ASMBS Activity Report

April 2015

Prepared by Christopher Gallagher, ASMBS Washington Representative

State Advocacy Efforts

State Insurance Commissioner Meetings

Missouri

During March, Dr. James Pitt met with the Missouri Department of Insurance (MDI) and presented ASMBS's case for including coverage of bariatric surgery in the state's essential health benefits (EHB) package. While MDI staff seemed supportive, they did state that the legislature would be required to act in order to add a bariatric surgery benefit. This was seen as very unlikely given the current composition of the legislature.

MDI staff did say that there will be a process for updating the state's EHB benchmark plan, which would allow for the legislature to choose from a slate of health plans such as the state employee plan or Medicaid plan which both do cover bariatric surgery.

Louisiana

During late March, Dr. Chu and Dr. Treen of the Louisiana Chapter met with State Insurance Commissioner Donelon to push the ASMBS agenda for covering obesity treatment services such as bariatric surgery. Drs. Chu and Treen presented Commissioner Donelon with the ASMBS's position and background documents supporting coverage of bariatric surgery under the hospitalization category of the state's EHB plan. As expected, Commissioner Donelon responded with the usual retort that adding bariatric surgery into the state's EHB package would require action by the legislature and

given that bariatric surgery would be viewed as an added benefit, the state would then have to pay for it…a very unlikely scenario given the state's poor economy.

Drs. Chu and Treen argued that bariatric surgery is the current standard of care and therefore should be a covered service under the hospitalization category. Commissioner Donelon did not agree – stating that the medical community is still not sold on bariatric surgery being the standard of care. Dr. Chu reminded Donelon of the recent AMA policy on patient access to obesity treatment services and told the commissioner that the chapter would follow up with his office in the immediate future with the specific language of the AMA policy, which states: "AMA supports patient access to the full continuum of care of evidence-based obesity treatment modalities such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions."

Dr. Chu and Treen also found Commissioner Donelon to be very engaged on the issues as he was already aware of the Maryland study and other such reports as he has done a great deal of advocacy work on his own regarding mental health parity issues as he has a family member affected by mental illness. Unfortunately he stated that while he understands our problem, his hands are tied by ACA rules on added benefits.

OCC Comments on CTAF Report on Obesity

On March 31st, the Obesity Care Continuum (OCC) submitted the following comments in response to a California Technology Assessment Forum's draft report on "Controversies in Obesity Management."

OCC COMMENTS:

The Obesity Care Continuum (OCC) appreciates the opportunity to submit comments related to the California Technology Assessment Forum's (CTAF) draft report entitled Controversies in Obesity

Management, which was released for public comment on March 24, 2015.

The leading obesity advocate groups founded the OCC in 2010 to better influence the healthcare reform debate and its impact on those affected by overweight and obesity. Currently, the OCC is composed of the Obesity Action Coalition (OAC), the Obesity Society (TOS), the Academy of Nutrition and Dietetics (AND), the American Society for Metabolic and Bariatric Surgery (ASMBS) and the American Society of Bariatric Physicians (ASBP). With a combined membership of more than 125,000 patient and healthcare professional advocates, the OCC covers the full scope of care from nutrition, exercise and weight management through pharmacotherapy to device and surgery.

The OCC has a number of concerns regarding the proposed scope of the draft report.

First, we question the fairness of choosing to evaluate certain obesity treatments that have yet to even be approved by the Food and Drug Administration (FDA), such as temporary intragastric balloon systems (e.g., Silimed®, ReShape®) or the duodenal-jejunal bypass liner (EndoBarrier®). Requiring two-year data for these new treatments places them at a clear disadvantage to their counterparts that have attained FDA approval and additional time to compile outcomes data.

Second, we would encourage CTAF to expand its scope of treatment avenues to include lifestyle (nutrition/activity) in addition to medications, devices, and surgical procedures when examining the evidence on the comparative clinical effectiveness and value of current approaches to manage obesity.

Third, CTAF's focus on treatment effectiveness within the body mass index (BMI) range of 25-35 kg/m2 is questionable given that range is considered off label for a number of treatments included for this

evaluation. For example, the lowest allowed BMI thresholds for the following treatments are: 27 for FDA approved obesity drugs; 30 for adjustable gastric banding; and 35 for electrical stimulation devices such as Maestro.

Finally, when evaluating benefits associated with obesity treatment avenues, the OCC applauds CTAF for including both cardio-metabolic and non-cardiometabolic outcomes in the analysis. Metrics such as functional status and quality of life are also critical to the equation – such as joint pain, mobility, urinary incontinence, or depression and anxiety. We must move toward models of patient centeredness, where patient input and preferences are valued as part of the evaluation process when determining effectiveness of outcomes.

Thank you again for this opportunity to comment regarding the issues raised in the draft report. Should you have any questions, please contact me either by email or telephone at 571-235-6475.