

Improving Access to Anti-Obesity Medication Through Insurance Coverage Is A Necessary Step Toward Reducing Bias and Racism in Healthcare and for Addressing Health Disparities

Obesity is a Chronic Disease.

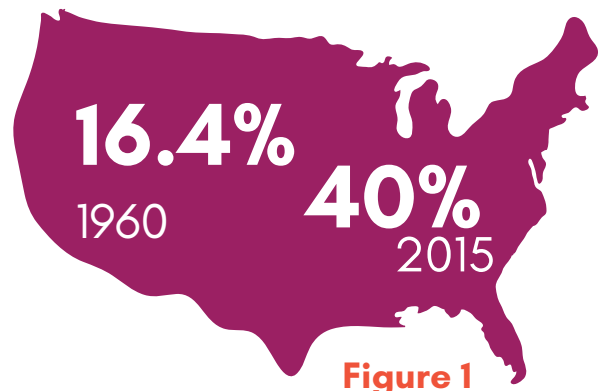
Chronic diseases are “conditions that last one year or more and require ongoing medical attention [and/or] limit activities of daily living” (Centers for Disease Control and Prevention, 2022b). In 2013, the American Medical Association adopted a policy to recognize obesity as a chronic disease “requiring a range of medical interventions... [for effective] treatment and prevention” (Obesity Medicine Association, 2013).

Prevalence.

Data shows that the prevalence of obesity among adults in the United States has been trending upward since the first National Health and Nutrition Examination Survey in 1960. At that time, the prevalence of obesity in the US was 13.4%, and the prevalence of severe obesity was <1%. By 2015, obesity and severe obesity among adults in the United States had risen to 40% and 8%, respectively (Figure 1) (Fryar, MSPH et al., 2019, p. 4). An urgent report in September 2022 released by the CDC indicated that the number of states and territories with more than one-third of its adult residents living with obesity has more than doubled and now includes 19 states and two territories (Centers for Disease Control and Prevention, 2022c).

Numerous states report a high prevalence of obesity among adults from racial/ethnic minority communities - 36 states and the District of Columbia reported that more than one-third of Black adults are living with obesity, 31 states reported that more than one-third of American Indian/Alaska Native adults live with obesity, and 27 states and Guam reported that more than one-third of Hispanic adults live with obesity. A 2019 paper predicted that the prevalence of obesity and severe obesity among adults in the United States will reach 50% by 2030, just under seven years from the document’s release (Ward et al., 2019).

Rate of Obesity in the United States from 1960 to 2015








Obesity Risk Factors.

Obesity is a complex chronic disease. Some key risk factors that are linked with a higher prevalence of obesity include genetic predisposition, poor nutrition, low levels of physical activity, and lack of sleep, all of which can interact to affect a person's metabolism and ability to regulate their body weight. Evidence suggests that the impact of genetics on obesity risks varies from 25% to 80% across individuals (Harvard Health Publishing, 2009). Genetics also plays a significant role in metabolism and can contribute to the development of obesity (Goodarzi, 2018). For example, genetic variations can impact the levels and functioning of the hormones that play a critical role in regulating appetite, energy expenditure, and metabolism. Genetic variations can also impact how efficiently the body stores and breaks down fat; how many calories a person burns at rest or during physical activity; and the composition and functioning of the microorganisms that live in the digestive tract and regulate energy extraction from food. Further complicating the issue, the interaction of genes with unhealthy environments has been shown to increase the risk of developing obesity even more. For example, a person with a genetic predisposition to obesity may be more likely to become obese if they consume a high-calorie, high-fat diet, lead a sedentary lifestyle, and do not get enough sleep.

Stigma suggests that obesity is caused primarily by an imbalance in caloric intake and expenditure. This imbalance is controlled mainly by individual self-discipline regarding dietary intake and physical activity. While energy imbalance plays a large part in the development of overweight and obesity, individual behaviors associated with caloric intake and expenditure are primarily a product of built and sociocultural environments and political decisions (i.e., social and political determinants of health) that dictate an individual's choices about their health. Social and political determinants of health, including structural racism, significantly impact the decisions and resources available to individuals that impact obesity-related behaviors.

Interestingly, obesity is one of the only chronic diseases viewed as a moral failure for the individual with the disease. The American Medical Association's decision to declare obesity a chronic disease in 2013 was met with skepticism, mainly because many individuals within and outside the healthcare field view obesity as a moral failing of the individual to balance calorie intake and expenditure. One argument suggested that "... labeling obesity as a disease may foster a culture of personal irresponsibility, whereby individuals are absolved from practicing healthy lifestyle behaviors" (Stoner & Cornwall, 2014).

