

Modernize Medicare by Covering Anti-Obesity Medications

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OVERVIEW

The Centers for Disease Control and Prevention calculates that nearly 42% of U.S. adults are living with obesity.¹ It projects that half of American adults will suffer from obesity by 2030, as will 60% of today's children before age 35.²

This is a serious health problem for millions of Americans and for our nation. Obesity is a chronic, complex disease defined as having a body mass index (BMI) of over 30. Related conditions include heart disease, stroke, type 2 diabetes, respiratory problems, and certain types of cancer, all among the leading causes of premature death. Adults living with obesity have a 55% higher risk of developing depression over their lifetime than those of normal weight.³ Obesity also has been identified as one of the greatest risk factors for severe COVID-19 infection.

The burden of obesity does not fall equally on all communities. It is a particularly significant concern for communities of color. Black adults have the highest level of adult obesity nationally at nearly 50%, with the highest rate among Black women at 57%. Forty-five percent of Latino adults are living with obesity.⁴

Obesity is a multi-faceted health condition that too often is wrongly attributed to a lack of personal discipline. This paper argues for making effective medical interventions available to those who are at risk and seek treatment for severe health and mobility implications.

¹ "Adult Obesity Facts," *Centers for Disease Control and Prevention*, last modified May 17, 2022, <https://www.cdc.gov/obesity/data/adult.html>.

² Zachary J. Ward et al, "Association of body mass index with health care expenditures in the United States by age and sex," *PLOS One*, March 24, 2021, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0247307#pone.0247307.ref001>.

³ Floriana Luppino et al, "Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies," *Archives of General Psychiatry* 67, no. 3 (2010): 220-229, doi: 10.1001/archgenpsychiatry.2010.2.

⁴ "The State of Obesity 2020: Better Policies for a Healthier America," *Trust for America's Health*, accessed January 23, 2023, <https://www.tfah.org/report-details/state-of-obesity-2020/>.



Action is Needed Now

Research consistently shows a correlation between obesity and higher medical expenditures. Obesity as a risk factor is by far the greatest contributor to the burden of chronic diseases in the U.S., accounting for up to 47.1% of the total cost of chronic diseases nationwide.⁵

Higher spending is associated with excess body weight across a broad range of ages and BMI⁶ levels, and costs and lost productivity are especially high for people with severe obesity. In 2016, obesity and its associated chronic conditions were estimated to account for more than \$480 billion in direct healthcare costs and \$1.24 trillion in indirect work loss costs in the US.⁷

A study by Harvard University researchers found that annual medical costs for adults with obesity were \$1,861 higher than medical costs for people of healthy weight.⁸ Excess medical costs for adults with severe obesity, defined as a body mass index of over 40, were \$3,097 for adults.⁹ But when direct and indirect expenses are considered, their costs were \$11,481 higher than medical costs for people with a healthy weight.¹⁰

Obesity also is associated with significant costs from lost productivity and from presenteeism and absenteeism.¹¹ A 2021 study found that obesity, relative

⁵ Ibid.

⁶ A person is considered to have obesity when they have a Body Mass Index (BMI) of 30 or higher. BMI measures the ratio of a person's height to their weight to estimate the amount of body fat they have.

⁷ Hugh Waters and Marlon Graf, "America's Obesity Crisis. The Health and Economic Costs of Excess Weight," *Milken Institute*, October 2018, <https://milkeninstitute.org/report/americas-obesity-crisis-health-and-economic-costs-excess-weight>.

⁸ Zachary Ward, et al, "Association of body mass index with health care expenditures in the United States by age and sex," "Adult Obesity Facts."

⁹ Zachary Ward, et al, "Association of body mass index with health care expenditures in the United States by age and sex."

¹⁰ Direct expenses are health costs for employees with obesity that exceed health costs for employees with normal weight. Indirect expenses are other costs incurred by the employer that exceed amounts for employees with normal weight, including lost productivity and some portion of workers' compensation payments. See: Abhilasha Ramasamy et al, "Direct and Indirect Cost of Obesity Among the Privately Insured in the United States," *Journal of Occupational and Environmental Medicine* 61, no. 11, (2019): 877-886, doi: 10.1097/JOM.0000000000001693.

