MILLIMAN REPORT

Comprehensive obesity and prediabetes coverage analysis

Prepared for the Colorado Division of Insurance

March 13, 2025

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Introduction

Under Colo. Rev. Stat. § 10-16-155, the Colorado Division of Insurance (DOI) under the Colorado Department of Regulatory Agencies (DORA) has retained Milliman, Inc. (Milliman), a global actuarial consulting firm, to perform actuarial reviews of legislative proposals that may impose a new health benefit coverage requirement on health benefit plans or reduce or eliminate coverage required under a health benefit plan. The legislative requirements may impact the individual, small group, and large group health insurance markets. The actuarial review must consider the predicted effects of the legislative proposal on the affected markets during the one, five, and 10 years immediately following the effective date of the legislative proposal, or during another time period following the effective date of the legislative proposal if such consideration is more actuarially feasible, including:

- An estimate of the number of Colorado residents who will be directly affected by the legislative proposal
- Estimates of changes in the rates of utilization of specific healthcare services that may result from the legislative proposal
- Estimates of changes in consumer cost sharing that would result from the legislative proposal
- Estimates of changes in health benefit plan premiums charged to covered persons or employers, in individual, small group and large group markets, that would result from the legislative proposal
- An estimate of the out-of-pocket healthcare cost changes associated with the legislative proposal
- An estimate of the potential long-term healthcare cost changes associated with the legislative proposal
- Identification of any potential health benefits for individuals or communities that would result from the legislative proposal
- Information concerning who would benefit from any cost changes and benefit expansions and any disproportionate effects it may have on protected classes, as available
- To the extent practicable, the social and economic impacts of the legislative proposal, including information concerning who would benefit from cost changes, and any disproportionate effects and qualitative analysis of the impacts of the legislative proposal

At the request of the DOI, Milliman was asked to provide an analysis of a legislative proposal that would require all Colorado state-regulated individual and group health benefit plans in Colorado to provide coverage for the treatment of the chronic disease of obesity and the treatment of prediabetes, including coverage for intensive behavioral or lifestyle therapy, bariatric surgery, and FDA-approved anti-obesity medication.

The legislative proposal requires coverage criteria for FDA-approved anti-obesity medication to not be more restrictive than FDA-approved indications for the medication. In addition, the coverage must not be different or separate from coverage for any other illness, condition, or disorder for purposes of determining copayments, deductibles, coinsurance, or annual maximum benefit. A plan may still apply utilization management to determine medical necessity for treatment of the chronic disease of obesity and the treatment of prediabetes if appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by the health benefit plan.

The proposed legislation defines “FDA-approved anti-obesity medication” as “any medication approved by the federal Food and Drug Administration with an indication for chronic weight management in patients with obesity.” “Intensive behavioral or lifestyle therapy” (IBT) is defined in the legislation as “an evidence-based, intensive, multi-component behavioral or lifestyle modification intervention that supports healthy weight management as recommended by current clinical standards of care. Interventions include a high frequency of counseling and focus on nutrition or dietary changes, physical activity, and behavioral counseling strategies to achieve health weight management. Interventions may be provided in office, virtual, or community-based settings to support patient access and needs.”

The proposed legislation would apply to state-regulated large group health plans issued or renewed on or after January 1, 2026, and individual and small group health benefit plans issued on or after January 1, 2027. Thus, the “first-year” impacts are considered 2026 for large group markets and 2027 for individual and small group markets.

Any five-year or 10-year cumulative impacts presented here are considered for the years 2026 through 2030 and 2026 through 2035 respectively, regardless of market.

Executive summary

The proposed legislation would require all state-regulated individual and group health benefit plans to provide coverage for the treatment of obesity and prediabetes.

Obesity is a chronic condition defined by the Centers for Disease Control and Prevention (CDC) as occurring in adults with a body mass index (BMI) of 30 or higher, and children with a BMI at or above the 95th percentile among children of the same age and sex.[1] Prediabetes is a condition where blood sugar levels are elevated above normal levels but not high enough to be considered diabetes. The CDC outlines that a blood glucose measurement (HbA1c level) between 5.7% and 6.4% indicates prediabetes, while an HbA1c level of 6.5% or more indicates diabetes.[2]

Obesity and prediabetes can increase the risk of developing several conditions, including heart disease, type 2 diabetes, stroke, and cancer. Based on self-reported data from 2023, in Colorado, 25% of adults and 10.6% of high school students are affected by obesity, with higher prevalence in communities of color.[3,4] In addition, 38% of the total U.S. adult population had prediabetes.[5]

On the other hand, based on using administrative diagnoses codes in claims data from the Colorado All Payer Claims Database (APCD), approximately 13% of Colorado's fully insured commercial population were diagnosed with obesity or prediabetes in 2023 (see Exhibit 2). Studies show that the use of administrative diagnoses coded in claims data to classify patients as overweight or obese may meaningfully underestimate the prevalence of those conditions.[6] Claims data diagnosed prevalence is based on healthcare providers coding an official diagnosis for an individual. CDC prevalence rates are based on self-reported data, not claims. To access the expanded services resulting from the proposed legislation, enrollees would need a diagnosis of obesity or prediabetes to determine appropriateness and medical necessity of treatments, which is why the prevalence rate from the APCD is used for this analysis.

