OBESITY CARE
ADVOCACY NETWORK

About Us

The mission of the Obesity Care Advocacy Network (OCAN) is to unite and align key obesity stakeholders and the community around key obesity-related education, policy and legislative efforts in order to elevate obesity on the national agenda.

Please Support the Treat and Reduce Obesity Act (TROA)

The Treat and Reduce Obesity Act (TROA) of 2017 will be introduced as a bipartisan, bicameral bill in that same form as the legislation previously introduced in the 114th Congress by Representatives Paulsen (R-MN) and Kind (D-WI) and Senators Cassidy (R-LA) and Carper (D-DE). The bill, which garnered 175 House and Senate cosponsors, aims to effectively treat and reduce obesity in older Americans by enhancing Medicare beneficiaries' access to healthcare providers that are best suited to provide intensive behavioral therapy (IBT) and by allowing Medicare Part D to cover FDA-approved obesity drugs.

Obesity is a Public Health Crisis that Strains America's Economy

Throughout the last 20 years, obesity rates have doubled among adults, resulting in more than 35 percent of adults living with obesity and an additional 33 percent being overweight. Evidence suggests that without concerted action, roughly half the adult population will have obesity by 2040. Research studies document the harmful health effects of excess body weight, which increases the risk for conditions such as diabetes, hypertension, heart failure, dyslipidemia, sleep apnea, hip and knee arthritis, multiple cancers, renal and liver disease, musculoskeletal disease, asthma, infertility and depression. Additionally, obesity accounts for 21 percent of total national healthcare spending, and some estimates have the direct medical costs related to obesity and overweight totaling $427 billion. Medicare and Medicaid patients with obesity cost $61.8 billion per year; eradicating obesity would result in an 8.5 percent savings in Medicare spending alone.

Current Barriers to Effective Obesity Treatment

Intensive Behavioral Therapy

IBT consists of measurement of Body Mass Index, dietary/nutritional assessments and intensive behavioral counseling that promotes sustained weight loss through high intensity (i.e., regular and frequent) diet and exercise interventions. In 2012, The United States Preventive Services Task Force (USPSTF) recommended "screening all adults for obesity and that clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions." In its accompanying evidence report, USPSTF concluded that these interventions are an effective component in obesity management, which can lead to an average weight loss of 4 to 7 kg (8.8 to 15.4 lb) and improve glucose tolerance, blood pressure and other physiologic risk factors for cardiovascular disease.

Unfortunately, when Medicare implemented a national coverage decision (NCD) on these services in 2012, the Centers for Medicare & Medicaid Services (CMS) chose to limit coverage for IBT only when these services are provided by a primary care provider in the primary care setting. Medicare's decision

is contradictory to the USPSTF evidence report, which highlighted that primary care providers are limited in their time, training and skills to conduct the high-intensity interventions that are scientifically proven to be the most effective to produce the greatest results. Because of CMS's narrow coverage decision, nutrition professionals, obesity medicine specialists, endocrinologists, bariatric surgeons, psychiatrists, clinical psychologists and other specialists are prevented from effectively providing IBT services.

Medicare Part D Coverage of Obesity Medications

When Congress enacted the Medicare prescription drug program (known as Medicare Part D), there were no widely-accepted FDA-approved obesity therapies on the market. This fact, combined with the false perception by many on Capitol Hill at that time that obesity was a lifestyle condition, led Congress to prevent Medicare Part D from covering "weight loss drugs." Throughout the last 10 years, significant medical advances have been made in the development of obesity medications. That fact combined with our country's current and growing obesity epidemic, clearly make the Part D statute out of date and out of touch with the current scientific evidence surrounding these new pharmaceutical treatments. For example, since Medicare Part D was passed, the FDA has approved a number of new obesity medications and several other promising therapies are quickly progressing through the agency's approval process.

The Treat and Reduce Obesity Act is a Clinically-Effective & Cost-Effective Answer

First, TROA gives CMS the authority to enhance beneficiary access for IBT by allowing additional types of qualified health care providers to offer IBT services -- in conformity with the USPSTF recommendation that (1) IBT can produce effective, demonstrable results for patients with obesity, and (2) that these services are more effective after referral to qualified healthcare professionals with proper training in obesity management. Second, TROA allows the Medicare Part D program the latitude to authorize coverage for FDA-approved weight loss medications that complement IBT. The bill provides coordinated, interdisciplinary care that increases efficiency and efficacy, which improves health care quality and reduces costs.

Action:

Please cosponsor and support final passage of the Treat and Reduce Obesity Act. Should you wish to cosponsor the bill, please contact Chris Gallagher, OCAN Washington Coordinator, at **chris@potomaccurrents.com**.