.4 trillion—or roughly \$4,300 for every man, woman, and child in the U.S.

Like other chronic diseases, obesity treatment requires a continuum of care, including primary and specialist care, anti-obesity medications (AOMs), and surgical interventions. In particular, new and more effective AOMs are bridging the gap in obesity treatment options between behavioral interventions and more invasive options like bariatric surgery.

While these new interventions can be highly effective in managing obesity, numerous barriers remain in the way of patients receiving them. Insurance coverage for obesity treatment, the focus of this toolkit, is often limited, and there is a patchwork of coverage for the continuum of obesity care treatments across the states.

States desiring to address these barriers to effective treatment have the ability to do so. This toolkit sets forth options, including a number of innovative approaches, that state policymakers can employ to expand coverage for obesity treatment in a cost-effective and fiscally responsible manner. These options include:

- Expanding coverage for obesity treatment in state employee benefit plans
- Amending the state’s Essential Health Benefits benchmark plan to expand coverage for obesity treatment
- Leveraging flexibility under ACA section 1332 waivers to reduce pricing uncertainty and incentivize private insurers to cover obesity treatments
- Including comprehensive obesity coverage in Medicaid

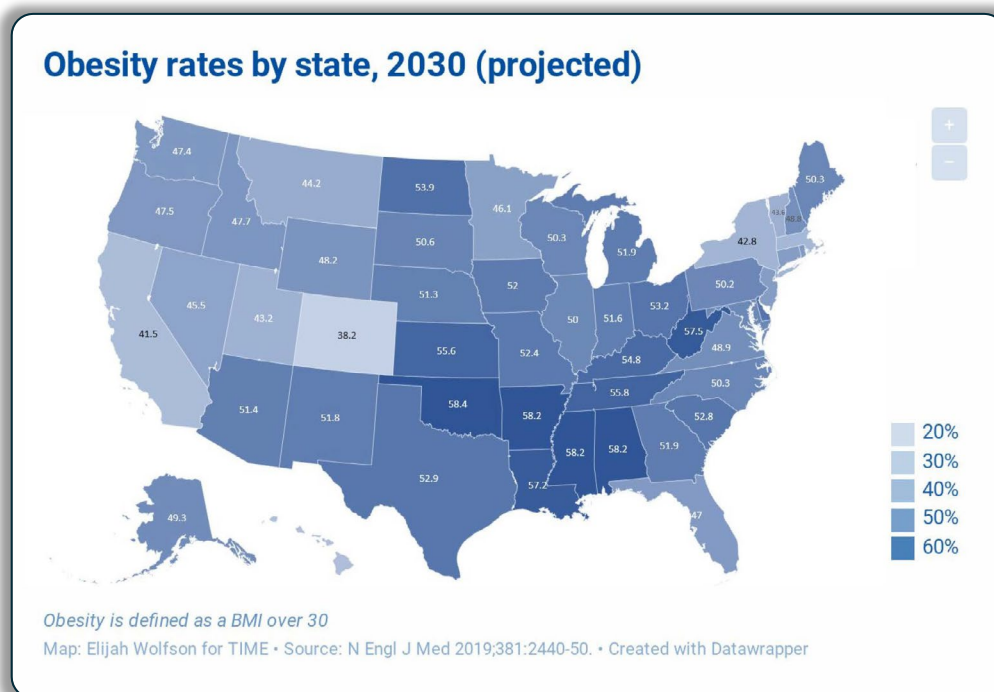
Several of the options included in this toolkit are bold and innovative, but each of the options also recognizes trade-offs and the need for states to manage costs wherever possible.

Today, state policymakers are grappling with the high cost of healthcare, but they should not lose sight of the end goal—to help their citizens lead healthier, more productive lives. The cost of inaction on obesity grows every day and can no longer be ignored. In fact, this toolkit cites evidence that greater coverage for effective obesity treatments can actually help to lower healthcare costs and increase economic efficiency as obesity and its related complications and illnesses decline. Wise, targeted policies promoting coverage for a broader range of obesity treatments can help America turn the tide of the obesity crisis. If undertaken carefully and appropriately, these options not only stand to help state residents lead healthier, more productive lives, but can also save money in the long run.

INTRODUCTION

Over 42 percent of Americans have obesity.¹ More than simply a matter of personal appearance or merely needing to “shed a few pounds,” obesity is a serious, chronic medical condition with linkages to many of the nation’s top causes of death, including heart disease, stroke, diabetes, and certain cancers. In fact, obesity and overweight combined are second only to smoking as the leading preventable cause of death in the U.S.² Obesity is associated with a host of maladies and complications that are placing a serious drain on our healthcare system, our economic productivity, our federal and state budgets, and ultimately our nation’s future.

For nearly two decades, both obesity prevalence and its related health complications have been steadily increasing in the United States. From 1999 through 2018, obesity prevalence jumped from 30.5 percent to 42.4 percent in the U.S.³ During that same time period, the prevalence of severe obesity (defined as having a Body Mass Index (BMI) of 35 or higher) nearly *doubled*, from 4.7 percent to 9.2 percent.⁴ In the year 2000, no state in the country had an obesity rate above 25 percent; now, all but three states have crossed that threshold.⁵ Federal data show that as of 2020, 16 states now have adult obesity rates of 35 percent or higher—representing an increase of four states (Delaware, Ohio, Iowa, and Texas) in a single year.⁶ A 2019 study found that, should current trends in obesity rates continue, *fully half* of Americans will have obesity by 2030, while nearly one in four Americans will have severe obesity.⁷ The same study projected that by 2030, state-level obesity prevalence will spike above 50 percent in 29 states, and will not fall below 35 percent in any state.⁸



THE STAGGERING COST OF OBESITY IN AMERICA

Along with the rise in U.S. obesity has come a staggering increase in costs to the nation. Obesity-related national healthcare costs in 2019 were estimated at nearly \$173 billion, while another recent study found that these costs translated to about \$3,500 higher each year for those with obesity compared with those of normal weight.^{9,10} Unsurprisingly, state and federal budgets are feeling the strain. A 2018 study estimated the cost of treating obesity-related illnesses in adults at roughly 8 percent of total US medical expenditures, including private payers (9.21 percent), the federal Medicare program (6.86 percent), and the joint federal-state Medicaid program (8.48 percent).¹¹ And costs are rising rapidly. It is projected the combined medical costs associated with treatment of obesity will increase by \$48-66 billion per year by 2030.¹² Research has also found that obesity is associated with negative labor market outcomes. When the indirect costs of obesity are considered—including negative labor market outcomes like job absenteeism, lost wages, and reduced probability of employment—the total economic costs of obesity in the U.S. were estimated at nearly \$1.4 trillion in 2018. These indirect costs are nearly tenfold the direct healthcare costs of obesity, representing 6.76 percent of the nation’s gross domestic product—roughly \$4,300 a year for every man, woman, and child in America.¹³