For Example:

- **Socioeconomic Status:** People in lower-income areas may have limited access to healthy foods, safe outdoor spaces for physical activity, and affordable healthcare. They may also experience higher stress levels, leading to overeating and weight gain. 
- **Food Environment:** The availability of healthy food options in a community can impact weight. Areas with limited access to healthy food may rely on convenience stores and fast-food restaurants, which can contribute to weight gain. 
- **Marketing and Advertising:** Advertising for unhealthy foods and drinks can impact people's eating habits, particularly children. Exposure to ads for unhealthy foods can increase the likelihood of choosing these options, leading to weight gain. 
- **Policy and Regulations:** Government policies can impact access to healthy foods, safe spaces for physical activity, and healthcare. For example, zoning laws that limit the number of fast-food restaurants in a community can help to promote healthier eating habits. 
- **Culture and Social Norms:** Cultural attitudes towards body size and shape can impact weight. Societal pressure to conform to a specific body type or size can contribute to disordered eating habits and weight gain. 

Genetic predisposition, combined with social and political determinants of health that negatively impact an individual's availability of opportunities to engage in obesity-preventing behaviors, can create a "perfect storm" that makes some population subgroups, particularly those who are disproportionately impacted by ongoing physical and cultural systems of oppression, more vulnerable to weight gain and can make weight management more difficult.

Impact.

Obesity costs \$173 billion annually in direct and indirect costs associated with treatment, obesity-related illnesses, and injuries, and lost wages (Ward et al., 2021). This averages to ~\$1,861 annually per person. Overweight and obesity are also linked to a myriad of related poor health outcomes, including morbidity and mortality associated mostly with type 2 diabetes, heart disease, stroke, some forms of cancer, and some infectious diseases like COVID-19.

According to the American Diabetes Association (ADA), in 2012, the total indirect and direct costs of diabetes were \$245 billion, rising to a massive \$327 billion in 2017—representing an unfortunate 26% increase in just five years (American Diabetes Association, 2018, p. 917). In 2017 and 2018, the indirect and direct costs of heart disease in the U.S. were roughly \$229 billion (Centers for Disease Control and Prevention, 2022f).

Impact (cont.)

While cancer does not cost the U.S. nearly as much as diabetes and heart disease, Mayo Clinic notes that maintaining a healthy weight and physical activity is critical in cancer prevention (Mayo Clinic Staff, 2022). In 2019 the U.S. estimated \$21.09 billion would be spent on indirect and direct cancer costs (Tangka, PhD et al., 2021).

Recent data collected during the COVID-19 pandemic showed that obesity was linked to a higher risk for disease-related hospitalization, impaired immune function, reduced lung capacity, and death (Centers for Disease Control and Prevention, 2022d). When considering the costs of chronic diseases associated with obesity, excess weight costs the United States \$480.7 billion and \$1.24 trillion in direct and indirect healthcare costs, respectively (Waters, PhD & Graf, PhD, 2018, p. 1).

Obesity Treatment.

A 2020 paper noted that “obesity is a chronic, progressive, relapsing disease... if left untreated, it worsens and leads to serious health consequences...” (Wharton et al., 2020, p. E875). Strategies to effectively treat obesity can affect the disease directly and drastically reduce morbidity and mortality for the many poor health outcomes that are driven by obesity. A 2020 paper noted, “Obesity complications drive many of the conditions that are seen routinely in clinical practice. By treating obesity first, many of these conditions improve or resolve” (Christensen, 2020). For most chronic diseases (e.g., hypertension, type 2 diabetes), the first line of treatment is to reduce the risk of developing disease by focusing on individual-level behavior changes to impact obesity-related behaviors, including nutrition, physical activity, and sleep. Once the chronic disease is present, however, an effective treatment plan often requires implementing daily routines, including medication therapy, to manage symptoms and reduce chronic disease's impact on quality of life and additional health complications associated with chronic disease.

Anti-obesity medications (AOMs) have been identified as part of a comprehensive obesity treatment plan. Current clinical guidelines suggest that effective obesity treatment may include medical nutrition therapy, exercise, psychological treatment, bariatric surgery, and medications (Wharton et al., 2020, pp. E884, E887, E877). The use of anti-obesity medication to treat obesity is expanding. It will likely continue as new medications are developed and released and as knowledge about how AOMs work to address obesity grows. Evidence suggests that these treatments can be effective, especially among populations with disproportionately high rates of obesity.

