US health policy and prescription drug coverage of FDA-approved medications for the treatment of obesity

TITLE PAGE

TITLE: US Health Policy and Prescription Drug Coverage of FDA-Approved Medications for the Treatment of Obesity

AUTHORS:

Gricelda Gomez, MD, MPH; Harvard Medical School, Boston, MA 02115

Fatima Cody Stanford, MD, MPH, MPA; Massachusetts General Hospital Weight Center, Boston, MA 02114

KEYWORDS: Obesity, health policy, weight-reducing drugs

CORRESPONDING AUTHOR CONTACT INFO:

Dr. Fatima Cody Stanford, fstanford@mgh.harvard.edu, 50 Staniford St. #430 Boston, MA 02114

WORD COUNT: 2815

DISCLOSURE: The are no relevant financial disclosures.

AUTHOR CONTRIBUTIONS: Drs. Gomez and Stanford participated in concept, study design, and manuscript preparation. Dr. Gomez collected the data and completed the statistical analysis.

ABSTRACT

Objective: Obesity is now the most prevalent chronic disease in the United States, which amounts to an estimated $147 billion in health care spending annually. The Affordable Care Act (ACA) enacted in 2010, included provisions for private and public health insurance plans that expanded coverage for lifestyle/behavior modification and bariatric surgery for the treatment of obesity. Pharmacotherapy, however, has not been included despite their evidence-based efficacy. We set out to investigate the coverage of FDA-approved medications for obesity within Medicare, Medicaid, and ACA – established marketplace health insurance plans. *Methods*: We examined coverage for phentermine, diethylpropion, phendimetrazine, Benzphentamine, Lorcaserin, Phentermine/Topiramate (Qysmia), Liraglutide (Saxenda), and Buproprion/Naltrexone (Contrave) among Medicare, Medicaid, and marketplace insurance plans in 34 states. *Results*: Among 136 marketplace health insurance plans, 11% had some coverage for the specified drugs in only 9 states. Medicare policy strictly excludes drug therapy for obesity. Only 7 state Medicaid programs have drug coverage. *Conclusions*: Obesity requires an integrated approach to combat its public health threat. Broader coverage of pharmacotherapy can make a significant contribution to fighting this complex and chronic disease.

Word Count: 178

INTRODUCTION

An alarming 39.8% of men and women in the United States suffer from obesity. This represents a rising trend over the past 20 years.[1, 2] Obesity is associated with several co-morbidities including heart disease, Type 2 diabetes mellitus, and stroke, which are all leading causes of death in the United States. [3] In the US, obesity-related health care spending is estimated at $147 billion annually. [4]

These trends in obesity, the most prevalent chronic disease in the US, have alerted policymakers and elected officials and has stimulated impetus to shaping better health policies. [5] The recognition and medical community consensus of obesity as a disease helped bring this issue to the forefront. [6, 7]The enactment of the Affordable Care Act (ACA) gave the Federal government and States leverage to make policy changes to its public programs, Medicare and Medicaid, in addition to setting standards for the private insurance marketplace to tackle the obesity epidemic. [4] Some of the health mandates for obesity integrated in the ACA included no consumer cost-sharing for obesity screening and counseling and no premium surcharges for having obesity. [8] Also, the Essential Health Benefits (EHB) Benchmark provision expanded coverage for bariatric surgery and nutrition counseling. However, because of wide variation in states' own EHB benchmarks, only 26 states have health plans offering bariatric surgery [8, 9] Medicare now is required to cover intensive behavioral counseling and therapy for its' beneficiaries who have obesity. Through the ACA, states are eligible for an enhanced federal Medicaid matching rate if their programs cover preventive services with no cost sharing to the beneficiary. [4]

