



Essential Care and Coverage for Those Living with Obesity

STATEMENT OF POSITION: *The Nurses Obesity Network supports the full continuum of care and coverage for those living with obesity, including behavioral therapy, medical nutrition therapy, anti-obesity medications, and bariatric surgery, when recommended by an appropriate licensed healthcare professional.*

BACKGROUND: Those in the nursing profession encounter patients every day who are living with obesity and struggling with the impact of the disease on their health and quality of life. The members of the Nurses Obesity Network have come together to change the way obesity is viewed and treated, and to advance care for people living with obesity, including members of their own nursing profession. This position statement lays out the impact of obesity on our country, identifies challenges to addressing the epidemic, and highlights potential policy solutions.

Obesity is a Disease

Obesity is a chronic disease with many contributing factors, including eating patterns, physical activity levels, sleep routines, social determinants of health, genetics, and the use of certain medications, among other factors. Obesity now impacts 42% of the US adult population and that number continues to grow, with nearly 1 in 2 adults expected to be living with obesity by 2030.¹ The number of states in which at least 35% of residents are living with obesity has more than doubled since 2018. Up from nine states in 2018, 12 in 2019 and 16 in 2020, the [2021 Adult Obesity Prevalence Maps](#) from the CDC now show 19 states in which adults are living with obesity at a prevalence of 35% or higher.² There are notable differences by race and ethnicity, age, education, geography and other variables.

Although BMI has limitations, and is flawed if applied as a single indicator of overall weight and health, it is widely leveraged to identify overweight and obesity in adults aged 20 years and older. BMI is interpreted using standard weight status categories which are applied consistently for men

¹Ward, Z et al. *Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity*. N Engl J Med (2019); 381:2440-2450.

²Centers for Disease Control and Prevention. (2021 Sept) *Number of States with High Obesity Prevalence Rises to Sixteen*.

<https://www.cdc.gov/media/releases/2021/s0915-obesity-rate.html#:~:text=Up%20from%20nine%20states%20in%202018%20and%2012,Tennessee%2C%20Texas%20%28new%20this%20year%29%2C%20and%20West%20Virginia.>

and women, all body types, and ages. Standard weight status categories associated with BMI ranges for adults are shown in the table below.

BMI	Weight Status
Below 18.5	Underweight
18.5–24.9	Healthy Weight
25.0–29.9	Overweight
30.0 and Above	Obesity

Obesity is frequently subdivided into categories:

- Class 1: BMI of 30 to < 35
- Class 2: BMI of 35 to < 40
- Class 3: BMI of 40 or higher. Class 3 obesity is sometimes categorized as “severe” obesity.

Obesity and Comorbidities

Obesity is associated with numerous comorbidities, including insulin resistance, Type 2 diabetes, hypertension, cardiovascular disease, heart failure, stroke, dyslipidemia, sleep apnea, arthritis, gall bladder disease, and certain types of cancer. The National Institutes of Health (NIH) has reported that obesity and overweight are now the second leading cause of death nationally, with an estimated 300,000 deaths a year attributed to the epidemic.³ Those living with obesity are also at increased risk of dying from an obesity-related comorbidity; in fact, a person living with obesity is 1.5 to 2.5 times more likely to die of heart disease than a person not living with obesity.⁴

According to the National Cancer Institute, obesity has been linked to higher rates of 13 types of cancer that make up 40 percent of cancers diagnosed in the United States. People living with excess weight and obesity are more likely to have endometrial cancer, esophageal adenocarcinoma, gastric cardia cancer, liver cancer, kidney cancer, ovarian cancer, thyroid cancer, breast cancer, gallbladder cancer, multiple myeloma, meningioma, pancreatic cancer, and colorectal cancer. Additionally, individuals with obesity experience higher rates of mortality with breast, ovarian, and colorectal cancer, are at increased risk of cancer recurrence, and are disproportionately represented in female and minority populations which leads to higher rates of obesity-related cancers in these groups.

