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Obesity Treatment Study Committee

Final Report
December 2025

Committee Members:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Cindy Komar
Dr. Christine Lovato
Dr. Douglas Maready
Representative Julie Willoughby Co-Chair
Representative Patricia Contreras
Amy McCallister
Emily Moree
Dr. Kiran Raman

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REPORT 2025

Background

The Obesity Treatment Study Committee's purpose is to: 1) conduct a comprehensive study to determine the cost, potential savings, effectiveness, health outcomes and value of extending coverage under the Arizona Health Care Cost Containment System to include comprehensive treatment for people living with obesity; 2) identify any additional resources or policy initiatives that would enhance public health and reduce costs associated with treating people living with obesity; 3) review current policies and practices and propose revisions to the Arizona Health Care Cost Containment system to improve outcomes for people living with obesity. On or before December 31, 2025, the Committee must submit a report of its activities, findings and recommendations for administrative or legislative action to the Governor, the President of the Senate and the Speaker of the House of Representatives and provide a copy of this report to the Secretary of State.

Summary of Committee Activity

Committee Hearing November 13, 2025

Chairman Gowan introduced the Committee and reviewed the purpose of the committee.

The Committee heard the following presentations:

- Overview of Obesity in Arizona, Emily Moree, Arizona Department of Health Services
- Treatment Options for Obesity, Dr. Douglas Maready. President of the Arizona Obesity Organization
- Current Insurance Coverage Landscape, Steve Berg, Arizona Health Care Cost Containment System (AHCCCS)

The Committee held a panel discussion on patient and provider perspectives and offered further comments. There was no public testimony.

A video recording of the committee can be found at:
https://www.azleg.gov/videoplayer/?eventID=2025111006

Committee Hearing November 25, 2025

The Committee heard the following presentations:

- Health and Economic Cost of Obesity to Arizona, Tim Dall, Life Sciences Consulting
- Current Medicaid Coverage and Expansion Considerations, Steve Berg, AHCCCS
- Private Insurance Coverage Landscape, Sterling Gavette, Arizona Department of Insurance and Financial Institutions

- State of Arizona Employee Health Plan Coverage and Expansion Analysis, Chandler Coiner, Joint Legislative Budget Committee
- Treating Obesity in Tribal and Rural Populations, Melinda White, Sage Memorial Hospital
- Arizona Ranks 49th out of 50 (almost last) in Obesity-Related Policy, Dr. Douglas Maready. President of the Arizona Obesity Organization

The Committee held discussion and received public testimony.

A video recording of the committee can be found at:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025111013

Committee Hearing December 17, 2025

The Committee heard the following presentations:

- Overview of Obesity in Arizona, Dr. Yaminikrishna Sabesan, Mercy Care
- GLP-1 Coverage, Steve Berg, AHCCCS
- GLP-1 Coverage, Paul Shannon, Arizona Department of Administration

The Committee held discussion on the proposed committee recommendations and shared final comments. A motion was made to adopt the recommendations presented on December 17, 2025. The motion CARRIED with a voice vote.

A video recording of the committee can be found at:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025121005

Committee Recommendations

RECOMMENDATION #1 – RECOGNIZE OBESITY AS A CHRONIC DISEASE

The Legislature and state agencies should consider policies which**:**

- Officially recognize obesity as a chronic disease.
- Treat obesity as a chronic illness, with necessary treatment that is lifelong as needed, rather than episodically, like the treatment of any other chronic disease.
- Looks at obesity treatment as part of a chronic care model.

RECOMMENDATION #2 – OBESITY PREVENTION AND TREATMENT ADVISORY COUNCIL

The Legislature should**:**

- Establish an advisory council which will analyze historical data, estimate potential cost-savings from covering preventative care, evaluate and recommend public policy and funding strategies, identify system gaps, and produce a report providing guidance and recommendations to educate the public, the Legislature and other government agencies and departments, as appropriate.

RECOMMENDATION #3 – CONTINUED ENGAGEMENT BY STATE AGENCIES

Relevant state agencies should**:**

- Continue and expand efforts to promote physical activity, nutrition education, and support obesity treatment approaches that focus on treating the whole individual.
- Consider creating or strengthening internal teams focused on addressing and preventing obesity and related chronic diseases.

Appendix A:

November 13, 2025

Minutes and Reference Materials

ARIZONA STATE LEGISLATURE

OBESITY TREATMENT STUDY COMMITTEE

Minutes of the Meeting
November 13, 2025
12:00 P.M., SHR 2

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025111006

Members Present:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Cindy Komar
Dr. Christine Lovato*
Dr. Douglas Maready
Representative Julie Willoughby, Co-Chair
Representative Elda Luna-Nájera
Amy McCallister
Emily Moree, Designee
Dr. Kiran Raman, Designee

*Participated remotely via a teleconference platform

Staff:
Michael Madden, Senate Research Analyst
Ahjahna Graham, House Senior Research Analyst
Tasja McMaster, House Assistant Research Analyst

Co-Chair Gowan called the meeting to order at 12:07 p.m. and attendance was taken.

MEMBER INTRODUCTIONS

Co-Chair Gowan provided opening remarks and requested that the Committee members introduce themselves.

OVERVIEW OF OBESITY IN ARIZONA, ARIZONA DEPARTMENT OF HEALTH SERVICES

Emily Moree, Committee Member, Designee, Arizona Department of Health Services, Bureau of Nutrition and Physical Activity, distributed and explained a PowerPoint presentation entitled "Obesity in Arizona" (Attachment A).

The Committee offered comments.

TREATMENT OPTIONS FOR OBESITY

Dr. Douglas Maready, Committee Member, President, Arizona Obesity Organization, distributed and explained handouts entitled "Obesity's Impact on Arizona's Economy and Workforce in 2023" (Attachment B) and "Medication Cost Modeling" (Attachment C).

CURRENT INSURANCE COVERAGE LANDSCAPE, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Steve Berg, Legislative Specialist, Arizona Health Care Cost Containment System, distributed and explained a PowerPoint presentation entitled "Obesity Treatment Study Committee 11.13.25" (Attachment D).

Dr. Kiran Raman, Committee Member, Designee, answered questions posed by the Committee.

The Committee offered comments.

PANEL DISCUSSION: PATIENT & PROVIDER PERSPECTIVES

The Committee offered comments.

COMMITTEE DISCUSSION & NEXT STEPS

The Committee offered comments.

PUBLIC TESTIMONY

No public testimony took place.

There being no further business, the meeting was adjourned at 1:30 p.m.

Respectfully submitted,

Jackson Cooper
Committee Secretary

(Audio recordings and attachments are on file in the Secretary of the Senate's Office/Resource Center, Room 115. Audio archives are available at http://www.azleg.gov)

November 13, 2025

Obesity Study Committee

Obesity in Arizona

Prevalence, Disparities and Systems-Level Strategies

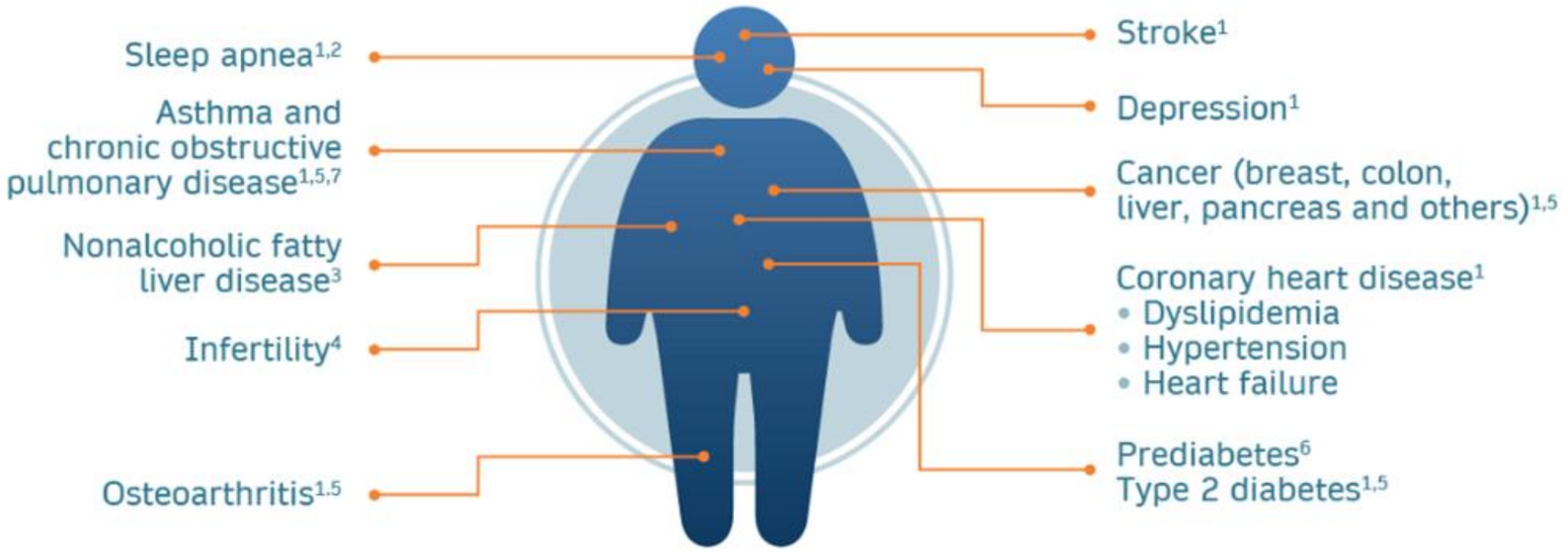
Emily Moree, MPA, RDN, IBCLC
Arizona Department of Health Services

ARIZONA DEPARTMENT OF HEALTH SERVICES

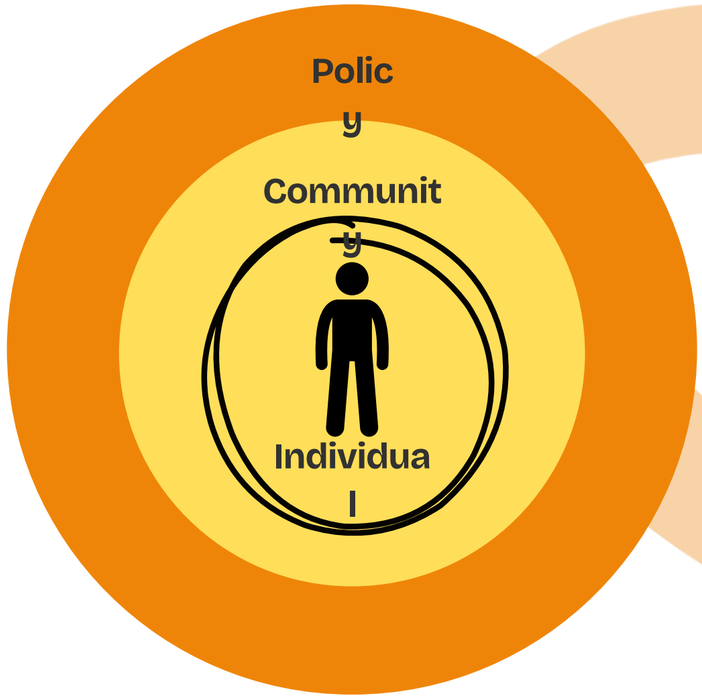
Bio

- Arizona Native
- Education
  - Bachelor of Science in Dietetics from Arizona State University
    - Dietetic Internship through the Maricopa County Department of Public Health
    - Credentialed Registered Dietitian Nutritionist (RDN)
    - Credentialed International Board Certified Lactation Consultant (IBCLC)
  - Master of Public Administration with an emphasis in Health Care Policy from Grand Canyon University
- Work
  - Mountain Park Health Center, Honor Health, ADHS

Chronic Diseases and Complications Impacted by Obesity



References: **1.** National Institutes of Health. *Obes Res*. 1998;6 Suppl 2:515-2095. **2.** LI C et al. *Prey Med*. 2010;51(1)1B-23. **3.** Church TS et al. *Gastroenterology*. 2006;130(7):2023-2030. **4.** Esmaellzadeh 5 et al. *Arch Med Sci*. 2013;9(3).499-505. **5.** Guh DP et al. *BMC Public Health*. 2009;9:88. **6.** Shalkh 5 et al. *Int J Diabetes Dev Ctries*. 2011;31:65-69. **7.** Liu Y et al. *Respir Med*. 2015; 109(7):851-859.



Beyond Individual Choice: A Systems Perspective

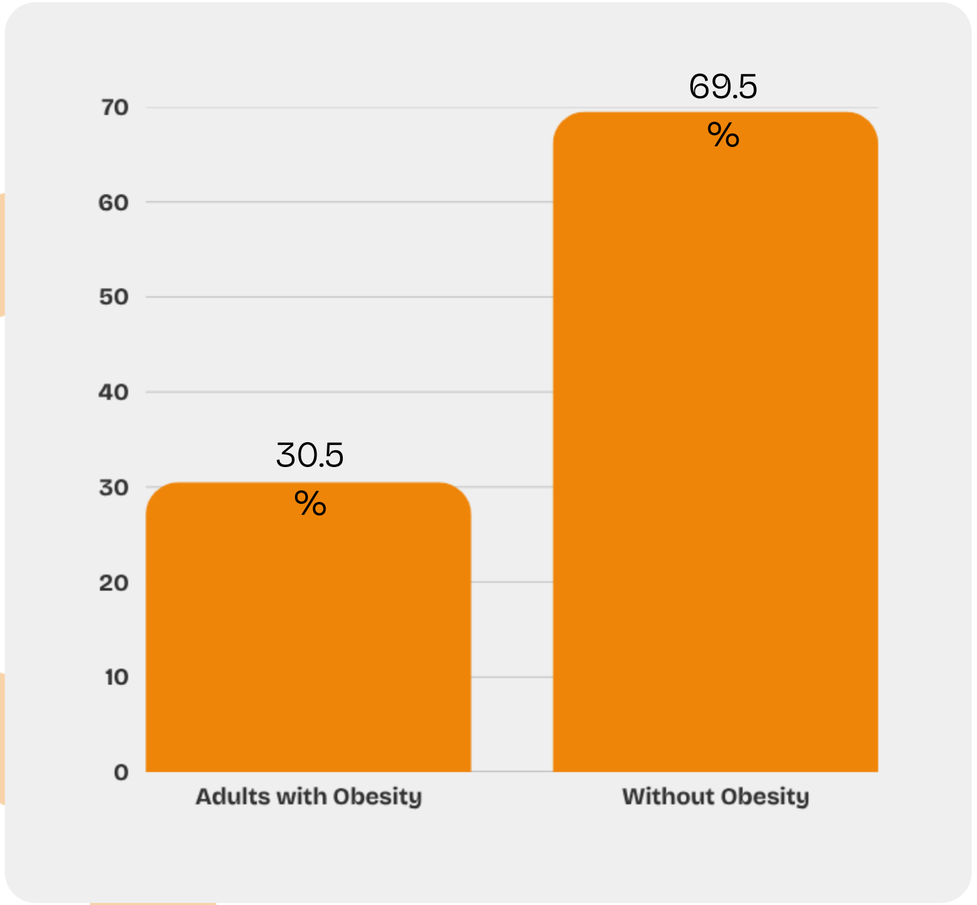
- Income
- Education
- Housing
- Healthy food
- Neighborhood Environment
- Access to healthcare

Current Statewide Data

Data Highlights:

- 30.5% of Arizona adults (≈ 1.5 million) have obesity (BMI ≥ 30 kg/m²).
- 69.5% (≈ 3.4 million) are below the obesity threshold.

Approximately
1 in 3

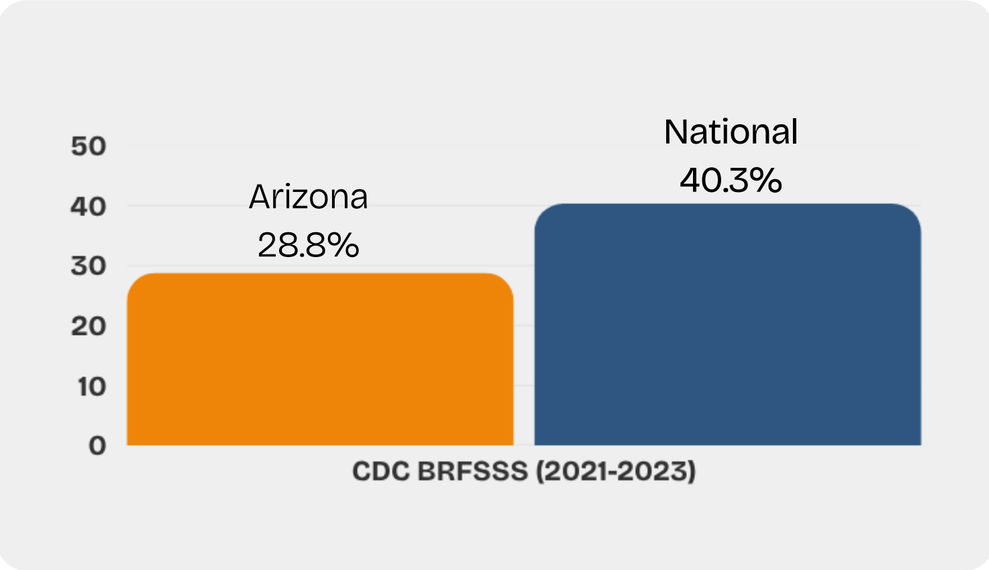


Source: Arizona BRFSS 2025

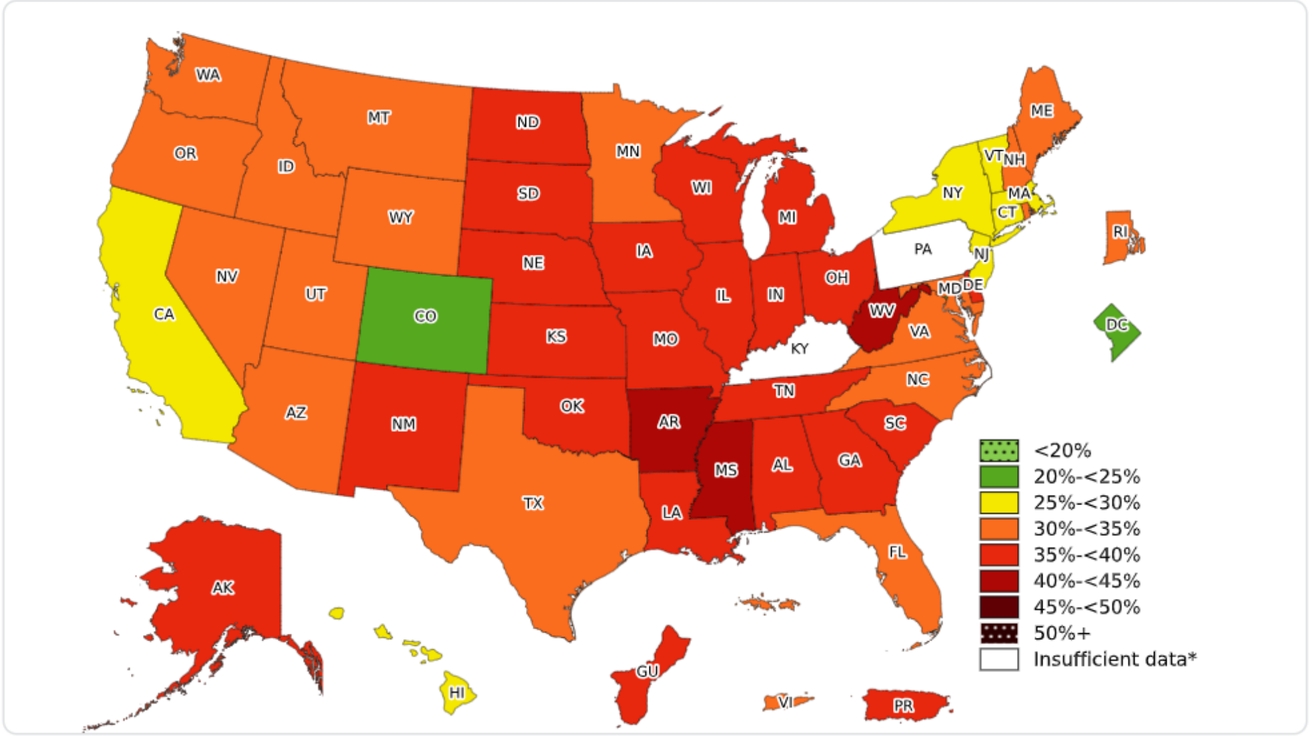
Arizona vs National Comparison

Data Highlights:

- Arizona's obesity rate is below the national average, but still represents a **major public health concern**.
- Obesity has risen from 25% (2011) to 33% (2022) - steady upward trend



Map: Overall Obesity



In 2023, more than 1 in 5 adults in all U.S. states and territories had obesity.

Source: Behavioral Risk Factor Surveillance System

Trends over time

Arizona rose from 25.1% to 33.2% (BFSSS 2011-2022)

National average rose from 34.9% to 40.3% (BFSSS 2011-2022)

This shows a consistent increase across the country—reinforcing the need for sustained, systems-level interventions.

