Obesity Treatment Landscape: Seeking Care for Obesity

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Obesity Action Coalition (OAC)

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Objectives

- Identify who seeks care for obesity
- Describe the current state of access to care for obesity treatments
- Assess the current barriers to care and what drives such barriers
- Identify potential initiatives to improve access

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Seeking Obesity Care

Who seeks care for Obesity?

- Individuals actually seeking comprehensive medical care for obesity is relatively rare. Most estimates are less than 10% of people eligible seek such care. Many don't publicly share seeking care.
- Societal pressures, bias and lack of understanding about obesity likely contribute to this. This is made more complicated by a healthcare system that seems to spend more time stigmatizing people with obesity then trying to improve their health.
- Unfortunately, short-term fixes, snake oil and other non-evidence based therapies are too prevalent and often lead to people with obesity either weight cycling or facing worsening weight and health issues.
- Comprehensive obesity care utilization is modest at best even when new obesity care is added by insurers/payors.

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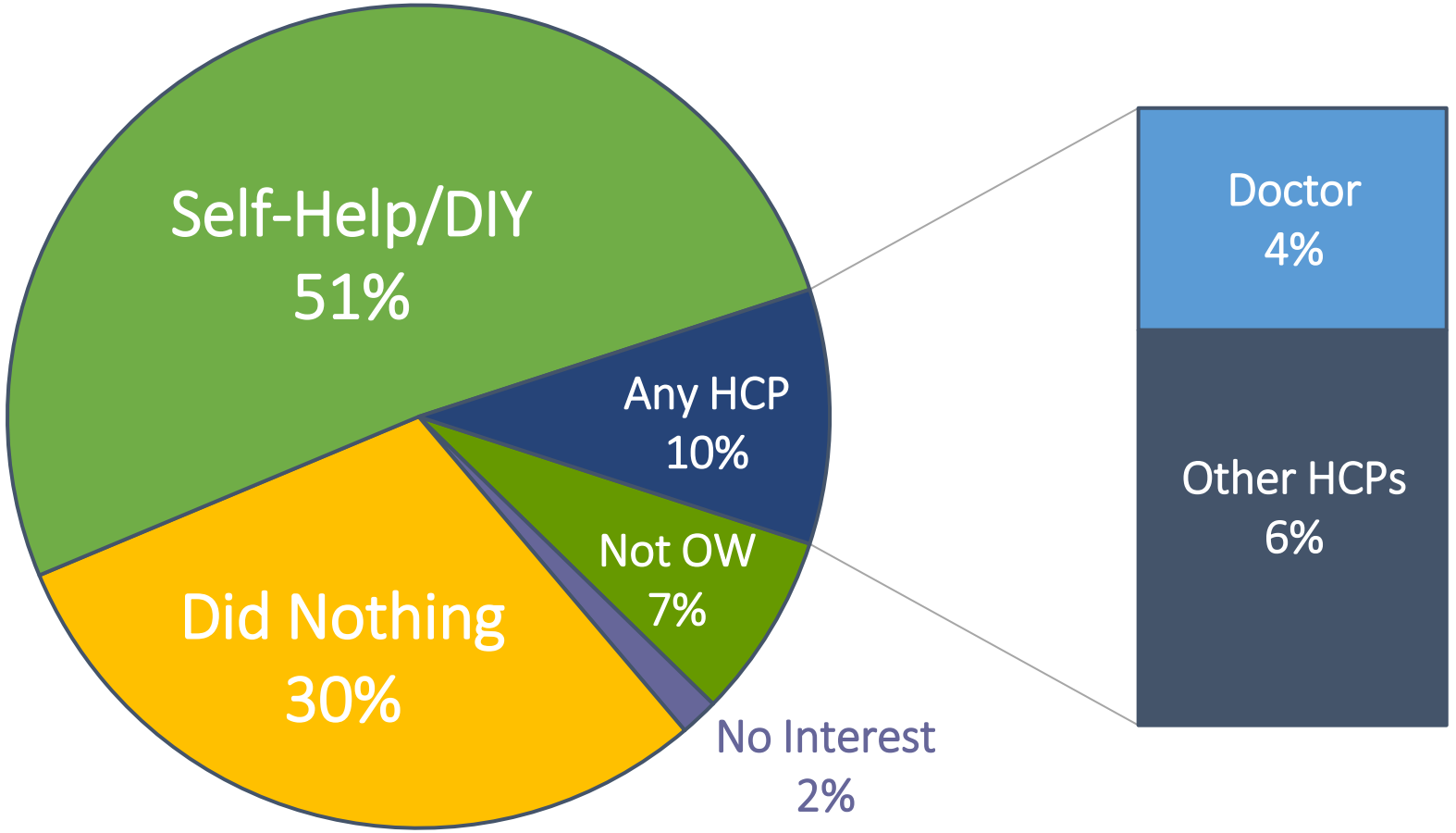
Only 10% of People with Obesity Get Help from Medical Professionals



