Measuring the Impact of Improved Coverage for Obesity Treatment

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Disclosures

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  - The Obesity Society

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Presentation Objectives

• Provide an overview of access to obesity care
• Discuss current patient perceptions
  – Access and coverage of obesity therapy
  – Discrepancies between perceptions & reality
• Discuss the impact of improved access
Access to Obesity Care

Background
Untreated Obesity Harms Nearly Every Organ System

- Pulmonary
- Nonalcoholic fatty liver
- Gall bladder disease
- Gynecologic
- Osteoarthritis
- Dermatologic
- Gout

- Intracranial hypertension
- Stroke
- Cataracts
- Cardiovascular
- Diabetes
- Pancreatitis
- Cancer
- Phlebitis
Our Sick Care System Treats the Results of Obesity

- Heart disease
  - Dyslipidemia
  - Hypertension
  - Coronary Artery Disease
  - $444 billion

- Diabetes
  - Heart attacks
  - Strokes
  - Kidney failure
  - Amputations
  - $245 billion

- Cancer, liver disease, and more
Treating Obesity? Not So Much

Primary Care Physician Practices

- Not 74%
- Routinely Assessing BMI and Following Up 26%

Source: Klabunde et al, 2014.01, Am J Health Promotion
Historical Bias About Obesity

The best place to start is by simply telling the patient the truth.
“Sir or Madam, it’s not OK to be obese. Obesity is bad. You are overweight because you eat too much. You also need to exercise more. Your obesity cannot be blamed on the fast food or carbonated beverage industry or on anyone or anything else.
You weigh too much because you eat too much.
Your health and your weight are your responsibility.”

Robert Doroghazi, MD
AJM, Mar 2015
Health Plans Have Long Discouraged People from Seeking Obesity Care

- Routine policy exclusions for obesity
  “Regardless of any potential health benefit”
- Lifetime procedure caps
- High out of pocket costs
- Problematic reimbursement rates and procedures
- Requirements for pre-authorization
Change Over Time in Barriers to Obesity Care

Milestones in Regarding Obesity as a Disease

- HCFA: "Obesity is not a disease"
- NIH Guidelines
- IRS Deductibility
- Social Security
- CMS: "Obesity is not a disease"
- CMS Surgery Coverage
- Obesity Society White Paper
- AACE Position
- AMA: "Obesity is a disease"

Evolving Reimbursement for Obesity Care: Counseling

Prior to 2012:
Considered fraud by most payers to bill for services rendered primarily to treat obesity

As of 2012:
Medicare and most private payers cover obesity treatment; Many also covering counseling given by PCPs

Going forward in 2015:
Affordable Care Act (ACA) mandates coverage of obesity treatments and counseling by PCPs

2010 2011 2012 2013 2014 2015

Prior to 2012:
Private payers covered medical visits only when BMI >40

Currently:
Medicare and most private payers provide coverage for annual obesity screening, obesity counseling and medical management of obesity if BMI ≥30.*

*Some payers limit coverage to BMI > 35 with a comorbidity
Source: Presentation by Michael S. Kaplan, 2015
CMS Expanding Coverage of Diabetes Prevention & Obesity Care

“This is the first-ever prevention program to be certified [as a money-saver] in this way,” said HHS Secretary Sylvia Mathews Burwell. “Now we know this kind of prevention saves money.” IAP Photo

Diabetes prevention programs score Medicare endorsement

By DARIUS TAHIR | 03/28/16 06:07 PM EDT
Bariatric Surgery Coverage in Employer Health Plans Steadily Improving

Source:
Ethicon Mercer National Survey of Employer Sponsored Health Plans, 2006-2014
Improvement in Obesity Med Coverage Largely Anecdotal

- Transparency lacking
- 2014: OPM warns against excluding obesity meds from federal employee plans
- 2015: NCOIL calls for coverage of the “full range of obesity treatments”
- Formularies with 74 million covered lives now include obesity meds
  - Aetna and Express Scripts began covering obesity meds in 2012
  - Saxenda was added to the CVS Caremark 2016 formulary
Access to Obesity Care

Consumer Perceptions Study
Objectives

Measure consumer perceptions

• Of coverage for obesity treatment by their health insurance

• Prevalence of wellness programs with financial incentives based on weight or BMI
Wellness Programs

- Substantial financial incentives allowed
- Based upon biometric outcomes
- Including BMI
- Reportedly being adopted by employers with increasing frequency
Health Insurance, Wellness, & Obesity Care Study

Methods & Results
Sample Recruitment

- Fielded in Q1/2015
- Anonymous, voluntary online surveys
- Utilizing Google Consumer Surveys
- Total sample of 9,388 respondents
- Post stratification weighting based on:
  - Region (IP address)
  - Age and gender inferred from browsing history
Total Sample

- General population: 3,852 (for insurance questions)
- Employed population: 5,536 (wellness & insurance questions)
Questions

General Population
• Do you have health insurance that would help pay the cost of [ ] if you needed it?

