EXPLORING OBESITY'S IMPACT ON WOMEN AND POLICY'S ROLE IN IMPROVING OUTCOMES

An SWHR Congressional Briefing | May 2, 2024

#SWHRtalksObesity

Society for Women's Health Research

About SWHR

MISSION

Advance women's health through science, policy, and education while promoting research on sex differences to optimize women's health.

VISION

Make women's health mainstream.

Obesity Program Overview

Key Phases/Timeline

February 2024

In-person, interdisciplinary roundtable convening

March 2024

Release of fact sheet highlighting how women may be disproportionately impacted by obesity

May 2024

Congressional briefing

June 2024

Webinar to highlight the experiences of patients living with obesity

Fall 2024

Release of SWHR policy agenda

Today's Speakers

Lisa Bailey-Davis, DEd, RD, Geisinger

Patty Nece, JD, Advocate

Tiffany Powell-Wiley, MD, MPH, National Heart, Lung, and Blood Institute

Tracy Zvenyach, PhD, MS, RN, Obesity Action Coalition

The SWHR Obesity Policy Program is supported by sponsorship from Novo Nordisk, Inc. SWHR maintains independence and editorial control over program development, content, and work products.

Special Remarks

The Honorable Sheila Cherfilus-McCormick, U.S. House of Representatives (FL-20)

Women's Health and Obesity: A life course perspective

Geisinger

Lisa Bailey-Davis, DEd, RD
Associate Professor
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Associate Director
Center for Obesity & Metabolic Health
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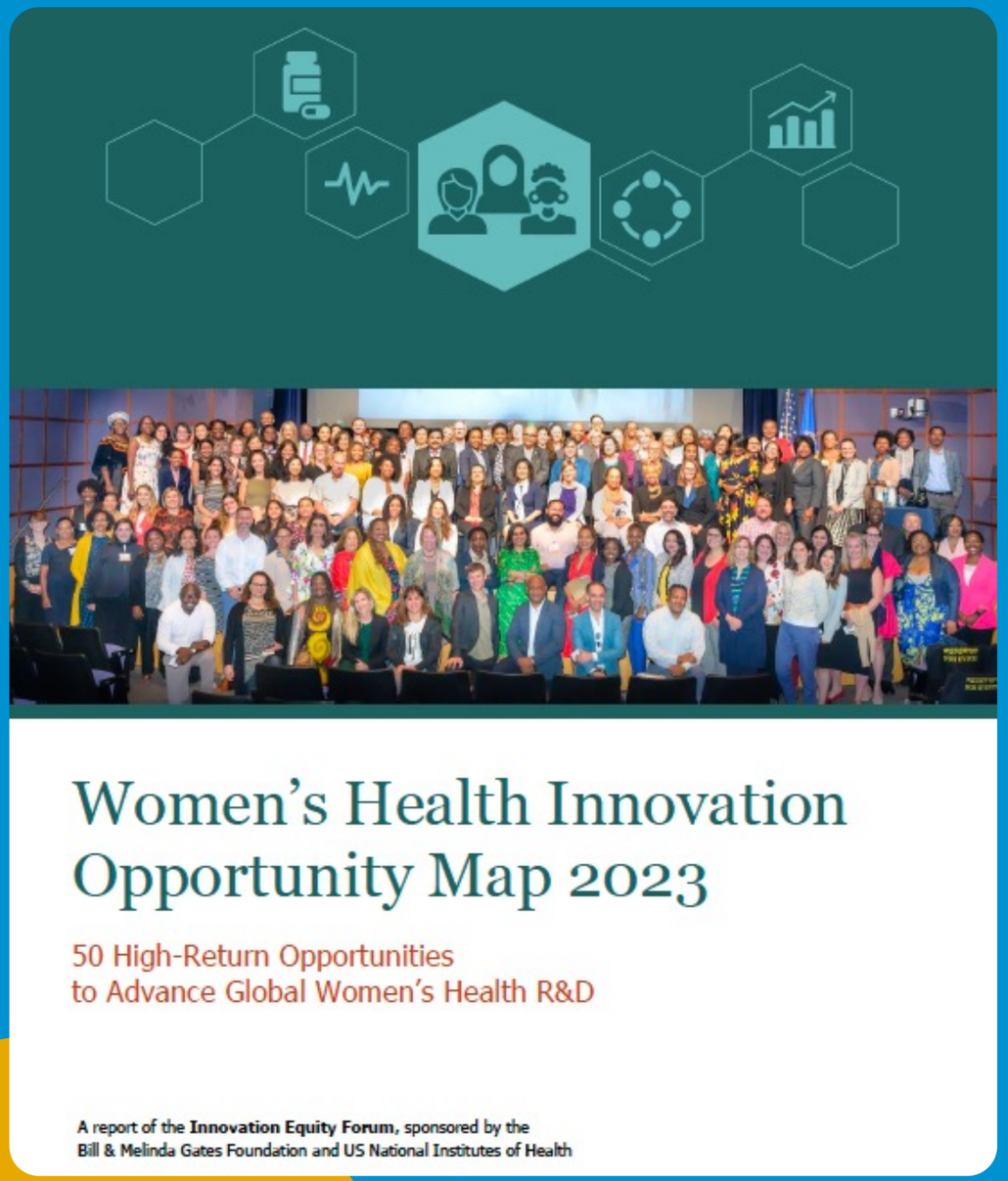
The egg that became **you** formed when **your mother** was developing in ***her*** **mother's** womb.

What your grandmother
ate before and during pregnancy
impacts your health throughout your life.

OHSU

This is called the **"100-year effect."**



Plan to prioritize resources and efforts to advance opportunities to lay a stronger foundation for equitable innovation across 9 topics including **non-communicable and chronic disease**

- Leading Opportunity
  - Evaluate **sex- and gender-related differences in the evolution and presentation of cardiometabolic diseases** and responses to available therapies to inform the development of optimal prediction, prevention, screening, diagnosis, monitoring, and treatments for women, with a specific focus on ischemic heart disease, diabetes, and **obesity**.

Women's Health Innovation Opportunity Map 2023: 50 High-Return Opportunities to Advance Global Women's Health R&D. October 2023. Bill & Melinda Gates Foundation and National Institutes of Health.

Obesity is a disease & a contributing factor to cardiometabolic diseases

Evidence: incidence, prevalence, morbidity, and mortality

Here are 10 other facts you need to know about women and cardiovascular disease:

1. Cardiovascular disease kills more women than all forms of cancer combined and yet only 44% of women recognize that cardiovascular disease is their greatest health threat.
2. Among females 20 years and older, nearly 45% are living with some form of cardiovascular disease and less than 50% of women entering pregnancy in the United States have good heart health.
3. Cardiovascular disease is the No. 1 killer of new moms and accounts for over on-third of maternal deaths. Black women have some of the highest maternal mortality rates.
4. Overall, 10% to 20% of women will have a health issue during pregnancy, and high blood pressure, preeclampsia and gestational diabetes during pregnancy greatly increase a women's risk for developing cardiovascular disease later in life.
5. Going through menopause does not cause cardiovascular disease, but the approach of menopause marks a point in midlife when women's cardiovascular risk factors can accelerate, making increased focus on health during this pivotal life stage is crucial.
6. Most cardiac and stroke events can be prevented through education and lifestyle changes, such as moving more, eating smart and managing blood pressure.
7. 51.9% of high blood pressure deaths, otherwise known as hypertension or the "silent killer," are in women, and out of all women, 57.6% of Black females have hypertension — more than any other race or ethnicity.
8. While there are an estimated 4.1 million female stroke survivors living today, approximately 57.5% of total stroke deaths are in women.
9. Women are often less likely to receive bystander CPR because rescuers often fear accusations of inappropriate touching, sexual assault or injuring the victim.
10. Women continue to be underrepresented in Science, Technology, Engineering and Math (STEM) fields, as well as in research. In fact, women occupy nearly half of all U.S. jobs (48%), but only 27% of jobs in STEM fields. Furthermore, only 38% of participants in clinical cardiovascular trials are women.

Gaps: mechanisms in disease presentation, progression

Solution Strategy

Leverage ongoing longitudinal studies on cardiometabolic conditions with a consortium-based approach to:

Share and pool existing data and biospecimens to enable research on life stage onset, preclinical and clinical manifestation of these conditions, risk of long-term complications, protective factors, access to and quality of timely identification of risk factors, diagnosis and healthcare delivery, response to treatment, incidence of fatal and non-fatal events, and additional stratification or cross-country comparisons, including natural experiments on the relationship of these conditions and changes in healthcare and public policies.

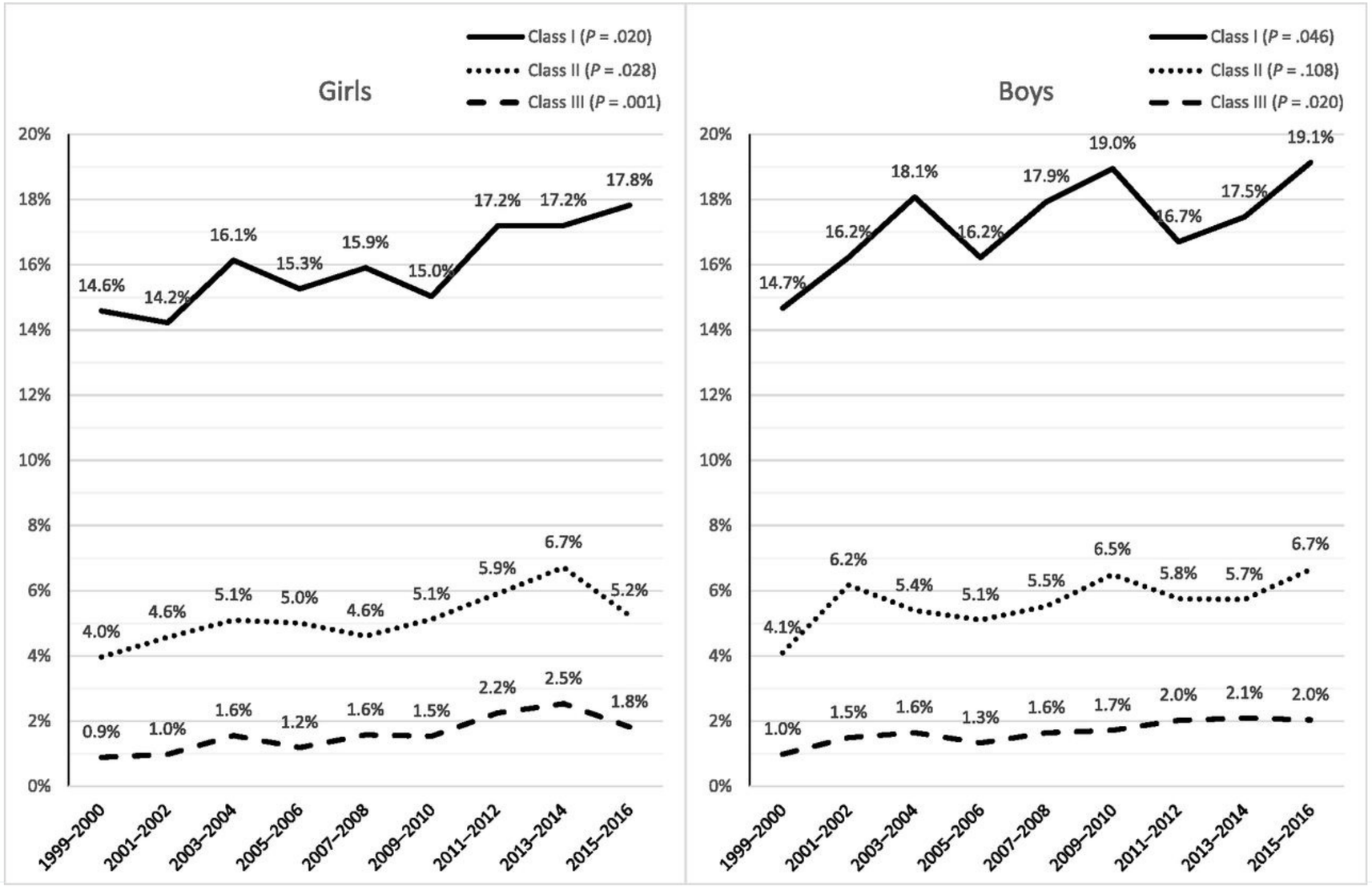
Path to personalized prediction, prevention, diagnostics, monitoring tools and treatments

www.GoRedforWomen.org; Women's Health Innovation Opportunity Map 2023: 50 High-Return Opportunities to Advance Global Women's Health R&D. October 2023. Bill & Melinda Gates Foundation and National Institutes of Health.

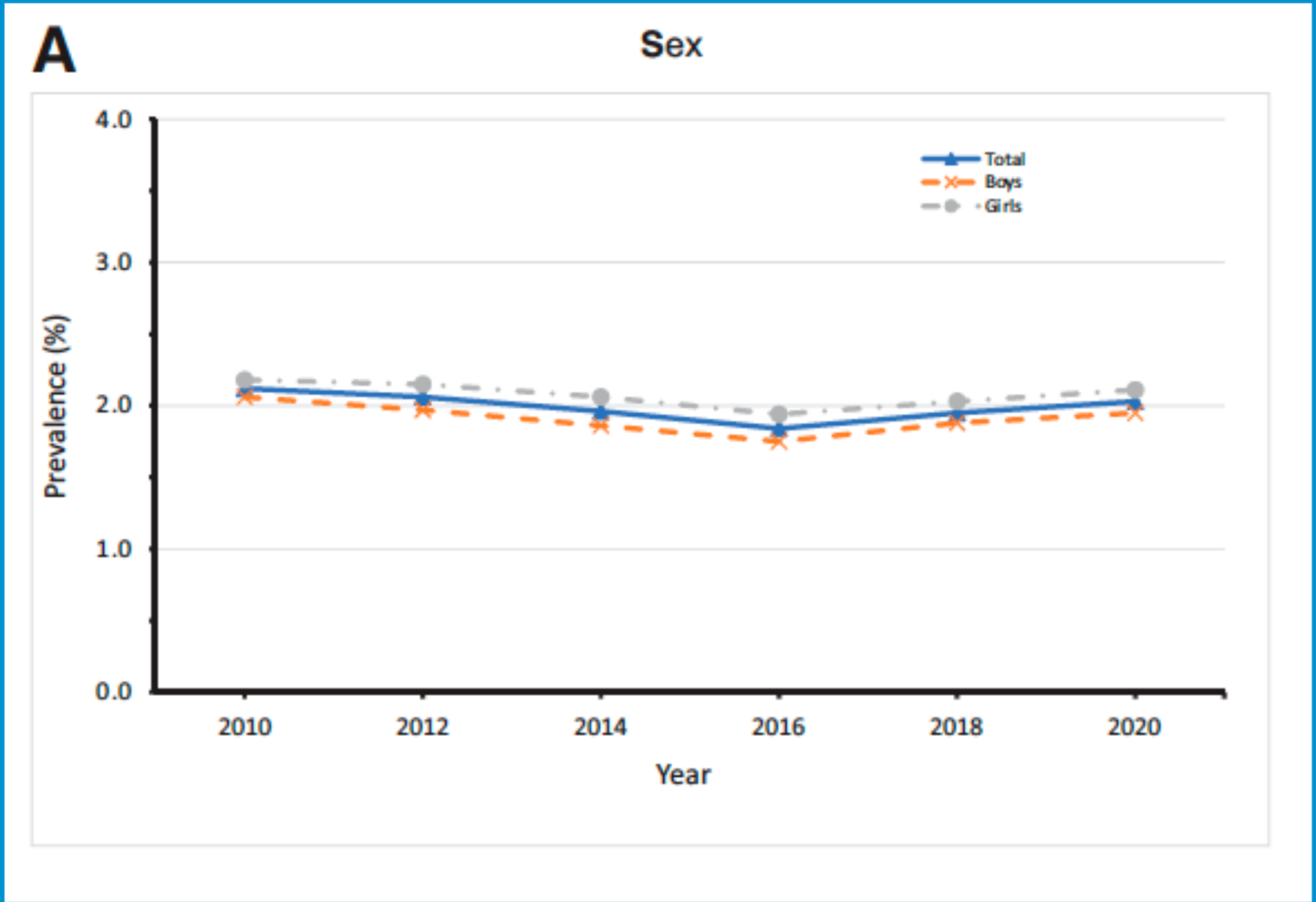
Class I BMI≥ 95th%tile
Class II BMI ≥120% of 95th%tile
Class III BMI≥140% of 95th%tile

Pediatrics. 2018;141(3). doi:10.1542/peds.2017-3459

Nationally representative samples of 2-19 year old children and adolescents in the U.S.