¹¹ Absenteeism refers to loss in productivity related to sick leave, while presenteeism refers to loss of productivity due to illness while working. See: Patti van Eys, "The Costs of Presenteeism and Absenteeism in the Workplace," *Pathways*, January 21, 2022, <https://www.pathways.com/pathways-at-work/blog/costs-of-presenteeism-and-absenteeism>.



to normal weight, raises job absenteeism due to injury or illness by 3.0 days per year (128%), and obesity-related productivity losses were estimated at \$13.4B to \$26.8B nationally in 2016, or from \$271 to \$542 per worker.¹² Additional cost borne by payors and employers support an economic rationale to treating obesity.

While cost estimates vary, they all underscore that chronic obesity is a major cost contributor. “The effects of obesity raised costs in every category of care: inpatient, outpatient, and prescription drugs [and] doubled the medical expenditures of adults relative to those of normal weight,” researchers found.¹³ “Increases in medical expenditures due to obesity were higher for adults covered by public health insurance programs (\$2,868) than for those having private health insurance (\$2,058).”

Analyses of those most likely to suffer serious illness and die from COVID-19 also show obesity and age are primary risk factors.

Some states in the U.S. recognized earlier than others that COVID protections should focus on seniors with multiple chronic conditions, especially obesity.¹⁴ Targeted actions are vital in a crisis so it is crucial to make public policy changes to mitigate contributing factors such as obesity to better manage future epidemics.

Action is needed, and now. Obesity is a major public health crisis, and public policies surrounding this issue must evolve as treatments advance.

People should be able to decide for themselves, in consultation with their physicians, from a full range of options available to treat obesity. Millions of Americans, especially seniors on Medicare, don’t have this choice. It is clear that they need access to all options, particularly innovative treatments that can bridge the gap between diet and exercise and bariatric surgery.

¹² John Cawley, et al, “Job Absenteeism Costs of Obesity in the United States National and State-Level Estimates,” *Journal of Occupational and Environmental Medicine* 63, no. 7, (2021): 565-573, doi: 10.1097/JOM.0000000000002198.

¹³ John Cawley et al, “Direct medical costs of obesity in the United States and the most populous states.” *Journal of Managed Care and Specialty Pharmacy* 27, no. 3, (2021):354-66. <https://www.jmcp.org/doi/pdf/10.18553/jmcp.2021.20410>.

¹⁴ Doug Badger and Norbert Michel, “Policymakers Should Adapt COVID-19 Responses to the Evidence,” *The Heritage Foundation*, May 23, 2020, <https://www.heritage.org/public-health/report/policymakers-should-adapt-covid-19-responses-the-evidence>.



Medicare and New Treatment Options

A new generation of innovative medical treatments is emerging that can treat obesity. Some private plans cover the medications, as do some Medicaid managed care organizations. Treatment with anti-obesity medications (AOMs) approved by the Food & Drug Administration (FDA) are recognized in clinical guidelines as an effective option for some individuals and need to be a part of the continuum of care.

But Medicare doesn't allow health plans participating in Part D to include obesity medicines as covered drugs. Because the whole class of AOMs is excluded, these treatments are not an option for seniors through their Medicare coverage.

Medicare Part D prohibits coverage of AOMs approved by the FDA under an exclusion for "weight-loss" medications in the Medicare Modernization Act that created the Part D prescription drug benefit in 2003.¹⁵ This ban on coverage of obesity medications creates a barrier for Medicare beneficiaries to access AOM treatments, and that makes it easier for private health plans and other Medicaid programs to deny coverage for the drugs as well.

