



Evaluation of HF XXXX – Coverage for the Management and Treatment of Obesity

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

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Executive Summary

This proposed mandate would require a health carrier to provide health insurance coverage for the management and treatment of obesity. Coverage would encompass evidence-based obesity treatments including but not limited to behavioral, dietary, and physical activity interventions; bariatric surgery; and medication approved by the U.S. Food and Drug Administration (FDA) to treat obesity. This proposed mandate would also require Minnesota Medicaid to cover the management and treatment of obesity in the same manner as is required of non-public health plan companies.

It is estimated that over 40% of Americans live with obesity, with a projected increase to 50% of Americans by 2030. According to the Centers for Disease Control and Prevention (CDC), 33.6% of Minnesotans were considered obese in 2022. Health conditions that may be associated with obesity include but are not limited to cardiovascular disease, type 2 diabetes, osteoarthritis, and several cancers. The public health and economic impacts of obesity and its comorbidities are often intertwined, and it is difficult to determine which disease is the contributing factor when determining impacts. Annual estimates of obesity-related financial costs range from \$116 billion to over \$300 billion.

Guidelines recommend a combination of lifestyle, medication, and surgical interventions to treat and manage obesity. While prevention efforts are widely prescribed prior to treatment interventions, this evaluation did not include any research on prevention of obesity, as the proposed health benefit mandate is focused only on the coverage for obesity treatment and maintenance.

At the federal level, the Medicare National Diabetes Prevention Program offers coverage of behavior change interventions for obesity. This program builds off the CDC's National Diabetes Prevention Program. Three states have proposed similar legislation to the proposed mandate, and two states have passed legislation that requires health carriers to provide comprehensive coverage of treatment of obesity, including bariatric surgery, behavioral therapy, and FDA-approved anti-obesity drugs.

Request for information respondents stated that it is unclear what clinical guidelines would determine medical necessity and eligibility, what services would be covered, what level of cost-sharing would be required, and when coverage would be discontinued. Respondents stated that it would be administratively burdensome to determine how to apply the benefit, who qualifies for the benefit, and how long enrollees qualify for covered interventions. Additionally, there was confusion among organizations on whether an obesity diagnosis is required as a prerequisite to coverage.

Given the current available data, the expenditures associated with this mandate are projected to result in a net increase of between \$0.18 per member per month (PMPM) under a low-impact scenario and \$3.77 PMPM under a high-impact scenario for the total non-public insured population in the first year, with an increase to \$1.72 and \$14.04 PMPM for the two scenarios in Year 10.

The potential state fiscal impact of this mandate is as follows:

- There is no estimated cost for the State Employee Group Insurance Program (SEGIP) because the required interventions associated with the bill are covered in the program's medical benefit package.
- Commerce has determined that this proposed mandate would likely require partial defrayal under the Affordable Care Act, with an estimated cost between \$2,600,000 and \$8,000,000 in the first year.

- This proposed mandate would apply to Minnesota health coverage programs (e.g., Medical Assistance and MinnesotaCare).

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Bill Requirements

This House bill is sponsored by Rep. Hortman and has yet to be introduced.

If enacted, this bill would require a health carrier to provide coverage for evidence-based interventions for the management and treatment of obesity. Additionally, this proposed mandate would require Medical Assistance to cover the management and treatment of obesity in the same manner as required of non-public health carriers.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and Minnesota public health coverage programs. It would not apply to self-insured employer plans, grandfathered plans, and Medicare.

Related Health Conditions and Associated Services/Treatments

This mandate does not specify any related conditions/comorbidities associated with obesity. Health conditions that may be associated with obesity include but are not limited to

- cardiovascular disease,
- type 2 diabetes,
- dyslipidemia,
- osteoarthritis,
- sleep apnea,
- depression, and
- some cancers.

Under this proposed mandate, coverage would encompass evidence-based obesity treatments including but not limited to behavioral, dietary, and physical activity interventions; bariatric surgery; and medication approved by the FDA to treat obesity. The proposed mandate does not define “evidence-based” in referring to coverage requirements for obesity.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic.

Relevant Federal Laws

The Medicare National Diabetes Prevention Program offers coverage of behavior change interventions for obesity treatment. This program builds on the CDC's National Diabetes Prevention Program (National DPP). It encourages participants to lose weight through behavior change sessions in order to manage or prevent type 2 diabetes. This lifestyle modification program is covered through Medicare for eligible enrollees.¹

Relevant Minnesota Laws

There are no existing health benefit mandates related to the management and treatment of obesity in Minnesota.

State Comparison

Several states have established or proposed health benefit mandates related to the treatment and management of obesity. Three states ([Massachusetts](#),² Pennsylvania,³ and [California](#)⁴) have proposed similar legislation, and two states ([New Hampshire](#)⁵ and [Virginia](#)⁶) have passed similar legislation. These five proposed or enacted mandates require health carriers to provide comprehensive coverage of treatment of obesity, including bariatric surgery, behavioral therapy, and FDA-approved anti-obesity drugs. Coverage for the treatment of obesity must be provided in the same manner as for any other illness, condition, or disorder for cost-sharing purposes.

Georgia took a different approach to mandating health benefits related to the treatment and management of obesity. It reinstated a pilot program to provide coverage for medically necessary bariatric surgery procedures for the treatment and management of obesity and related conditions for patients covered by state insurance health plans specific to state employees and public school teachers and employees.⁷

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations that responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received comments from four commercial health carriers that provided information related to insurance coverage.

Respondents noted that the language in the bill is not clear and leaves room for interpretation on what clinical guidelines would determine medical necessity and eligibility, what services would be covered, what level of cost-sharing would be required, and what the parameters for discontinuation of coverage would be. Respondents stated that the bill would result in an administrative burden to determine how to apply the benefit, who

qualifies for the benefit, and how long enrollees qualify for covered interventions. Additionally, there was confusion among respondents on whether an obesity diagnosis is required as a prerequisite to coverage.