Research has also revealed a complex interrelationship between obesity and mental health, with each posing treatment barriers to the other. According to the National Alliance on Mental Illness, people living with mental illness have significantly higher rates of obesity, cardiovascular disease, and metabolic disease. While obesity itself can often be the catalyst for individuals to have a negative self-image and other mental health challenges, it is also true that many medications used

³ West Virginia Health Statistics Center. (n.d.) *Obesity: Facts, Figures, Guidelines*. <https://www.wvdhhr.org/bph/oehp/obesity/mortality.htm>

⁴ Blumenthal, D., & Seervai, S. (2018, April 28) *Rising Obesity in the United States is a Public Health Crisis*. <https://www.commonwealthfund.org/blog/2018/rising-obesity-united-states-public-health-crisis>

to treat mental illness may cause weight gain. Therefore, the need to focus on mental and physical health simultaneously is quite important.

Costs Associated with Obesity

Living with obesity has a significant impact on the health of an individual and carries a significant cost burden. Obesity as a risk factor is by far the greatest contributor to the burden of chronic diseases in the U.S., accounting for 47.1 percent of the total cost of chronic diseases nationwide.⁵ The total cost of chronic diseases due to obesity and overweight was \$1.72 trillion—equivalent to 9.3 percent of the U.S. gross domestic product.⁶ The direct health care costs to treat chronic diseases driven by the risk factor of obesity and overweight in the U.S. are compounded by the indirect costs of lost economic productivity.⁷ One recent study examining data from the Medical Expenditure Panel Survey estimated that annual individual health care expenditures increase by approximately \$3,500 for people living with obesity.⁶ Total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, are estimated to be \$91.6 billion per year.⁸

Disproportionate Impact of Obesity

Communities of color are disproportionately impacted by the obesity epidemic. Non-Hispanic Blacks live with the highest prevalence of obesity at 49.6%, followed by Hispanics at 44.8%, and non-Hispanic Whites at 42.2%.⁹ Native Hawaiians/Pacific Islanders were 80 percent more likely to live with obesity than non-Hispanic Whites in 2016.¹⁰ The Asian American population may experience lower rates of overweight and obesity compared to the non-Hispanic White population, but develop health complications at lower BMIs than other racial and ethnic groups.¹¹ Some Asian subgroups such as Asian Indians carry a disproportionately high risk for chronic disease conditions and have a remarkably high prevalence of obesity while using Asian Pacific criteria by WHO for overweight and obesity. Asian Indians are the second largest immigrant population in the US. It is a challenge for this population to receive the right care on obesity management when the national surveys are not utilizing the Asian Pacific criteria for identifying overweight and obesity among Asians. Thus, Asians are often underrepresented in discussions on obesity management.

Unfortunately, communities of color will continue to bear much of the burden of the obesity epidemic. The projections for 2030 show a large disparity in obesity prevalence across subgroups,

⁵ Hammond R, Levine. *The economic impact of obesity in the United States*. Diabetes Metab Syndr Obes. 2010;3:285-295 <https://doi.org/10.2147/DMSO.S7384>

⁶ Hammond R, Levine. *The economic impact of obesity in the United States*. Diabetes Metab Syndr Obes. 2010;3:285-295 <https://doi.org/10.2147/DMSO.S7384>

⁷ *ibid*

⁸ Benjamin, H., & Harris, AW. (2014, December 12). *Obesity costs evident at the state level*. <https://www.brookings.edu/blog/up-front/2014/12/12/obesity-costs-evident-at-the-state-level/>.

⁹Centers for Disease Control and Prevention. (2022, May 17). *Adult obesity facts*. Centers for Disease Control and Prevention. [https://www.cdc.gov/obesity/data/adult.html#:~:text=Obesity%20affects%20some%20groups%20more%20than%20others&text=Non%20Hispanic%20blacks%20\(49.6%25\),%20Hispanic%20Asians%20\(17.4%25\)](https://www.cdc.gov/obesity/data/adult.html#:~:text=Obesity%20affects%20some%20groups%20more%20than%20others&text=Non%20Hispanic%20blacks%20(49.6%25),%20Hispanic%20Asians%20(17.4%25).).

