The Treat and Reduce Obesity Act of 2015

(H.R. 2404/S. 1509)

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In 2010, the nonpartisan Congressional Budget Office (CBO) released a report showing obesity rates among Americans had more than doubled from 13 to 28 percent from 1987 to 2007, and that nearly 20 percent of the increase in U.S. health spending was caused by obesity. Since then, obesity rates have grown measurably worse with nearly 70 percent of Americans affected by excess weight or obesity, and 42 percent of Americans projected to be affected by obesity by 2030.

Since obesity increases the risk for chronic diseases such as high blood pressure, heart disease, and Type 2 diabetes, obesity is an underlying driver of health care expenditures. Health care costs related to obesity reach nearly $200 billion each year.

According to the Centers for Disease Control and Prevention, nearly 35 percent of adults aged 65 and over were affected by obesity in the period of 2007 through 2010, or about 8 million adults in this Medicare age bracket. On average, a Medicare beneficiary affected by obesity in 2008 cost $1,723 ($1,964 in 2012 dollars) more than a beneficiary of normal weight. According to the Congressional Research Service, the expected linear growth in the number of Medicare-aged Americans affected by obesity will result in nearly half of the elderly population classified as obese by 2030.

The obesity epidemic—especially for Medicare beneficiaries—requires more than just diet and exercise and surgery. Medicare patients need access to a full array of treatment options, in conjunction with education, diet, and exercise.

The Treat and Reduce Obesity Act of 2015 will provide Medicare beneficiaries and their health care providers with meaningful tools to reduce obesity by improving access to weight-loss counseling and by allowing coverage for new FDA-approved prescription drugs for chronic weight management.

<u>Outline of The Treat and Reduce Obesity Act of 2015</u>

- **Title and Findings**—this part of the bill includes facts and figures regarding the prevalence of obesity among Medicare beneficiaries, the other costly conditions associated with obesity and the cost of caring for Medicare beneficiaries with obesity.

- **Improves Access to Intensive Behavioral Therapy**—Gives the Centers for Medicare and Medicaid Services (CMS) authority to further develop the existing Medicare benefit for intensive behavioral counseling for obesity by allowing additional types of health care providers to offer this service.

- **Allows Medicare Part D Coverage for Obesity Drugs**—Strikes the prohibition on Medicare Part D coverage for "weight loss drugs" and gives CMS authority to provide coverage of FDA-approved prescription drugs under Medicare Part D for chronic weight management to individuals who meet the statutory definition of "obese" (BMI of 30 or higher) or who meet the statutory definition of being overweight (BMI of 27 to 29.9 with one more co-morbidity).

- **Recommendations to be Developed**—Requires the Department of Health and Human Services (HHS) to report back to Congress on steps taken to implement the Act and to provide Congress with recommendations for better coordination of US government efforts on obesity.

The Treat and Reduce Obesity Act Gives Patients and Doctors Access to Full Array of Treatment Options and Parity with Commercial Payers

Why are Obesity Drugs Excluded from Medicare Part D Coverage?

- When Part D was enacted 10 years ago, there were no widely-accepted, FDA-approved obesity drugs on the market.
- Rightfully so, Congress did not want to cover non-prescription treatments and nutritionals for weight loss.
- Due to significant medical advances resulting in the development of weight-loss drugs and the current and growing epidemic, the Part D statute has become out of date.
- Commercial payers and Medicare Advantage plans can, and many do, now cover these products.
- FEHBP prohibited plans beginning in plan year 2015 from barring obesity therapy coverage on the grounds they are cosmetic or "life-style" drugs.

A Next Generation of Safe and Effective Therapies Can Help Address the Obesity Epidemic.

- Current treatment options in Medicare include behavioral counseling and surgery. There is no lower-cost, middle ground for patients with moderate needs.
- Access to a full array of treatment options, in conjunction with education, diet, and exercise, is needed to confront obesity and the 60 associated chronic conditions with the disease.
- To build on Medicare's counseling program, drug therapy will only add to the beneficiary's success.
- Labels include important, responsible protections against overutilization.
    - Patients must have a BMI <30 or over 27 with at least one co-morbid condition.
    - If patients do not achieve 5 percent weight-loss within 12 weeks, they must cease treatment.
- American College of Cardiology/American Heart Association/Obesity Society guidelines recommend consideration of pharmacotherapy for individuals consistent with FDA labels.

Obesity is a Core Health Care Cost Driver. Reducing It Will Save Our System Considerable Dollars.

- Obesity is responsible for $61.8 billion in Medicare and Medicaid spending**.** In the absence of obesity, Medicare spending would be 8.5 percent lower and Medicaid spending would be 11.8 percent lower. [1]
- In 2010, the nonpartisan Congressional Budget Office reported that nearly 20 percent of the increase in U.S. health care spending (from 1987-2007) was caused by obesity.
- Sixty-six percent of American adults with doctor-diagnosed arthritis are overweight or affected by obesity.
- More than 75 percent of hypertension cases are directly related to obesity.
- More than 80 percent of people with Type 2 diabetes are overweight.
- In 2008, a Medicare beneficiary affected by obesity cost on average $1,723 ($1,964 in 2012 dollars) more than a normal-weight beneficiary.

To bend the Medicare cost curve, addressing the growing obesity epidemic among older Americans is imperative
Please cosponsor **The Treat and Reduce Obesity Act of 2015**

[1] *Source: Campaign to End Obesity, "The Long-Term Returns of Obesity Prevention Policies," Alex Brill, April 2013.*