Obesity Action Coalition

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January 08, 2024

Centers for Medicare & Medicaid Services
Attention: CMS-9895-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9895-P: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program

Dear CMS,

The Obesity Action Coalition (OAC) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program proposed rule. There are several areas within the proposed rule that we would like to express support for as positive steps toward establishing essential health benefits (EHB) for comprehensive obesity care. Specifically, we are pleased to see the proposed reforms for updating the state EHB benchmarking process, the adoption of the United State Pharmacopeia Drug Classification (USP-DC) for determining covered drug classes within state EHB benchmark plans, flexibility on defrayal of non-EHB state mandates, and minimum standards for network adequacy.

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. OAC has a strong and growing membership of over 80,000 individuals across the United States.

Treatment for obesity is an Essential Health Benefit

Obesity is a chronic disease. As such, treatments for obesity should be viewed as “essential” under the ACA’s mandated 10 EHB categories. For example, metabolic and bariatric surgery should be covered under the “hospitalization” category; Food & Drug Administration (FDA) approved anti-obesity medications (AOMs) should be covered under the “prescription drug” category; and behavioral health and counseling services should fall under the broad “preventive and wellness services and chronic disease management” category pursuant to the relevant USPSTF recommendations.

Many national, federal and state organizations recognize obesity as a complex and chronic disease and provide coverage for comprehensive evidence-based treatments. We applaud the Office of Personnel and Management (OPM) for taking strong actions across health plans, stating that plan carriers are not allowed to exclude anti-obesity medication from coverage "based on a benefit exclusion or a carve out." Like OPM, CMS should issue guidance recognizing obesity care as an EHB, following the numerous agencies of the federal government that have already categorized obesity as a disease and provide coverage.

USP-DC for Determining Covered Drug Classes within State EHB Benchmark Plans

The FDA has fully reviewed and approved several AOMs over the last decade – showing promise and more effective treatment options for adults and adolescents. We are pleased that CMS recognizes advancements in AOMs and is proposing to support utilization of the United States Pharmacopeia Drug Classification (USP-DC) as the standard for determining covered drug classes within state EHB benchmark plans. We agree the USP DC is a more appropriate classification system for the exchange patient population as it provides a more comprehensive inclusion of outpatient drugs and undergoes more frequent revisions. In addition, a drug classification system that allows for more granular category and class distinctions will better represent evolving standards of care and updated clinical guidelines for patients in this marketplace. For example, evidence from the SELECT trial found a 20 percent reduction in major adverse cardiovascular events for study participants taking Semaglutide, demonstrating lives saved from cardiovascular deaths, strokes, and heart attacks. There is an ethical obligation to provide coverage for lifesaving treatment.

OAC also supports CMS' proposal to require insurers' Pharmacy & Therapeutics (P&T) Committees include at least one consumer representative. We share the belief that patient representation provides additional insight into the lived experience regarding the real-world use of therapies and effect on quality-of-life outcomes, which can inform the formulary evaluation process. Additionally, the patient's perspective should be a key voice in formulary decisions as they can provide better understanding of the value of different treatments and medications for patients.

Flexibility for State Selection Of EHB-Benchmark Plans and Defrayal of Non-EHB State Mandates

OAC supports CMS's proposal to consolidate the options for states to change their EHB-benchmark plans as we believe these new rules would allow for expanded coverage and patient protections for obesity care. Under the proposal, states would need to assess only two typical employer plan options (the most and least generous available) to establish a range for the scope of benefits, which the state's EHB-benchmark could match. These proposals should reduce the time and cost to states seeking to update their EHB-benchmark plans and support a wider range of benefit changes to reflect changes in the employer coverage more broadly, such as metabolic and bariatric surgery (MBS). OAC applauds CMS for recognizing that MBS is now a standard benefit in many employer plans across the country and widely covered in many public health plans such as Medicare, TRICARE, the Federal Employees Health Benefits program, and nearly every State Medicaid and State employee plan. We strongly encourage flexibility for the EHB-Benchmark plans to follow suit.

Minimum Standards for Network Adequacy

Beginning in plan year 2023, insurers in the federally facilitated marketplaces (FFMs) were required to comply with federal standards for network adequacy that include a maximum time or distance an enrollee must travel to access provider services. OAC supports this recent change and is pleased that CMS is proposing that state-based marketplaces (SBMs) and state-based marketplaces using the federal platform (SBM-FPs) would

have to establish their own quantitative time and distance network adequacy standards for Marketplace plans that are "at least as stringent" as those in place in the FFMs. We request that the network adequacy review and standard be applied to include providers who are appropriately trained and qualified to deliver obesity care.

The Lived Experience - Challenges in Accessing Obesity Care through the Exchange Marketplace

The OAC hears from members daily about the challenges they face trying to access quality obesity care. Our members who have health insurance plans from the Exchange Marketplace often report various coverage exclusions, for example prohibiting anti-obesity medications and metabolic and bariatric surgery. Our members also share that intensive behavioral therapy services are often limited in one way or another, when they should be fully covered as a Grade B recommendation under the United States Preventive Service Task Force (USPSTF).

> OAC member with an ACA Exchange Marketplace Plan -
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> "I have a strong family history of obesity, diabetes, and heart disease. My parents and grandparents all have lived with these diseases. It comes as no surprise that I have issues in these areas starting back in my childhood. Now in my 40s, I find myself with mild obesity, plus pre-diabetes, fatty liver disease, and high cholesterol. I want to take control of my health so I don't develop full-blown diabetes or have a heart attack or develop serious liver disease. I try to do my best to live a healthy lifestyle and eat well, but it doesn't help as much as I need it to. My physician prescribed a GLP-1 anti-obesity medication. It made a lot of sense that one medication could help several of my health problems. When I called the pharmacy, they said my Exchange health insurance plan won't cover the drug. I can't afford to pay the full price. It doesn't make sense that I have to get sicker to access medicine. If I had stage 1 cancer, they wouldn't make me wait until I developed stage 4 cancer to get treatment. I need obesity care now."

This was just one example of the kind of stories we hear from our members. There are many more just like it. As you can see, people living with obesity and its serious complications need help and better coverage. If you would like to hear more stories or personal accounts, we would be happy to meet and share them.

OAC appreciates the opportunity to provide comments on the proposed rule regarding the Notice of Benefit and Payment Parameters for 2025. Should you have any questions or need additional information, please feel to contact me or OAC Policy Consultant Chris Gallagher via email at chris@potomaccurrents.com. Thank you.

Sincerely,

Joseph Nadglowski, Jr.
OAC President and CEO