Data → Solutions

Bureau of Women and Children's Health - Home Visiting Programs

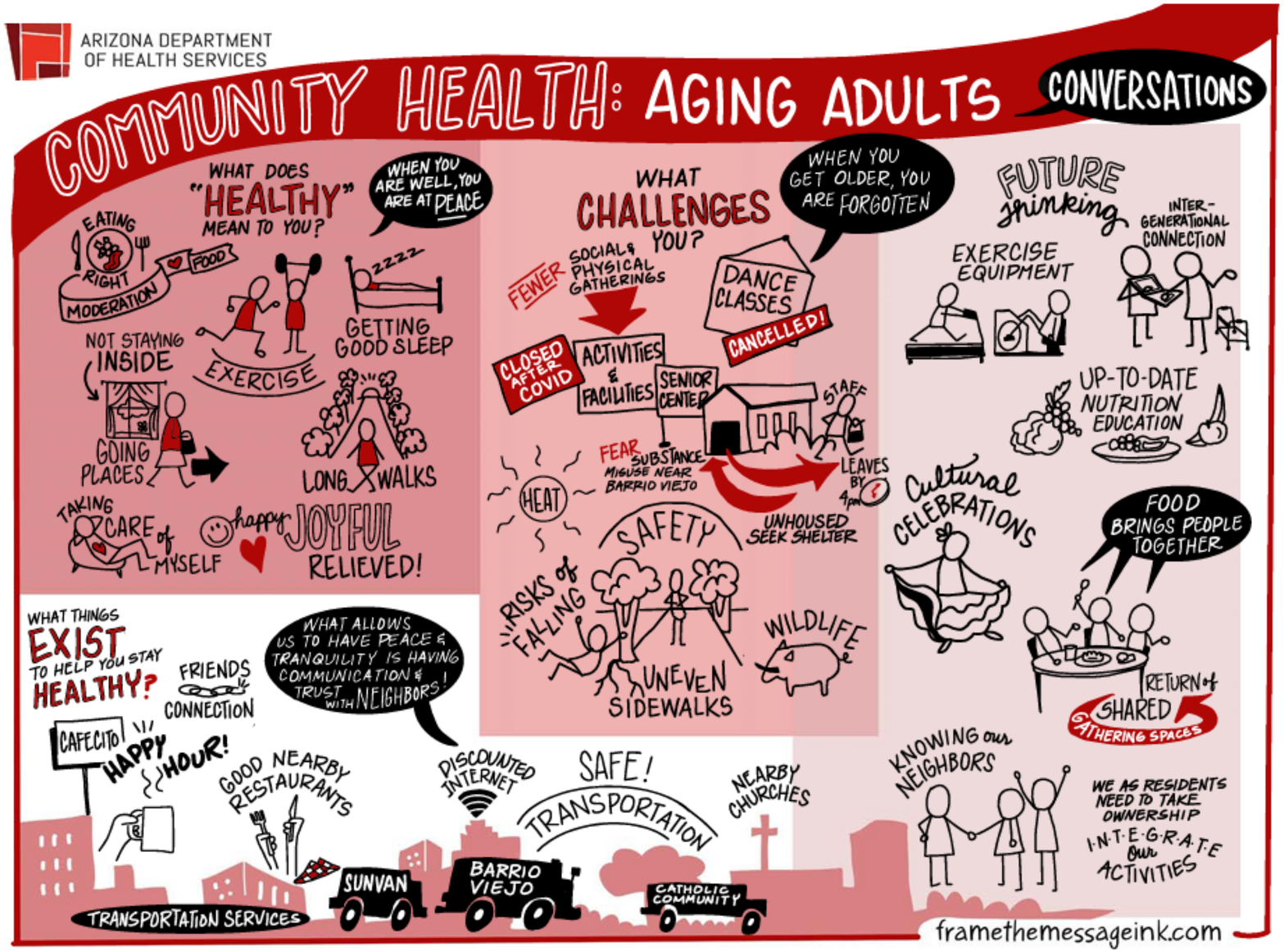
- Proven strategies for educating families

Bureau of Nutrition and Physical Activity

- 25 Registered Dietitians and 8 IBCLCs

Who work on programs focused on:

- Protective Benefits of Breastfeeding
  - LATCH AZ
  - 24/7 Breastfeeding Hotline
- Empower Program
  - Standards for Childcare centers (structured physical activity, limiting screen time, family meals, 100% fruit juice)
- WIC Program
  - Fruit and Vegetables (minimum stock requirement and increased dollar amount)
  - WIC Cookbook and recipe videos
  - Online nutrition and breastfeeding education platform
- Healthy Arizona Worksites Program
  - Toolkit, training and award


ARIZONA DEPARTMENT OF HEALTH SERVICES
COMMUNITY HEALTH: AGING ADULTS CONVERSATIONS
WHAT DOES "HEALTHY" MEAN TO YOU?
WHEN YOU ARE WELL, YOU ARE AT PEACE
EATING RIGHT
MODERATION
FOOD
EXERCISE
ZZZZ
GETTING GOOD SLEEP
NOT STAYING INSIDE
GOING PLACES
LONG WALKS
TAKING CARE of MYSELF
happy
JOYFUL
RELIEVED!
WHAT CHALLENGES YOU?
WHEN YOU GET OLDER, YOU ARE FORGOTTEN
FEWER SOCIAL & PHYSICAL GATHERINGS
DANCE CLASSES
CANCELLED!
CLOSED AFTER COVID
ACTIVITIES & FACILITIES
SENIOR CENTER
STAFF
FEAR
SUBSTANCE MISUSE NEAR BARRIO VIEJO
LEAVES BY 4pm?
HEAT
SAFETY
UNHOUSED SEEK SHELTER
RISKS of FALLING
WILDLIFE
UNEVEN SIDEWALKS
FUTURE thinking
INTER-GENERATIONAL CONNECTION
EXERCISE EQUIPMENT
UP-TO-DATE NUTRITION EDUCATION
Cultural CELEBRATIONS
FOOD BRINGS PEOPLE TOGETHER
RETURN of SHARED GATHERING SPACES
WHAT THINGS EXIST TO HELP YOU STAY HEALTHY?
FRIENDS CONNECTION
WHAT ALLOWS US TO HAVE PEACE & TRANQUILITY IS HAVING COMMUNICATION & TRUST WITH NEIGHBORS!
CAFECITO! HAPPY HOUR!
GOOD NEARBY RESTAURANTS
DISCOUNTED INTERNET
SAFE! TRANSPORTATION
NEARBY CHURCHES
KNOWING our NEIGHBORS
WE AS RESIDENTS NEED TO TAKE OWNERSHIP I·N·T·E·G·R·A·T·E our ACTIVITIES
TRANSPORTATION SERVICES
SUNVAN
BARRIO VIEJO
CATHOLIC COMMUNITY
framethemessageink.com

Thank You

“Health is created in our communities long before it’s treated in a clinic.” - World Health Organization

Emily Moree, MPA, RDN, IBCLC emily.moree@azdhs.gov 480-253-2224

American Diabetes Association®

AZ

Help Prevent Diabetes. Treat Obesity.

Diabetes and obesity remain significant health issues in the United States. While millions struggle with diabetes, the comorbid condition of obesity affects nearly 42% of U.S. adults.[1] What's true nationwide is especially true in Arizona. Treating the chronic disease of obesity can help prevent or delay type 2 diabetes and may even result in diabetes remission.

Arizona Obesity Epidemic

- Approximately 2.3 million adults in Arizona, or 31% of the adult population, have obesity.[2]
- 27% of AZ adults ages 65 and older have obesity.[2]
- The AZ adult obesity rate is projected to increase to 51% by 2030.[3]

Obesity in the U.S.

- **Roughly 42% (110 million) of American adults are affected by obesity.[4]**
- **Nearly 15 million children and adolescents in the U.S. are affected by obesity.[5]**
- **Almost 500,000 annual deaths are attributable to excess weight.[6]**
- **Nationwide, one in three young adults between the ages of 17 and 24 cannot qualify for military service due to overweight status.[7]**

The Costly Consequences of Obesity

- Health care expenses in AZ from obesity are estimated to reach nearly $10.2 billion annually.[8]
- Obesity-related medical costs in the United States are estimated to be nearly $173 billion each year.[4]
- On average, out-of-pocket costs have increased 37% over the last decade for people with large employer coverage who have an obesity diagnosis.[9]

Person-Centered Treatment for Obesity

The *Standards of Care in Diabetes* of the American Diabetes Association® recommends person-centered interventions across the care continuum to ensure comprehensive support for those affected. Proven and effective treatments exist to treat and manage obesity, but health insurance and federal and state programs do not allow access to these science-based approaches.[10] Addressing the obesity epidemic involves a multifaceted approach to support improved health, including:

- **Screening and prevention**: Screen for obesity by documenting height, weight, waist circumference, and BMI. If needed, annual screening for obesity-related comorbidities.
- **Intensive behavioral therapy (IBT):** Offer intensive lifestyle modification program that includes personalized nutrition, physical activity, and behavioral support with a trained professional.
- **Pharmacotherapy:** Provide access to approved obesity medications according to FDA guidelines.
- **Bariatric surgery:** Provide access to bariatric/metabolic surgery as recommended by an appropriate health care professional.

Sources:

1. National Institute of Diabetes and Digestive and Kidney Diseases. (2021). Overweight & Obesity Statistics. https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity
2. Centers for Disease Control and Prevention. (2023). BRFSS Prevalence & Trends Data: Home. BRFSS Prevalence & Trends Data. https://www.cdc.gov/brfss/brfssprevalence/
3. Ward, Z. et al.(2019). *Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity*. New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMsa1909301
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5. Stierman, B., et al. (2021). National Health and Nutrition Examination Survey 2017–March 2020 Prepandemic Data Files -- Development of Files and Prevalence Estimates for Selected Health Outcomes. (158)
6. Ward, Z. J., et al. (2022). Excess mortality associated with elevated body weight in the USA by state and demographic subgroup: A modelling study. EClinicalMedicine, 47, 101389. https://pubmed.ncbi.nlm.nih.gov/35516446/
7. Unfit to Serve. (2023, June 20). Centers for Disease Control and Prevention. https://www.cdc.gov/physicalactivity/resources/unfit-to-serve/index.html
8. GlobalData Plc. (2024). *Obesity's impact on Arizona's economy and labor force*. https://www.globaldata.com/health-economics/US/Arizona/Obesity-Impact-on-Arizona-Factsheet.pdf
9. Telesford, I. et al. (2023, July 6). How have costs associated with obesity changed over time? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-have-costs-associated-with-obesity-changed-over-time/#Average%20out-of-pocket%20cost%20for%20enrollees%20with%20and%20without%20an%20obesity%20diagnosis,%202011-2021
10. American Diabetes Association Professional Practice Committee; 8. Obesity and Weight Management for the Prevention and Treatment of Type 2 Diabetes: Standards of Care in Diabetes–2025. Diabetes Care 1 January 2025; 48 (Supplement_1): S167–S180. https://doi.org/10.2337/dc25-S008.

American Diabetes Association®

AZ

Help Prevent Diabetes. Treat Obesity. Support HB-XXX

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3. Ward, Z. et al.(2019). *Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity*. New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMsa1909301
4. GlobalData Plc. (2024). *Obesity's impact on Arizona's economy and labor force*. https://www.globaldata.com/health-economics/US/Arizona/Obesity-Impact-on-Arizona-Factsheet.pdf
5. *Adult obesity Facts*. (2024, May 14). Obesity. https://www.cdc.gov/obesity/php/data-research/adult-obesity-facts.html
6. Telesford, I. et al. (2023, July 6). How have costs associated with obesity changed over time? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-have-costs-associated-with-obesity-changed-over-time/#Average%20out-of-pocket%20cost%20for%20enrollees%20with%20and%20without%20an%20obesity%20diagnosis,%202011-2021
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THE DOCTOR DOUG PODCAST

💊 GLP-1 Medication Access & Pricing Reference

Summary of 2025 Trump Administration Announcement
Effective: Late 2025 – 2027 (Projected Rollout)

✅ Medications with Price Negotiations

Obesity-specific injections

- **Zepbound** – Eli Lilly
- **Wegovy** – Novo Nordisk

Diabetes-specific injections

- **Mounjaro** – Eli Lilly (same ingredient as Zepbound)
- **Ozempic** – Novo Nordisk (same ingredient as Wegovy)

Upcoming products

- **Wegovy (oral tablet, Novo):** expected early 2026; similar efficacy to injectable form
- **Orforglipron (Eli Lilly):** oral GLP-1 expected 2026 (early)
- **Next-generation injectables:** CagriSema (Novo) and Retatrutide, projected 2026–2027; FDA fast-track designation in progress

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💵 Self-Pay Pricing (If No Insurance Coverage)

New Federal Purchasing Platform: TrumpRx.gov (launch by end of 2025)

- Zepbound / Mounjaro – avg $346 per month (anticipate starting doses to be less expensive and higher pricing for higher doses)
- Wegovy / Ozempic – $350 per month (flat pricing)
- Prices negotiate to reduce progressively until reaching ≈ $245 per month by 2027
- GLP-1 tablets – starting doses $149 per month (higher doses TBD)

Manufacturer Direct Programs

- **Lilly Direct** (announced to be effective immediately, though not changed on website as of 11/10/2025)
    - Price reduction of $50 per dose per month
    - 2.5 mg vials $299 / month
    - 5 mg vials and higher dosing $449 / month
    - Multi-dose pen in development; vials eligible for discount; single-use pens insurance only

- **Novo Nordisk Direct:** no announced price reduction as of Nov 2025

🧾 Medicare Coverage (Pilot Program – 2026 Start)

Availability: Spring 2026 (Zepbound); later in 2026 (Wegovy)
Patient Out-of-Pocket Cost: $50 copay for approved uses
Eligibility Criteria

- **BMI ≥ 27** with prediabetes or cardiovascular disease (heart attack, stroke, PVD)
- **BMI ≥ 30** with prior conditions or uncontrolled hypertension, kidney disease, or heart failure
- **BMI > 35** for any patient

Notes

- Coverage retained for diabetes indications (for Ozempic and Mounjaro)
- Coverage for Wegovy in patients with liver disease (FDA-approved Aug 2025)--not yet announced
- Administration acknowledged coverage narrowed to “obesity with medical disease complications”

🏥 Medicaid

- Price of $245 per month is available for any state program that wants to enroll (and they encourage enrollment)
- Each state will need to determine their enrollment

🏢 Commercial Insurance

- RFK stated goal to make these medications available to all Americans, but private insurance would need to individually negotiate pricing with the manufacturers
- Commercial plans must **add GLP-1 coverage before price negotiations can begin**

📌 Key Takeaways

- TrumpRx.gov expected to reduce out-of-pocket GLP-1 costs by ≈ 70% by 2027.
- Medicare pilot establishes first-ever national coverage for anti-obesity medications with out-of-pocket costs at a fraction of prior costs
- Commercial and Medicaid coverage will need to be determined by those plans still
- Multiple new oral and injectable GLP-1 options anticipated by 2026–2027 at this current pricing

References:

Trump administration announcement--Fox News
CNBC article w/ details on the announcement
Interview with Dave Ricks, Eli Lilly CEO
Interview with Mike Doustdar, Novo Nordisk CEO

Forte Well-Being – Dr. Maready's Integrated primary care and obesity medicine (Arizona)
👉 www.Forte-Wellbeing.com | **@fortewellbeing**

Arizona Obesity Organization (AOO) – Non-profit advocacy and education
👉 www.ArizonaObesity.org | **@ArizonaObesityOrganization**

Doctor Doug Podcast & Social Channels
🎧 YouTube: @doctor.dougmd
📘 Facebook: Doug Maready
📸 Instagram: @doctor.dougmd
🎵 TikTok: @doctor.dougmd

Arizona Obesity Treatment Committee

Members of the committee—thank you for giving me the chance to present. I'm Dr. Doug Maready, a full-time Obesity Medicine specialist and President of the Arizona Obesity Organization.

This committee has to determine whether obesity treatment deserves coverage.
Do we decide based on the suffering and disability we see every day in our patients?
Do we decide based on cost, strategy, and the economic burden on our state?
Do we look at return on investment?
Or do we act out of a moral obligation to take care of our people?

I've spent years witnessing the profound change that happens when we treat this chronic disease. I've also believed that it's economically responsible. Now, for the first time, I have data to present to show that economic benefit.

And Thanks to the recent price reductions negotiated by the Trump administration, it's finally financially feasible. All of these factors now argue for Arizona to join Medicare in covering obesity treatment.

After we address treatment, we need to figure out how to address prevention. Our society is flooded with foods and drinks that have driven this obesity epidemic, complete with marketing and other system infrastructure. If we don't create state policies to control this, we'll continue to fuel the fire of the obesity epidemic. Thank you. I'm happy to take questions.

Obesity Medication Cost Modeling

Source: Medication cost model, produced by GlobalData, using publicly-available data. Funded by Eli Lilly. Calculated using their modeling calculator with input of custom data. Shared with permission.

Medication cost modeling

- 2yr modeling, discount rate 3% (value of money over time)
- 1 million Medicaid patients (age 18-80, from most recent data in Kaiser Fam Found), Also AHCCCS data
- Patients with obesity = 484,000
    - Reduction of this total number for numerous variables
    - Those without diabetes = 338,000
    - Those without cardiovascular disease = 316,000
    - 61% diagnosis rate = 206,000
    - 20% of those can be treated with Lifestyle counseling only. 2% referred to surgical treatment = 160,000
    - 80% using GLP-1 medication = 129,000, 20% using 1st gen med, # initiating care w/in 12mo–5% (very conservative, most are seeing 1-2%)=8k total and 7k for GLP-1 and 1k for 1st gen.
- Cost: $245. Calculate in an FMAP component (could ultimately be lower, 65% FMAP and 35% state responsibility). Dispense fee $10.
- Discontinuation: 50% short-term. 10% long-term.
- Total cost 2026-2027: 15mil, FMAP 5.2mil.
- Medical cost offset 3.5mil
- Net cost tx: 11.3mil total, 4mil state, 7.4mil federal.
    - Doesn't even include oral GLP-1s
- **State medicaid budget effect: +0.01% total budget, +0.49% drug budget**
- **Does not include anticipated cost savings to Medicaid and the Arizona Economy**

Data Sheets

Obesity Impact on Arizona Economy

Economic Benefits of Obesity Treatment--Literature Review

Detailed Summary of Trump Administration Announcement–11/6/2025

States in US that cover anti-obesity medication

Impact of Obesity and Weight-Related Comorbidities

Economic Benefits of Obesity Treatment: Review of the Current Literature

This review synthesizes evidence from 31 studies published between January 2012 and June 2025 across a range of obesity treatment categories to evaluate the annual benefits per treated person:

Healthcare Cost Savings | **Quality of Life Value** | **Indirect Cost Benefits**

Strong evidence exists for healthcare savings and quality of life benefits from obesity treatment but the indirect economic benefits such as productivity improvements have not been rigorously studied

Note: All cost estimates in 2025 dollars

TREATMENTS CATEGORIES

Intensive Lifestyle Management

Intensive lifestyle management (diet, exercise, behavior support) yields ~5.2% weight loss

Metabolic/Bariatric Surgery

Surgery (bypass, sleeve, banding) yields ~24.8% weight loss in severe obesity

Obesity Medications

Obesity medications (OMs) are pharmacological treatments that work through mechanisms including appetite suppression, delayed gastric emptying, and improved glucose metabolism

Modern OMs

Incretin-based OMs (e.g., semaglutide, tirzepatide) achieving up to 20.1% average weight loss in trials

First-Generation OMs

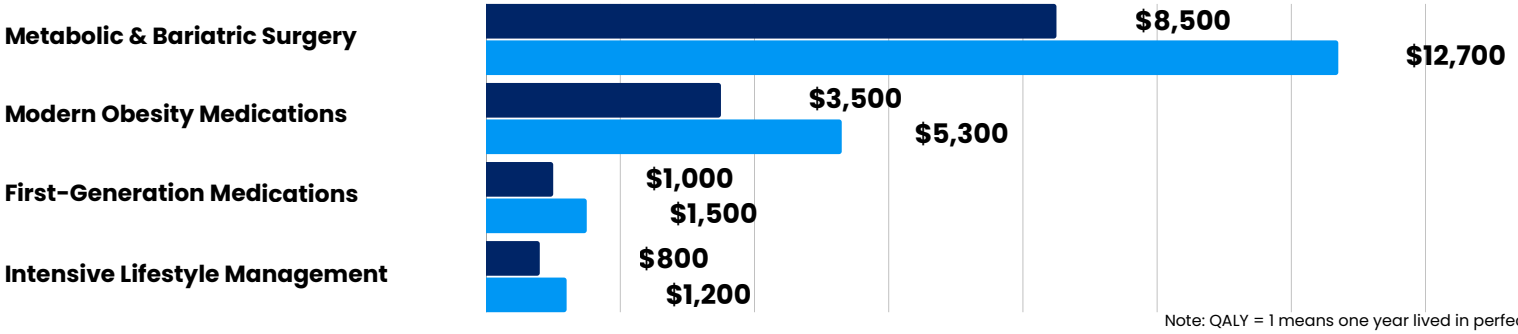
Prior FDA-approved OMs (orlistat, phentermine/topiramate, bupropion/naltrexone) yield ~5.2% weight loss

ESTIMATED ANNUAL HEALTHCARE COST SAVINGS

INTERVENTION TYPE	INSURANCE	ANNUAL HEALTHCARE COST SAVINGS - OBESITY	ANNUAL HEALTHCARE COST SAVINGS - OBESITY WITH DIABETES
Metabolic & Bariatric Surgery	Commercial	$1,880 - $2,780	$4,270 - $5,830
	Medicaid	$940 - $1,190	$2,180 - $2,430
Modern Obesity Medications	Commercial	$1,530 - $2,250	$3,460 - $4,720
	Medicaid	$760 - $960	$1,770 - $1,970
First-Generation Medications	Commercial	$400 - $580	$890 - $1,220
	Medicaid	$200 - $250	$460 - $510
Intensive Lifestyle Management	Commercial	$400 - $580	$890 - $1,220
	Medicaid	$200 - $250	$460 - $510

ANNUAL QUALITY OF LIFE YEAR (QALY) VALUE PER TREATED PERSON

Using established thresholds of $100,000 to $150,000 per QALY



Note: QALY = 1 means one year lived in perfect health

RECOMMENDATIONS

1. **Adopt comprehensive economic frameworks that capture healthcare savings, QALYs, and broader benefits for a more complete picture of obesity treatment value**
2. **Ensure access to the full spectrum of evidence-based treatments so patients and providers can choose the most effective, cost-efficient options**
3. **Align cross-payer value through policy risk-sharing arrangements, outcomes-based contracts, cross-payer coordination, and expanded public coverage**
4. **Support long-term treatment durability with ongoing clinical support, real-world data collection, and tailored patient-centered care**
5. **Strengthen evidence on indirect economic benefits, such as productivity gains and reduced disability costs, to capture obesity's full societal impact**

For more information: Consulting@globaldata.com

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Obesity's Impact on Arizona's Economy and Workforce in 2023

REDUCED ECONOMIC ACTIVITY BY $10.2B

67% of adults have obesity or overweight

$4.1B in higher healthcare, absenteeism, and disability costs to employers

$1.1B detrimental state budget impact

COST OF OBESITY ON ARIZONANS

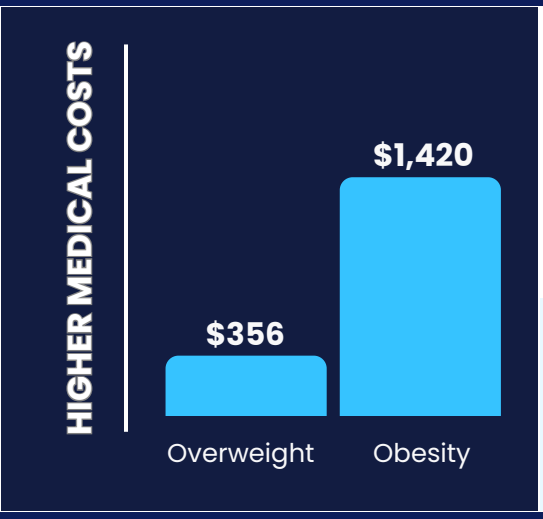
Reduced Labor Force Participation
60,700 fewer adults with obesity working

Reduced Earnings for Employed Women
Women with obesity earn 9% less than women with healthy weight

Obesity-Attributed Early Mortality
9,500 premature deaths occur annually

Higher Medical Costs
$694M spending by households

COST OF OBESITY ON EMPLOYERS



$1B in higher healthcare costs to employers

$3.1B in health-related lost workdays and disability

2.0% reduction in Arizona's Gross Domestic Product (GDP)

5%-25% weight loss among adults age **<65 over 10 years** has potential to **save $5.4B-$17.9B** in medical costs

COST OF OBESITY ON STATE & LOCAL GOVERNMENT

$638M reduced tax revenues from lost economic activity

Medicaid	**$201M higher Medicaid spending**
Healthcare Coverage	**$200M for employee healthcare coverage**
Public Assistance Program	**$21M in public assistance program costs**
TOTAL	**$422M increased spending**

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Impact of Obesity and Weight-Related Comorbidities

Actor portrayal

What is obesity?