As the American Enterprise Institute's Joseph Antos noted recently on the topic of insurance coverage for AOMs, "If Medicare covers something that also has an application for the general population, you'll generally see that insurers, if they haven't already covered it, [will do so] pretty quickly. It's virtually inevitable. So, in this case, although I think the private sector...has been the leader, it hasn't necessarily been the aggressive leader. And if Medicare provides coverage, then I think you'll see a shift in the way the insurance industry as a whole looks at this issue."¹⁶

The lack of coverage in Medicare also means that Medicare Advantage plans, which cover nearly half of Medicare enrollees and a disproportionate number

¹⁵ Prohibition of AOMs is at: SSA § 1860D-2(e)(2) which references SSA§1927(d)(2), where there is a list of drugs subject to restriction. "The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted: (A) Agents when used for anorexia, weight loss, or weight gain." See: Douglas Holtz-Eakin, "Weekly Checkup: Modernizing the Medicare Modernization Act?" *American Action Forum*, August 26, 2022, <https://www.americanactionforum.org/weekly-checkup/modernizing-the-medicare-modernization-act/#ixzz7i0Ojudgy>.

¹⁶ "Access to Obesity Care in the US: Coverage in a New Era of Treatments," panel discussion, *American Enterprise Institute*, September 22, 2022, <https://www.aei.org/wp-content/uploads/2022/09/220922-Access-to-Obesity-Care-in-the-US.pdf>.



of seniors of color,¹⁷ are only able to cover AOMs if they are provided as a supplemental benefit, which in turn can come at a substantially higher cost to beneficiaries.

That prohibition means that many physicians therefore are limited in their options to treat patients who may have struggled with obesity for years or even decades and for whom recommendations for improved diets and exercise are insufficient.

Medicare DOES cover more invasive, and more costly, bariatric surgery for some seniors with a BMI of 40 or higher. In fact, Medicare requires that beneficiaries fail on other medical treatments, which paradoxically includes AOMs which are not covered under Medicare, prior to covering surgery, which is covered by Medicare.¹⁸ Since 2011, Medicare has covered obesity screenings and behavioral counseling for beneficiaries with a BMI of 30 or higher, technically described as intensive behavioral therapy for obesity.¹⁹ It also reimburses primary care providers for obesity screenings and counseling but not for referral to specialists who might be able to provide specialty treatments. Medicare also covers diabetes self-management training and the Medicare Diabetes Prevention Program (DPP). These are not enough.

Outdated regulatory policies reflect antiquated thinking as if this is simply about lifestyle choices for people who want to lose a few pounds on the latest “diet drugs.” The traditional advice of telling people to exercise and control their diet is rooted in the false assumption that obesity is a lifestyle choice. It is estimated from meta-analyses that “only about 25% of people are able to lose and maintain upwards of 10% total body weight loss with lifestyle alone.”²⁰ This advice seldom works. According to the CDC, the prevalence of severe obesity is getting worse, not better. In the early 1960s, fewer than 14% of Americans had a body mass index of more than 30 compared to 42% of the population in

¹⁷ Meredith Freed et al, “Medicare Advantage 2023 Spotlight: First Look,” *Kaiser Family Foundation*, November 10, 2022, <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/#:~:text=Over%20the%20last%20decade%2C%20Medicare,of%20the%20total%20Medicare%20population.>

¹⁸ “Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity,” *Centers for Medicare and Medicaid Services*, last modified December 17, 2013, <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=57>.

¹⁹ “Intensive Behavioral Therapy for Obesity,” *Centers for Medicare and Medicaid Services*, last modified March 6, 2021, <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=353>.

²⁰ “Pandemic Pounds? Obesity Rate Spikes in Active-Duty Military Members,” *Medpage Today*, November 7, 2022, https://www.medpagetoday.com/meetingcoverage/obesityweek/101630?utm_source=ourcommunitynow&utm_medium=web.



2018,²¹ and the prevalence has doubled over the last 20 years, with older adults most impacted.²²

The need for policymakers to address coverage issues for AOMs is increasingly urgent.

The Medicare Modernization Act (MMA) passed in 2003, and the Medicare Prescription Drug Benefit (Part D) program it created began covering seniors in 2006.

