CAMPAIGN TO END OBESITY
ACTION FUND

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

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 Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

The Campaign to End Obesity Action Fund (CEOAF) appreciates the opportunity to provide recommendations in response to the Committee's May 22, 2015 invitation for feedback on legislative solutions to the challenges associated with growing numbers of Medicare beneficiaries suffering from chronic conditions. CEOAF applauds the Chairman and Ranking Member for holding their May 14th hearing on chronic care management, and for the subsequent formation of the Senate Finance Committee Chronic Care Working Group (the "Working Group").

Obesity is associated with over 90 other chronic medical conditions, including cardiovascular disease, diabetes, and cancer. In this respect, it is the disease of diseases and, accordingly, it is our hope that policy options to address this epidemic are included in the group's final recommendations. Obesity rates in America have reached epic proportions, and the cost of this epidemic to U.S. taxpayers has the potential to cripple the federal budget as well as the public health care system. Currently, more than one in three U.S. adults have obesity, putting those individuals at a considerably higher risk of developing diabetes, cardiovascular disease, stroke, and an array of cancers. All told, nearly 100 million Americans – adults and children – have obesity. Absent changes, some projections show that, by 2030, 50 percent of Americans will suffer from obesity.

Today, the costs associated with treating obesity in the United States are staggering. We spend over $200 billion annually in health care costs treating Americans with obesity – a cost that is unsustainable now, and yet certain to rise if the trendlines continue.

In the Medicare population, the statistics are equally concerning. More than 40 percent of adult Medicare beneficiaries between the ages of 65 to 74 have obesity. Annual medical costs for a Medicare beneficiary with obesity are, on average, $1,964 greater (in 2012 dollars) than a "normal-weight" beneficiary. This results in an annual estimated Medicare expenditure of $50 billion on treating obesity and obesity-related conditions. Indeed, the obesity epidemic in America is one of the major drivers of the growth in annual Medicare spending. This is a problem policymakers cannot afford to ignore.

These sobering facts, coupled with the growing science surrounding obesity, led the American Medical Association (AMA) to declare obesity a disease in 2013. The AMA subsequently adopted a 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 health care professional, public health, and patient organizations – along with the CEOAF – support the AMA position.

While "solving" obesity is a laudable goal, incremental changes to Americans' weight can significantly improve health outcomes and produce meaningful and positive economic benefits for the U.S. system. One study found that a population-wide reduction in body mass index (BMI) of just five percent could lead to more than $29 billion in health care savings in just five years.[i] The same study found that, with the same reduction of BMI, the country could save $158 billion over ten years and $611 billion in 20 years. Other studies have shown that we can save nearly $12 billion by simply increasing access to needed pharmaceutical options to treat obesity.[ii]

By addressing obesity, even with meaningful incremental change, and decreasing the prevalence of other chronic medical conditions commonly associated with it, policymakers have the ability to save billions of dollars in Medicare and other spending. Moreover, real policy levers are available to Congress to move the needle on the U.S. obesity epidemic. We would, therefore, respectfully urge the Working Group to include the following bipartisan policy solutions in the group's final set of recommendations.

KEY POLICY RECOMMENDATIONS

1. **Allow non-Primary Care Physician (PCP) based health care providers the ability to furnish Intensive Behavioral Therapy (IBT) benefit to Medicare beneficiaries** (as included in the Treat and Reduce Obesity Act of 2015 (S. 1509/H.R. 2404))

Background:

In 2003, the U.S. Preventive Services Task Force (USPSTF) recommended that clinicians offer or refer adult patients with a BMI greater than or equal to 30 kg/m^2 to intensive, multicomponent behavioral interventions (also known as IBT).

In November 2011, CMS echoed the USPSTF's recommendation and allowed coverage for IBT for Medicare Parts A and B beneficiaries in the primary care setting. Unfortunately, according to a November 2014 article in the *USA TODAY*, less than one percent of all Medicare beneficiaries avail themselves of this benefit.[iii] Much of the underutilization can be attributed to time pressures on primary care medical practitioners and a lack of formal education on obesity counseling for primary care providers.