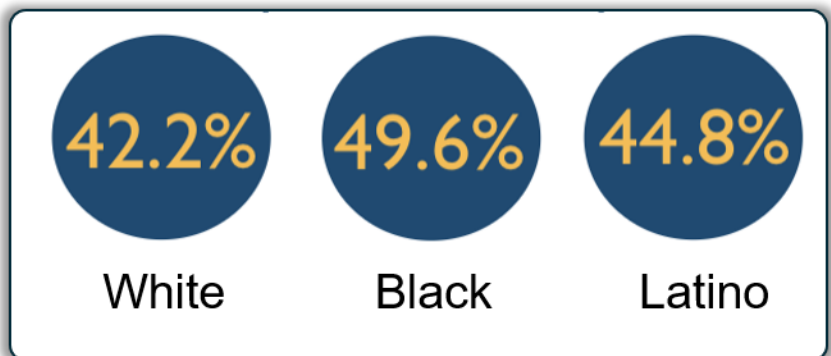
RACIAL AND ETHNIC DISPARITIES IN OBESITY

The available data are also clear that racial and ethnic disparities play a significant role in the obesity epidemic. Today, nearly half of all black people and 57 percent of black women have obesity. In the Latino population, the rate is slightly lower at nearly 45 percent, but is also higher than overall U.S. obesity prevalence.¹⁴ According to federal data, among non-Hispanic black adults, 31 states and the District of Columbia have an obesity prevalence of 35 percent or higher, eight states have an obesity prevalence of 35 percent or higher among Hispanic adults, yet only one state had an obesity prevalence of 35 percent or higher among non-Hispanic white adults.¹⁵ Underlying risks that may help explain disparities in obesity prevalence among non-Hispanic black and Hispanic populations include lower high school graduation rates, higher rates of unemployment, higher levels of food insecurity, greater access to poor quality foods, and less access to convenient places for physical activity.¹⁶

OBESITY AND COVID-19

The COVID-19 pandemic has placed a stark spotlight on the nation’s ongoing obesity crisis. Not only has obesity continued its steady rise during the pandemic, but the disease has placed its own indelible mark on the pandemic’s tragic loss of life.¹⁷ For example, a recent analysis found that individuals with obesity were 46 percent more likely to test positive for, 113 percent more likely to be hospitalized for, and 48 percent more likely to die from COVID-19.¹⁸ Emerging evidence suggests that the pandemic may have also accelerated the obesity epidemic.¹⁹ Factors contributing to increased weight gain and obesity during the pandemic include stress, job loss, excessive screen time, and reduced access to physical recreation during lockdowns. Added to these trends is a significant spike in childhood obesity, which represents a ticking time bomb for the nation’s health. A recent study examined pediatric health records,

National Obesity Statistics Based on Race/ Ethnicity



finding a trend of rapid weight gain among children ages 5 to 11 during the pandemic. Among these children, overweight or obesity increased from 36.2 percent to 45 percent, an 8.8 percent increase.²⁰

TOWARDS A NEW VIEW OF OBESITY

In the past, obesity has been viewed primarily the result of flawed character or a lack of willpower.²¹ This view, still strong today, has perpetuated significant social stigma and shame for people with obesity, deterring millions from seeking the medical help they need. Instead of seeking care rooted in sound medicine, Americans with obesity have often been forced to resort to self-help, turning to unsustainable fad diets, dangerous dietary supplements, and other unproven and potentially harmful approaches. Yet the belief that obesity is solely the result of personal choice or a lack of willpower is clearly false. Lifestyle factors play some role, but research indicates the underlying causes of obesity are complex, multifactorial, and often include factors completely out of the individual's control, such as genetics and socio-economic status.²²

In a recent *Wall Street Journal* editorial, University of Chicago economist and former member of the Council of Economic Advisors Tomas J. Philipson posits two major economic shifts as the primary causes of the obesity crisis: first, technological advancement, which caused Americans' work to become more sedentary; and second, increased agricultural output that greatly reduced the cost of food.²³ Supporting his thesis is the fact that the obesity epidemic is not merely an American phenomenon, but one observed in many other developed nations that have experienced the same shifts.²⁴ As a potential solution, Philipson proposes that public programs like Medicare and Medicaid as well as private insurers should invest in coverage of new AOMs as a means to reverse obesity trends and lower overall healthcare costs.²⁵

Thankfully, a number of key developments are helping to reshape attitudes and willingness to seek medical treatment, representing a potential new era in the fight against obesity. First, in 2013, the American Medical Association (AMA) officially recognized obesity as a chronic disease.²⁶ The CDC defines a chronic disease as a condition lasting one year or more, and that 1) requires ongoing medical attention, 2) imposes limits on activities of daily living, or 3) both.²⁷ While there is still much work to be done to shift attitudes both within and without the healthcare system, this recognition represents a marked shift in the healthcare system's disposition toward obesity, away from the view of obesity as purely a matter of personal choice or character and towards obesity as a treatable disease that the system should work to address.

Second, new and more effective treatments for obesity have recently arisen, including a new generation of anti-obesity medications (AOMs) proven safe and effective in reducing body weight. These new interventions work in concert with other clinically proven behavioral interventions like intensive counseling and surgical interventions, forming a continuum of obesity care (see call-out box below). Many of the newer interventions, unavailable only a decade ago, have only recently begun to be broadly adopted. They are potential game changers for millions of Americans struggling with obesity.

Obesity treatment is a continuum of care, meaning an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care. Evidence shows that, by focusing on helping patients throughout every aspect of care, the chances for long-term success increase exponentially.²⁸ For obesity, the continuum of care starts with behavioral intervention, then moves to pharmacotherapy, and finally bariatric surgery as determined by a patient and their physician.²⁹

Finally, new technologies such as telehealth and smart devices allow the healthcare system to reach patients where they are, improve monitoring and progress tracking, and ultimately improving outcomes. While widespread adoption of these technologies is still relatively new, evidence is mounting that telehealth can be

at least as effective as other treatment modalities across a range of health services.³⁰ When coordinated with face-to-face visits, telehealth has also been shown to be effective in addressing obesity in children and adolescents through reducing traditional barriers to care like distance and transportation.³¹ Other innovations such as wearables, texting, apps, video visits, and AI-based targeted medical interventions also hold the possibility of increasing patient adherence and engagement to achieve lasting change.³²

BARRIERS TO OBESITY CARE

While changing one's lifestyle, including improving diet and physical activity, remains a cornerstone of obesity treatment and should almost always be the first prescription, lifestyle change alone does not always work for everyone. In addition to lifestyle change, there are a number of medical interventions that can help patients achieve lasting obesity control. Like other chronic diseases, obesity treatment requires a continuum of care, including primary and specialist care, AOMs, and surgical interventions. New AOMs in particular are promising, because they can bridge the gap in obesity treatment options between behavioral interventions and more invasive options like bariatric surgery.³³

