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Broadening Coverage to Combat the Obesity Epidemic: Policy Ideas for State Innovation

This presentation was commissioned by Novo Nordisk, which also partnered with Randolph Pate Advisors LLC in developing the ideas summarized herein. Randolph Pate Advisors LLC accepted edits and suggestions but maintained full editorial control over the ideas and content.

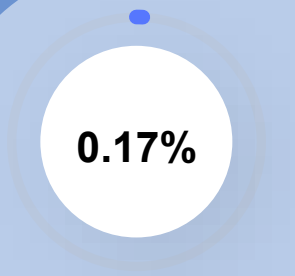
Costs of Obesity

$1.72 Trillion

Total Cost of Obesity

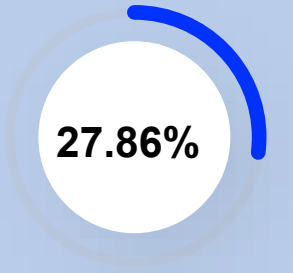
$61.8 Billion

Medicare & Medicaid Spending on Obesity



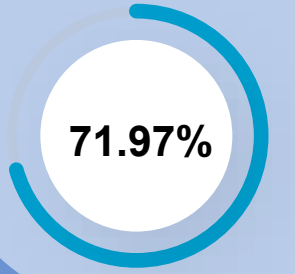
$2.9 Billion

Direct Costs of Childhood Obesity



$480 Billion

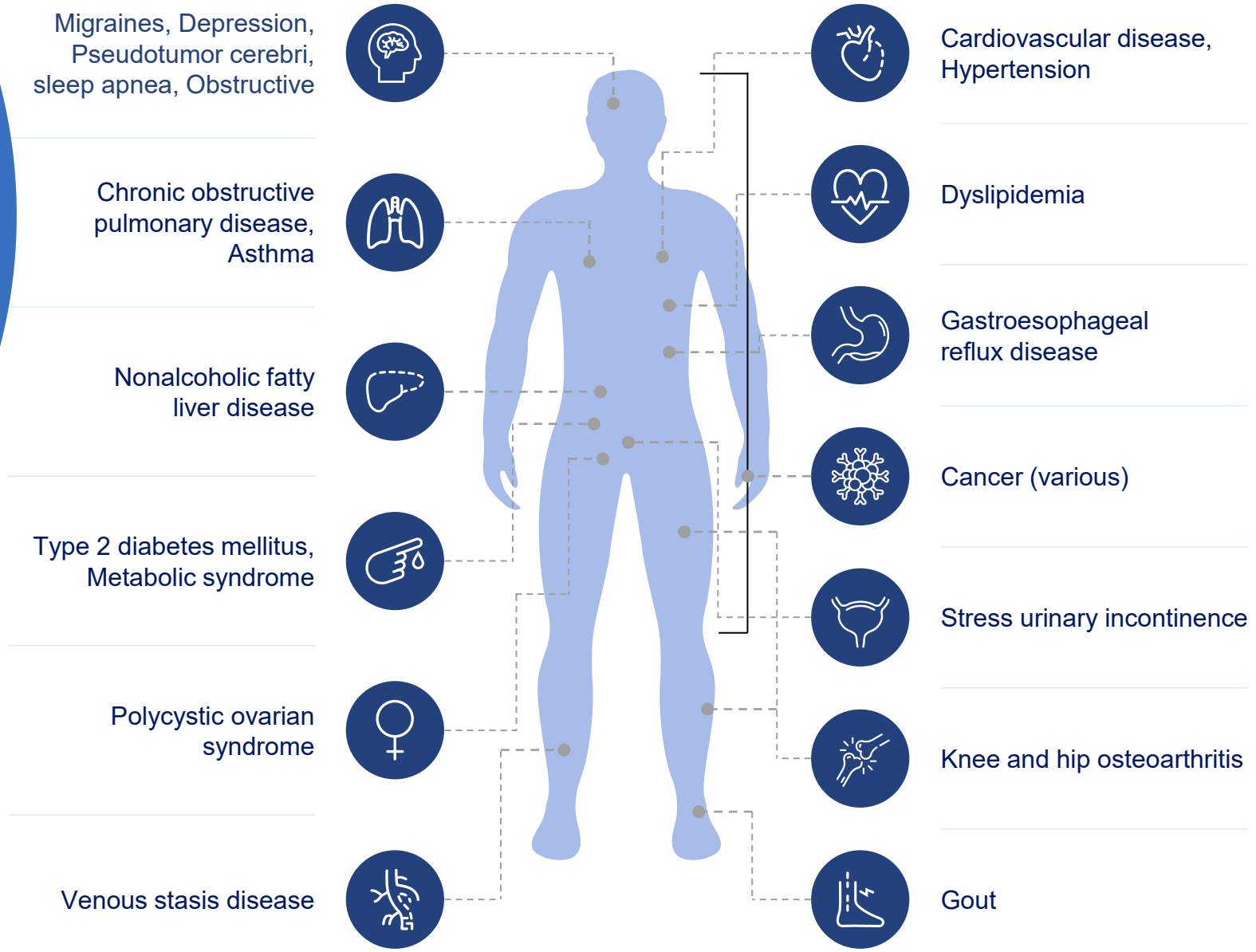
Direct Healthcare Costs of Obesity



$1.24 Trillion

Indirect Costs of Obesity

Patients living with obesity are at an **increased risk** of developing weight-related comorbidities

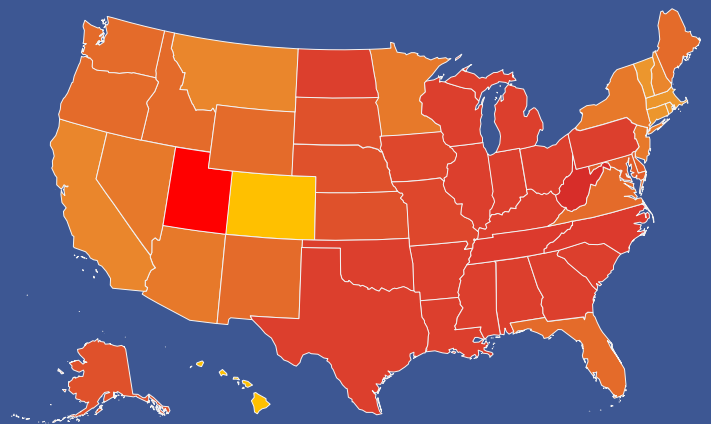


This list is not exhaustive and is intended to illustrate only a range of key complications.

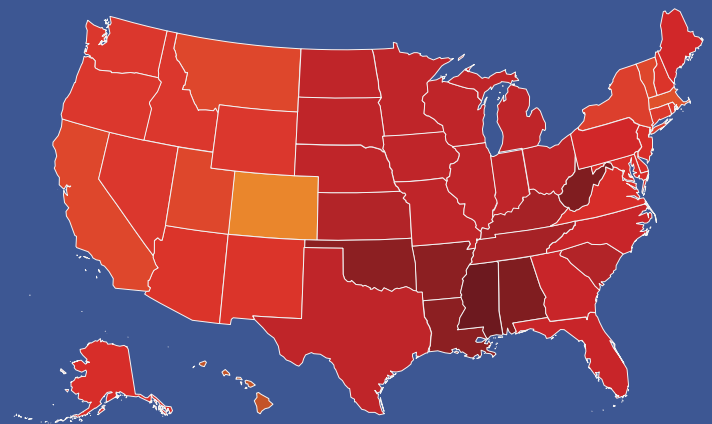
Garvey WT et al. Endocr Pract. 2016;22(suppl 3):1-203.