Most organizations stated that coverage for glucagon-like peptide 1 (GLP-1) drugs is expensive. Respondents also noted that GLP-1 drugs are effective in the short term and would have a significant short-term impact on costs, but there is limited literature on the long-term effectiveness or benefits of these medications. Additional concerns were raised regarding providers potentially prescribing medications without first prescribing less costly interventions, such as medical nutrition therapy. Prescribing drugs or surgery without attempting lifestyle interventions first would increase overall costs and be contrary to current guidelines for treating obesity.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB provided Commerce with a cost estimate produced by SEGIP. According to SEGIP, there would not be any fiscal impact on the state plan from this legislation based on current and upcoming coverage of obesity treatment and management (see the State Fiscal Impact section). This assumes that only widely recognized evidence-based interventions would be included in coverage.
- Respondents noted that plan premiums would likely increase due to coverage of GLP-1 drugs used for weight loss given the growing popularity of this obesity treatment. Issuer respondents cited very large ranges in potential per member per month (PMPM) cost increases attributed to these drugs, with some high-impact estimates roughly 26 times other estimates. The average increase across all respondents is approximately \$80 PMPM.

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Stakeholders' results may or may not reflect generalizable estimates for the mandate.

Evaluation of Proposed Health Benefit Mandate

Methodology

The following section includes an overview of the literature review and actuarial analysis performed to examine the potential public health and economic impact of the mandate. The literature review includes moderate- to high-quality relevant peer-reviewed literature and/or independently conducted domestic research that was published within the last 10 years and is related to the public health, economic, or legal impact of the proposed health benefit mandate. For further information on the literature review methodology, please reference <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

Public Health Impact

Literature Review

Obesity Prevalence and Trends. Obesity is on the rise in both Minnesota and the United States generally. Obesity is known to have a wide variety of comorbidities and to disproportionately impact certain populations. Guidelines suggest a multimodal treatment strategy of lifestyle, medication, and/or surgical interventions. Obesity has been widely recognized as a complex disease requiring a multimodal treatment strategy by the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), and the Obesity

Society.^{8,9} Obesity is a leading cause of preventable death and is the most common nutritional disease in the United States.^{8,10} Weight status is determined using the body mass index (BMI), which is calculated using height and weight. Individuals with a BMI of 30kg/m² or higher fall into the obese weight status category (see Table 1). It is estimated that over 40% of Americans are obese, with a projected increase to 50% of Americans by 2030.¹¹ According to the Centers for Disease Control and Prevention (CDC), 33.6% of Minnesotans were considered obese in 2022.¹² This percentage has been steadily increasing over the last decade.

Table 1. Weight Status by BMI

Weight status category	BMI (kg/m ²)
Underweight	Below 18.5
Normal	18.5–24.9
Overweight	25.0–29.9
Obese	30.0 and above

There are a wide range of comorbidities associated with obesity that impact most major organ systems in the body. The most commonly cited comorbidities include cardiovascular disease, type 2 diabetes, dyslipidemia, osteoarthritis, sleep apnea, depression, and several cancers.^{10,13} Guidelines suggest that reducing weight by 5%–15% in individuals who are overweight or obese can prevent or delay the onset of some comorbidities.¹⁴ The public health and economic impacts of obesity and its comorbidities are frequently intertwined, and it is often difficult to determine which disease is the contributing factor when determining impacts.

While obesity occurs across all populations, certain communities are impacted at a higher rate. Populations with an increased prevalence of obesity include adults with at least one disabling condition, adults with lower education levels, adults with income at or below 130% of the federal poverty line, American Indian or Alaskan Native and Black adults, and individuals with Hispanic ethnicity.^{11,12,14,15}

When it comes to the standard of care for treating and managing obesity, there are two recognized guidelines:¹⁶

- 2013 American Heart Association (AHA)/American College of Cardiology (ACC)/The Obesity Society (TOS) Guideline for the Management of Overweight and Obesity in Adults
- 2016 American Association of Clinical Endocrinologists (AACE)/American College of Endocrinology (ACE) Comprehensive Clinical Practice Guidelines for Medical Care of Patients With Obesity

Both guidelines acknowledge that obesity can be treated and managed through a combination of lifestyle, medication, and surgical interventions.

Lifestyle Interventions

Outcomes and Adherence for Lifestyle Interventions. Lifestyle interventions, such as behavioral, dietary, and physical activity interventions, are considered the initial standard of care for treating and managing obesity.¹⁴ There are no serious side effects associated with lifestyle interventions, but with adherence rates of 60%, lifestyle interventions alone may not be appropriate for all individuals.¹⁴ Adherence rates vary by socioeconomic status, with individuals of higher socioeconomic status having higher adherence rates.¹⁴ For individuals who do find initial success losing weight with lifestyle interventions, research has found that approximately 33%–66% of weight is regained 1 year after stopping treatment.¹⁷ The clinical guidelines suggest using lifestyle interventions in combination with anti-obesity medications (AOMs) or bariatric surgery to reduce this high level of recidivism.¹⁸

Medication Interventions

Medication Utilization and Efficacy. There are currently six AOMs^a approved by the FDA for the long-term treatment of obesity, with the most recent being approved in November 2023.²⁰ The appropriate age range for these medications varies, with some only approved for adults and others approved for adults and children over 12 years of age.¹³ Clinical guidelines recommend considering medication interventions for individuals who fail to respond to lifestyle interventions and have a BMI of ≥ 30 kg/m² or have a BMI of ≥ 27 kg/m² and at least one weight-related comorbidity.⁸ The use of AOMs among adults with obesity is low, at approximately 2.9%, despite their proven effectiveness in combination with lifestyle interventions.^{13,15} AOMs are known to have some side effects, such as gastrointestinal issues, insomnia, headaches, and fatigue.¹⁴ Of those who use AOMs, more than half discontinue or change medications within 6 months of initiation, although this varies by medication.¹⁴ Individuals who use a combination of lifestyle and medication interventions are more successful at losing weight and maintaining weight loss than those who use medication interventions alone.

