Weekly Checkup

# Modernizing the Medicare Modernization Act?

DOUGLAS HOLTZ-EAKIN | AUGUST 26, 2022

**When the Medicare Modernization Act (MMA) was enacted nearly 20 years ago, it created the Part D program – an insurance program that covered the cost of seniors' outpatient prescription drugs.** At the time, there was good reason to modernize Medicare, as prescription drugs had become an essential part of modern medical science and effective therapies. It made sense for Medicare to cover these costs.

Congress also decided that Medicare would not cover the costs of every drug on the market. **In particular, lawmakers decided that Medicare would not reimburse for the purchase of anti-obesity medications (AOMs). These were deemed to be "lifestyle" drugs outside the boundaries of the accepted practice of medicine and were thus excluded from reimbursement.** If a senior wanted to lose weight, he was on his own.

**(Official Weekly Checkup Aside: This exclusion is hard to find in the MMA. Prohibition of AOMs is at: SSA § 1860D-2(e)(2) which references SSA§1927(d)(2), where there is a list of drugs subject to restriction.** "The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted: (A) Agents when used for anorexia, weight loss, or weight gain." You are welcome.)

That was 2003. Twenty years later the situation is a bit different. **First, obesity was recognized by the medical community – specifically, the American Medical Association – as a disease as of June 2013. Indeed, it is a quite prevalent chronic disease affecting 42 percent of adults in the United States.** Its consequences are far greater than the impact on one's physical appearance. Those who carry extra weight are at greater risk of heart disease, stroke, and type 2 diabetes, to name just a few common comorbidities. And it costs a lot of money, including federal taxpayer dollars. **One estimate is that total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, were equal to 30 percent of Medicare spending.**

Second, there are non-pharmaceutical treatments for obesity, and Medicare covers the costs of those treatments. **In particular, for those with a sufficiently high body mass index (a measure of body fat), Medicare will reimburse the cost of treatments such as intensive behavioral therapy and bariatric surgery.**

**Third, there are now promising AOMs on the market. According to *Barron's* "No one has ever seen the kind of weight loss achieved by these new drugs, known as incretins. In scientific studies, they have let people safely shed more than 20% of their weight**."

**If obesity is a disease and Medicare will cover the costs of treating that disease, why not further modernize the program by adding AOMs to the drugs covered by Part D?**

There are at least two important hurdles. While some of these drugs have been approved by the Food and Drug Administration, the broader medical community remains to be convinced of their efficacy. **AOMs may be widely used if studies can show they prevent diabetes, heart disease, and other costly ailments. Doctors are unlikely to prescribe a drug they don't believe in.**

The second hurdle is the price tag. As *Barron's* put it: **"If every hefty American got treated at these drugs' current prices, the annual market for incretins would be a trillion dollars." That kind of price tag from the Congressional Budget Office can stop legislation in its tracks.**

Still, adding AOMs to Medicare should not be dismissed out of hand. Medical science continues to advance, and the conduct of modern medicine evolves accordingly. **AOMs may prove much more promising than invasive surgery in the future. And new advances often carry a sticker shock that market forces ameliorate over time.**