General Population: **Prevalence & Projections**

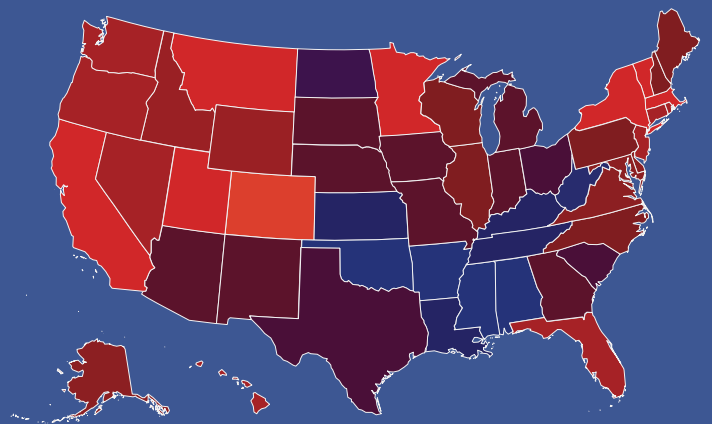
2010

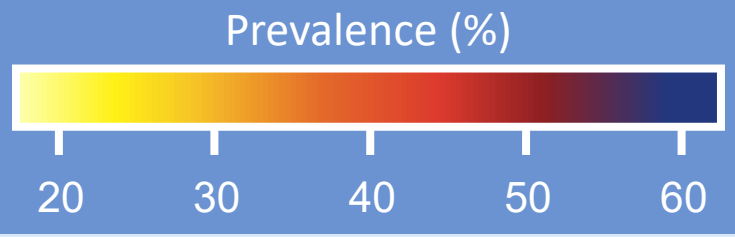


2020



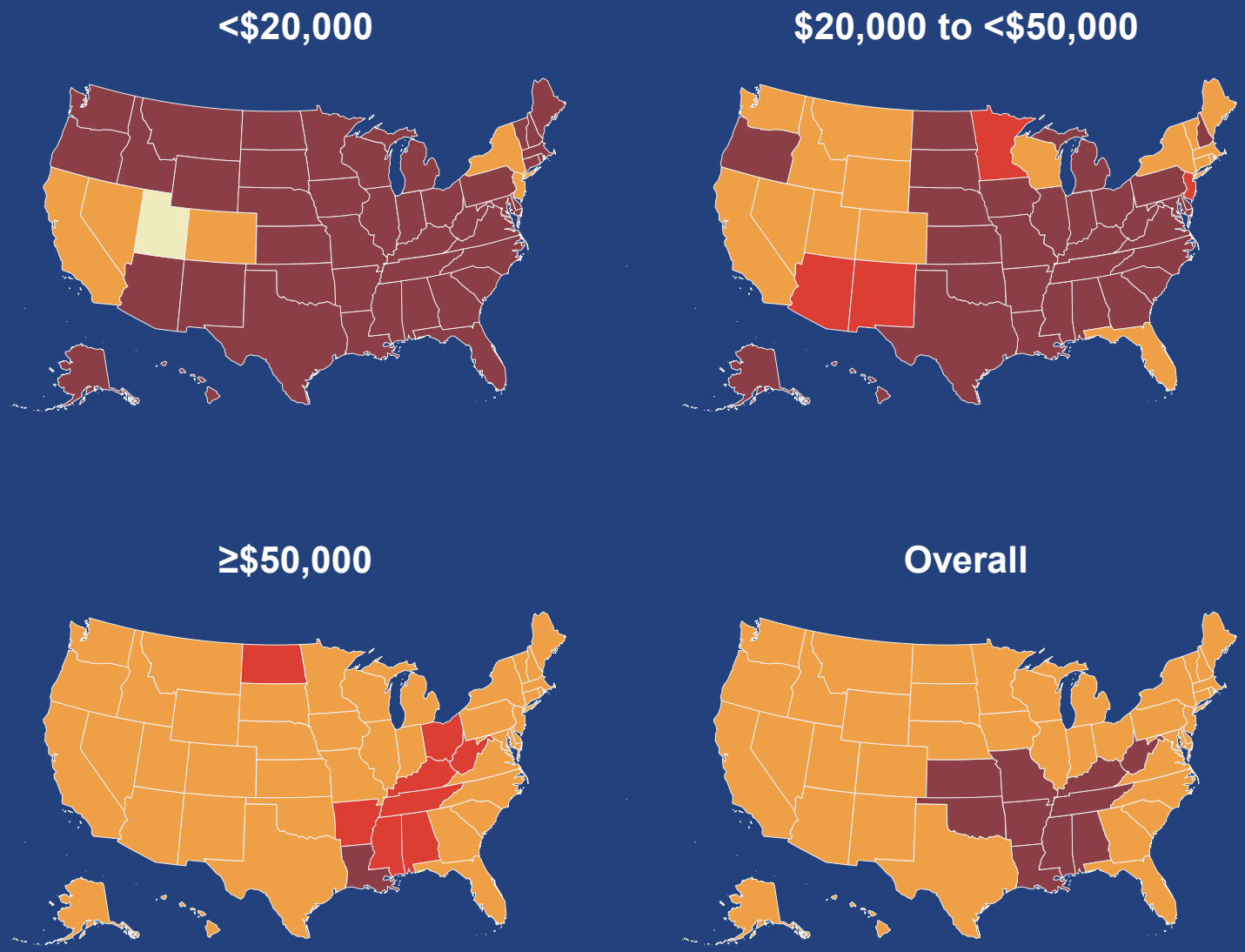
2030