But today, in 2023, Medicare will pay for expensive bariatric surgery, the last-resort treatment for obesity, but not for new treatments that scientists have developed that can address the disease itself.

This goes against one of the key arguments for creating the Medicare drug benefit program in the first place. When former President George W. Bush promoted passage of the Medicare drug benefit in 2003, he argued that it didn't make sense for Medicare to pay for surgery for ulcers that could be treated by medications.

Medicare needed to be reformed "because it did not provide prescription drug coverage," he said. "Medicare would pay for a surgery, say, like ulcer surgery, for \$28,000, but wouldn't pay \$500 for the prescription drugs that would have prevented the ulcer in the first place." Mr. Bush argued that "medicine had changed with the advent of prescription drugs, but Medicare hadn't."²³

Yet today, 20 years since the MMA was enacted, doctors still are treating medical problems caused by obesity, including coronary artery disease, high blood pressure and diabetes, instead of prescribing AOM treatments for seniors that could address the underlying cause. This is bad public health policy, and it is inconsistent with a focus on care management and disease prevention. It also imposes a substantial fiscal burden on the nation.

²¹ "The obesity epidemic, transcript," panel discussion, *Centers for Disease Control and Prevention*, December 4, 2017, <http://www.cdc.gov/cdctv/diseaseandconditions/lifestyle/obesity-epidemic-transcript.html>.

²² "Adult Obesity Facts."

²³ George Bush, "President George W. Bush discusses Medicare Prescription Drug Benefit," at Kings Point Clubhouse, Sun City Center, Florida, May 9, 2006, <https://georgewbush-whitehouse.archives.gov/news/releases/2006/05/20060509-5.html>.



Patients and physicians need access to the full continuum of care options to decide what treatment is best for their patients. It is well past time for Medicare to include obesity-fighting drugs to help doctors and patients work together to determine treatment plans that will reduce the need for surgical and other costly treatments, leading to better health for patients and a reduction in overall treatment costs.

Better Understanding of the Science

Since Medicare Part D's passage with the exclusion of coverage for AOMs, the medical community has come a long way in understanding obesity and its far-reaching health implications.

In 2013, the American Medical Association House of Delegates voted to recognize obesity as a disease state requiring treatment and prevention efforts. "Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans," Dr. Patrice Harris, a member of the association's board, said following the AMA vote. She added that the definition could help in the fight against Type 2 diabetes and heart disease that are linked to obesity.²⁴

The American Association of Clinical Endocrinologists, the American College of Endocrinology, and the American Gastroenterology Association all have published clinical practice guidelines to diagnose, manage, and treat obesity that includes the use of AOMs.²⁵

These guidelines reflect the fact that modern research is leading to innovative anti-obesity treatments; the stage was set for these innovations when the FDA in 2007 published guidelines for the development of new products in this space.²⁶

²⁴ AMA Recognizes Obesity as a Disease," *New York Times*, June 18, 2013, <https://www.nytimes.com/2013/06/19/business/ama-recognizes-obesity-as-a-disease.html>.

²⁵ W. Timothy et al, "American Association of Clinical Endocrinologists and American College of Endocrinology Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity," *American Association of Clinical Endocrinology* 22, no. 3, (2016): 1-203, [https://www.endocrinepractice.org/article/S1530-891X\(20\)44630-0/fulltext](https://www.endocrinepractice.org/article/S1530-891X(20)44630-0/fulltext); Eduardo Grunvald et al, "AGA Clinical Practice Guideline on Pharmacological Interventions for Adults with Obesity," *Guidelines* 163, no. 5, (2022): 1198-1225, [https://www.gastrojournal.org/article/S0016-5085\(22\)01026-5/fulltext](https://www.gastrojournal.org/article/S0016-5085(22)01026-5/fulltext).

²⁶ "Guidance for Industry- Developing Products for Weight Management," *Food and Drug Administration*, February 2007, <https://www.fda.gov/media/71252/download>.