The broader understanding of obesity as a disease and its biochemical and metabolic effects on one's physiology has enlightened the clinical management of obesity.[7] Lifestyle and behavior modification ***alone*** leads to a reduction in food intake and/or increases in energy expenditure that facilitate weight loss. However, our body's adaptive biologic responses to weight loss leads to altered physiology that ultimately results in weight regain.[7] Clinical guidelines reflect this knowledge and do not recommend lifestyle and behavior modification for the treatment of obesity *alone*. It is recommended that patients with obesity be treated with adjuncts such as pharmacotherapy and/or bariatric surgery to decrease weight recidivism.[7] . Despite this, most of the changes in the ACA encouraged health insurance

plans to cover lifestyle and behavior modification as the primary treatment modality for persons with obesity without concurrent consideration for adjunctive therapies. Concurrently, the Food and Drug Administration (FDA) approved several new drugs for the short and long-term treatment of obesity. There are now several US FDA approved medications for the treatment of obesity (Table 1). [10, 11] These drugs, of which many were FDA approved as late as 2014, are recommended as an adjunct to lifestyle therapies. [12] Compared to new drugs available for diabetes, these new obesity drugs are 15 times less likely to be dispensed and have only taken 20% of the obesity medication market share.[6] With obesity serving as a major public health concern in the US, are policymakers, health care systems, and health insurance markets incorporating these new therapies and making prescription drugs available for the treatment of obesity? We set out to investigate the coverage of FDA approved medications for obesity within Medicare, Medicaid, and State Marketplace health plans.

METHODS

Medicare and Medicaid are public health insurance programs. Newly established ACA marketplace exchanges are facilitated by the government, but they provide private insurance plans to individuals.

Marketplace Exchanges. Post-ACA States' Exchanges take one of four forms: 1) a State-based marketplace, 2) Federally-supported state-based marketplace, 3) State-partnership marketplace (SPM) and 4) a Federally-facilitated marketplace (FFM). [13] We chose to investigate health insurance plans in states participating completely or at a partial capacity in the FFM through healthcare.gov. 34 States fall into this category, 27 FFMs and 7 SPMs (Table 2). We investigated the drug formularies of four "silver" plans with the lowest, second-lowest, median, and highest premiums. We chose silver plans, because according to 2016 enrollment data, 71% of enrollees using healthcare.gov chose silver plans. [14]

For each state, we first chose the most populous county based upon number of enrollees. [15] We then used 2016 Qualified Health Plan (QHP) Landscape Data [16], which includes data from health plans from states participating in FFMs and SPMs. We identified health plans for individuals and families and

assessed the 4 silver plans we mentioned above. We investigated each plan's formularies to determine coverage for the FDA-approved obesity medications listed in Table 1.

Medicare. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted into law updating provisions of the Social Security Act regulating the Medicare prescription drug benefit which established what we now know as Medicare Part D. [17] CMS provides guidance to sponsors of Part D plans with regards to their formularies and outlines benefits and establishes protections for beneficiaries, which sets limits to cost-sharing, co-insurance, deductibles, in-network and out of network pharmacy access, and mail-in services. [18] Therefore, we investigated coverage of the obesity medications through the Centers for Medicare and Medicaid Services (CMS) website and their specific policy guiding health insurance plans. [19]

Medicaid. States establish and administer their own Medicaid programs and determine scope of benefits and services within broad federal guidelines. While the federal law established by the Social Security Act denote prescription drug coverage as an optional benefit, all States currently provide coverage for outpatient prescription drugs to enrollees within their state Medicaid programs. [20]

We first searched federal policy guiding excluded drug coverage for Medicaid enrollees through Medicaid's federal website. [21] Each state has its own list of excluded drugs that are not covered under their Medicaid program. We investigated these lists for the same 34 states we investigated in the Federal marketplace exchanges. Since some of the excluded drug coverage policies for each state were updated as recently as 2009, we also investigated each state's individual Medicaid program's prescription drug policies and coverage, which are updated on an annual basis. We identified each state's Preferred Drug List (PDL) and their pharmacy and provider policy handbooks to formulate an accurate picture of the coverage offered by each state within their Medicaid health insurance plans.