Surgery Interventions

Indications for Surgery and Associated Outcomes. In the United States, there are three main bariatric surgery interventions performed.²¹ Clinical guidelines recommend consideration of bariatric surgery for individuals who (a) have a BMI of ≥ 40 kg/m² or have a BMI of ≥ 35 kg/m² and at least one weight-related comorbidity and (b) have been unsuccessful with other treatments for obesity.¹⁴ The American Society for Metabolic and Bariatric Surgery estimates that only approximately 1% of qualified patients received bariatric surgery annually despite the proven effectiveness of surgery interventions for weight loss in the long term.^{14,15,22} This may be attributed to the potential surgical complications (e.g., infection, bleeding, and need for reoperation) and adverse effects (e.g., nausea, vomiting, and malnutrition).^{14,21} For individuals who undergo surgical interventions, implementation of lifestyle interventions is recommended for improved long-term outcomes and maintenance of weight loss.¹⁴

Treatment Barriers

Access to Care. While a variety of obesity management and treatment options are available, people with obesity often face barriers at an individual, facility, and societal level. Research suggests that at the individual level people with obesity may have negative perceptions of and lack knowledge about obesity and associated treatments, may lack resources to access care and treatment, may have issues with treatment adherence, and/or may have had negative prior experiences with physicians that dissuade them from seeking treatment options.^{8,11,14} Barriers at the facility level include limited provider knowledge regarding the appropriate provision of covered services, inconsistent or absent communication of treatment guidelines through program materials, negative provider perceptions of obesity and treatment, and a perceived inability on the part of providers to change patient behaviors.^{9,14,23} At the societal level, stigma related to obesity and the view that obesity is a choice instead of a disease can create barriers to individuals getting the help they need.^{11,18}

Once an individual decides to start treatment for obesity, they may also face coverage barriers. While an individual may seek care based on clinical guidelines, their insurance may not cover the recommended intervention.¹¹ If an individual does have coverage, they may face low payment reimbursement, challenges with the approval process, loss of treatment coverage when their BMI falls below a certain threshold, and difficulty receiving a formal obesity diagnosis that may be required for coverage.^{8,14,22} These barriers can also exacerbate the disparities in obesity-related care, as they tend to have a greater impact on economically disadvantaged and at-risk populations.²²

^a The FDA has not approved Ozempic for weight loss, but it is approved for treatment of type 2 diabetes.¹⁹

Economic Impact

Literature Review

Cost Data for Obesity and Potential for Long-Term Savings. The rising rate of obesity has increased costs for individuals and the health care system. Annual estimates of obesity-related financial costs range from \$116 billion to over \$300 billion.²² Annual medical spending is on average 42% higher for an individual living with obesity than for someone of average weight.^{13,22} With each 1 kg/m² increase in BMI over 19 kg/m², medical costs rise nearly 4% among males and over 2% among females.⁹ Employees who are considered morbidly obese (BMI of ≥ 40 kg/m²) may be less productive at work and take more sick days than their colleagues with normal BMI.^{13,23} These individuals also average 2 times more workers' compensation claims than employees with a normal BMI.²³ While obesity and its treatment and management interventions have a cost, the associated health care costs of related comorbidities should be considered when evaluating the economic impact of obesity.²⁴ It is estimated that obesity and its comorbidities were responsible for 27% of U.S. health care inflation-adjusted growth in spending from 1987 to 2011.²² It is also estimated that obesity is responsible for 42.7% of diabetes spending, 13.6% of cardiovascular disease spending, and 8.6% of hyperlipidemia spending.²⁴ While obesity treatments have upfront costs, the long-term savings to the health care system resulting from these treatments may outweigh these costs.²⁴

Lifestyle Interventions. Due to the wide range of obesity-related services, there is limited available literature that estimates the average cost of lifestyle interventions. As lifestyle interventions are the initial standard of care and are often combined with other interventions to treat obesity, they are typically covered by most insurance. Medicare provides an intensive behavioral therapy program for enrollees that includes coverage for nutritional counseling.⁸ Across all plans, nutritional counseling is usually covered if recommended by a physician, but the frequency of visits covered may vary by plan.^{14,25} Among lifestyle interventions, physical activity interventions are the least likely to be covered.

Medication Interventions. The average cost of AOMs per prescription typically ranges between \$4 and \$500 in the United States.²³ This wide range can be attributed to differences in state policies, brand-name versus generic prescription use, and variations in coverage. Coverage for AOMs is highly variable and often includes requirements, such as prior authorization or determination of medical necessity, that further reduce access to treatment.¹⁴ The literature shows that private insurance offers the highest rates of coverage, public insurance offers the lowest rates of coverage, and no coverage is available via Medicare.^{8,14} This may cause a treatment gap for individuals who have moderate obesity and a history of unsuccessful weight management efforts and might benefit most from treatment with AOMs.²³ It is estimated that coverage of AOMs could generate \$20 billion to \$23 billion in budgetary savings for Medicare over 10 years.²⁶

Surgery Interventions. Of the three surgical interventions most commonly used for obesity treatment, the average cost ranges from \$9,000 to \$41,000.^{22,23} While this is a high upfront investment, estimates suggest that this cost is recouped within 2–4 years through increased quality of life and added workforce years.²² Regardless, many insurers, particularly small group plans, do not cover surgical interventions for obesity.²⁵ Medicare covers several bariatric surgery procedures, but only if an individual has a BMI of ≥ 35 kg/m² and at least one weight-related complication that has not been treated through other interventions.¹⁴

Actuarial Analysis^b

Objective

This actuarial analysis includes analysis of the current prevalence of diagnoses, current levels of coverage and utilization, and potential effects of increased utilization with expanded coverage on cost-sharing, premiums, and overall expenditures.