¹⁰ Centers for Disease Control and Prevention. (2023, February 23). *FastStats - health of Asian population*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/fastats/asian-health.htm>

¹¹American Psychological Association. (n.d.). *Ethnicity and health in america series: The issue of obesity among Asian Americans and Pacific Islanders*. American Psychological Association. <https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/obesity>

estimating that severe obesity (BMI >40) will be the most common BMI category in the US among non-Hispanic Black adults.¹²

Treatment Requires a Continuum of Care

The underlying causes of obesity are complex, multifactorial, and often include factors completely out of the individual's control, such as genetics and socio-economic status. Prior to 2013, when the American Medical Association declared obesity a disease, most of the public and medical community viewed obesity as both a result of personal lifestyle choices including unhealthy eating habits, lack of willpower and insufficient physical activity. While attitudes have shifted over the years to understand that obesity requires treatment like any other chronic disease, most people living with obesity still lack access to the full continuum of care. Guideline-recommended treatment for obesity includes lifestyle intervention (efficacy = 2%-4% weight loss),¹³ pharmacotherapy (efficacy = 5%-17% weight loss),^{14,15,16} and bariatric surgery (efficacy = 16%-23% weight loss).¹⁷ The six types of lifestyle interventions include 1) a health dietary pattern 2) physical activity 3) restorative sleep 4) avoidance of risky substances 5) positive social interactions and 6) stress management.

Despite the numerous clinical practice guidelines from major medical associations that include the use of comprehensive lifestyle interventions, pharmacotherapy, and bariatric surgery in the standard of care, patients' access to the full continuum of services is limited by a lack of insurance coverage, among other barriers. A review of coverage found that while all beneficiaries of Medicare, Medicaid, State Employee Health Plans (SEHP), and Essential Health Benefits Benchmark Plans (EHB) have coverage for screening and counseling, and the majority have access to bariatric surgery, coverage of pharmacotherapy is much more limited.

Due to an outdated statutory restriction which does not recognize obesity as a chronic disease, nor the scientific advancements made to address the disease, Medicare beneficiaries are unable to access anti-obesity medications (AOMs). And coverage for AOMs is only offered in 19 state Medicaid programs, 16 State Employee Health Plans, and two state EHB benchmark plans.¹⁸ In order for health care providers to be able to fully support their patients' efforts to address their disease, they must have the full continuum of care in their armamentarium.

¹² Ward, Z et al. *Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity*. N Engl J Med (2019); 381:2440-2450.

¹³ Galaviz KI, et al. *Global Diabetes Prevention Interventions: A Systematic Review and Network Meta-analysis of the Real-World Impact on Incidence, Weight, and Glucose*. Diabetes Care. 2018 Jul;41(7):1526-1534. doi: 10.2337/dc17-2222. PMID: 29934481; PMCID: PMC6463613.

¹⁴ Currax Pharmaceuticals LLC. (2020 August) *Contrave® Prescribing Information*. Morristown, NJ.

¹⁵ Vivus Inc. (2020 October) *Qsymia® Prescribing Information*. Campbell, CA.

¹⁶ Wilding, J, et al. *Once-Weekly Semaglutide in Adults with Overweight or Obesity*. N Engl J Med 2021; 384:989-1002

DOI: 10.1056/NEJMoa2032183

¹⁷ Elangovan, A, et al. *Pharmacotherapy for Obesity-Trends Using Population Level National Database*. Obes Surg. 2021 Mar;31(3):1105-1112. doi: 10.1007/s11695-020-04987-2.

¹⁸ Waidmann, T, et al. (2022 February) *Obesity Across America: Geographic Variation in Disease Prevalence and Treatment Options*. The Urban Institute. <https://www.urban.org/sites/default/files/2022-02/obesity-across-america.pdf>

The Role of Nurses in Obesity Care

Nurses and nurse practitioners (NPs) can significantly impact the care of people living with obesity. Nurses are often the members of the health care team who spend the most time with a patient and may be responsible for educating the patient on behavioral and lifestyle changes as well as medically recommended treatments to address their disease.