Employed Respondents
• Does your employer have a wellness program with incentives or penalties based on your weight or BMI?
• Do you have health insurance that would help pay the cost of [ ] if you needed it?
“Do you have health insurance that would pay the cost of [ ] if you needed it?”

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor</td>
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</tr>
<tr>
<td>BP Meds</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Dietitian</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Obesity Meds</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Medical Wt Mgmt</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>Bariatric Surg</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

Note that remaining respondents were unsure of coverage.
Employed Respondents

“Does your employer have a wellness program with incentives or penalties based on your weight or BMI?”

Yes

No/Not Sure
Employed Respondents With BMI-Based Wellness Programs

“Do you have health insurance that would pay the cost of [ ] if you needed it?”

- **Doctor**: 90% Yes, 10% No
- **Dietitian**: 80% Yes, 20% No
- **Obesity Meds**: 40% Yes, 60% No
- **Medical Wt Mgmt**: 60% Yes, 40% No
- **Bariatric Surg**: 30% Yes, 70% No

Note: that remaining respondents were unsure of coverage.
Study Findings

• Consumers most often report not having health insurance that will cover obesity treatment

• Even when employers target BMI in wellness programs
  – As they increasingly do
  – Consumers often believe their health insurance excludes obesity treatment
Access to Obesity Care

The Impact of Access to Obesity Care
Metabolic Surgery Outcomes
Bringing Calls for Better Access

Type 2 Diabetes Remission Rates

Intensive Lifestyle
0%
0%
0%

Gastric Band
0%
29%
29%

Gastric Bypass
0%
29%
45%

Source: Courcoulas et al, 2015.07.01, JAMA Surg.
Cost Benefit Analysis
Increasingly Favors Surgery

• UK NICE Guidelines
  – Expedited assessment in BMI>35 with recent-onset type 2 diabetes
  – Also assess for BMI 30-35

• California Technology Assessment Forum
  – Unanimous decision favoring surgery for BMI 30-35 with type 2 diabetes
Cost Benefits Driving Better Access for Behavioral Care

• Growing movement to expand programs following the Diabetes Prevention Program

• CMS actuaries found $2650 cost savings per Medicare member over 15 months
Access to Care Is
Most Problematic in the Middle

Bariatric Surgery

Treatment Gap

Limited Pharmacotherapy

Behavioral Therapy
Health Economics Literature on Obesity Drugs Is More Limited

- **Cawley et al, 2014**
  Savings in Medical Expenditures Associated with Reductions in Body Mass Index
  - Savings in annual medical costs from a 5% weight reduction
  - $2,137 for a starting BMI of 40
  - $528 a starting BMI of 35
  - $69 for those with a starting BMI of 30
  - Costs for individuals with diabetes are greater
  - At high levels of BMI, thousands of dollars per year.

- **Ara et al, 2012**
  Clinical effectiveness and cost-effectiveness of using drugs in treating obese patients
  - Cost-effective when using a threshold of £20,000 per QALY
  - Analysis reflects older obesity drugs only

- **Finkelstein et al, 2015**
  Cost-Effectiveness Analysis of Qsymia for Weight Loss
  - Cost-effectiveness highly dependent upon sustained use & benefit
Conclusions and Reasons for Encouragement

• Health policy on obesity playing catch-up
• Bad coverage habits die hard
• But they are dying
  – OPM ruling banning cosmetic/lifestyle exclusions
  – ACA Guidance: broad exclusions impermissible
  – Recognition of value for surgery
  – Cost benefits of intensive behavioral care
  – Steady improvements in formulary status for obesity drugs
  – Rising patient advocacy
More Information

• More information: www.conscienhealth.org/news

• For these slides: http://conscienhealth.org/wp-content/uploads/2016/04/obesitycare.pdf