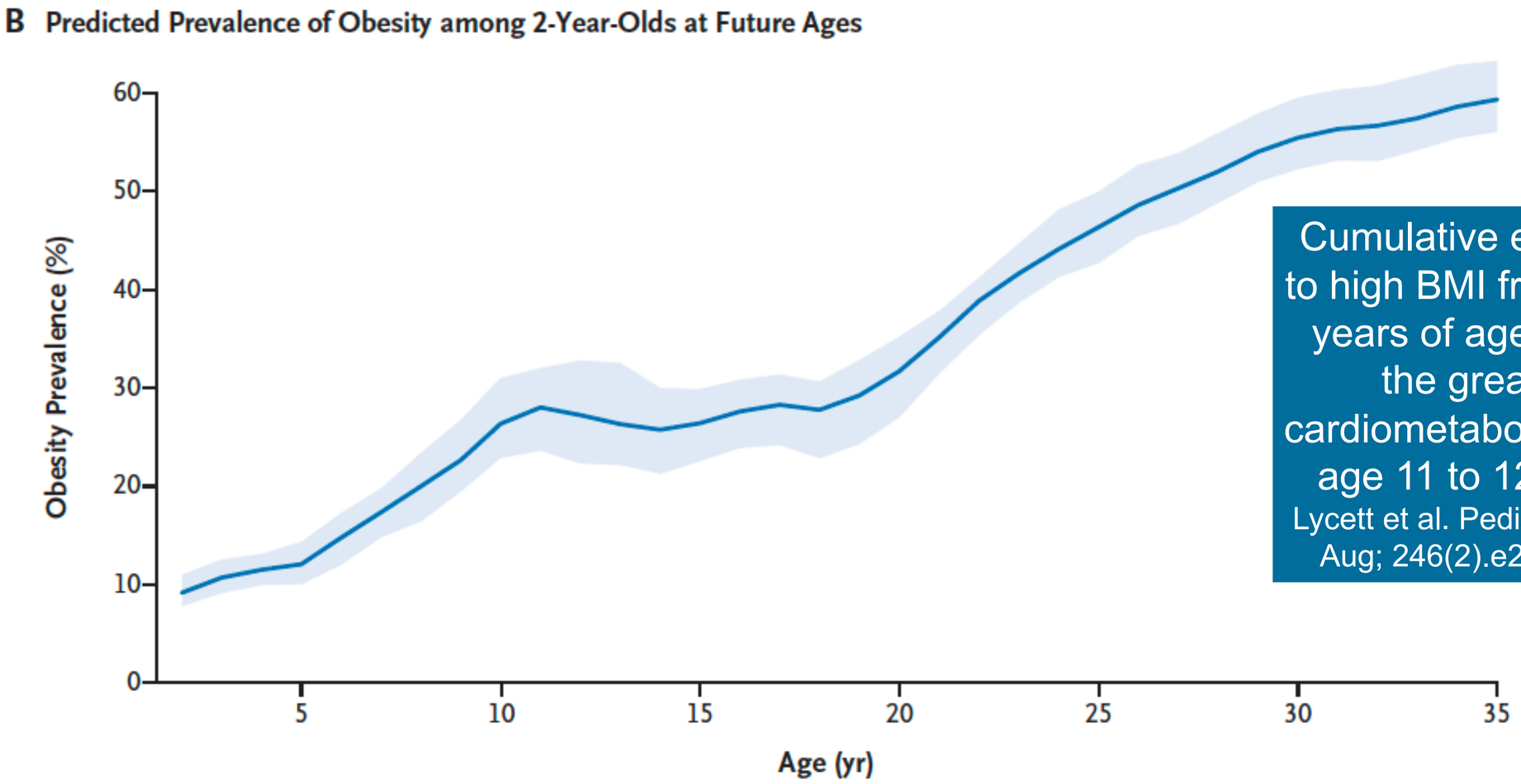


Higher Prevalence of Severe Obesity (Class II) among 2 to 4-year-old Girls Compared to Boys Enrolled in WIC



Zhao L, Freedman DS, Blanck HM, Park S. Trends in Severe Obesity Among Children Aged 2 to 4 Years in WIC: 2010 to 2020. Pediatrics. 2024 Jan 1;153(1):e2023062461.

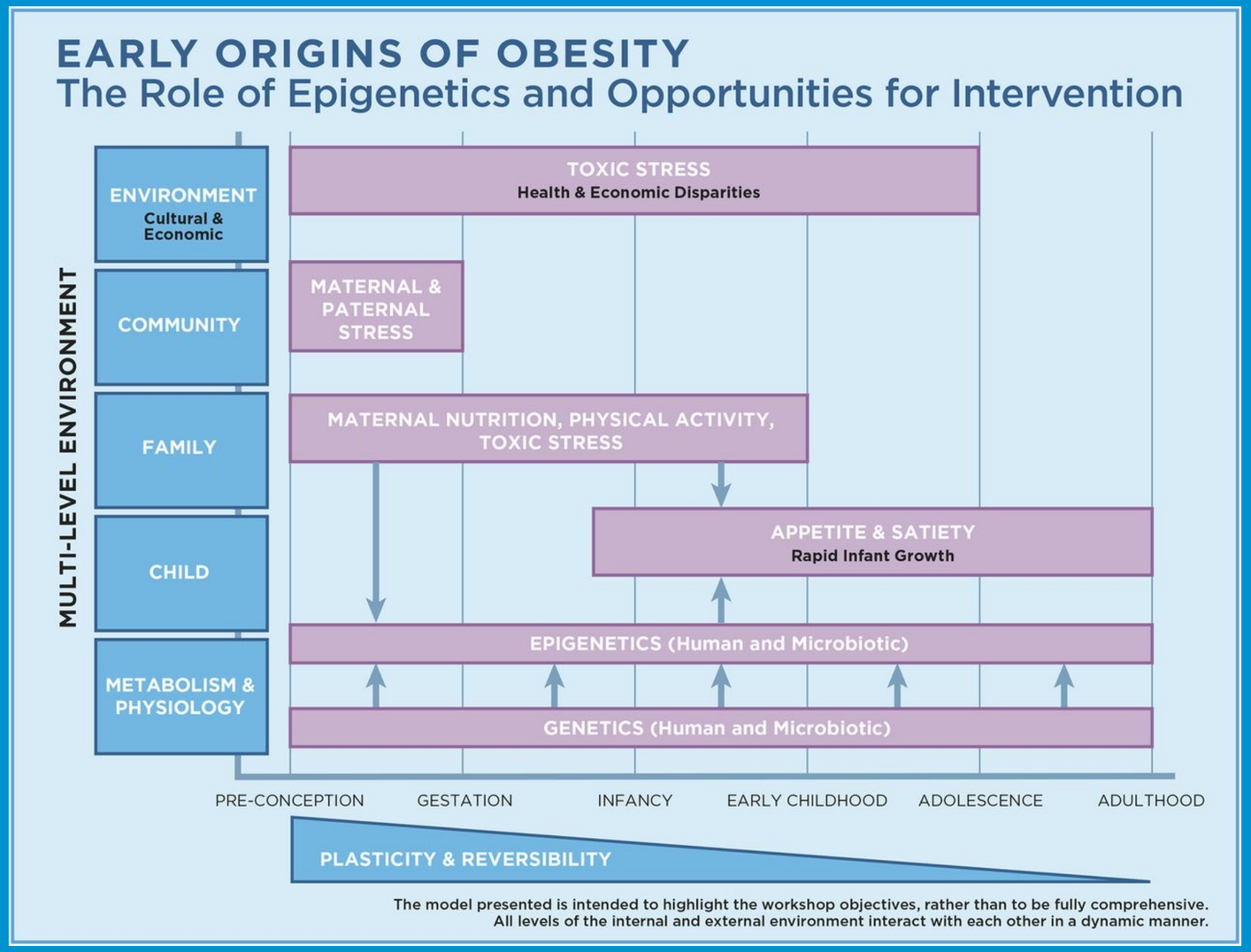
Obesity Persistence: Projected prevalence of obesity at future ages among 2-year-olds in 2016



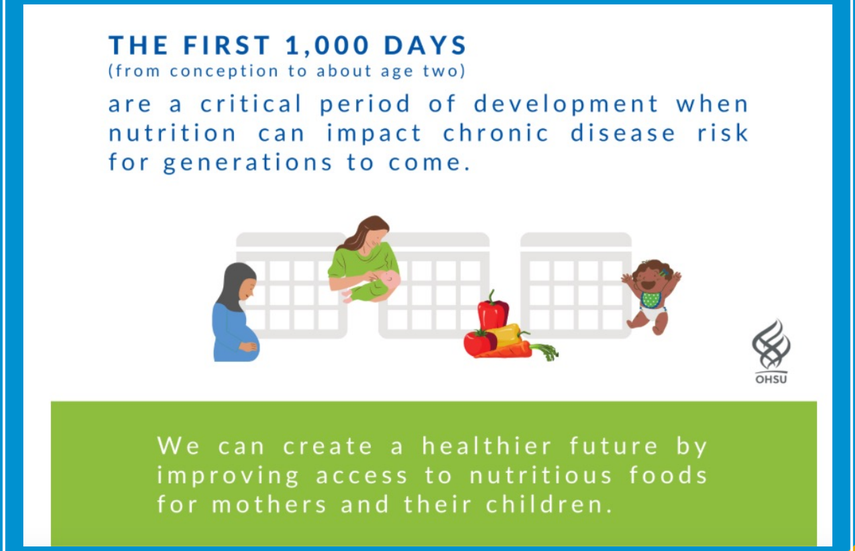
Cumulative exposure to high BMI from 2 to 3 years of age carries the greatest cardiometabolic risk by age 11 to 12 years.

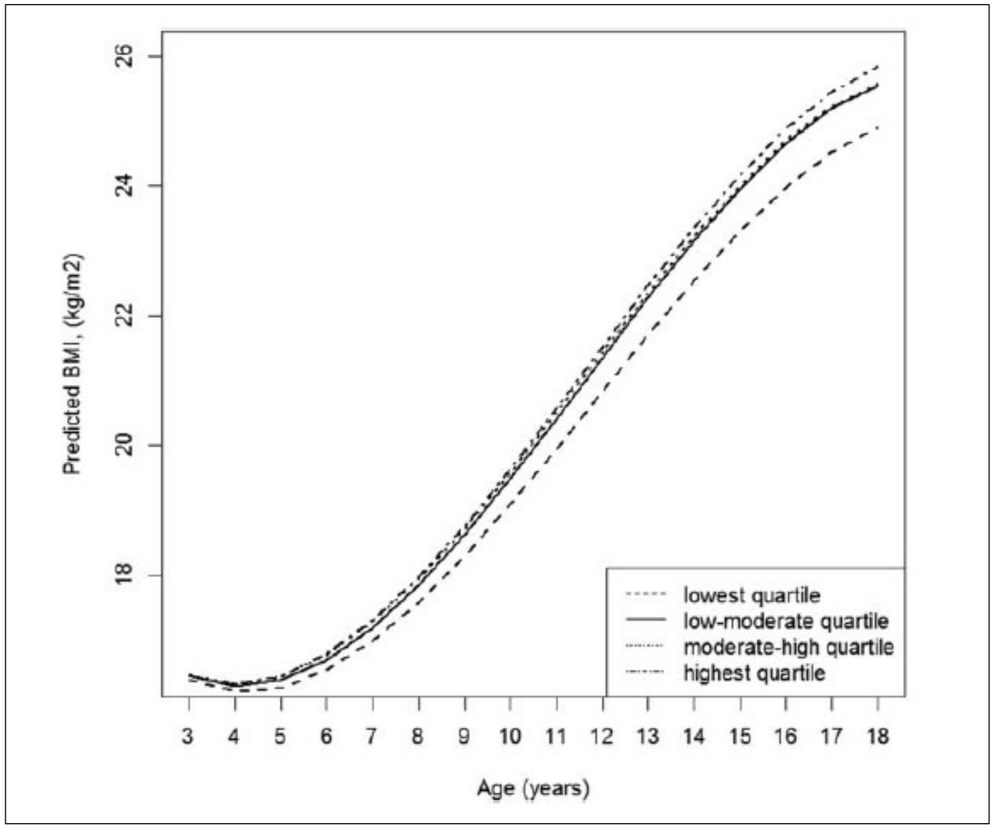
Lycett et al. Pediatrics. 2020 Aug; 246(2).e20193666.