Effective weight management can delay the progression from prediabetes to type 2 diabetes and is beneficial in treating type 2 diabetes.[7,8] Therefore, similar to obesity, the recommended treatment for prediabetes is weight management. The following weight-management treatments were considered in this analysis:

- FDA-approved anti-obesity medication
- Intensive behavioral or lifestyle therapy, and bariatric surgery

According to a survey of Colorado health plans conducted by the Colorado Division of Insurance in 2024, current coverage for these treatments among the commercially insured population in Colorado varies across different insurance plans. Medication therapies are the least-covered treatment, with coverage ranging by market from 0% to 10%. Intensive behavioral therapy coverage, which includes nutrition or dietary counseling, physical therapy education and behavioral health therapies, varies by market and type of therapy from 56% to 100%. Bariatric procedures are covered for 100% of individual and small group enrollees, and 53% of large group enrollees.

Some results of our analysis of the impact of the proposed legislation are highlighted below. For information on how these values were determined, please see the Methodologies and Assumptions section of the report.

For medication therapies, the estimated average cost per prescription[a] (generally a one month's supply) is estimated to be $710 in 2026. The current low coverage, high cost, and high interest in these medication therapies result in these therapies accounting for over 90% of the total estimated premium impact of the proposed legislation for the individual and small group markets.

The estimated average cost of bariatric surgery in 2026 is $34,400. Although utilization is considerably lower than that of medication therapies, the high cost per service and low current coverage in the large group market of bariatric procedures causes 18.21% of the total large group premium impact to be attributed to these services (see Exhibit 8).

As shown in Exhibit 1, the estimated premium impact from implementation of the proposed legislation without medical cost offsets is a first-year premium increase of $54,683,000 across all markets. The five-year cumulative premium

[a] Cost per prescription is a unit cost and is standardly used as a measure for pharmacy costs, similar to the cost per service for medical claims.

increase is $271,366,000 for all markets. The 10-year cumulative premium increase is $628,169,000 for all markets. When spread over the insured population, the total impact on premium equates to $4.33 per member per month (PMPM) for the first year across all markets. Exhibit 1 also includes illustrative scenarios estimating savings associated with the expansion of coverage of weight-loss services impacted by the proposed legislation.

EXHIBIT 1: ESTIMATED PREMIUM IMPACT OF PROPOSED LEGISLATIVE LANGUAGE

	1 YEAR (2026) IMPACT	1 YEAR (2027) IMPACT	5 YEAR (2026-2030) CUMULATIVE IMPACT	10 YEAR (2026-2035) CUMULATIVE IMPACT
WITHOUT MEDICAL COST OFFSETS				
Individual - Total Dollars		$10,800,000	$45,975,000	$115,097,000
Individual - PMPM		$3.23	$3.39	$3.67
Individual - Percent Change		0.60%	0.57%	0.51%
Small Group - Total Dollars		$11,864,000	$50,418,000	$125,868,000
Small Group - PMPM		$3.68	$3.85	$4.16
Small Group - Percent Change		0.50%	0.47%	0.42%
Large Group - Total Dollars	$32,019,000		$174,973,000	$387,204,000
Large Group - PMPM	$5.28		$5.66	$6.10
Large Group - Percent Change	1.02%		0.94%	0.84%

	1 YEAR (2026 LG, 2027 IND AND SG) IMPACT	5 YEAR (2026-2030) CUMULATIVE IMPACT	10 YEAR (2026-2035) CUMULATIVE IMPACT
All Commercial - Total Dollars	**$54,683,000**	**$271,366,000**	**$628,169,000**
All Commercial - PMPM	**$4.33**	**$4.71**	**$5.03**
All Commercial - Percent Change	**0.75%**	**0.73%**	**0.64%**

WITH MEDICAL OFFSETS

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
Low Savings - All Commercial - Total Dollars	$49,517,000	$245,011,000	$560,879,000
Low Savings - All Commercial – PMPM	$3.92	$4.25	$4.49
Low Savings - All Commercial - Percent Change	0.68%	0.66%	0.57%
High Savings - All Commercial - Total Dollars	**$46,995,000**	**$232,149,000**	**$528,037,000**
High Savings - All Commercial – PMPM	$3.72	$4.03	$4.22
High Savings - All Commercial - Percent Change	0.64%	0.62%	0.54%

Developing estimates of medical cost offsets for treating obesity and prediabetes through weight-loss interventions is complex, and involves modeling transitions of disease states considering starting BMI, comorbidities, adherence to treatment, amount of weight lost, and weight-loss intervention used. GLP-1 medication therapies are fairly new to the market, and research on these inputs is scant, as are studies estimating long-term effectiveness and resulting cost savings. Prime Therapeutics published a study in October of 2024 describing the real-world impact of two years of Ozempic or Wegovy use for obesity on healthcare costs and found no evidence of medical offsets after two years.[9] We are not aware of any studies that quantify the long-term impact of anti-obesity medications on healthcare costs.

We have prepared illustrative scenarios estimating savings associated with the expansion of coverage of weight-loss services impacted by the proposed legislation. We calculated the savings under two scenarios:

1. Low savings: Assume that all health plan members achieving at least 5% weight loss save $670 annually
2. High savings: Assume that 15% of the enrollees achieving at least 5% weight loss save $2,850 annually and the other 85% save $670 annually

Under both scenarios, the cost savings associated with weight loss partially offset the cost of weight-loss interventions. As shown in Exhibit 1, the illustrative medical costs offsets result in a savings of $0.41 to $0.61 PMPM on the estimated premium impact in the first year. The high-savings scenario results in a 0.64% premium increase in the first year compared to a 0.75% premium increase when cost savings associated with weight loss are not included.

