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Meaningful Lives As We Age

The Interplay of Obstructive Sleep Apnea and Obesity in Older Adults

Applications from the *GSA KAER Toolkit on the Management of Obesity in Older Adults*
Momentum Discussions Podcast from the Gerontological Society of America
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Announcer:
Welcome to the Gerontological Society of America's Momentum Discussions, where we explore groundbreaking topics in the field of aging.

Elana Kieffer Blass:
Welcome to this GSA Momentum Discussions podcast episode, titled The Interplay of Obstructive Sleep Apnea and Obesity in Older Adults. We are grateful to Lilly and Haleon for their support of the GSA KAER Toolkit for the Management of Obesity in Older Adults and for this podcast episode.

My name is Elana Kieffer Blass, and I am the Director of Strategic Alliances at the Gerontological Society of America, otherwise known as GSA. I am pleased to serve as the host for today's Momentum Discussion.

Our conversation today focuses on the intersection of obesity and obstructive sleep apnea, otherwise referred to as OSA, and we will discuss this intersection in general and specifically as it relates to older adults. We will review these two diseases and their relationship, explore comprehensive treatment options for older adults with OSA and obesity, and discuss the challenges that remain.

I am delighted to be joined by two professionals who are leaders in this area. Dr. Brian Wojeck is an assistant professor of medicine in the endocrinology section at Yale University. He specializes in comprehensive weight management and focuses, both clinically and in research, on the intersection of obesity, diabetes, and sleep disorders. Dr. Tracy Zvenyach is the Vice President of Advocacy and Research at the Obesity Action Coalition (OAC). Dr. Zvenyach provides leadership in developing and implementing policy priorities and strategy for OAC and represents the organization in alliances and coalitions to advance obesity care. Dr. Wojeck and Dr. Zvenyach, welcome and thank you for joining me today.

Elana Kieffer Blass:
Dr. Wojeck, let's start with you. What is obstructive sleep apnea or OSA? How does it relate to obesity, and why is it a topic that GSA is focusing on?

Brian Wojeck:
Obstructive sleep apnea occurs when the upper airway closes, causing someone to stop breathing at night. That airway obstruction can lead to low oxygen levels, cause people to wake up, and, if severe enough, have downstream effects over time. It is related to obesity because weight can increase airway collapsibility and may also affect loop gain, which is how the body responds to carbon dioxide. GSA is focusing on this issue because obesity is prevalent and increasingly common among older adults.

These two comorbid conditions commonly occur together. Older adults living with obesity have a unique risk profile that should be considered when evaluating and treating obstructive sleep apnea.

Elana Kieffer Blass:
Can you talk a little bit more about how obstructive sleep apnea is one type of sleep apnea, or a sleep disorder?

Brian Wojeck:
Certainly. We think of sleep apnea as complex; it has different components. We think about airway collapsibility, loop gain, airway responsiveness, and other factors. There is also a type of sleep apnea that is central, and someone can have a mixed disorder with both obstructive and central components.

Obstructive sleep apnea occurs when the airway collapses, a condition that can result from many factors. You can have poor airway architecture and other features I mentioned. Obstructive sleep apnea is often due to a lack of an impulse to breathe, which may be due to a loop gain issue, a poor ventilatory response, nerve disease, or other diseases like heart failure.

Patients with obesity can have complex diseases that include both an issue with an impulse to breathe, related to a nerve issue or an acid-base issue, or obstructive sleep apnea, in which the airway collapses. Those patients are more difficult to treat. Treating obesity has effects on obstructive sleep apnea, and that is the target for these interventions.

Elana Kieffer Blass:
Dr. Zvenyach, based on your work at the OAC, what are some of the biggest challenges people living with obesity and sleep apnea face in terms of diagnosis, treatment, and insurance coverage?