Ward ZJ, Long MW, Resch SC, Giles CM, Cradock AL, Gortmaker SL. Simulation of Growth Trajectories of Childhood Obesity into Adulthood. N Engl J Med. 2017 Nov 30;377(22):2145-2153



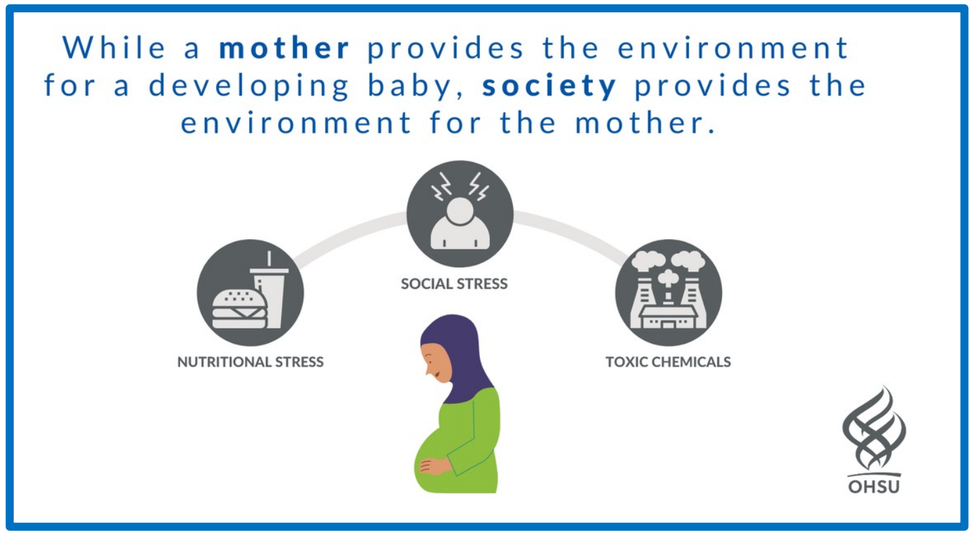
Adv Nutr, Volume 6, Issue 4, July 2015, Pages 487–488. Reprinted from the Institute of Medicine and National Research Council, Examining a developmental approach to childhood obesity: the fetal and early childhood years: workshop in brief, Washington (DC): The National Academies Press; 2015, with permission





Nau C, Schwartz BS, Bandeen-Roche K, Liu A, Pollak J, Hirsch AG, Bailey-Davis L, Glass TA. Community socioeconomic deprivation and obesity trajectories in children using electronic health records. *Obesity* (Silver Spring). 2015 Jan;23(1):207-12

The project described was supported by grant number U54HD070725 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).



Community Environment

Community socioeconomic deprivation: less than high school education, unemployed, not in labor force, in poverty, receiving public assistance, households without a car

At age 18, the difference in average BMI of adolescents in the least and most deprived communities is comparable to the size of the most potent childhood obesity interventions.

Positive parenting approaches and their association with child eating and weight: A narrative review from infancy to adolescence

	Infancy	Early Childhood	Middle Childhood	Adolescence
Demandingness/Structure (Monitoring & engagement, rules/limit setting, routines, provision of healthful foods)	• *Repeatedly introduces nutrient-dense foods* • *Establishes feeding routines* • *Provides developmentally appropriate feeding environment*	• *Offers guided choices at meals and snacks* • *Offers food at regular meal and snack times* • *Models eating behavior*	• *Limits excessive portion sizes* • *Has rules about the purchase of unhealthy foods outside the home* • *Limits frequent snacking*	• *Provides age appropriate monitoring of the child's food purchasing and eating behaviors* • *Conveys expectations about participation in family meals*
Continuum of Influence Across Development				
Responsiveness/Autonomy Support (Encouragement, praise, social modeling, responsiveness to cues)	• *Helps child hold spoon* • *Terminates feeding in response to fullness cues*	• *Helps children serve themselves* • *Allows child to decide when to terminate meal or snack*	• *Involves children in food shopping and cooking* • *Providing knowledge about nutrition and health*	• *Financial support to child for food purchases* • *Encourages children to learn to prepare meals independently*

Optimal Outcomes
- Food acceptance
- Appetite regulation
- Nutrition knowledge
- Healthy food choices
- Higher diet quality
- Healthy growth

Balantekin KN et al. Pediatric Obesity, Volume: 15, Issue: 10, First published: 03 September 2020, DOI: (10.1111/ijpo.12722)

Signs a Child is Hungry or Full

Birth Through Age 5 Months

A child may be **hungry** if he or she:
- Puts hands to mouth.
- Turns head toward breast or bottle.
- Puckers, smacks, or licks lips.
- Has clenched hands.

A child may be **full** if he or she:
- Closes mouth.
- Turns head away from breast or bottle.
- Relaxes hands.

Age 6 Through 23 Months

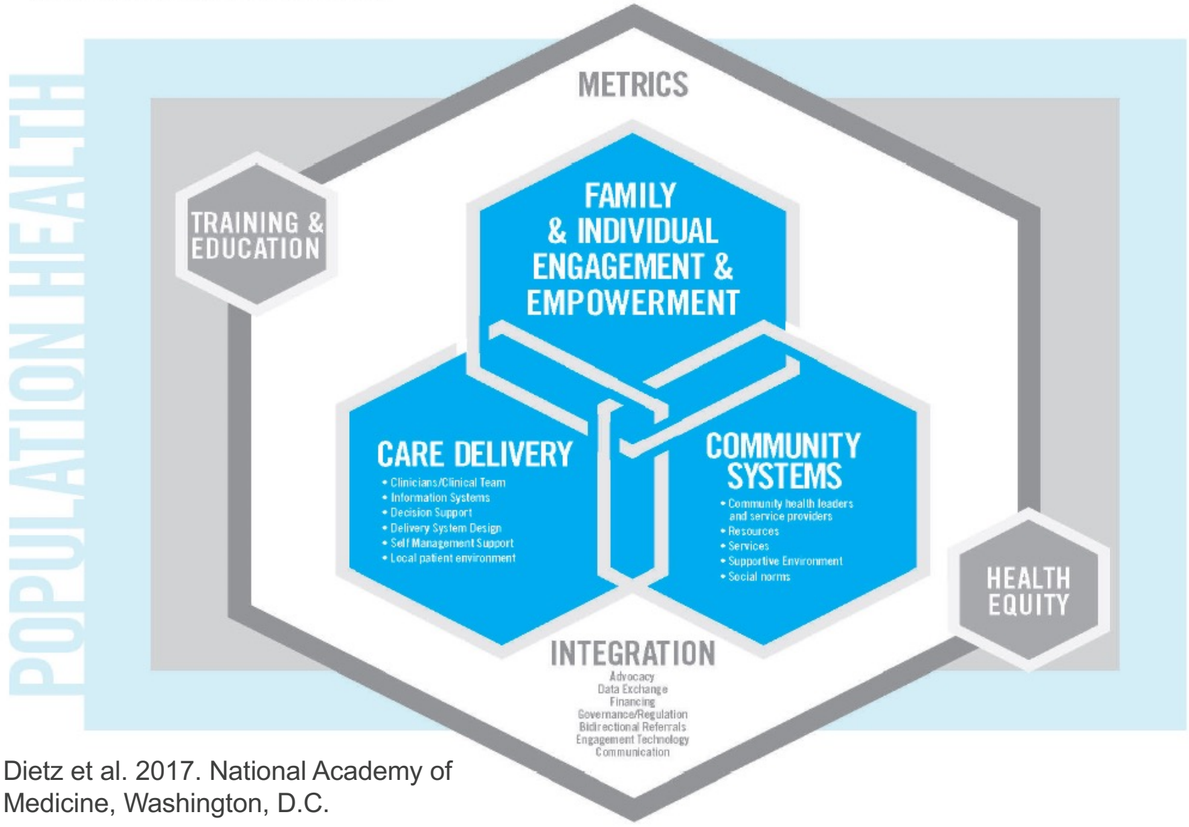
A child may be **hungry** if he or she:
- Reaches for or points to food.
- Opens his or her mouth when offered a spoon or food.
- Gets excited when he or she sees food.
- Uses hand motions or makes sounds to let you know he or she is still hungry.

A child may be **full** if he or she:
- Pushes food away.
- Closes his or her mouth when food is offered.
- Turns his or her head away from food.
- Uses hand motions or makes sounds to let you know he or she is still full.

CLINICAL-COMMUNITY INTEGRATION TO ACHIEVE HEALTHY PEOPLE & COMMUNITIES:

A FRAMEWORK TO OPTIMIZE THE PREVENTION AND TREATMENT OF OBESITY AND IMPROVE POPULATION HEALTH

People are more likely to engage in a healthcare system integrated within their community, where settings and resources reinforce healthy behaviors, provide person-centered care, and undergo continuous evaluation and improvement. Stakeholders recognize their interdependency and act in a coordinated and collaborative fashion to improve health and achieve health equity. This drives behavior change and ultimately helps to prevent and treat obesity and improve population health.



Dietz et al. 2017. National Academy of Medicine, Washington, D.C.

CHILDHOOD OBESITY
December 2023 | Volume 19, Number 8
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DOI: 10.1089/chi.2022.0137

Open camera or QR reader and scan code to access this article and other resources online.

Coordination Between Primary Care and Women, Infants, and Children to Prevent Obesity for Infants from Low-Income Families: A Pragmatic Randomized Clinical Trial

Jennifer S. Savage, PhD,[1] Amy M. Moore, PhD, RD,[1] Samantha M.R. Kling, PhD, RD,[2] Michele Marini, MS,[1] Erika Hernandez, PhD,[1] Jennifer Franceschelli Hosterman, DO,[3] Sandra Hassink, MD,[4] Ian M. Paul, MD, MSc,[5] and Lisa Bailey-Davis, DEd, RD[6]

This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number R40MC28317, Maternal and Child Health Field-Initiated Innovative Research Studies Program.

Bailey-Davis et al. BMC Public Health (2022) 22:2429
https://doi.org/10.1186/s12889-022-14827-w

BMC Public Health

STUDY PROTOCOL Open Access

Comparing enhancements to well-child visits in the prevention of obesity: ENCIRCLE cluster-randomized controlled trial

Lisa Bailey-Davis[1,2*], Amy M. Moore[3], Melissa N. Poulsen[1], David A. Dzewaltowski[4], Stacey Cummings[5], Laina R. DeCriscio[6], Jennifer Franceschelli Hosterman[5,7], Daniel Huston[6], H. Lester Kirchner[1], Shawnee Lutcher[2], Carolyn McCabe[1,2], Gregory J. Welk[8] and Jennifer S. Savage[3]

This work was supported through a Patient-Centered Outcomes Research Institute (PCORI®) Project Program Award (CER-2019C1-16040).

American Academy of Pediatrics Clinical Practice Guideline

KAS 11. Pediatricians and other PHCPs should provide or refer children 6 y and older (Grade B) and may provide or refer children 2 through 5 y of age (Grade C) with overweight (BMI ≥ 85th percentile to <95th percentile) and obesity (BMI ≥ 95th percentile) to intensive health behavior and lifestyle treatment. Health behavior and lifestyle treatment is more effective with greater contact hours; the most effective treatment includes 26 or more hours of face-to-face, family-based, multicomponent treatment over a 3- to 12-mo period.

Aggregate Evidence Quality	Grade B: Children ≥6 y of Age. Grade C: Children 2 Through 5 y of Age.
Benefits	BMI reduction, quality of life improvement, comorbidity improvement or resolution is associated with 26 or more hours of face-to-face, family-based, multicomponent treatment over 3 to 12 mo.
Risks, harms, costs	Minimal risk or harm. Participation is time-intensive and requires repeated visits. Treatment is costly to administer and inconsistently paid.
Benefit-harm assessment	Benefit outweighs risk.
Intentional vagueness	Impact is inconsistent in studies with significant heterogeneity of treatment response. Increasing dose of treatment is associated with more BMI improvement.
Role of patient preference	Patient preference is central.
Exclusions	Patients not responsible for their behavior change, such as children who are young or with developmental or cognitive impairment.
Strength	Moderate.
Key references	625

Hampl SE, Hassink SG, Skinner AC, et al. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity. Pediatrics. **2023**;151(2):e2022060640

Compared with women with normal weight, **women with Class I and Class II obesity have a 45% and 88% increased number of admissions,** respectively; this results in antenatal hospital **costs that are 5-fold higher**

Obesity-related complications: excessive gestational weight gain, preterm birth, preeclampsia, gestational diabetes, and cesarean delivery

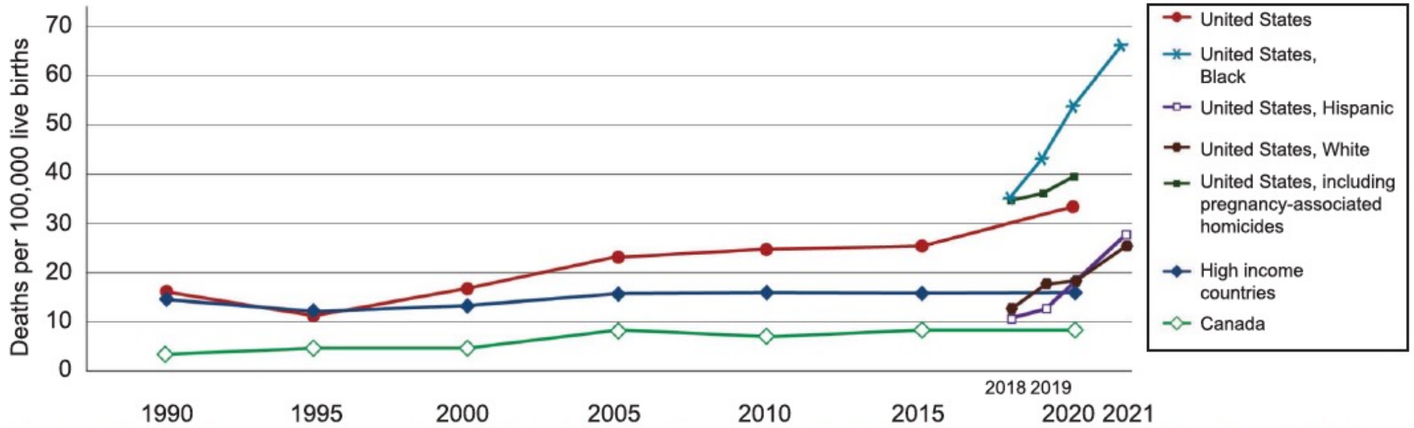


Fig. 1. Maternal mortality rates in the United States, Canada, and all high-income countries. Data from 2021 provisional.[9,36–38]

Davidson. Preventable Maternal Mortality. Obstet Gynecol 2024.