The FDA's promulgation of guidelines were a necessary response to the "Fen-Phen" fiasco a generation ago that led to negative perceptions around the safety of pharmacotherapy for weight loss. "Fen-Phen," the use in combination of the drugs fenfluramine and phentermine, and phentermine and dexfenfluramine, led to a weight loss craze in the early 1990s. All three of those drugs were FDA approved, but using them *in combination* never received FDA approval.

In 1997, the FDA asked manufacturers to voluntarily withdraw fenfluramine and dexfenfluramine from the market after a study showed they caused damage to heart valves. That effectively put an end to the craze. The perception problem of that era was put into sharper focus because several other weight-loss drugs were withdrawn from the market due to severe cardiovascular side effects.

"The obesity pandemic continues to grow at an alarming rate," BG Tchang et al warn.²⁷ "Because lifestyle modifications have been limited in their success in weight loss maintenance, pharmacotherapy plays an important role in achieving clinically significant weight loss and preventing the development or exacerbation of comorbid conditions. As society and the scientific community furthers our understanding of obesity, obesity management will evolve to match the standard of care of other chronic conditions, recognizing polypharmacotherapy as a vital component of comprehensive care."

The current generation of FDA-approved AOMs allows patients to lose weight and manage obesity with increased effectiveness.²⁸ In certain cases these newer products are also usable for the long-term treatment of obesity. And directly contrary to Phen-Fen and other drugs that have been withdrawn from the market due to cardiovascular risks, some of the newer generation also have shown favorable cardiometabolic effects.

Better Health and Cost Savings

Milliman,²⁹ a respected economic modeling and research firm, analyzed how establishing coverage for AOMs in Medicare Part D would impact Medicare costs over a 10-year period.

²⁷ Ibid.

²⁸ Beverly Tchang et al, "Pharmacologic Treatment of Overweight and Obesity in Adults," *National Library of Medicine*, last modified August 2, 2021, <https://www.ncbi.nlm.nih.gov/books/NBK279038/>.

²⁹ Katie Holcomb, Jake Klaisner, and Chris Gerenak, "Impact of Covering Anti-Obesity Medications in Medicare Part D," *Milliman*, August 16, 2023, https://www.theglobalipcenter.com/wp-content/uploads/2021/12/Impact-of-Covering-AOMs-in-Part-D_FINAL_16Aug211.pdf.



In summary, it found that:

- Adding coverage for anti-obesity medications to the Part D benefit could result in federal Medicare savings of \$1.5 billion to \$12.3 billion over 10 years, assuming that treating obesity leads to medical cost offsets. Peer-reviewed research documents that medical costs are higher for people with obesity.³⁰
- Even if no medical savings are assumed, the federal government’s cost of adding coverage for anti-obesity medications is modest. The report states, “...absent consideration for any medical savings offsets, government costs are projected to increase by \$3.6 billion” over 10 years. This represents about 0.036% of total federal Medicare spending over 10 years.
- Higher uptake of AOMs could lead to more patients with permanent weight loss, and to the extent medical cost offsets occur, could yield higher federal savings. Scenarios that estimated the impact of higher uptake of AOMs, and therefore a greater proportion of beneficiaries with reductions in BMI, yielded greater savings to the federal government if medical cost offsets occur.

The report also finds that Part D beneficiaries would not see significant premium increases from coverage of AOMs, with premium increases ranging from \$0.02 to \$0.14 per member per month. If significant medical savings are achieved, Medicare beneficiaries could see aggregate savings in their health care costs, Milliman concludes.

The report reflects the AOM market as of May 2021, and notes: “If newer products are more efficacious, this could increase utilization. Greater efficacy could produce greater total savings, if it results in a larger proportion of users with medical and drug cost offsets.”

Compare these potential savings with the adverse economic impact of obesity in the United States in significant medical costs and in productivity losses and human capital costs, and the conclusion should be clear for policymakers.

³⁰ Victoria Divino et al, “Complication-specific direct medical costs by body mass index for 13 obesity-related complications: a retrospective database study,” *Journal of Managed Care and Specialty Pharmacy* 27, no. 2, (2021):210-222, doi 10.18553/jmcp.2020.20272.