Tracy Zvenyach:
Our community faces numerous challenges throughout their treatment and care journeys. Some of the biggest ones we see are access-to-care-related, specifically whether someone can determine whether they have access to and coverage for obesity-related treatments as part of their health insurance benefits, which varies a bit depending on the type of health insurance they have. Then, if there is coverage, it usually leads to a discussion of affordability: can someone afford it? If someone does not have health insurance coverage, there are approaches to discuss, but again, affordability is often front and center when determining whether an option is viable for them.

The second top challenge is finding a qualified, trained health care provider who knows how to help people with their obesity and sleep apnea concerns. On the obesity medicine side, education and training are lacking. There is substantial evidence in the literature that medical and other health care professional training does not include sufficient dedicated clinical hours to provide a solid educational foundation for serving this patient population. Third, patients are navigating stigmas and bias in the health care system. They may ask for help and receive negative feedback because someone does not know how to help them with their medical treatment, or because they have spent decades seeking help for chronic weight management and being told that it is their fault and that they should be able to manage it on their own.

Science has evolved and given us many reasons why that adage is outdated, and there are many ways clinicians can help people living with the disease of obesity. We are seeing some improvements in that space, which is encouraging, but stigma and bias remain persistent barriers in health care settings.

Elana Kieffer Blass:
Definitely, and Dr. Wojeck, within the last few years, GLP-1s have become an option for older patients living with OSA and obesity. Just broadly speaking, how do these medications work, and what have they been shown to do specifically for sleep apnea severity?

Brian Wojeck:
Great and important question. The studies that led to the FDA approval were specifically the SURMOUNT-OSA trial of Zepbound. SURMOUNT-OSA included patients from two trial populations. One population was adherent to CPAP, and one was not. Patients, on average, had class 2 obesity, with BMI between 35 and 40, typically in the 38 range, if I am recalling correctly. Patients on these medicines lost an average of 20% to 22% of their body weight and had a 50% reduction in apnea severity; their apnea-hypopnea index was about 50.

That means that, on average, patients in this population stopped breathing about 50 times an hour and had relatively severe sleep apnea. All in all, they had about a 50% reduction in severity. At the end of the study, they were still experiencing apnea, averaging 20-25 times per hour. These are averages, and we can get into the weeds on what that means for an individual, but that is still a substantial difference. That does not mean these patients should discontinue CPAP. CPAP remains a mainstay therapy and is a helpful adjunct. In the past, we would say PAP, or positive airway pressure, was something patients might need for the rest of their lives. For the first time, we can say, "You may not have to be on this for the rest of your life."

Elana Kieffer Blass:
Just a couple of follow-up questions. Can you explain what you mean by saying people stop breathing 20 or 50 times an hour? What does that mean, and what counts as stopping breathing?

Brian Wojeck:
How do you define apnea versus hypopnea? These are 10-second events. Apnea means you look at airflow and see no flow. Hypopnea is a 30% reduction in airflow. The apnea-hypopnea index counts those reductions, but they are related to something else. For hypopneas, if there is an EEG arousal (meaning someone wakes up), it will be counted; if there is an oxygen desaturation, it will also be counted.

These factors are related. When we look at outcomes associated with sleep apnea and long-term complications, low oxygen levels appear to be especially important. Although the data often focuses on the number of apnea or hypopnea events, oxygenation seems to be a key factor in long-term risk.

Elana Kieffer Blass:
Dr. Zvenyach, you mentioned that health care providers sometimes do not quite know how to treat patients in this category. Can you say what you think health care providers need to know about GLP-1 therapy for OSA and obesity?

Do you think, on average, they're receiving sufficient education, particularly on these new medications coming out? Then the third part is: how can providers respond when patients say they no longer want to use a CPAP machine or another type of PAP intervention because they're now trying this medication?