Contributing Factors: High rates of cesarean delivery, lack of prenatal care, & high rates of obesity, diabetes, and heart disease

Gunja et al. What is the status of women's health and health care in the U.S. compared to ten other countries? The Commonwealth Fund. Survey Brief. December 2018

Galtier-Dereure et al. Am J Clin Nutr. 2000;71:1242S-1248S; Denison et al. Br J Obstet Gynaecol. 2014;121:72-82; McDowell et al; J Midwifery Womens Health. 2019;64(1):46-54; Kominiarek et al. Am J Obstet Gynecol. 2017;217(6):642-651; Farpour-Lambert NJ et al. Front Endocrinol. 2018;9:546

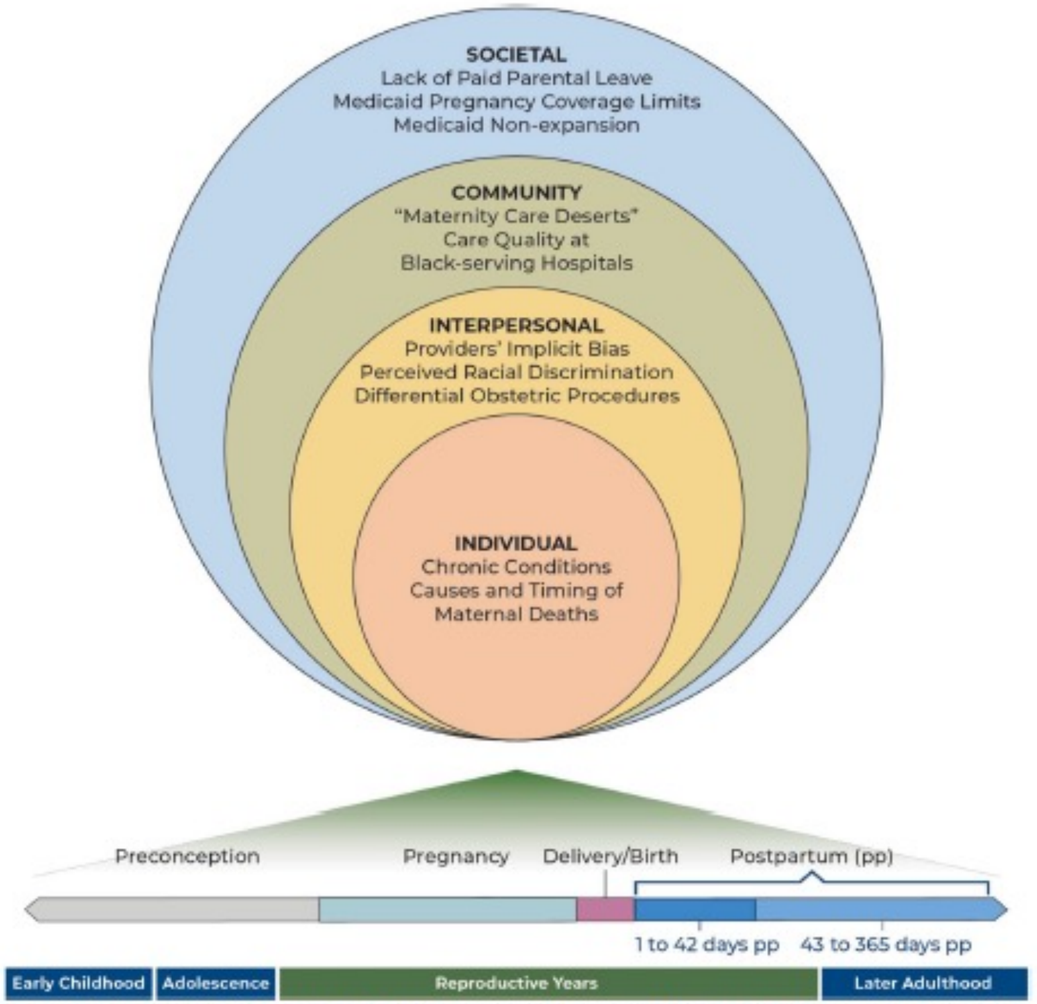
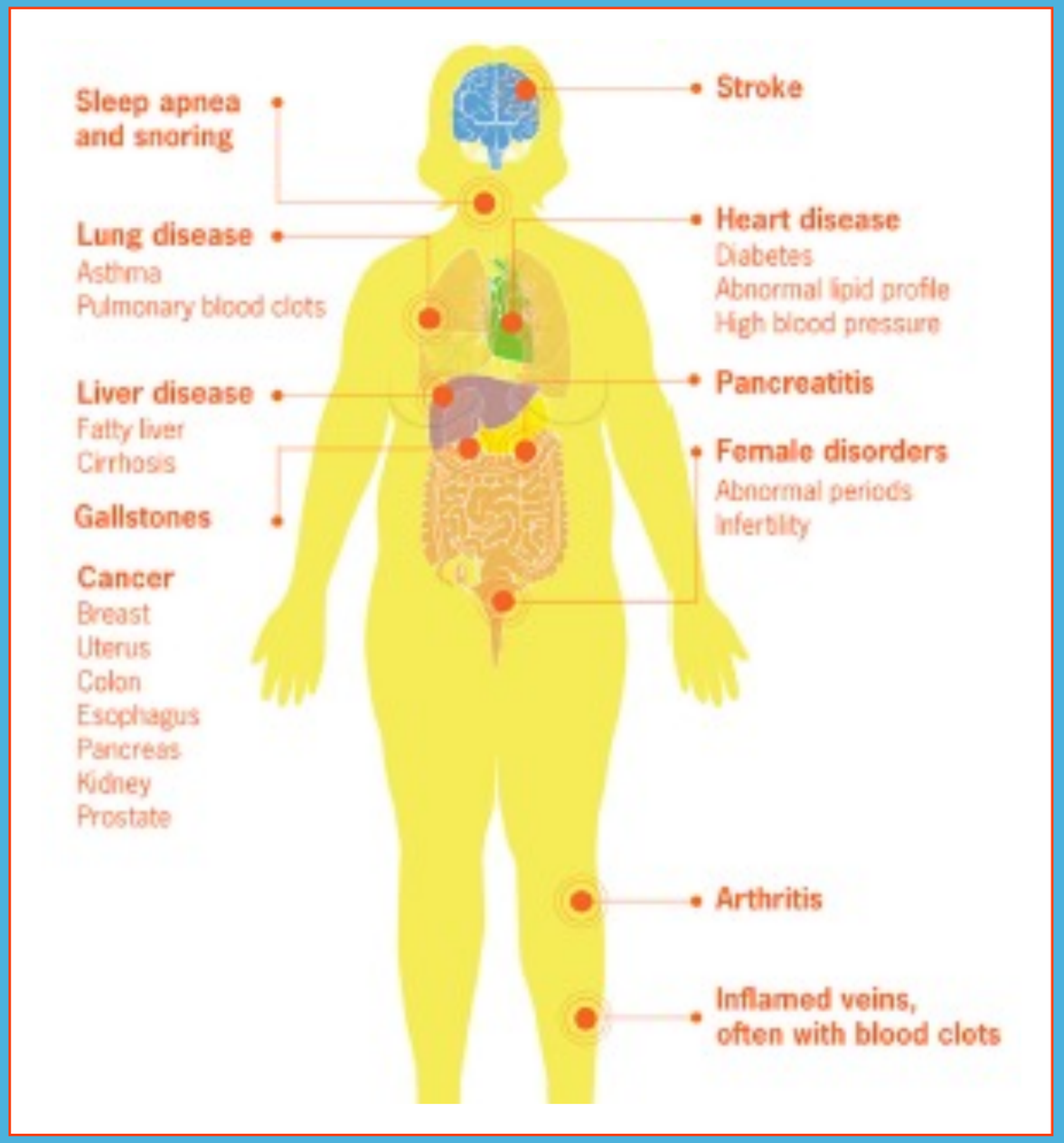
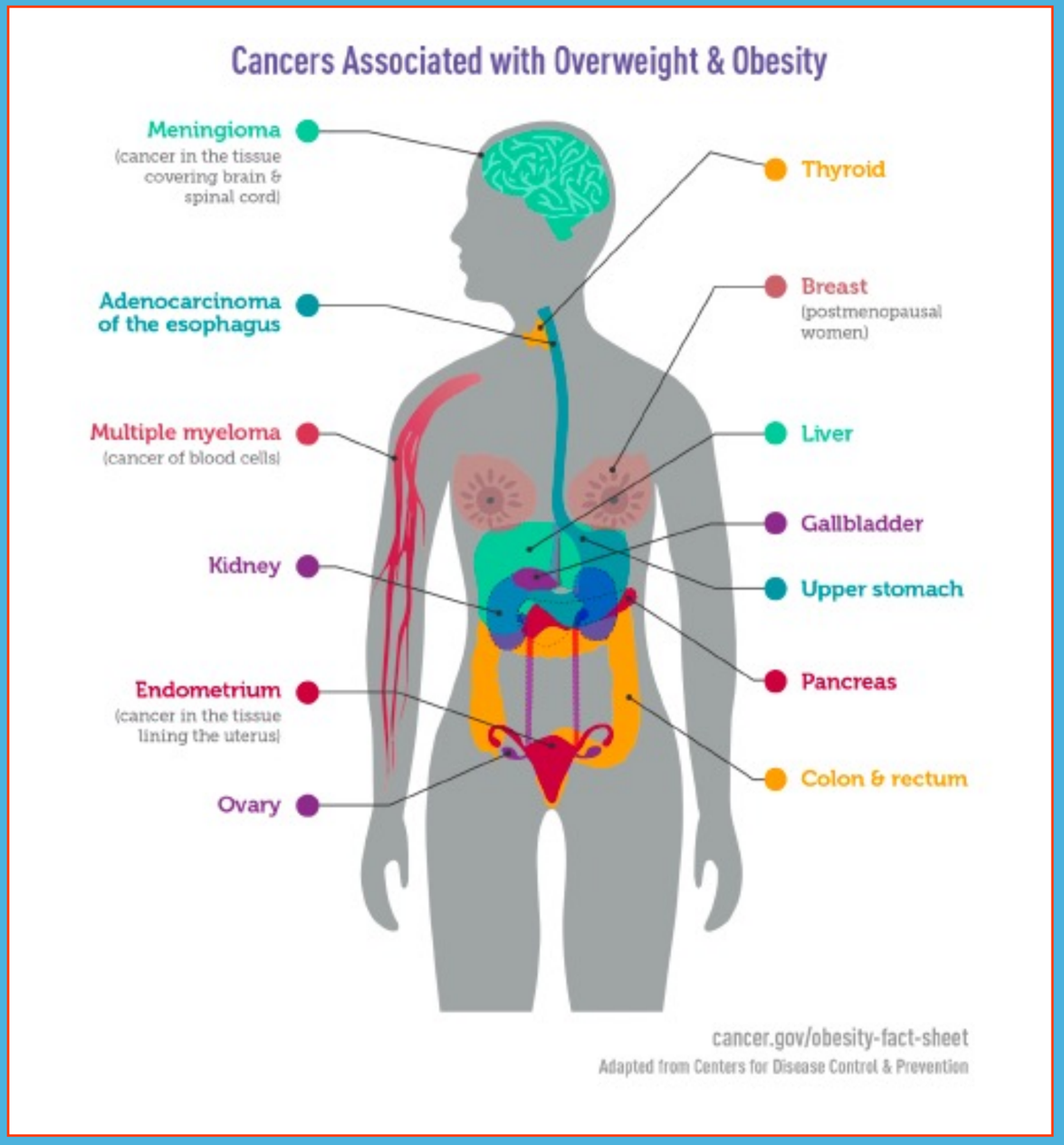


Fig. 3. Example of one multilevel life course conceptual framework from ecologic systems theory. Adapted with permission from Noursi S, Saluja B, Richey L. Using the ecological systems theory to understand Black/White disparities in maternal morbidity and mortality in the United States. J Racial Ethn Health Disparities 2021;8:661–9. doi: 10.1007/s40615-020-00825-4[1,2]

Davidson. Preventable Maternal Mortality. Obstet Gynecol 2024.





Maxwell et al. Int J Gynecol Obstet. 2023; 160(Suppl.1):35-49

Thank you

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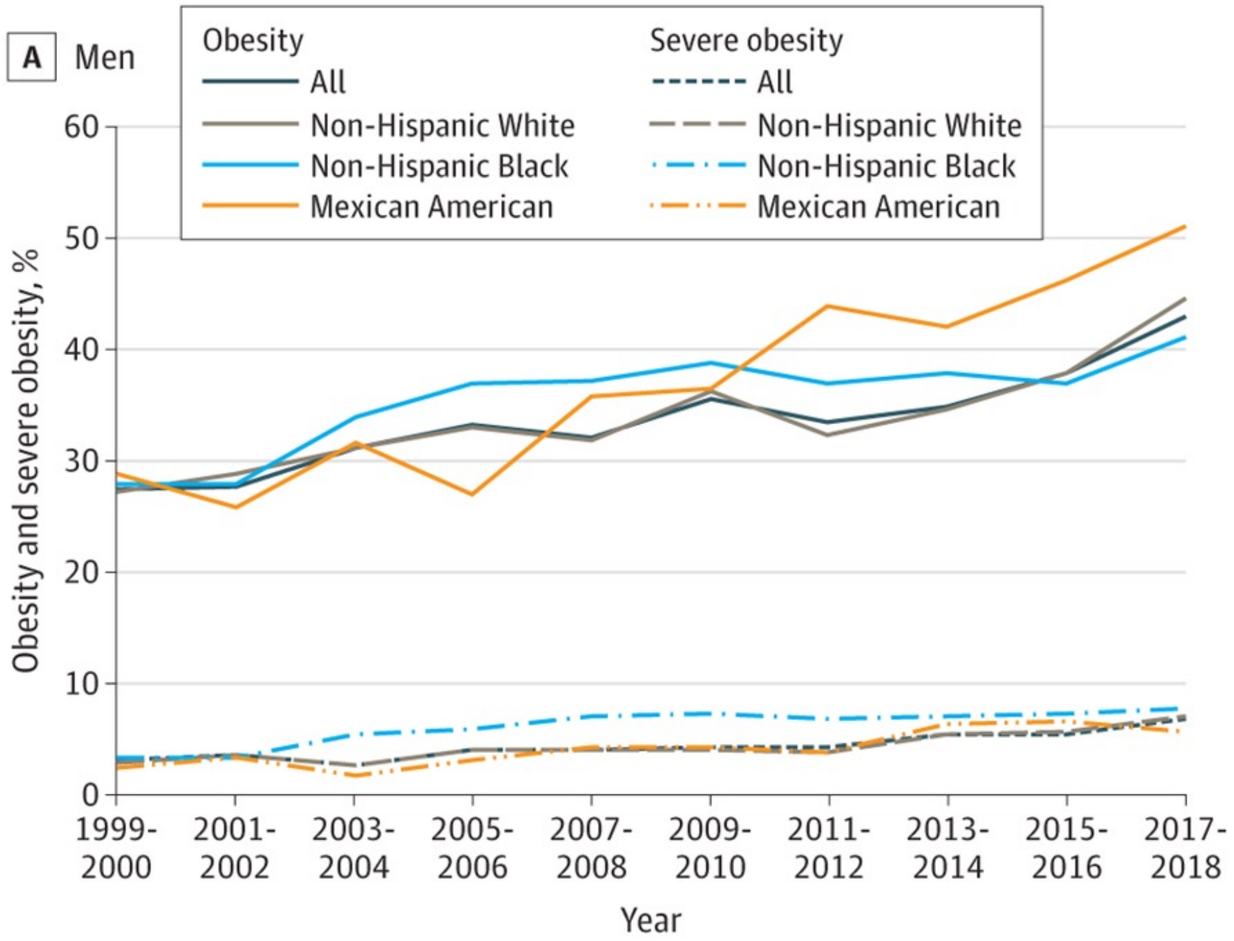
Geisinger