The proposed legislation would have a financial impact for obese and prediabetic members who currently do not have coverage for the specified services. However, cost sharing for weight-management treatment may continue to present a financial burden to members, especially for high-cost services like medication therapies and bariatric surgery.

Background

OBESITY AND PREDIABETES

Obesity is a chronic condition that affects millions of adults and children in the United States. The Centers for Disease Control and Prevention (CDC) defines obese adults as those with a body mass index (BMI) of 30 or higher, and obese children as those with a BMI at or above the 95th percentile among children of the same age and sex.[1] Obesity in children and adults can increase the risk of developing many chronic conditions including heart disease, type 2 diabetes, osteoarthritis, and gall stones and gall bladder disease.[10,11] Obesity in adults is also associated with higher risk of stroke and 13 types of cancer.[12] The presence of obesity and diabetes also leads to higher risk for more severe coronavirus infection and hospitalization.[13,14]

Prediabetes is a condition where blood sugar levels are elevated above normal levels but not high enough to be considered diabetes. The CDC outlines that an HbA1c level between 5.7% and 6.4% indicates prediabetes, while an HbA1c level of 6.5% or more indicates diabetes.[2] Prediabetes can be asymptomatic. Risk factors for prediabetes include being overweight or obese, having a history of gestational diabetes, having a family history of type 2 diabetes, being over 45 years old, or having polycystic ovary syndrome.[15]

OBESITY AND PREDIABETES PREVALENCE

According to the 2023 CDC Behavioral Risk Factor Surveillance System (BRFSS), obesity affects 24.9% of Colorado adults, with higher prevalence in communities of color; Black,(29.5%), Hispanic (30.9%) and American Indian/Alaska Native (33.6%) adults have a higher prevalence of obesity, relative to white adults (23.7%).[3] In 2023, 10.6% of high school students in Colorado reported being obese,[4] and nationally, more than one in five youth ages 10 to 17 were obese between 2017 and 2020.[16] Research has found obesity prevalence in children and adults to be higher in rural areas relative to urban areas.[17,18]

In 2021, 38% of the total U.S. adult population had prediabetes and 48.8% of adults 65 and older had prediabetes. Prevalence was found to be similar among all racial and ethnic groups.[5]

The diagnosed prevalence rate of obesity or prediabetes for the 2023 enrolled population from the 2023 Colorado All Payer Claims Database (APCD) was much lower and ranged from 10.9% in the individual market to 14.9% in the large group market.

Studies show that the use of administrative diagnoses coded in claims data to classify patients as overweight or obese may meaningfully underestimate the prevalence of those conditions.[6] Claims data diagnosed prevalence is based on healthcare providers coding an official diagnosis for an individual. CDC prevalence rates are based on self-reported data, not claims. Additionally, the diagnosed prevalence rates from the claims data included are across all ages.

For purposes of our analysis, we are relying on diagnosed prevalence rates to inform our utilization assumptions since a diagnosis would be required to determine appropriateness and medical necessity of treatments. It is possible that the diagnosed prevalence rates may increase as a result of this proposed legislation if more enrollees seek to utilize newly covered benefits that require an obesity diagnosis. However, the diagnosed prevalence rate would be less than the self-reported obesity and prediabetes prevalence rates cited above because some enrollees may not use their health insurance or utilize services requiring an obesity diagnosis. We have not assumed an increase in diagnosed prevalence rates in our analysis, as this increase in prevalence rate would be hypothetical and our analysis represents a low-end estimate of the impact of the proposed legislation.

TREATMENT

Evidence shows that effective weight management can delay the progression from prediabetes to type 2 diabetes and is highly beneficial in treating type 2 diabetes. Weight loss may be achieved through lifestyle changes (including

diet and exercises) or through clinical interventions, similar to that of weight-management treatments for obesity without prediabetes. Treatment for weight loss in an obese population may include the following:[19,20,21]

- Intensive behavioral or lifestyle therapy as specified in the legislative proposals, including:
  - Nutrition-related services such as dietary counseling, medical nutrition therapy, weight-management class.
  - Physical activity related services such as exercise counseling, exercise class, gym club membership.
  - Behavioral health therapies such as cognitive behavioral therapy, exposure and response prevention therapy, health behavior assessment and intervention, preventive medicine counseling, and risk factor reduction.
  - Diabetes prevention program services (for those with prediabetes): The National Diabetes Prevention Program is a lifestyle intervention operated through the Centers for Medicare and Medicaid Services (CMS) that aims to prevent diabetes through weight loss using improved diet and exercise. The program incorporates a year-long CDC-certified curriculum, along with one-on-one health coaching and support groups.[22] The program is offered through Medicare, some state Medicaid programs, and some commercial health plans.
- Bariatric surgery (e.g., laparoscopic bariatric surgery, gastric bypass surgery): A surgical procedure that reduces weight by altering the digestive tract. There are several approaches, including reducing the size of the stomach or rerouting the small intestine.
- FDA-approved anti-obesity medications – Brand names (generic)
  - Glucagon-like peptide 1 (GLP-1) receptor agonists: These medications work by slowing gastric emptying, which in turn makes the person taking the medication feel full for longer and reduces appetite. They may suppress appetite by affecting the brain's desire for food.[23]
    - Saxenda (liraglutide)
    - Wegovy (semaglutide)
    - Zepbound (tirzepatide)
  - Non-GLP-1s: These medications work to reduce weight through a variety of mechanisms including appetite suppression, metabolism stimulation, or enzyme inhibition related to the breakdown and absorption of fat.
    - Contrave (bupropion and naltrexone)
    - Alli and Xenical (orlistat)
    - Qsymia (phentermine and topiramate)
    - Imcivree (setmelanotide)
    - Adipex-P (phentermine)