In certain states, Medicaid programs have historically contracted with managed care entities (MCE) to provide their benefits rather than health insurance plans that function under a traditional fee-for-service model. Table 3 lists whether states utilize managed care programs for their beneficiaries and how many beneficiaries are enrolled. Whether Medicaid finances a health insurance plan with a FFS

model or under a MCE, they both operate under the state's approved prescription drug formulary and the state's PDL. The plans differ with regards to reimbursement. Managed care entities receive a pre-determined amount of money for caring for a Medicaid beneficiary from the government, which it then uses to cover the costs of certain medical services, mental health services, and/or prescription drugs. The covered services of a MCE may differ from one state to the next. If a MCE is responsible for the payment of prescription drugs, referred to as being "carved in" to the plan, then they work directly with pharmacies and pay their beneficiaries' drugs needs with the lump sum received by the state's Medicaid agency. [22] Whereas, with a FFS model, the government provides the reimbursement for a drug directly to the pharmacy.

When reviewing each states' Medicaid Excluded Drug Coverage information, by default, all lists included the statement "Drugs when used for anorexia, weight loss, or weight gain." If there were an exception to this statement it would be listed below the statement. It would include a list of drugs or it would include the drug class that was not excluded from coverage. If there were no additional statements added to the default statement, then the state received a score of "0" for this category. If the state added a favorable statement providing an exception to the default statement that included coverage for an obesity medication, the state received a score of "1." If the state included an unfavorable statement that specifically excluded an obesity medication the state received a score of "-1."

When reviewing their preferred drug lists and their policy handbooks, if it included none of the FDA approved obesity medications, the state received a score of "0", "1" if it included some coverage, and "-1" if information was mentioned that excluded any of the obesity medications.

RESULTS

In the marketplace exchanges, only 9 states had at least one silver plan that included some type of coverage for obesity medications. These were Arizona, Nebraska, North Carolina, North Dakota, South Dakota, Virginia, Delaware, Iowa, and West Virginia (Table 4A and 4B). The other 25 states had no drug coverage provided within the four silver plans investigated. Among the 9 states, only 15 plans out of the 36 silver plans evaluated, offered some type of coverage for obesity medications: 2 low-premium plans, 5

second lowest premium plans, 3 median premium plans, and 5 highest premium plans. For most of the plans there were medications available as tier 1. The covered medications were generally the older FDA approved medications for the treatment of obesity. The newer FDA approved obesity medications tend to be covered as tier 3 medications. Prescription drug tiering for health insurance plans is a mechanism utilized to build in cost sharing for the beneficiary. Lower tiered drugs tend to be generic and often are included in the plan's drug formulary, in which case the co-payment is lower and often does not require prior authorization. Higher tiered drugs tend to be brand named drugs which are more expensive. Consequently, it is accompanied with higher co-payments and often requires prior authorization and/or has quantity limits.

In terms of Medicare prescription drug coverage, CMS outlines Medicare's Formulary requirements for qualifying prescription drug plans (PDPs) in Chapter 6 of its Prescription Drug Coverage Manual. We did not need to investigate each individual drug because CMS's policy specifically states in Section 20.1 – "Weight loss drugs are excluded from Part D Coverage – even if used for a non-cosmetic purpose." [23]

Of the 34 States' Medicaid prescription drug policies reviewed, 8 states have some form of possible coverage for obesity medications for beneficiaries (Table 5). These were Alabama, North Dakota, South Carolina, South Dakota, Texas, Virginia, Wisconsin, and Delaware, but they do require prior reauthorization and extensive medical evaluation for demonstration of treatment need. One state, Texas, is one of the 8 because it did include "lipase inhibiting drugs" as not excluded in their excluded drug coverage. However, when reviewing their pharmacy handbook, Orlistat (Xenical) is only covered for hypertension only, not for weight loss.

DISCUSSION

Obesity remains a significant public health threat in the United States. It is associated with three of the top 10 leading causes of death including the first leading cause of death, cardiovascular disease. [24] Despite growing evidence of efficacy of pharmacotherapy for the treatment of obesity and recent FDA approval of obesity medications for long term use, the US government's health policy and health