Obesity Treatment (cont.)

Unfortunately, access to the full continuum of obesity care, including access to AOMs, is inequitable and may be more likely to impact individuals living with obesity and related chronic diseases negatively. Most Americans continue to get healthcare through employer-sponsored insurance, 58% in 2019. People without employer-sponsored insurance are often left uninsured, with Black and Hispanic people 1.5 to 2.5x more likely to be uninsured. If low-income workers of color are insured, they are disproportionately covered – with higher out-of-pocket expenses – and have access to plans with poorer coverage. For those on public insurance, 34.8% of the population in 2020, stigma and bias similarly influence coverage decisions (Keisler-Starkey & Bunch, 2021). Insurance companies may charge higher premiums and deductibles to people who are perceived to be at a higher risk of developing certain health conditions or diseases, such as those who are living with overweight or obesity or those who have a pre-existing medical condition. This can disproportionately affect certain groups, such as low-income individuals or people of color, who may have higher rates of obesity or chronic diseases due to social determinants of health. Insurance companies may exclude specific medical procedures or treatments that are more likely to be used by certain groups, including individuals with chronic diseases like obesity. This can make it more difficult for individuals in these groups to access necessary care. Insurance companies may deny claims for certain medical procedures or treatments that are more likely to be used by certain groups, such as people with disabilities or people of color. This can result in individuals being unable to access necessary care or paying out-of-pocket for services their insurance should cover.

Obesity cannot continue to be seen as a monolith of a disease, nor can the stigmas of laziness or lack of willpower continue to be furthered. If so, numerous Americans are at risk of adverse health outcomes directly from obesity or co-morbid conditions associated with obesity. The stigma surrounding obesity in healthcare must be eliminated. Policies that require health insurance plans to cover evidence-based treatments for obesity, such as nutrition counseling, weight-loss medications, and bariatric surgery, can help to ensure that people living with obesity have access to the care they need. These policies can also help to reduce disparities in access to care by ensuring that all individuals have access to the same level of care regardless of their income or insurance status.

Improving Access to Obesity Treatment.

The Food and Drug Administration (FDA) has approved AOMs to help treat obesity and are part of the recommended clinical guidelines for effective treatment. Players across the healthcare system, including the Federal Employees Health Benefits Program, the Department of Veterans Affairs, and TRICARE, all cover AOMs as part of their policies. Coverage among Medicaid and commercial payers varies but includes some coverage (Medicare Access for Patients Rx, 2022, p. 4). Medicare serves 63 million beneficiaries annually, 74% enrolled in Part D drug coverage (Tarazi et al., 2022, p. 1). Part D is the only payer that explicitly excludes coverage of AOMs, primarily because the Centers for Medicare & Medicaid Services (CMS) has not accepted the American Medical Association's declaration of obesity as a chronic disease. There are several arguments for insurance coverage of weight loss drugs:

- **Obesity is a medical condition:** Obesity is a complex medical condition that can lead to various health problems such as diabetes, hypertension, heart disease, and sleep apnea. Treating obesity with medication can improve overall health outcomes and reduce the risk of developing other health problems.
- **Cost-effectiveness:** Obesity is associated with high healthcare costs and treating it with medication can be cost-effective. In some cases, weight loss drugs can prevent or delay the need for expensive medical procedures such as bariatric surgery.
- **Improved quality of life:** Obesity can significantly affect a person's quality of life, including their physical health, emotional well-being, and social interactions. Weight loss drugs can help improve a person's self-esteem, mental health, and overall quality of life.
- **Lack of alternatives:** For some individuals, lifestyle changes alone may not be sufficient to achieve significant weight loss. Weight loss drugs can be an essential tool for those who have struggled to lose weight through diet and exercise alone.
- **Reduced healthcare utilization:** Weight loss drugs can reduce healthcare utilization by preventing or treating obesity-related health problems. This can result in lower healthcare costs for both individuals and insurers.

Overall, insurance coverage of weight loss drugs can benefit individuals by improving their health outcomes and quality of life while reducing healthcare costs for insurers.

Summary.

Obesity is a complicated chronic disease that requires a multifaceted approach at all levels of the socio-ecological model for successful treatment. The combined variety of risk factors influencing weight status highlights the need for comprehensive approaches to obesity treatment that address individual behaviors and the policies, systems, and environments that drive obesity-related behaviors (Figure 2).