NPs serve as a valuable resource in caring for people living with obesity. They work to ensure that the patient becomes a partner in preventive health measures to avoid chronic diseases. Their educational training prepares highly skilled primary and acute health care providers with advanced history taking, physical examination, and diagnosis skills. NPs' focus on health maintenance involves identifying individuals at risk of health problems, such as obesity, and encouraging behaviors that reduce these risks. Additionally, many NPs have prescribing authority. An important aspect of obesity prevention and treatment is behavior modification. Intensive behavioral therapy, often combined with AOMs prescribed by an NP, will amplify the treatment effect for obesity.

Addressing the obesity epidemic is of critical importance for the general population, but also vital to the health of those in the nursing profession. A study looked at cross-sectional data of 394 nurses in California and found that 31% live with overweight and 18% were living with obesity. Another convenience study of 5400 nurses and nursing student by ANA Enterprise in 2021 showed this group having a BMI of 27.58 (overweight) with about 30% living with obesity. These findings suggest that occupational factors associated with the nursing profession, such as long shifts of work without breaks, operating in a high stress environment and lack of restorative sleep, contribute to obesity and physical inactivity, and that nurses can benefit from access to the full continuum of obesity care.¹⁹

Needed Reforms

As mentioned above, access to the full continuum of obesity care is unequal across payers. Much of this is due to an outdated Centers for Medicare and Medicaid Services (CMS) policy that excludes access to some obesity services. Current CMS guidance does not permit coverage for drugs that treat obesity under Part D, on the grounds that such drugs are excluded under the Part D statute as agents "used for anorexia, weight loss, or weight gain." CMS has held this policy for more than a decade, and in the meantime our scientific understanding of obesity as a chronic disease, and methods to treat it, has evolved substantially. Medicare only covers medical nutrition therapy services and certain related services for those with diabetes, kidney disease, or kidney transplant in the past 36 months. Medicaid may provide medical nutrition therapy, but it varies by state.

CMS' current Part D policy denying coverage of AOMs has the unintended effect of creating and perpetuating an unnecessary gap in access to a standard treatment, not only in Medicare but also

¹⁹ Chin DL, et al. *Occupational factors associated with obesity and leisure-time physical activity among nurses: A cross sectional study.* Int J Nurs Stud. 2016 May;57:60-9.

in Medicaid and Affordable Care Act (ACA) Marketplace plans. Although there is no prohibition on coverage in Medicaid, many states have mirrored the exclusionary Medicare language and do not provide access to this and other important components of the continuum of care. Additionally, ACA Marketplace plans are not required to cover AOMs under the Essential Health Benefits (EHB) due to the Medicare exclusion.

RECOMMENDATIONS:

Nurses should advocate at the state and national level for appropriate coverage of the full continuum of obesity care. The Nurses Obesity Network urges policymakers on the state and Federal level to implement the following policy changes to ensure access to the full continuum of obesity care.

CMS should use its authority to clarify that AOMs are Part D covered drugs and that medical nutrition therapy services are covered, regardless of diagnosis, when the patient is diagnosed with obesity and their healthcare provider recommends it.

- We believe it is within CMS' authority to update its coverage policies for pharmacotherapy. CMS could interpret the current statutory exclusion in a manner that would permit coverage of FDA-approved therapies for purposes of treating the chronic disease of obesity instead of restricting them as weight loss medications.
- CMS has used its authority to interpret the statute to include drugs under Part D that might otherwise be excluded on several occasions.

State policymakers should ensure access to the full continuum of obesity care for all their citizens.

- Medicaid Directors should provide coverage of obesity care benefits, including AOMs, surgery, lifestyle obesity behavioral counseling, and medical nutrition therapy, to beneficiaries through the State Plan Amendment process
- State Employee Health Plan Administrators should ensure that beneficiaries have access to all obesity services, including AOMs and others as noted above, through at least one health plan.
- State Insurance Commissioners should update their EHB benchmark plan to add coverage of AOMs and others noted above. Depending on the actuarial analysis, the added benefit may have to be defrayed through elimination of low value services from the benchmark plan.