OBESITY CARE
ADVOCACY NETWORK

December 20, 2019

OCAN Comments regarding HHS Prevention X RFI Comment

The Obesity Care Advocacy Network (OCAN) appreciates the opportunity to provide feedback in response to the Department of Health and Human Services' (HHS) October Request for Information (RFI) regarding its Prevention X initiative.

OCAN is a diverse group of organizations that have come together with the purpose of changing how we perceive and approach the problem of obesity in this nation. As part of this effort, we strive to prevent disease progression, improve access to evidence-based treatments for obesity, improve standards of quality care in obesity management, eliminate weight bias, and foster innovation in future obesity treatments.

We welcome HHS's deep interest in addressing the hurdles that patients across our country face when attempting to prevent or manage their chronic disease – especially when that disease is weight-related. In our estimation, there are numerous barriers to effective treatment for weight related chronic disease and these hurdles are the contributing factor to why the prevalence of obesity and weight-related conditions continue to grow.

Critical Need to Address Weight Bias, Stigma and Discrimination

The alarming rates of obesity and overweight have brought widespread attention to the medical consequences of this public health problem. Often ignored, however, are the public policy, social and personal obstacles that individuals with excess weight or obesity face. Bias, stigma, and discrimination associated with overweight and obesity pose major barriers to treatment.

Weight stigma plays a role in everyday life, including public policy, work, school and healthcare settings. It remains a socially acceptable form of prejudice in American society which then leads to weight bias embedding into public policy and it is rarely challenged. Perceptions about the causes of obesity contribute to weight stigma and bias. Assumptions that obesity can be prevented by self-control, that individual non-compliance explains failure at weight-loss, and that obesity is caused by emotional problems, are all examples of attitudes that contribute to the bias.

While evidence and science demonstrate that obesity is a disease, weight bias impedes treating obesity as a disease in public policy surrounding public health and health insurance coverage issues. For example, the draft objectives for Healthy People 2030 identified several weight related diseases as health objectives but did not include addressing obesity and overweight as a specific objective. Health insurance coverage policy permits limitations and exclusion of obesity treatment, yet obesity is a disease and as eloquently noted by the Prevention X initiative is a disease that is driving our country's current public health chronic condition crisis.

Weight stigma also exists in healthcare settings. Negative attitudes about individuals with excess weight have been reported by physicians, nurses, dietitians, psychologists and medical students. Research shows that even healthcare professionals who specialize in the treatment of obesity hold negative attitudes.[i] This bias is negatively impacting access to, and coverage of life saving and life changing obesity treatment services.

Promote Comprehensive Coverage for Obesity Treatment Services

Research over the last 20 years transformed the scientific understanding of obesity. The research shows that obesity is a chronic, relapsing, multifactorial condition consistent with a disease. This research led the American Medical Association (AMA), with support from well-respected and established medical associations, to pass landmark policy in 2013 that recognized "obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention." The AMA's declaration came on the heels of official statements to the same effect by dozens of other professional organizations, medical and public health entities, and governmental and nongovernmental agencies, including the World Health Organization and the National Institutes of Health.

Despite these facts, health insurance and health program coverage for obesity prevention and treatment is limited and often excludes treatment(s) in the professional standards of care.

For example:

Initial treatment to prevent weight related chronic disease is intensive behavioral therapy (IBT) for healthy lifestyle [USPSTF B rated recommendation for obesity, CVD risk reduction, and prediabetes]. Yet, Medicare beneficiaries continue to face barriers to this treatment, because Medicare's 2012 national coverage decision limits coverage for IBT to those with obesity and 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, community providers (which include innovative digital delivery platforms), obesity medicine specialists, endocrinologists, bariatric surgeons, psychiatrists, clinical psychologists and other specialists are prevented from effectively providing IBT services. Private plans, following Medicare coverage policy, limit access to IBT in ways that make it generally inaccessible for those with obesity or overweight and risk for a chronic health condition.

Coverage for obesity prevention and treatment avenues remain fragmented across the country in both public and private health plans. For example, the Medicare prescription drug program continues to prohibit Part D coverage for "weight loss drugs" based on a dated policy that fails to recognize the significant medical advances that have been made in the development of obesity medications. Medicare coverage of FDA-approved obesity drugs would have a profound impact on other public and private health plan coverage of this critical treatment avenue.

While coverage has improved somewhat in state health plans as highlighted in the recent STOP Obesity Alliance *"Coverage for Adult Obesity Treatment Services: Medicaid & State Employee Health Insurance Programs,"* there remain a number of areas for improvement. For example, clinical research shows coverage for several forms of treatment at each step and allows multiple attempts is key to addressing this health crisis. Yet, plans typically provide very limited options such as primary care

provision of IBT and limit enrollees to one round of treatment. Public policy must encourage plan coverage that aligns with the plentiful evidence on what works to address obesity and weight related chronic disease. Plans must then provide clarity to their enrollees on what constitutes appropriate and reimbursable care in plan descriptions and provider manuals and facilitate coordinated, interprofessional care for adults with obesity who seek treatment. Finally, health plans must develop and maintain referral networks of obesity care providers and collaborate with community providers to expand the reach of care.

Another recent resource from the STOP Obesity Alliance is their *"Comprehensive Benefit for Outcomes-based Obesity Treatment in Adults,"* which was developed in consultation with key stakeholders, including representatives from large employers, health plan administrators, payers, patients, and providers. This Comprehensive Benefit is intended to: identify evidence-based obesity treatment modalities that can support clinically-significant weight loss (≥5% reduction in body weight) among persons with obesity; provide guidance on the appropriate amount, scope, duration, and delivery of obesity-related benefit offerings; highlight real-world examples from plans that cover obesity treatment modalities; and support efforts to standardize the scope and availability of obesity treatment modalities that are covered across plans/systems. The hope is that this tool will inspire employers, payers, and others involved in benefit design and administration to reassess the adequacy of coverage for obesity treatment services in current plan offerings.

