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June 26, 2008

The Honorable Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Policy and Technical Changes to the Medicare Prescription Drug Benefit. Definitions: Morbid Obesity. 42 CFR Part 423

Dear Mr. Weems:

On behalf of DMAA: The Care Continuum Alliance, I wish to express concern with Medicare Part D's prohibition of coverage for drugs used in the treatment of morbid obesity and to encourage support for comprehensive treatments that reduce complications and improve quality of life for the millions of Medicare beneficiaries who are obese.

As you may know, DMAA convenes all stakeholders providing services along the care continuum toward the goal of population health improvement. These care continuum services include strategies such as health and wellness promotion, disease management, and care coordination. DMAA: The Care Continuum Alliance promotes the role of population health improvement in raising the quality of care, improving health outcomes and reducing preventable health care costs for individuals with chronic conditions and those at risk for developing chronic conditions. DMAA represents wellness, disease and care management organizations, pharmaceutical manufacturers and benefit managers, health information technology innovators, biotechnology innovators, employers, physicians, nurses and other health care professionals, and researchers and academicians. In our efforts to reduce health inequities among population groups, DMAA recognizes many opportunities to promote healthful lifestyles, weight management and treatment in the Medicare program.

DMAA, through its Obesity with Comorbidities Initiative, is taking an active role in research, education and advocacy to raise awareness of overweight and obesity and evidence-based, high-quality approaches to fighting these conditions. In 2006, DMAA produced a first-ever definition of obesity with comorbid conditions, which concluded that obesity should be considered in the context of chronic disease and that overweight

and obesity substantially increase the risk of hypertension, type 2 diabetes, coronary artery disease, stroke, certain types of cancer and other chronic illnesses. The definition is part of a broader research and education effort by DMAA that includes an annual Obesity Management Symposium; a 2007 literature review of assessment and management options published in DMAA's peer-reviewed journal, *Disease Management;* and development of a Value-Based Benefit Design for Obesity and Comorbidities that combines the best available scientific evidence on effective obesity management strategies with pricing structures universally accepted by insurers to build a suggested approach to obesity benefit design.

There may be no greater threat to the health and welfare of our population than the growing epidemic of obesity and the many chronic conditions associated with it. The rate of obesity among Medicare beneficiaries more than doubled from 1987 to 2002, and spending on health care for those beneficiaries also more than doubled over the same period, according to a *Health Affairs* study. Twenty-five percent of Medicare beneficiaries are obese (BMI 30 +). Obese beneficiaries have higher prevalence of diabetes, hypertension, heart failure, osteoarthritis, and other costly diseases compared to normal weight individuals. They also have significantly more ADL limitations and are far more likely to report being in fair or poor health.

It is critical, then, that we begin to manage and treat the condition of obesity directly rather than only addressing obesity's co-morbidities. Excluding drugs used to treat morbid obesity from the definition of Medicare Part D drugs overlooks additional opportunities provided by obesity-related medical treatments to reduce significant health risks that may increase morbidity and mortality among Medicare populations.

Promising new strategies to combat obesity continue to emerge, and making pharmaceutical treatments available to beneficiaries in conjunction with behavioral therapies is imperative. The prohibition of Medicare Part D coverage of drugs that combat obesity provides a disincentive to further study pharmacotherapy approaches and reinforces the costly argument that obesity treatments should be classified as optional.

DMAA encourages you to review implementation of the Final Rule and recognize advances in pharmaceutical treatments as critical to addressing obesity as a cross-sectional threat to American society. We look forward to working with CMS as you continue to realize progress in preventing and treating obesity in Medicare beneficiaries.

Sincerely,

Tracey Moorhead

President & CEO