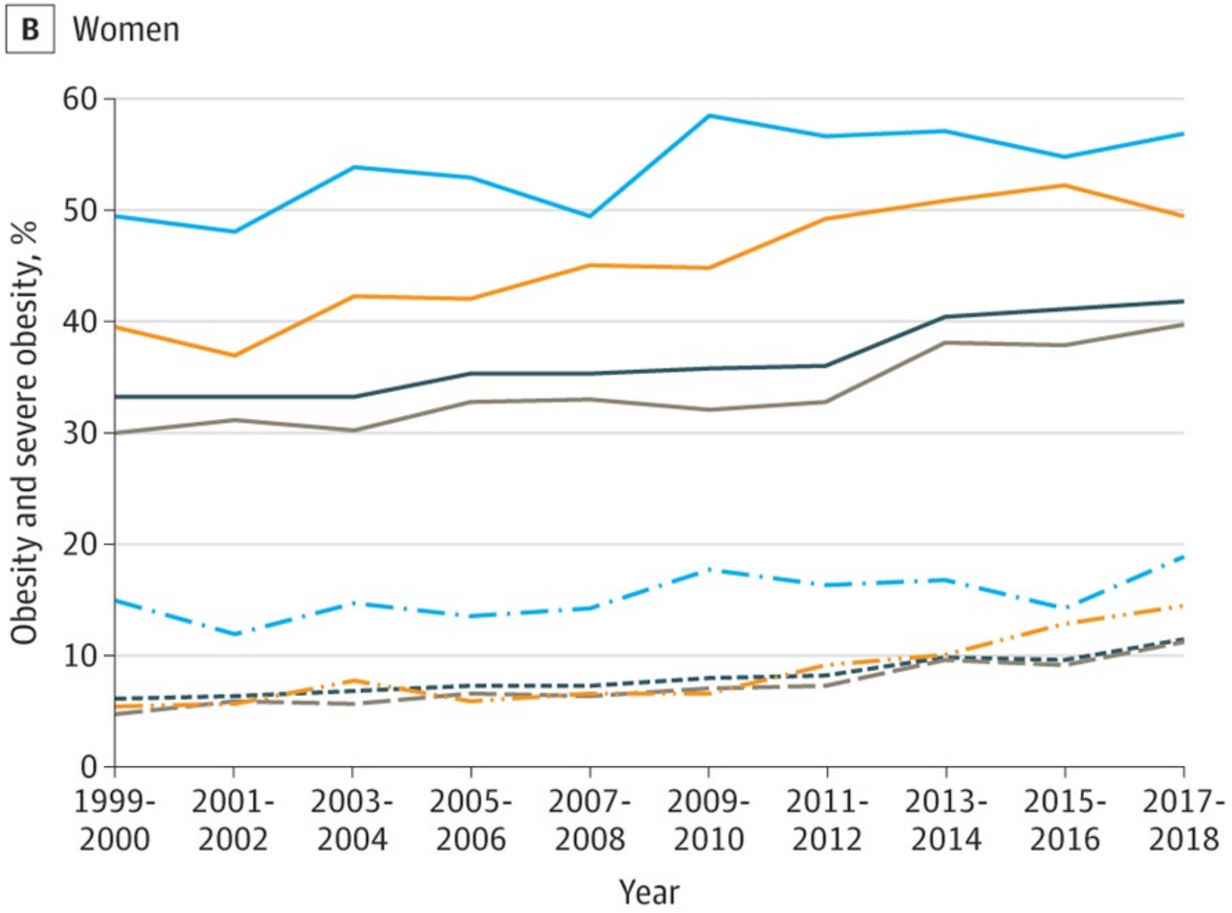
The Complexity of Obesity and Cardiometabolic Disease

Tiffany M. Powell-Wiley MD, MPH, FAHA, FABMR
Stadtman Investigator
Chief, Social Determinants of Obesity and Cardiovascular Risk Laboratory
Cardiovascular Branch, Division of Intramural Research, NHLBI
Adjunct Investigator, Intramural Research Program, NIMHD

NIH National Heart, Lung, and Blood Institute

Trends in Obesity Prevalence Among U.S. Adults: NHANES 1999-2018



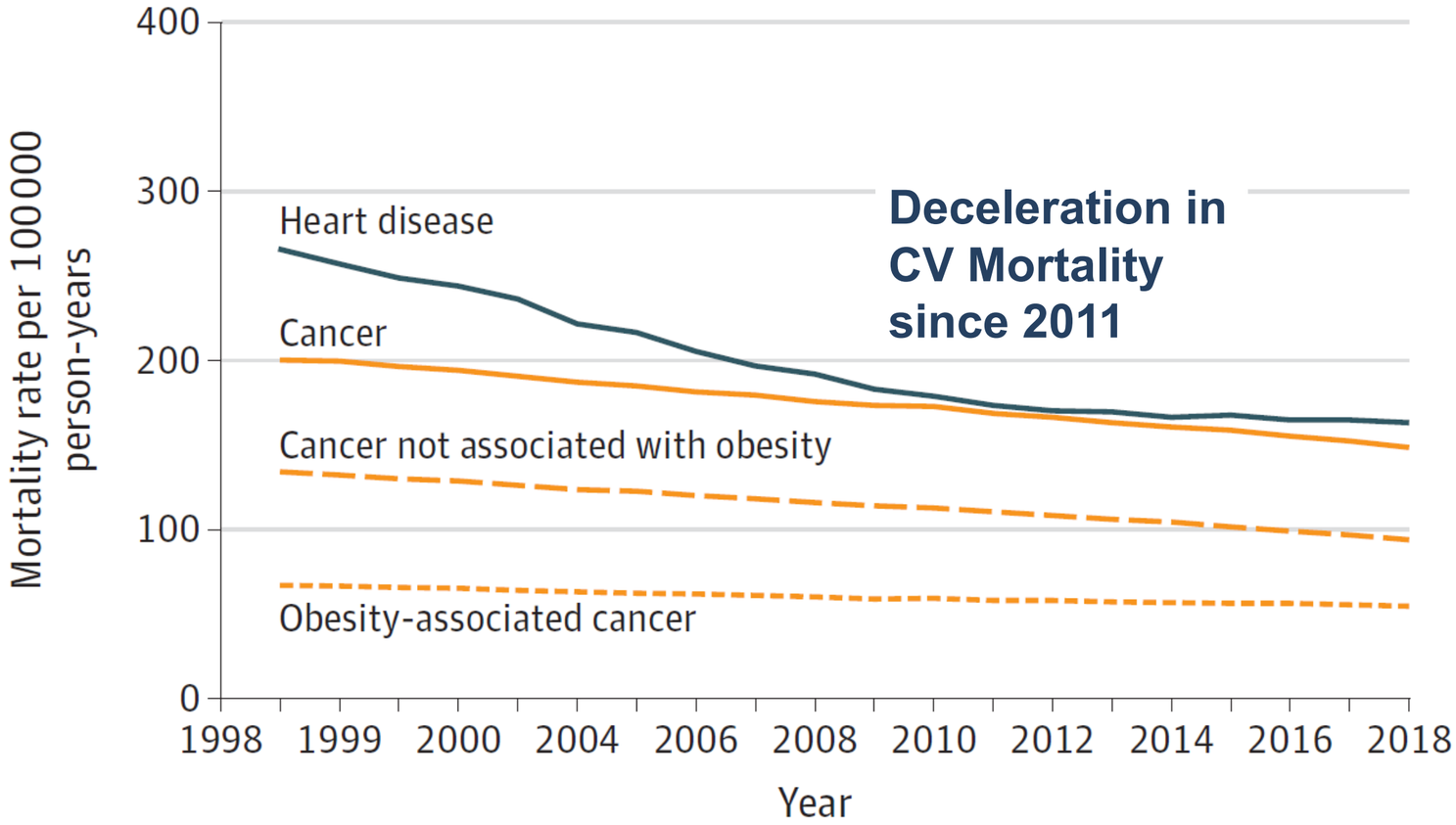


- Obesity and severe obesity increases over time for women of all racial and ethnic groups

Ogden C et al. JAMA 2020

Obesity Epidemic Contributes to Slower Decline in Cardiovascular and Cancer Mortality in U.S.

Age-Adjusted Mortality Rates in U.S., 1998-2018

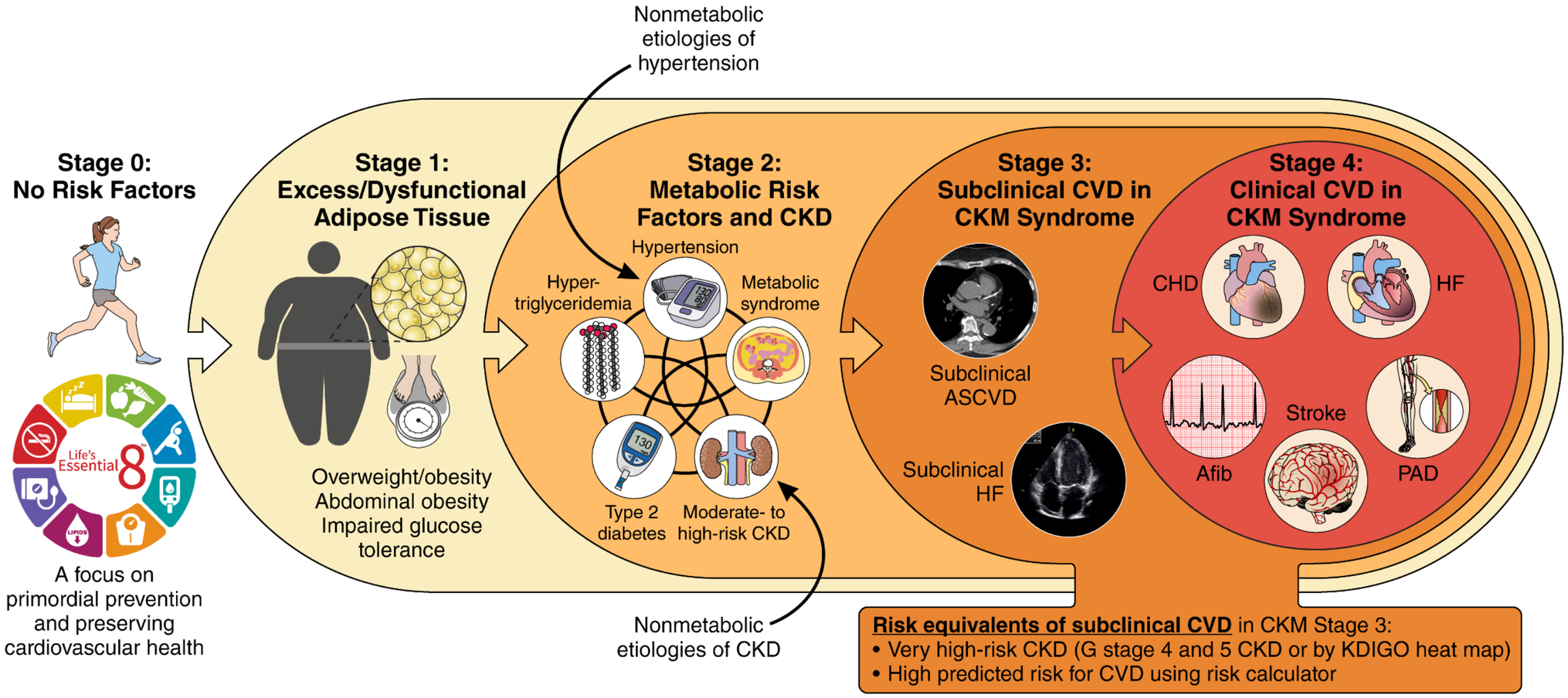


Sidney S, et al., JAMA Cardiology 2016

Deceleration in Obesity-Related Cancer Mortality in 2011

Avery C et al. JAMA Network Open 2021; Sidney S, et al. JAMA Cardiology 2016

Stages of Cardiovascular-Kidney-Metabolic Syndrome



Ndumele CE et al. Circulation 2023

Received: 8 November 2023 | Revised: 6 January 2024 | Accepted: 18 January 2024
DOI: 10.1111/dom.15478

SPECIAL ISSUE ARTICLE

WILEY

Hypothalamic control of body fat mass by food intake: The key to understanding why obesity should be treated as a disease

Jonathan Q. Purnell MD [1] | Carel W. le Roux MBChB [2]

Appetite and food intake are controlled by the brain not by will power

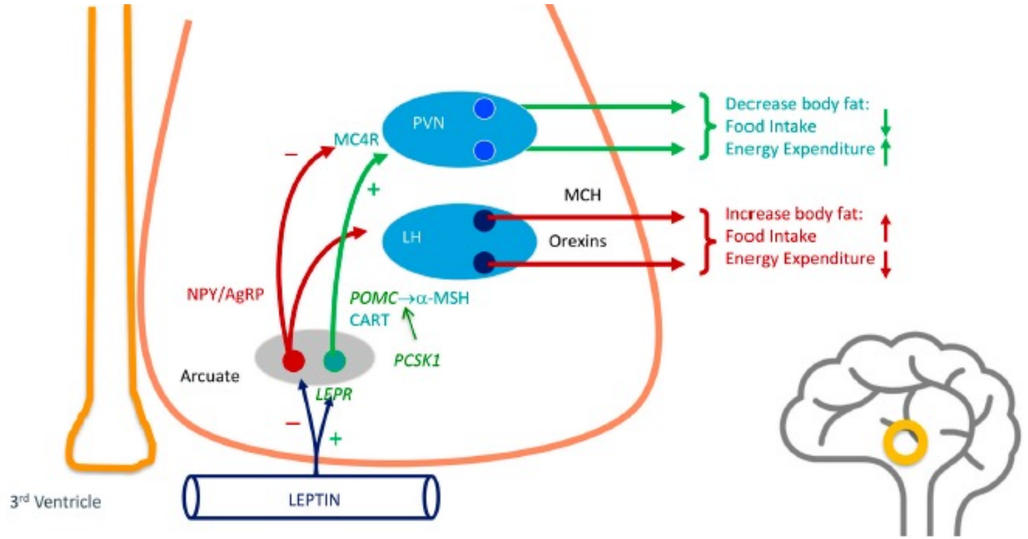
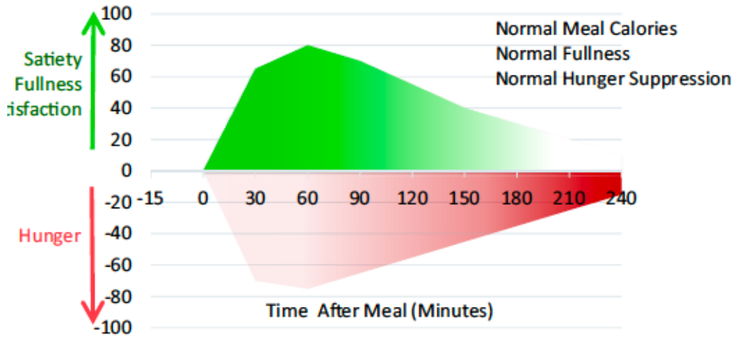
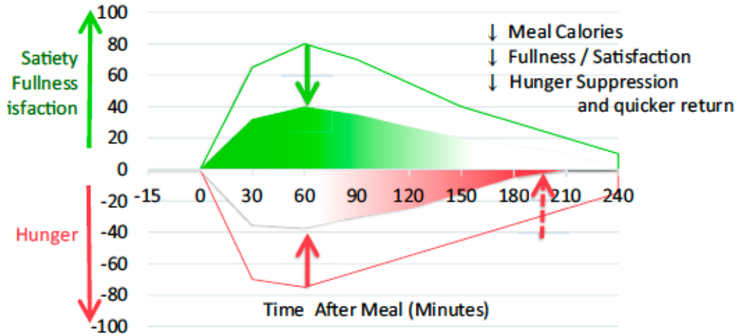