Support Obesity Education & Training in Clinical and Community Settings

Another area where we can do better revolves around supporting greater education and training for healthcare professionals and community providers. One such example is the Obesity Medicine Education Collaborative -- an intersociety initiative that was formed in 2016 with the purpose of promoting and disseminating comprehensive obesity medicine education across the continuum spanning undergraduate medical education, graduate medical education, and fellowship training.

We also need to better support community-based efforts for addressing obesity such as the Diabetes Prevention Program and encourage continuing education for non-physician providers such as the Obesity Medicine Association's NP and PA Certificate of Advanced Education in Obesity Medicine. This program offers nurse practitioners and physician assistants an opportunity to earn a certificate in obesity medicine and demonstrate to their patients an extensive knowledge of evidence-based obesity treatment approaches and an ongoing commitment to their health.

We also need to support efforts on childhood obesity management: Less than 3 of 10 high school students get at least 60 minutes of physical activity every day. 80 percent of adolescents with overweight grow up to be adults with obesity who may have a higher risk for early death, heart disease, stroke, type 2 diabetes, depression, and some cancers.

The Y's Healthy Weight and Your Child Program was launched in 2015. It is an evidence-based program that empowers children aged 7-13 and their families to manage weight and help them live a healthier lifestyle. As of June 2019, the program has expanded from 19 pilot Ys to 114 Ys serving more than 1,800 children and their families. The program's curriculum is adapted from the most widely disseminated and evaluated child weight management program in the world (known as "MEND"). Research on the original program showed a statistically significant reduction in body mass index, waist circumference, and sedentary activities, and improvements in physical activity and self-esteem at 6 and 12 months. The family-centered program emphasizes three elements: healthy eating, regular physical activity, and behavior change to elicit a positive life-long lifestyle transformation. The

program engages the child and adult, so together they can understand how the home environment and other factors influence the choices that lead to a healthy weight. [ii]

Recognize and Support Treatment Options for Pediatric Obesity

We also believe that policymakers need to address the medical needs of children who have obesity, especially children with severe obesity. Doing so is essential to preventing a tremendous burden of chronic diseases that will affect those children for a lifetime. Research shows that the chronic diseases that result from obesity are most responsive to treatment when that treatment occurs early in the course of those diseases. The Centers for Disease Control and Prevention (CDC) initiative on childhood obesity provides an excellent resource and needs to be highlighted throughout HHS. Public policy that advances the CDCs work on community-based programs delivering IBT to address childhood obesity is essential.

This is especially true for adolescents with severe obesity and why the American Academy of Pediatrics (AAP) recently unveiled guidance entitled, "Pediatric Metabolic and Bariatric Surgery: Evidence, Barriers, and Best Practices." This guidance is based on a comprehensive review of the literature and consultation with experts in surgical and medical pediatric weight management. According to the AAP, "Over the past decade, evidence has emerged that bariatric surgery is a safe and effective treatment option for youths with obesity." Despite the surge of supporting evidence for their position statement, AAP also highlights data surrounding the significant underutilization of these services – especially for low-income teens.

One reason for this likely is related to insurance coverage; plans that include bariatric surgery for patients under 18 are uncommon. Less than half (47%) of qualifying teens who enter surgical programs have their procedure approved on the first request, and 11% never have them approved. Teens from low-income backgrounds have a much lower rate of insurance approval for surgery, despite bearing a higher burden of obesity and related comorbid disease.

A second reason for underutilization is low referral rates from primary care. Until now, little guidance has been available for pediatricians to identify appropriate patients, to educate families on the risks and benefits of surgery, to provide pre- and post-operative care for patients, and to identify high-quality surgical programs near them.[iii]

Leveraging CDC Grant Programs and Research

Finally, we urge HHS to recognize the wide array of grant programs and research efforts aimed at both studying and directly addressing the obesity epidemic that are currently underway at the CDC. Much of this money leaves CDC and goes directly to states, tribes, local public health departments, community health organizations, and universities to implement or study evidence-based interventions that are tailored to the local needs and social contexts.

These efforts have directly improved the understanding of how to identify, prevent, and treat obesity and more could be done to leverage the findings from this research. CDC could scale these programs to a significantly higher reach if appropriate levels of funding and staffing were made available. Prevention X should consider how to fast-track the most highly evidence-based prevention interventions from research to sustainably-funded, wide-spread practice.

Again, we appreciate the opportunity to provide HHS with the above feedback and look forward to working with the Department on both prevention & treatment efforts in 2020 and beyond. Should you have any questions or need additional information, please feel free to contact OCAN Washington Coordinator Chris Gallagher via email at chris@potomaccurrents.com or telephone at 571-235-6475.

Thank you.

Sincerely,

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[i] Rebecca Puhl, PhD, Deputy Director at the Rudd Center for Food Policy and Obesity.

[ii] Sacher, Paul M., et al. "Randomized controlled trial of the MEND program: a family‐based community intervention for childhood obesity." Obesity 18.S1 (2010).

[iii] Pediatric Metabolic and Bariatric Surgery: Evidence, Barriers, and Best Practices, Sarah C. Armstrong, Christopher F. Bolling, Marc P. Michalsky, Kirk W. Reichard and SECTION ON OBESITY, SECTION ON SURGERY
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