In the News

Report Finds Large Variation in States' Coverage for Obesity Treatments

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Although obesity is a substantial and growing problem throughout the US, affecting more than 4 in 10 adults, coverage by states and state Medicaid programs for the full range of obesity treatments varies widely, according to a new report from the Urban Institute.

The report, "Obesity Across America," provides a snapshot of the prevalence of obesity at the state and county levels and changes in prevalence in each state from 2011 to 2020. It also delves into insurance coverage for 4 types of treatment options—screening and counseling, nutritional counseling, pharmacotherapy, and bariatric surgery—for fee-for-service Medicaid, Medicaid managed care, state employee health plans, and state essential health benefits benchmark plans.

The authors found that in all states, the health burden of obesity—which is associated with increased risks for mortality and a number of health conditions, such as hypertension, type 2 diabetes, heart disease, and stroke—increased from 2011 to 2020. However, they said, the health burden is not equally distributed across communities or across the states, noting that Black, Hispanic/Latinx, Native American and Alaska Native, and Pacific Islander communities have higher rates of obesity compared with their White and Asian counterparts. Regionally, obesity is more common in the Southeast and Midwest and less so in some parts of the western US and the Pacific Northwest.

Prevalence of obesity varies considerably from state to state, ranging from about 24% in Colorado to nearly 40% in Mississippi, the report said, based on data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System. On the county level, there is even wider variation in the prevalence of obesity, from about 16% in Boulder County, Colorado, to 50% in Holmes County, Mississippi.

Given that obesity rates and associated comorbidities differ across states—and occur in the context of geographic differences in insurance coverage for obesity—"place is an important consideration in developing and scaling obesity interventions," the authors said.

Reviews of evidence by the Department of Veterans Affairs and Department of Defense and by endocrinology organizations support treatment approaches that feature comprehensive lifestyle interventions, including behavioral, dietary, and physical activity elements for people with obesity—as well as medication and surgical treatment for individuals with higher BMIs. However, the authors noted, "patients' access to the full spectrum of these services is limited by a lack of insurance coverage."

All types of insurance nationwide, including private and group plans, cover preventive screening and counseling services under the Affordable Care Act, but coverage for other treatment options varies a great deal. In addition to covering screening and counseling by a primary care clinician, traditional fee-for-service Medicare also provides coverage for weight loss programs, but only if they are part of treatment to manage an obesity-related associated condition, such as hypertension or diabetes. The military health insurance program, TRICARE, covers surgery and medications but not nutritional counseling.

Using data from a variety of sources, including the Centers for Medicare & Medicaid Services, the STOP Obesity Alliance at George Washington University, and the US Census Bureau's American Community Survey, the researchers investigated the types of obesity services covered at the state level, finding considerable variation in coverage offered by state governments to their employees or Medicaid beneficiaries or mandated for Affordable Care Act Marketplace plans.
Of the 4 types of treatment, drug therapy is the least likely option to be covered. Only 15 Medicaid programs cover antiobesity medications in fee-for-service Medicaid, and only 4 additional programs have at least 1 Medicaid managed care plan that covers these drugs. Only 2 states cover the medications in their benchmark Marketplace plan, and 16 state employee plans offer such coverage.

On the other hand, 48 states (excluding Mississippi and Montana) cover some form of bariatric surgery under Medicaid—including gastric bypass, gastric band, and sleeve gastrectomy—as do benchmark plans in 23 states and state employee plans in 42 states.

In contrast, only 26 Medicaid fee-for-service programs and 28 Medicaid managed-care programs cover specific nutritional counseling to support modified diets. Nutritional counseling is covered in 37 state benchmark plans and in 13 state employee health plans.

The researchers said that the “correlations between the treatments covered and the obesity rates in each state are not obvious.”

For example, they noted, 3 of the 10 states with the highest obesity prevalence and 3 of the 10 states with the lowest obesity rates offered coverage of antiobesity drugs. Also, twice as many Medicaid programs in states with low obesity rates offered coverage for nutritional counseling vs states with high obesity rates.

The report said that differences for states’ coverage of nutritional counseling “are even more apparent.” Three states with high prevalence of obesity and 6 states with low prevalence cover nutritional counseling in Medicaid; 8 of the 10 lowest-prevalence states cover this service in state-level essential health benefits benchmark plans, whereas only 5 of the 10 highest-prevalence states do so.

State employee plans cover nutritional counseling in 9 of the 10 highest-prevalence states and in 8 of the 10 lowest-prevalence states.

The authors noted that these differences suggest that states with the largest burdens of obesity may not be providing the full range of available treatment options to help mitigate that burden.

“Expanding health insurance access through Medicaid and covering obesity treatments through Medicaid and Medicare would help states combat obesity,” the authors wrote. In addition, enhancing coverage through the insurance Marketplace plans and state employee plans would help address the obesity epidemic, they noted, but the variation in obesity prevalence in counties within a state suggests that policies at the state level alone may not be sufficient to address the problem.

“To the extent that access to high-quality, local providers of comprehensive services or some other factor drives those intrastate differences, locally targeted interventions may also be necessary,” the authors said.