Assumptions and Approach

The Minnesota Department of Health provided the Actuarial Research Corporation with tabulations from the Minnesota All Payer Claims Database (MN APCD) for all obesity diagnoses and claims for associated National Drug Code (NDC) codes and procedure codes for 2019–2022 as a snapshot of current prevalence and drug and procedure utilization, expenditures, and enrollee cost-sharing for obesity treatment for Minnesota commercial health plan enrollees.²⁷

Enrollees were identified as having an obesity diagnosis if they had one of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes in Appendix C.

The following criteria were used by MDH to identify enrollees with an obesity diagnosis and claims for associated drugs and/or procedures:

- Enrollees were identified as having an obesity diagnosis if they had Expanded Diagnosis Cluster (EDC) “NUT03” based on Version 13.0 of Johns Hopkins ACG System.
- The NDC codes in Appendix C were used to identify prescription drug claims related to obesity treatment.
- The Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes in Appendix C were used to identify procedures associated with obesity treatment.

Developing the methodology and related assumptions for the data collection and analysis for this proposed mandate was complex, given the rapidly evolving nature of obesity treatment, practice patterns, market dynamics, and research. With limited data and rapidly increasing and frequently contradictory research on the future utilization, cost, and interaction between GLP-1 agonists and other obesity treatments, this actuarial estimate relied on the most robust and available metrics available at the time of analysis.

Data for enrollees in 2019–2022 who had a qualifying obesity diagnosis, based on the Johns Hopkins ACG System (Version 13.0) for categorizing EDC codes and on the number of enrollees utilizing non-surgical intervention services, gastric and bariatric surgeries, and prescription drugs approved to treat obesity, were tabulated by MDH. Total expenditures and enrollee cost-sharing were tabulated for each of the categories. For the historical period 2019–2022, as tabulated by MDH, the proportion of enrollees with an obesity diagnosis increased from 8.9% in 2019 to 11.9% in 2022 among the full commercial population in the MN APCD (which, per MDH, includes approximately 40% of the total commercial market in Minnesota).²⁸ These figures are significantly lower than the proportion of all Minnesotans identified as obese by the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDC BRFSS), which showed an increase from 30.1% in 2019 to 33.6% in 2022. The Minnesota utilization rates for nonsurgical interventions (behavioral, dietary, and physical activity interventions such as counseling, nutrition therapy, and classes) among enrollees identified as having an EDC

^b Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation. They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

code-based obesity diagnosis held steady in the 92%–93% range over the historic observation period. This is higher than the treatment prevalence figures in recent studies, which ranged from about 35% to 60%. The observed gastric surgery utilization rate ranged from 0.4% to 0.5% of enrollees with an obesity diagnosis, right in line with the national average, which plateaued in recent years at about 0.5% of eligible enrollees. The utilization rate for AOMs among Minnesota enrollees identified as having an obesity diagnosis increased significantly, from 0.4% in 2019 to 1.6% in 2022. While still low, this figure closely follows national trends, and anecdotal studies suggest this increase has accelerated in 2023 and might continue accelerating.

While no data are available to identify and track existing coverage levels for obesity interventions, given 90% plus utilization rates for nonsurgical interventions and a significant difference between EDC code-based diagnoses and CDC BRFSS obesity rates for Minnesota, it is possible that level of coverage could be a catalyst for formal diagnosis. Expanded coverage for the management and treatment of obesity could lead to meaningful increases in obesity diagnosis rates by EDC codes.

For the purposes of this analysis, obesity prevalence rates and total expenditures were projected at current law as well as for three scenarios based on different assumptions. The per-user expenditure rates for each of the three categories were trended forward to the projection period 2025–2034 using category-specific projection factors derived from the National Health Expenditure data compiled by CMS as well as the 2023 Medicare Trustees Report. For gastric surgery utilization under current law, the analysis applied a 0.45% utilization rate based on the overall average in the historic data for Minnesota. For all impact scenarios, the analysis instead applied a 0.5% constant utilization rate throughout the projection period, which is consistent with the national level of utilization estimated from the literature review.

The current law scenario projects a 3% annual increase in obesity prevalence and, among enrollees with an obesity diagnosis, a 5% annual increase in AOM utilization and a constant 90% nonsurgical intervention utilization rate.

The low-impact scenario, like the current law scenario, assumes a 3% annual increase in obesity prevalence; it also assumes a 7% annual increase in AOM utilization and a modest increase in nonsurgical intervention utilization (0.5 percentage points annually).

The moderate-impact scenario assumes an obesity prevalence increase of one quarter of the projected gap between the EDC code-based diagnosis rate and the CDC BRFSS MN obesity rate,^c assumes an 8% annual increase in AOM utilization, and moderates the nonsurgical intervention utilization rate to 70%, with an annual increase of 1 percentage point.

The high-impact scenario assumes an obesity prevalence increase of one half of the projected gap between the EDC code-based diagnosis rate and the CDC BRFSS MN obesity rate, assumes a 9% annual increase in AOM utilization, and moderates the non-surgical intervention utilization rate to 60%, with an annual increase of 1 percentage point.

The overall Minnesota population projections for 2025 (the base year) through 2034 are based on the figures published by the Minnesota State Demographic Center. Given the historic non-public health insurance coverage

^c For example, in 2025, the gap is 24.5% (37.8% vs. 13.4%), and in 2034, the gap is 31.8% (49.3% vs. 17.5%). To calculate the projected obesity prevalence for 2025 using this model: $.25 \times (37.8\% - 13.4\%) = 6.1\%$.

levels from Minnesota Public Health Data Access, 65% of the total state population were assumed to be included in the non-public insured population.

Results

This analysis projects obesity diagnosis prevalence in Minnesota for the total non-public insured population as well as current law utilization and expenditures for the management and treatment of obesity, then projects potential utilization and total expenditures under the mandate's expanded coverage.

Table 2 shows the total projected obesity prevalence, alongside projected current law utilization and expenditures based on historic claims.

Table 3 shows the total projected obesity prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the low-impact scenario assumption set.