Obesity, commonly misperceived as a lifestyle choice, is a multifaceted, chronic condition influenced by social, environmental, genetic, and behavioral elements[1]

Major medical associations refer to obesity:

The **American Medical Association (AMA)** asserts that "obesity is a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention."[2]

The **American Association of Clinical Endocrinology (AACE)** also recognizes "obesity as a complex, multifactorial condition characterized by excess body fat. It must be viewed as a chronic disorder that essentially requires perpetual care, support, and follow-up. Obesity can cause many other diseases, and it warrants recognition by healthcare providers and payers."[3]

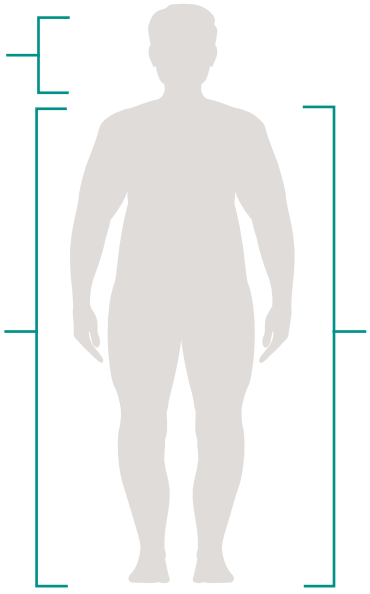
The link between obesity and comorbidities

Obesity-related comorbidities may have far-reaching consequences, affecting not only physical health but also daily life.[4]

Select examples of weight-related comorbidities[5-7,a]

- Depression

- Gastroesophageal reflux disease (GERD)
- Diabetes risk, metabolic syndrome, and prediabetes
- Type 2 diabetes
- Metabolic dysfunction-associated steatotic liver disease (MASLD)[b]
- Female infertility
- Male hypogonadism
- Cancer (various)



- Obstructive sleep apnea
- Dyslipidemia
- Asthma/reactive airway disease
- Cardiovascular disease and cardiovascular disease mortality
- Hypertension
- Polycystic ovary syndrome
- Urinary stress incontinence
- Osteoarthritis

The comorbidities of obesity may pose a serious threat to individuals within your organization.[5,6]

There are also ways that obesity can impact how the body responds to certain infections.[7]

The subsequent pages/sections will explore the above-mentioned comorbidities in more detail.

[a]The above list is not exhaustive and is intended to illustrate only a range of key complications.
[b]MASLD was formerly known as nonalcoholic fatty liver disease (NAFLD).

Prevalence of obesity and cases of comorbidities attributable to obesity

Obesity continues to be a significant concern in the United States, with its prevalence on a steady rise.[1]

- The adult obesity prevalence rate in the United States increased from 30.5% during the period of 1999-2000 to 41.9% for 2017-March 2020[8,a]
- The link between obesity and numerous severe diseases and health conditions is extensively documented[1]

Attributable cases of select obesity-related comorbidities, 2018[1,b]

Disease	Total Attributable Cases
Asthma	4,766,263
Congestive heart failure	1,481,286
Coronary heart disease	4,119,416
Type 2 diabetes	13,183,232
Dyslipidemia	17,881,860
Hypertension	35,048,396
Osteoarthritis	25,493,351
Stroke	1,841,188

By 2030, nearly **1** in **2** adults are projected to have obesity.[9]

[a]Age-adjusted data, adults aged 20 and over.

[b]Population attributable risk (PAR) was used to calculate the approximate number of cases of a particular disease that are attributed to obesity.[1]

The economic burden of obesity and associated health conditions

- Calculating the full economic impact of obesity is complex. Medical (direct) costs and missed workdays (indirect cost) are just part of the broader expenses linked to obesity[1]
- The combined (direct and indirect) estimated costs for people who have obesity with comorbidities are high; the costs are shown in the table below

Annual estimated costs attributable to obesity in select obesity-related comorbidities in the United States (2018 costs adjusted to 2023 costs)[1,a]

Disease	Direct Costs in Millions[b]	Indirect Costs in Millions[b]	Total Costs in Millions
Asthma	$10,041	$16,111	$26,152
Congestive heart failure	$7,326	$2,837	$10,164
Coronary heart disease	$20,373	$31,605	$51,979
Type 2 diabetes	$107,074	$198,668	$305,742
Dyslipidemia	$16,156	$0	$16,156
Hypertension	$33,746	$519,383	$553,129
Osteoarthritis	$60,421	$157,060	$217,480
Stroke	$12,518	$13,421	$25,939

[a]Inflation adjusted using the United States Consumer Price Index inflation calculator at https://data.bls.gov/cgi-bin/cpicalc.pl, with December 2018 and July 2023 as the index dates.

[b]Direct cost includes medical treatment and indirect costs were determined by lost workdays (absenteeism, etc), calculated as lost employee output.[1]

Obesity and certain weight-related comorbidities can increase risk of cardiovascular diseases[10]

- Obesity contributes to certain cardiovascular risk factors such as dyslipidemia, type 2 diabetes, and hypertension (HTN)[10]
- Every 5 kg/m^2 increase in body mass index (BMI) is associated with an increased risk of adverse cardiovascular outcomes for the following[11,a]:

Overweight and obesity are linked to increased cardiovascular disease risk[12]

A meta-analysis established a significant association between overweight and obesity with the incidence of cardiovascular diseases.[12]

	Obesity increases risk	
CAD	≥1.7x[12,b]	
Stroke	~1.5x[12,b]	Obesity is estimated to impact 18% to 44% of stroke patients[13]

CAD=coronary artery disease; CHD=coronary heart disease; HF=heart failure.

[a]Analysis was performed using 12 systematic reviews and 53 meta-analyses (including >501 cohort studies) and 12 Mendelian randomization (informing causality) studies that were published until January 2021 to evaluate the association between obesity-related indices and CVD risks (eg, coronary heart disease, heart failure, hypertension, etc). In this review, the all-cause and CVD-specific mortality risks increased with adiposity in cohorts, while there was no causal effect of adiposity on all-cause mortality demonstrated in the Mendelian randomization studies.[11]

[b]A meta-analysis was performed using 89 prospective cohort studies with a sample size of at least 200 subjects with risk estimates based on the incidence of disease. Incidence rate ratios and risk ratio proportions were used to obtain pooled risk ratios with 95% CIs to provide a review of the incidence of comorbidities related to obesity and overweight.[12]

Obesity and dyslipidemia: contributors to cardiovascular disease[14]

BMI (between 25 and 34.9 kg/m^2) and/or a high waist circumference may be associated with increased risk of type 2 diabetes, dyslipidemia, hypertension, and cardiovascular disease[10,15]

In clinical practice, waist circumference predicts health-risk more accurately than BMI alone.[14]

In one study, compared with individuals of normal weight, the prevalence of dyslipidemia was higher in those with overweight and obesity.[16,17,a]

↑**55%** adults with **overweight**

↑**74%** adults with **obesity**

Clinical data showed[18]:

- Weight reduction ranging from **2.5% to over 15%** is associated with **triglyceride reductions** (applicable across all BMI classes)
- Similarly, weight reduction ranging from **5% to over 15%** is associated with **increased HDL levels**, excluding BMI >40 kg/m^2

Obesity increases diabetes risk[14,19]

A meta-analysis suggests that obesity can increase the risk of T2D **6.7x in men** and **12.4x in women**.[12,b]

Overweight or obesity affects **90% of patients with diabetes**.[20]

According to the American Diabetes Prevention Program, an average body-weight reduction of ~6% (5.6 kg), achieved through lifestyle modification, reduced the incidence of diabetes by 58%.[21,c]

[a]The study analyzed NHANES survey data from 1999-2010, involving 10,568 adults aged 18 and older. Cardiovascular risk factors (eg, diabetes, hypertension, dyslipidemia, and smoking) were assessed. Prevalence and temporal trends of these risk factors within each BMI group were estimated.[16]

[b]A meta-analysis was performed using 89 prospective cohort studies with a sample size of at least 200 subjects with risk estimates based on the incidence of disease (9 studies met the inclusion criteria and were included). Incidence rate ratios and risk ratio proportions were used to obtain pooled risk ratios with 95% CIs to provide a review of the incidence of comorbidities related to obesity and overweight.[12]

[c]In this lifestyle intervention study, patients without diabetes (N=3243, average BMI=34 kg/m^2) with elevated fasting and post-load plasma glucose levels were randomly assigned to 1 of 3 groups: placebo, 850 mg metformin twice daily, or a lifestyle modification program. The program aimed for at least a 7% body weight loss and at least 150 minutes of weekly physical activity.[21]

The risk of developing MASLD is increased for patients with obesity[22,23,a,b,c]

Obesity is independently (ie, irrespective of other metabolic factors) linked with MASLD.[22,23]

- People with obesity have a **3.5-fold higher risk** of MASLD compared to lean individuals

Polycystic ovary syndrome (PCOS) and overweight or obesity

PCOS is one of the most prevalent (range 5% to 13%) endocrine disorders in reproductive-aged women.[24] Epidemiological data suggest that between **38% and 88% of women with PCOS** have either overweight or obesity.[25]

Obesity can exacerbate PCOS, which can lead to issues such as hyperandrogenism, hirsutism, and pregnancy complications.[26]

- Benefits in reproductive and metabolic outcomes can be achieved with a modest weight reduction of **5% to 10%**. Lifestyle changes demonstrate benefits even if women stay within the overweight or obesity range[26]

A systematic review and meta analysis showed that women with PCOS are almost twice as likely to have overweight (1.95 relative risk) and nearly three times as likely to have obesity (2.77 relative risk) compared to women without PCOS.[27,d]

Obesity may be associated with reproductive health issues, especially in women[28]

There is a **3% increased risk of infertility** associated with each 1-unit increase in BMI in women whose BMI is ≥19.5 kg/m^2.[29,e]

[a]MASLD (metabolic dysfunction-associated steatotic liver disease) was formerly known as non-alcoholic fatty liver disease (NAFLD).

[b]A meta-analysis of 21 cohort studies (13 prospective and 8 retrospective, with a total of 381,655 participants) was performed to assess the NAFLD risk associated with obesity or increased BMI. The data was analyzed for pooled relative risks (RRs) with 95% confidence intervals (CIs) using a random-effects model.[23]

[c]The data in these studies were utilizing the NAFLD definition.

[d]A systematic review and meta analysis was performed using a literature search using different search engines for studies reporting the prevalence of overweight, obesity, or central obesity in women with and without PCOS. The data were presented as prevalence (%) and RR (95% CI). Random-effect models were used to calculate the pooled RR.[27]

[e]The study's design was a cross-sectional analysis including 3623 adult females ages 18 to 45 using the NHANES database's 2013-2018 cycle. With BMI serving as the independent variable and reproductive status as the dependent variable, the survey's main goal was to investigate the association between infertility and BMI in women of childbearing age. The reproductive health questionnaire (eg, have you ever attempted to become pregnant over a period of at least a year without becoming pregnant?) was used to self-report infertility; a "yes" response indicated "infertile" status, while a "no" response was assumed to be "fertile" status.[29]

Obesity and overweight may be associated with cancers throughout the body[30]

Obesity and overweight have been linked with an increased risk of at least **13 types of cancer**, such as adenocarcinoma of the esophagus; cancers of the breast (in postmenopausal women), colon and rectum, endometrium (corpus uterus), gallbladder, gastric cardia, kidney (renal cell), liver, ovary, pancreas, and thyroid; meningioma, and multiple myeloma.[30]

Notably, 40% of all cancers diagnosed in 2014 were linked to overweight or obesity.[30]

Obesity's impact on the chest wall and lung mechanics: links to asthma and reactive airway disease[31]

Obesity affects ~38% of adults (aged 18 years and older) with asthma[31]

The risk of developing asthma is increased for people with overweight and obesity compared with individuals with a BMI in the normal range.[32,a]

Patients with severe or difficult to treat asthma and overweight or obesity who gained at least 5 pounds reported worse asthma control and a greater number of steroid bursts than those who had stable weight or lost at least 5 pounds.[33,b]

Classification[32]	BMI[32]	Increased risk[32]
Overweight	25 to <30 kg/m^2	12%
Class I Obesity	30 to <35 kg/m^2	37%
Class II Obesity	35 to <40 kg/m^2	64%
Class III Obesity	40 to <50 kg/m^2	97%
	≥50 kg/m^2	149%

The link between obesity and obstructive sleep apnea (OSA)

~45% of adults with obesity have OSA[34,c]

Individuals with mild OSA are 6x more likely to experience OSA progression if they gain 10% or more of their initial weight.[34]

The risk of OSA may decrease with increased physical activity.[35,36,d]

[a]This retrospective cohort study analyzed electronic health record data from 2012-2013, covering 2.8 million adults with a BMI of ≥23.0 kg/m^2 who were enrolled in 9 different health plans across the United States. The study investigated the association between obesity (body weight), asthma control, and the incidence of adult-onset asthma.[32]

[b]In this study, baseline and 12-month follow-up data of TENOR patients aged 18 years and older with severe or difficult-to-treat asthma were analyzed using 2396 patients (1730 women, 666 men). Patients were categorized into 3 groups (≥5 lb loss, stable, or ≥5 lb gain) based on a ±5 lb difference between baseline and 12-month follow-up weight. Five pounds were chosen for assessing weight gain or loss, because changes of that magnitude were sufficiently common in the cohort to allow for comparisons. Main objective of the study was to evaluate the effect of weight change on asthma control, asthma-related quality of life, asthma symptoms, and number of steroid bursts.[33]

[c]Obesity is only one of the risk factors for OSA.[34]

[d]In this prospective study, 50,332 women (Nurses' Health Study 2002-2012), 68,265 women (Nurses' Health Study II 1995-2013), and 19,320 men (Health Professionals Follow-up Study 1996-2012) were followed. Recreational physical activity and sedentary time were assessed every 2 to 4 years, and physician-diagnosed OSA incidence was identified via self report. Hazard ratios for OSA incidence associated with physical activity and sedentary behavior was determined using Cox models.[35]

Obesity contributes to soft tissue damage and osteoarthritis (OA) of the hip and knee[37]

Obesity may increase the risk of OA and is associated with an increased need for joint replacement surgery.[37,38]

Patients undergoing total joint arthroplasty in the United States[37]

A reduction of 5% to 10% in weight may improve knee functionality, walking speed and distance, and pain.[18]

Gastroesophageal reflux disease (GERD)

GERD affects up to 70% of people with severe obesity[39]

In one analysis, compared to people of normal weight, the likelihood of experiencing GERD symptoms was[40,a]:

1.5x greater	**2.0x greater**
People with **overweight**	People with **obesity**

A reduction of **5%** to **10%** of body weight in women and **≥10%** in men may reduce GERD symptoms.[41,b]

[a]A meta-analysis of published literature spanning from 1966-2004, this study explored the link between obesity (BMI) and GERD symptoms. The analysis was performed using the data from 9 pooled studies identified through a Medline search based on risk estimates and defined criteria for exposure and reporting outcomes.[40]

[b]In this prospective cohort study, 332 adult subjects (mean age 46 years, 66% women) were enrolled. Participants with overweight or obesity (BMI 25-39.9 kg/m^2) joined a structured weight reduction program involving dietary changes (including reduced calories), increased physical activity, and behavioral modifications. Baseline and 6-month assessments included measurements of BMI, waist circumference, and completion of a validated reflux disease questionnaire.[41]

The interrelationship between obesity and depression is complex

43% of adults aged ≥20 years in the United States with depression have obesity.[42]

There is a bidirectional connection between depression and obesity, with obesity increasing the risk of depression and vice versa.[43,44]

Association between obesity/overweight exposure and depression onset, and vice versa: findings from a systematic review and meta analysis

Overweight or obesity → depression[44]	Depression → overweight or obesity[44]
27% greater risk for people with overweight	**20% greater risk** of developing overweight
55% greater risk for people with obesity	**58% greater risk** of developing obesity

Obesity increases the risk of complications and adverse outcomes from acute illnesses and infections[45]

Obesity also affects respiratory infections[45]

Obesity can contribute to[45]:

- Greater risk of getting certain infectious diseases
- Greater infectious disease severity

In contrast to adults with a normal weight, the likelihood of hospitalization related to respiratory issues during the influenza season are[46,a]:

1.45x↑	2.12x↑
BMI 30.0 kg/m^2 to <35 kg/m^2	BMI ≥35.0 kg/m^2

[a]A cohort study conducted over 12 influenza seasons (1996-2008) in Ontario, Canada, included 82,545 respondents aged 18 to 64 years who had completed population health surveys. Individuals who had responded to a survey within 5 years prior to the beginning of an influenza season were enrolled for the study. Logistic regression was employed to investigate the association between self-reported BMI and hospitalization for specific respiratory diseases (pneumonia and influenza, acute respiratory diseases, and chronic lung diseases) in both the entire cohort and when stratified by chronic condition status for the analysis. The study's main focus was to assess hospitalization rates for pneumonia and influenza as its primary outcome measure.[46]

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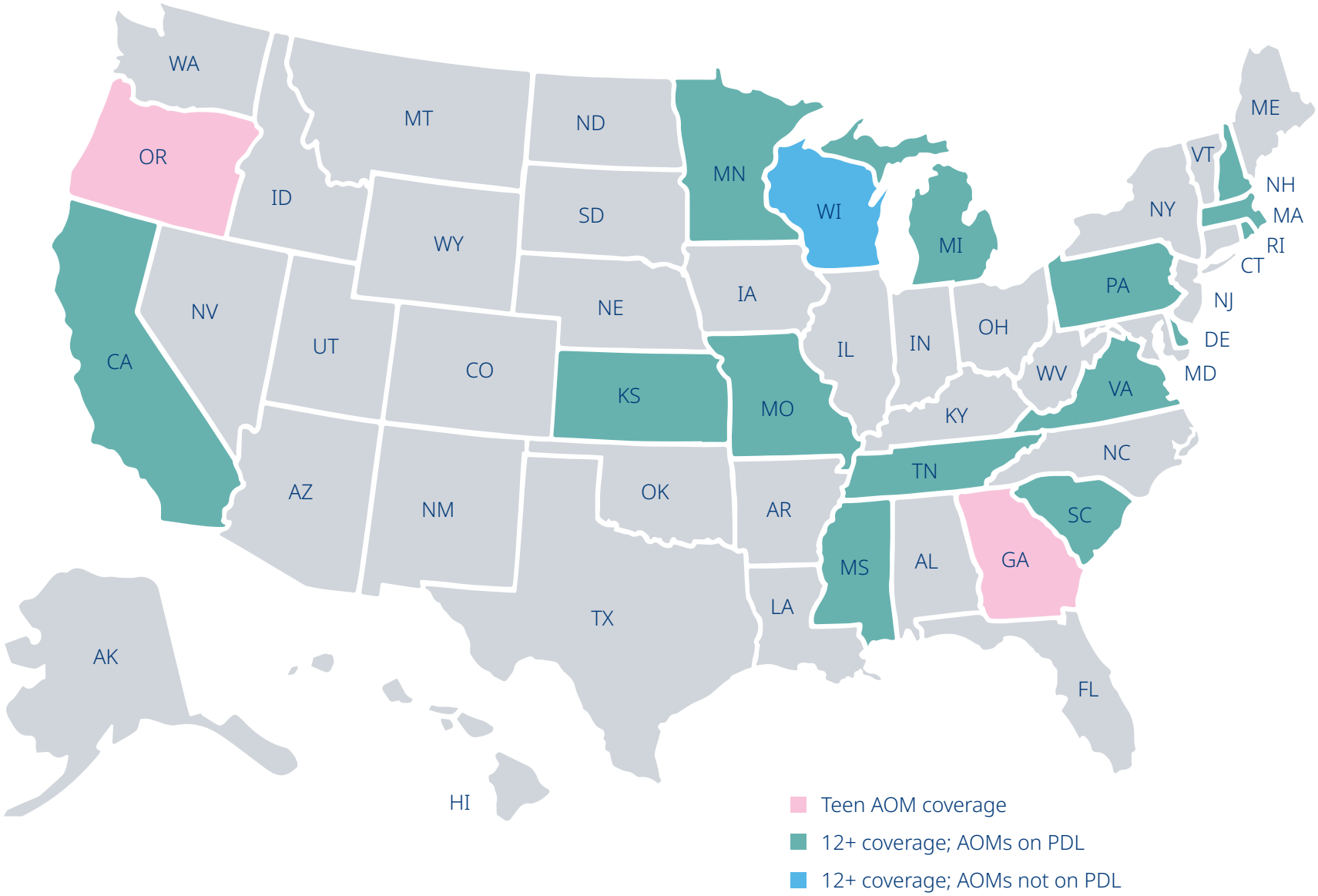
Anti-Obesity Medication (AOM) Coverage on Medicaid Fee-for-Service Plans by State, as of November 2025



PDL=prescription drug list.

Source: Data on File. Novo Nordisk Inc, Plainsboro, NJ.

