Whereas, Obesity has been recognized by our AMA as a disease (AMA Policy H-440.842); and

Whereas, There are many evidence-based, effective and safe treatment options for obesity including intensive lifestyle intervention\(^1\),\(^2\),\(^3\), pharmacotherapy\(^4\), and surgery\(^5\); and

Whereas, Our AMA “will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions) (D-440.954);” and

Whereas, Weight-bias is a significant problem in our society, at the state and federal level, and even in our health-care system with most patients affected by obesity often being victims of weight-bias including from their health care provider (H-440.821); and

Whereas, Our AMA has recognized that medical education regarding evidence-based treatment is inconsistent and inadequate\(^6\); and

Whereas, Pharmacotherapy for obesity has been proven to safely and effectively double to triple the odds of losing 5-10% body weight, an amount that has been proven to prevent diabetes, improve blood pressure and decrease health care costs\(^7\); and

Whereas, Current state and federal regulations make it even more difficult for healthcare providers to provide treatment:

- Medicare does not allow payment for any anti-obesity medication (AOM) due to an out-of-date policy, which prohibits Medicare from covering any “drugs for weight loss or weight gain.”
- Medicare further restricts payment for intensive lifestyle intervention to primary care providers in the primary care setting. For this reason, this benefit is scarcely being used.
- Our AMA has already supported the Treat and Reduce Obesity Act (TROA)\(^8\) in the 114th Congress, and will continue to support the bill in the 115th congress, H.R. 1953/S. 830 – legislation that would eliminate the Medicare Part D prohibition on weight loss medications and allow other qualified health care providers such as registered dietitians and social workers to provide behavioral treatment.
- Most states allow physicians to utilize FDA medications for off-label uses to treat chronic conditions should these practices be viewed as within the standard of care for that

\(^1\) [https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management], accessed 1/15/2018

\(^2\) Centers for Medicare and Medicaid Services (CMS), November 29th, 2011


\(^4\) [https://doi.org/10.1210/jc.2015-1782], accessed 1/15/2018


\(^6\) Counsel on Medical Education Report CME-3, Obesity Education at a

\(^7\) Milken Institute Report. [https://www.milkeninstitute.org/publications/view/833], Accessed 1/15/2018

\(^8\) [https://www.congress.gov/bill/115th-congress/house-bill/1953]
condition. However, this is not the case in some areas of the country regarding off-label prescribing for AOMs\(^9,10\). For example, some older drug labels state that the medications are for “short-term” use only, which is now inconsistent with what we know about the chronic nature of obesity. It has been proven that treatment is only effective so long as it is continued as is the case with all chronic disease such as diabetes and heart disease. Current publications including one from our Endocrine colleagues\(^11\) call for chronic prescribing of all AOMs, and include guidelines to be used for safe prescribing of these older medications; and

Whereas, The use of AOMs long-term for obesity has been approved by the FDA for our 4 newest drugs, and recent studies of our older drugs shows that “abuse or psychological dependence (addiction) does not occur…”\(^12\), and

Whereas, Due to these issues and many others, patients affected by obesity are unlikely to receive proper evidence-based treatments including behavioral intervention and medication. Current research shows that only 2% of patients affected by obesity with an on-label indication for pharmacotherapy are receiving medication. In contrast, 86% of patients affected by type 2 diabetes receive pharmacotherapy\(^13\), therefore be it

RESOLVED, That our American Medical Association work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA actively lobby with state medical societies and other interested stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 03/21/18

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842 - Our AMA recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. Res. 420, A-13

Addressing Obesity D-440.954 - 1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. 2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions). BOT Rep. 11, I-06 Reaffirmation A-13 Appended: Sub. Res. 111, A-14 Modified: Sub. Res. 811, I-14

Person-First Language for Obesity H-440.211 - Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. Res. 402, A-17 Modified: Speakers Rep., I-17

\(^9\) http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/PRESCRIBER-RESOURCES-PAGE/Weight-Loss-Drugs/PrescribingQsymiaBelviqforChronicWeightManagement.pdf
\(^12\) https://doi.org/10.1210/jc.2015-1782, accessed 1/15/2018
\(^13\) https://www.ncbi.nlm.nih.gov/pubmed/23736363/, accesses 1/24/2018