Academy of Nutrition and Dietetics

The Treat and Reduce Obesity Act (H.R. 2404, S. 1509)

Bill Summary:

The Treat and Reduce Obesity Act of 2015 is a bipartisan, bicameral bill that was recently reintroduced in the 114th Congress by Representatives Erik Paulsen (Minn.) and Ron Kind (Wis.) and Senators Tom Carper (Del.), Dr. Bill Cassidy (La.), and Lisa Murkowski (Alaska). The bill aims to effectively treat and reduce obesity in older Americans by increasing Medicare beneficiaries' access to qualified practitioners and safe, approved pharmaceuticals for obesity.

Issue Overview:

The nation is paying the price for overlooking the importance of food and nutrition. Over the last 20 years obesity rates have doubled among adults, resulting in more than 35% of adults living with obesity and an additional 33% being overweight.[1] Evidence suggests that without concerted action, roughly half the adult population will be obese by 2040. These numbers are particularly troubling because one out of every eight deaths in America is caused by an illness directly related to obesity; therefore, millions of Americans are at risk from a preventable and treatable disease.[2] 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. **The Treat and Reduce Obesity Act offers clinically- and cost-effective solutions to the obesity epidemic.**

The Costs of Obesity:

Obesity is an astronomically expensive problem for our nation and families. Obesity accounts for 21% of total national health care spending, equating to $210 billion annually.[3] Medicare and Medicaid patients with obesity cost $61.8 billion per year; eradicating obesity would result in an 8.5% savings in Medicare spending.[4] The indirect costs are far higher. Recent data indicates that increased health and work-related expenses associated with obesity cost an excess of $4,879 for women and $2,646 for men annually.[5] Many of these costs typically carry over into older adulthood. Obesity is a public health crisis with a widespread, devastating and costly impact.

Key Takeaways

Problem – Obesity:

- The nation is paying the price for overlooking the importance of food and nutrition.
- We are an increasingly overweight and obese nation, with 2/3 of the adult population carrying excess weight.
- Obesity is an astronomically expensive problem for our nation ($210 billion per year).

Solution – A Bipartisan Bill:

- The bipartisan bill, H.R. 2404 / S. _____, has promise to clinically and economically tackle the obesity epidemic.
- There are already dozens of original co-sponsors in the House and many in the Senate from both parties.

Clinically Effective:

- The bill removes unnecessary barriers to (1) allow a variety of qualified practitioners, such as RDs, to effectively treat obesity through IBT and (2) authorize coverage for FDA-approved weight loss medications that complement IBT.
- esearch shows that after two years, patients who received IBT from a RD are twice as likely to achieve clinically significant weight loss, experience greater average weight loss, and exercise more than patients who did not receive IBT.
- The expert consensus is that RDs are the best practitioners to carry out IBT, as stated by the IOM, the US Preventive Services Task Force, and most physicians.

Effectiveness of Obesity Management:

The U.S. Preventive Services Task Force (USPSTF) concluded that intensive behavioral therapy (IBT) is an effective component in obesity management. 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.

Studies show less than six months of RD-provided nutrition therapy for people with overweight or obesity yields significant weight loss of approximately one to two pounds per week. IBT provided for six to twelve months yields significant mean weight loss of up to 10% of body weight, which is typically maintained beyond one year.[6]

The USPSTF reviewed existing evidence and found that IBT 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.[7]

A USPSTF report indicates that for patients with obesity and elevated plasma glucose levels, IBT interventions decreased the development of diabetes by about 50% over two to three years. These patients also demonstrated improved blood pressure, waist circumference and glucose tolerance.[8]

Key Takeaways

Cost Effective:

- Supporting RDs to provide IBT is cost effective.
  - RDs' services cost 25% less per 2 pounds of weight loss.
  - RDs' payment fee is 85% of primary care providers' fees.
- RDs can help minimize costs for nutrition services, like IBT, while delivering the best results.
- The bill provides coordinated, interdisciplinary care that increases efficiency and efficacy, which improves health care quality and reduces costs.

Benefits of the Treat and Reduce Obesity Act:

The Treat and Reduce Obesity Act gives the Center for Medicare and Medicaid Services (CMS) the authority to enhance beneficiary access for IBT by allowing additional types of health care providers, such as registered dietitians, to offer IBT services. To be most effective, obesity management must encompass the best standards of treatments, coordination of care and clinical environment. With coordinated care, each practitioner delivers the right care at the right time utilizing their advanced skill set and allowing reimbursement for only the most efficient and effective services. This is particularly important because studies have shown that primary care practitioners are limited in time, training, and skills to conduct the most effective, high-intensity interventions.[9] **In fact, the Institute of Medicine "rate[d] dietary counseling performed by a trained educator such as a [registered] dietitian as more effective than by a primary care clinician."**[10]

Allowing registered dietitians to treat obesity is not only clinically effective, but cost-effective as well. IBT services provided by registered dietitians save 15% of the cost of services associated with primary care physicians. Moreover, studies show that the cost of losing a kilogram of weight is more expensive under a physician ($9.76) than it is under a registered dietitian ($7.30).[11] This legislation would allow for CMS to align coverage 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 registered dietitians or other experts and should not be limited to primary care providers in the primary care setting.

The Treat and Reduce Obesity Act also revises the Medicare Part D statute to allow safe and effective pharmacological agents as a complement to obesity management therapies. Since Medicare Part D was passed, the U.S. Food and Drug Administration approved four obesity drugs. The federal savings estimate of covering weight management drugs under Medicare Part D could be $11,400 for a female Medicare beneficiary and $113 for a male Medicare beneficiary.[12]

1 Ogden et al. *Prevalence of Obesity in the United States, 2009-2010*. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. January 2012. http://www.cdc.gov/nchs/data/databriefs/db82.pdf

2 Carmona, Richard. *The Obesity Crisis in America*. Surgeon General's Testimony before the Subcommittee on Education Reform, Committee on Education and the Workforce, United States House of Representatives. 16 July 2003. www.surgeongeneral.gov/news/testimony/obesity07162003.htm

3 Finkelstein et al. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." *Health Affairs*, 28, no. 5 (2009). 27 July. http://content.healthaffairs.org/content/28/5/w822.full.pdf+html

4 Ibid.

5 Dor et al. *A Heavy Burden: The Individual Costs of Being Overweight and Obese in the United States*. The George Washington University, School of Public Health and Health Services, Department of Health Policy. 21 November 2010. http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_35308C47-5056-9D20-3DB157B39AC53093.pdf

6 Grade 1 data. ADA Evidence Analysis Library, http:www.adaevidencylibrary.com/topic.cfm?cat=3949.

7 U.S. Preventive Services Task Force. *Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force Recommendation Statement*. AHRQ Publication No. 11-05159-EF-2. June 2012. http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.htm

8 Ibid.

9 Bleich et al. "National survey of US primary care physicians' perspectives about causes of obesity and solutions to improve care." *BMJ Open* 2012:2:e001871. doi:10.1136/bmjopen-2012-001871.

10 Committee on Nutrition Services for Medicare Beneficiaries. "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." Washington, DC: Food and Nutrition Board, Institute of Medicine; January 1, 2000 (published) at 2, 267.

11 Pritchard et al. "Nutritional Counseling in General Practice: A Cost-Effectiveness Analysis." *Journal of Epidemiology and Community Health*, 53 (2009): 311-316.

12 Brill, Alex. *The Long-Term Returns of Obesity Prevention Policies*. A Campaign to End Obesity, Matrix Global Advisors. April 2013.