While these interventions can be highly effective in managing obesity, currently there are numerous obstacles preventing patients receiving them. Barriers to care on the patient side include misinformation, cost concerns, geographical limitations (such as distance to providers), and other environmental and social factors.³⁴ On the other hand, many physicians lack the time to dedicate to obesity treatment as well as the knowledge and training required to effectively treat people living with obesity.³⁵ Finally, insurance coverage for obesity treatment may be dramatically limited (e.g., limited to one visit per year) or even non-existent. Currently there is a patchwork of coverage for the continuum of obesity care treatments across the states. For example, while every state's Essential Health Benefits benchmark plan (which governs ACA-compliant plans in the individual and small group health insurance markets in that state) covers obesity screening and counseling, only 38 states' benchmark plans include coverage for nutritional counseling, 23 states cover bariatric surgery, and only two cover AOMs.³⁶

HOW TO USE THIS TOOLKIT

State policymakers wishing to address barriers to effective obesity treatment have a range of policy options. This toolkit sets forth a number of targeted options that legislators, governors, regulators, and other state leaders may employ to expand coverage for obesity treatment in a cost-effective and fiscally responsible manner. These options include making updates to ACA Essential Health Benefits (EHB) benchmark plans, expanding coverage in Medicaid, applying for state waivers from federal requirements in the ACA private insurance markets, and broadening coverage in state employee health plans.

States may pursue one or more of these options in tandem, and should adapt the toolkit's options to suit the unique circumstances of their residents and markets. For example, states pursuing reform of their state employee health benefit plans may wish to include obesity coverage as part of an overall strategy to lower costs and improve employee health along with other measures to increase value. The options are not intended to create an exhaustive list of potential ways to increase coverage for obesity treatment, but can form the basis of additional reforms. Finally, depending on the state, some options are likely to be administrative in nature while others may require the enactment of legislation. Each option identifies potential state policymakers and officials who may take action.

While state policymakers grapple with runaway healthcare costs in state employee plans and the threat of burgeoning costs of entitlement programs such as Medicaid crowding out other budgetary priorities like

education and transportation, the cost of inaction on the obesity crisis grows every day and can no longer be ignored.

In fact, greater coverage for effective obesity treatments can actually serve to lower healthcare costs and increase economic efficiency as obesity and its related complications and illnesses are reversed. For example, one study pegged the savings in annual medical care costs alone from a 5 percent weight loss for those with a BMI of 40 or more at over \$2,000 per year, while another study found that the fiscal impact of 100 percent uptake of AOMs would actually reduce Medicare and Medicaid spending and increase tax revenue over time.^{37,38} As this evidence suggests, wise, targeted policies promoting coverage for a broader range of obesity treatments can help America turn the tide of the obesity crisis. If undertaken carefully and appropriately, the options contained in this toolkit can not only help state residents lead healthier, more productive lives, but can also save money in the long run.

OPTIONS TO BROADEN OBESITY COVERAGE

STATE EMPLOYEE HEALTH BENEFITS

BACKGROUND



Combined, state and local governments employed roughly 16.2 million full-time equivalent employees in 2014.³⁹ This number includes approximately 6.6 million workers in elementary and secondary education and 2.1 million workers in higher education.⁴⁰ In half of states, local government employees, including schoolteachers and college employees, participate in the state employee health plan. Among state and local government workers, 89 percent received an offer of health coverage, with a take-up rate of 88 percent.⁴¹

State and local employer contributions to public employee health insurance represent the second-largest cost driver for state health care expenditures, second only to Medicaid.⁴² According to a 2014 report, states and their employees spent \$30.7 billion on insurance premiums in 2013, of which states paid nearly 82 percent of the total.⁴³ State health plans are generally very rich in benefits, with plans covering an average of 92 percent of employee health care costs.⁴⁴ In addition, most states provide some coverage for their retired state employees as well. A report found that states spent roughly \$18.4 billion on retiree benefits beyond pensions in 2013.⁴⁵ Due to the rising costs of providing coverage and their huge impact on state budgets, not to mention increasing co-pays, deductibles, and other out-of-pocket costs for state employers, State policymakers have become increasingly engaged in reform and oversight of state employee health plans.

States have significant latitude over how they choose to finance and operate their employee health plans. For example, most states (29) self-fund their employee plans, contracting with a third-party administrator to process claims and provide other services.⁴⁶ Because self-funded plans are free from many state and federal requirements, state policymakers can pursue innovative strategies for controlling costs and maintaining or increasing plan quality. Not only that, but because state governments are often the state's largest employers, state employee plans provide a useful proving ground to test and scale up innovative reforms.

PROBLEM



Like many other segments of the nation's workforce, the state employee workforce is aging; higher obesity rates have come with it.⁴⁷ Employment in either public administration or the community and social service sector is associated with higher obesity prevalence.⁴⁸ As the costs for obesity continue to rise in the U.S., so will the impact of the disease on state employee benefit plans. In addition, as their employees reach retirement age, states will face increasing pressure to cut costs.

Yet, while most state employee health plans cover screening and nutritional counseling, today less than half (17) cover AOMs.⁴⁹ States should explore expanding

coverage for the full range of obesity treatments, including AOMs, as a means to reducing long-term health care expenditures and improving workforce productivity.

OPTION



State Employee Benefits: Include Comprehensive Obesity Coverage in Employee Benefits

State policymakers should consider expanding coverage for the full range of obesity treatments, including AOMs. To ensure fiscal sustainability while expanding coverage, policymakers should also consider cost containment measures such as prior authorization and other utilization management techniques.

In analyzing whether to expand coverage for obesity treatments, states should consider long-term savings as well as short-term costs. For example, a recent analysis found that the fiscal impact of 100 percent uptake of AOMs would actually reduce Medicare and Medicaid spending and increase tax revenue over the study's evaluation period.⁵⁰ Other economists and experts have come to a similar conclusion, finding coverage for obesity treatment will lead to lower costs for the population over time.⁵¹

WHO CAN ACT?

State legislators

Governors

State Benefit Directors



ESSENTIAL HEALTH BENEFITS

BACKGROUND



Federal law requires nearly all individual and small group market health insurance plans to cover Essential Health Benefits (EHB).⁵² Under the Affordable Care Act (ACA), EHBs comprise ten statutory benefit categories ranging from inpatient and outpatient hospital services and prescription drugs, to mental health and substance abuse treatment and preventive services (see table below).⁵³ However, rather than dictating a single set of benefits or a single benefit design for the entire country, federal regulations permit states to select a “benchmark plan” from among a set of available options.⁵⁴ The EHB benchmark plan determines the scope of benefits that many individuals and employees of small businesses will receive in the private market in each state. Most states initially chose EHB benchmark plans based on the most popular small group plan that was available in 2013.