An earlier study by Brookings Institution scholars³¹ found that people living with obesity have nearly 36% higher average annual health costs compared to healthy-weight individuals.

Real world evidence suggests that uptake of the drugs among those with obesity may not be high. The Government Accountability Office produced a report on utilization and found that, “Of an estimated 71.6 million U.S. adults with obesity, an estimated 660,000 per year, on average, used an obesity drug from 2012 through 2016, according to national estimates. Among adults who reported trying to lose weight, about 3 percent reported that they took prescription medication for weight loss from 2013 through 2016.”³²

Utilization within plans can be seen in a more recent article about access to AOMs in state employee health plans studied. The authors conclude: “Despite promising new therapies, states in 2021 were less likely to provide coverage for antiobesity medications. Additionally, limited use data suggested that few eligible individuals may be receiving these services. In conclusion, state employee health plans are currently inadequate given the prevalence, severity, and costs of obesity.”³³ Even as additional states expand access to AOMs for their employees, coverage remains inadequate, and utilization remains low.

A clinical trial reported in *Lancet* found in 2018 that, “Newer AOMs have demonstrated long-term safety and efficacy and offer an opportunity to enhance weight loss and weight maintenance. For example, AOMs have been shown to benefit a significantly larger group of patients versus placebo, with most patients achieving weight loss of $\geq 5\%$,” the researchers conclude. “Further, new and novel AOMs are currently in development which will likely achieve even greater magnitude of weight loss.”³⁴

³¹ Ross Hammond and Ruth Levine, “The Economic Impact of Obesity in the United States,” *Diabetes, Metabolic Syndrome and Obesity* 3, (2010), doi: 10.2147/DMSOTT.S7384.

³² “Obesity Drugs: Few Adults Used Prescription Drugs for Weight Loss and Insurance Coverage Varied.” *Government Accountability Office*, August 2019, <https://www.gao.gov/assets/710/700883.pdf>. The GAO undertook the study because the Bipartisan Budget Act of 2018 included a provision for it to review the prevalence of obesity and the use of obesity drugs, including spending for and insurance coverage of these drugs. Pub. L. No. 115-123, div. E, tit. III, § 50352, 132 Stat. 64, 212

³³ Samuel Hughes, William Dietz, and Christine Gallagher, “Coverage for obesity prevention and treatment: analysis of state employee health plans and use of benefits,” *Obesity* 30, no. 8, (2022), doi: 10.1002/oby.23468.

³⁴ Patrick O’Neil et al, “Efficacy and safety of semaglutide compared with liraglutide and placebo for weight loss in patients with obesity: a randomised, doubleblind, placebo and active controlled, dose-ranging, phase 2 trial,” *Lancet* 18, (2018): 637-649, doi: 10.1016/S0140-6736(18)31773-2.



According to a peer-reviewed study in *Pharmacoeconomics*, overall, adult obesity in the U.S. raises annual medical care costs by \$315.8 billion (or \$3,508 per individual) a year. Costs rise exponentially for patients with class II and III obesity, as well as patients with Type 2 diabetes.³⁵

While access varies across states and plans, AOM treatments are covered in some Medicaid managed care plans and commercial coverage. In addition, access to the full continuum of care for obesity is covered by other federal programs, including the Federal Employees Health Benefits Program, the Department of Veterans Affairs, and TRICARE.

Growing Clinical Evidence

A recent report commissioned by the Lupus Foundation of America's Medicare Access for Patients Rx (MAPRx) examines the growing clinical evidence for coverage of FDA-approved anti-obesity medications in Medicare Part D.³⁶

“As the medical community’s understanding of disease states evolves, MAPRx is calling on the Part D program to evolve alongside it to ensure it is providing the best possible coverage to the more than 48 million Americans served by Part D. This is especially necessary for those living with obesity,” the report reads.