Source: Stokes et al, 2018

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Bias Impacts Overall Care for People with Obesity

Provider Interactions with those Affected:

- Less time spent in appointments
- Less discussion with patients
- More assignment of negative symptoms
- Reluctance to perform certain screenings
- Less intervention

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Bias Impacts Overall Care for People with Obesity

Patients with obesity are less likely to obtain:

- Preventive health services and exams
- Cancer screens, pelvic exams, mammograms

And are more likely to:

- Cancel appointments
- Delay appointments and preventive care services

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Obesity and Communities of Color

Obesity is more prevalent in communities of color than in non-Hispanic white Americans. [1,2]

1.3x
more likely for **Black Americans**

1.2x
more likely for **Hispanic Americans**

4 out of 5 Black or Hispanic American women have **obesity or overweight**

Social Determinants of Health

- Access to healthy food and places to exercise
- Access to medical care/affordable insurance
- Employment in lower wage jobs

Health inequities and higher obesity rates may have contributed to the disparate impact of COVID-19 in communities of color

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Realities of Seeking Obesity Care

Access to Comprehensive Obesity Care is often limited:

- Coverage of screening for Obesity and intensive counseling for Obesity is required to be covered under the Affordable Care Act (Obamacare) as a preventative service benefit, but the requirement to cover such services if often ignored or dramatically limited (one visit per year, etc.).
- Many insurers still include blanket exclusions of obesity care services. For example *"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." (Louisiana State EHB Benchmark plan).*
- Bariatric surgery is the best covered service. Medicare, Federal Employee health plans, 49 of 51 Medicaid programs, 44 of 50 state employee plans, 24 of 50 state essential benefit plans and approximately 65% of employer plans cover bariatric surgery.
- Coverage is often hidden and/or difficult to decipher inside other services as obesity care can exist in wellness, employee assistance, medical, pharmaceutical or surgical benefits.

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Realities of Coverage

Even when patients do have coverage for obesity care, hurdles exist:

- Patients are often required to participate in one last “diet” or non-pharmaceutical/non-surgical treatment before being able to access treatments beyond behavior change. These can last 6-months or more with very demanding reporting requirements.
- Pre-authorization processes are time consuming and frustrating.
- Lifetime limits on treatment (one surgery per lifetime, one year of medication only)
- Specific co-morbidity requirements (i.e. a patient must have poorly controlled hypertension while on 3 anti-hypertensives)
- Caps on the number of visits (1 dietician visit per year, for example)
- Higher than usual co-pays or deductibles