insurance programs have not embraced this form of therapy for the treatment of obesity. Medicare strictly does not cover the cost of any of the obesity medications in their prescription drug plans for their beneficiaries. Medicaid health insurance plans cover obesity medications with wide variation from state to state. Only a quarter of the states evaluated had some sort of coverage. Within the ACA marketplace health insurance plans, we observe state-to-state disparities in the coverage of obesity medications, with also only a quarter of the states evaluated providing some coverage. Among the 34 states evaluated, 13 states had some form of coverage among their health insurance plans within their Medicaid programs or their Marketplace plans. Of these 13 states, six are among the states with the highest prevalence of obesity. [25] Conversely, six of the 21 states with no coverage for obesity medications are among the states with the highest prevalence of obesity. The difference among states for coverage of weight loss medications may be logical if the health insurance plans with coverage existed among the states with the highest prevalence of obesity. However, clearly that is not the case, when six states – Arkansas, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, and Tennessee – do not offer their Medicaid beneficiaries and Marketplace enrollees' access to obesity medications.

However, patient access to obesity medications through health insurance plan coverage is not the only barrier to the wide adoption of these medications. There are patient and healthcare provider factors that thwart the use of obesity medications. First, patients, providers, and our governmental health policies continue to stigmatize obesity as a lifestyle and behavior condition, when in fact, we know the underlying biology and physiology of obesity is much more complex. The medical community, represented by the American Medical Association (AMA), recognized obesity as a disease only four years ago in June 2013. [26] The US government recognized obesity as a disease, earlier than the AMA, in 2004. [5] The stigma of obesity however, is still widely pervasive. One views obesity as a reflection of a person's self-control or nutrition status, which prevents the adoption of pharmacotherapy. When we view obesity as a disease process affecting a person's metabolic and hormonal homeostasis, we may begin to accept pharmacotherapy as a solution. [5, 26, 27]

Patients and providers, furthermore, may feel the perceived risks of these medications outweigh their benefits. Due to the widely publicized scandal of early obesity medications such as Fen-Phen® that were linked with significant adverse cardiovascular effects and even death, patients and providers may not be comfortable with pharmacotherapy for the treatment of obesity. [28] Some of the common adverse side effects associated with the current FDA-approved medications include dry mouth, insomnia, nausea, constipation and other gastrointestinal complaints In phentermine/topiramate users, an increased heart rate was an associated side effect of the medication. However, there was also an associated induced blood pressure (BP) reduction with its use. In a study of patients with obesity and concurrent hypertension, there was a dose-dependent reduction in the number of participants using anti-hypertensive medications with the use of phentermine/topiramate. These results were after a 56-week study, and more data with longer-term use is needed to evaluate cardiovascular endpoints with phentermine/topiramate, in addition to the other obesity medications. There were also favorable results of decreased major cardiovascular events (HR=0.88) with the use of naltrexone/bupropion compared to placebo, but long-term evaluation of cardiovascular endpoints is needed. [28] Since cardiovascular disease is the number one leading cause of death in the United States, demonstrating the associated benefit of obesity medication use for cardiovascular disease may ease the concerns of patients and providers and increase the use of these safe medications.

Another barrier to the use of pharmacotherapy for the treatment of obesity may be due to the increased knowledge and established efficacy of bariatric surgery for the treatment of obesity. After establishment of the ACA and increased focus on obesity as a public health concern, we observed an increase in the coverage for bariatric surgery. [9, 29] However, a patient must meet strict guidelines to qualify for bariatric surgery, such as having a BMI>=40, or BMI>=35 with co-morbidities which include hypertension, diabetes, or sleep apnea. For patients who have overweight or obesity with a BMI<35, pharmacotherapy can be an effective treatment to achieve weight control to prevent weight gain. Bariatric surgery also is not without significant risks that include, nausea, vomiting, dehydration, and severe surgery related adverse effects, which may include death and suicide. [28]

In addition, since more and more patients with obesity are undergoing bariatric surgery, patients still need to manage their obesity, although it may be in remission. For patients who do have weight regain after achieving a healthier BMI or with inadequate weight loss, pharmacotherapy may be an option for postoperative patients to achieve a healthy weight. [30]

CONCLUSION

The use of anti-obesity pharmacotherapy will not solve the obesity epidemic in the US, but they do serve as part of the solution. We must embrace an integrated obesity treatment framework which incorporates changes in the way we think of obesity as a disease and provides measures on how we will begin to destigmatize obesity. The integrated framework may also create useful strategies that will provide a meaningful investment in the future of our citizens by preventing and controlling obesity in ways supported by scientific evidence. To ensure all US citizens benefit from these successful strategies, our national, state, and local health policies should lead the way by incorporating them in the fight against obesity. With annual spending of $147 billion due to obesity-related healthcare, not only is obesity a public health threat, it is also a risk to our nation's financial security.