FIGURE 2 Enlarged representation of hypothalamic centres (yellow circle in brain region lower right corner) responsible for control of appetite and energy expenditure. See text for description. AgRP, agouti-related peptide; CART, cocaine- and amphetamine-regulated transcript; LH, lateral hypothalamus; MC4R, melanocortin-4 receptor; MCH, melanocyte-concentrating hormone; MSH, melanocyte stimulating hormone; NPY, neuropeptide-Y; POMC, pro-opiomelanocortin; PVN, paraventricular nucleus.[37]

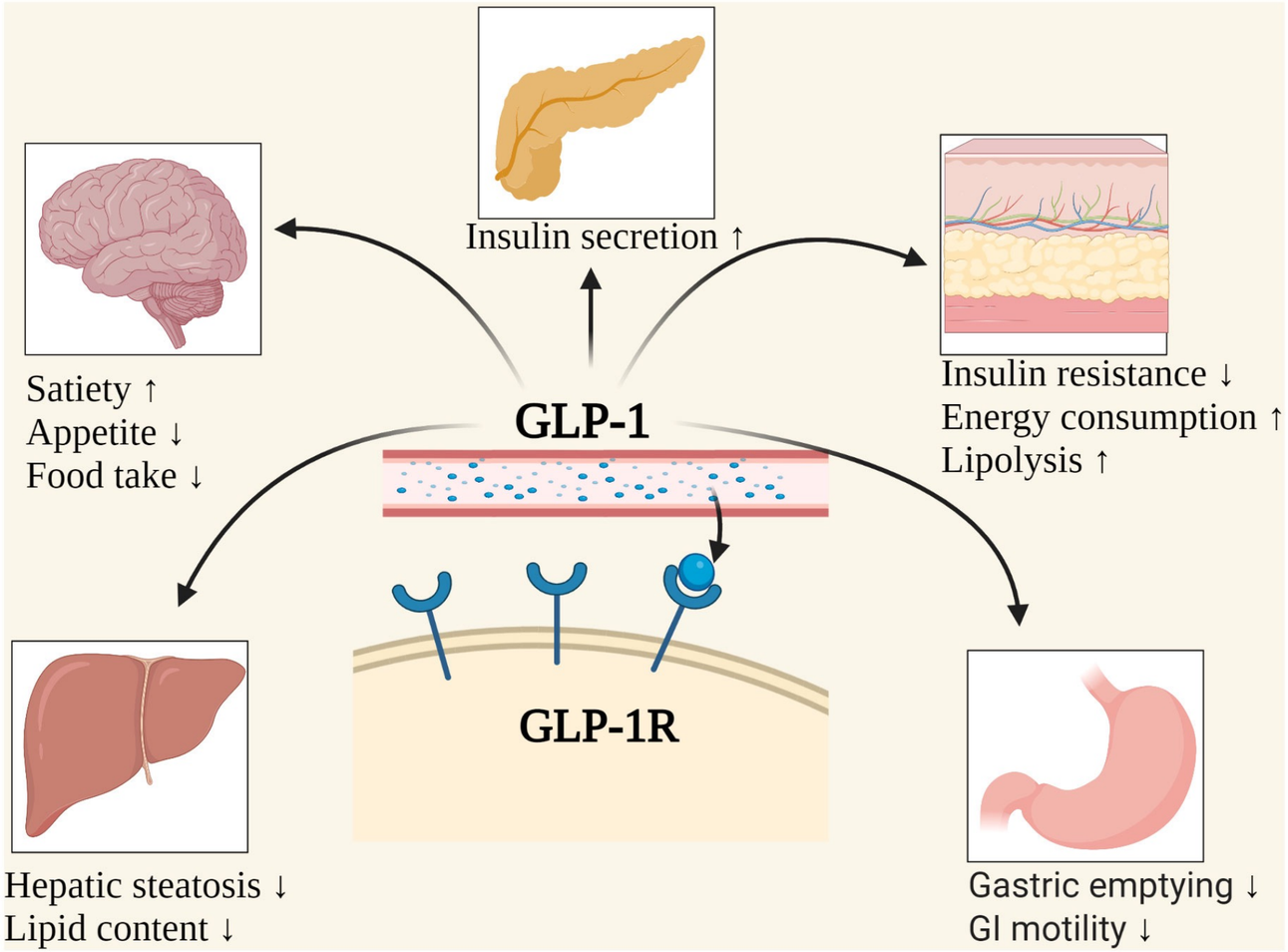
Our body works for a fat mass set point





Glucagon-like Peptide-1 Receptor Agonists

- GLP-1 RAs are currently one of the most promising obesity pharmacotherapies
  - Semaglutide, liraglutide and tirzepatide have been FDA-approved for weight loss
- Mechanism of Action
  - Appetite suppression
  - Delays gastric emptying
  - Increases satiety
  - Other biological effects



Wang JY et al. Front Endocrinol 2023

SELECT Trial Highlights Options for Obesity Pharmacotherapy for CVD Risk Reduction

SCALE Trial
Liraglutide Effective for Weight Management

LEADER Trial
13% CV Event Reduction in Patients with Diabetes

2015 - 2016

2019-2021

STEP Trials
Semaglutide Effective for Weight Loss

SUSTAIN Trials
Semaglutide Lowers CV Events in Patients with Diabetes

SELECT Trial
20% CV Event Reduction with Semaglutide in Patients with Overweight or Obesity and No Diabetes
Lower All-Cause Mortality

2023

Ongoing GLP1-RA Trials

Lincoff AM et al. NEJM 2023; Wilding JPH et al. NEJM 2021; Sori C et al. Lancet Diab and Endo 2017; Marson SP et al. NEJM 2016; Pi-Sunyer X et al. NEJM 2015; Jastreboff AM et al. NEJM 2023

How Can We Focus on Health Equity And Accessibility in Obesity Treatment?

Circulation

AHA SCIENTIFIC STATEMENT

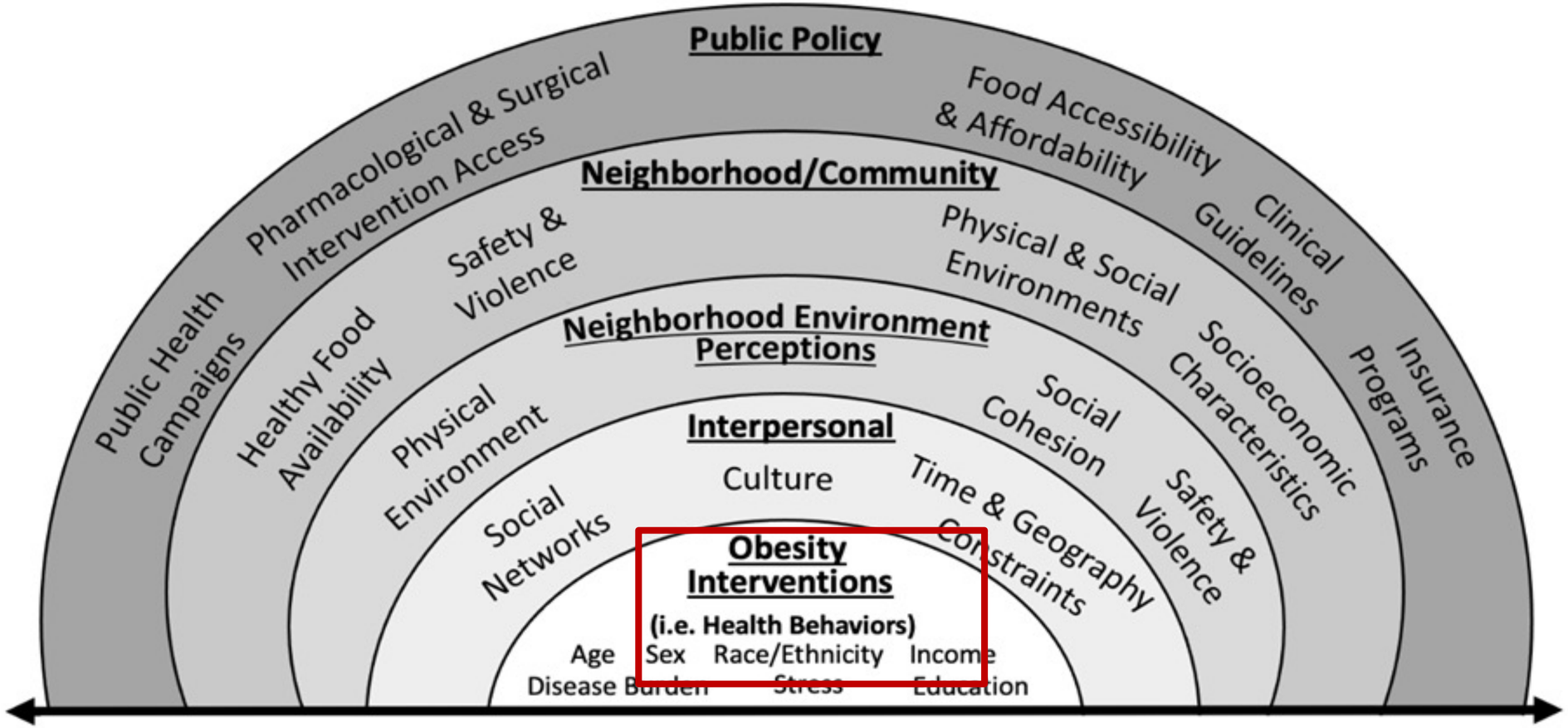
Obesity and Cardiovascular Disease

A Scientific Statement From the American Heart Association

"Obesity is a multifactorial disease with a complex pathogenesis related to biological, **psychosocial, socioeconomic and environmental** factors and heterogeneity in the pathways and mechanisms by which it leads to adverse health outcomes."

Powell-Wiley TM et al. Circulation 2021

Community-Engaged, Multi-Level Interventions to Address Obesity and CVD Disparities