ESSENTIAL HEALTH BENEFIT STATUTORY BENEFIT CATEGORIES:	
Ambulatory Patient Services	Prescription Drugs
Emergency Services	Rehabilitative And Habilitative Services and Devices
Hospitalization	Laboratory Services
Maternity And Newborn Care	Preventive And Wellness Services and Chronic Disease
Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment	Pediatric Services, Including Oral and Vision Care

EHB benchmark plans should be updated over time to reflect changes in the practice of medicine, the availability of new therapies and services, and the needs of the population. Recent changes in federal regulations have made it easier for states to update and make needed changes to their EHB benchmark plans.

PROBLEM



Most states initially chose a small group plan available in 2013 as their EHB benchmark plan. And while a number of states have updated their benchmarks over the years, most were chosen before obesity was designated as a chronic condition or before the availability of new, more effective treatments such as AOMs. Therefore, many benchmarks entirely exclude or greatly limit coverage for these treatments. For example, Louisiana’s benchmark plan contains a blanket exclusion of all obesity care services.⁵⁵ Other benchmark plans include some coverage for obesity treatments, but may contain limitations or exclusions that discourage many patients from seeking or obtaining care. Such limitations or exclusions include, but are not limited to:

- Requiring patients to participate in “one last diet” or undergo non-pharmaceutical/non-surgical treatment before being able to access treatments beyond behavioral change therapy; these treatment periods can last six-months or more, and may include very demanding reporting requirements
- Extensive and overly burdensome pre-authorization processes
- Lifetime limits on treatment (e.g., one surgery per lifetime, one year of medication only)
- Specific co-morbidity requirements (e.g., a patient must have poorly controlled hypertension while on already on three anti-hypertensive medications)
- Caps on the number of visits (e.g., one dietician visit per year)
- Higher than typical co-pays or deductibles

Today, nearly half of states (23) cover bariatric services in their benchmarks. But other obesity treatment options like AOMs are not covered at all; today, only two states’ benchmark plans cover AOMs. And while intensive counseling is required to be covered without cost sharing as a preventive service under federal law, this requirement is sometimes ignored or dramatically limited (e.g., one visit per year as

opposed to multiple visits as required under the federal preventive services regulations).

Finally, whether a patient's health insurance covers obesity treatment can be difficult to decipher, since such coverage may be scattered across wellness benefits, employee assistance programs, or other benefit areas. As a result of these and other barriers, most studies have found that only 10 percent of people with obesity actually get help from medical professionals, and even fewer still (roughly 2 percent) utilize AOMs.⁵⁶

OPTIONS



EHB Option 1: Amend the state's EHB benchmark plan to include increased coverage for obesity treatments

Starting in 2020, the federal government provided new options for states to make adjustments to their existing EHB benchmark plans.⁵⁷ Several states have already used this flexibility to make changes to their EHB benchmark plans by, for example:⁵⁸

Requiring insurers to cover specific services or items, such as opioid treatments

- Removing coverage for ineffective or low-value treatments⁵⁹
- Adding a new required drug category to the EHB benchmark plan formulary (e.g., adding a new drug category to the formulary and requiring insurers to cover at least one drug in this category)

For a state's benchmark change to receive approval from the Centers for Medicare & Medicaid Services (CMS), the state must submit an application by early May, two years before the effective date of the new EHB benchmark plan.⁶⁰ The application package should include a description of the change, a spreadsheet containing the revisions, and actuarial certification and report studies estimating the change's impact on utilization and premiums.

In order to be approved, the EHB adjustments must meet two actuarial requirements:

- Typicality test:** The new EHB benchmark plan must be equal to or greater than the scope of benefits provided under a typical employer plan
- Generosity test:** The new EHB benchmark plan does not exceed the generosity of the most generous among the plans listed at Section 156.111(b)(2)(ii)⁶¹

If a state is only making targeted changes to, for example, add AOM coverage to its benchmark plan, then meeting the typicality test is relatively simple. This is because the resulting benchmark plan will be greater than the scope of benefits provided in the existing benchmark plan.

However, in order to meet the generosity test, the cost of any new benefit to be included in the benchmark plan cannot have a material impact on premium rates. This means that any premium impact must be less than a 1 percent increase. This requirement helps to ensure that EHB changes do not significantly reduce the affordability of coverage and promotes good stewardship of federal premium tax credit dollars.

STATES OPTIONS FOR EHB BENCHMARK PLANS FOR PLAN YEARS 2020 AND BEYOND*

Option 1: Select the EHB-benchmark plan that another State used for the 2017 plan year.

Option 2: Replace one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.

Option 3: Otherwise select a set of benefits that would become the State's EHB-benchmark plan.

**Note that because no state's EHB benchmark plan included coverage for AOMs in 2017, states wishing to update their benchmark plans to include AOM coverage should use Option 3.*

While states may amend their EHB benchmarks to include coverage of new treatments, states also have the ability to incorporate appropriate utilization management in order to manage costs associated with covering new or existing treatments, including:

- Removing treatments that are unnecessary or not cost effective from the EHB benchmark to partially or wholly offset the cost of additional benefits
- Incorporating treatment limitations or guidance along with coverage of new treatments to manage cost and utilization, including preauthorization, step therapy, or other utilization management techniques

This ability can be important in situations where there are cost overrun concerns, or to ensure that a state's EHB benchmark plan amendment meets the generosity test.

“[W]e are very supportive of states making improvements to the scope of EHB in their markets and encourage state utilization of the methods available...” – Center for Consumer Information and Insurance Oversight (CCIIO), CMS, 2023 Notice of Benefit and Payment Parameters

As an example, states wishing to expand coverage for behavioral therapy for obesity could consider including performance metrics, such as a metric requiring participants to meet targets for weight loss by certain deadlines (e.g., participants must meet specified, reasonable weight loss targets within certain period of time) to continue coverage of the treatment. States have the ability to include such guidelines in their EHB benchmark changes and should reflect any expected savings in their actuarial reports.

So far, two states (New Mexico and North Carolina) have changed their EHB benchmark plans to specifically cover AOMs. New Mexico's benchmark “includes coverage for drugs and programs if medically necessary for morbid [severe] obesity and obesity.”⁶² North Carolina covers drugs “approved by the U.S. Food and Drug Administration (FDA) for short-term and long-term use in the treatment of clinical obesity.”⁶³ New Mexico successfully updated their EHB-benchmark plan in 2020. In submitting its successful application to CMS, the state relied on a study finding that expanding weight loss drug coverage to patients with obesity, rather than those with morbid obesity alone, would not materially increase premiums.⁶⁴

EHB Option 2: Ensure compliance with existing EHB benchmark and other requirements

While the ACA and other recently enacted federal laws such as the No Surprises Act set minimum federal standards in health insurance markets, states are still entrusted as the primary overseers of health insurance.⁶⁵ Using their traditional oversight and enforcement authority, states have the ability to ensure compliance with EHB benchmark standards and other requirements.

As discussed above, even if a state's EHB benchmark plan includes coverage for a particular obesity treatment or treatments, in practice the plans available in the market sometimes include insufficient or inappropriate coverage for required treatments, erecting a barrier to obesity care. The same holds true for preventive services rules and other state and federal requirements applicable to private insurance coverage. State regulators should ensure compliance with benchmark requirements.