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Medication Cost Modeling

Source: Medication cost model, produced by GlobalData, using publicly-available data. Funded by Eli Lilly. Shared with permission

Medication cost modeling

- 2yr modeling, discount rate 3% (value of money over time)
- 1 million Medicaid patients (age 18-80, from most recent data in Kaiser Fam Found), Also AHCCCS data
- Patients with obesity = 484,000
    - Reduction of this total number for numerous variables
    - Those without diabetes = 338,000
    - Those without cardiovascular disease = 316,000
    - 61% diagnosis rate = 206,000
    - 20% of those can be treated with Lifestyle counseling only. 2% referred to surgical treatment = 160,000
    - 80% using GLP-1 medication = 129,000, 20% using 1st gen med, # initiating care w/in 12mo–5% (very conservative, most are seeing 1-2%)=8k total and 7k for GLP-1 and 1k for 1st gen.
- Cost: $245. Calculate in an FMAP component (could ultimately be lower, 65% FMAP and 35% state responsibility). Dispense fee $10.
- Discontinuation: 50% short-term. 10% long-term.
- Total cost 2026-2027: 15mil, FMAP 5.2mil.
- Medical cost offset 3.5mil
- Net cost tx: 11.3mil total, 4mil state, 7.4mil federal.
    - Doesn't even include oral GLP-1s
- **State medicaid budget effect: +0.01% total budget, +0.49% drug budget**
- **Does not include anticipated cost savings to Medicaid and the Arizona Economy**

Data Sheets

Obesity Impact on Arizona Economy

Economic Benefits of Obesity Treatment--Literature Review

Detailed Summary of Trump Administration Announcement–11/6/2025

States in US that cover anti-obesity medication

Impact of Obesity and Weight-Related Comorbidities

Obesity's Impact on Arizona's Economy and Workforce in 2023

REDUCED ECONOMIC ACTIVITY BY $10.2B

67% of adults have obesity or overweight

$4.1B in higher healthcare, absenteeism, and disability costs to employers

$1.1B detrimental state budget impact

COST OF OBESITY ON ARIZONANS

Reduced Labor Force Participation
60,700 fewer adults with obesity working

Reduced Earnings for Employed Women
Women with obesity earn 9% less than women with healthy weight

Obesity-Attributed Early Mortality
9,500 premature deaths occur annually

Higher Medical Costs
$694M spending by households

COST OF OBESITY ON EMPLOYERS

$1B in higher healthcare costs to employers

$3.1B in health-related lost workdays and disability

2.0% reduction in Arizona's Gross Domestic Product (GDP)

5%-25% weight loss among adults age **<65 over 10 years** has potential to **save $5.4B-$17.9B** in medical costs

COST OF OBESITY ON STATE & LOCAL GOVERNMENT

$638M reduced tax revenues from lost economic activity

Medicaid	**$201M higher Medicaid spending**
Healthcare Coverage	**$200M for employee healthcare coverage**
Public Assistance Program	**$21M in public assistance program costs**
TOTAL	**$422M increased spending**

For more information: Consulting@globaldata.com

Access more factsheets & reports: https://www.globaldata.com/health-economics/US/

GlobalData

Economic Benefits of Obesity Treatment: Review of the Current Literature

This review synthesizes evidence from 31 studies published between January 2012 and June 2025 across a range of obesity treatment categories to evaluate the annual benefits per treated person:

Healthcare Cost Savings | **Quality of Life Value** | **Indirect Cost Benefits**

Strong evidence exists for healthcare savings and quality of life benefits from obesity treatment but the indirect economic benefits such as productivity improvements have not been rigorously studied

ote: All cost estimates in 2025 dollars

TREATMENTS CATEGORIES

Intensive Lifestyle Management

Intensive lifestyle management (diet, exercise, behavior support) yields ~5.2% weight loss

Metabolic/Bariatric Surgery

Surgery (bypass, sleeve, banding) yields ~24.8% weight loss in severe obesity

Obesity Medications

Obesity medications (OMs) are pharmacological treatments that work through mechanisms including appetite suppression, delayed gastric emptying, and improved glucose metabolism

Modern OMs

Incretin-based OMs (e.g., semaglutide, tirzepatide) achieving up to 20.1% average weight loss in trials

First-Generation OMs

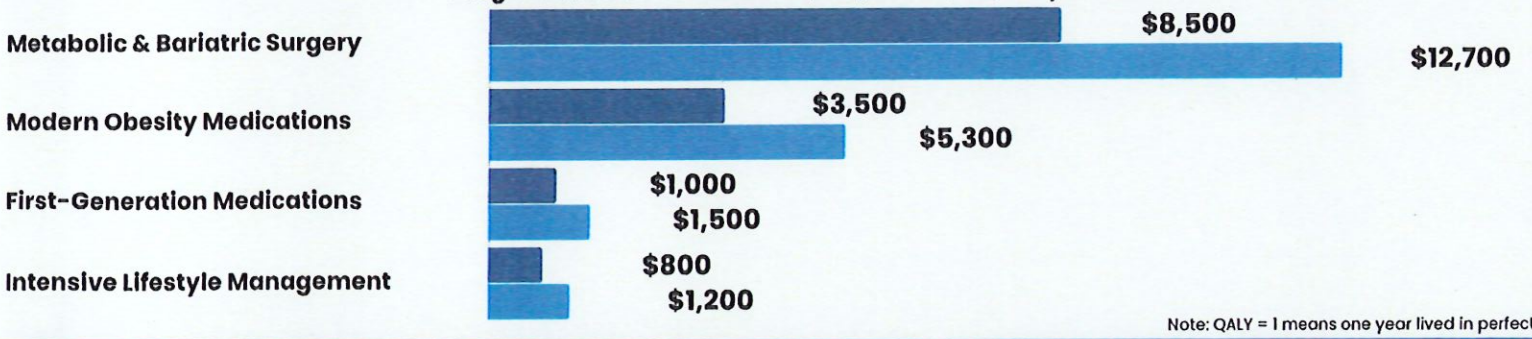
Prior FDA-approved OMs (orlistat, phentermine/topiramate, bupropion/naltrexone) yield ~5.2% weight loss

ESTIMATED ANNUAL HEALTHCARE COST SAVINGS

INTERVENTION TYPE	INSURANCE	ANNUAL HEALTHCARE COST SAVINGS - OBESITY	ANNUAL HEALTHCARE COST SAVINGS - OBESITY WITH DIABETES
Metabolic & Bariatric Surgery	Commercial	$1,880 - $2,780	$4,270 - $5,830
	Medicaid	$940 - $1,190	$2,180 - $2,430
Modern Obesity Medications	Commercial	$1,530 - $2,250	$3,460 - $4,720
	Medicaid	$760 - $960	$1,770 - $1,970
First-Generation Medications	Commercial	$400 - $580	$890 - $1,220
	Medicaid	$200 - $250	$460 - $510
Intensive Lifestyle Management	Commercial	$400 - $580	$890 - $1,220
	Medicaid	$200 - $250	$460 - $510

ANNUAL QUALITY OF LIFE YEAR (QALY) VALUE PER TREATED PERSON

Using established thresholds of $100,000 to $150,000 per QALY



Note: QALY = 1 means one year lived in perfect healt

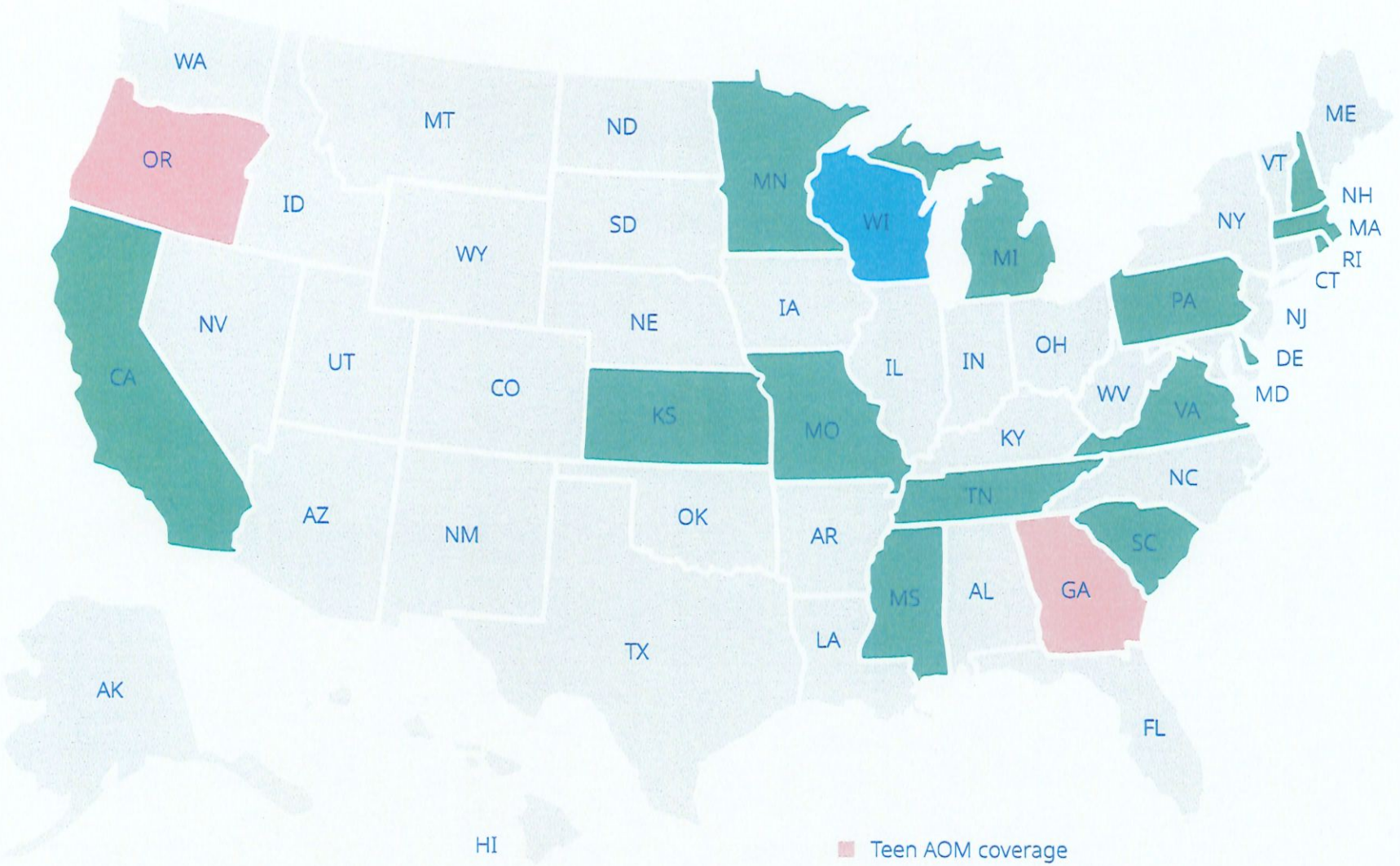
RECOMMENDATIONS

1. **Adopt comprehensive economic frameworks that capture healthcare savings, QALYs, and broader benefits for a more complete picture of obesity treatment value**
2. **Ensure access to the full spectrum of evidence-based treatments so patients and providers can choose the most effective, cost-efficient options**
3. **Align cross-payer value through policy risk-sharing arrangements, outcomes-based contracts, cross-payer coordination, and expanded public coverage**
4. **Support long-term treatment durability with ongoing clinical support, real-world data collection, and tailored patient-centered care**
5. **Strengthen evidence on indirect economic benefits, such as productivity gains and reduced disability costs, to capture obesity's full societal impact**

For more information: Consulting@globaldata.com

GlobalData

Anti-Obesity Medication (AOM) Coverage on Medicaid Fee-for-Service Plans by State, as of November 2025



PDL=prescription drug list.

Source: Data on File. Novo Nordisk Inc, Plainsboro, NJ.

 US23OB00574 December 2023

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THE DOCTOR DOUG PODCAST

💊 GLP-1 Medication Access & Pricing Reference

Summary of 2025 Trump Administration Announcement
Effective: Late 2025 – 2027 (Projected Rollout)

✅ Medications with Price Negotiations

Obesity-specific injections

- **Zepbound** – Eli Lilly
- **Wegovy** – Novo Nordisk

Diabetes-specific injections

- **Mounjaro** – Eli Lilly (same ingredient as Zepbound)
- **Ozempic** – Novo Nordisk (same ingredient as Wegovy)

Upcoming products

- **Wegovy (oral tablet, Novo):** expected early 2026; similar efficacy to injectable form
- **Orforglipron (Eli Lilly):** oral GLP-1 expected 2026 (early)
- **Next-generation injectables:** CagriSema (Novo) and Retatrutide, projected 2026–2027; FDA fast-track designation in progress

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💵 Self-Pay Pricing (If No Insurance Coverage)

New Federal Purchasing Platform: TrumpRx.gov (launch by end of 2025)

- Zepbound / Mounjaro – avg $346 per month (anticipate starting doses to be less expensive and higher pricing for higher doses)
- Wegovy / Ozempic – $350 per month (flat pricing)
- Prices negotiate to reduce progressively until reaching ≈ $245 per month by 2027
- GLP-1 tablets – starting doses $149 per month (higher doses TBD)

Manufacturer Direct Programs

- **Lilly Direct** (announced to be effective immediately, though not changed on website as of 11/10/2025)
    - Price reduction of $50 per dose per month
    - 2.5 mg vials $299 / month
    - 5 mg vials and higher dosing $449 / month
    - Multi-dose pen in development; vials eligible for discount; single-use pens insurance only

- **Novo Nordisk Direct:** no announced price reduction as of Nov 2025

🧾 Medicare Coverage (Pilot Program – 2026 Start)

Availability: Spring 2026 (Zepbound); later in 2026 (Wegovy)
Patient Out-of-Pocket Cost: $50 copay for approved uses
Eligibility Criteria

- **BMI ≥ 27** with prediabetes or cardiovascular disease (heart attack, stroke, PVD)
- **BMI ≥ 30** with prior conditions or uncontrolled hypertension, kidney disease, or heart failure
- **BMI > 35** for any patient

Notes

- Coverage retained for diabetes indications (for Ozempic and Mounjaro)
- Coverage for Wegovy in patients with liver disease (FDA-approved Aug 2025)--not yet announced
- Administration acknowledged coverage narrowed to "obesity with medical disease complications"

🏥 Medicaid

- Price of $245 per month is available for any state program that wants to enroll (and they encourage enrollment)
- Each state will need to determine their enrollment

🏢 Commercial Insurance

- RFK stated goal to make these medications available to all Americans, but private insurance would need to individually negotiate pricing with the manufacturers
- Commercial plans must **add GLP-1 coverage before price negotiations can begin**

📌 Key Takeaways

- TrumpRx.gov expected to reduce out-of-pocket GLP-1 costs by ≈ 70% by 2027.
- Medicare pilot establishes first-ever national coverage for anti-obesity medications with out-of-pocket costs at a fraction of prior costs
- Commercial and Medicaid coverage will need to be determined by those plans still
- Multiple new oral and injectable GLP-1 options anticipated by 2026–2027 at this current pricing

References:

Trump administration announcement--Fox News
CNBC article w/ details on the announcement
Interview with Dave Ricks, Eli Lilly CEO
Interview with Mike Doustdar, Novo Nordisk CEO

Forte Well-Being – Dr. Maready's Integrated primary care and obesity medicine (Arizona)
👉 www.Forte-Wellbeing.com | **@fortewellbeing**

Arizona Obesity Organization (AOO) – Non-profit advocacy and education
👉 www.ArizonaObesity.org | **@ArizonaObesityOrganization**

Doctor Doug Podcast & Social Channels
🎧 YouTube: @doctor.dougmd
📘 Facebook: Doug Maready
📸 Instagram: @doctor.dougmd
🎵 TikTok: @doctor.dougmd

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Obesity Treatment Study Committee 11.13.25

Steve Berg
Legislative Specialist

Current AHCCCS Obesity and Obesity-related Covered Treatments

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Disease/Chronic Care Management

- Pursuant to AMPM 1023 (Disease/Chronic Care Management), AHCCCS requires its managed care organizations (MCOs) to implement a Disease/Chronic Care Management Program that focuses on members at high risk and/or with chronic conditions that have the potential to benefit from a concerted intervention plan.
- AHCCCS covers disease/chronic care management services for FFS members determined to be at risk for, or already experiencing, poor health outcomes due to their disease burden or chronic conditions.

Nutritional Therapy

- According to AMPM 310-GG (Nutritional therapy, Metabolic Foods, and Total Parenteral Nutrition), AHCCCS covers Medical Nutritional Therapy services provided by a registered dietician when determined to be medically necessary and referred by the members PCP or the Specialist that manages the chronic disease.
    - Medical nutritional therapy services means nutritional assessment and intervention services provided by a registered dietician, which may include nutrition education and behavioral counseling, to prevent and/or manage a medical condition and improve health outcomes.

MCO Efforts to Combat Obesity

- Molina Health has a "MyHealth Weight Management Program" that assigns a case manager that works closely with the member to develop a weight management plan of care that is individualized to meet the member's needs and assist the member in achieving their weight loss goals.
- Molina Health also has a "MyHealth Nutrition Consult Program" to support member's health educational needs relative to nutrition.
    - The program assigns a registered dietician to work closely with the member and their doctor to understand the member's health concerns and the connection between nutrition and health management.

MCO Efforts to Combat Obesity

- Together, the member's team will develop a nutrition plan of care that is individualized to meet the member's needs and provides the member with more tools and resources needed to be able to better self-manage the member's health conditions.

- AZ Complete Health utilizes the "AzCH Disease Management Program" that focuses on seven targeted high-risk conditions, providing comprehensive support to address the whole person.
    - The care team includes experienced care managers and a dedicated health coach who work collaboratively to ensure members are connected to providers, specialists, medications, and equipment necessary to manage their conditions.

MCO Efforts to Combat Obesity

- The health coach plays a key role in educating and supporting members on the importance of lifestyle modification and its impact on overall health and well-being.
- This integrated team partners internally and with community agencies to meet all member needs, driving optimal outcomes through coordinated care.

Diabetes Self-Management

- AHCCCS covers up to 10 program hours annually of diabetes outpatient self-management training services to members with a new or existing diabetes diagnosis.

GLP-1

- AHCCCS currently does not cover GLP-1 for the treatment of obesity.
- For the treatment of type 2 diabetes, members must have a documented failure of non GLP-1 treatments (metformin).
- AHCCCS also covers 1 GLP-1 Receptor Agonist (Wegovy) in specific circumstances to reduce the risk of major adverse cardiovascular events when medically necessary and approved via prior authorization.

Bariatric Surgery

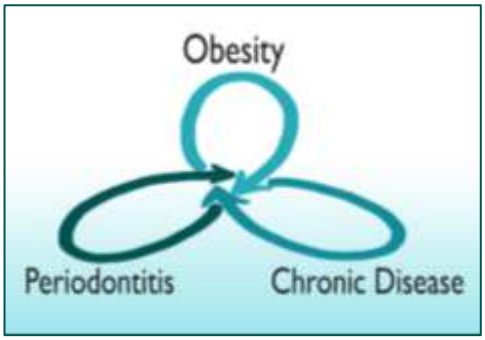
- AHCCCS covers bariatric surgeries when medically necessary but does not cover elective bariatric surgeries.
    - Procedures include Gastric Sleeve (LSG), Roux-en-Y Gastric Bypass (RYGB), Duodenal Switch (BPD-DS), etc.
    - Comorbidities include Type 2 diabetes, obstructive sleep apnea, etc.

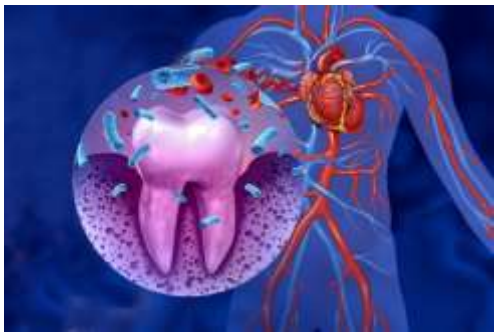
Thank you

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

The Nexus Between Obesity, Chronic Disease, and Periodontitis

AZOHC
Arizona Oral Health Coalition





Periodontal Disease

- Periodontitis is a **chronic health** condition characterized by inflammation of the gums caused by bacterial deposits on the teeth.
- One of the most prevalent diseases, periodontitis affects **42% of adults 30 years or older, with 7.8% having severe periodontitis.**

Diabetes

- Risk of periodontitis is **3x higher** in patients with diabetes, and unmanaged diabetes is associated with more severe periodontal destruction.
- Periodontal therapy can **reduce HbA1c levels** and **improve glycemic control**, but these impacts don't last if diabetes is not effectively managed.

Hypertension

- Patients with periodontitis have a **22% increased risk of hypertension**, and patients with hypertension have more severe periodontal destruction.
- Unmanaged hypertension affects eligibility for dental treatment due to risk of **stroke**.
- Hypertension medications have oral side effects.

Quality of Life

- Tooth loss affects the ability to eat a **nutritious diet**.
- By affecting speech and smiling, tooth loss may cause self-esteem issues, reduced social interaction, and **harms to mental health** and community cohesion.
- A visible tooth gap is shown to be a **barrier to employment**.

Obesity Treatment Study Committee Responses

1) **We understand that state employee health insurance currently excludes coverage "for all medications administered for the purpose of weight loss/obesity," including GLP-1 drugs prescribed for that purpose. Can you confirm our understanding is correct?**

   That is correct. The weight loss/obesity exclusion on prescription drugs for state employee health insurance was implemented in the early 2000s.

2) **We were asked to have ADOA estimate the fiscal impact of implementing GLP-1 coverage provisions for state employees similar to what was outlined in President Trump's recent announcement for Medicare. Specifically, we understand those provisions to include:**
   a) **Coverage of Wegovy and Zepbound for obesity/weight loss**
   b) **Application of a $50 monthly copayment for state employees using Wegovy/Zepbound specifically for weight loss**

ADOA assumes an estimated 37,923 State Employee Health Insurance members would qualify as obese without diabetes (approximately 25% of membership). We assume 23%, or 8,722 members, would opt into treatment if it were covered by insurance. Under the TrumpRx plan, the net cost per member would be $3,600 (allowed cost minus copays). The cost to implement this coverage would be $31.4 million. As a self-insured (non-Medicaid) plan, HITF does not have access to TrumpRX plan rates.

3) **We were also asked that you provide the following:**
   a) **The average monthly/annual cost to HITF of GLP-1 drugs for state employees currently using GLP-1s to treat Type 2 diabetes. Please indicate the number of members and the cost per member in your estimates.**

GLP-1 coverage for Diabetics (2025 Actual)	
Distinct Members	3,254
Guarantee Rebates	-$9,786,395
Plan Paid	$37,890,391
Net Annual Costs	$28,103,996
Net **Annual** Plan Paid per member	$8,637

   b) **The projected monthly/annual cost to HITF of providing GLP-1 drugs to state employees with pre-diabetes. Please indicate the number of members and the cost per member in your estimates.**

ADOA assumes an estimated 13,374 State Employee Health Insurance members have a pre-diabetes diagnosis. We assume 16%, or 2,182 members, would opt into treatment if it were covered by insurance. Under the TrumpRx plan, the net cost per member would be $3,600 (allowed cost minus copays). The cost to implement this coverage would be $7.9 million. As a self-insured (non-Medicaid) plan, HITF does not have access to TrumpRX plan rates.

c) **Modeling showing the lifetime health care expenses for an employee who takes GLP-1 drugs to treat Type 2 diabetes versus the lifetime health care expenses for a state employee receiving GLP-1 drugs to treat pre-diabetes.**

Estimated Net Lifetime Cost of an Employee		
	no GLP-1 usage	**W/ GLP-1 usage**
With Type II Diabetics	$3,631,484	$5,194,151
With Prediabetes	$2,253,441	$4,622,974
(net of the reduction cost of Obesity)		
Assumptions:		
Employee age		20
Retirement age		65
Coverage years		45
Average trend over 40 years		6%

Interim agendas can be obtained via the Internet at http://www.azleg.gov/Interim-Committees

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

OBESITY TREATMENT STUDY COMMITTEE

Date: **Thursday, November 13, 2025**

Time: **12:00 P.M.**

Place: **SHR 2**

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025111006

AGENDA

1. Call to Order
2. Member Introductions
3. Overview of Obesity in Arizona, Arizona Department of Health Services
4. Treatment Options for Obesity
5. Current Insurance Coverage Landscape, Arizona Health Care Cost Containment System
   - ~~Arizona Department of Insurance and Financial Institutions~~
   - ~~Arizona Health Care Cost Containment System~~
6. Panel Discussion: Patient & Provider Perspectives
7. Committee Discussion & Next Steps
8. Public Testimony
9. Adjourn

Members:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Cindy Komar
Dr. Christine Lovato
Dr. Douglas Maready

Representative Julie Willoughby, Co-Chair
~~Representative Patricia Contreras~~
Representative Elda Luna-Nájera
Amy McCallister
Emily Moree, Designee
Dr. Kiran Raman, Designee

~~11/07/2025~~
~~11/10/2025~~
11/12/2025
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For questions regarding this agenda, please contact Senate Research Department.
Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602) 926-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

Appendix B:

November 25, 2025

Minutes and Reference Materials

ARIZONA STATE LEGISLATURE

OBESITY TREATMENT STUDY COMMITTEE

Minutes of the Meeting
November 25, 2025
1:00 P.M., SHR 1

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025111013

Members Present:

Senator David Gowan, Co-Chair
Julie Hoffman
Cindy Komar
Dr. Douglas Maready
Amy McCallister
Representative Julie Willoughby, Co-Chair
Representative Patricia Contreras
Emily Moree, Designee
Dr. Kiran Raman, Designee

Members Excused:

Senator Sally Ann Gonzales
Dr. Christine Lovato

Staff:

Michael Madden, Senate Research Analyst
Samuel Rosenberg, Senate Assistant Research Analyst
Ahjahna Graham, House Senior Research Analyst

Co-Chair Gowan called the meeting to order at 1:07 p.m. and attendance was taken.