Ironically, federal government employees, with 2.7 million beneficiaries, have benefitted from the recognition of obesity as a complex disease. Their health benefit plans are not allowed to exclude coverage of obesity medications. In this cohort, one study has determined that "with adequate medication reimbursement, patients stay on [obesity] medication longer, see their doctor more often, and lose more weight." [26]Medicare, Medicaid and ACA-established Marketplaces should have health insurance plans that incorporate these changes in order to affect a broader group of our country's population who suffer from obesity. [26] Federal/state coverage mandates and the emergence of quality-driven healthcare initiatives (that include obesity-related chronic diseases) might contribute to broader coverage of obesity medications. [26]

REFERENCES

1. Hales CM CM, Fryar CD, Ogden CL. Prevalence of Obesity Among Adults and Youth: United States, 2015–2016. In. Hyattsville, MD: National Center for Health Statistics, 2017.

2. Flegal KM, Kruszon-Moran D, Carroll MD, Fryar CD, Ogden CL. Trends in Obesity Among Adults in the United States, 2005 to 2014. *JAMA* 2016; **315**(21)**:** 2284-91.

3. Heron M. Deaths: Leading Causes for 2014. In: Reports NVS, (ed). Hyattsville, MD: National Center for Health Statistics, 2016.

4. Winterfield A, Cauchi R. Obesity: Progress and Challenges. In: *Legisbrief*. Washington, D.C.: National Conference of State Legislatures, 2014.

5. Kahan S, Zvenyach T. Obesity as a Disease: Current Policies and Implications for the Future. 2016; **5**(2)**:** 291-297.

6. Apovian CM, Aronne LJ, Bessesen DH, McDonnell ME, Murad MH, Pagotto U *et al.* Pharmacological management of obesity: an endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2015; **100**(2)**:** 342-62.

7. Thomas CE, Mauer EA, Shukla AP, Rathi S, Aronne LJ. Low adoption of weight loss medications: A comparison of prescribing patterns of antiobesity pharmacotherapies and SGLT2s. *Obesity (Silver Spring)* 2016; **24**(9)**:** 1955-61.

8. Cauchi R. Health Reform and Health Mandates for Obesity. In: *Health*. Washington, D.C.: National Conference of State Legislatures, 2016.

9. Yang YT, Pomeranz JL. States variations in the provision of bariatric surgery under affordable care act exchanges. *Surgery for Obesity and Related Diseases* 2015; **11**(3)**:** 715-720.

10. Colman E. Food and Drug Administration's Obesity Drug Guidance Document. *Circulation* 2012; **125**(17)**:** 2156-2164.

11. Daneschvar HL, Aronson MD, Smetana GW. FDA-Approved Anti-Obesity Drugs in the United States. *The American Journal of Medicine* 2016; **129**(8)**:** 879.e1-879.e6.

12. Butsch WS. Obesity medications: what does the future look like? *Curr Opin Endocrinol Diabetes Obes* 2015; **22**(5)**:** 360-6.

13. Foundation KF. State Health Insurance Marketplace Types. In: *Source: Data compiled through review of state legislation and other Marketplace document by Kaiser Family Foundation*: KFF, 2016.

14. Services USDoHaH. *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*: Washington, D.C., 2016.

15. Plan Selection by Zip Code and County in Health Insurance Marketplace:March 2016. In. Washington, D.C.: U.S. Department of Health and Human Services, 2016.

16. 2016 QHP Landscape Data. In. HealthCare.gov: Centers for Medicare and Medicaid Services, 2016.

17. 42 CFR Parts 400, 403, 411, 417, and 423 Medicare Program; Medicare Prescription Drug Benefit; Final Rule. In: Services DoHaH, (ed). Washington, D.C.: Federal Register, 2005. pp 4193-4742.

