



# Preliminary Cost Analysis

## *Medical Nutrition Equity Act*

### S. 2013/ H.R. 3783

The Patients & Providers for Medical Nutrition Equity (PPMNE) Coalition commissioned Vital Statistics Consulting LLC to complete a cost estimate of the *Medical Nutrition Equity Act* (MNEA) as introduced in the 116<sup>th</sup> Congress. The bill was re-introduced in the 117<sup>th</sup> Congress as S. 2013/ H.R. 3783. VSC completed an analysis in January 2020 and estimated the federal cost to enact the legislation at \$132 million per year.

- VSC conducted a comprehensive literature review and economic analysis to estimate the cost of MNEA based on 2018 data and across a 10-year period (2020-2029). The estimate takes existing federal and state coverage into account to avoid over-estimation.
- Federal coverage for medically necessary nutrition is available through TRICARE as a result of legislation passed by Congress in 2016. Today, nearly all states – with the exception of Alabama and Georgia – have some level of coverage, although that coverage varies greatly by condition. At the time of the analysis, 36 states had adopted some form of medical nutrition coverage.
- The methodology utilized by VSC results in what is likely a conservative cost estimate and does not account for potential cost savings that would be realized from enactment of the MNEA, including:
  - Replacing pharmacologic and biologic therapies that are routinely covered, oftentimes at a greater cost and with an increased risk of adverse effects than drinkable formulas.
  - Reducing medical complications, poorer outcomes, and the economic costs associated with lack of coverage of medically necessary nutrition.
  - Expanding the methods by which medically necessary nutrition can be administered. For example, oftentimes insurers will cover the cost of medically necessary nutrition but only when the mode of administration is through a j-tube or nasogastric tube. Meaning, insurers will deny coverage if the patient is able to drink the formula, but will cover the extra costs associated with tube feeding, including surgical placement.
  - Reducing the administrative costs associated with the significant time medical providers devote to routinely appealing coverage decisions, many times unsuccessfully, to get approval of medically necessary nutrition for their patients, resulting in delayed access to treatment.
- Examples highlighting the need for this legislation include:
  - A child with Tyrosinemia type 1 (TYR1) required both pharmaceutical intervention (Nitisinone or NTBC) and medically necessary nutrition which would reduce his intake of tyrosine, an amino acid found in most protein sources. The insurance company approved NTBC (average annual cost of ~ \$71,000<sup>i</sup>) but would not cover the medically necessary nutrition that provided the child with the protein necessary for normal development.
  - A three-year old child required medically necessary nutrition due to a growth delay related to one of the disorders covered by MNEA. The patient's insurer initially covered medically necessary nutrition treatment; however, when the patient gained weight and resumed normal development, the insurer denied authorization for continued treatment because the child was no longer malnourished – a direct result of treatment efficacy and evidence of the need to continue this treatment modality.
  - A child diagnosed with Crohn's Disease is typically prescribed medical formula for 6-8 weeks and is capable of drinking the formula orally. However, insurers will frequently cover the formula only when it is administered via a surgically placed tube in the abdomen or a nasogastric tube, which puts undue stress on the child and can cause complications.
- Medically necessary nutrition, when administered under an order of a physician or other health care professional, constitutes a patient's treatment with lower costs and fewer risks.

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<sup>i</sup> <https://www.ncbi.nlm.nih.gov/books/NBK533438/> accessed February 3, 2020.