HEALTH AND ECONOMIC COST OF OBESITY TO ARIZONA

Tim Dall, Executive Director, Life Sciences Consulting, distributed and explained a PowerPoint presentation entitled "Economic Analysis of Obesity Treatment Coverage in Arizona's Medicaid Program" (Attachment A).

CURRENT MEDICAID COVERAGE AND EXPANSION CONSIDERATIONS

Steve Berg, Legislative Specialist, Arizona Health Care Cost Containment System, distributed and explained a PowerPoint presentation entitled "Arizona Health Care Cost Containment System, Obesity Treatment Study Committee 11.25.25" (Attachment B) and answered questions posed by the Committee.

The Committee offered comments.

PRIVATE INSURANCE COVERAGE LANDSCAPE

Sterling Gavette, Product Filing and Compliance Manager, Arizona Department of Insurance and Financial Institutions, distributed and explained a PowerPoint presentation entitled "Private Insurance Coverage for Obesity Treatments" (Attachment C), handouts entitled "7.10 Continuing or Follow-up Treatment" (Attachment D) and "CMS, Center for Medicare and Medicaid Services" (Attachment E).

STATE OF ARIZONA EMPLOYEE HEALTH PLAN COVERAGE AND EXPANSION ANALYSIS

Chandler Coiner, Joint Legislative Budget Committee, distributed and explained a PowerPoint presentation entitled "State Employee Health Insurance – Coverage of Obesity Treatments" (Attachment F) and a handout entitled "Arizona" (Attachment G). Mr. Coiner answered questions posed by the Committee.

Paul Shannon, Director, Benefit Services Division, Arizona Department of Administration, answered questions posed by the Committee.

TREATING OBESITY IN TRIBAL AND RURAL POPULATIONS

Melinda White, Chief Executive Officer, Sage Memorial Hospital, distributed and explained a PowerPoint Presentation entitled "Sage Memorial Hospital, SB 1711 Obesity Study Committee Presentation" (Attachment H) and answered questions posed by the Committee.

COMMITTEE DISCUSSION

Dr. Douglas Maready, Committee Member, President, Arizona Obesity Organization, distributed and explained a PowerPoint Presentation entitled "Arizona Ranks 49th out of 50 (almost last) in Obesity-Related Policy, Recommendations for the Obesity Committee" (Attachment I) and a handout entitled "Why Does Arizona Rank 49th out of 50 in Obesity-Related Policy? Recommendations for the Obesity Committee" (Attachment J). Dr. Maready answered questions posed by the Committee.

The Committee offered comments.

PUBLIC TESTIMONY

Jennifer J. Burns, Children's Action Alliance, Director, Government Relations and Health Policy, offered testimony and answered questions posed by the Committee.

Taron Walstad, Arizona Oral Health Coalition, offered testimony, distributed a handout entitled "The Nexus Between Obesity, Chronic Disease, and Periodontitis" (Attachment K) and answered questions posed by the Committee.

There being no further business, the meeting was adjourned at 3:05 p.m.

Respectfully submitted,

Jackson Cooper
Committee Secretary

(Audio recordings and attachments are on file in the Secretary of the Senate's Office/Resource Center, Room 115. Audio archives are available at http://www.azleg.gov)

Arizona Ranks 49th out of 50 (almost last) in Obesity-Related Policy

Recommendations for the Obesity Committee

Dr. Doug Maready — President, Arizona Obesity Organization

Arizona State Senate Obesity Committee — November 25, 2025

Deficiencies in Current Policies

- No recognition of obesity as a disease — we must be united on this.
- Arizona lacks a statewide obesity response strategy (the 2014–2017 Action Plan is outdated).[1]
- No coverage for obesity medications in Medicaid.
- Limited coverage for bariatric surgery.

1) https://impact.economist.com/health/obesity-response-index/us

Deficiencies in Current Policies

- No effective, statewide programs for healthy behaviors and obesity prevention.
- No tax laws to deter unhealthy consumption (including ultra-processed foods/drinks).
- Inadequate school lunch nutrition policy and access to healthy food.
- Inadequate exercise/physical activity policies for schools and workplaces.

Priority Actions Now

- Approve coverage for obesity medications (adopt criteria consistent with the Medicare expansion proposed for 2026).
- Broaden bariatric surgery coverage with clear, evidence-based eligibility criteria.
- Create an Obesity Response Committee to study and recommend policies that support:
  - Defining obesity as a disease
  - Analyzing the gaps in state policy and recommending policy changes to fill those gaps
  - Addressing obesity prevention through state policy recommendations and public health initiatives

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Emergency Transportation/Ambulance	Yes	Covered	No				
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	Yes	Covered	No			The following bariatric procedures are excluded: 1. Open vertical banded gastroplasty; 2. Laparoscopic vertical banded gastroplasty; 3. Open sleeve gastrectomy; 4. Open adjustable gastric banding.	1. The patient must have a body-mass index (BMI) ≥35. 2. Have at least one co-morbidity related to obesity. 3. Previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record: Active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components: a. Weight b. Current dietary program c. Physical activity (e.g., exercise program) 4. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by your Health Network to perform bariatric surgery. 5. The member must be 18 years or older, or have reached full expected skeletal growth.
Cosmetic Surgery	No	Not Covered	No				Cosmetic surgery or procedures excluded, other than to treat congenital defects and birth abnormalities.
Skilled Nursing Facility	Yes	Covered	Yes	90	Day(s) per Year		
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				Newborn benefits do not apply to the newly born child of an Eligible Dependent daughter unless placement with the Employee is confirmed through a court order or legal guardianship.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Prosthetic Devices	Yes	Covered	No			1. Any biomechanical devices. Biomechanical devices are any external prosthetics operated through or in conjunction with nerve conduction or other electrical impulses; 2. Replacement of external prosthetic appliances due to loss or theft; and 3. Wigs or hairpieces (except where indicated in column "I").	The Plan covers the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury, congenital defect, or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns. External prosthetic appliances shall include artificial arms and legs, wigs, hair pieces and terminal devices such as a hand or hook. Wigs and hair pieces are limited to one per Plan Year and $150 maximum. Members must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns with a submitted claim for coverage. All other diagnosis are excluded. Replacement of artificial arms and legs and terminal devices are covered only if necessitated by normal anatomical growth or as a result of wear and tear.
Infusion Therapy	Yes	Covered	No				Infusion/IV Therapy in an Outpatient setting including, but not limited to: Infliximab (Remicade), Alefacept (Amevive), and Etanercept (Enbrel).
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				Benefits are payable for covered services and supplies which are necessary to treat TMJ disorder which is a result of: 1. An accident; 2. Trauma; 3. A congenital defect; 4. A developmental defect; or 5. A pathology.
Nutritional Counseling	Yes	Covered	No				Covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to: 1. Morbid obesity 2. Diabetes 3. Cardiovascular disease 4. Hypertension 5. Kidney disease 6. Eating disorders 7. Gastrointestinal disorders 8. Food allergies 9. Hyperlipidemia

7.10 Continuing or Follow-up Treatment

Continuing or follow-up treatment by providers out of the Service Area is not covered unless it is Pre-Certified by the Medical Management Organization.

7.11 Ambulance Service

Ambulance services to/from an appropriate provider or facility are covered for emergencies. Pre-Certification/Prior Authorization for non-emergency ambulance services may be obtained from the Medical Management Organization by a provider that is treating the Member.

Covered Expenses include charges for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided.

7.12 Bariatric Surgery

The plan covers the following bariatric surgery procedures: open roux-en-y gastric bypass (RYGBP), laparoscopic roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS), laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and laparoscopic sleeve gastrectomy (LSG) if all the following criteria are met:

1. The patient must have a body-mass index (BMI) ≥35.
2. Have at least one co-morbidity related to obesity.
3. Previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record:

   Active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:

   a. Weight
   b. Current dietary program
   c. Physical activity (e.g., exercise program)

4. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by your Health Network to perform bariatric surgery.

5. The member must be 18 years or older, or have reached full expected skeletal growth.

If treatment was directly paid or covered by another plan medically necessary adjustments will be covered.

The following bariatric procedures are excluded:

1. Open vertical banded gastroplasty;
2. Laparoscopic vertical banded gastroplasty;
3. Open sleeve gastrectomy;
4. Open adjustable gastric banding.

7.13 Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following services and supplies are covered:

1. Surgical services for reconstruction of the breast on which the mastectomy was performed;
2. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
3. Post-operative breast prostheses; and
4. Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatments of physical complications, including lymphedema, are covered.

7.14 Cancer Clinical Trials

Coverage shall be provided for Medically Appropriate covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment

7.44 Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from mental health and substance abuse services:

1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Appropriate and otherwise covered under this Plan;
2. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
3. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice;
4. Developmental disorders, including but not limited to:
   a. developmental reading disorders;
   b. developmental arithmetic disorders;
   c. developmental language disorders; or
   d. articulation disorders.
5. Counseling for activities of an educational nature;
6. Counseling for borderline intellectual functioning;
7. Counseling for occupational problems;
8. Counseling related to consciousness raising;
9. Vocational or religious counseling;
10. I.Q. testing;
11. Marriage counseling;
12. Custodial care, including but not limited to geriatric day care;
13. Psychological testing on children requested by or for a school system;
14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and
15. Biofeedback is not covered for reasons other than pain management.

7.45 Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension

5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

7.46 Self-Management Training

Chronic Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

7.47 Obstetrical and Gynecological Services

Obstetrical and gynecological services are covered when provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

7.48 Organ Transplant Services

Human organ and tissue transplant services are covered at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations. Due to the specialized medical care required for transplants, the Provider Network for this specific service may not be the same as the medical network in which you enrolled.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is an

Private Insurance Coverage for Obesity Treatments

Arizona Department of Insurance and Financial Institutions
Presentation to the Senate Obesity Treatment Study Committee – November 25, 2025

Sterling Gavette, Product Filing and Compliance Manager
Gio Espinosa, Assistant Director, PFC Division

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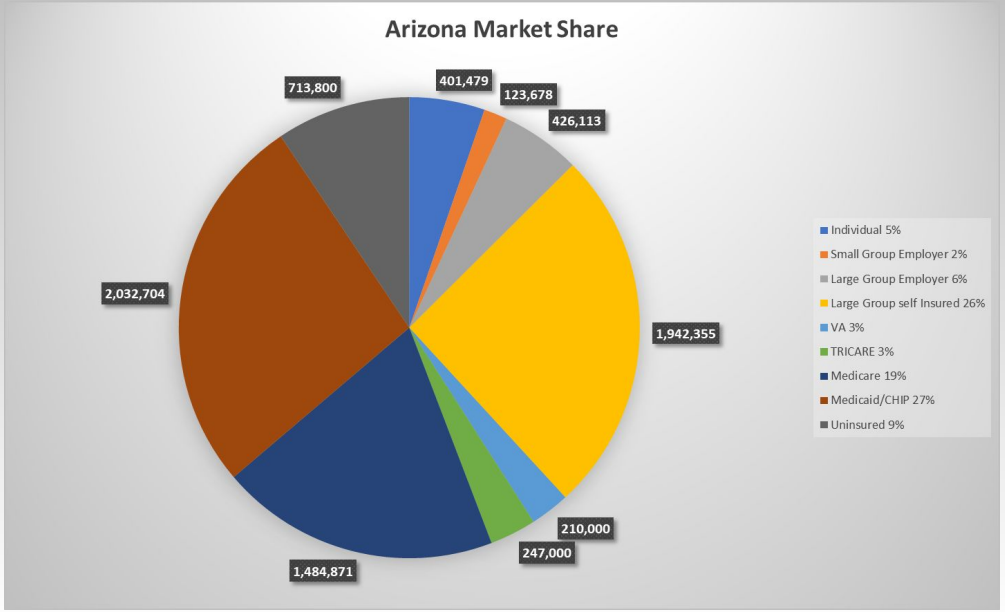
Arizona Private Health Insurance Market



- DIFI estimates that only 13% of the Arizona population is covered by private insurance
  - ↳ 951,270 covered lives
- About 9% of Arizonans are uninsured
- The rest of the state is covered by employer self-insured plans, the VA, TRICARE, Medicare, or Medicaid

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Essential Health Benefits (EHBs)

The federal Affordable Care Act (ACA) requires all major medical plans in the individual and small group market to include coverage for 10 EHBs:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including vision and dental care

EHB Benchmark Plan

- The ACA requires states to designate an EHB-benchmark plan that establishes all of the health benefits that must be covered by ACA compliant plans and include all of the required benefits within the 10 EHBs (45 CFR § 156.10 *et seq.*)
  - ↳ Arizona designated the 2014 state employee plan as the state's EHB benchmark plan

Coverage of Obesity Treatments

Arizona's EHB benchmark plan requires the following coverages related to obesity:

1. Bariatric surgery
   - ↳ Covered when all of the following apply:
     - BMI ≧ 35
     - At least one comorbidity related to obesity
     - Previously unsuccessful with medical treatment for obesity
2. Nutritional counseling
   - ↳ Covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including morbid obesity

Coverages Offered by Private Insurers

- Coverages provided by Arizona's major medical carriers closely mirror those required by the EHB benchmark plan
- Exclusions*: In general, private health plans exclude coverage of treatments, programs, surgeries, and medications primarily for the purpose of weight management (no comorbidity present)
  - ↳ Some plans may cover such treatments with prior authorization
  - ↳ No insurers are prohibited from providing such coverage

** Exclusions and coverages differ from plan to plan. Consumers should refer to their plan documents to determine their coverages.*

Questions?

ARIZONA
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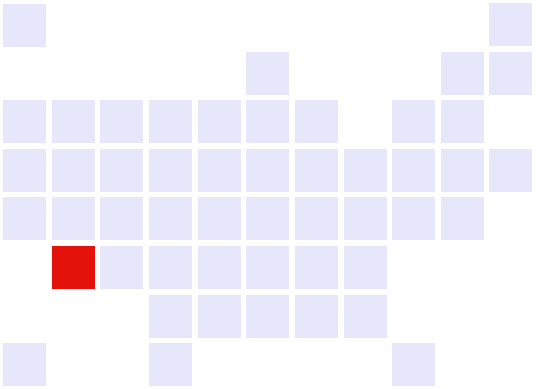
Arizona

Obesity is one of America's most urgent health challenges. Almost half of adults—around 117m people—are living with obesity.[1,2] Without policy intervention, that share could rise to two-thirds by 2050.[3] One in five children is already living with obesity, with many likely to carry it into adulthood, increasing the risk of lifelong health complications.[4]

The outlook is not all bleak. Obesity is a chronic, relapsing disease, but with inclusive policies and coordinated, cross-sector action, it can be prevented and managed effectively.

Economist Impact's United States Obesity Response Index, supported by Eli Lilly and Company, evaluates US state efforts to prevent and manage obesity. It uses 23 indicators across three pillars to assess: the strength of obesity policy and access to care; access to affordable, nutritious food at home and in schools; and opportunities for physical activity. The Index highlights where action is most needed and where states can learn from each other.

This state profile highlights some of the actions Arizona is taking to address obesity.



Score	Rank
38.8/100	49/50

Background indicators:

Adult obesity prevalence (%)	32
Childhood obesity prevalence (%)	19
Median household income (US$)	82,660
Healthcare spending per capita (US$)	84

State overview

Obesity-related policy

Arizona lacks a current statewide obesity strategy. The most recent plan, the Action Plan for Improving Arizonans Well-being through Healthy Eating and Active Living for 2014-2017, has not been updated.[25] Obesity is no longer a priority area in the state's current health improvement plan, and there is no legal recognition of obesity as a chronic disease or protection against weight-based discrimination.[26]

Access to evidence-based obesity care

Arizona's Medicaid covers three of the four core components of comprehensive obesity care—nutrition counselling, metabolic and bariatric surgery, and intensive behavioural therapy—but does not cover obesity medications.[27] While several Medicaid providers offer Healthy Behaviour Incentive Programmes, there is no evidence that they target weight loss.[28,29]

Nutrition regulation and food practices in schools

Arizona does not tax unhealthy food or drinks, and local governments are prohibited from using taxes to deter unhealthy food and drinks consumption.[30] In schools, the state mandates nutrition education from kindergarten through to 12th grade and implements minimum nutrition standards for school food that align with federal guidelines, including limits on sugar and fat, and requirements for fruits and vegetables in school meals.[31,32] Public schools are required to offer free or reduced-price meals to low-income students, but the state does not mandate universal free school meals.[33]

Opportunities for physical activity

The state supports activity in the workplace and childcare centres, and implements an Active Transportation Program that aims to reduce reliance on motorised transit and encourages walking and cycling.[34,35,36] However, Arizona does not mandate physical activity in schools (the US Department of Health and Human Services recommends that children and adolescents undertake 60 minutes of exercise per day).[37]

Why Does Arizona Rank 49th out of 50 in Obesity-Related Policy? Recommendations for the Obesity Committee

Dr. Doug Maready — President, Arizona Obesity Organization
Arizona State Senate Obesity Committee — November 25, 2025
Email: aoopresident@gmail.com

Deficiencies in Current Policies

- **No recognition of obesity as a disease** — the state must adopt a unified definition so agencies and payers speak the same language.
- **No current statewide Obesity Response Strategy** (the Action Plan for Healthy Eating & Active Living, 2014–2017, is outdated).
- **No Medicaid coverage for obesity medications.**
- **Limited coverage for bariatric surgery.**
- **No effective statewide programs** to support healthy behaviors and obesity prevention.
- **No fiscal/tax policies** to deter consumption of unhealthy and ultra-processed foods and drinks.
- **Inadequate school lunch nutrition policy** and limited access to healthy food in schools.
- **Insufficient exercise/physical-activity policies** for schools and workplaces.

Priority Actions (recommended)

1. **Recommend to approve coverage for obesity medications** (adopt criteria consistent with the Medicare expansion proposed for 2026).

2. **Broaden bariatric surgery coverage with clear, evidence-based eligibility criteria.**

3. **Create an Obesity Response Committee to study and recommend policies that support**:
    - Defining obesity as a disease
    - Analyzing the gaps in state policy and recommending policy changes to fill those gaps
    - Addressing obesity prevention through state policy recommendations and public health initiatives

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Sources / Notes

Economist Impact — United States Obesity Response Index (Arizona snapshot); GlobalData — Economic Analysis of Obesity Treatment Coverage for Arizona Medicaid. Data and economic modeling shared with the Arizona Obesity Study Committee informed these recommendations.

State Employee Health Insurance – Coverage of Obesity Treatments

November 25, 2025

JLBC

Trump Admin Announced Agreements With Drug Manufacturers
- Price Impacts Limited to Medicare, Medicaid, and the Uninsured

- On November 6, 2025, the Trump Administration announced a series of agreements with drug manufacturers to lower the prices of glucagon-like peptide-1 (GLP-1) drugs.
  - Discounts available when purchasing GLP-1s without insurance.
  - Medicare/Medicaid programs will pay lower prices for GLP-1s.
  - Medicare enrollees that meet certain criteria will pay a $50 monthly copay for GLP-1 weight loss drugs.
- These agreements do not directly impact employer-based coverage.

AZ State Health Plan Spends $28 M on GLP-1s

- Coverage Does Not Include Weight Loss Treatment

- Health plan for active/retired state employees covers several GLP-1s for treatment of diabetes and other conditions.
  - The plan does not cover any drug solely for the purpose of weight loss/obesity.
- In Plan Year 2025, spending on GLP-1s was $28 M.
  - 3,254 plan enrollees used GLP-1 drugs to treat Type 2 diabetes.
  - Average annual amount paid per member was $8,637.

Expanding GLP-1 Coverage Estimated to Cost $39 M

- To estimate the cost of expanding coverage for treating prediabetes ($8 M) and obesity ($31 M), the ADOA actuary assumes:
  - 2,200 prediabetic members opt in (16% of those w/prediabetic diagnosis).
  - 8,700 obese members opt in (23% of obese members w/o diabetes).
  - $3,600 annual plan cost per member.
- The $39 M represents the direct costs of coverage.
  - ADOA assumes lifetime net costs of diabetics and prediabetics are greater w/GLP-1 usage.

How AZ State Health Plan Costs Are Funded

- The $39 M in additional costs would be paid for via the Health Insurance Trust Fund (HITF).
- HITF is primarily funded from 2 sources (overall system split 90/10):
  1. Employer premiums (i.e. state agencies and universities), of which the General Fund pays for approximately 46%.
  2. Employee premiums (active and retirees).

Sage Memorial Hospital
NAVAJO HEALTH FOUNDATION

Sage Memorial Hospital

SB 1711 Obesity Study Committee Presentation

Sage Memorial Hospital

Obesity Data, Impacts, and Challenges

SMH serves approx.