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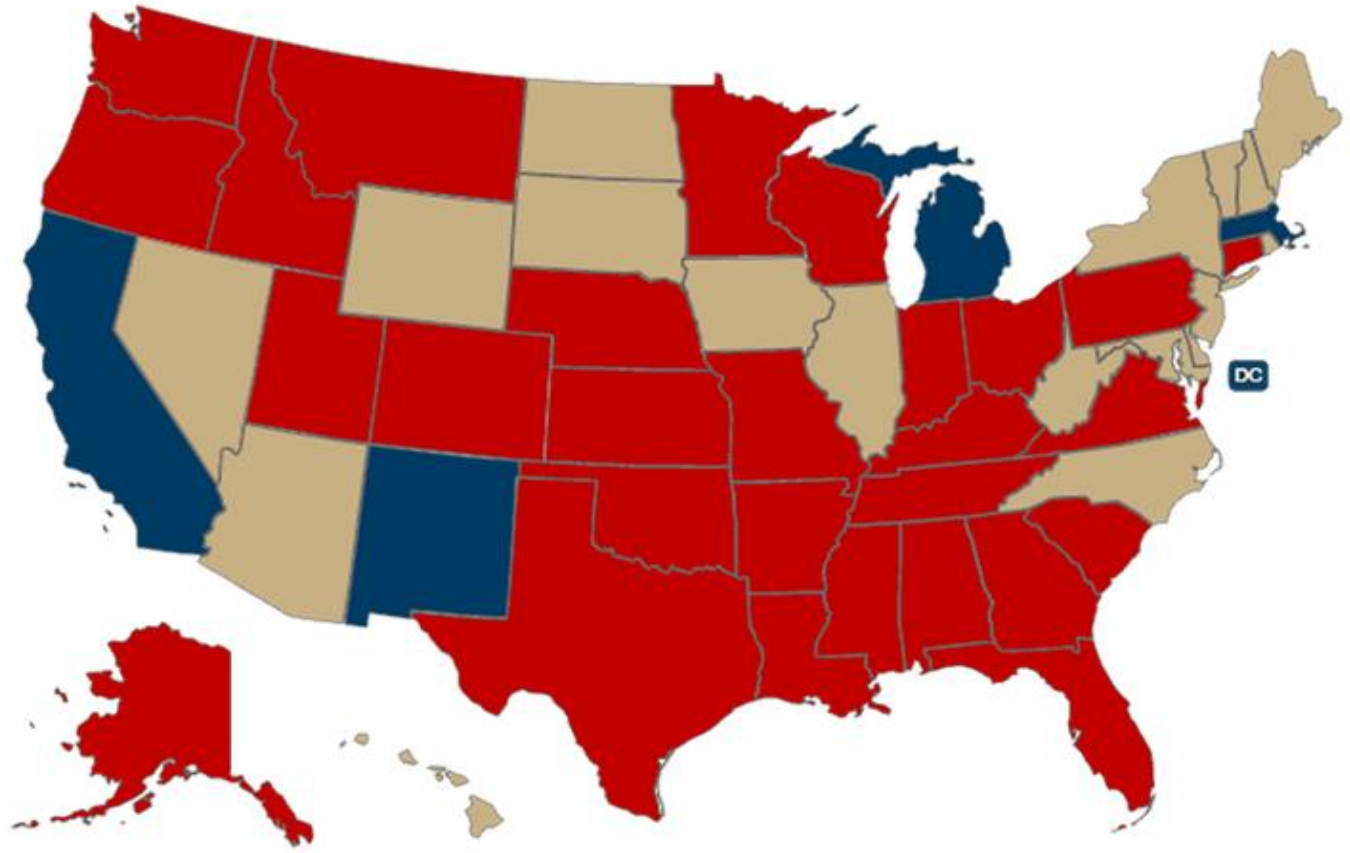
Obesity Coverage Under the Affordable Care Act (Obamacare)



Source: ASMBS Access to Care Toolkit www.asmbs.org

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Obesity Counseling under Medicaid/State Employee Plans