Applicable to: individual market, small group market, large group fully insured market, self-insured large group market

For example, even though United States Preventive Services Task Force guidelines require plan sponsors and insurers in the individual and group markets to cover, without cost sharing, “intensive” behavioral interventions for adults with BMI of 30 or greater (including coverage of multiple sessions over a period of one to two years), in practice some plans may limit the number of visits to a maximum of only one per year.⁶⁶ State policymakers can take steps to improve insurer compliance, such as working with their state departments of insurance to review offerings in the state subject to EHB requirements to ensure compliance with existing rules in this area.

Applicable to: individual market, small group market, large group fully insured market.

If a state's benchmark plan already includes coverage for obesity treatment, the state may conduct reviews of insurer compliance with EHB benchmark requirements specifically focused on obesity care coverage. CMS periodically conducts similar reviews and has in the past made grant funds available to states to conduct market scans for this and other purposes.⁶⁷ States can also review insurer provider networks and work with insurers to include specialists and services targeted for obesity and can review existing prescription drug formularies to ensure sufficient coverage of AOMs.⁶⁸

States can ensure that any covered obesity care benefits in private insurance plans are clearly and concisely explained in consumer-facing

Applicable to: individual market, small group market, large group fully insured market.

coverage documents such as Summaries of Benefits and Coverage (SBCs).⁶⁹

WHO CAN ACT?

State legislators

Governors

Departments of Insurance



SECTION 1332 STATE INNOVATION WAIVERS

BACKGROUND



Section 1332 State Innovation Waivers allow states to waive part or all of certain ACA provisions to implement innovative programs for increasing access to quality health care. States may apply for State Innovation Waivers (otherwise known as section 1332 waivers) to modify many of the ACA's central coverage provisions, including the health insurance exchanges, related subsidies, the individual and employer mandates, and rules regarding which plans may be offered in the individual market. These provisions may be waived as part of the state's plan under the waiver to implement innovative programs that best fit the state's unique healthcare needs. The following table describes the specific ACA statutory provisions that may be waived.

SPECIFIC ACA PROVISIONS THAT CAN BE WAIVED UNDER SECTION 1332

Part I of Subtitle D of Title I	Sections 1301-1304: QHP and EHB requirements; requirements for QHP issuers; insurance related definitions
Part II of Subtitle D of Title I	Sections 1311-1313: Exchange requirements
Subpart A of Part I of Subtitle E of Title I	Section 1402: Cost-sharing reductions
Internal Revenue Code of 1986	Sections 36B, 4980H and 5000A: Premium tax credits; large employer mandate requirement; individual mandate requirement

The federal government may grant a state’s waiver if the waiver meets four statutory requirements (or “guardrails”). Namely, the section 1332 waiver must:

- Provide coverage that is at least as comprehensive as the coverage as would be provided absent the waiver (comprehensiveness guardrail)
- Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as coverage absent the waiver (affordability guardrail)
- Provide coverage to at least a comparable number of residents as would be provided absent the waiver (coverage guardrail)
- Not increase the federal deficit (deficit neutrality guardrail)

Prior to submitting a section 1332 waiver, states must go through the process of enacting a law or revising an existing state law providing authority to carry out the waiver; in some instances, existing state legislative authority may suffice. Next, states must provide public notice of the intent to submit a waiver application and must expose the draft waiver application for public comment, including providing a written public comment period and holding public hearings.

To be deemed complete, the state’s application must include information on the state’s authorizing legislation, a description of the state plan under the waiver (including the specific ACA provisions to be waived), and an actuarial analysis and certification demonstrating that the waiver meets the statutory guardrails. Following submission, state waiver applications are made available on the CMS website for public review and comment. Following the determination of completeness, a final decision on the waiver must be provided within 180 days.

If a section 1332 waiver results in a reduction of federal spending on premium tax credits, small business health insurance tax credits, or cost-sharing reductions, states can receive the difference in “pass-through funding” to support the state’s waiver plan. In 2022, the federal government awarded states over \$1.87 billion in pass-through payments to carry out their section 1332 waivers.⁷⁰ Since 2017, the federal government has approved 18 section 1332 waivers. Sixteen of the approved waiver applications are for state reinsurance programs aimed at improving affordability of coverage.

Once approved, waivers can last for a term of up to five years and may be renewed. If the waiver involves pass-through funding, the federal government will calculate the amount of pass-through funding and distribute it to the state each year for use in carrying out the waiver.

PROBLEM



In deciding whether to cover a new drug or therapy and determining how to reflect the cost of such coverage in the premiums they charge, insurers are often faced with having limited data on a treatment’s long-term effectiveness or its potential impact on improving health and lowering costs. The challenges in capturing adequate data on cost and quality associated with a new therapy can make it more difficult to demonstrate the potential benefits and cost savings of both new and existing interventions. As a result, insurer pricing actuaries may react conservatively by, in some instances, assuming greater utilization of a new drug or therapy than may be warranted. In the case of obesity treatments however, underutilization is an ongoing challenge. For example, in considering whether to cover new AOMs on the market, insurers might look at the low take-up rates of obesity drugs among veterans participating in a weight loss program conducted by the Department of Veterans

Affairs, which found that only 1 percent of the over 150,000 veterans who enrolled were prescribed an AOM within the first year of participation.⁷¹

Focusing in on the individual health insurance market, another key issue is that, even if insurance company actuaries possess solid data on likely utilization and the cost savings associated with adopting a new or existing therapy and decide to cover it, the insurers themselves often do not share in the savings resulting from improved health and lower health care costs. This is because enrollees in the individual health insurance market frequently shift plans from year to year due to changing jobs, experiencing a change in income, or other life events. This frequent enrollee “churn” in the health insurance market gives rise to a so-called “wrong pocket problem,” whereby an insurer makes an investment in or bears the cost of covering a new therapy that will ultimately generate savings for another insurer down the road. While this issue is not as pronounced in the large group health insurance market, it can slow adoption of new interventions or strategies demonstrating the potential for long-term cost savings.

While long-term solutions for these problems are needed, such as improving the availability of solid data on cost and quality of healthcare services, there are steps states can take now to minimize pricing uncertainty for coverage of new or existing obesity treatments and foster a health insurance market that makes it more likely that insurers will incorporate such new treatments into coverage.

OPTIONS



Section 1332 Waiver Option 1: Establish a state reinsurance program to lay the groundwork for improving coverage of obesity treatment

Reinsurance is a reimbursement system that protects insurers from very high claims. It usually involves a third-party paying part of an insurance company’s claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable. States can apply for section 1332 waivers to establish their own reinsurance programs. Section 1332 waivers offer a mechanism for the state to recapture savings from federal programs and use them to benefit the state’s residents: as discussed above, if a state’s section 1332 waiver plan is projected to reduce federal costs, then the state may be able to receive federal “pass-through” payments equal to the difference.