Table 4 shows the total projected obesity prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the moderate-impact scenario assumption set.

Table 5 shows the total projected obesity prevalence, projected utilization and expenditures, and net projected effect on the total non-public insured population PMPM under the high-impact scenario assumption set.

Table 2. Total Projected Current Law Obesity Prevalence and Expenditures^d

	Population		Obesity prevalence rates			Enrollees utilizing ...			Plan paid expenditures			Total cost-sharing		
	Total Minnesota population	Non-public insured population	CDC BRFSS rate	Obesity diagnosis rate	Obesity diagnosis enrollees	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs ^e	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Non-surgical interventions	Gastric and bariatric surgery	Rx drugs
2025	5,833,655	3,101,454	37.8%	13.4%	416,131	387,002	1,873	8,323	\$238,989,058	\$37,545,411	\$47,106,185	\$85,620,266	\$731,695	\$2,665,402
2026	5,863,731	3,107,430	38.9%	13.8%	429,441	399,380	1,932	9,018	\$265,870,468	\$40,799,849	\$52,319,601	\$95,250,805	\$795,119	\$2,960,392
2027	5,893,080	3,112,920	40.1%	14.2%	443,105	412,088	1,994	9,770	\$289,418,557	\$43,234,737	\$61,161,620	\$103,687,148	\$842,571	\$3,460,698
2028	5,921,625	3,117,886	41.3%	14.7%	457,127	425,128	2,057	10,584	\$317,685,610	\$46,922,171	\$69,895,671	\$113,814,108	\$914,432	\$3,954,896
2029	5,949,303	3,122,300	42.5%	15.1%	471,507	438,502	2,122	11,462	\$348,650,881	\$50,818,167	\$79,408,440	\$124,907,732	\$990,359	\$4,493,155
2030	5,976,058	3,126,137	43.8%	15.6%	486,249	452,212	2,188	12,412	\$384,001,169	\$55,237,006	\$86,931,594	\$137,572,333	\$1,076,474	\$4,918,836
2031	6,001,850	3,139,298	45.1%	16.0%	502,945	467,739	2,263	13,480	\$423,797,829	\$60,104,589	\$95,545,276	\$151,829,892	\$1,171,335	\$5,406,223
2032	6,026,651	3,151,878	46.5%	16.5%	520,109	483,702	2,340	14,637	\$465,871,506	\$65,574,388	\$106,443,718	\$166,903,216	\$1,277,932	\$6,022,888
2033	6,050,458	3,163,936	47.9%	17.0%	537,762	500,119	2,420	15,890	\$508,175,896	\$71,190,001	\$117,523,777	\$182,059,195	\$1,387,371	\$6,649,829
2034	6,073,273	3,175,472	49.3%	17.5%	555,914	517,000	2,502	17,248	\$557,374,680	\$77,419,887	\$129,478,862	\$199,685,161	\$1,508,780	\$7,326,282

^d The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

^e Rx drugs = prescription medication.

Table 3. Total Projected Obesity Prevalence and Expenditures and Total Non-Public Insured PMPM, Low Impact^f

	Population		Obesity prevalence rates		Enrollees utilizing ...			Plan paid expenditures			Total cost-sharing			
	Total Minnesota population	Non-public insured population	Obesity diagnosis rate	Obesity diagnosis enrollees	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Non-surgical interventions	Gastric and bariatric surgery	Rx drugs	Total non-public insured PMPM change
2025	5,833,655	3,101,454	13.4%	416,131	391,163	2,081	8,323	\$241,558,832	\$41,717,124	\$47,106,185	\$86,540,914	\$812,995	\$2,665,402	\$0.18
2026	5,863,731	3,107,430	13.8%	429,441	405,822	2,147	9,190	\$270,158,701	\$45,333,166	\$53,316,165	\$96,787,109	\$883,465	\$3,016,780	\$0.26
2027	5,893,080	3,112,920	14.2%	443,105	420,950	2,216	10,146	\$295,642,612	\$48,038,596	\$63,513,777	\$105,916,979	\$936,190	\$3,593,790	\$0.36
2028	5,921,625	3,117,886	14.7%	457,127	436,556	2,286	11,200	\$326,225,546	\$52,135,746	\$73,966,270	\$116,873,627	\$1,016,036	\$4,185,222	\$0.48
2029	5,949,303	3,122,300	15.1%	471,507	452,647	2,358	12,361	\$359,897,684	\$56,464,630	\$85,633,674	\$128,937,014	\$1,100,398	\$4,845,396	\$0.62
2030	5,976,058	3,126,137	15.6%	486,249	469,230	2,431	13,640	\$398,452,825	\$61,374,451	\$95,532,257	\$142,749,786	\$1,196,082	\$5,405,486	\$0.78
2031	6,001,850	3,139,298	16.0%	502,945	487,857	2,515	15,096	\$442,025,692	\$66,782,877	\$106,998,106	\$158,360,210	\$1,301,483	\$6,054,257	\$0.97
2032	6,026,651	3,151,878	16.5%	520,109	507,107	2,601	16,704	\$488,413,676	\$72,860,431	\$121,473,455	\$174,979,178	\$1,419,924	\$6,873,313	\$1.19
2033	6,050,458	3,163,936	17.0%	537,762	527,007	2,689	18,480	\$535,497,180	\$79,100,001	\$136,672,636	\$191,847,324	\$1,541,523	\$7,733,326	\$1.43
2034	6,073,273	3,175,472	17.5%	555,914	547,576	2,780	20,441	\$590,337,699	\$86,022,096	\$153,443,742	\$211,494,498	\$1,676,423	\$8,682,283	\$1.72

^f The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 4. Total Projected Obesity Prevalence and Expenditures and Total Non-Public Insured PMPM, Moderate Impact^g