POTENTIAL HEALTH BENEFITS OF TREATMENT

Studies have shown that sustained weight loss for individuals with obesity can reduce health risks and improve health outcomes of treated comorbidities.[24] In people with type 2 diabetes who are overweight or obese, weight management has been shown to reduce glycemia levels and reduce the need for glucose-lowering medications.[25] Weight loss has also been shown to reduce the risk of developing diabetes in a prediabetic population.[7,8] Evidence also suggests that cardiometabolic health risk and incidence are improved through weight loss[24,26] and can reduce the risk of certain cancers.[12]

Long-term health outcomes will depend on the degree of weight loss and whether the achieved weight loss is maintained.

Behavioral or lifestyle therapies have been shown to be effective in achieving modest weight loss for a subset of participants, but few participants in these programs have been shown to maintain weight loss after ceasing these programs. In a study of a Colorado-based weight-loss program that offered community-based weigh-ins, health coaching, and daily access to cognitive-theory based email and text support, 24% of participants lost at least 5% of body weight at the end of the 12-month program. Of those who lost at least 5% of their body weight, 36% maintained their weight loss at six months after achieving weight loss and 19% maintained their weight loss at 12 months.[27] The

study found similar results for individuals who lost 3% of body weight.[27] A systematic review of 21 behavioral and lifestyle therapies found that weight regain by 12 months post-enrollment occurred in half of the interventions.[28]

Weight loss from bariatric surgery is more drastic and durable than lifestyle changes alone. Patients have been shown to lose at least 20% of initial body weight within the first two to three years post-surgery[29,30] and maintain this weight loss for the next 10 years.[31]

Last, adherence among GLP-1 users has been shown to be poor. Research suggests that non-GLP-1 and GLP-1 medications must be taken consistently and over the long-term to maintain weight loss.[32,33] A study of adherence to any of six GLP-1 products for obesity among commercially insured individuals found that across all products, 27.2% of members were adherent to the GLP-1 at one-year follow-up.[34] Adherence by GLP-1 product ranged from 15% to 41.5%. Another study showed that 32% of people continued to adhere to the therapy at 12 months.[35] One drug manufacturer's study showed that people who stopped taking semaglutide (Wegovy) after regular use gained back two-thirds of prior weight loss within a year of stopping the drug.[32] These drugs are relatively new to the market, and longer-term studies are needed to determine the impact on health benefits and net weight loss in the long term. Similar issues with poor adherence have been found with non-GLP-1 medications. [36]

In addition to diabetes and anti-obesity treatment, GLP-1s are beginning to receive other clinical indications. Wegovy was approved by the FDA in March 2024 for use in adults with cardiovascular disease and either obesity or overweight indications to reduce the risk of cardiovascular events such as cardiovascular death, heart attack, and stroke problems.[37] The FDA also recently approved an indication for semaglutide for use in adults with chronic kidney disease[38] and Zepbound (tirzepatide) for sleep apnea.[39]

Ongoing research is also exploring the benefits of GLP-1s on depression, [40,41] substance use disorders,[42] neurological diseases,[43] and liver disease.[44]

INSURANCE COVERAGE OF TREATMENTS FOR OBESITY AND PREDIABETES

In December 2024, the Colorado Division of Insurance surveyed Colorado insurance carriers in the individual, small group, and large group markets regarding their coverage of obesity and prediabetes services. Bariatric procedures are covered by all individual and small group plans, but only approximately 53% of members have coverage in large group plans. While components of intensive behavioral therapy (IBT) such as nutrition classes and dietary counseling, weight management, and behavioral therapies are covered by plans for 74% to 87% of members, components such as exercise classes are covered by plans for fewer members (66%). Medication therapies are the least-covered component of weight-management treatment. Approximately 12% of members surveyed with large group plans have coverage for medication therapies to treat obesity; however, no small group or individual plans offer this coverage for obesity. These survey results suggest that the proposed legislation would increase plan-covered utilization of weight-management treatments in individuals with obesity and prediabetes. Please see Exhibit 3 for the full results of this survey.

PUBLIC DEMAND, DISPARITY, AND AVAILABILITY OF SERVICES

Our review of literature suggests that there are disparities in who receives obesity and prediabetes care. Throughout our review of the literature, we observed that utilizers of weight-loss therapies were predominantly women. A few examples of this include: 81% of participants in a study of GLP-1 treatment were women,[35] 78% of participants in a community lifestyle program were women,[27] 76% of National Diabetes Prevention Program (DPP) participants between 2015 and 2019 were women,[45] and 85% of all anti-obesity prescriptions were for women in a study of eligible adults across eight major health systems.[46]

There are also known racial and ethnic disparities in the utilization of weight-management treatments for obesity.[47,48] For example, Black patients are less likely to be diagnosed with obesity (odds ratio = 0.73)[b] relative to white patients,