As of plan year 2021, 14 states were operating state-based reinsurance programs established through Section 1332 waivers. These waivers have permitted states to design and implement different reinsurance models targeted to the needs of their state. State reinsurance programs have contributed to meaningful reductions in premiums. Between plan year 2018 and plan year 2021, states with reinsurance waivers reduced their statewide average second-lowest-cost silver plan premiums between 3.75 percent and 41 percent compared to premiums absent the waiver.⁷²

In addition to placing downward pressure on premiums, reinsurance programs can make insurers and plan actuaries more comfortable about incorporating new therapies into coverage by reducing some of the risk involved. Analysis of CMS data has shown that not only do reinsurance programs result in lower premiums, but they are also associated with increased insurer competition in those markets.⁷³ The more competition in a market, the more likely insurers will be willing to adopt new therapies or broaden coverage in order to attract enrollees. Thus, reinsurance waivers can help to create a market environment that is more conducive to expanding coverage for obesity treatment.

A “hybrid reinsurance-EHB waiver” can combine coverage for obesity treatment with reinsurance, essentially creating a low-risk pathway for states to expand this coverage.

States wishing to go further to provide coverage for obesity treatments can explore even more innovative approaches through section 1332 waivers. For instance, states could directly combine a reinsurance waiver with increased coverage for comprehensive obesity care or specific treatments such as AOMs.

Under a “hybrid reinsurance-EHB waiver” approach, the state would first waive the definition of EHB to require insurers to incorporate obesity coverage into the benchmark. On its own, waiving EHB to broaden coverage of a health care service or add a new benefit could violate the deficit neutrality guardrail, because it would likely lead to increased federal outlays for premium tax credits. But the next step would be to combine the EHB waiver with a state reinsurance program that lowers premiums across the board in the individual market. This reduces federal outlays, resulting in pass-through funding for the state to carry out its waiver, including incorporating obesity coverage. In the third step, the state could then use a portion of the pass-through funds to offset any higher costs of covering obesity treatments. In other words, a portion of the pass-through funding from a reinsurance program are redirected to offset any premium increases attributable to covering the new therapies—creating a low-risk pathway for expanding coverage for obesity treatment while still lowering overall premiums in the market. States with existing reinsurance programs under Section 1332 waivers may simply amend their existing waiver to include coverage for obesity treatment as part of the EHB benchmark plans.

Section 1332 Waiver Option 2: Create specialized plans designed to improve care and access for individuals with obesity

Obesity is a known risk factor for many costly chronic conditions, including diabetes, heart disease, and some cancers. In light of obesity’s significant impact on health and the healthcare system, an innovative approach for states wishing to expand coverage for effective obesity treatments while still managing costs is to craft a waiver authorizing specialized individual market plans that are specifically designed for people with obesity. Waivers of this kind mirror the policy goals of the Patient-Centered Medical Homes authorized by section 1945 of the ACA.

Under this option, states would waive provisions of the ACA to create “state complex care plans,” which are state-authorized coverage options made available to individual market enrollees with specific chronic conditions or complex care needs. Complex care plans could include enhanced benefits targeted for people with obesity.⁷⁴ Enrollment would be voluntary; individual market enrollees would be able to select the plans instead of a traditional Qualified Health Plan (QHP) based on customized plan features such as lower cost-sharing for obesity treatment (such as for AOMs) and additional benefits (such as bariatric surgery coverage).

States have a range of levers within this option. For example, similar to the hybrid reinsurance-EHB waiver discussed above, states could waive the definition of EHB for these specific plans to be offered in the individual market. Waiving EHB would allow the state greater flexibility to offer enhanced benefits (for example, providing for reduced or even zero cost sharing for obesity treatments) by limiting other EHBs to offset the additional cost. Another option would be for states to offer an additional subsidy targeted exclusively to those with obesity or severe obesity to reduce those

individuals' premiums and/or out-of-pocket costs for obesity treatment. A third, even more novel and innovative approach would be to waive the ACA's single risk pool requirement to create a state-authorized program limited to those with complex care needs such as obesity or severe obesity. Such a program, which would operate alongside the individual market risk pool, could be administered by a state or a third-party administrator. There are several advantages to such an approach. First because the program would not be considered an insurance product, it would permit states to limit enrollment to those with complex care needs such as obesity/severe obesity and would also enable states to pursue cost-containment opportunities similar to those used by self-funded large employers. Second, by removing higher-risk individuals from the risk pool, it would reduce premiums in the individual market and generate pass-through through funds similar to reinsurance programs. These funds could be used to implement a state subsidy structure to provide reduced cost-sharing and other benefits to program participants. Finally, under this approach, receipt of enhanced benefits could be conditioned on continued active participation and adherence or meetings specified weight-loss targets.

WHO CAN ACT?

State legislators

Governors

Departments of Insurance



MEDICAID

BACKGROUND



Medicaid is a means-tested entitlement program jointly administered by the states and the federal government that finances the delivery of primary and acute medical services as well as long-term services and supports (LTSS) to eligible low-income people. States can design their Medicaid plans within the flexibility allowed by the Medicaid statute and receive federal matching funds to partially offset the cost of the program. Federal matching payments vary by state and sometimes by type of service. The Social Security Act authorizes several waivers (e.g., section 1115) and demonstration authorities that allow states to operate their Medicaid programs outside of federal rules. Due to this flexibility, there is substantial variation among the states in terms of who is eligible for Medicaid, what benefits are covered, and how much providers are paid. Each state's Medicaid program is governed by a State Plan, which is the agreement between the state and federal government documenting how the program will be administered.

The majority of states choose to provide Medicaid benefits through Medicaid managed care organizations (MCOs) rather than administering the benefit themselves. In states where the Medicaid benefit is administered through MCOs, those organizations must generally adhere to the same prescription drug coverage and prior utilization standards that are applicable to states.

PROBLEM

Lower-income U.S. households tend to have higher rates of obesity. In 2015, over 35 percent of the population had obesity in states where median household incomes were below \$45,000 per year, while obesity was less than 25 percent in state populations where median incomes were above \$65,000. Among children, low-



income children with a sedentary lifestyle had 3.7 times higher odds of obesity than their more active, affluent counterparts.⁷⁵ And while nearly all state Medicaid programs cover bariatric surgery and the number of states covering obesity treatment has increased, only 21 states currently cover nutritional counseling and only 16 states cover AOMs.⁷⁶

OPTIONS



Medicaid Option 1: Include comprehensive obesity treatment in Medicaid through State Plan Amendments

States should consider including comprehensive obesity treatment in Medicaid. When a state is planning to make a change to its program policies or operational approach, states must send state plan amendments (SPAs) to CMS for review and approval. States can also submit SPAs to request permissible program changes, make corrections, or update their state plan with new information. The SPA should include a description of the benefit, the providers to be included, the amount of the benefit, the duration and scope of the benefit, as well as the reimbursement methodology. SPAs submitted to CMS usually receive a response within a few months. In states wishing to add AOMs to their Medicaid formularies, the process may be as simple as checking a box on a form.⁷⁷ Once new coverage for a benefit is added to Medicaid, states will receive federal matching funds for the cost.