“Coverage policies constantly evolve as clinical evidence advances and, with that, the Medicare program advances its coverage of medications and services. The program has evolved over time, covering previously non-covered items based on new indications and clinical evidence. For example, Medicare has changed the way it covers mental health services and bariatric surgery. Yet it has not kept pace with advances in the medical community’s understanding of obesity or its treatment, despite the prevalence of obesity, its significant negative impact on the health of Medicare beneficiaries, and the cost to society.”

The MAPRx paper attests that “Given the linkage of obesity with chronic, life-threatening diseases; the higher risk of adverse COVID-19 outcomes

³⁵ John Cawley et al, “Savings in Medical Expenditures Associated with Reductions in Body Mass Index Among US Adults with Obesity, by Diabetes Status,” *Pharmacoeconomics* 33, no. 7, (2015): 707-22. doi: 10.1007/s40273-014-0230-2.

³⁶ “Clinical Evidence Driving Patient Access in Medicare Part D,” *Medicare Access for Patients Rx*, accessed January 27, 2023, <https://maprx.info/wp-content/uploads/2022/09/MAPRx-Clinical-Evidence-Driving-Patient-Access-Obesity.pdf>.



for those living with obesity; and the availability of multiple, safe, long-term anti-obesity treatments, it is long overdue that Medicare Part D recognize AOMs as important therapies that treat a severe, chronic disease—obesity. Further, AOMs help manage associated conditions, beyond weight loss alone, to reduce overall morbidity and mortality.”³⁷

MAPRx finds that the total cost of chronic diseases due to obesity and overweight is \$1.72 trillion—equivalent to 9.3% of the U.S. gross domestic product.

Estimates vary of the direct costs to the federal government of covering obesity drugs as do the estimated savings by mitigating obesity-associated illnesses. But it is undeniable that patients would be helped if there were greater awareness and better access to effective anti-obesity medications.

There is no time to waste, especially since we know that Americans with obesity are much more susceptible to the kinds of global contagions the world has just gone through with COVID-19.

An industry-commissioned study by Xcenda, a life-sciences consulting firm, reports on “The Impact of Obesity on COVID-19 outcomes.” The economics analysis firm created a model to determine how lowering the prevalence of obesity could reduce severe COVID-19 outcomes, such as hospitalizations, intensive care unit admissions, and deaths.³⁸

It found that if the obesity rate were 25% lower, COVID deaths and ICU admissions would have been reduced by 11.5% and hospitalizations would have been reduced by nearly 7%. With the COVID death rate having surpassed one million in the U.S., extrapolating their calculations means 115,000 lives could have been saved.

Providing more and better options for obesity treatment would also represent a step forward in addressing health disparities by race and ethnicity. “Due partly to the association between severe obesity and increased morbidity and mortality from COVID-19, Black and Hispanic Americans represent a disproportionate share of COVID-19 hospitalizations and deaths. Black Americans have a 287% greater rate of COVID-19–associated hospitalization compared

³⁷ Ibid.

³⁸ “The impact of obesity on COVID-19 outcomes of hospitalizations and mortality,” *AmerisourceBergen*, accessed January 27, 2023, https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_covid_obesity_update_june2021.pdf?1a=en&hash=5F2453A6E21F811539ACCF3EB6D-0F67064BA9C5E.



to White Americans, and Hispanic Americans have a 271% greater rate of COVID-19–associated hospitalization compared to White Americans,” according to the Xcenda report.³⁹

Conclusion and Summary

Today, 42% of American adults are living with obesity, and the prevalence is projected to increase to nearly half by 2030.⁴⁰ More than half of today’s children will be suffering from obesity by the time they reach age 35.⁴¹ The association with much higher risk of other serious illnesses is incontrovertible.

Patients with obesity are likelier to experience worse outcomes if they are infected with COVID-19 and likely with future contagions as well. This is a serious public health concern. Doctors and patients need access to all available tools to address this growing problem.

While some private plans cover AOMs, patients on public programs, especially Medicare, have limited access to the full spectrum of effective interventions.