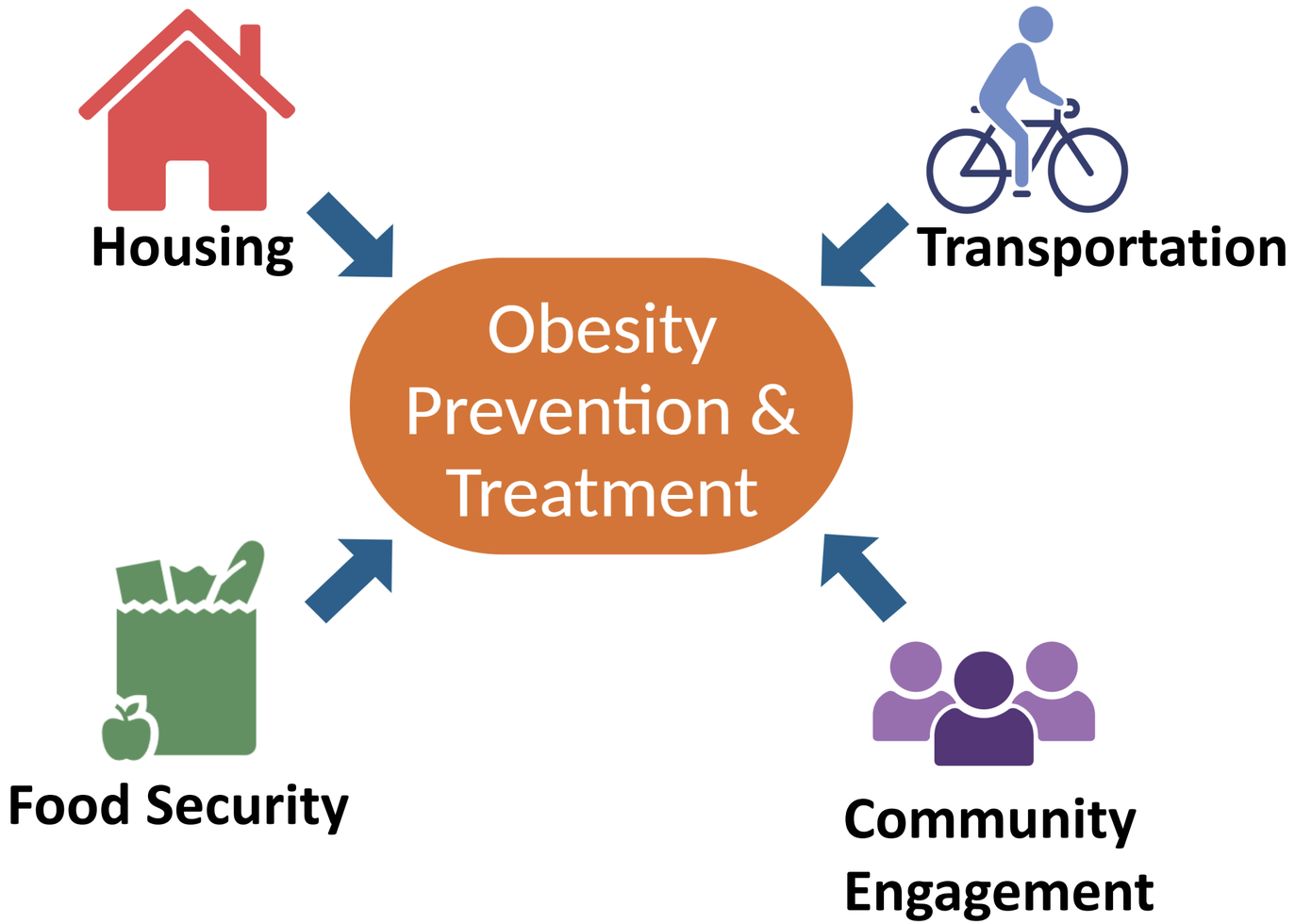


Community Engagement for Intervention Design and Implementation

Baez A, Ortiz-Whittingham L et al. Progress in Cardiovascular Diseases 2023

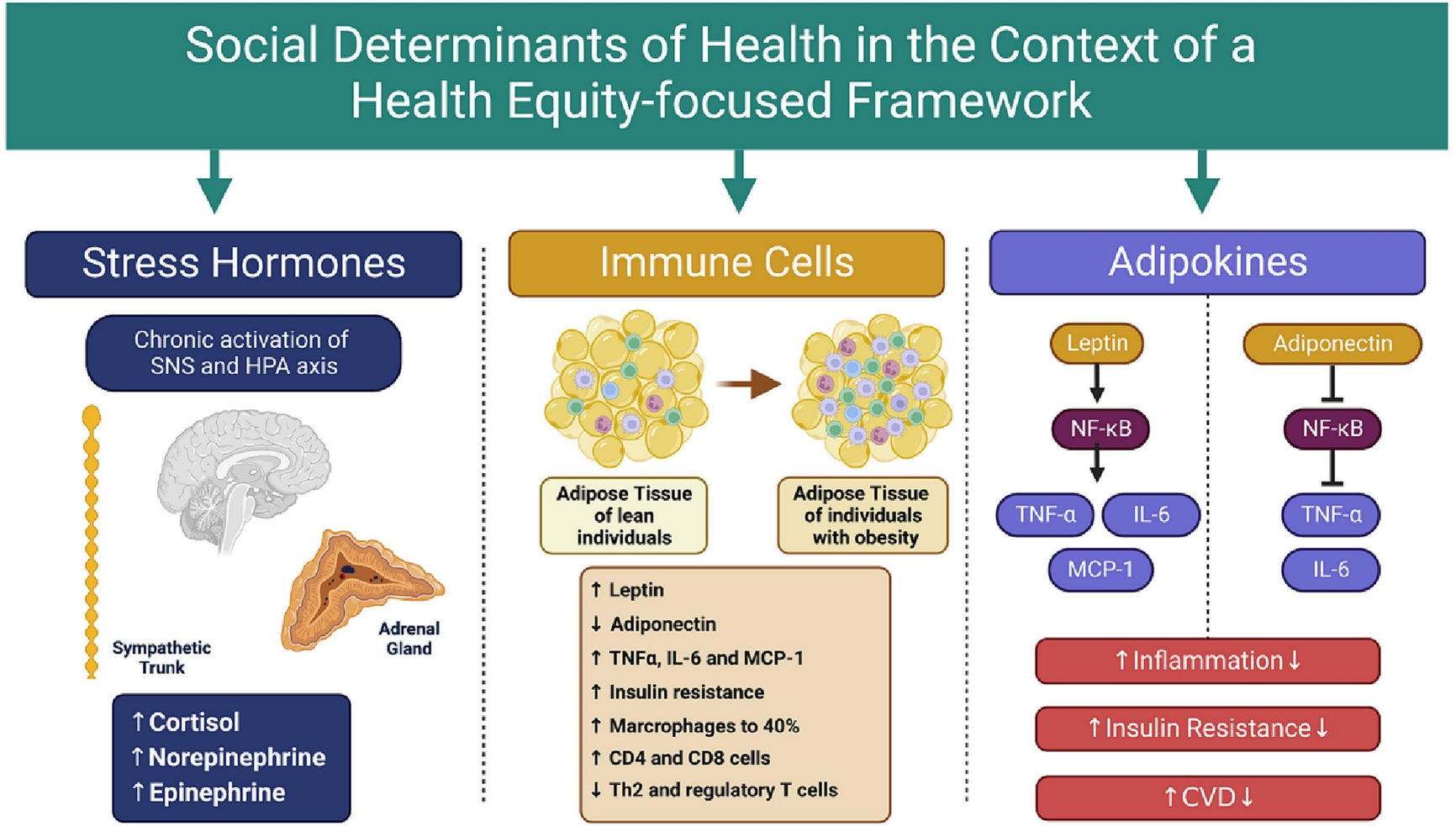
Public Health Interventions Targeting Community Engagement and Social Determinants of Health

- Housing voucher programs
- Built environment changes with increased public transportation
- Produce prescriptions - ‘Food as Medicine’
- Community-engaged interventions



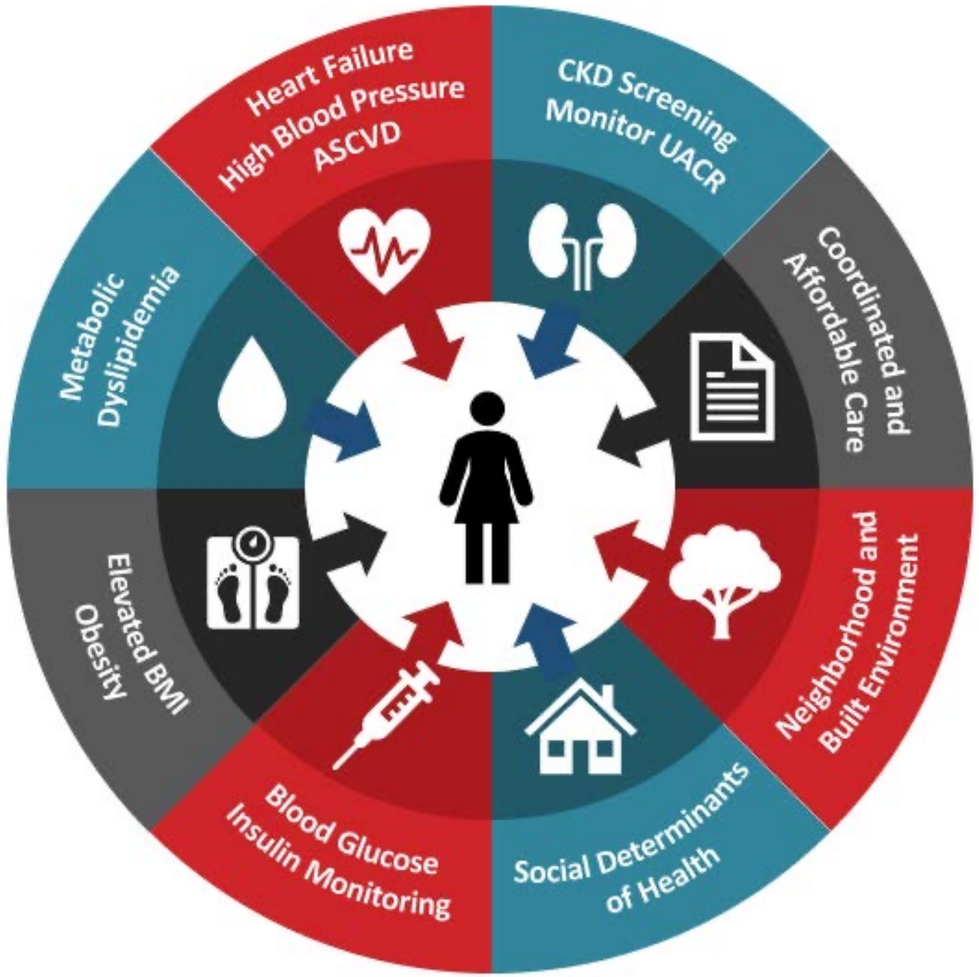
Ludwig J et al. NEJM 2011;Stappers NEH et al. Health and Place 2018; Hager K et al. Circ CV Qual and Outcomes 2023; Economos CD et al. Preventive Medicine 2013; Thomas VE et al. Current Athero Reports 2023

Social Determinants of Health Affect Biologic Pathways Connecting Obesity and CVD



Baez A, Ortiz-Whittingham L et al. Progress in Cardiovascular Diseases 2023

Patient-Centered Obesity Treatment for Cardiovascular-Kidney Metabolic Health



- Address weight stigma and bias
- Access to tools across the obesity treatment continuum, including lifestyle interventions, GLP1-RA, and bariatric surgery
- Interdisciplinary teams for care coordination and addressing social needs that limit access

Ndumele CN et al. Circulation 2023; Puhl RM et al. AJPH 2010; Powell-Wiley TM et al. JACC 2022; Hanchate AD et al. 2021

National Heart, Lung, and Blood Institute

Email: tiffany.powell@nih.gov
Phone: 301-594-3735
@PowellWileyLab

EXPLORING OBESITY'S IMPACT ON WOMEN AND POLICY'S ROLE IN IMPROVING OUTCOMES

Society for
Women's Health Research

Women & Obesity Policy

Dr. Tracy Zvenyach, PhD, MS, RN

Director, Policy Strategy & Alliances

May 2, 2024

Obesity Action Coalition

My Organization and Our Values

The Obesity Action Coalition is a 501(c)(3) non-profit organization dedicated to educating and advocating for individuals affected by the disease of obesity. We currently have more than 80,000 members nationwide.

MISSION STATEMENT:

To elevate and empower those affected by obesity through education, advocacy and support.

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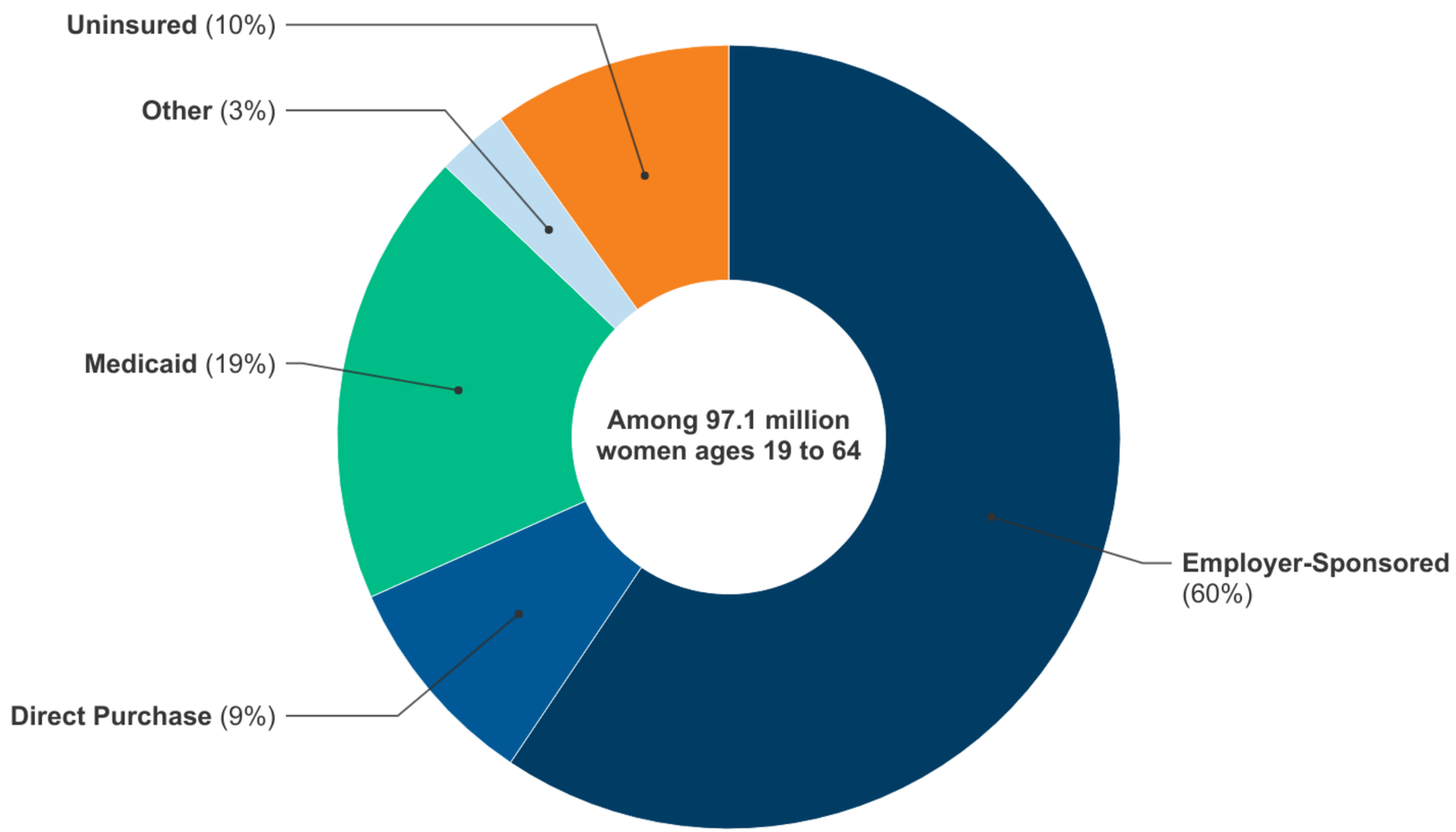
Obesity Action Coalition

Figure 1

Women's Health Insurance Coverage, 2022



NOTE: "Other" includes those covered under the military or Veteran's Administration, as well as non-elderly Medicare enrollees
SOURCE: KFF estimates based on 2022 American Community Survey, 1-Year estimates

KFF

Women in Medicare, 2022

32.4 million, 65 years or older

55.2% of Medicare enrollees

Source: KFF Distribution of Medicare Beneficiaries by Sex, 2022

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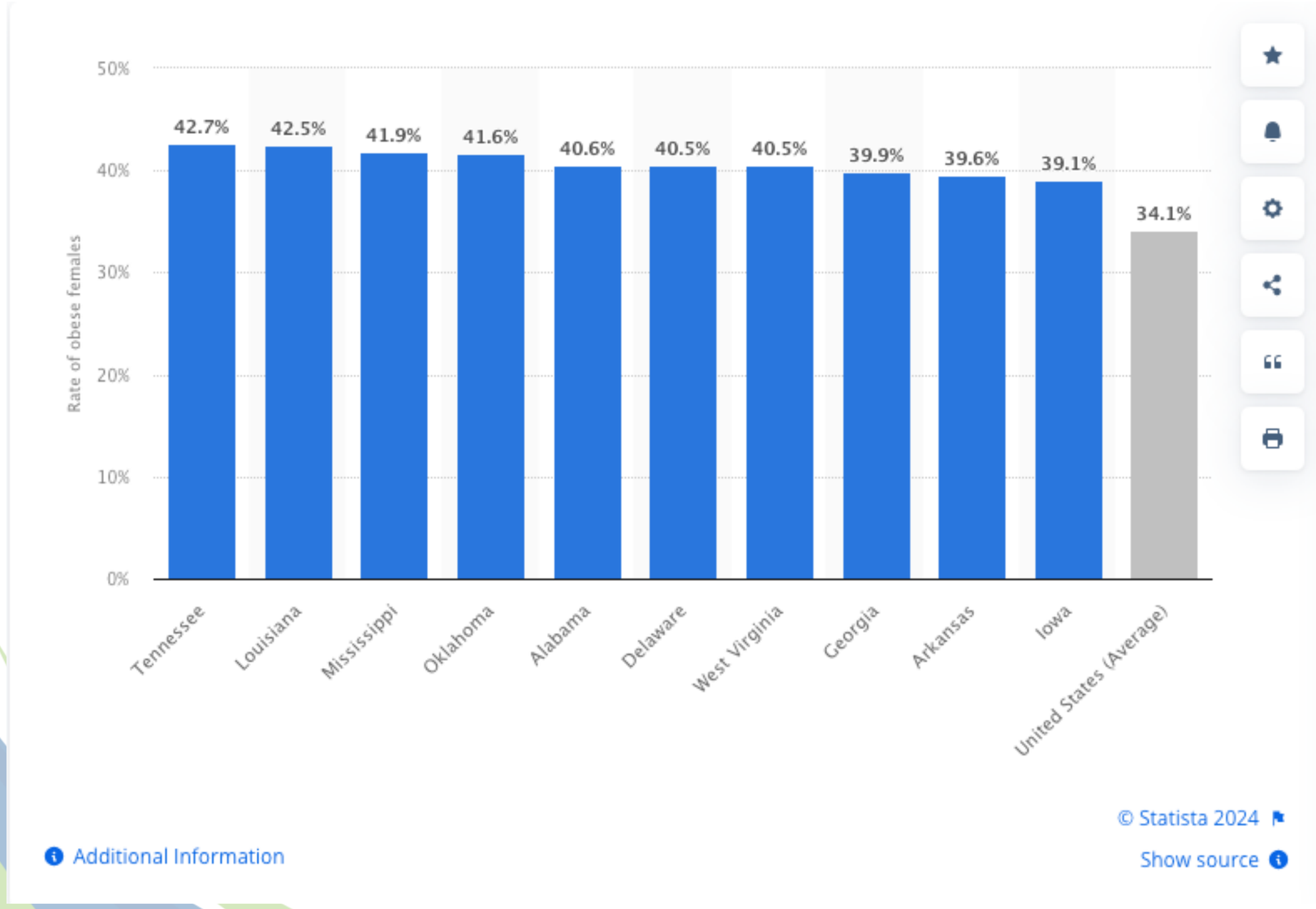
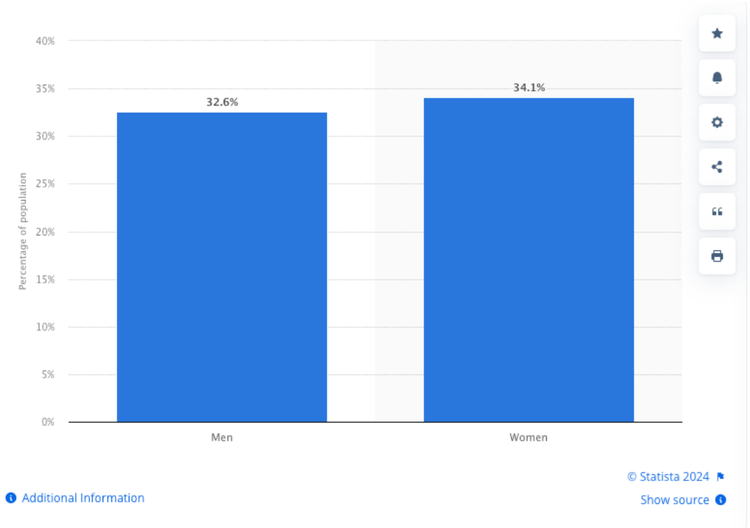
Highest rates of obesity among women (in U.S. 2022)



