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June 15, 2017
Vice Admiral Raquel C. Bono
Director, Defense Health Agency

Dear Vice Admiral Bono,

On behalf of the more than 54,000 members of the Obesity Action Coalition (OAC), I was hoping that I could meet with you in the coming weeks to discuss the OAC's support for patient access to the full range of treatment options for the disease of obesity for patients covered under the DOD/TRICARE health plan and our concerns regarding the Defense Health Agency's (DHA's) strict interpretation of dated and discriminatory coverage language surrounding obesity drugs.

We understand that current statutory language may be behind DHA's rationale for denying access to Food and Drug Administration (FDA) – approved obesity drugs because these drugs are not also approved for the treatment of an accompanying co-morbidity (i.e. diabetes, cardiovascular disease, hypertension, amputation). In light of this possible rationale, we wonder how DHA will address Department of Defense (DOD) priorities for reducing obesity and overweight in the armed services as well as recent clinical practice obesity treatment guidelines issued by the DOD and Department of Veterans Affairs (VA).

For example, the 2014 VA/DOD Clinical Practice Guideline for Screening and Management of Overweight and Obesity state that "Obesity and associated chronic health conditions cause significant morbidity and negatively impact military readiness. Sixty-one to 83% of DOD beneficiaries and 78% of Veterans are overweight or obese, and excess weight is estimated to cost at least $370 per patient per year in additional medical and non-medical costs. Treatment of both overweight and obesity is consistent with the priorities outlined by the leadership of the Department of Veterans Affairs as a part of personalized, proactive Veteran-driven care. Similarly, it is consistent with the DoD's priority for a fit fighting force and embodied in the US Army's Performance Triad of Nutrition, Physical Activity, and Sleep."

Additionally, we note that the Clinical Practice Guideline contains 10 "key elements of weight loss management," including that "obesity is a chronic disease requiring lifelong commitment to treatment and long-term maintenance; comprehensive lifestyle intervention is central to successful and sustained weight loss and; and pharmacotherapy and bariatric surgery may be considered as adjuncts to comprehensive lifestyle intervention."

Finally, we question how DHA will successfully, and fairly, implement Section 729 of the 2017 National Defense Authorization Act, which requires DHA to develop new intervention incentive programs to address chronic disease states –including obesity. Specifically, Section 729 states that "The Secretary shall establish a program to incentivize lifestyle interventions for covered beneficiaries, such as smoking cessation and weight reduction, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost share amounts for health care services during a particular year for covered beneficiaries who met participation milestones, as determined by the Secretary, in the previous year with respect to such lifestyle interventions, such as quitting smoking or achieving a lower body mass index (BMI) by a certain percentage."

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Because this intervention/incentive program could adjust patient cost sharing for those affected by overweight or obesity depending on whether these individuals can meet certain milestones (such as a BMI target), we question if such an approach would be fair given the unequitable coverage policies surrounding obesity when compared to other disease states.

For example, we presume that DHA does provide pharmacotherapy for those with diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease or mood disorders. Given this assumption, wouldn't the exclusion of pharmacotherapy coverage for obesity place affected individuals at a severe disadvantage in terms of meeting certain milestones compared to an individual with hypertension or diabetes?

The advancements in pharmacotherapy, as well as in bariatric surgery, are now providing a broader array of treatment options for those with overweight or obesity. Unfortunately, a number of 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 30 other chronic medical conditions including cardiovascular disease, diabetes, and cancer.

It is imperative that our veterans and the members of our armed forces and their families have access to all evidence-based obesity treatment avenues. We look forward to working with you and the Defense Health Agency toward this goal. Please feel free to contact me via telephone at 813-872-7835 or via email at jnadglowski@obesityaction.org. Thank you.

Sincerely,

Joseph Nadglowski, Jr.
OAC President and CEO