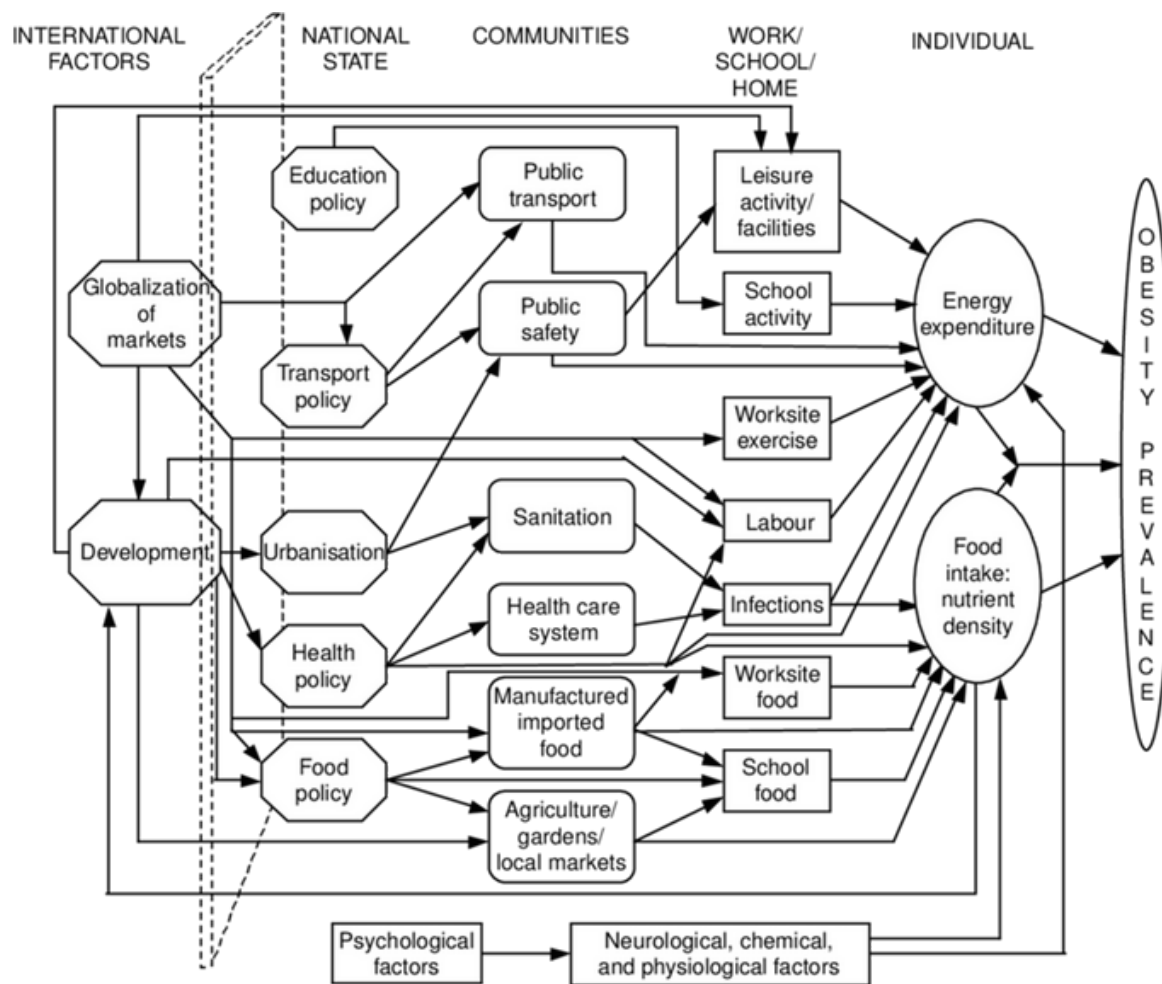


Figure 2: Societal influences on the prevalence of obesity and overweight. Note: Popkin, B. (2005). Using research on the obesity pandemic as a guide to a unified vision of nutrition. Public Health Nutrition, 8, 724-729. <https://doi.org/10.1079/PHN2005776>

Since the CDC labels obesity as a chronic, common, costly disease, CMS must do the same to ensure that more people are given the necessary medical therapies that are part of the recommended clinical guidelines for the effective treatment of obesity (Centers for Disease Control and Prevention, 2022e). The expansion of covering AOMs will be transformative for those living with obesity and overweight and will drive down the indirect and direct costs of chronic diseases once implemented. AOMs can serve as a secondary prevention method, and CMS must explore options for coverage. CMS must ensure citizens have access to this essential treatment, regardless of race, class, socioeconomic status, or disability status. Otherwise, we risk more people falling ill or dying from obesity, a chronic and costly disease.

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