Most Common BMI Group by State: 2030 Projections Based on Income

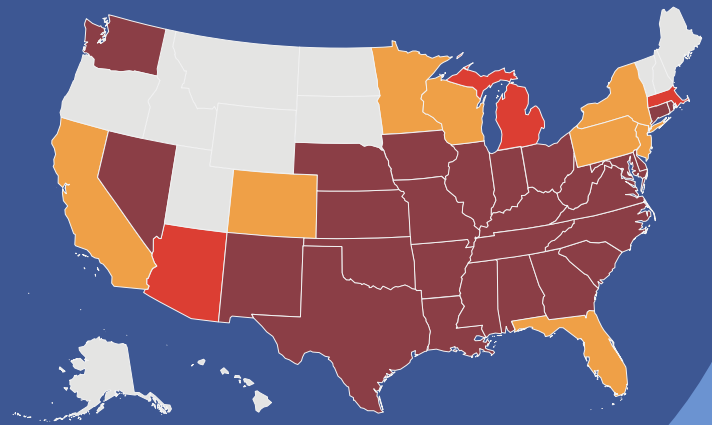
2030 Projections



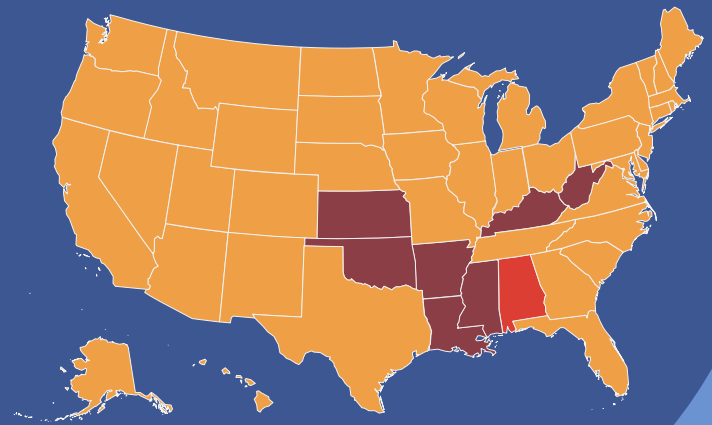
Most **Common BMI** group by State:

2030 Projections based on **Race**

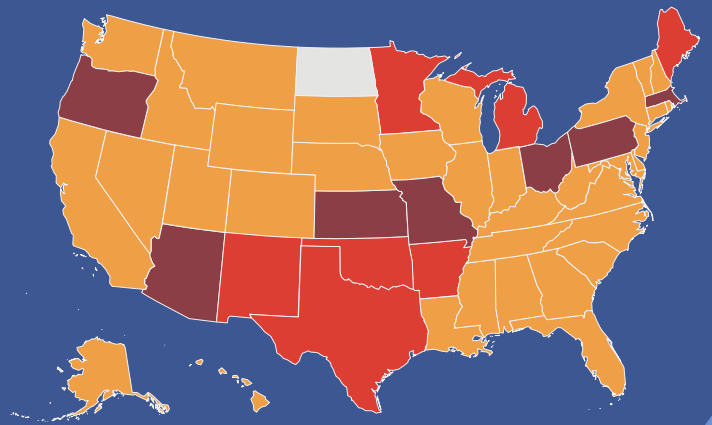
Non-Hispanic Black



Non-Hispanic White



Hispanic



Underweight or normal weight (BMI, <25)

Overweight (BMI, 25 to <30)

Moderate Obesity (BMI, 30 to <25)

Severe Obesity (BMI, ≥35)

Suppressed Estimate

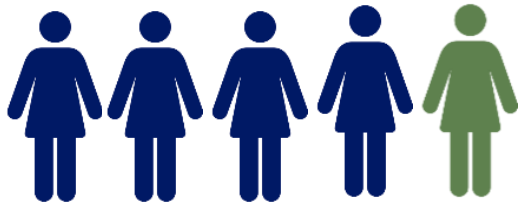
Obesity and Disparities

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

Obesity is more prevalent in non-white communities than in non-Hispanic white Americans

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**

"The number one thing state insurance regulators can do [to address health disparities] is address obesity"

- Mark Fendrick, MD

Professor in both Internal Medicine & Health Management and Policy
Director of the University of Michigan Center for Value-Based Insurance Design

OLD VIEW

Obesity seen primarily as a lack of willpower

Diet & exercise, surgery are only effective treatments; few seek medical help; over-reliance on self-help, fad diets, etc.

Moving **towards a new view of obesity**

NEW VIEW

Obesity is a chronic disease

Reduced stigma; more seek medical help; new, more effective therapies available (e.g., AOMs) to support traditional approaches

Obesity Continuum of Care

Obesity treatment requires a **continuum of care**, including behavioral counseling, primary and specialist care, anti-obesity medications (AOMs), and bariatric surgery.

New and **more effective AOMs are bridging the gap** in obesity treatment options between behavioral interventions and more invasive options like bariatric surgery.

Barriers to Treatment

- **Partial coverage/lack of coverage** for obesity continuum of care
- **Lack of access** to/coverage for AOMs
- Providers **lack time** to dedicate to obesity treatment as well as **knowledge** and **training** needed for successful treatment
- **Many more**, including misinformation, cost considerations, environmental/social factors, and geographic barriers to care

Balancing Cost and Access

States have a range of options for addressing cost and utilization concerns associated with expanding benefits, including examining state approaches and implementing best practices

- How much will coverage cost?
- What mechanisms will be put into place to manage costs while ensuring those who need treatment have access?

Pathways to Broaden Coverage

State Options

- State Employee Health Plans
- Essential Health Benefit (EHB) Benchmark Plan Amendments
- Section 1332 State Innovation Waivers
- Medicaid State Plan Amendments and Section 1115 demonstration waivers

State Employee Health Plans

Expanding coverage in State Employee Health Plans

- **Improves the health of state workers**, reduces absenteeism, increases productivity
- Drives change in broader healthcare market by **setting coverage standard**
- Implement **prior authorization** requirements for higher-cost treatments
- Use **step therapy** approach to manage utilization
- Start with **less invasive and less costly options** like behavioral counseling before progressing to more intensive treatments
- Learn from existing **state approaches** for **managing costs** and **ensuring access**

Essential Health Benefits

Essential Health Benefits

Amend the EHB benchmark plan

- Essential Health Benefits (EHBs) include **10 categories of services all ACA-compliant plans must cover**
  - Includes hospitalization, prescription drugs, mental health services, and more
  - EHB-benchmark plan sets the standard for coverage in **each state's individual and small group market**
- EHB-benchmark plans need regular updates to **keep pace with medical advances**
- States have flexibility to amend EHB benchmarks to **better meet residents' needs**
- Can select another state's benchmark, supplement current benchmark**, or create new plan**
- Allows tailoring of EHB coverage to each state's **unique demographics and health priorities**