Range: # of visits

Medicaid | 0.5 – 24 per year
Employee | 1 – 26 per year

Covered Not Covered Undetermined

Medicaid

State Employee

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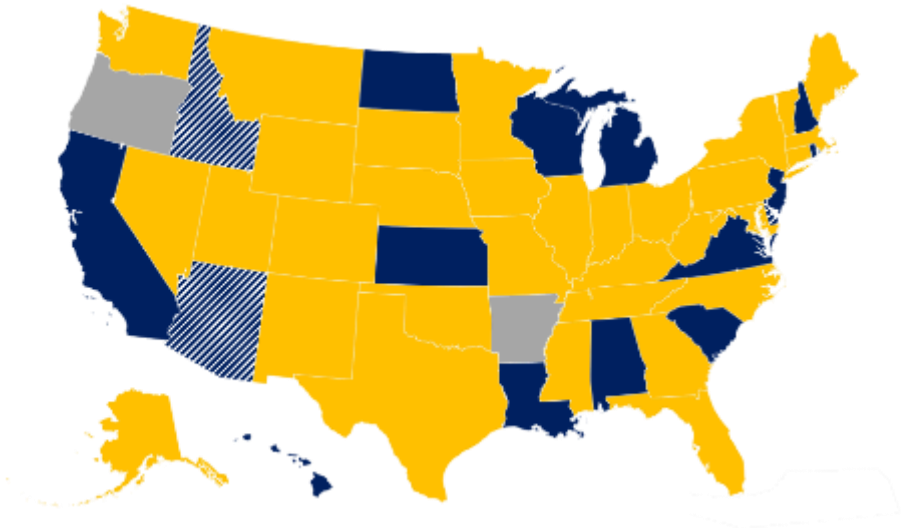
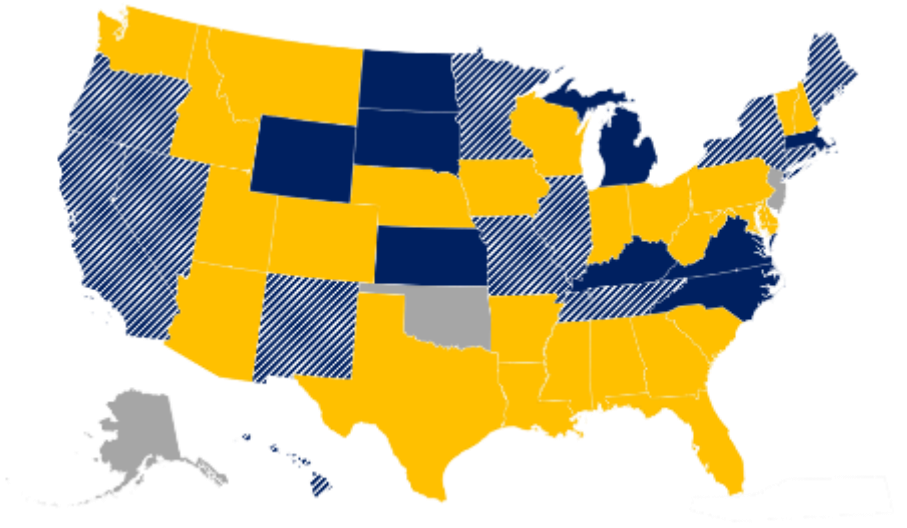
Obesity Medications under Medicaid/State Employee Plans

Note most states covered only one or two of AOM's, not all

Covered Not Covered Undetermined



Medicaid



State Employee

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Medicare Coverage of Obesity Care Services

- Medicare covers intensive behavioral counseling for obesity when provided by a recipient's primary care provider.
- Medications are excluded by statute in Medicare Part D. Some Medicare Advantage Plans do cover medications.
- Bariatric surgery is covered for those BMI 35 and above with comorbidities and has a National Coverage Decision (NCD) from CMS.

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Employer Coverage of Obesity Care Services

- While we have good data around the access to bariatric surgery in employer plans (Mercer data report), the data around counseling and medications is lacking.
- Some large employers may be exempt from the required counseling benefit under Obamacare.
- Many offer wellness programs or community-based (WW, TOPS club) treatments for obesity. Patient Satisfaction with wellness programs is low among those with obesity.
- Anecdotal trend is that medication coverage is modest but growing slowly.