	Population		Obesity prevalence rates		Enrollees utilizing ...			Plan paid expenditures			Total cost-sharing			
	Total Minnesota population	Non-public insured population	Obesity diagnosis rate	Obesity diagnosis enrollees	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Non-surgical interventions	Gastric and bariatric surgery	Rx drugs	Total non-public insured PMPM change
2025	5,833,655	3,101,454	19.5%	605,150	423,605	3,026	12,103	\$261,593,080	\$60,666,299	\$68,503,235	\$93,718,387	\$1,182,282	\$3,876,107	\$1.80
2026	5,863,731	3,107,430	20.1%	624,506	443,399	3,123	13,489	\$295,174,368	\$65,924,856	\$78,258,591	\$105,749,226	\$1,284,762	\$4,428,093	\$2.16
2027	5,893,080	3,112,920	20.7%	644,377	463,952	3,222	15,032	\$325,843,501	\$69,859,175	\$94,098,139	\$116,736,756	\$1,361,435	\$5,324,340	\$2.57
2028	5,921,625	3,117,886	21.3%	664,768	485,280	3,324	16,748	\$362,635,734	\$75,817,373	\$110,608,065	\$129,917,948	\$1,477,550	\$6,258,518	\$3.06
2029	5,949,303	3,122,300	22.0%	685,680	507,403	3,428	18,657	\$403,434,171	\$82,112,566	\$129,252,107	\$144,534,404	\$1,600,233	\$7,313,451	\$3.63
2030	5,976,058	3,126,137	22.6%	707,118	530,339	3,536	20,780	\$450,343,609	\$89,252,577	\$145,540,234	\$161,340,188	\$1,739,379	\$8,235,080	\$4.24
2031	6,001,850	3,139,298	23.3%	731,398	555,862	3,657	23,213	\$503,642,665	\$97,117,672	\$164,531,516	\$180,435,119	\$1,892,656	\$9,309,660	\$4.93
2032	6,026,651	3,151,878	24.0%	756,359	582,396	3,782	25,925	\$560,927,934	\$105,955,836	\$188,536,036	\$200,958,150	\$2,064,897	\$10,667,904	\$5.75
2033	6,050,458	3,163,936	24.7%	782,030	609,983	3,910	28,950	\$619,810,398	\$115,029,606	\$214,108,808	\$222,053,393	\$2,241,729	\$12,114,884	\$6.64
2034	6,073,273	3,175,472	25.5%	808,428	638,658	4,042	32,321	\$688,532,622	\$125,095,926	\$242,628,673	\$246,673,831	\$2,437,904	\$13,728,619	\$7.66

^g The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

Table 5. Total Projected Obesity Prevalence and Expenditures and Total Non-Public Insured PMPM, High Impact^h

	Population		Obesity prevalence rates		Enrollees utilizing ...			Plan paid expenditures			Total cost-sharing			
	Total Minnesota population	Non-public insured population	Obesity diagnosis rate	Obesity diagnosis enrollees	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Nonsurgical interventions	Gastric and bariatric surgery	Rx drugs	Non-surgical interventions	Gastric and bariatric surgery	Rx drugs	Total non-public insured PMPM change
2025	5,833,655	3,101,454	25.6%	794,169	476,502	3,971	15,883	\$294,258,791	\$79,615,474	\$89,900,284	\$105,421,211	\$1,551,569	\$5,086,813	\$3.77
2026	5,863,731	3,107,430	26.4%	819,571	499,938	4,098	17,867	\$332,812,871	\$86,516,547	\$103,653,686	\$119,233,604	\$1,686,059	\$5,865,020	\$4.40
2027	5,893,080	3,112,920	27.2%	845,649	524,302	4,228	20,094	\$368,229,215	\$91,679,753	\$125,787,216	\$131,921,870	\$1,786,681	\$7,117,398	\$5.14
2028	5,921,625	3,117,886	28.0%	872,408	549,617	4,362	22,596	\$410,712,831	\$99,499,000	\$149,226,174	\$147,142,059	\$1,939,064	\$8,443,641	\$6.01
2029	5,949,303	3,122,300	28.8%	899,853	575,906	4,499	25,404	\$457,900,291	\$107,760,503	\$175,994,294	\$164,047,447	\$2,100,067	\$9,958,257	\$7.01
2030	5,976,058	3,126,137	29.7%	927,987	603,192	4,640	28,556	\$512,207,675	\$117,130,703	\$200,007,724	\$183,503,621	\$2,282,676	\$11,317,005	\$8.08
2031	6,001,850	3,139,298	30.6%	959,851	633,501	4,799	32,195	\$573,988,038	\$127,452,468	\$228,199,947	\$205,637,066	\$2,483,829	\$12,912,201	\$9.30
2032	6,026,651	3,151,878	31.5%	992,608	665,047	4,963	36,291	\$640,532,441	\$139,051,240	\$263,914,684	\$229,477,276	\$2,709,869	\$14,933,042	\$10.72
2033	6,050,458	3,163,936	32.4%	1,026,298	697,882	5,131	40,899	\$709,125,582	\$150,959,211	\$302,486,822	\$254,051,468	\$2,941,935	\$17,115,563	\$12.27
2034	6,073,273	3,175,472	33.4%	1,060,941	732,049	5,305	46,085	\$789,217,135	\$164,169,755	\$345,952,752	\$282,745,084	\$3,199,386	\$19,574,989	\$14.04

^h The state health benefit mandates generally only apply to fully insured individual and small group health plans regulated in Minnesota, except where explicitly indicated. However, the actuarial analysis is based on gross expenditures for all non-public insurance in Minnesota. Although the analysis was not limited to individual and small group data, this does not affect the accuracy of the PMPM estimates. Using all non-public claims improves the robustness and accuracy of the PMPM estimates because the analyses rely on a larger, more representative set of data.

The total statewide non-public insured population potential plan paid expenditures for the management and treatment of obesity are projected to be between \$330.4 million and \$829.8 million in Year 1 and to increase to between \$463.8 million and \$1.3 billion in the 10th and final year of the projection period. These expenditures are projected to result in a net increase of between \$0.18 under the low-impact assumption set and \$3.77 PMPM under the high-impact assumption set for the total non-public insured population in the first year and to result in a net increase of between \$1.72 and \$14.04 PMPM in Year 10.