[b] An odds ratio is a statistical term that measures the likelihood of an event occurring in one group compared to another. An odds ratio of one means that there is an equal chance of an event happening in both groups. An odds ratio of less than one means that the event is less likely to occur in the first group compared to the second.

which can result in fewer referrals to obesity specialists, bariatric surgery, and prescriptions for weight-loss medications.[49]

Residents in rural areas have less access to weight-management treatments for obesity than urban residents. In the United States in 2019, travel time to an obesity specialist was nine minutes in urban areas, 45 minutes in suburban areas, and 67 minutes in rural areas.[50] Additionally, between 2019 and 2023 there were nearly 3.8 times the number of obesity-related specialists in metropolitan counties relative to rural counties.[51] Rural residents have also been found to be 23% less likely to receive bariatric surgery than urban residents.[52]

There is variation in the availability of services, and public demand varies by service. We describe service-specific availability and demand in the following sections.

Intensive behavioral or lifestyle therapy

Enrollment into intensive behavioral or lifestyle therapies is low relative to the eligible population, and attrition in these programs is high. Participation in the nationally available Medicare Diabetes Prevention Program (DPP) has been far lower than expected. The program was predicted to enroll 110,000 people in the first 10 years but had only enrolled 3,600 in the first three years.[53] In one study of a weight management program implemented across five urban community health centers, 12,487 patients were identified through screening as being overweight or obese; 40% received a provider referral to the program, 15.6% had at least one contact with the program, and 2.1% had more than 10 contacts. This study found the population with less than 10 program contacts did not have significant weight loss.[54]

Behavioral changes may be harder to implement for racial and ethnic minorities due to disparities in social determinants of health.[47] For example, in the United States, food insecurity was found to be more common among non-Hispanic Black (20.9%) and Hispanic populations (24.6%) than among white populations (8.1%).[55] Further discussion on this topic can be found in the Social and Economic Impact section.

The availability of programs and exercise facilities in Colorado include 26 suppliers offering the CDC's DPP (the majority of which are located in the Denver-Boulder area), and their classes are delivered in-person only. There are also several online versions of the program offered nationwide.[56]

Bariatric surgery

Bariatric surgery has been estimated to be utilized by 1% of the eligible population.[57] This level of utilization is thought to be driven by several factors, including patient perception of safety,[58] low provider referrals,[59] and cost.[60]

In one survey describing demographic differences among primary care patients with BMI greater than 35, only 20% of participating patients reported being recommended surgery by their doctor, and African-American participants were less likely than white participants to receive a recommendation, as were men relative to women.[58]

FDA-approved anti-obesity medications

In a 2023 survey conducted by the Kaiser Family Foundation, 59% of respondents trying to lose weight said they would be interested in taking a safe and effective weight-loss drug, and about 70% of adults trying to lose at least 20 pounds said they would be interested.[61] An update to this survey in 2024 found that 12% of respondents had ever taken a GLP-1 for any clinical indication, and 6% of respondents were currently taking one.[62] Of respondents who had ever used a GLP-1, 23% took them to both lose weight and treat a chronic condition, and 38% took them exclusively to lose weight.

GLP-1 prescribing has risen quickly. One study reported a 700% increase in prescribing between 2019 and 2023. This study also found that the proportion of users without diabetes but with a BMI of 27 or greater doubled during that same time period.[63]

There has been significant public demand for GLP-1s, resulting in a shortage of these drugs through the fall of 2024.[64] In October 2024, the FDA determined the shortage of GLP-1s had resolved. For our analysis, we have assumed no supply chain issues.

Despite the high public interest in weight-loss medication, the prescribing of non-GLP-1 anti-obesity medication is low.[46,65] In a study of electronic medical records from eight health systems across the United States between 2009 and 2015, only 1.3% of the 2.2 million eligible patients filled at least one prescription.[46] In another study of a large, nationally representative EHR database, 2.4% of the 11,195,020 adults identified with obesity were prescribed an anti-obesity medication between 2010 and 2019. Rates increased from 1.1% in 2010 to 2.9% in 2019.[66]

Financial analysis

The proposed legislative language we relied upon would require all individual and group health benefit plans to provide coverage for the treatment of the chronic disease of obesity and the treatment of prediabetes, including coverage for:

1. Intensive behavioral or lifestyle therapy.
2. Bariatric surgery.
3. FDA-approved anti-obesity medication. The coverage criteria for FDA-approved anti-obesity medication must not be more restrictive than FDA-approved indications for the medication.

We considered outcomes-based weight-management treatments for individuals with obesity and prediabetes, including all modalities that support clinically significant weight loss of at least 5% in body weight among persons with obesity. Services considered include the following:

- Intensive behavioral or lifestyle therapy
    - Nutrition-related services (e.g., dietary counseling, medical nutrition therapy, weight-management class)
    - Physical-activity-related services (e.g., exercise counseling, exercise class, gym club membership)
    - Behavioral health therapies (e.g., cognitive behavioral therapy, exposure and response prevention therapy, health behavior assessment and intervention, preventive medicine counseling, and risk factor reduction)
    - Diabetes prevention program services (for those with prediabetes)
- Bariatric surgery (e.g., laparoscopic bariatric surgery, gastric bypass surgery)
- FDA-approved anti-obesity medications – Brand names (generic)
    - Glucagon-like peptide 1 (GLP-1) receptor agonists
        - Saxenda (liraglutide)
        - Wegovy (semaglutide)
        - Zepbound (tirzepatide)
    - Non-GLP-1s
        - Contrave (bupropion and naltrexone)
        - Alli and Xenical (orlistat)
        - Qsymia (phentermine and topiramate)
        - Imcivree (setmelanotide)
        - Adipex-P (phentermine)

In addition, the proposed legislation would not allow coverage to be different or separate from coverage for any other illness, condition, or disorder for purposes of determining copayments, deductibles, coinsurance, or the annual maximum benefit. The legislative proposal would not prohibit a plan from applying utilization management to determine medical necessity for treatment of the chronic disease of obesity and the treatment of prediabetes if appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by the plan.