18. Tudor C. Medicare Prescription Drug Benefit Manual – Chapter 5 Update. In: Services DoHaH, (ed). Baltimore, MD: Center for Medicare and Medicaid Services, 2011.

19. Prescription Drug Coverage - General Information. In: *Medicare*. Baltimore, MD: Center for Medicare and Medicaid Services, 2016.

20. Prescription Drugs. In: *Medicaid Benefits*. Baltimore, MD: Centers for Medicare and Medicaid Services, 2016.

21. Excluded Drug Coverage. In: *Prescription Drugs*. Baltimore, MD: Centers for Medicare and Medicaid Services, 2016.

22. *Medicaid Managed Care: Key Data, Trends, and Issues*. Kaiser Commission on Medicaid and the Uninsured: Washington, D.C., 2012.

23. Medicare Prescription Drug Benefits Manual - Chapter 6. In: *Medicare Part D*. Baltimore, MD: Department of Health and Human Services, 2016.

24. Leading Causes of Death, 2014. In: *FastStats*. Atlanta, GA: CDC National Center for Health Statistics, 2015.

25. BRFSS Prevalence and Trends Data. In. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, 2015.

26. Baum C, Andino K, Wittbrodt E, Stewart S, Szymanski K, Turpin R. The Challenges and Opportunities Associated with Reimbursement for Obesity Pharmacotherapy in the USA. *Pharmacoeconomics* 2015; **33**(7)**:** 643-653.

27. Dietz WH, Solomon LS, Pronk N, Ziegenhorn SK, Standish M, Longjohn MM *et al.* An Integrated Framework For The Prevention And Treatment Of Obesity And Its Related Chronic Diseases. *Health Affairs* 2015; **34**(9)**:** 1456-1463.

28. Gotthardt JD, Bello NT. Can we win the war on obesity with pharmacotherapy? *Expert Rev Clin Pharmacol* 2016**:** 1-9.

29. Courcoulas AP, Belle SH, Neiberg RH, et al. Three-year outcomes of bariatric surgery vs lifestyle intervention for type 2 diabetes mellitus treatment: A randomized clinical trial. *JAMA Surgery* 2015; **150**(10)**:** 931-940.

30. Stanford FC, Alfaris N, Gomez G, Ricks ET, Shukla AP, Corey KE *et al.* The utility of weight loss medications after bariatric surgery for weight regain or inadequate weight loss: A multi-center study. *Surg Obes Relat Dis* 2016.

TABLE 1. LIST OF FDA-APPROVED OBESITY MEDICATIONS	
FDA Approved for Short Term Use	**Year Approved**
Drug Name (Brand Name)	
Phentermine (Adipex, Suprenza)	1959
Diethylpropion (Tenuate)	1950
Phendimetrazine (Bontril PDM)	1956-1960
Benzphetamine (Regimex, Didrex)	1956-1960
FDA Approved for Long Term Use	
Drug Name (Brand Name)	
Orlistat (Xenical)[a]	1999
Lorcaserin (Belviq)	2012
Phentermine/Topiramate (Qysmia)	2012
Liraglutide (Saxenda)	2014
Bupropion/Naltrexone (Contrave)	2014
a- available over-the-counter since 2007 as Alli® 60mg	

TABLE 2. STATES BASELINE CHARACTERISTICS			
State	**Marketplace Type**	**County[a]**	**# Silver Plans Available**
Alabama	FFM	Jefferson County	7
Alaska	FFM	Anchorage Municipality	6
Arizona	FFM	Maricopa County	27
Florida	FFM	Miami-Dade County	22
Georgia	FFM	Gwinnett County	30
Indiana	FFM	Marion County	30
Kansas	FFM	Johnson County	11
Louisiana	FFM	Jefferson Parish County	15
Maine	FFM	Cumberland County	10
Mississippi	FFM	Hinds County	13
Missouri	FFM	St. Louis County	18
Montana	FFM	Gallatin County	9
Nebraska	FFM	Douglas County	13
New Jersey	FFM	Bergen County	21
North Carolina	FFM	Mecklenburg County	10
North Dakota	FFM	Cass County	9
Ohio	FFM	Cuyahoga County	42
Oklahoma	FFM	Oklahoma County	9
Pennsylvania	FFM	Philadelphia County	9
South Carolina	FFM	Greenville County	33
South Dakota	FFM	Minnehaha County	11
Tennessee	FFM	Shelby County	30
Texas	FFM	Harris County	20
Utah	FFM	Salt Lake City County	27
Virginia	FFM	Fairfax County	16
Wisconsin	FFM	Milwaukee County	24
Wyoming	FFM	Laramie County	12*
Arkansas	SPM	Pulaski County	17
Delaware	SPM	New Castle County	8
Illinois	SPM	Cook County	22
Iowa	SPM	Polk County	11
Michigan	SPM	Oakland County	50
New Hampshire	SPM	Hillsborough County	11
West Virginia	SPM	Kanawha County	8
a- Most populous county; FFM=Federally-facilitated Marketplace; SPM=State-Partnership Marketplace			
*All run by Blue Cross Blue Shield			