Recently introduced bipartisan legislation (the Treat and Reduce Obesity Act of 2015; H.R. 2404 and S. 1509) in both the House and Senate would, however, expand the existing Medicare benefit for intensive behavioral counseling for obesity by allowing additional types of health care providers to offer this service. Under the new definition provided in the text, the list of qualified health care practitioners able to furnish this benefit would be extended to include registered dieticians, nutritionists, clinical endocrinologists, community-based lifestyle interventions, and other obesity medicine specialists. Accordingly, the proposal would create systems under the current Medicare fee-for-service program that would improve patient access to care options for patients with obesity.

The benefit, as proposed in the Treat and Reduce Obesity Act, would explicitly provide for care coordination among a primary care practitioner and another qualified health care professional in administering IBT for Medicare beneficiaries. In doing so, the proposal would increase access to counseling services for beneficiaries, while simultaneously ensuring coordinated care between and among health care professionals.

This proposal responds to the Working Group's request for policies to reform Medicare's current fee-for-service program, incentivizing providers to coordinate care for patients living with chronic conditions and policies for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

2. **Facilitate and improve access among Medicare patients to FDA-approved therapies for the treatment of chronic weight management** (as included in the Treat and Reduce Obesity Act of 2015 (S. 1509/H.R. 2404))

Background:
Current law prohibits Medicare Part D coverage of "drugs for weight gain or weight loss," which inhibits patient access to needed, effective, and safe treatment options for Medicare beneficiaries with obesity. When Part D was initially enacted a decade ago, there were no widely-accepted, FDA-approved obesity drugs on the market. Accordingly, Congress decided not to provide Part D coverage for non-FDA-approved weight loss therapies.

In recent years, we have seen several medical advances in this space and the FDA has deemed some therapies appropriate, safe, and effective for use in chronic weight management. Despite this, the specific – and now outdated – exclusion under Part D still exists, limiting patient access to viable obesity treatment options.

Fortunately, some plans do provide access to these needed therapies. Specifically, the Federal Employee Health Benefits (FEHB) Program now prohibits plans from barring coverage for obesity therapies. Additionally, some commercial and Medicare Advantage plans also provide coverage for these therapies, further illustrating the dated nature of the exclusion under Part D.

With the precedent of covering these therapies being set, it is important to also provide that same access to Medicare patients seeking treatment for obesity. Included in the Treat and Reduce Obesity Act of 2015 is a proposal that would strike the prohibition on Part D coverage for those weight loss drugs. Additionally, the legislation would give CMS the authority to provide coverage for FDA-approved prescription drugs under Part D for chronic weight management to individuals who meet the statutory definition of "obese" (defined as a BMI of 30 or higher by the Centers for Disease Control and Prevention (CDC)) or who meet the statutory definition for being overweight (BMI of 27 to 29.9 with one or more co-morbidity).

In 2013, the American Medical Association declared obesity as a disease yet, as discussed above, it is not treated on par with several other chronic diseases. This is perhaps most noteworthy given the utter lack of coverage for pharmaceutical therapies available for individuals with obesity.

It is therefore critical that patients have access to a full array of treatment options to confront obesity and the 90 chronic conditions associated with the disease. Current Medicare treatment options include behavioral counseling and surgery, and many patients with moderate needs are left with no lower-cost, middle-ground alternative.

The current law is clearly outdated and unnecessarily limits patient access to medically relevant, effective, and safe treatment options for beneficiaries with obesity. We must ensure that patients have access to what science tells us are the best – and most effective – solutions to addressing chronic disease. Unfortunately, the Part D exclusion denies patients access to these needed tools. We recommend that the Working Group examine these barriers and recommend changes along the lines of those espoused in the Treat and Reduce Obesity Act of 2015 (S. 1509/H.R. 2404).