12,000
community members

BMI >30kg/m2

3,493
Relatives

Specialists Referrals

6,574
referrals

Dollars spent on

transportation to higher level of care
$584,314

Dollars spent on

Specialty/hospital/ DME external care services
$2,092,838

Challenges

- No running water – water desert
- Distance to travel to store – grocery store location – food desert
- Convenient Stores offer high processed foods
- Fast food availability
- Electricity issue – no freezer or refrigerator
- Unresolved historical trauma
- Technology

Source: FY2026 Meditech Data

Clinical Resources

Clinical Disease Management

Clinical Services – Patient Centered Care

Care moves from Clinical Setting to Community/Home Setting for continuity and integration of care coordination

Patient-Centered Care Team

- Provider, RN Care Coordinator/Case Manager, Medical Assistant
- Medication Reconciliation (consider stopping medications that promote weight gain)
- Medication treatment plan based on diagnosis and co-morbidities
  - (dulaglutide, tirzepatide, semaglutide)
- Diabetes / High-Risk Clinic - Multidisciplinary approach
  - Provider visit
  - Dental, Eye, Foot Exams
  - Evidence-Based Curriculum education
  - Healthy snacks
  - Connection to resources, referrals
- Promote lifestyle changes

Ancillary Services

Physical Therapy, Occupational Therapy, Speech Therapy
Lab, Radiology, Respiratory Therapy

Specialty Services

Pulmonology, Cardiology, Gastroenterology, Obstetrics, General Surgery, Neurology, Rheumatology, Nuclear Stress Testing, Wound Clinic

Community Health and Traditional Programs

Special Diabetes Program for Indians (SDPI)

- Mobile Unit: Access to care - Chapters & events
- Diabetes Education
- Community Garden
- 2026: Clinical Diabetes Clinic/High-Risk Clinic; Raised Garden Beds at Homes

Wellness Center

- Referred exercise programs
- Community and School events
- 2026: At-home exercise programs; adding Health Promotion Disease Prevention staffing

Traditional Healing

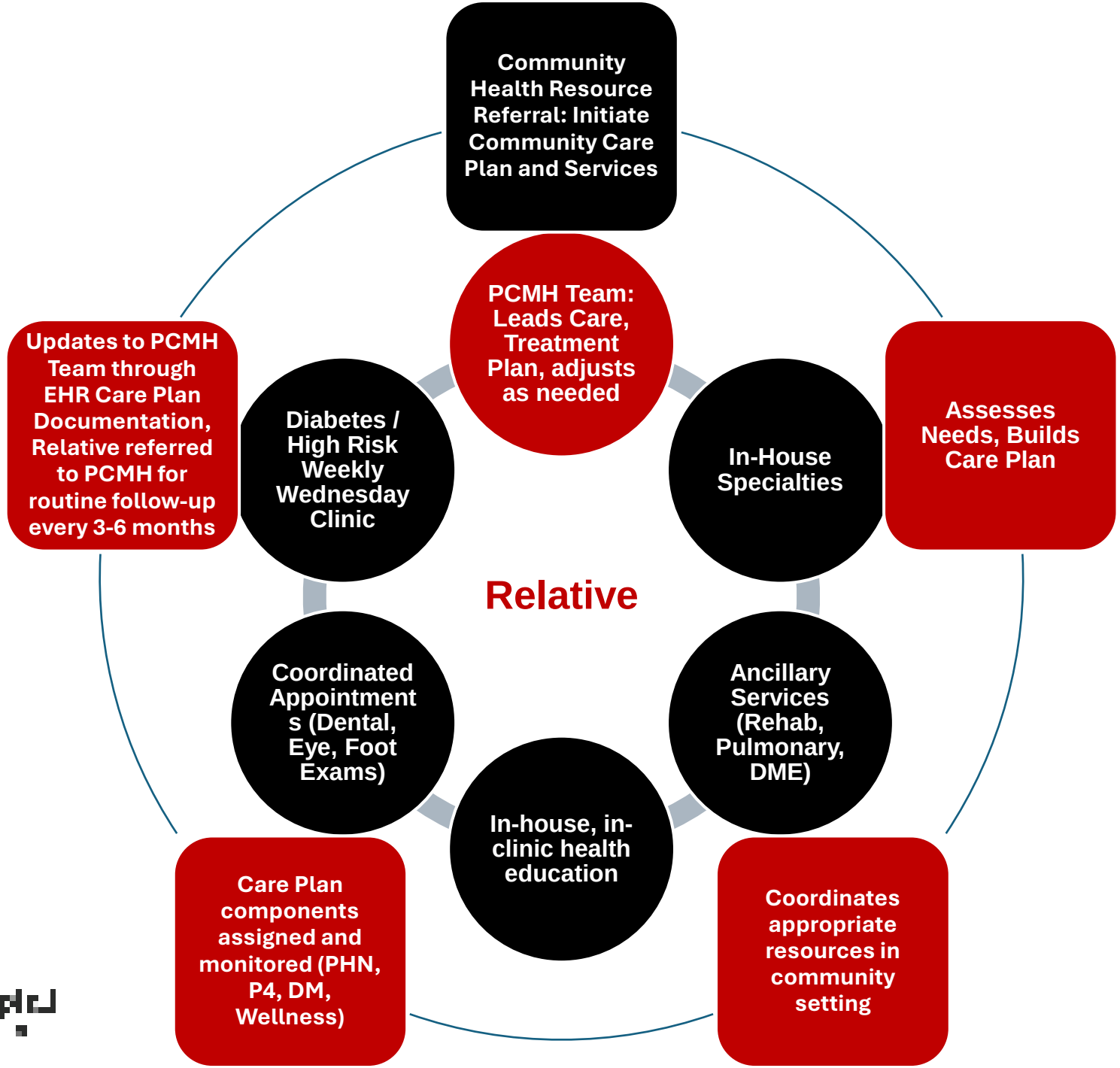
- Prayers / Ceremonies
- Cultural Teaching
- Food is Medicine

Produce Prescription Pilot Program (P4)

- Addresses food insecurity with 100 participants/cohort - $200 food voucher / month x 1 year (shopping for self or staff will shop/deliver)
  - Health Education
  - Food demonstrations
- 2026: In-home health checks (blood glucose, blood pressure, weight/BMI); community education (senior centers, chapters) using evidence-based curriculum

Public Health Nursing/Elder Care

- Nursing Home Visits
- Medication Management
- Health Education
- Safety Assessments
- 2026: Adding Elder Care Services, RN Case Management, High-Risk follow-up


Community Health Resource Referral: Initiate Community Care Plan and Services
PCMH Team: Leads Care, Treatment Plan, adjusts as needed
Assesses Needs, Builds Care Plan
In-House Specialties
Ancillary Services (Rehab, Pulmonary, DME)
Coordinates appropriate resources in community setting
In-house, in-clinic health education
Care Plan components assigned and monitored (PHN, P4, DM, Wellness)
Coordinated Appointments (Dental, Eye, Foot Exams)
Diabetes / High Risk Weekly Wednesday Clinic
Updates to PCMH Team through EHR Care Plan Documentation, Relative referred to PCMH for routine follow-up every 3-6 months
Relative

Safety Net

Bridging the Gap

Prevention Focus - Youth

Wellness Activity and Education in Schools

- Anthropometric measures
- Health and Nutrition Education
- Physical Activity

In-home visiting and education for prenatal/postpartum/infants

- Family Spirit
- Family Nurturing
- Taught by paraprofessionals
- Oversight by RN/PHN

Partner youth with elders on community gardens and health education at Elder Centers

Healthy Foods through P4 program, Community and Home Gardens

Prevention Focus - Adults

Clinic, Community, Home

- Consistent standardized health and nutrition education

Healthy Foods, Shopping, Cooking, Storage

- Healthy Foods from P4 program, community and home gardens
- Healthy shopping habits, label reading, best choices available, recipes, cooking demonstrations, canning/storing food

Physical Wellness/Activity

- Wellness center, community setting, home setting

Clinical Health

- Routine provider visits with PCMH team, PHN health checks and education

Cultural and Spiritual Health

- Traditional ceremonies and teachings
- Applying cultural significance to all aspects of care

Policy Revision Recommendations

Moving Forward to Sustainability

Policy Revision and Recommendations

- Reimbursement for PHN Services (New Mexico has accomplished this)
- Wellness classes
- Health/Wellness Equipment coverage
- Health Education Classes (community setting)
- In-home health/nutrition education
- Dental care (treatment and devices) for all members
- GLP-1 coverage for obesity; continuation of GLP-1 after A1C in range so obesity can be fully addressed
- NEMT coverage to wellness appointments/activities (non-conventional appointment)
- Consider alternate provider types that can deliver services (Example: MNT-difficult to hire RD/LD in remote areas)
- Prevention Program Support (most are grant-funded – P-4 or Navajo FvRx Program)
- Revisit prior authorization requirements for NEMT, EMS transportation services (AHCCCS)

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Economic Analysis of Obesity Treatment Coverage in Arizona's Medicaid Program

Presentation to Arizona Obesity Study Committee

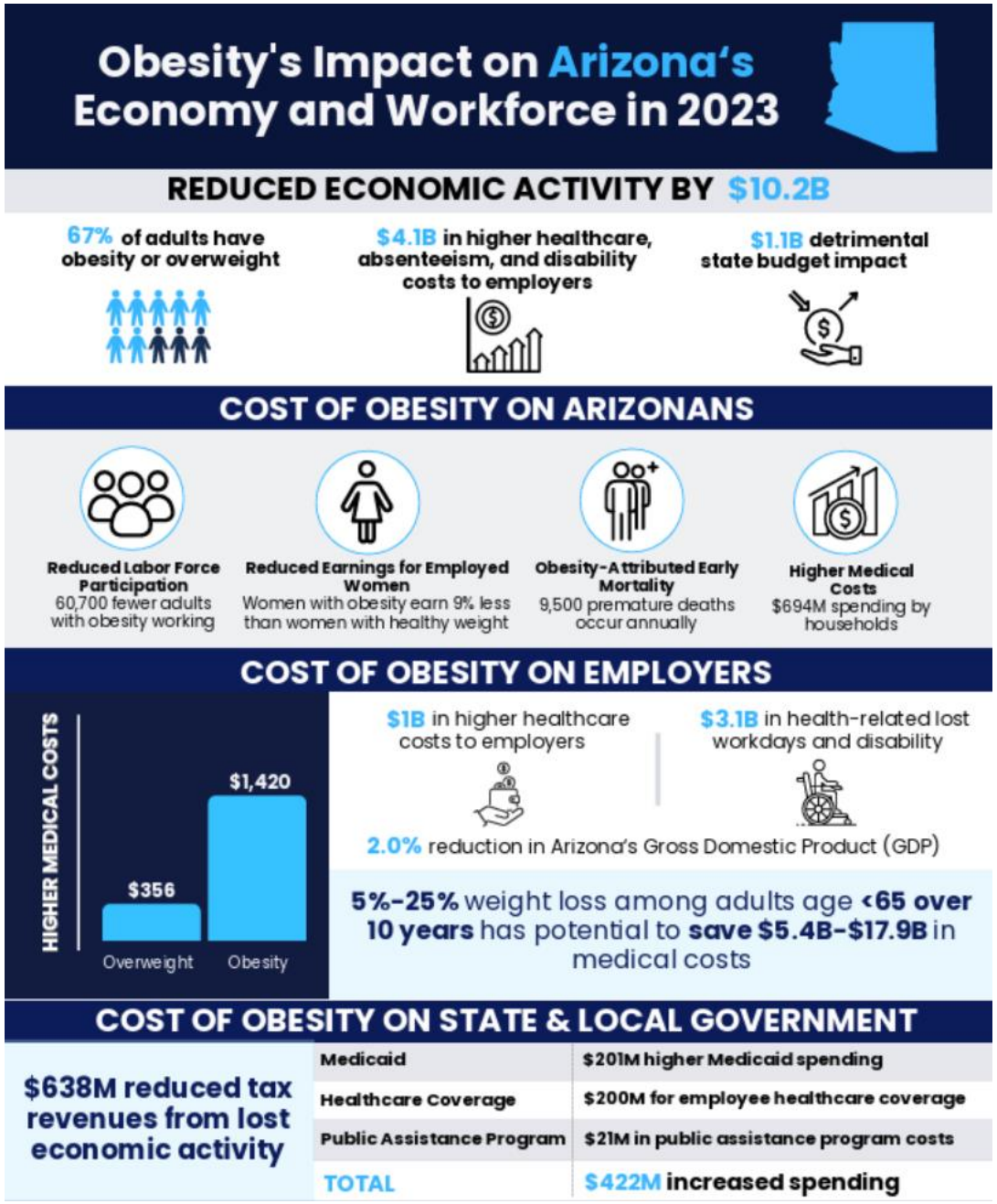
By Tim Dall

Preliminary Findings; not for Public Dissemination

November 25, 2025

Disclaimer

- The estimates in this presentation are derived from a State Obesity Calculator developed with funding from the American Diabetes Association
- GlobalData's Health Economics team has conducted research funded by
  - Eli Lilly & Company, manufacturer of obesity medications
  - Omada Health, provider of cardiometabolic virtual-first care programs
- This analysis presents preliminary estimates for Arizona Medicaid. The findings are intended to inform policy discussion and should not be considered an official program assessment or budget projection.

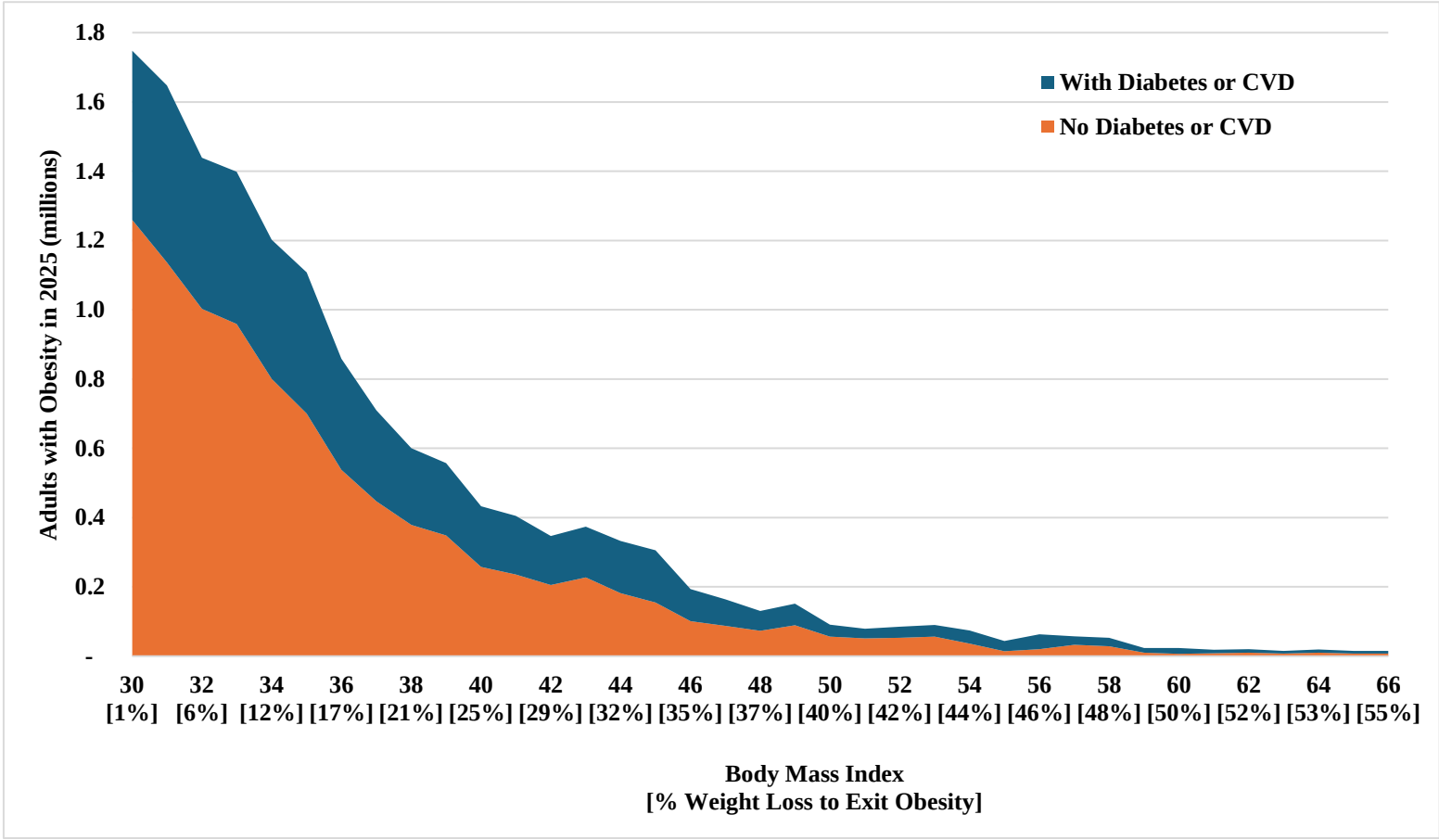


https://www.globaldata.com/health-economics/US/Arizona/Obesity-Impact-on-Arizona-Factsheet.pdf

Comprehensive Obesity Treatment Tailors Intervention to Patient Needs

- Intensive Lifestyle Intervention: 5.2% initial body weight
  - Look AHEAD trial: 8.6% weight loss at 12 months, with gradual regain to 4.7% at 8 years
- First-generation obesity medications: 5.2%
  - Phentermine/topiramate and bupropion/naltrexone
- Second-generation incretin-based therapies: up to 20.1%
  - GLP-1 receptor agonists and GIP/GLP-1 dual receptor agonists (e.g., semaglutide, tirzepatide)
- Metabolic/bariatric surgery: 23.4%
  - Substantial initial weight loss with gradual regain over time

BMI Distribution of Medicaid Adults with Obesity: US Total



People in Medicaid Varies Month-to-Month

- Approximately 961,400 adults aged 18-64 enrolled in Arizona Medicaid
- 443,300 have obesity (46%)
  - 148,800 have type 2 diabetes and/or cardiovascular disease
  - 294,600 have no history of type 2 diabetes and/or cardiovascular disease
- Literature suggests that only 61% of adults with obesity in public insurance programs are diagnosed, and thus likely to be recommended for intervention
  - Many people with undiagnosed diabetes are near the threshold of obesity (BMI≥30)
  - BMI≥30 serves as a population-level screening criterion; clinical diagnosis considers additional factors for individual treatment decisions
- Model assumption: 179,700 referred for treatment (61% of 294,600)

Obesity Treatment Scenario Assumptions

- Treatment allocation by cost-effectiveness
  - 32% intensive lifestyle management or earlier FDA-approved medications
  - 64% second-generation obesity medications
  - 4% metabolic/bariatric surgery: Surgery capacity limits population-level application
- Treatment initiation rate
  - Congressional Budget Office Medicare analysis: 3-5% annually
  - Nationwide rates remain low due to coverage and access barriers
  - Model assumption: 10% annually
- Treatment discontinuation (lifestyle intervention and obesity medications)
  - 50% discontinue within 3 months
  - 10% discontinue at each subsequent 1-year treatment anniversary
- Treatment costs
  - Intensive lifestyle management, earlier FDA-approved medications, and metabolic/bariatric surgery: established pricing
  - Second-generation incretin-based therapies: $245/month (based on recent White House announcement)
    - Prices may fall further over time with increased competition
    - Prices may decline when pill form of GLP-1s is approved for treatment
- Arizona's Medicaid cost share remains at 35%
- Assume 0% annual discount rate

Number of People in Treatment

Benefits	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total Person Years
Total Person Years	9,350	17,730	24,970	30,940	35,540	118,530
Intensive Lifestyle Management	1,980	3,730	5,230	6,460	7,380	24,780
First-generation OMs	900	1,700	2,390	2,940	3,360	11,290
Second-generation OMs	5,750	10,870	15,240	18,790	21,480	72,130
Metabolic/Bariatric Surgery	720*	710*	680*	640*	570*	1,033

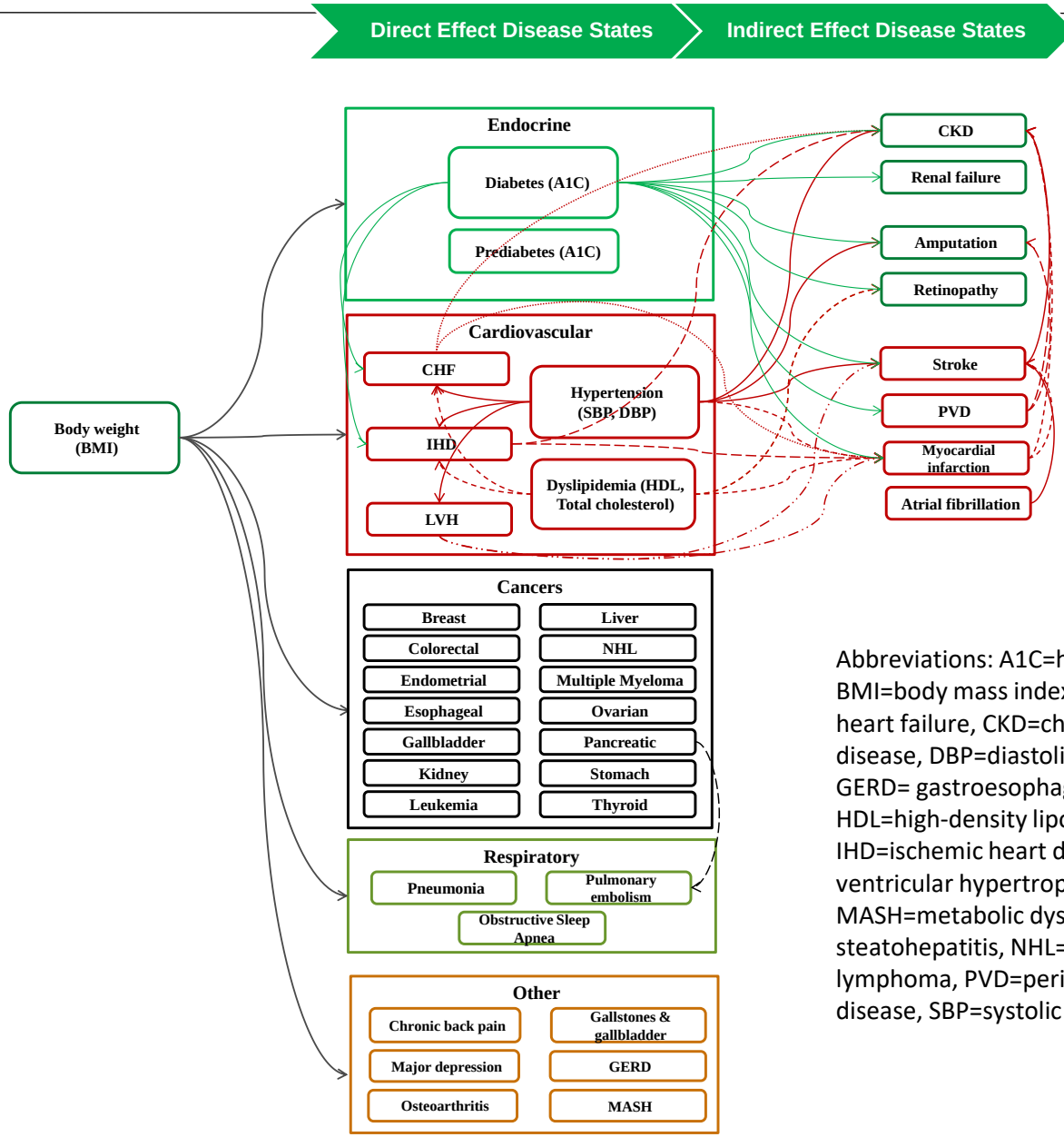
* Number of surgeries performed

The Obesity Component of the Disease Prevention and Treatment Microsimulation Model (DPTMM)

Obesity Module

- BMI is a key model driver, directly affecting:
  - Endocrine conditions and complications
  - Cardiovascular conditions and complications
  - Cancers
  - Respiratory conditions
  - Other conditions
  - Mortality risk (some conditions)