Like the other options discussed in this toolkit, states wishing to control costs have flexibility within Medicaid to do so. For example, states may impose prior authorization or other utilization management strategies to limit costs.

Medicaid Option 2: Include comprehensive obesity treatment in Medicaid through Medicaid Managed Care

States increasingly choose to provide their Medicaid benefits through Medicaid managed care organizations (MCOs) rather than administer the benefit themselves. The majority of states contract with MCOs, and this is the dominant delivery system in Medicaid.⁷⁸

In states where the Medicaid benefit is administered through MCOs, those organizations must generally adhere to the same benefits, prescription drug coverage, and prior utilization standards that are applicable to states.⁷⁹ If a state elects to cover AOMs, it can require its MCOs to do so.⁸⁰ If the state does not require its MCOs to cover AOMs and the MCOs decline to cover such drugs, MCO enrollees must be able to seek coverage of such drugs from the state's own fee-for-service program.⁸¹

WHO CAN ACT?

State legislators

Governors

State Medicaid Directors



ENDNOTES

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⁴⁹ See endnote 35, supra.

⁵⁰ See endnote 38, supra.

⁵¹ See endnote 22, supra.

⁵² Since 2011, each state has been required to select an EHB benchmark, which will serve as the basis of the benefits package offered to those in the Exchange, Basic Health Plans, and non-grandfathered plans sold in the small group and individual markets. This is similar to the Medicaid benchmark plans, which is discussed in more detail below.

⁵³ These benefits do not apply to the large group fully insured market or self-insured market. They do, however, apply to the annual/lifetime bans applicable to these markets, meaning to the extent a plan in one of these markets covers EHB, they cannot impose annual/lifetime limits on these benefits.

⁵⁴ See 45 CFR 156.100, et seq.

⁵⁵ From Louisiana’s state benchmark plan: “Regardless of medical necessity, benefits are not available for any of the following, except as specifically provided under this Benefit Plan: a. weight reduction programs; b. removal of excess fat or skin, or services at a health spa or similar facility; or c. obesity or morbid obesity.”

⁵⁶ STOP Obesity Alliance, “Obesity Treatment Coverage,” 2021, <https://stop.publichealth.gwu.edu>.

⁵⁷ Options include selecting another state’s benchmark plan; replacing one or more EHB categories with the same category or categories of EHB from another state’s benchmark plan; or selecting its own new set of benefits that would be included in the state’s benchmark plan.

⁵⁸ According to CMS, six states (Illinois, South Dakota, Michigan, New Mexico, Oregon, and Colorado) have used this flexibility to make adjustments to their benchmark plans. See <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>.

⁵⁹ Note that that EHB benchmark plan represents a floor for coverage; insurers may cover services beyond EHB, but any additional services covered above EHB would not be eligible for premium tax credits.

⁶⁰ For example, states must submit their applications by May 3, 2023 for plan year 2025 and by May 4, 2024 for plan year 2026.

⁶¹ See 45 CFR section 156.111(b)(2)(ii) Not exceed the generosity of the most generous among a set of comparison plans, including: (A) The State’s EHB-benchmark plan used for the 2017 plan year, and (B) Any of the State’s base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110.

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⁶⁶ Most of the intensive behavioral weight loss interventions considered by the USPSTF lasted for 1 to 2 years, and the majority had 12 or more sessions in the first year. See USPSTF, “A & B Recommendations: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults”

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⁷² See CMS, “Section 1332 State Relief and Empowerment Waiver Concepts: Risk Stabilization Strategies Waiver Concept,” July 5, 2019 <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SCCP-Blue-Paper.pdf>.

⁷³ See CMS, “Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability,” 2020, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf>.

⁷⁴ Id.

⁷⁵ Singh, Kogan, Van Dyck, Siahpush, “Racial/Ethnic, Socioeconomic, and Behavioral Determinants of Childhood and Adolescent Obesity in the United States: Analyzing Independent and Joint Associations,” *Annals of Epidemiology*, Vol. 18, Issue 9, 2008, Pages 682-695, <https://doi.org/10.1016/j.annepidem.2008.05.001>.

⁷⁶ Jennah, Hild, Gallagher, Dietz, “Coverage for Obesity Prevention and Treatment Services: Analysis of Medicaid and State Employee Health Insurance Programs” *Obesity*, Vol. 26, Issue 12, November 14, 2018, <https://doi.org/10.1002/oby.22307>.

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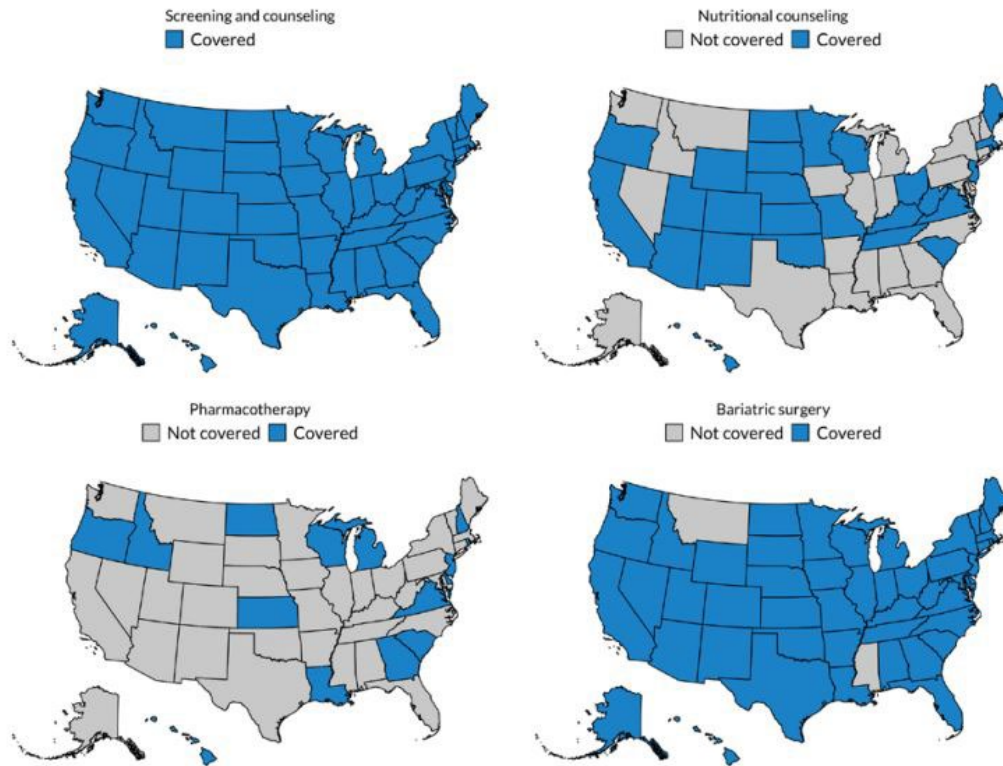
⁷⁹ See 2 CFR section 438.3(s).