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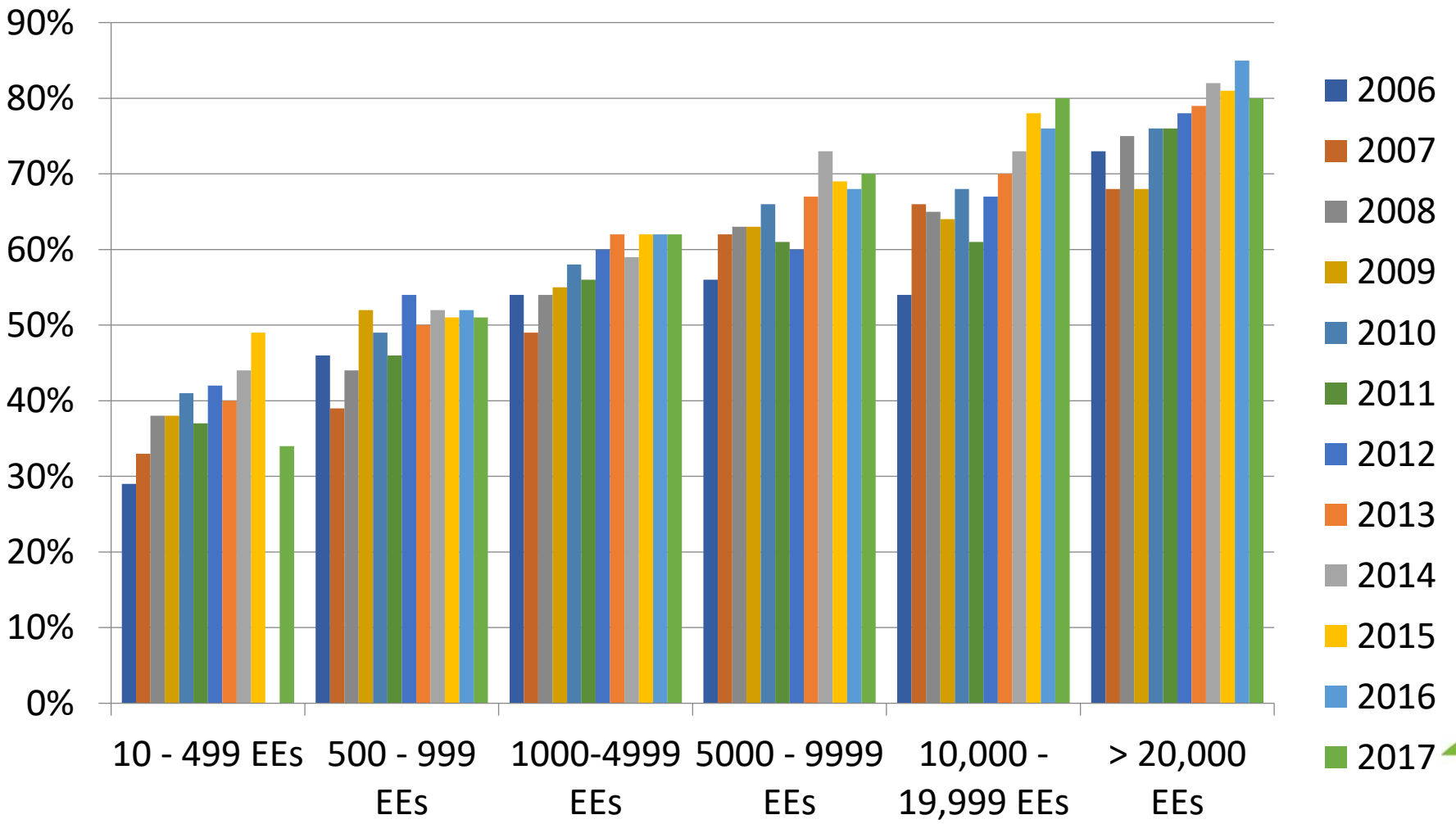
Snapshot of Bariatric Surgery Coverage

Bariatric Surgery Coverage – US Employer Size, 2006-2017



Source: Mercer National Survey of Employer Sponsored Health Plans, 2006-2014Note: In 2016, Mercer only interviewed large employers >500 EEs

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Potential Initiatives to Improve Access

- Encourage State Employee, Medicaid and/or Other State Regulated Plans to produce comprehensive explanations of their obesity care services. A flyer specifically on what services are available will help individuals cut through the clutter as well as help us evaluate where improvements can be made.
- Once we have an understanding of what is and isn't covered under those plans, consider efforts to incentivize expanding such coverage. Obesity care requires a comprehensive approach so missing any part of a comprehensive approach jeopardizes long-term success.
  - A great resource on what should be included in a comprehensive approach for Obesity Care: https://publichealth.gwu.edu/sites/default/files/Comprehensive%20Obesity%20Care%20v.%2011.2.19.pdf
- Look at barriers and utilization. Is utilization low? Better health and the long-term cost savings associated with it requires people utilize the services. Re-evaluate "hurdles" and copays.
- Recognize in all policies that stigmatizing people with obesity does not improve health outcomes or cause people to seek better care/health.

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For More Information on the Obesity Action Coalition, visit www.ObesityAction.org

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