TABLE 3. STATE MANAGED CARE ENTITIES (MCE) WITH MEDICAID AND PERCENT OF TOTAL MEDICAID BENEFICIARIES ENROLLED IN AN MCE			
	State	**Contract with MCE (Y/N)**	**Medicaid beneficiaries enrolled in a MCE (%)**
1	Alabama	Y	64.3%
2	Alaska	N	0.0%
3	Arizona	Y	87.3%
4	Florida	Y	79.0%
5	Georgia	Y	66.4%
6	Indiana	Y	77.9%
7	Kansas	Y	95.0%
8	Louisiana	Y	71.0%
9	Maine	Y	-
10	Mississippi	Y	67.0%
11	Missouri	Y	50.5%
12	Montana	Y	73.7%
13	Nebraska	Y	74.0%
14	New Jersey	Y	93.0%
15	North Carolina	Y	-
16	North Dakota	Y	62.0%
17	Ohio	Y	78.3%
18	Oklahoma	Y	69.9%
19	Pennsylvania	Y	70.0%
20	South Carolina	Y	75.0%
21	South Dakota	Y	86.0%
22	Tennessee	Y	100.0%
23	Texas	Y	88.0%
24	Utah	Y	62.8%
25	Virginia	Y	66.0%
26	Wisconsin	Y	67.0%
27	Wyoming	N	-
28	Arkansas	Y	57.6%
29	Delaware	Y	90.0%
30	Illinois	Y	79.3%
31	Iowa	Y	49.0%
32	Michigan	Y	77.0%
33	New Hampshire	Y	89.8%
34	West Virginia	Y	67.0%

TABLE 4A. MARKETPLACE EVALUATION OF SILVER PLANS FOR COVERAGE OF OBESITY MEDICATION BY STATE		
	State	**Silver Plans Provided No Drug Coverage[A]**
1	Alabama	✔
2	Alaska	✔
3	Arizona	--
4	Florida	✔
5	Georgia	✔
6	Indiana	✔
7	Kansas	✔
8	Louisiana	✔
9	Maine	✔
10	Mississippi	✔
11	Missouri	✔
12	Montana	✔
13	Nebraska	--
14	New Jersey	✔
15	North Carolina	--
16	North Dakota	--
17	Ohio	✔
18	Oklahoma	✔
19	Pennsylvania	✔
20	South Carolina	✔
21	South Dakota	--
22	Tennessee	✔
23	Texas	✔
24	Utah	✔
25	Virginia	--
26	Wisconsin	✔
27	Wyoming	✔
28	Arkansas	✔
29	Delaware	--
30	Illinois	✔
31	Iowa	--
32	Michigan	✔
33	New Hampshire	✔
34	West Virginia	--
A - All four silver plans investigated for each state		