⁸⁰ “Nothing in this final rule prevents states or managed care plans from either restricting coverage or covering in full the drugs listed at section 1927(d)(2) of the Act, including agents when used for weight loss (see section 1927(d)(2)(A) of the Act). However, if a state elects to provide coverage of one of the agents listed at section 1927(d) of the Act and include such drugs under the managed care contract, the managed care plans must provide coverage consistent with the state’s approved state plan for such drugs.” 81 Fed. Reg. at 27554.

⁸¹ Id.

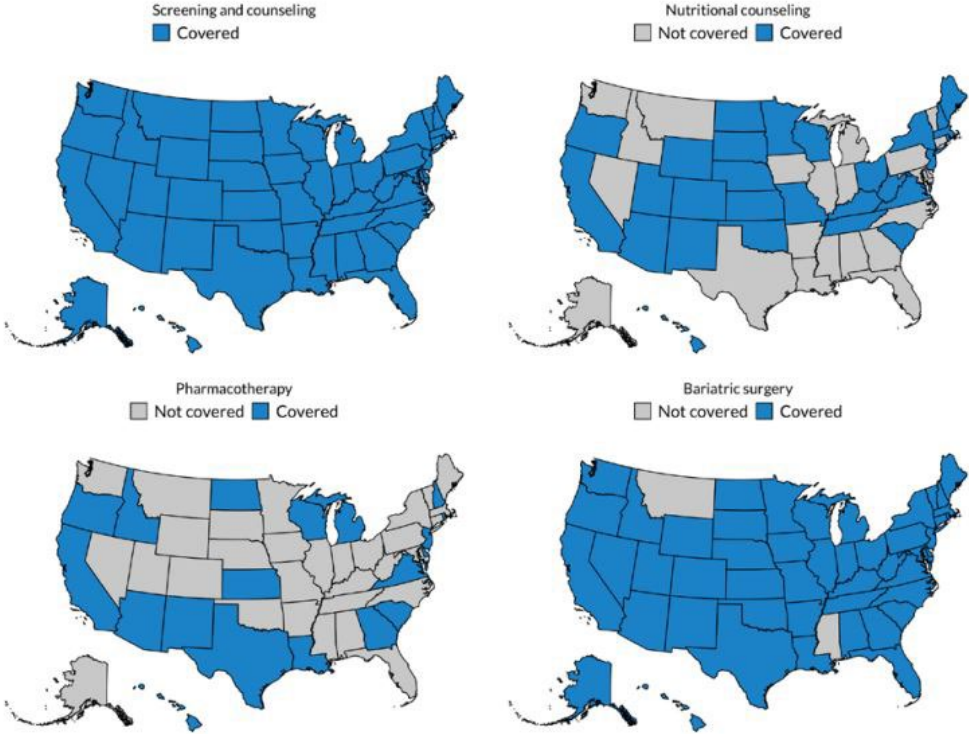
APPENDIX

State-Level Medicaid Fee-for-Service Coverage of Obesity Treatments, 2016-17



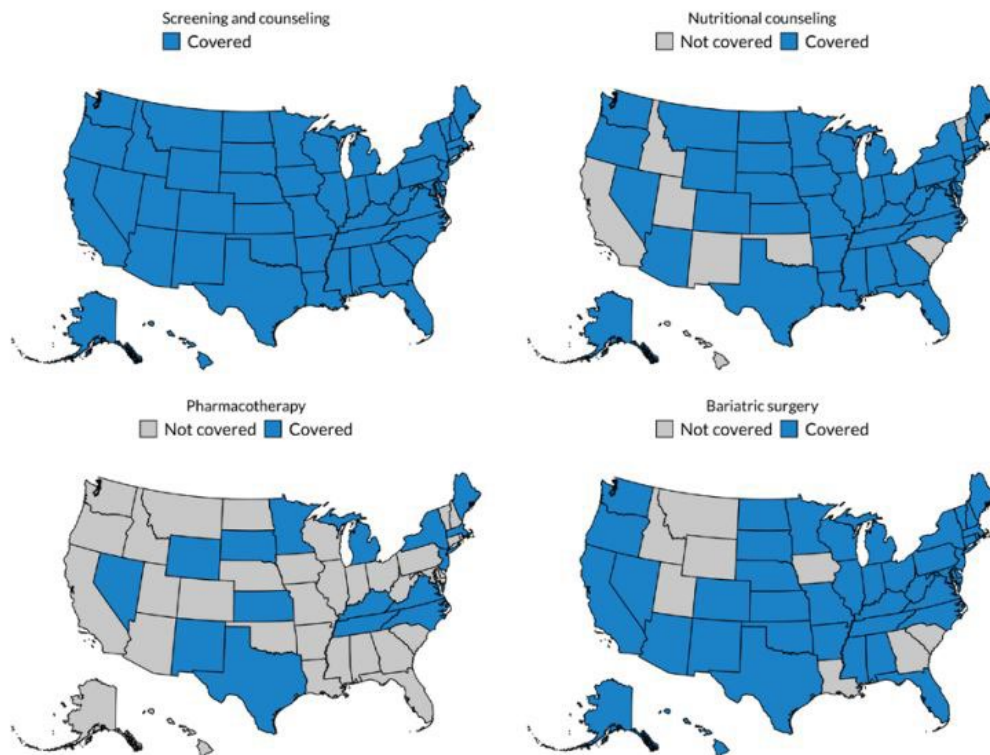
Source: Waidmann, Waxman, Pancini, Gupta, Tabb, "Obesity across America: Geographic Variation in Disease Prevalence and Treatment options." Urban Institute. February 17, 2022. <http://www.urban.org/research/publication/obesity-across-america>.

State-Level Medicaid Managed-Care Coverage of Obesity Treatments, 2016-17



Source: Waidmann, Waxman, Pancini, Gupta, Tabb, "Obesity across America: Geographic Variation in Disease Prevalence and Treatment options." Urban Institute. February 17, 2022. <http://www.urban.org/research/publication/obesity-across-america>.

State-Level Employee Health Plan Coverage of Obesity Treatments, 2020–21



Source: Waidmann, Waxman, Pancini, Gupta, Tabb, “Obesity across America: Geographic Variation in Disease Prevalence and Treatment options.” Urban Institute. February 17, 2022. <http://www.urban.org/research/publication/obesity-across-america>.

Notes: Coverage for nutritional counseling was undetermined for California, Hawaii, New Mexico, and Oklahoma. Coverage for pharmacotherapy was undetermined for Illinois, Missouri, Montana, North Dakota, Oklahoma, Oregon, and Vermont. Coverage for bariatric surgery was undetermined for Iowa, Montana, and Wyoming. Treatments for which coverage was undetermined were coded as "not covered." Undetermined coverage means information was unavailable or conflicting information was found in separate documents.