Tracy Zvenyach:
There are a few things that health care providers can keep in mind. As Dr. Wojeck discussed, GLP-1 therapy treats contributors to OSA but not all components of apnea or its etiology. It is part of the plan. Another thing to consider is that improvement in someone's OSA does not mean a cure; ongoing evaluation and management are needed. The evidence and guidelines are pretty clear that CPAP should not be discontinued without proper reassessment and diagnostic evaluation. For patients living with obesity, it is also important to understand that weight recurrence matters. Weight can fluctuate during the treatment journey, and that is part of the disease process, not a failure. It is part of that biology and physiology.

OSA can return or worsen with weight fluctuations, so follow-up and ongoing or scheduled evaluation are essential for effective management and to help patients achieve the best possible outcomes. Those are a few things clinicians could keep in mind.

On the education side, we know that obesity management, as well as obesity plus OSA management, is not uniformly incorporated into curricula. Thus, education varies considerably by specialty. Specialists like Dr. Wojeck and those in sleep medicine are generally the best informed about integrating pharmacological treatment into OSA management, as well as other adjunct therapies.

These professional associations are leading in clinical trial data, evolving guidelines, and clinical practice guidance to help clinicians interested in managing patients with obesity and OSA. Then I go to the obesity medicine specialists. They're also becoming increasingly familiar with the relationship between OSA and chronic weight management. They are starting to develop strong partnerships and referral pathways with their sleep medicine colleagues to inform care plans better and support diagnostic decisions regarding patient treatment.
We have the big bucket of primary care providers, who are the health care clinicians who are seeing a lot of people living with obesity and OSA, and prescribing a lot of the GLP-1 medications, and we really see a mix.

Some primary care providers have sought additional education and expertise in this and may feel comfortable with an initial level of disease management, have identified appropriate referrals, and have relationships with their specialist colleagues. Then there's a spectrum of primary care providers that really are brand new to the management of obesity as a chronic disease and have a steep learning curve. These clinicians are seeing patients, yes, with obesity, diabetes, cardiovascular disease, and also the sleep complaints coming in all at the same time and trying to figure out and manage what they are going to deal with first on their treatment plan and their differential diagnoses and their list of codes.

It is not easy for the primary care community to keep up with the rapidly evolving evidence and science in this space, because there have been many innovations and advancements which are fantastic for patients and very good for science. Still, there is a lot of information to keep track of. We know there is growing recognition that obesity and sleep medicine are specialties. However, we still have a long way to go to bring them together and break down the siloed fragmentation of the health care system so we can provide more comprehensive, coordinated care. Patients need to work with their health care provider and the broader care team to achieve the best possible treatment and health outcomes.

Elana Kieffer Blass:
Speaking of a long way to go, I imagine that there are still some policy barriers and concerns that exist around access to comprehensive care for OSA and obesity. Can you talk about that? On the same note, can you tell us about the Medicare GLP-1 Bridge Program that has recently become available, and who is eligible to participate?

Tracy Zvenyach:
I do want to shout out to the American Academy of Sleep Medicine because they have been doing some great collaborative work, bringing multiple health care professional associations together to bridge the gaps I spoke about and really raise awareness of obesity and the sleep medicine tracks.

On the policy barriers side, there are many. This is all rooted in the understanding of obesity as a chronic disease. Up until 2013, the American Medical Association officially did not recognize obesity as a chronic disease. All the policies, statutes, and laws we still face today are mostly rooted in the pre-2013 era; they're dated. They have not yet caught up with the science. That's what all of our access-to-care and advocacy efforts are really trying to do: to catch policies up with the innovations available today.

When we look at coverage for GLP-1 medications for chronic weight management and the OSA indication, there's variation in which plans provide coverage. I'll start with some commercial and employer-sponsored insurance. There's a lot of variation in that. There is some coverage for chronic weight management. There is some coverage for the sleep apnea indication. However, it's really based on the insurance plan and also whether or not they recognize obesity as a chronic disease or they put it under their exclusionary terms, under that more cosmetic or just weight loss exclusion language that some of the health insurance policies have. There is also variability in the Affordable Care Act marketplace health plans. In Medicaid, each state determines its coverage policies, so we see variation across states.