A more comprehensive actuarial analysis and modeling of all services related to and associated with obesity, including downstream effects, and a full picture of what current coverage and expenditures are for Minnesota were not possible with the available data. A literature review was conducted to assess the broader environment of coverage, utilization, and expenditures and look at avenues of potential long-term savings and improved health outcomes.

A National Institutes of Health (NIH) study offered a look at coverage levels for ACA marketplace plans, as well as public health plans, though Minnesota was not specifically studied. At the time, only 11% of marketplace health insurance plans nationwide had some coverage of AOMs. Only seven state Medicaid programs had some level of drug coverage, and Medicare had no drug coverage. Over the past 6 years, coverage has expanded as these medications have proliferated, and the expansion of coverage is expected to accelerate as other states enact mandates similar to Minnesota's proposed mandate and as additional studies and data regarding the efficacy of these medications become available.¹⁸

Another study examined utilization rates using the National Health and Nutrition Examination Survey (NHANES) and the Medical Expenditure Panel Survey (MEPS) and found strikingly low rates of utilization, about 1% of the eligible population, during the study period (2015–2018). An NIH study, *Long-Term Efficacy and Safety of Anti-Obesity Treatment: Where Do We Stand?* published in January 2021, found the rate of long-term adherence to lifestyle modifications to be low and found nonpharmacological interventions alone to be inadequate for achieving long-term and persistent weight loss. This study strongly recommended medical treatment for patients with obesity who struggled to achieve and maintain weight loss from lifestyle interventions.²⁹

A CDC study showed a steady increase in the prevalence of health care provider counseling over the preceding decade. However, at the time of that study, approximately 75% of adults classified as overweight and 50% of those with Class 1 obesity were still not receiving provider weight-loss counseling.³⁰

A Department of Veterans Affairs (VA) study found that VA patients who had bariatric surgery did not realize lower total health care costs in the 10 years following surgery than VA patients who had similarly severe obesity but did not undergo bariatric surgery. The results suggest that the primary benefit of bariatric surgery is to improve health and quality of life, not reduce health care expenditures.³¹

An NIH study found significant total health care cost savings for adults with obesity who experienced and maintained a weight loss of 3% or more compared with those who had no weight change. This study employed a retrospective cohort methodology and found Year 1 savings of \$57.36 PMPM for the 3%–5% weight loss cohort, \$135.35 PMPM for the 5%–10% cohort, and \$193.54 PMPM for the 10%–20% cohort. For patients who sustained weight loss in Year 2, the study found net savings of \$26.38 for the 3%–5% cohort, \$157.41 for the 5%–10% cohort, and \$185.41 for the 10%–20% cohort. However, the study makes no effort to isolate and tease out the effects of interventions or randomize a control group.³²

Data Sources

- Minnesota state population projections are from the “Long-Term Population Projections for Minnesota” published by the Minnesota State Demographic Center.³³
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.³⁴
- Trends and projection factors are derived from the National Health Expenditure data compiled by CMS as well as the 2023 Medicare Trustees Report.^{35,36}
- CDC estimates from the Behavioral Risk Factor Surveillance System of Minnesota were used as the obesity prevalence rates.³⁷
- MDH tabulations of the MN APCD from 2019 to 2022 were used for the estimation of obesity diagnosis prevalence and historical utilization, expenditures, and enrollee cost-sharing for procedures related to obesity.²⁷

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to public programs.

- This mandate is estimated to have no fiscal impact on SEGIP.
- There are partial defrayal costs associated with this proposed mandate.
- The proposed mandate applies to state public programs.

Literature Review

State Employee Insurance Programs

The treatment and management of obesity has a fiscal impact on state employee insurance programs. There has been an increase in obesity treatment coverage (including coverage for nutritional counseling, medicinal interventions, and bariatric surgery) in state employee insurance programs over the past decade. While this is a positive change, coverage for AOMs falls behind other intervention types: Twenty-three states covered AOMs in 2017, compared with 42 states that covered nutritional counseling and 43 states that covered bariatric surgery.²³ Coverage is often restricted by imposing conservative annual or lifetime caps, covering services only in certain plans, and requiring a serious comorbid condition for coverage.²³ State insurance programs in Minnesota currently cover nutritional consultation (Medicaid and SEGIP), pharmacotherapy (SEGIP), and bariatric surgery (Medicaid and SEGIP).²³

State Health Insurance Exchanges

The treatment and management of obesity also has a fiscal impact on state health exchanges because of the ACA provisions that apply to them. The ACA mandates that state health exchanges provide coverage for services included in the essential health benefits (EHBs), such as prescription drugs and chronic disease management.⁹ Specific to obesity, the ACA provides two avenues for coverage: States can cover metabolic treatment or bariatric surgery in their exchanges or they can exclude these services but then must provide mandatory obesity screening and counseling.⁹ While this requires all states to provide some level of obesity treatment, comprehensive treatment varies widely across states, and many states do not cover physical activity or pharmaceutical interventions for obesity treatment and management.^{9,10}

Limitations

There were three main limitations identified during the literature review on the potential public health, economic, and fiscal impacts of the proposed mandate: (a) potential bias of self-reporting of BMI and use of BMI as a measure for obesity, (b) limited research on non-FDA approved AOMs and exclusion of reviews for medications with weight loss as a side effect, and (c) exclusion of prevention efforts, which are a key element of decreasing obesity.

Some studies included in the review use self-reported BMI data, which may be biased and skew results. Additionally, BMI may not be the best measure for determining overweight and obese status, as it does not distinguish factors such as body composition (muscle vs. fat), sex, or age in the calculation. As a result, individuals can be incorrectly categorized as overweight or obese.

