Academy of Nutrition and Dietetics

Treat and Reduce Obesity Act

Overview

The Academy of Nutrition and Dietetics supports the Treat and Reduce Obesity Act because it provides cost-effective and clinically-effective solutions to our obesity epidemic. The Treat and Reduce Obesity Act of 2021 is a bipartisan, bicameral bill introduced in the 117th Congress by U.S. Sens. Tom Carper (Del.) and Bill Cassidy (La.) and U.S. Reps. Ron Kind (Wis.), Tom Reed (N.Y.), Raul Ruiz (Calif.) and Brad Wenstrup (Ohio).

The Academy is urging members of Congress to co-sponsor and pass the bill to ensure that people with obesity have access to the most effective recommended treatment, intensive behavioral therapy provided by qualified health care practitioners. This bill would amend the Social Security Act to enable the Centers for Medicare and Medicaid Services to enhance beneficiary access to the most qualified existing Medicare providers of intensive behavioral therapy for obesity, resulting in decreased health care costs and lower obesity rates among older adults.

The Cost of Obesity

Obesity is a public health crisis with a widespread, devastating and costly impact. 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, every year millions of deaths could be prevented if patients had access to effective treatment and prevention programs.[2] Research documents the harmful health effects of excess body weight, which increases 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.

Our nation is paying the price for overlooking the importance of food and nutrition related diseases. Obesity accounts for 21% of total national health care spending, summing to as much as $210 billion annually.[3] Medicare and Medicaid patients with obesity cost the government $61.8 billion per year; eradicating obesity would result in an 8.5% savings in Medicare spending.[4] Obesity places an enormous financial burden on American families, our economy and our nation's health care system.

Current Barriers to Effective Obesity Treatment

Under current law, Medicare only covers intensive behavioral therapy when provided by a primary care provider in the primary care setting; nutrition professionals, bariatricians, endocrinologists, psychiatrists, and clinical psychologists are prevented from effectively providing IBT. However, 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. **The National Academies of Science, Engineering, and Medicine (formerly the Institute of Medicine) "rates dietary counseling performed by a trained educator such as a [registered] dietitian as more effective than by a primary care clinician,"[5] and the U.S. Preventative Services Task Force has recommended that IBT should not be limited to primary care providers in the primary care setting.[6]**

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

The Treat and Reduce Obesity Act offers clinically- and cost-effective solutions to the obesity epidemic by ensuring that Medicare patients have access to the best possible care at only a fraction of the cost. The bill removes unnecessary barriers, which would allow a variety of qualified practitioners, such as registered dietitians, to effectively treat obesity through IBT. The bill also authorizes coverage for FDA-approved weight loss medications that complement IBT.

The USPSTF found that IBT helps people with obesity lose significant weight and decrease their risk for cardiovascular disease and diabetes. Results demonstrated that on average recipients lost 6% of their baseline weight over the course of a year. Additionally, they benefited from improved glucose tolerance, lower blood pressure and decreased waist circumference. Furthermore, for patients with elevated plasma glucose levels IBT decreased the development of diabetes by about 50% over two to three years.[7]

IBT provided by RDNs for six to twelve months yields significant mean weight loss of up to 10% of body weight, which is typically maintained beyond one year. Additionally, studies show that RDN-provided IBT for people with overweight or obesity yields significant weight loss at an appropriate rate of one to two pounds per week.[8]

Expanding Medicare coverage of IBT to RDNs can decrease health care costs. RDNs are reimbursed by Medicare at a 15% lower rate than primary care physicians. Moreover, studies show that it is less expensive to lose weight under the care of a RDN than other providers.[9] Modifying Medicare coverage to include RDNs as another direct provider of IBT is a cost-effective alternative and will **enhance access to the obesity management benefit that only 1% of eligible beneficiaries are using**.

The bill provides coordinated, interdisciplinary care that increases efficiency and efficacy, which improves health care quality and reduces costs. To be most effective, obesity management must encompass the best standards of treatments and coordination of care. 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 effective services.

[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] 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.

[6] 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

[7] Ibid.

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

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