



June 22, 2015

The Honorable Johnny Isakson  
United States Senator  
131 Russell Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
United States Senator  
475 Russell Senate Office Building  
Washington, DC 20510

Dear Senators Isakson and Warner:

The Obesity Care Continuum is pleased to provide the following comments in response to the May 22, 2015 letter to Stakeholders requesting feedback on possible solutions to improve outcomes for Medicare patients requiring chronic care.

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

Obesity is a multi-factorial chronic disease requiring a comprehensive approach to both prevent and treat. Obesity is associated with a large number of related conditions such as type 2 diabetes, hypertension, heart disease, lipid disorders, certain cancers, sleep apnea, arthritis and mental illness. Therefore, care should not be seen as simply having the goal of reducing body weight, but should additionally be focused on improving overall health and quality of life.

Today, more than one in three U.S. adults have obesity. In the Medicare population, the statistics are even more concerning with more than 40 percent of adults between the ages of 65 to 74 affected by obesity. Absent change, some projections show that 50 percent of Americans will have obesity by 2030. Clearly, we need to start treating obesity seriously.

Similar to many other chronic disease states, obesity requires a multidisciplinary treatment approach. This approach must encompass the best standards of care, both in terms of the treatments chosen, and the care coordination and clinical environment in which they are delivered. Unfortunately though, many private and public health plans continue to exclude coverage for obesity treatment services -- partly due to shortsighted cost savings efforts and partly due to the false assumption that these services are either not medically necessary, or not in line with generally accepted standards of medical care despite scientific evidence to the contrary.

These discriminatory coverage practices, combined with the growing scientific evidence surrounding obesity, led the American Medical Association (AMA) to declare obesity as a disease in 2013 and subsequently adopt formal policy supporting “patient access to the full continuum of care of evidence-based obesity treatment modalities such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions.” Numerous other healthcare professional and patient organizations support the AMA policy because these groups recognize that obesity is associated with, or a precursor to, more than 90 other chronic medical conditions including cardiovascular disease, diabetes, and cancer.

The OCC appreciates the opportunity to address the numerous issue areas raised by the working group. While we are confident that we can offer constructive suggestions during this process, the OCC truly believes that before any constructive conversation can begin about treating obesity, policymakers must first accept obesity for the complex and chronic disease that it is and evaluate proposals for better expanding and coordinating treatment options just as they would for other chronic disease states.

## **Reforms for Medicare’s current fee-for-service that incentivize providers to coordinate care for patients living with chronic conditions**

For example, when policymakers at CMS proposed new Medicare payments for non face-to-face chronic care management services beginning in 2015, obesity was left out of the discussion because it was not on Medicare’s list of chronic conditions eligible for this new enhanced payment, which are listed in the Medicare Chronic Conditions Chartbook.

LINK TO MEDICARE CHRONIC CONDITIONS CHARTBOOK:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>

The Chartbook highlights the prevalence of chronic conditions among Medicare beneficiaries and the impact of chronic conditions on Medicare service utilization and spending. The obesity community argued that the Chartbook should include obesity especially given that 13 of the 15 conditions listed (high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, COPD, atrial fibrillation, certain cancers, asthma, and stroke) are commonly associated with obesity and/or are exacerbated by obesity.

In making this argument, we highlighted how obesity clearly met the criteria CMS outlined in the proposed rule as the rationale for selecting the 15 conditions eligible for the chronic care management payments. Specifically, (1) obesity is highly prevalent among the Medicare population; (2) obesity is chronic; i.e., typically lasts for more than 12 months; (3) obesity poses increased risk for death, acute exacerbation/decompensation, or functional decline; (4) obesity results in increased use of health care services; and (5) successful care management of obesity can improve outcomes/reduce costs.

1. **The prevalence of obesity in older adults is high.** The prevalence of obesity is estimated to be 37% among men and 34% among women ages 60 years and over.<sup>1</sup> About 35% of

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<sup>1</sup> NHANES (Flegal) 2010

people aged 65 and older were affected by obesity in 2007-2010.<sup>2</sup> The prevalence of obesity in the U.S. continues to rise, including for individuals aged 65 and older. In fact, by 2050, the number of persons aged 65 and older in the US is expected to more than double, rising from 40.2 million to 88.5 million.<sup>3</sup>

**2. Obesity is a chronic condition, which typically lasts well longer than 12 months.**

Obesity is a chronic condition that poses lifelong challenges for many individuals. In addition to the AMA via its recent Board decision, numerous healthcare professional organizations, such as the American Heart Association, American Diabetes Association, and the American Association of Clinical Endocrinologists define obesity as a chronic disease. Obesity is also recognized as a chronic disease in the NHLBI Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, which state, “Obesity is a complex multifactorial chronic disease developing from interactive influences of numerous factors—social, behavioral, physiological, metabolic, cellular, and molecular.”<sup>4</sup> The long-term negative effects of obesity have been well-documented (see number 3, below).