The lack of Medicare coverage for pharmacotherapy is particularly jarring even as the program pays the high costs of covering medical care for patients with obesity-associated illnesses such as heart disease, stroke, diabetes, respiratory problems and some cancers.

Federal programs often set the standard for medical coverage, but the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 explicitly excludes coverage of weight loss agents for Part D beneficiaries. The

³⁹ Since the Xcenda report was produced, the demographics of Covid have changed. Covid took a disproportionate toll on Black and Latino Americans in the pandemic’s early stages; the per capita death rate for Black Americans was almost twice as high as the white rate and more than twice as high as the Asian rate. But Covid’s racial gaps have narrowed and more recently, even flipped. Over the past year, the Covid death rate for white Americans has been 14% higher than the rate for Black Americans and 72% higher than the Latino rate, according to the latest CDC data. See: “COVID and Race,” *New York Times*, June 9, 2022, <https://www.nytimes.com/2022/06/09/briefing/covid-race-deaths-america.html>. But the risks to minorities seen early in the Covid pandemic still call for action to protect them against future pandemics.

⁴⁰ “Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity,” Zachary J. Ward, Sara N. Bleich, Angie L. Craddock, Jessica L. Barrett, Catherine M. Giles, Chasmine Flax, Michael W. Long, and Steven L. Gortmaker, *New England Journal of Medicine*, December 19, 2019, doi:10.1056/NEJMsa1909301.

⁴¹ “Simulation of Growth Trajectories of Childhood Obesity into Adulthood,” Zachary J. Ward, M.P.H., Michael W. Long, Sc.D., Stephen C. Resch, Ph.D., Catherine M. Giles, M.P.H., Angie L. Craddock, Sc.D., and Steven L. Gortmaker, Ph.D. *New England Journal of Medicine* 2017;377:2145-53 doi:10.1056/NEJMoa1703860.



Centers for Medicare & Medicaid Services (CMS) has interpreted the law as not granting the flexibility to cover anti-obesity medications.

An unlikely alliance of groups is coming together to urge Congress to allow coverage of anti-obesity medications in Medicare. “It’s not every day that the pharmaceutical industry, the NAACP, a cancer center, and a nonpartisan think tank are all lobbying to achieve the same policy goal,” an article in STAT reads. “But an effort to expand Medicare coverage for obesity drugs has managed to unite them all, and many more groups across the health care industry, too.”⁴²

One of the hallmarks of the Medicare Modernization Act was to *modernize* the program. That meant emphasizing preventive care and disease management to keep people healthier longer and giving physicians and health plans latitude to adopt modern disease-management models. The lack of coverage for anti-obesity medications has long been an issue of conversation and has been an issue that the Galen Institute called attention to as far back as 2007.⁴³

Medicare already is going broke, but its bankruptcy will be accelerated if it continues to pay for care only after people get sick instead of allowing a broader range of treatment options to help keep them well.

Leading members of Congress stress the importance of health and prevention. One important step it could take now, likely with bipartisan support, is to take a serious look at amending the 2003 MMA statute to allow coverage of this new generation of anti-obesity medications. Finally updating Medicare to enable seniors with obesity to get the care they need would be a welcome gift to beneficiaries to celebrate in 2023 the 20th anniversary of passage of the Medicare prescription drug benefit. Several experts believe that Medicare Advantage plans would find it beneficial to cover AOMs, alongside other obesity treatment measures, and that they would be most attentive to managing the benefit.

Prevention saves money and lives. As the obesity problem grows, Medicare needs to make sure that physicians and patients have all available treatment options, including the new class of anti-obesity medications.

⁴² Rachel Cohrs, “The unexpected alliance lobbying for Medicare to pay for new obesity drugs,” *STAT*, January 26, 2023, <https://www.statnews.com/2023/01/26/medicare-obesity-drugs/>.

⁴³ Grace-Marie Turner, “Medicare’s obesity policy flawed,” *The Oklahoman*, August 10, 2007, <https://www.oklahoman.com/story/news/2007/08/10/medicares-obesity-policy-flawed/61737820007/>.



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