U.S. Rate of obesity: Men | Women



Obesity Action Coalition

Table 5. Prevalence of adults aged 20 and over with obesity, by demographic characteristics: United States, 2017–March 2020

Characteristic	Both sexes		Men		Women	
	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)	Sample size	Prevalence percentage (95% confidence interval)
Total (age adjusted)	8,295	41.9 (39.4–44.3)	4,051	41.8 (37.7–45.9)	4,244	41.8 (39.3–44.4)
Total (crude)	8,295	41.9 (39.4–44.3)	4,051	41.6 (37.4–45.8)	4,244	42.1 (39.6–44.8)
Age group (years):						
20–39	2,489	39.8 (35.3–44.3)	1,177	39.9 (33.1–47.0)	1,312	39.6 (34.9–44.3)
40–59	2,765	44.3 (41.3–47.4)	1,320	[1]45.9 (41.0–50.9)	1,445	42.8 (38.7–47.1)
60 and over	3,041	41.5 (38.4–44.7)	1,554	38.4 (32.9–44.1)	1,487	44.2 (40.5–47.9)
Race and Hispanic origin:						
Non-Hispanic white	2,866	[2,3]41.4 (37.9–44.9)	1,432	[3]43.1 (37.4–48.9)	1,434	[2–4]39.6 (36.2–43.0)
Non-Hispanic black	2,213	[3,4]49.9 (47.2–52.6)	1,058	[3]40.4 (36.3–44.6)	1,155	[3–5]57.9 (54.0–61.7)
Non-Hispanic Asian	1,014	[4]16.1 (13.6–18.9)	466	[4]17.6 (13.7–22.2)	548	[4]14.5 (11.4–18.1)
Hispanic	1,806	45.6 (42.9–48.2)	880	45.2 (41.7–48.8)	926	45.7 (42.4–49.1)
Family income relative to federal poverty level (FPL):						
130% or less FPL	2,019	43.9 (41.7–46.1)	892	38.6 (33.6–43.8)	1,127	[5,6]47.9 (44.0–51.7)
More than 130% through 350% FPL	2,815	[6]46.5 (43.6–49.4)	1,400	43.9 (40.5–47.3)	1,415	[6]48.8 (44.5–53.0)
More than 350% FPL	2,312	39.0 (34.2–43.9)	1,189	42.4 (34.9–50.2)	1,123	35.1 (31.1–39.3)
Education:						
Less than high school diploma	1,538	[7,8]40.1 (36.5–43.8)	803	[7]35.3 (30.4–40.6)	735	[5,8]45.3 (41.0–49.7)
High school diploma or some college	4,709	[8]46.4 (44.0–48.9)	2,259	[8]45.9 (41.9–50.0)	2,450	[8]46.8 (43.9–49.8)
College degree or above	2,037	34.2 (30.1–38.5)	984	36.3 (29.0–44.1)	1,053	32.2 (28.5–36.1)

[1]Significantly different from those aged 60 and over.
[2]Significantly different from non-Hispanic black adults.
[3]Significantly different from non-Hispanic Asian adults.
[4]Significantly different from Hispanic adults.
[5]Significantly different from men.
[6]Significantly different from those with family income more than 350% FPL.
[7]Significantly different from those with a high school diploma or some college.
[8]Significantly different from those with a college degree or above.

NOTES: Obesity is defined as a body mass index of greater than or equal to 30 kg/m^2. Except where reported as crude estimates, estimates were age adjusted by the direct method to the projected U.S. Census 2000 population using the age groups 20–39, 40–59, and 60 and over. Statistical comparisons were not performed on crude estimates. Pregnant women were excluded from the analysis.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey, 2017–March 2020 prepandemic data files.

Policy gaps for women and obesity coverage

Evidence-based obesity care:

- Nutrition counseling and Intensive behavioral therapy
- FDA-approved obesity medications
- Metabolic & bariatric surgery
- FDA-approved endoscopic bariatric therapies

Policy and coverage gaps:

- Medicare
- Medicaid
- Employer Insurance
- ACA Exchange Marketplace
- DOD
- VA

Limited and variable coverage across payer types

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Medicare policy and obesity coverage

Medicare Part B

- Limited access to **providers** equipped to administer intensive behavioral therapy.
- Limited access to **settings of care** to receive intensive behavioral therapy

Medicare Part D

- Statue **prohibits coverage** of drugs used for “weight loss” (2003)
- Needs to be updated for advances in science and for access to life-saving treatment

Policy implication – Medicare coverage can have a ripple effect on coverage in both private health plans and public health programs

OAC
Obesity Action Coalition

Medicare policy solution: Treat and Reduce Obesity Act (TROA)

Cosponsors:

House – 97 (D=70, R=27)

Senate – 22 (D=11, R=11)

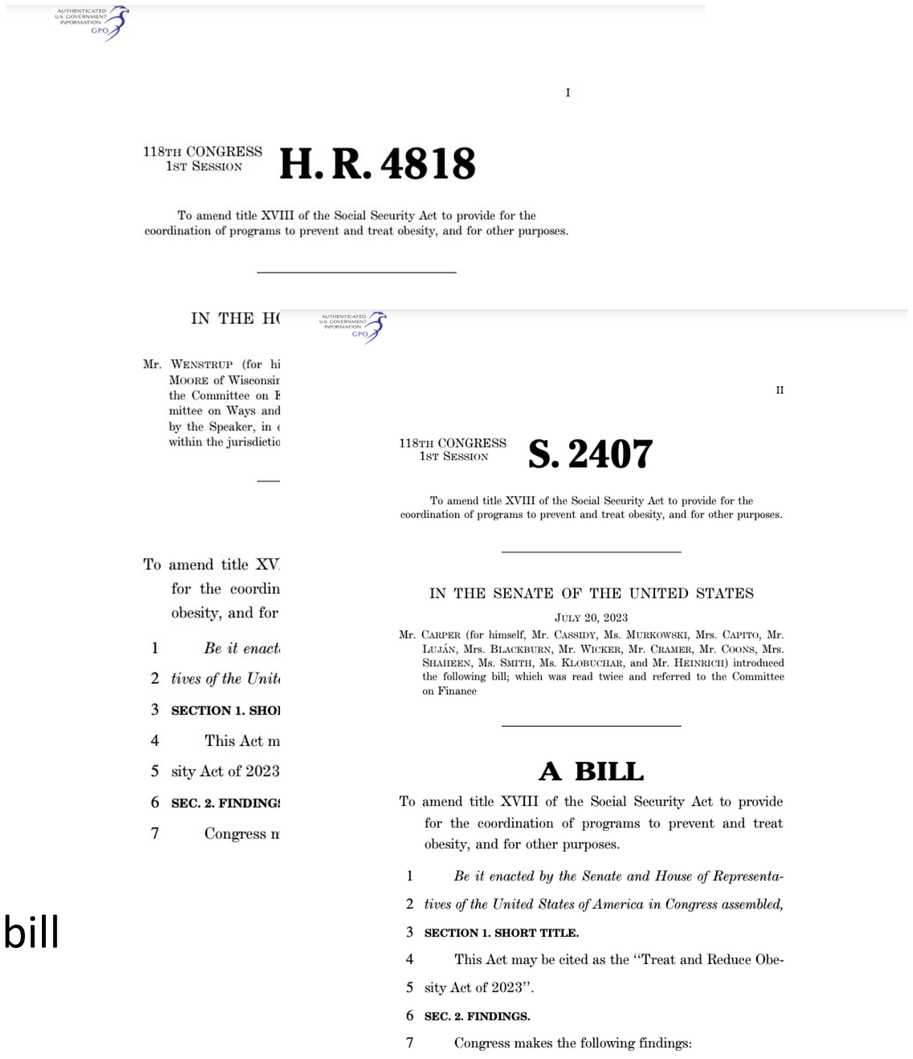
Committees:

House – Ways & Means,

Energy & Commerce

Senate – Finance

CBO – actively scoring the bill



I

118TH CONGRESS
1ST SESSION

H. R. 4818

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

IN THE H(

Mr. WENSTRUP (for hi
MOORE of Wisconsir
the Committee on F
mittee on Ways and
by the Speaker, in (
within the jurisdictio

To amend title XV
for the coordin
obesity, and for

1 *Be it enact*
2 *tives of the Unit*
3 **SECTION 1. SHO**
4 This Act m
5 sity Act of 2023
6 **SEC. 2. FINDING**
7 Congress m

II

118TH CONGRESS
1ST SESSION

S. 2407

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 20, 2023

Mr. CARPER (for himself, Mr. CASSIDY, Ms. MURKOWSKI, Mrs. CAPITO, Mr. LUJÁN, Mrs. BLACKBURN, Mr. WICKER, Mr. CRAMER, Mr. COONS, Mrs. SHAHEEN, Ms. SMITH, Ms. KLOBUCHAR, and Mr. HEINRICH) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide for the coordination of programs to prevent and treat obesity, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Treat and Reduce Obe-
5 sity Act of 2023".
6 **SEC. 2. FINDINGS.**
7 Congress makes the following findings:

Next Steps:

House W&M – Ask to include in next committee markup

Senate Finance – Ask to include in Chronic Care 2.0

Goal:

Get TROA included in end of year package

OAC
Obesity Action Coalition

Please help pass TROA in 2024

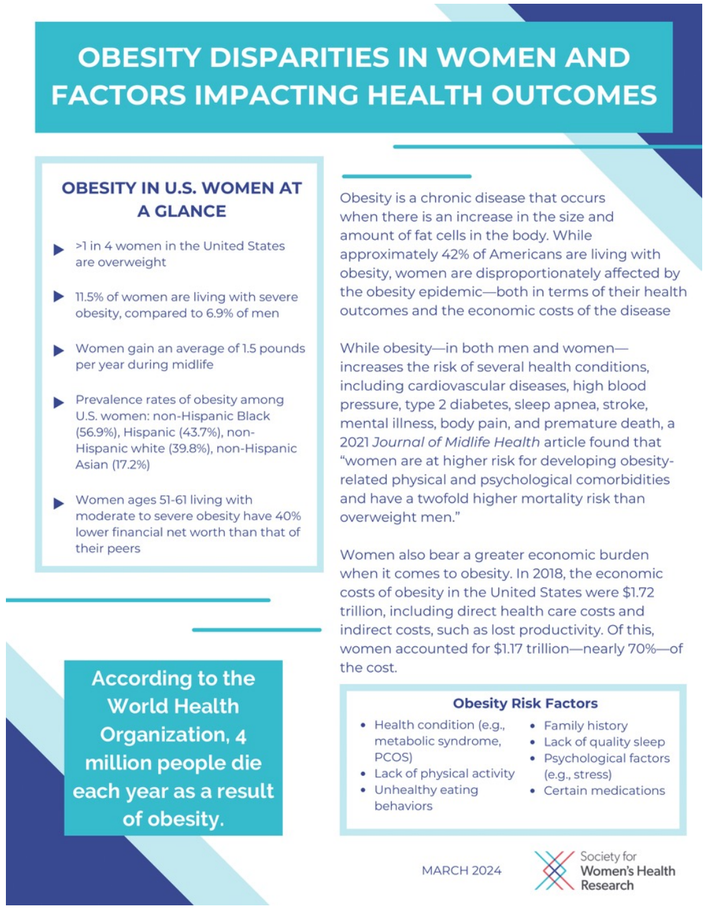
Thank you

tzvenyach@obesityaction.org

www.Obesityaction.org

Obesity Action Coalition

Stay Connected with SWHR



OBESITY DISPARITIES IN WOMEN AND FACTORS IMPACTING HEALTH OUTCOMES

OBESITY IN U.S. WOMEN AT A GLANCE

- >1 in 4 women in the United States are overweight
- 11.5% of women are living with severe obesity, compared to 6.9% of men
- Women gain an average of 1.5 pounds per year during midlife
- Prevalence rates of obesity among U.S. women: non-Hispanic Black (56.9%), Hispanic (43.7%), non-Hispanic white (39.8%), non-Hispanic Asian (17.2%)
- Women ages 51-61 living with moderate to severe obesity have 40% lower financial net worth than that of their peers

Obesity is a chronic disease that occurs when there is an increase in the size and amount of fat cells in the body. While approximately 42% of Americans are living with obesity, women are disproportionately affected by the obesity epidemic—both in terms of their health outcomes and the economic costs of the disease

While obesity—in both men and women—increases the risk of several health conditions, including cardiovascular diseases, high blood pressure, type 2 diabetes, sleep apnea, stroke, mental illness, body pain, and premature death, a 2021 *Journal of Midlife Health* article found that "women are at higher risk for developing obesity-related physical and psychological comorbidities and have a twofold higher mortality risk than overweight men."

Women also bear a greater economic burden when it comes to obesity. In 2018, the economic costs of obesity in the United States were $1.72 trillion, including direct health care costs and indirect costs, such as lost productivity. Of this, women accounted for $1.17 trillion—nearly 70%—of the cost.

According to the World Health Organization, 4 million people die each year as a result of obesity.

Obesity Risk Factors

- Health condition (e.g., metabolic syndrome, PCOS)
- Lack of physical activity
- Unhealthy eating behaviors
- Family history
- Lack of quality sleep
- Psychological factors (e.g., stress)
- Certain medications

MARCH 2024

Society for Women's Health Research

View our resources online at swhr.org!

www.swhr.org

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Society for Women's Health Research