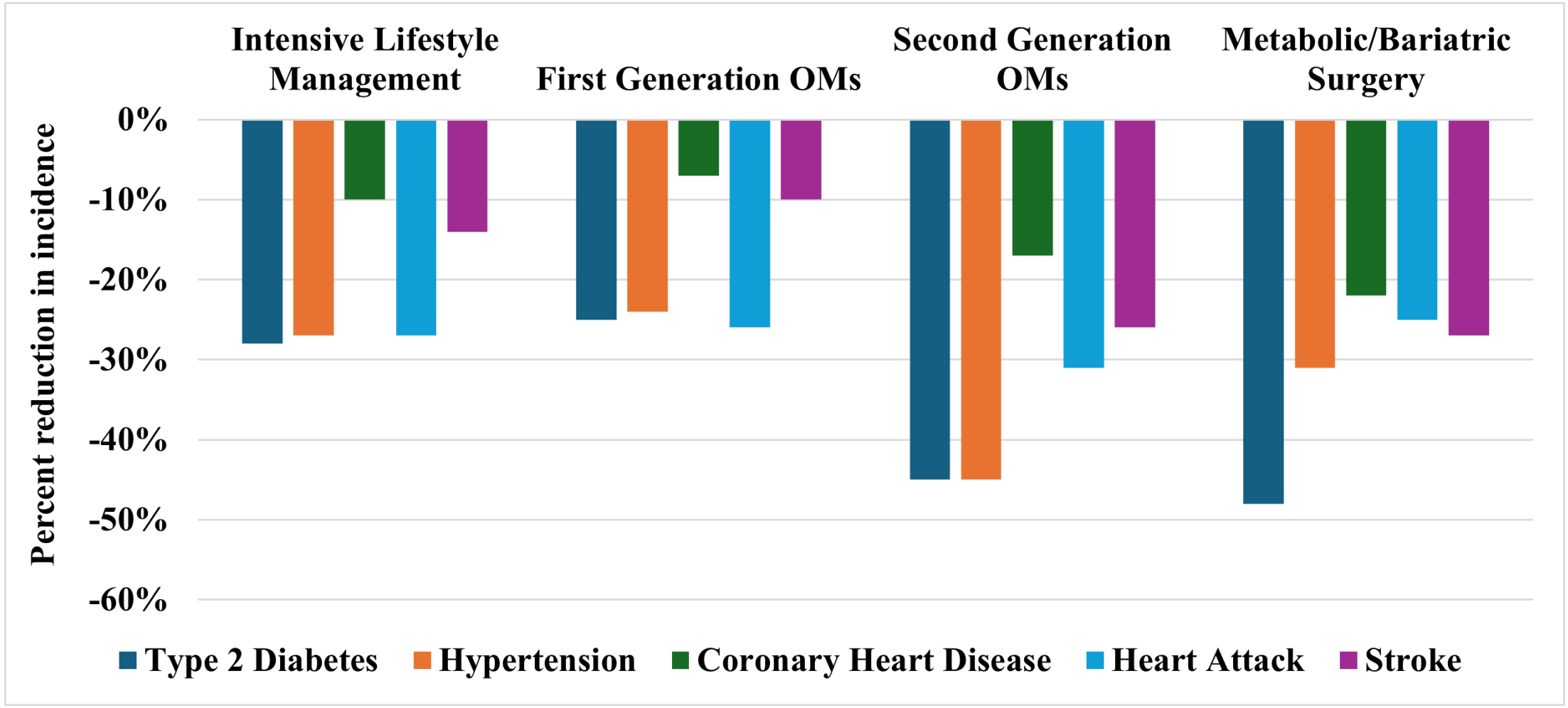
  And indirectly impacting:
  - Direct medical expenditures
  - Indirect costs
  - Mortality risk (some conditions)
  - Quality of life



Abbreviations: A1C=hemoglobin A1C, BMI=body mass index, CHF=congestive heart failure, CKD=chronic kidney disease, DBP=diastolic blood pressure, GERD= gastroesophageal reflux disease, HDL=high-density lipoprotein cholesterol, IHD=ischemic heart disease, LVH=left ventricular hypertrophy, MASH=metabolic dysfunction-associated steatohepatitis, NHL=non-Hodgkin lymphoma, PVD=peripheral vascular disease, SBP=systolic blood pressure.

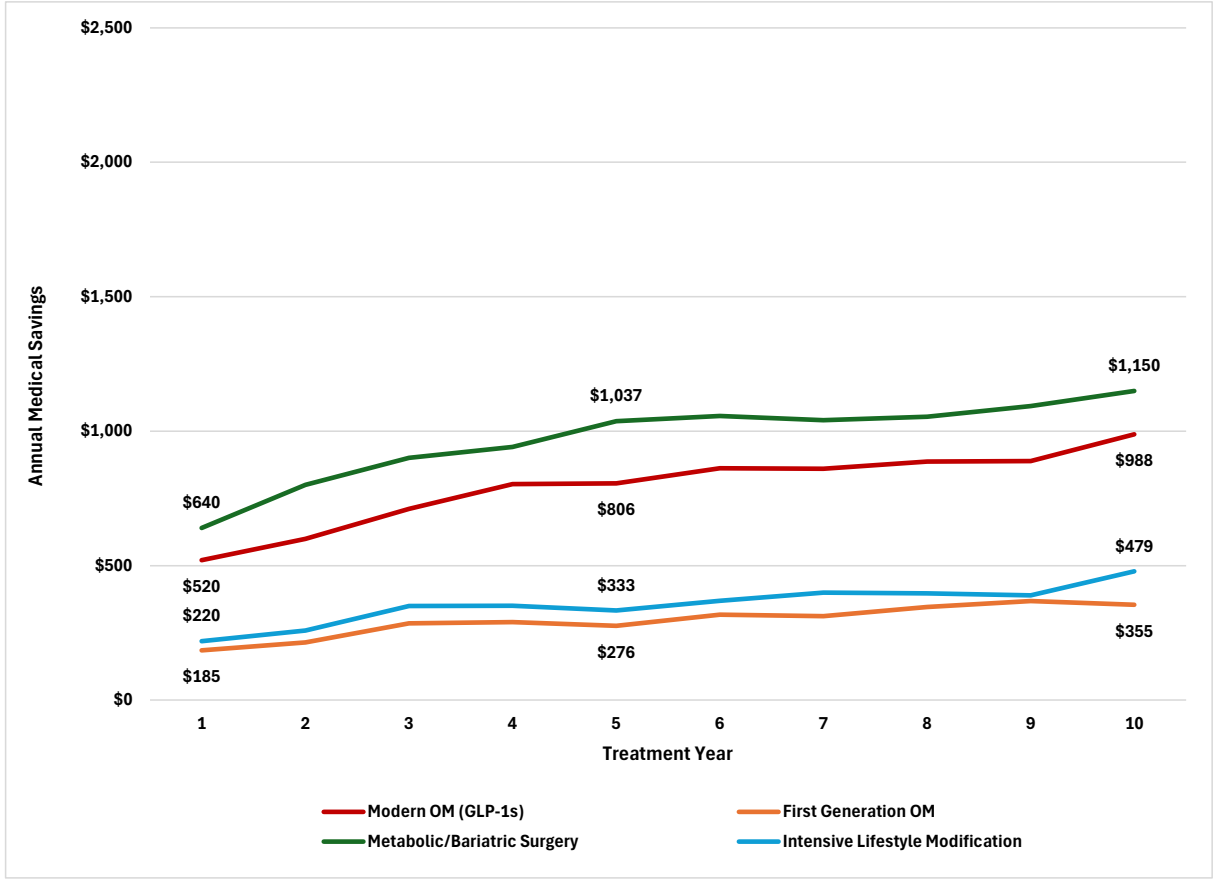
5-Year Reduction in Disease Onset Among Medicaid Adults treated for Obesity

Among adults without prior history of type 2 diabetes or cardiovascular disease

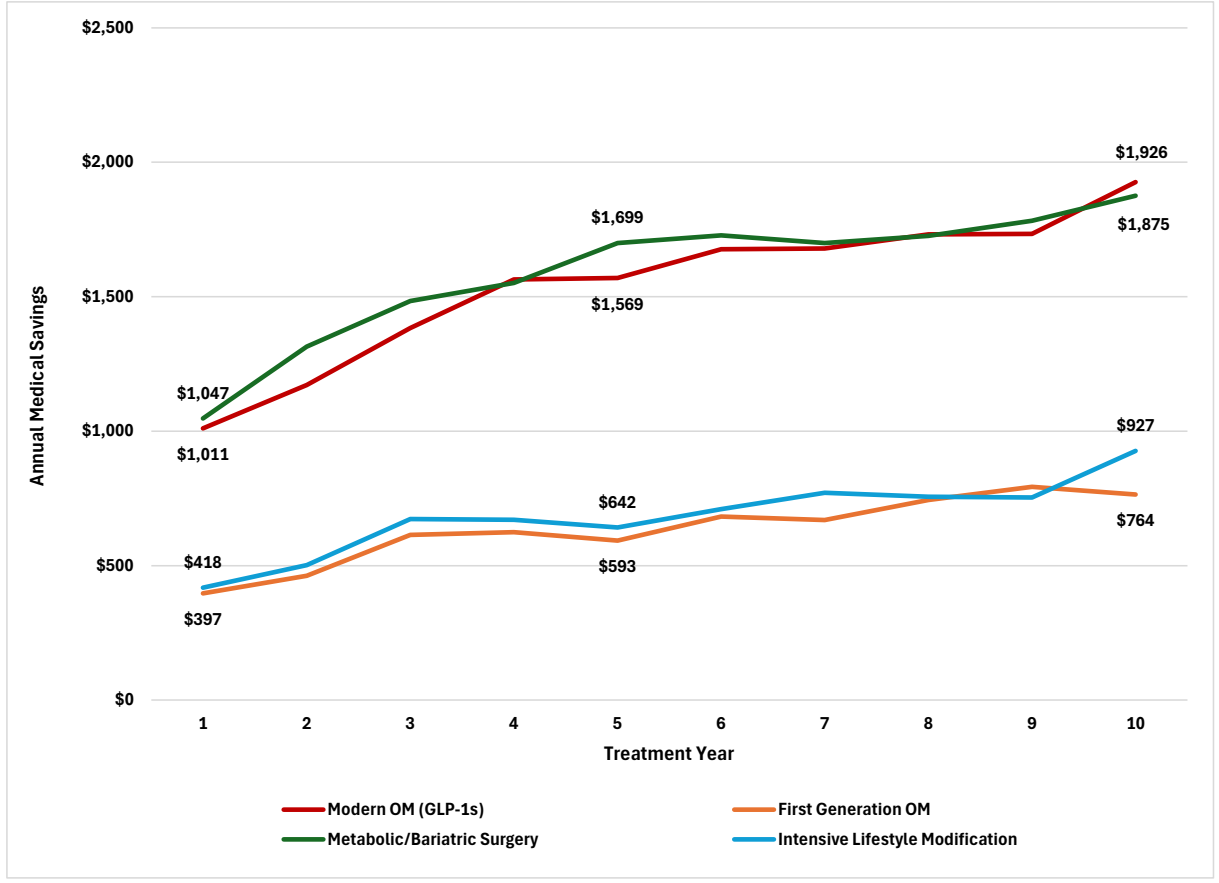


Simulated Annual Medicaid Cost Savings, by Treatment Type and Year

People without Type 2 Diabetes or CVD



People with Type 2 Diabetes or CVD



Medicaid Net Costs to Arizona

Arizona Medicaid Costs	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total
Cost of treatment	**$13,519,000**	**$17,527,000**	**$22,250,000**	**$26,957,000**	**$30,162,000**	**$110,415,000**
Intensive Lifestyle Management	$1,830,000	$2,894,000	$3,632,000	$4,153,000	$4,380,000	$16,889,000
First-generation OMs	$680,000	$912,000	$1,338,000	$1,678,000	$1,929,000	$6,537,000
Second-generation OMs	$7,707,000	$10,351,000	$13,951,000	$17,889,000	$20,850,000	$70,748,000
Metabolic/Bariatric Surgery	$3,302,000	$3,370,000	$3,329,000	$3,237,000	$3,003,000	$16,241,000
Medical costs avoided	**$1,263,000**	**$2,214,000**	**$3,776,000**	**$5,231,000**	**$6,376,000**	**$18,860,000**
Intensive Lifestyle Management	$71,000	$230,000	$420,000	$575,000	$685,000	$1,981,000
First-generation OMs	$55,000	$86,000	$155,000	$212,000	$253,000	$761,000
Second-generation OMs	$985,000	$1,560,000	$2,664,000	$3,713,000	$4,518,000	$13,440,000
Metabolic/Bariatric Surgery	$152,000	$338,000	$537,000	$731,000	$920,000	$2,678,000
Net cost of treatment	**$12,256,000**	**$15,313,000**	**$18,474,000**	**$21,726,000**	**$23,786,000**	**$91,555,000**
Intensive Lifestyle Management	$1,759,000	$2,664,000	$3,212,000	$3,578,000	$3,695,000	$14,908,000
First-generation OMs	$625,000	$826,000	$1,183,000	$1,466,000	$1,676,000	$5,776,000
Second-generation OMs	$6,722,000	$8,791,000	$11,287,000	$14,176,000	$16,332,000	$57,308,000
Metabolic/Bariatric Surgery	$3,150,000	$3,032,000	$2,792,000	$2,506,000	$2,083,000	$13,563,000

National Medicaid Costs (AZ + Federal)	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total
Cost of treatment	$38,504,000	$49,923,000	$63,372,000	$76,780,000	$85,909,000	$314,488,000
Medical costs avoided	$3,598,000	$6,304,000	$10,755,000	$14,898,000	$18,159,000	$53,714,000
Net cost of treatment	$34,906,000	$43,619,000	$52,617,000	$61,882,000	$67,750,000	$260,774,000

Indirect Economic Benefits of Treatment

Benefits	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total
Total	**$1,774,000**	**$6,845,000**	**$12,450,000**	**$16,838,000**	**$20,990,000**	**$58,897,000**
Reduced Absenteeism	$(167,000)	$736,000	$1,745,000	$2,656,000	$3,431,000	$8,401,000
Reduced Presenteeism	$382,000	$1,202,000	$2,104,000	$2,797,000	$3,457,000	$9,942,000
Increased Labor Force Participation	$885,000	$2,783,000	$4,876,000	$6,468,000	$8,004,000	$23,016,000
Reduced Disability/Worker's Compensation	$674,000	$2,124,000	$3,725,000	$4,917,000	$6,098,000	$17,538,000

- Improvements in quality of life
  - Quality Adjusted Life Year (QALY) = 1 means one year of perfect health, often valued at $100,000 - $150,000
  - Model estimated 4,260 QALY increase

- Reduced mortality
  - Federal government’s most conservative estimate is $231,000 per statistical life year
  - Model estimated 3,108 statistical life years saved

Net Social Value of Treatment

Arizona Costs & Benefits (with cost sharing)	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total
Net Social Value ($millions)	**$46**	**$151**	**$238**	**$306**	**$357**	**$1,098**
Direct cost of treatment	-$14	-$18	-$22	-$27	-$30	-$110
Direct medical savings	$1	$2	$4	$5	$6	$19
Indirect economic benefits	$2	$7	$12	$17	$21	$59
Quality of life	$22	$60	$92	$117	$135	$426
Reduced mortality	$37	$102	$155	$197	$227	$719
Treatment time value	-$3	-$3	-$3	-$3	-$3	-$14
ROI ($)	**$4.62**	**$9.79**	**$11.84**	**$12.46**	**$12.92**	**$11.08**

National Costs & Benefits	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total
Net Social Value ($millions)	**$23.6**	**$122.9**	**$204.0**	**$265.8**	**$312.8**	**$929.2**
ROI ($)	**$1.68**	**$3.52**	**$4.27**	**$4.50**	**$4.67**	**$4.00**

Conclusions

- Net costs and health outcomes of treatment vary based on treatment comprehensiveness, initiation rates, and adherence patterns
- Social return on investment remains relatively stable across sensitivity analyses
  - Arizona state perspective: $11.08 in social value per $1.00 invested in treatment
  - National perspective (federal + state): $4.00 in social value per $1.00 invested in treatment
- Comprehensive social benefit-cost analysis captures value beyond medical budget impacts alone

Tim Dall

Executive Director

tim.dall@globaldata.com

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Obesity Treatment Study Committee 11.25.25

Steve Berg
Legislative Specialist

Current AHCCCS Data

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Current AI-CCCS Obesity Data

- In 2024, there were 272,995 AI-CCCS members with an obesity diagnosis.
  - Of the 272,995, there were 195,482 AI-CCCS members with an obesity diagnosis, but without type 2 diabetes.
    - Meaning there are approximately 77,513 members with an obesity diagnoses and a type 2 diabetes diagnosis.
  - Of the 272,995, there were 219,988 AI-CCCS members with an obesity diagnosis, but without obstructive sleep apnea.
    - Meaning there are approximately 53,007 members with an obesity diagnoses and an obstructive sleep apnea diagnosis.

Current AI-CCCS GLP-1 Utilization Data

- In 2024, 15,789 AI-CCCS members living with obesity were prescribed a GLP-1.
- In 2024, 19,161 AI-CCCS members were prescribed a GLP-1.

Efforts by Other States

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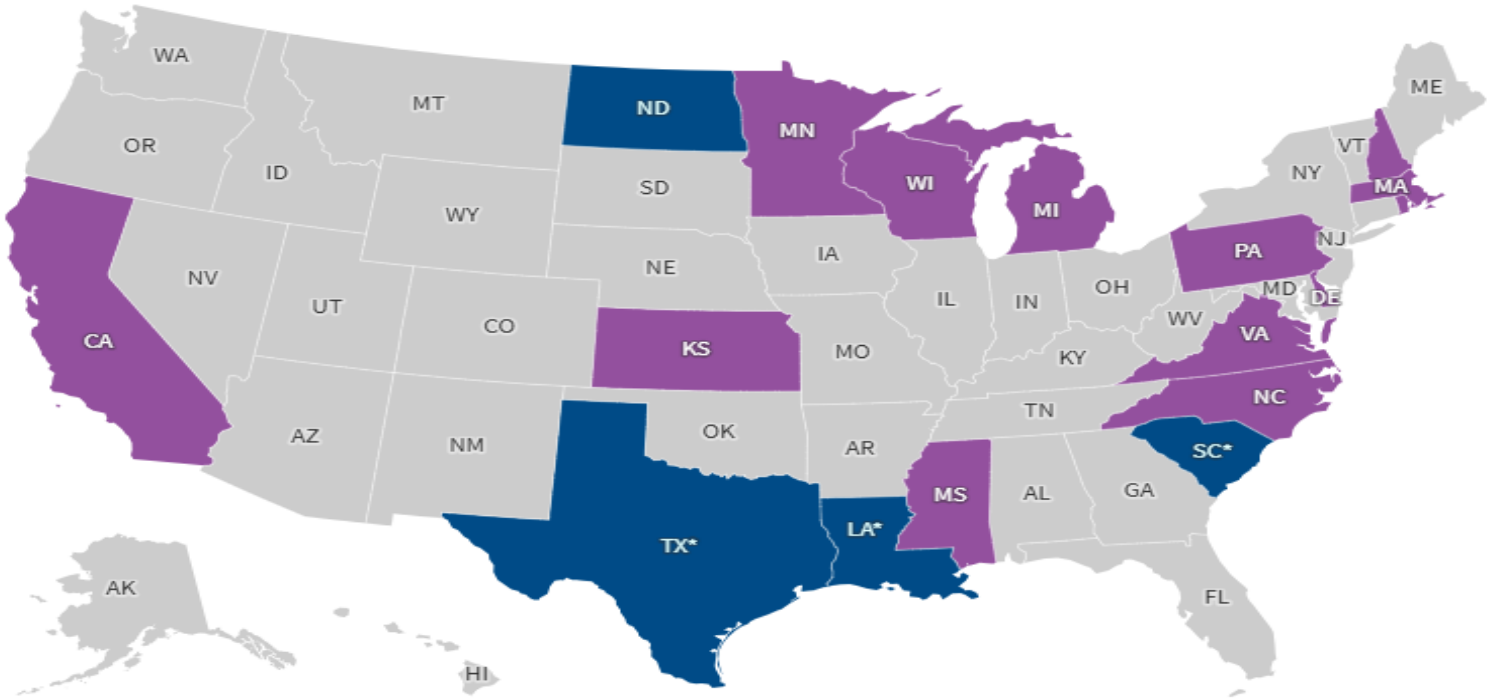
States That Have Expanded GLP-1 Coverage for Obesity

- According to KFF, there were 13 state Medicaid programs covering GLP-1s for obesity treatment as of August 2024.
- In nearly all 13 states, utilization controls are used to prevent overuse of the drugs with the most common being prior authorization and/or BMI requirements.
- Currently, some of the 13 states are facing budget deficits and are having to make the decision whether or not to continue covering these drugs.

Thirteen States Covered GLP-1s for Obesity Treatment as of August 2024

- Coverage in place and covers GLP-1s for obesity treatment (13 states)
- Coverage in place but does not cover GLP-1s for obesity treatment (4 states)
- Not covered (34 states including DC)



Note: GLP-1 = glucagon-like peptide-1. Coverage is under fee-for-service as of August 2024. FL did not respond to the 2024 survey; publicly available data used to verify status. NC reported adding coverage of obesity drugs in August 2024 and is included here. *These states, either in survey responses or publicly available data, noted coverage was limited to one drug (Orlistat).

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024 • Get the data • Download PNG

KFF

Fiscal Estimates from Other States

- Pennsylvania saw costs for covering GLP-1s rise from $222 million in 2022 (before covering GLP-1s for obesity) to $650 million in 2024, and projected costs for 2025 to be nearly $1.3 billion.
  - To combat these rising costs, Pennsylvania is proposing BMI restrictions for GLP-1 coverage related to obesity treatment.
- South Carolina also saw costs rise for coverage of GLP-1s in its Medicaid program.
  - The state determined it needed to eliminate GLP-1 coverage related to obesity treatment to address the rising costs.

Fiscal Estimates

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CONTAINMENT SYSTEM

2024 AHCCCS/JLBC GLP-1 Fiscal Estimates

- During the 2024 session, Representative Amish Shah, MD introduced legislation (HB2517) that would require AHCCCS to provide comprehensive coverage of obesity treatment, including GLP-1, prevention and wellness, nutrition counseling, intensive behavioral therapy, and bariatric surgery.
- A fiscal note was added to the bill that estimated costs for coverage of GLP-1.
- AHCCCS/JLBC were not able to provide an estimate for the other obesity treatments included in the bill.