When reviewing medication interventions, this review was limited to AOMs that are approved by the FDA as of November 2023, resulting in the exclusion of information on non-FDA approved medications for weight loss or medications for other conditions that have weight loss as a side effect (e.g., Ozempic).ⁱ

Prevention efforts are widely prescribed prior to implementation of treatment and maintenance interventions for obesity. This review did not include any research on prevention of obesity, as the proposed health benefit mandate is focused only on obesity treatment and maintenance coverage.

Fiscal Impact Estimate for SEGP

MMB does not estimate any fiscal impact to the state plan from this legislation. SEGP currently provides coverage in its medical benefit package for the relevant services listed in the bill, including services to manage and treat obesity such as weight loss programs, health education, nutrition counseling, and pharmaceutical interventions. However, because what is meant by “evidence-based” services for managing and treating obesity is not specified, it is unclear whether the bill requires health plans to provide coverage for all services that could potentially be used to manage and treat obesity. If health plans were required to do that, MMB expects there would be a large fiscal impact impossible to estimate with any specificity.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 EHBs defined by the ACA, but they must defray the costs, either through payments to individual enrollees or directly to issuers, and they can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA.^{38,39} For further defrayal requirements and methodology, please visit <https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/>.

If enacted, this proposed mandate would likely require partial defrayal. The proposed mandate creates new coverage requirements for bariatric surgery for all non-HMO qualified health plans, medications for obesity management, and weight-loss programs that are not already covered by Minnesota's benchmark plan (e.g.

ⁱ Ozempic was excluded from the analysis because it does not currently have FDA approval as a weight-loss medication, the rates of off-label prescription of Ozempic for weight loss are unknown, and the existing rates of coverage for Ozempic are unrelated to the proposed health benefit mandate.

nutritional counseling).⁴⁰ In addition, the ACA only requires coverage for obesity screening and counseling and does not specify coverage for non-surgical, medical, or surgical interventions for obesity.^{41,42}

The cost of defrayal associated with this bill is estimated to be between \$2,600,000 and \$8,000,000 in the first year. Commerce based this estimate on data, methods, and assumptions that are consistent with those used by the Actuarial Research Corporation in their actuarial analysis, with adjustments to reflect enrollment and enrollee cost-sharing specific to the individual QHP market.

It should be noted that given the significant differences between the obesity diagnosis rates for the commercial population derived from the MN APCD and the corresponding CDC rates (differences mentioned in the actuarial analysis), along with data limitations related to existing coverage levels and the cost and uptake of new AOMs, it is possible that the estimated cost is understated.

Costs associated with defrayal are estimated to increase in future years due to expected medical cost trends, utilization increases anticipated as a result of the coverage requirement, and projected increasing rates of obesity.

Fiscal Impact on State Public Programs

This proposed mandate would apply to Minnesota public health coverage programs (e.g., Medical Assistance and MinnesotaCare).

Appendix A. Bill Text

A bill for an act relating to insurance; health; requiring coverage for the management and treatment of obesity; amending Minnesota Statutes 2022, section 256B.0625, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62Q.474] COVERAGE FOR THE MANAGEMENT AND TREATMENT OF OBESITY.**

A health plan company must provide coverage for the management and treatment of obesity.

Coverage must include evidence-based obesity treatments, including, but not limited to:

(1) behavioral, dietary, and physical activity interventions;

(2) bariatric surgery; and

(3) medication approved by the Food and Drug Administration to treat obesity.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 72. **Coverage for the management and treatment of obesity.** Medical assistance covers the management and treatment of obesity in the same manner as is required of health plan companies
31 under section 62Q.474.

EFFECTIVE DATE. This section is effective January 1, 2025.

Appendix B. Key Search Terms for Literature Scan

Bariatric surgery

Diet

Hypoglycemic agents

Nutrition counseling

Obesity management

Obesity treatment

Physical activity

Semaglutide

Surgery

Weight-loss drugs

Weight-loss therapies

Appendix C. Associated Codes

CPT/HCPCS Code(s):

Code type	Code(s)	Procedure description
CPT	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions provided to an individual
CPT	99202, 99203, 99204, 99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate HX and/or examination
CPT	99211, 99212, 99213, 00214, 99215	Office or other outpatient visit for the E&M of an established patient
CPT	99078, 99411, 99412	Preventive medicine counseling and/or risk factor reduction interventions provided to individuals in a group setting
CPT	97802, 97803, 97804	Medical nutrition therapy
HCPCS	G0447, G0473	Face-to-face behavioral counseling for obesity
HCPCS	S9499, S9451, S9452, S9470	Classes
CPT	00797, 43644, 43645, 43775, 43842, 43843, 43845, 43847, 43848	Gastric restrictive procedures and anesthesia

Prescription Names and NDCs

Drug name	NDC
Bupropion, naltrexone (Contrave)	51267-0890-07
	51267-0890-99
	50090-2945-00
Liraglutide (Saxenda)	00169-2800-15
	00169-2800-90
	00169-2800-97
	50090-4257-00
Orlistat (Xenical, Alli)	61269-0565-90
	61269-0460-90
Phentermine, topiramate (Qsymia)	62541-0202-30
	62541-0204-30
	62541-0201-30
	62541-0203-30
	62541-0201-14

Drug name	NDC
Semaglutide (Wegovy)	50090-5824-00
	00169-4501-14
	00169-4505-14
	00169-4517-14
	00169-4524-14
	00169-4525-14
	00169-4525-94
	00169-4501-01
	00169-4505-01
	00169-4517-01
	00169-4524-01
	00169-4525-01
	00169-4525-90
Setmelanotide (Imcivree)	72829-0010-01

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3. An Act Amending the Act of May 17, 1921 (P.L. 682, No. 284), S.B. 544, Gen. Assemb., Reg. Sess. (Pa. 2023–2024). <https://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?year=2023&sind=0&body=S&type=B&bn=0544>
4. Obesity Treatment Parity Act. S.B. 839 (2023). https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB839&search_keywords=obesity
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