**3. Obesity poses an increased risk for death, acute exacerbation/decompensation, or functional design.** Studies have demonstrated that obesity results in higher morbidity for a range of health conditions – including many on the list of 15 chronic conditions proposed by CMS - hypertension, type 2 diabetes, coronary heart disease (CHD), stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer (endometrial, breast, prostate, and colon), among others.<sup>5</sup> Approximately 75% of people with morbid obesity have at least one co-morbid condition, often type 2 diabetes, hypertension or sleep apnea, which increases the risk of premature death.<sup>6</sup>

**4. Obesity results in increased use of health care services, including hospitalizations.**

The medical costs of obesity in the US were estimated to be \$147 billion, and per person health care spending for adults with obesity is 56% higher than for normal weight adults.<sup>7</sup> Patients affected by obesity incur 46% increased inpatient costs, 27% more physician visits and outpatient costs, and 80% increased spending on prescription drugs.<sup>8</sup> A recent study of Medicare beneficiaries noted that patients with obesity were more likely than normal weight patients to have five or more office/clinic visits and visits to a personal physician.<sup>9</sup>

**5. Successful care management can improve outcomes/reduce costs.** Most importantly, CMS notes that care management can improve outcomes and/or reduce costs for the identified conditions. The benefits of care management in individuals with obesity have been well documented. As noted in a report by STOP Obesity Alliance Research Team at The

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<sup>2</sup> Tala H.I. Fakhouri, Ph.D., M.P.H.; Cynthia L. Ogden, Ph.D., M.R.P.; Margaret D. Carroll, M.S.P.H.; Brian K. Kit, M.D., M.P.H.; and Katherine M. Flegal, Ph.D. NCHS Data Brief, No. 106, September 2012. Prevalence of Obesity Among Older Adults in the United States, 2007–2010.

<sup>3</sup> Vincent GK, Velkoff VA. The next four decades, the older population in the United States: 2010 to 2050. Current Population Reports P25–1138. Washington, DC: U.S. Census Bureau. 2010.

<sup>4</sup> NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

<sup>5</sup> NHLBI, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 98-4083, September 1998.

<sup>6</sup> A Must et al. The disease burden associated with overweight and obesity. JAMA. 1999. 282:1523-1529.

<sup>7</sup> EA Finkelstein et al. Annual medical spending attributable to obesity: payer-and service-specific estimates. Health Affairs. 2009, 28(5):w822-31.

<sup>8</sup> IBID.

<sup>9</sup> Malinoff RL, Elliott MN, Giordano LA, Grace SC, and Burroughs JN. Obesity Utilization and Health-Related Quality of Life in Medicare Enrollees. J Ambulatory Care Manage, Vol. 36, No. 1, pp. 61–71.

George Washington University School of Public Health and Health Services, “In general, care coordination mechanisms can take a variety of forms, many of which may be useful for improving primary care practice around obesity. Providers make decisions in the context of health care systems (e.g., care settings, payment structures and arrangements) and patient access depends on the system structure and ease of navigating health care resources.”<sup>10</sup> Inclusion of obesity in the proposed complex chronic care management payment would build on CMS’ 2011 coverage of face-to-face intensive behavioral therapy (IBT) for obesity, giving providers a mechanism to be reimbursed for the extensive non-face-to-face time they spend managing their patients with obesity and other chronic illnesses.

Sadly though, CMS sidestepped this issue when the agency issued its final regulations surrounding chronic care management. We hope that the working group will address this and other payment issues associated with obesity in its recommendations.

### **The effective use, coordination, and cost of prescription drugs & Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with health care providers.**

The use, coordination and cost of prescription drugs is extremely problematic for those affected by obesity given that the Medicare Part D prescription drug program specifically prohibits “drugs for weight gain or weight loss.” A critical first step toward addressing this inequity would be for working group to recommend passage of S 1509/HR 2404, the Treat and Reduce Obesity Act (TROA).

This legislation will provide Medicare recipients and their healthcare providers with meaningful tools to treat and reduce obesity by improving access to obesity screening and counseling services, and new prescription drugs for chronic weight management. Specifically, the TROA would strike the prohibition on Medicare Part D coverage for “weight loss drugs” and give CMS the 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).

When Medicare 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. However, in light of the significant medical advances resulting in the development of weight loss drugs and the current and the growing obesity epidemic, the Part D statute has become out of date. In addition, we note that commercial payers and Medicare Advantage plans can, and many do, now cover these products. Finally, we hope that the working group will examine new guidance from the Office of Personnel Management (OPM), which now prohibits FEHB program carriers, beginning in plan year 2015, from excluding coverage for evidence-based obesity treatment services on the grounds that they are cosmetic or “life-style” drugs.

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<sup>10</sup> Ferguson CF, Langwith C, Muldoon A, and Leonard J. Improving Obesity Management in Adult Primary Care. White Paper released March 6, 2010.

A second aspect of the TROA will address another key area of concern to the work group -- options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with health care providers. The legislation gives CMS the 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. In essence, the legislation would allow for CMS to act in conformity with the USPSTF recommendation that (1) intensive behavioral therapy can produce effective, demonstrable results for patients with obesity, and (2), that these services are more effective after referral to registered dietitians or other experts and should not be limited to primary care providers in the primary care setting.

Again, we appreciate the opportunity to participate in the efforts of the Senate Finance Committee to improve care for Medicare patients affected by chronic disease. Our hope is that the working group will step up on the issues outlined above, and make strong recommendations regarding the need to treat obesity seriously! Let's make sure that Medicare beneficiaries have access to all evidence-based treatment avenues for this complex and chronic disease.

Should you have any questions, please contact me either by telephone at 571-235-6475 or via email at [chris@potomaccurrents.com](mailto:chris@potomaccurrents.com).

Sincerely,



Christopher Gallagher  
Washington Coordinator  
Obesity Care Continuum