TABLE 4B. STATES WITH AT LEAST ONE SILVER PLAN WITH OBESITY MEDICATION COVERAGE AND THEIR CORRESPONDING TYPE OF COVERAGE			
State	**Plans with Coverage (#)**	**Plan**	**Type of Coverage**
Arizona	1	Second Lowest-Premium	Tier 1- Phentermine
Nebraska	1	Highest- Premium	Tier 1 - Benzphetamine Tier 3 - Bontril, Regimex, Didrex, and Xenical
North Carolina*	1	Highest- Premium	Tier 1 - Bontril, Phentermine, Benzphetamine with Prior Review (PR) Tier 4 - Suprenza (PR and Restricted Access (RA)), Xenical, Adipex, Regimex, Belviq, Qsymia, Saxenda, Contrave, Phendimetrazine (PR)
North Dakota*	3	Lowest- Premium	Tier 1 - Benzphetamine Tier 3 - Bontril, Regimex, Didrex, Xenical
		Second Lowest-Premium	Tier 1 - Benzphetamine Tier 3 - Bontril, Regimex, Didrex, Xenical
		Median- Premium	Tier 1 - Phentermine and Phendimetrazine with PA
South Dakota*	1	Highest- Premium	Tier 1 - Phentermine and Phendimetrazine with PA
Virginia*	2	Second Lowest-Premium	Tier 3 - Saxenda (Quantity Limit) and Contrave
		Median- Premium	Tier 3 - Saxenda (Quantity Limit) and Contrave
Delaware*	3	Lowest- Premium	Tier 1 - Phentermine, Benzphetamine, Phendimetrazine Tier 3 - Adipex, Bontril, Didrex, Xenical, Belviq, Qsymia, Saxenda, Contrave
		Second Lowest-Premium	Tier 1 - Phentermine, Benzphetamine, Phendimetrazine Tier 3 - Adipex, Bontril, Didrex, Xenical, Belviq, Qsymia, Saxenda, Contrave
		Median- Premium	Tier 1 - Phentermine, Benzphetamine, Phendimetrazine Tier 3 - Adipex, Bontril, Didrex, Xenical, Belviq, Qsymia, Saxenda, Contrave
Iowa*	1	Highest- Premium	Tier 1 - Benzphetamine Tier 3 - Bontril, Regimex, Didrex, Xenical
West Virginia*	2	Second Lowest - Premium	Tier 3 - Adipex, Bontril, Didrex, Xenical, Belviq, Qsymia, Saxenda, Contrave, Phentermine, Diethylpropion, Phendimetrazine, Benzphetamine
		Highest- Premium	Tier 3 - Adipex, Bontril, Didrex, Xenical, Belviq, Qsymia, Saxenda, Contrave, Phentermine, Diethylpropion, Phendimetrazine, Benzphetamine

TABLE 5. MEDICAID PRESCRIPTION OBESITY MEDICATION COVERAGE BY STATE					
	State	**Expanded Medicaid? (Y/N)**	**Excluded Drug Coverage List (EDL)**	**EDL Year Last Updated**	**Drug Coverage based on Preferred Drug List and Policy Handbook**
1	Alabama	N	1	2013	0
2	Alaska	Y	-1	2014	0
3	Arizona	Y	0	2013	0
4	Florida	N	0	2013	0
5	Georgia	Y	0	2009	0
6	Indiana	Y	-1	2009	0
7	Kansas	Y	-1	2009	0
8	Louisiana	Y	-1	2009	0
9	Maine	N	0	2009	-1
10	Mississippi	N	0	2014	0
11	Missouri	N	0	2009	0
12	Montana	Y	0	2009	0
13	Nebraska	N	-1	2014	0
14	New Jersey	Y	-1	2013	0
15	North Carolina	N	0	2014	0
16	North Dakota	Y	1	2013	1
17	Ohio	Y	0	2009	0
18	Oklahoma	N	-1	2009	0
19	Pennsylvania	Y	-1	2013	0
20	South Carolina	N	1	2014	1
21	South Dakota	N	1	2009	0
22	Tennessee	N	-1	2014	0
23	Texas*	N	1	2014	0
24	Utah	N	0	2014	0
25	Virginia	N	1	2014	1
26	Wisconsin	N	1	2014	1
27	Wyoming	N	0	2013	0
28	Arkansas	Y	-1	2009	0
29	Delaware	Y	0	2009	1
30	Illinois	Y	0	2009	0
31	Iowa	Y	0	2014	0
32	Michigan	Y	0	2009	0
33	New Hampshire	Y	-1	2009	0
34	West Virginia	Y	0	2013	0