Our evaluation projects the population subject to the benefit requirements, the cost of benefits, and the premium and enrollee cost sharing for the implementation year (calendar year 2026 for large group and calendar year 2027 for individual and small group), the cumulative first five years (calendar years 2026 through 2030 for all markets), and the cumulative first 10 years (calendar years 2026 through 2035 for all markets) under the following two scenarios:

1. Baseline – Proposed legislation **does not** go into effect

2. Post-benefit requirement – Proposed legislation **does** go into effect

The difference between the baseline and post-benefit requirement values is the impact of the proposed legislation.

OBESITY AND PREDIABETES PREVALENCE

Exhibit 2 displays the diagnosed prevalence of obesity and prediabetes by coverage type for the 2023 enrolled population from the Colorado APCD.

EXHIBIT 2: PREVALENCE OF OBESITY AND PREDIABETES, PER 1,000 – COLORADO 2023 APCD

	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Obesity (but Not Prediabetes)	65.1 per 1,000	80.4 per 1,000	98.5 per 1,000
Prediabetes (but Not Obesity)	29.3 per 1,000	22.1 per 1,000	27.8 per 1,000
Obesity and Prediabetes	14.9 per 1,000	16.1 per 1,000	22.9 per 1,000
Total Prevalence of Obesity or Prediabetes	109.2 per 1,000	118.6 per 1,000	149.2 per 1,000

According to the 2023 CDC Behavioral Risk Factor Surveillance System (BRFSS) 25% of Colorado adults were obese in 2023.[3] In 2023, 10.6% of high school students in Colorado reported being obese.[4] The CDC also estimates that in 2021, 38% of the total U.S. adult population had prediabetes.[5]

Studies show that the use of administrative diagnoses coded in claims data to classify patients as overweight or obese may meaningfully underestimate the prevalence of those conditions.[6] Claims data diagnosed prevalence is based on doctors coding an official diagnosis for an individual. CDC prevalence rates are based on self-reported data, not claims. Additionally, the diagnosed prevalence rates from the claims data are across all ages.

It is possible that the diagnosed prevalence rates may increase as a result of this proposed legislation if more enrollees seek to utilize newly covered benefits that require an obesity diagnosis. However, the diagnosed prevalence rate would be less than the self-reported obesity and prediabetes prevalence rates cited above because some enrollees may not use their health insurance or utilize services requiring an obesity diagnosis. We have not assumed an increase in diagnosed prevalence rates in our analysis, as this increase in prevalence rate would be hypothetical and our analysis represents a low-end estimate of the impact of the proposed legislation. Should the diagnosed prevalence rate be equal to the 25% adult obesity rate cited above, the premium impacts would nearly double.

INSURANCE COVERAGE OF TREATMENTS FOR OBESITY AND PREDIABETES

As noted in the Background section of this report, there are varying levels of coverage for treatment options for obesity and prediabetes in Colorado. In particular, medication therapies are the least commonly covered treatment. Exhibit 3 displays the percentage of enrollees who have coverage for each type of treatment based on survey responses received from carriers.

EXHIBIT 3: PERCENT OF ENROLLEES WITH CURRENT COVERAGE FOR TREATMENTS FOR OBESITY AND PREDIABETES AT BASELINE

	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Medication Therapies	0.0%	0.0%	12.5%
IBT: Nutrition-related Services	81.0%	100.0%	84.6%
IBT: Physical-activity-related Services	56.0%	66.7%	73.2%
IBT: Behavioral Health Therapies	81.2%	100.0%	84.6%
Bariatric Procedures	100.0%	100.0%	52.8%

Information regarding current coverage of diabetes prevention IBT services was not included in the carrier survey because it was not included in the draft legislation language available at the time of sending the carrier survey, so we assumed that diabetes prevention IBT is currently covered by 94% of plans; because most diabetes prevention programs are certified by the CDC, we relied on their list of commercial plans who currently cover the National DPP lifestyle change program to develop our estimate.[67]

The proposed legislation would require all carriers to cover comprehensive weight-management treatments for obesity and prediabetes. Therefore, we have modeled all treatment categories having 100% coverage post legislation.

UTILIZATION

Weight-management treatments were split into medication therapies, intensive behavioral therapy (IBT), and bariatric procedures. IBT includes nutrition-related services, physical activity services, behavioral counseling services, and diabetes prevention program services. Exhibit 4 displays the projected baseline utilization per 1,000 enrollees in the first year (2026 for large group and 2027 for individual and small group). This baseline utilization includes assumed utilization for those that currently have coverage and those that do not currently have coverage and are paying out of pocket for these services. For medication therapies, the utilization figures reflect the expected number of prescriptions per 1,000 enrollees in the first year (2026 for large group and 2027 for individual and small group).