2024 AHCCCS/JLBC GLP-1 Fiscal Estimates

- The 2024 annual fiscal estimates for GLP-1 coverage are as followed:
  - Low end - $962.9M Total Fund and $191.5M General Fund
  - High end - $2.5B Total Fund and $496.2M General Fund

2025 AHCCCS GLP-1 Fiscal Estimates

- Per the Committee's request, AHCCCS has put together fiscal estimates to assist the Committee with making its recommendations.
- The fiscal estimates look at both potential Total Fund and General Fund costs and use the following variables:
  - 6-month utilization
  - AHCCCS counts of members with an obesity diagnosis plus those with bipolar or schizophrenia and CDC estimates of the number of Arizonans living with obesity
  - 30%, 50%, and 60% utilization across the two different populations

2025 AHCCCS GLP-1 Fiscal Estimates

- The 2025 Total Fund annual fiscal estimates for GLP-1 coverage are as follows:

Total Fund – Current Pricing		
Utilization	AHCCCS Data	CDC Estimate
30%	$496M	$940M
50%	$827M	$1.567B
60%	$993M	$1.88B

Total Fund – Trump Admin Negotiated Pricing		
Utilization	AHCCCS Data	CDC Estimate
30%	$169M	$320M
50%	$282M	$533M
60%	$338M	$640M

Numbers are preliminary and are subject to change

2025 AHCCCS GLP-1 Fiscal Estimates

- The 2025 General Fund annual fiscal estimates for GLP-1 coverage are as follows:

General Fund – Current Pricing		
Utilization	AHCCCS Data	CDC Estimate
30%	$88.23M	$167.2M
50%	$147.1M	$278.73M
60%	$176.63M	$334.41M

General Fund – Trump Admin Negotiated Pricing		
Utilization	AHCCCS Data	CDC Estimate
30%	$30.06M	$56.92M
50%	$50.16M	$94.81M
60%	$60.12M	$113.84M

Numbers are preliminary and are subject to change

Thank you

ARIZONA
HEALTH CARE COST
CONTAINMENT SYSTEM

Interim agendas can be obtained via the Internet at http://www.azleg.gov/Interim-Committees

ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

OBESITY TREATMENT STUDY COMMITTEE

Date: **Tuesday, November 25, 2025**

Time: **1:00 P.M.**

Place: **SHR 1**

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025111013

AGENDA

1. Call to Order
2. Roll Call
3. Presentations
   - Health and Economic Cost of Obesity to Arizona, Tim Dall, Executive Director, Life Sciences Consulting
   - Current Medicaid Coverage and Expansion Considerations, Arizona Health Care Cost Containment System
   - Private Insurance Coverage Landscape, Arizona Department of Insurance and Financial Institutions
   - State of Arizona Employee Health Plan Coverage and Expansion Analysis, Joint Legislative Budget Committee
   - Treating Obesity in Tribal and Rural Populations, Melinda White, CEO, Sage Memorial Hospital
4. Committee Discussion
5. Public Testimony
6. Adjourn

Members:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Cindy Komar
Dr. Christine Lovato
Dr. Douglas Maready
Representative Julie Willoughby, Co-Chair
Representative Patricia Contreras
Amy McCallister
Emily Moree, Designee
Dr. Kiran Raman, Designee

11/20/2025
hf

For questions regarding this agenda, please contact Senate Research Department.
Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602) 926-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

Appendix C:

December 17, 2025

Minutes and Reference Materials

ARIZONA STATE LEGISLATURE

OBESITY TREATMENT STUDY COMMITTEE

Minutes of the Meeting
December 17, 2025
12:00 P.M., SHR 1

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025121005

Members Present:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Dr. Douglas Maready
Amy McCallister
Representative Julie Willoughby, Co-Chair
Representative Patricia Contreras
Dr. Kiran Raman
Cindy Komar
Emily Moree

Members Excused:

Dr. Christine Lovato

Staff:

Michael Madden, Senate Research Analyst
Samuel Rosenberg, Senate Assistant Research Analyst
Ahjahna Graham, House Senior Research Analyst
Tasja McMaster, House Assistant Research Analyst

Co-Chair Willoughby called the meeting to order at 12:10 p.m. and attendance was taken.

PRESENTATION FROM DR. YAMINIKRISHNA SABESAN, ASSOCIATE CHIEF MEDICAL OFFICER, MERCY CARE

Dr. Yaminikrishna Sabesan, Associate Chief Medical Officer, Mercy Care, distributed and explained a PowerPoint Presentation entitled "Obesity Study Committee December 17, 2025" (Attachment A).

PRESENTATIONS ON GLP-1 COVERAGE

Arizona Health Care Cost Containment System

Steve Berg, Legislative Specialist, Arizona Health Care Cost Containment System, distributed and explained a handout entitled "AHCCCS GLP-1 Data for Obesity Treatment Study Committee – 12/17/25" (Attachment B) and answered questions posed by the Committee.

Dr. Raman answered questions posed by the Committee.

Mr. Berg answered additional questions posed by the Committee.

Dr. Raman answered additional questions posed by the Committee.

Mr. Berg answered additional questions posed by the Committee.

The Committee offered comments.

Mr. Berg answered additional questions posed by the Committee.

Dr. Raman answered additional questions posed by the Committee.

Arizona Department of Administration

Paul Shannon, Benefits Director, Arizona Department of Administration, distributed and explained a handout entitled "Questions and Answers" (Attachment C) and answered questions posed by the Committee.

REVIEW OF DRAFT RECOMMENDATIONS

Senator Gowan reviewed the draft recommendations of the Committee.

COMMITTEE DISCUSSION

The Committee offered comments.

ADOPTION OF RECOMMENDATIONS

Senator Willoughby moved that the Committee adopt the recommendations as distributed with the revisions as noted:

RECOMMENDATION #1 – RECOGNIZE OBESITY AS A CHRONIC DISEASE

The Legislature and state agencies should consider policies which:

- **Officially recognize obesity as a chronic disease.**
- **Treat obesity as a chronic illness, with necessary treatment that is lifelong as needed, rather than episodically, like the treatment of any other chronic disease.**
- **Looks at obesity treatment as part of a chronic care model.**

RECOMMENDATION #2 – OBESITY PREVENTION AND TREATMENT ADVISORY COUNCIL

The Legislature should:

- **Establish an advisory council which will analyze historical data, estimate potential cost-savings from covering preventative care, evaluate and recommend public policy and funding strategies, identify system gaps, and produce a report providing guidance and recommendations to educate the public, the Legislature and other government agencies and departments, as appropriate.**

RECOMMENDATION #3 – CONTINUED ENGAGEMENT BY STATE AGENCIES

Relevant state agencies should:

- **Continue and expand efforts to promote physical activity, nutrition education, and support obesity treatment approaches that focus on treating the whole individual.**
- **Consider creating or strengthening internal teams focused on addressing and preventing obesity and related chronic diseases.**

The motion CARRIED by voice vote.

There being no further business, the meeting was adjourned at 1:03 p.m.

Respectfully submitted,

Jackson Cooper
Committee Secretary

(Audio recordings and attachments are on file in the Secretary of the Senate's Office/Resource Center, Room 115. Audio archives are available at http://www.azleg.gov)

2025 Final Recommendations of the Obesity Treatment Study Committee

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- Consider creating or strengthening internal teams focused on addressing and preventing obesity and related chronic diseases.

Q: At the November 25, 2025 Obesity Treatment Study Committee meeting, Sen. Gowan posed several questions to the agencies that we believe require follow-up for the next meeting on December 17th. We ask that you respond to these questions to us by Wednesday, December 10th so we have time to convey the information to members and ask any follow-up questions as needed. Sen. Gowan asked: What are the average annual costs and life expectancy for an individual on the state employee health plan with:

- Diabetes;
- Prediabetes;
- Obesity;
- An average adult on the state employee health plan?

A: All costs include the allowed treatments for the condition and the costs of comorbidities associated with the condition. For fiscal year 2025:

FY 2025 data			
	Member count	Medical and Rx costs	Annual Plan Cost
Diabetics (may include Obesity as a comorbidity)	10,289	$244,333,995	$23,747
Prediabetes (may include Obesity as a comorbidity)	7,177	$84,788,843	$11,813
Obesity (may include Prediabetes or Diabetics as a comorbidity)	11,879	$197,183,413	$16,599
An average adult on the state employee health plan	104,975	$972,595,272	$9,265

The categories include some duplication of members because of comorbidities common among diabetics, pre-diabetics and the obese. ADOA does not have sufficient data about medium or long-term use of GLP-1 drugs and their effect on plan cost asGLP-1 drugs have only been widely prescribed for 3 years. The experience during that time may not be representative of future use and clinical patterns.

ADOA does not calculate life expectancies for our members, nor do we have any experience or methodological experience in those calculations. It should be noted that many members have a transient experience with the State and may incur significant lifetime costs under coverages that are provided by other employers, the Medicare program or other programs that provide health insurance.

Data on the costs of GLP-1s has been provided previously.

AHCCCS GLP-1 Data for Obesity Treatment Study Committee – 12/17/25

Regarding the request by Sen. Gowan, the agency has been able to analyze the most recently complete calendar year of utilization for members with ICD-10 codes indicating a diagnosis of type two diabetes and/or obesity (Dates of Service 1/1/2024-12/31/2024):

- The total annual cost for members aged 21 and older with type two diabetes AND obesity was approx. $1.470 billion (59,977 members), or an average of $24,502/member
- The total annual cost for members aged 21 and older with type two diabetes OR obesity was approx. $3.816 billion (250,417 members), or an average of $15,238/member
- The total annual cost for members aged 21 and older with no documentation of having a diagnosis of type two diabetes or obesity was approx. $6.176 billion (702,076 members), or an average of $8,797/member
- If needed, the agency can attempt to further delineate the third line item into those with documentation of a diagnosis of prediabetes versus those without such documentation. However, prediabetes is often asymptomatic and therefore tends to be under-documented, so including that information may be less helpful than above.

Regarding estimated life expectancies, it does not appear possible to estimate life expectancies for cohorts of AHCCCS members with the data/resources currently available to the agency. To our knowledge, CMS has not published Medicaid-specific life expectancy figures/tables in the past, but the following information is currently available from the CDC:

- Life expectancy for an average adult: https://www.cdc.gov/nchs/fastats/life-expectancy.htm
- Life expectancy for individuals with type two diabetes: https://www.cdc.gov/diabetes/data-research/research/treatment-goals.html

Regarding the questions from other members:

Question 1. For the other state Medicaid programs that have expanded GLP-1 coverage, what are they doing in terms of utilization management?

Response: The agency has identified information on 14 states of which 6 have ended, or will be ending, coverage of GLP-1s for obesity.

California - Will be ending coverage on 1/1/2026

- https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/publications/2025.10_A_Important_Update_GLP-1s_Weight_Loss_Not_Covered_Benefit.pdf

Delaware - Still covered

- https://www.delawarepublic.org/politics-government/2024-07-22/delaware-paid-over-12-million-more-on-weight-loss-drugs-than-expected-trend-increases-to-follow
    - Includes figures on trend assumptions for their state Group Health Insurance Plan
- https://news.delaware.gov/2025/09/04/department-of-insurance-issues-first-ever-glp-1-report/
    - Another analysis that does not include the state Group Health Insurance Plan

Kansas - Requires PA

- https://www.kdhe.ks.gov/DocumentCenter/View/15513/Anti-Obesity-Medications-PA-Form-PDF
    - PA form

Massachusetts - Requires PA and other limitations

- https://www.mass.gov/doc/issue-3-october-2024-0/download
    - Coverage began
- https://mhdl.pharmacy.services.conduent.com/MHDL/pubtheradetail.do?id=478
    - PA requirements

Michigan - Will be adding further restrictions on 1/1/2026 to limit to "morbidly obese"

- https://www.cbsnews.com/detroit/news/michigan-medicaid-weight-loss-drugs-diabetes-morbid-obesity/
- Adding limitations

Minnesota - Requires PA

- https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/rx/pa-criteria/anti-obesity-medications.jsp
- PA description

Mississippi - Requires PA, news article highlighting that GLP-1s have not been popular in the state

- https://kffhealthnews.org/news/article/mississippi-medicaid-glp-1s-weight-loss-drugs-obesity/
- GLP-has failed to be popular in the state
- https://medicaid.ms.gov/wp-content/uploads/2024/03/Anti-obesity-Select-Agents-PA-Criteria-3_12_2024.V3.pdf
- PA criteria

New Hampshire - Will be ending coverage 1/1/2026

- https://www.nhhealthyfamilies.com/newsroom/glp-1-medications-change-in-coverage-effective-january-1--2026.html#:~:text=Effective%20January%201%2C%202026%2C%20NH,for%20other%20chronic%20health%20conditions.
- News release announcing end of coverage

North Carolina - Coverage ended 11/2025

- https://medicaid.ncdhhs.gov/blog/2025/11/04/updates-nc-medicaid-coverage-wegovy-and-zepbound-clinical-indications-other-weight-loss

Pennsylvania - Will be ending coverage 1/1/2026 (See bottom of the list for further details)

- https://www.spotlightpa.org/news/2025/06/medicaid-weight-loss-cuts-pennsylvania-budget-savings-deficit/
- News article

Rhode Island - Considering adding restrictions

- https://rhodeislandcurrent.com/2025/10/10/rhode-island-considers-ending-medicaid-coverage-of-glp-1-drugs-for-weight-loss/
- News article

South Carolina - Will be ending coverage 1/1/2026

- https://scdailygazette.com/2025/11/17/sc-medicaid-program-to-stop-covering-expensive-weight-loss-drugs-for-obesity/
- News article

Virginia - Still covered, changing requirements

- https://vamedicaid.dmas.virginia.gov/bulletin/upcoming-changes-service-authorization-criteria-weight-loss-drugs

Wisconsin - PA required, considering adding further restrictions

- https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=48&s=3&c=11&nt=Anti-Obesity+Drugs&adv=Y
- PA requirements

Particularly noteworthy is the following update AHCCCS received from the Pharmacy Director of the Pennsylvania Medicaid agency: "Pennsylvania began covering Obesity Treatment Agents on the Statewide PDL (applies to FFS and MCOs) in January 2023 with prior authorization. Utilization and spend rose sharply. Effective January 1, 2026, PA will no longer cover GLP-1s for the treatment of overweight or obesity.
The fiscal impact for Fiscal Year 2025-2026 is a savings of $348.333 million in total funds ($112.965 million in state funds) in the physical health capitation rates. The fiscal impact in Fiscal Year 2026-2027 is a savings of $836.000 million in total funds ($266.684 million in state funds) in the physical health capitation rates."

See linked provider bulletin and prior authorization guidelines:
https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/pharmacy-services/documents/clinical-guidelines-sw-pdl/2025-11-26-glp-1-receptor-agonists.pdf

Question 2. What are the cost savings from the recently announced price reductions for the current population using GLP-1s? Please provide both Total Fund and General Fund figures.

Response: Presuming the request is simply asking how costs would change for current GLP-1 utilization if the federal negotiated price of $245 per month was implemented:

Current Pricing
2024 GLP-1 utilization=19,161 at $3,795 – Approx. $73M TF (Approx. $13M GF)

Federal Negotiated Pricing
2024 GLP-1 utilization=19,161 at $1,470 – Approx. $28M TF (Approx. $5M GF)

Question 3. Does AHCCCS levy a penalty on the contracted health plans when certain disease management metrics are not met?

Proposed Response: The agency requires health plans to calculate and report several performance measures annually. If a health plan does not meet the performance standard for any given measure (usually the standard is set at the NCQA Medicaid Mean and/or CMS Medicaid Median), the agency requires the health plans to submit corrective action plans (CAPs) and/or additional information related to their improvement efforts for those measures. While the agency has not implemented sanctions related to performance measures in some time, there is contract language in place that allows for this. For example, this is some of the language in the current ACC contract:

AHCCCS may impose sanctions on the Contractor if it does not show statistically significant improvement in its official performance measure/submeasure rates. Sanctions may also be imposed for:

1. Any rate that does not meet the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median.
2. A rate that has a significant impact on the program/population/LOB or statewide aggregate rate (including a significant impact to the program/population/LOB or statewide aggregate rate based on the Contractor's failure to utilize the performance measure calculation methodology required by AHCCCS).
3. Statistically significant declines in official rates, even if they meet or exceed the associated program/population/LOB aggregate rate, as applicable, and/or the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median.
4. Any rate that declines in percentile/quartile performance based on the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median benchmark data.

Regarding the specific performance metric for "Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (Greater than 9%)," this performance metric has been trending in a favorable direction in the most recently available years of data, and our state is trending more favorably than most states.
In terms of withhold activities related to performance metrics, this would be tied to our ACOM Policy 306 whereby withhold payments and quality measure performance incentive payments for health plans are calculated based their performance for a select set of performance measures. The details of the payment calculations can be accessed in the policy. Over the years, the program outlined in this policy has resulted in some of the health plans receiving payments and others losing withhold funds.

Question 4: What are the total costs of treating diabetes, sleep apnea, and cardiovascular issues over the last 5 years to AHCCCS?

Response: The total cost of the last five years is not reflective of the present/future given the uniqueness of the public health emergency period. The agency has been able to analyze the most recently complete calendar year of utilization for members with ICD-10 codes indicating a diagnosis of cardiovascular disease and/or obstructive sleep apnea (Dates of Service 1/1/2024-12/31/2024).

- The total annual cost for members aged 21 and older with obesity AND cardiovascular disease is approx. $2.453 billion
- The total annual cost for members aged 21 and older with obesity OR cardiovascular disease is approx. $5.385 billion

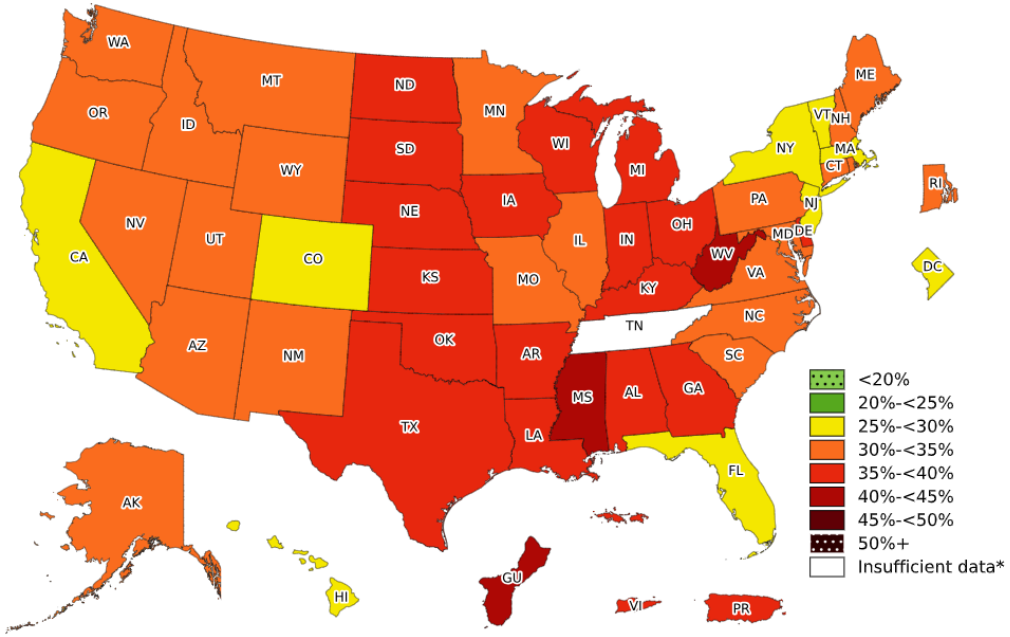
    - Note: Cardiovascular disease can occur in individuals who have never been obese or overweight
- The total annual cost for members aged 21 and older with obesity AND obstructive sleep apnea is approx. $723.1 million
- The total annual cost for members aged 21 and older with obesity OR obstructive sleep apnea is approx. $2.992 billion
    - Note: Obstructive sleep apnea can occur in individuals who have never been obese or overweight

Note: These line items have overlap with the previously cited costs associated with type two diabetes/obesity.

Obesity Study Committee
December 17, 2025

mercy care

Prevalence of Obesity in Adults- Arizona



- Nationwide: 34%
- Arizona: 31% (projected to increase to 51% in 2030)
- AHCCCS(Arizona Health Care Cost Containment System) Population: low of 12.8% to a high of 33.2%.

https://www.azleg.gov/legtext/56leg/2R/fiscal/HB2517.DOCX.pdf
https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-maps.html

mercy care

Health Impact of Obesity

Direct and indirect health impacts due to obesity are overwhelming (examples below):

- Diabetes/prediabetes
- Hyperlipidemia
- Metabolic- associated liver disease
- Depression/low self-esteem
- Impaired quality of life
- Musculoskeletal disorders
- Sleep apnea

These risk factors/associated conditions can increase morbidity and mortality and overall health care costs.

Obesity Comprehensive Management

Screening and assessment

Lifestyle modification

- Nutrition Education and Dietary Support- starting from childhood
- Physical Activity Promotion
- Weight Monitoring
- Behavioral Health and Psychosocial support
- Social Determinants of Health (SDOH) Interventions

Pharmacological treatment such as GLP 1 agonists

Devices

Surgery

Interventions and Outcomes of Obesity Management

Interventions	Outcomes	Concerns /Considerations
Lifestyle	5 +% weight loss	Maintaining this is challenging without strong support, and regaining weight is common.
Medications	5-20% weight loss, 0.5 to 2% A1c reduction	There are risks, such as not getting enough vitamins and minerals, weak bones, losing muscle, stomach problems, kidney issues, and feeling sad or depressed. Weight loss may slow down or stop after about 18 months, and people might gain back weight if they stop taking their medicine. Many people stop treatment for different reasons.
Surgery	25-30% weight loss, 2-3.5% A1C reduction	Surgery has its own risks. These include problems during the procedure, trouble absorbing vitamins and minerals, getting gallstones or kidney stones, and stomach problems.

Example weight loss for various GLP-1 drugs and bariatric surgery across different starting weights (lbs)

Starting weight	Semaglutide – weight loss	Semaglutide -Final	Tirzepatide weight loss	Tirzepatide Final	Bariatric Surgery weight loss	Bariatric Surgery Final
200	30	170	44	156	60	140
250	37.5	212.5	55	195	75	175
300	45	255	66	234	90	210
350	52.5	297.5	77	273	105	245

Assumptions:

- Semaglutide (Wegovy): Average ~15% total body weight loss at 68 weeks (STEP trials).Tirzepatide (Zepbound): Average ~20% total body weight loss at 72 weeks (SURMOUNT trials).Bariatric Surgery: Average ~25–30% total body weight loss at 1–2 years (ASMBS data).

Strategy Considerations for Obesity Management

- Expand access to effective treatments (including GLP-1s) with safeguards
- Invest in early childhood interventions and community prevention programs
- Improve provider coordination
- Offer behavioral support services
- Promote nutrition and exercise
- Address social factors impacting health

References

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https://www.globaldata.com/health-economics/US/Arizona/Obesity-Impact-on-Arizona-Factsheet.pdf

American Society for Metabolic and Bariatric Surgery

https://www.kff.org/state-health-policy-data/state-indicator/total-population

https://diabetes.org/sites/default/files/2025-05/the-burden-of-obesity-arizona-05-08-25.pdf

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ARIZONA STATE LEGISLATURE

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

OBESITY TREATMENT STUDY COMMITTEE

Date: **Wednesday, December 17, 2025**

Time: **12:00 P.M.**

Place: **SHR 1**

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2025121005

AGENDA

1. Call to Order
2. Roll Call
3. Presentation from Dr. Yaminikrishna Sabesan, Associate Chief Medical Officer, Mercy Care
4. Presentations on GLP-1 Coverage
   - Arizona Health Care Cost Containment System
   - Arizona Department of Administration
5. Review of Draft Presentations
6. Committee Discussion
7. Adoption of Recommendations
8. Adjournment

Members:

Senator David Gowan, Co-Chair
Senator Sally Ann Gonzales
Julie Hoffman
Cindy Komar
Dr. Christine Lovato
Dr. Douglas Maready

Representative Julie Willoughby, Co-Chair
Representative Patricia Contreras
Amy McCallister
Emily Moree
Dr. Kiran Raman

~~12/12/2025~~
12/17/2025
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