Medicare issued a very clear policy announcement regarding GLP-1s with indications other than chronic weight management. That old statute says that Medicare can't cover medications for weight loss or weight gain. That's the exact language. It has then been interpreted that the new obesity treatments fall under the weight-loss language. Medicare, to date, interprets that language as prohibiting coverage of medications for the chronic weight management indication.

However, in a policy guidance memo, they clearly stated that they will and do provide coverage for GLP-1 medications for other FDA-approved indications. That's diabetes, that's cardiovascular risk reduction, and that's OSA, as well as chronic kidney disease and liver disease indications. Those other FDA-approved indications are covered under Medicare.

That's under someone's Medicare Part D plan or their Medicare Advantage prescription drug plan. There should be coverage there if the patients meet the clinical criteria for that indication. Now there's this new Medicare GLP-1 Bridge program. Now, that program is a new demonstration by the administration expanding coverage of GLP-1 medications for the chronic weight management indication. They're using demonstration authority to act outside the prohibition they have been under to date. They're using this new authority to expand coverage of GLP-1 medications for chronic weight management. It is a time-limited demonstration. It started on July 1st, 2026, and will go through December 31st, 2027. This does allow access for Medicare beneficiaries who do not meet the clinical criteria for those other FDA-approved indications.

For someone who might have mild sleep apnea plus one of the other qualifying clinical criteria for the Medicare Bridge program, or someone who has one of the other qualifying criteria for the Medicare Bridge program, all of that is laid out and publicly available. It's based on BMI and associated complications due to their obesity.

That's a new pathway in which some people with a mild form of sleep apnea plus one of the other qualifying criteria, such as prediabetes or uncontrolled hypertension, could access GLP-1s through their Part D plan, even if they may not meet the clinical criteria for the already-approved FDA indication.

Elana Kieffer Blass:
Well, I guess, for demonstration programs in general, is the goal that if the data show that a GLP-1 has helped treat OSA and support weight management, then policymakers would have the evidence they need to make changes to Medicare guidelines or coverage for these medications?

Tracy Zvenyach:
That is the hope: to see success in the program, they will be looking at utilization data, how Medicare beneficiaries are doing, and whether they have access to it. Are there changes in their health outcomes? Are there changes in other health benefits? I want to quickly clarify that, for the Medicare Bridge program, mild OSA is not one of the specific clinical criteria. However, if someone has one of the other listed clinical criteria and mild sleep apnea, that could qualify.

Brian Wojeck:
Unfortunately, about 30% of my job is figuring out insurance for these patients and getting coverage. When many of these drugs first came out, Medicare covered them for everyone.

Remember, there's an FDA indication for obesity alone, without sleep apnea, without coronary disease, without diabetes, and without kidney disease. Adding these other indications is adding artificial barriers for our patients. I wanted to make that clear: these medicines are still appropriate for patients with obesity who do not have these indications. Whether it's covered or not, frankly, changes every three to six months with many programs. For example, Connecticut's Medicaid program changed its coverage in January. These things change with some frequency, and it is a frustrating fact of life. We were hoping that the Medicare Bridge program would be better than it is, and I have had more struggles than I expected since it rolled out. Patients I thought would qualify easily have required letters and appeals. You will find that any endocrinologist who treats obesity as part of their practice is writing appeal letters.

All these medicines are appropriate for many indications outside of obesity. Obesity itself is a disease and needs to be treated as such, and we don't need to wait until someone develops a complication to treat obesity. This may be how we get coverage for someone, but that's not how we should be practicing.

Elana Kieffer Blass:
GSA also does some work in the agetech and wearable spaces, which are growing by leaps and bounds. Do your patients ever come to you with data from wearable devices such as an Apple Watch or a Fitbit that provide information about their sleep? As a provider, do you find that information useful, a nuisance, or both?