EXHIBIT 4: BASELINE TREATMENT FOR OBESITY AND PREDIABETES UTILIZATION PER 1,000 IN 2026 AND 2027

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
Medication Therapies	10.3	1.2	1.2
IBT	217.3	120.2	156.7
Bariatric Procedures	0.4	0.2	0.4

The estimated marginal increase in utilization, or utilization added as a result of the proposed legislation, for weight-management treatment benefits, assuming all carriers must provide comprehensive coverage of obesity and prediabetes, is shown in Exhibit 5. Details about the development of the utilization estimates can be found in the Methodology and Assumptions section of this report.

EXHIBIT 5: MARGINAL UTILIZATION INCREASE PER 1,000 FOR WEIGHT MANAGEMENT TREATMENTS IN 2026 AND 2027

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
Medication Therapies	64.5	56.3	61.2
IBT	23.4	20.6	11.7
Bariatric Procedures	0.4	-	-

COST PER SERVICE AND ENROLLEE COST SHARING

As noted in prior sections of the report, we anticipate that weight management treatments for obesity and prediabetes will be split into three broad categories: medication therapies, intensive behavioral therapy (IBT), and bariatric procedures. We have summarized the cost per service for each of these treatments below.

We do not anticipate that the proposed legislation will change the underlying price of the treatments, and thus did not assume the average cost per service of weight management treatments to change after the effective date of the proposed legislation.

Medication therapies

We leveraged drug prices from the Medi-Span drug database to develop average cost estimates for both GLP-1 and non-GLP-1 FDA-approved anti-obesity medications for those diagnosed with obesity or prediabetes. We estimate that the average cost per prescription (generally a one-month supply) net of manufacturer rebates is approximately $710 in 2026.

IBT

The average cost per service for IBT will vary by type of therapy. The estimated average cost per service in the first year (2026 for large group and 2027 for individual and small group) is shown in Exhibit 6.

EXHIBIT 6: AVERAGE COST PER SERVICE FOR IBT SERVICES

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
Nutrition-related Services	$232	$243	$243
Physical Activity Services	$16	$16	$16
Behavioral Counseling Services	$221	$231	$231
Diabetes Prevention Program Services	$183	$191	$191

Where sufficient data existed, we leveraged the APCD to develop average cost estimates for various IBT treatments for those diagnosed with obesity or prediabetes. Sufficient claims data did not exist for physical activity services, and the average cost per service (equivalent of one fitness class) was estimated based on a review of various prices for exercise classes offered by Colorado town recreation departments and universities as well as gyms and punch pass services.

Bariatric procedures

We leveraged the APCD to develop average cost estimates for those diagnosed with obesity or prediabetes. We estimate that the average cost per bariatric procedure case is approximately $34,789 in 2027 for individual plans and small group plans, and $34,444 in 2026 for large group plans.

PREMIUM IMPACT

The estimated premium impact from implementation of the proposed legislative language is shown in Exhibit 7. Because the legislative language proposes an implementation date of January 1, 2026, for large group plans and January 1, 2027, for individual and small group plans, we are showing a one-year implementation impact for calendar year 2026 for large group plans and for calendar year 2027 for individual and small group plans. The five-year cumulative impact is for years 2026 through 2030, and the 10-year cumulative impact is for years 2026 through 2035, for all groups.

- For individual insurance, we estimate a one-year (2027) total premium increase of $10,800,000, a five-year (2026-2030) cumulative total premium increase of $45,975,000, and a 10-year (2026-2035) cumulative total premium increase of $115,097,000 or $3.23, $3.39, and $3.67 per member per month, respectively. As a percentage, this increase ranges from 0.51% to 0.60% over the baseline period.
- For small group insurance, we estimate a one-year (2027) total premium increase of $11,864,000, a five-year (2026-2030) cumulative total premium increase of $50,418,000, and a 10-year (2026-2035) cumulative total premium increase of $125,868,000 or $3.68, $3.85, and $4.16 per member per month, respectively. As a percentage, this increase ranges from 0.42% to 0.50% over the baseline period.

- For large group insurance, we estimate a one-year (2026) total premium increase of $32,019,000, a five-year (2026-2030) cumulative total premium increase of $174,973,000, and a 10-year (2026-2035) cumulative total premium increase of $387,204,000 or $5.28, $5.66, and $6.10 per member per month, respectively. As a percentage, this increase ranges from 0.84% to 1.02% over the baseline period.

EXHIBIT 7: ESTIMATED PREMIUM IMPACT OF PROPOSED LEGISLATIVE LANGUAGE

	1-YEAR (2026) IMPACT	1-YEAR (2027) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
Individual - Total Dollars		$10,800,000	$45,975,000	$115,097,000
Individual - PMPM		$3.23	$3.39	$3.67
Individual - Percent Change		0.60%	0.57%	0.51%
Small Group - Total Dollars		$11,864,000	$50,418,000	$125,868,000
Small Group - PMPM		$3.68	$3.85	$4.16
Small Group - Percent Change		0.50%	0.47%	0.42%
Large Group - Total Dollars	$32,019,000		$174,973,000	$387,204,000
Large Group - PMPM	$5.28		$5.66	$6.10
Large Group - Percent Change	1.02%		0.94%	0.84%

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
All Commercial - Total Dollars	$54,683,000	$271,366,000	$628,169,000
All Commercial - PMPM	$4.33	$4.71	$5.03
All Commercial - Percent Change	0.75%	0.73%	0.64%

The estimated premium impact attributable to each service category is shown in Exhibit 8. The contribution of each service category to the total premium impact is displayed in the bottom section of the exhibit.