This proposal responds to the Working Group's request for policies addressing <u>the effective use, coordination, and cost of prescription drugs.</u>

3. **Facilitate physician education efforts that allow health care providers to more effectively counsel patients on weight-related issues** (as included in the Expanding Nutrition's Role in Curricula and Healthcare (ENRICH) Act (H.R. 1411))

Background:

Despite the fact that more than two out of three Americans are overweight or have obesity, only one out of eight patients receives weight counseling at visits to their primary care doctors. This unfortunate math leaves millions of Americans with obesity or being overweight struggling to find out what options they have or how to achieve a healthier weight.

Despite Medicare covering primary care-based intensive behavioral therapy, less than one percent of those eligible Medicare beneficiaries utilize the benefit. Primary care providers' lack of training in exercise and nutrition seems to be one major reason why individuals are not receiving this care and are unable to engage with their physicians and chart a path towards a healthier weight.

In fact, less than 25 percent of physicians say that they are prepared to treat patients suffering from weight-related issues. This is due, in part, to the fact that less than 30 percent of U.S. medical schools provide the minimum number of education hours on nutrition and exercise science, as recommended by the National Academy of Sciences.

If we are to truly promote and provide a comprehensive set of treatment options for Medicare beneficiaries – and allow them to engage and discuss treatment options with their doctors – we must ensure that our primary care provider workforce is appropriately equipped and trained to speak with patients about these issues. Fortunately, legislation introduced in the House of Representatives (the so-called ENRICH Act; H.R. 1411) addresses this challenge by providing grants to accredited medical schools for the purpose of designing curricula to improve communication and provider preparedness to identify, prevent, manage, and treat individuals with obesity, cardiovascular disease, diabetes, and cancer.

Arming our primary care workforce with the needed tools to address obesity is a vital cog in a comprehensive obesity mitigation strategy. Without physician education and training on obesity counseling, patients will continue to go without needed guidance to engage their health care providers in determining appropriate care pathways and treatment intensity options. Patients can and should be at the center of these decisions; however, without providing doctors with the information, they will be unable to communicate these treatment options to their patients – many of whom are already suffering from being overweight or having obesity.

This proposal responds to the Working Group's request for policies to empower Medicare patients to play a greater role in managing their health and meaningfully engage with their health care providers.

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Conclusion

Addressing the obesity epidemic in America will necessitate a comprehensive approach – one that empowers patients by providing them access to the information, services, and products they need to be healthy. The recommendations outlined above are excellent and impactful elements of such an approach, and they would treat obesity like other chronic medical diseases

in many important respects. It is our hope that these recommendations will be included in the Working Group's final submission to the Senate Finance Committee. We would be pleased to serve as a resource to the Working Group staff as you consider these and related policy issues.

CEOAF appreciates the opportunity to provide these comments to the Working Group and we look forward to working with the Working Group and the Senate Finance Committee to advance these needed policy recommendations that support the effective treatment of Medicare beneficiaries suffering from obesity.

Thank you in advance for your consideration.

Sincerely,

Chris Fox
Vice President, External Affairs

[i] Levi, Jeffrey. 2012. . "F as in Fat: How Obesity Threatens America's Future 2012". September. http://healthyamericans.org/assets/files/TFAH2012FasInFatFnlRv.pdf

[ii] Brill, Alex. 2013. "The Long Term Returns of Obesity Prevention Policies," Campaign to End Obesity. April. http://obesitycampaign.org/documents/FinalLong-TermReturnsofObesityPreventionPolicies.pdf

[iii] Galewitz, Phil. "Seniors' obesity-counseling benefit goes largely unused," November 15, 2014. *Kaiser Health News*. http://www.usatoday.com/story/news/nation/2014/11/15/obesity-counseling-benefits-fails-to-entice-seniors-doctors/18914149/