Obesity Action Coalition

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December 13, 2023

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The Obesity Action Coalition (OAC) is pleased to provide the following comments regarding possible benefit changes, which the Oregon Health Authority's (OHA) Public Employees Benefits Board (PEBB) and Oregon Educators Benefit Board (OEBB) are considering for state employee health coverage – specifically related to FDA-approved anti-obesity medications (AOMs). After reviewing the documents presented during the December 5, 2023, meeting of the OEBB, OAC urges the OHA to adopt the "alternative option" outlined by Mercer – albeit without discriminatory patient cost-sharing after the first year of treatment.

Mercer Alternative Option:
Cover exclusively via lifestyle modification vendor (cover according to FDA label but require concurrent enrollment with ongoing active participation in lifestyle modification program) with appropriate prior authorization in place at the start, and appropriate screening to renew after 12 months, at an increased cost-share compared to current pharmacy benefits.
- BMI 30+ no comorbidities
- BMI 27+ w/ at least 1 comorbid condition
- 12+

The OAC is the leading national non-profit dedicated to serving people living with obesity through awareness, support, education, and advocacy. Our vision is to create a society where all individuals are treated with respect and without discrimination or bias regardless of their size or weight. We strive for those affected by the disease of obesity to have the right to access safe and effective treatment options. And we educate all individuals to understand that when it comes to health, weight matters. OAC has a strong and growing membership of over 80,000 individuals living with obesity, across the United States and 863 members in Oregon.

OAC is pleased that the Oregon Health Authority is evaluating state employee coverage for AOMs – including the latest round of GLP-1 agonists. However, we are concerned with some of the aspects of the presentation that Mercer shared with the PEBB/OEBB as we believe some of the points are misleading. In addition, some of Mercer's proposed coverage options would discriminate against plan beneficiaries seeking access to life changing and lifesaving treatments based solely on cost.

Obesity is a Chronic Disease
Obesity is a serious chronic disease that requires treatment and management just like diabetes, cancer, or high blood pressure. Obesity has been recognized as a disease by major medical organizations such as the American Medical Association, American Diabetes Association, American Academy of Family Physicians, American Association of Clinical Endocrinologists, American Heart Association, National Institutes of Health, and the World Health Organization. Obesity is driven by strong biology, not by choice.

Patients are Entitled to Care
AMA's recognition of obesity as a disease in 2013 was the catalyst behind numerous other organizations declaring support for patient access to comprehensive obesity care, such as the National Council of Insurance Legislators, National Lieutenant Governors Association, National Hispanic Caucus of State Legislators, National Black Caucus of State Legislators, Veterans Administration, the Department of Defense, and the Federal Employees Health Benefits Program.

The Double Standard for Obesity Care
Despite the broad acceptance of obesity as a chronic disease and the recognition that patients deserve access to care, many policymakers continue to apply a double standard when evaluating coverage of obesity care – especially in the areas of utilization, cost and return-on-investment (ROI).

Utilization
We know that obesity rates continue to rise with more than 42 percent of Americans affected by obesity nationwide – including nearly 31 percent of Oregonians who currently struggle with this complex and chronic disease. Too often though, policymakers will extrapolate these rates into utilization figures for calculating potential costs should everyone affected suddenly seek care and access to treatment. While we wish this were the case, only a small fraction of individuals with obesity actively seeks out treatment, i.e. AOMs.[1] Policymakers must refrain from using unrealistic utilization projections to dissuade decision makers from providing coverage.

Cost
Once utilization projections are set astronomically high, policymakers will often marry these numbers with the industry-posted list price for these GLP-1 medications as opposed to the net cost that the plan pays after rebates. A recent study by the American Enterprise Institute, entitled "Estimating the Cost of New Treatments for Diabetes and Obesity" found that, on average, the net price for one month of Ozempic is $290 and $701 for Wegovy as opposed to the list prices for these drugs of $936 and $1349, respectively.[2]

We are pleased that Mercer highlighted this issue on slide 22 of its presentation where they indicate the "average rebate (considering expected market share and market competition) is expected to be in the range of 50%-60% of list price… and that any discussion of benefit options and coverage limitations must include a discussion of rebate availability." These rebate assumptions appear to be reflected in Mercer's cost projection formula on slide 32 of its presentation: Number of Eligible Members x $564 x 6 Months =

We recommend updating the assumed utilization rate of 15-20 percent of eligible members to better reflect real-world utilization, which is closer to 2-3 percent for AOMs.[3]

Return on Investment
As a nation, we must stop evaluating coverage of obesity care through a return-on-investment lens. What other chronic disease state is judged along these cost/benefit parameters? Would we be looking at ROI studies if we were talking about treating childhood cancer or rheumatoid arthritis? The goal of healthcare is not to save money but improve the health and well-being of people.

OAC understands policymaker concerns with the cost of GLP-1s indicated for chronic weight management versus those indicated for diabetes. We agree that the cost of anti-obesity medications is too high and understand why OHA is evaluating numerous approaches toward its coverage policy for AOMs.

For example, the Health Authority could vote to adopt an approach like the one taken by the Connecticut state employee health plan, which only covers GLP-1s if prescribed by a specific program that provides anti-obesity specialists, and an online app to help the members manage their weight loss and lifestyle interventions. OHA could also look to the VA MOVE! program or Federal Employee Health Benefit (FEHB) plans that provide coverage for comprehensive obesity care, including GLP-1s, with various utilization management approaches.

As a voice for people living with obesity, OAC looks forward to working with the OHA to ensure state employee access to comprehensive obesity care – including AOM coverage that encompasses all FDA-approved medications for this complex and chronic disease. We would be happy to meet and share further information and perspectives of people living with obesity. Should you have questions or need additional information, please reach out to our Policy Advisor, Chris Gallagher at chris@potomaccurrents.com. Thank you.

Sincerely

Joseph Nadglowski, Jr.
OAC President and CEO

cc: Members of PEBB Board, OEBB Board and SEOW Weight Loss Drugs Workgroup

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[1] Saxon DR, Iwamoto SJ, Mettenbrink CJ, et al. Antiobesity Medication Use in 2.2 Million Adults Across Eight Large Health Care Organizations: 2009-2015. Obesity (Silver Spring). 2019;27(12):1975-1981. doi:10.1002/oby.22581
[2] American Enterprise Institute. Estimating the Costs for New Treatment for Diabetes and Obesity. https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208
[3] See reference 1