Essential Health Benefits

Amend the EHB benchmark plan

- CMS has **streamlined the EHB-benchmark amendment process** for plan years starting in 2027
- Consolidated options into a **single, more flexible pathway**
- Could **reduce administrative burden and cost** for states seeking updates
- Three states (North Carolina, New Mexico, and North Dakota) **have amended their benchmark plans** to cover anti-obesity medications
- North Dakota **successfully amended its EHB-benchmark** for 2025 to cover obesity treatments
  - Adds coverage for anti-obesity medications and other evidence-based services
  - **Increases premiums by just 0.44%** according to actuarial analysis
  - Shows how states can cost-effectively expand access to needed care

Section 1332 State Innovation Waivers

Section 1332 Waiver Options: Key Questions for States

- What is the **ACA statutory provision** to be waived (i.e., *replaced* by the state plan)?
- Will the **waiver meet the statutory guardrails** (coverage, comprehensiveness, affordability, deficit neutrality)?
- How will any **pass-through funds be calculated**, and what are the likely funding levels?
- Will the waiver require a **commitment of state funding**?
- Are there opportunities to **coordinate**/align the waiver **with other programs**?

Section 1332 Waiver Option:

"Hybrid" Reinsurance/EHB Waiver

- **Waive the definition of Essential Health Benefits** (EHB) to require issuers to **cover the full range of obesity treatments**, including anti-obesity medications (AOMs)
- **Pair the EHB waiver with a new or existing state reinsurance program**, directing a portion of the reinsurance **pass-through funding to offset increased costs** from obesity treatment and AOM coverage
- Set a **target savings amount** (e.g., a small percentage of premium) associated with improving obesity-related healthcare costs (e.g., reduced claims for stents, joint replacements, etc.) **to trigger pass-through funding**
- **Evaluate the impact** over the term of the waiver (up to 5 years)

Section 1332 Waiver Option:

Complex Care Plans

- Create **specialized plans** designed to improve care and access for individuals with obesity
- **Waive the definition** of Qualified Health Plans (QHP) to create **state complex care plans**
  - ✓ State-authorized coverage options made available to individual market enrollees with specific chronic conditions or complex care needs
  - ✓ May also waive the definition of single risk pool (like an “invisible high-risk pool” approach)
- Complex care plans could include or with certain BMIs; **enhanced benefits targeted for people with obesity** enrollment would be voluntary
- Provide opportunity for intensive case management and targeted care focusing on **preventive care** and **effective treatments** for obesity

Medicaid State Plan Amendments and Section 1115 Demonstration Waivers

Medicaid Coverage Today

- **Medicaid agencies are required to cover nearly all medications approved by the Food and Drug Administration (FDA) -** but anti-obesity medications have been expressly excluded from this requirement, and coverage remains optional and sporadic.

- **A similar dynamic exists for such medications in the Medicare Part D program.** Many state Medicaid agencies have retained this coverage gap by refraining from defining obesity as a medical condition, despite the American Medical Association recognizing obesity as a complex chronic disease since 2013.

- **Some states specifically exclude coverage for obesity treatments in their Medicaid programs -** This exclusion of comprehensive lifestyle interventions and adjunct antiobesity medications undermines opportunities for addressing inequities associated with obesity and obesity-related morbidity for the Medicaid-covered population, particularly for members of marginalized racial and ethnic groups that are disproportionately affected by obesity and related health conditions and have high rates of Medicaid coverage.

Factors for Consideration

- Percent of the **Medicaid population** who have obesity
- **Cost of AOMs** (class average)
- **Estimated utilization** (average estimate in the overall market is estimated at 2%)
- Consider and account for **drug rebates** (e.g. statutory, and federal matching)

Questions

More Information

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Download full toolkit and slides:
www.randolphpateadvisors.com

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