Brian Wojeck:
Yes, to all of those. There is data on wearables, and some of it is useful, while other parts are not. Wearables are growing in popularity and will become more useful in a few years. They are probably most useful for determining circadian rhythms, including when someone goes to bed and wakes up. They do a reasonable job at that. They are not very good at predicting sleep staging. They may claim someone had a certain amount of REM sleep, but they are not very good at that.

The bigger point is that it brings the patient into the office for the conversation. From my perspective, someone who comes in with a wearable and says, "I'm worried about my sleep." Great, let's talk about it. That is something to talk about. Why are you worried? Are you worried because this device is making you anxious? Or is there a real sleep problem? I've had both. Frankly, more often, there's a real sleep problem. It opens the conversation by saying, "I think there's something wrong." We can say, "Maybe there is." More often than not, there is. I'm not against wearables, but we have to interpret the data thoughtfully and say, "What can this tell us? What can this not tell us?

You cannot diagnose apnea with one of those devices. You need a sleep study. If someone is worried about sleep apnea and frequently waking up, we should test them to see whether they have sleep apnea or another sleep disorder. That is my big picture view of wearables: they produce useful data, but they can sometimes make patients anxious.

They open the conversation by asking, "Is there something to worry about?" In my experience, more often than not, there is something to talk about.

Elana Kieffer Blass:
For both of you, what is one key takeaway that you want our listeners to walk away with on this overall topic?

Tracy Zvenyach:
My key takeaway would be that this builds on Dr. Wojeck's painful reality of his paperwork. Honestly, it is to encourage patients and clinicians to go through that appeals process and submit the evidence and documentation to push back on the denials we see. We do have some evidence that suggests that one denial doesn't mean no or stop. It means gathering more information and evidence to put forward and moving it to the next level of appeal. There are three levels of appeal. No clinician wants to face that for every single patient, but the system is there for a reason, and we have decent data suggesting that when you go through an appeal, you are often successful. It does take that extra work.

It is an administrative burden. It is frustrating and scary for patients not to know whether they'll be able to get the treatment their clinician says they really need and would help them. At OAC, we help a lot of folks understand the process and the information needed to appeal. OAC can be a resource on that side as well.

Brian Wojeck:
First of all, I'd like to thank Dr. Zvenyach. We've worked together. I work with the ASM, and it's been lovely to collaborate with you and to talk with you again about this.

My shout-out is to the docs to feel comfortable managing these patients. I'm a specialist in endocrine, obesity, and sleep. I see many complex cases. The truth is that most of these medicines and therapies are prescribed by primary care providers. That’s not just physicians; that's PAs, that's APRNs. The data will support that obesity is a very prevalent disease process.

I would encourage physicians and other practitioners to become comfortable managing it, because not every patient can see me. I wish that were true, but there's only one of me. We have plenty of obesity specialists here at Yale, but we are finite compared to the scale of this disease. I'm not going to say that primary care docs haven't stepped up. They have. Many of them manage this. I would say that, among sleep physicians, we're working to make our sleep community feel more comfortable managing these medicines. If there are physicians and other practitioners interested in developing this skill set, please reach out to me.

We have resources at the ASM to help you get comfortable, and we're happy to help you become skilled at this, because it's a new world. This is an FDA-approved therapy for sleep apnea, so this needs to be something that everyone is becoming increasingly comfortable managing. I'd say join us if you haven't yet. If you need help, ask for help. Resources are out there, and organizations are happy to help you.

Elana Kieffer Blass:
Well, Dr. Wojeck and Dr. Zvenyach, thank you both so much for sharing your expertise, your guidance, and your vision for transforming how we think about health. You've both educated our listeners about the real dangers of OSA, the many ways to address it, and the exciting advances in medicine, particularly in OSA and obesity and in general. To our listeners, thank you for joining us for this episode of the GSA Momentum Discussions Podcast.

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