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Statement of the Obesity Care Continuum: Patient Access to Care Issues Surrounding Obesity and COVID-19

COVID-19 is disrupting the normal life of many Americans and throughout the world, especially individuals with obesity and its related health complications that often put them at higher risk. A growing body of literature demonstrates a direct link between obesity and poor outcomes from the COVID-19 virus. Data from New York City indicates that people with both COVID-19 and obesity are two times more likely to be admitted to the hospital, and people with severe obesity are 3.6 times more likely to require critical care, such as mechanical ventilation. Our country must acknowledge obesity for the chronic disease that it is and take steps to treat it in the same serious fashion as others such as diabetes and hypertension.

While there are evidence-based treatments for people with obesity that mitigate the impacts of the disease and improve health outcomes, the present landscape of obesity care coverage remains piecemeal and laden with arbitrary hurdles to comprehensive care. As a nation we must move to eliminate these random and unscientific barriers to care – both for the long term and immediate health of those affected by obesity!

Throughout the past decades, the prevalence of obesity has skyrocketed across our country. Despite this fact, many policymakers continue to view obesity as a lifestyle choice or personal failing. Others acknowledge that obesity is a chronic and complex disease, but they believe that all that's needed is more robust prevention. These perceptions and attitudes, coupled with bias and stigma, have resulted in health insurance plans taking vastly different approaches in determining what and how obesity treatment services are covered for their members. It's time for a paradigm change and for health plans to adopt a comprehensive benefit approach toward treating obesity. This is especially true in the age of COVID-19 given the growing body of literature, which demonstrates a direct link between obesity and poor outcomes from this novel coronavirus.

Currently, only a few health plans provide coverage for evidence-based behavioral, nutritional, pharmacological, and surgical obesity treatment modalities. Many plans allow their members to access only one of these treatment avenues such as bariatric surgery, but only after they have navigated numerous arbitrary hurdles to demonstrate they "are worthy" of treatment. These include documentation of supervised diet attempts of various lengths of time (e.g., typically 3-18 months), with specified providers and formats, visits that must be continuous or consecutive in nature, that occur within a specified time period (e.g., 12-24 months) prior to surgery, and in certain cases must also meet a specified percentage of preoperative weight loss of 5-15%, or failure to achieve a certain percentage of weight loss 5-10%. Furthermore, these arbitrary requirements are strictly enforced without consideration of the severity of obesity present, the status of other life-threatening co-morbid conditions or life circumstances that may force a patient to miss a required visit, whether the patient can afford the additional costs of the adjunct dietary and exercise programs, medications and visits to providers in order to comply with the requirements.

Those beginning their journey to address their overweight or obesity are entitled to be referred to robust intensive behavioral counseling (12-26 sessions per year) – one of numerous Affordable Care Act recognized preventive care services that are to be provided free of any patient cost sharing. Despite the law, a large majority of plans provide at best one to three nutritional visits per year – a benefit that is often overshadowed by the health plan's contract language explicitly excluding coverage for any weight or obesity related services. Additionally, plans often limit patient access solely to primary care providers who often lack either the training or the time to adequately manage these patients. Those with specialized training such as registered dietitian nutritionists (RDNs), obesity medicine specialists, clinical psychologists and community providers must also be viewed as covered treatment avenues for these critical services.

Those “in the middle” who have tried counseling alone, may not be a candidate for surgery or who are post-operative bariatric surgery, deserve access to FDA-approved medications for chronic weight management. Unfortunately, many plans continue to deny coverage for comprehensive pharmacotherapy options for obesity. Plans that do offer coverage will often allocate these drugs into their highest patient cost-sharing formulary tier. In other cases, providers and their patients will be stymied by archaic prescribing laws, which were formulated and initiated decades earlier by state legislatures or state medical boards when few FDA-approved obesity drugs were on the market and our understanding of obesity was not as advanced. Given that several medications have now been approved by the FDA throughout the last decade, these arbitrary restrictions do not conform with prescribing standards of care surrounding other chronic disease states.

Additionally, this pandemic has magnified the health inequities experienced by racial and ethnic minority communities. Early data is showing that African Americans are impacted by COVID-19 at a much higher rate than other ethnicities. These same communities also experience high rates of obesity and diabetes. Among African American adults, 48% have obesity and 13% have diabetes. Meanwhile, people of color and low-income households are disproportionately living in communities with comparably less access to health care, healthy food, and opportunities to be active. Further complicating the risks, these individuals are more likely to hold “frontline” jobs that increase their risk of exposure to COVID-19.

Obesity currently affects more than 93 million Americans and needs to be treated seriously. While our nation and those around the world are appropriately focused on the COVID-19 pandemic, we must recognize that obesity is a pandemic in its own right, and we should respond with equal vigor!

Should you have any questions or need additional information, please contact OCC Washington Office Director Chris Gallagher via email at chris@potomaccurrents.com or telephone at 571-235-6475.

About the Obesity Care Continuum:

The leading obesity advocate groups founded the Obesity Care Continuum (OCC) in 2010 to better influence the healthcare reform debate and its impact on those affected by overweight and obesity. Currently, the OCC is composed of the Obesity Action Coalition (OAC), the Obesity Society (TOS), the Academy of Nutrition and Dietetics (AND), the American Society for Metabolic and Bariatric Surgery (ASMBS), and the Obesity Medicine Association (OMA). With a combined membership of nearly 200,000 patient and healthcare professional advocates, the OCC covers the full scope of care from nutrition, exercise and weight management through pharmacotherapy to device and bariatric surgery. Members of the OCC also challenge weight bias and stigma-oriented policies – whenever and wherever they occur.