EXHIBIT 8: INSURER PREMIUM CHANGE ATTRIBUTABLE TO PROPOSED BENEFITS, BY SERVICE CATEGORY

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
PMPM - Medication Therapies	$4.06	$3.05	$3.62
PMPM – IBT	$0.25	$0.19	$0.05
PMPM - Bariatric Procedures	$0.96	$0.00	$0.00
PMPM - All Services	$5.28	$3.23	$3.68
Contribution to Impact - Medication Therapies	76.97%	94.26%	98.51%
Contribution to Impact – IBT	4.81%	5.74%	1.49%
Contribution to Impact - Bariatric Procedures	18.21%	0.00%	0.00%

For medication therapies, the estimated average allowed cost, net of rebates, per prescription is estimated to be $710 in 2026. The estimated unit cost is based on a 30-day supply and reflects pricing concessions from manufacturer rebates, which are highly confidential and specific to each carrier and market, but we have assumed to be 40% based on a publicized 40% manufacturer rebate that the North Carolina State Health Plan would have received for Wegovy and Saxenda from Novo Nordisk.[68] Please see the Methodology and Assumptions section for more details on these assumptions. The current low coverage, high cost, and high consumer interest in these medication therapies result in these therapies accounting for 90% of the total premium impact of the proposed legislation for the individual and small group markets.

The estimated average cost of bariatric surgery in 2026 is $34,400. According to the carrier survey, bariatric procedures are covered by all individual and small group plans, but only approximately 53% of members have coverage in large group plans. Although utilization for bariatric procedures is considerably lower than that of medication therapies, the high cost per service and significantly lower current coverage of bariatric procedures in the large group market causes the proposed legislation to have a greater premium impact on the large group market. Consequently, the total premium impact for the large group market ($5.28 PMPM in 2026) is notably higher than the impact to the individual and small group markets ($3.23 and $3.68 PMPM respectively in 2027).

STATE DEFRAYAL OF MANDATED BENEFITS IN EXCESS OF ESSENTIAL HEALTH BENEFITS

Under federal law, states must defray the premium cost of mandated benefits in excess of essential health benefits (EHBs) for qualified health plans (QHPs) offered on the individual and small group markets.

With respect to the services in the proposed legislation, it appears that carriers offering individual and small group health benefit plans in Colorado are currently covering some of the benefits, such as nutrition-related services, behavioral health services, and bariatric surgery services, as part of the coverage required under the state's EHB benchmark plan. As long as the law is written in a manner to be clear that the coverage is not in excess of EHBs, it does not appear that the legislative proposal would be a new coverage that exceeds EHB.

Some of the other services in the proposed legislation, specifically medication therapies and physical activity services, however, appear to be in addition to EHB. Exhibit 9 shows the estimated average first-year (2026), five-year cumulative (2026-2030), and 10-year cumulative (2026-2035) premium cost that may need to be defrayed if it is determined that they are in addition to EHB. Note that since we have no way of distinguishing QHPs from non-QHPs, we have presented our results assuming that all individual and small group market enrollees are included.

EXHIBIT 9: POSSIBLE PREMIUM DEFRAYAL, BY SERVICE CATEGORY

	1-YEAR	5-YEAR CUMULATIVE	10-YEAR CUMULATIVE
Total Small Group and Individual Enrollment	**547,294**	**2,222,336**	**5,129,158**
PMPM - Medication Therapies	$3.33	$3.48	$3.77
PMPM - Physical Activity Services	$0.06	$0.06	$0.07
PMPM - All Defrayed Services	**$3.39**	**$3.54**	**$3.83**
Total Dollars - Medication Therapies	$21,867,000	$92,904,000	$231,779,000
Total Dollars - Physical Activity Services	$364,000	$1,595,000	$4,199,000
Total Dollars - All Defrayed Services	**$22,232,000**	**$94,499,000**	**$235,978,000**

The Colorado DOI believes that if these services were determined to be in excess of EHB coverage, the state could be required to defray the costs of mandating coverage for all of the proposed benefits. In that case, the possible premium defrayal would be greater than what is presented in Exhibit 9.

ENROLLEE OUT-OF-POCKET AND TOTAL COST OF CARE IMPACT

We assumed that there is some portion of the obese and prediabetic population that is currently paying for non-covered IBT services and medication therapies completely out of pocket at baseline. For more expensive services such as bariatric surgery, we assume that obese and prediabetic individuals are not currently paying for non-covered services fully out of pocket. We have assumed that all non-covered benefits that were paid in full by the enrollee at baseline would be included as covered benefits. An enrollee's share of cost will ultimately depend on their benefit design. The average cost sharing per service for the first year for those with and without coverage can be seen in Exhibit 10. Note that the average cost sharing for enrollees without coverage for medication therapies is greater than the cost of medication therapies covered by insurance because these enrollees do not receive rebates.

EXHIBIT 10: AVERAGE YEAR 1 (2026 LARGE GROUP, 2027 INDIVIDUAL AND SMALL GROUP) ENROLLEE OUT-OF-POCKET PER SERVICE

TYPE OF SERVICE	WITHOUT COVERAGE	WITH COVERAGE
Medication Therapies	$1,180	$110
Nutrition-related Services	$230	$90
Physical Activity Services	$20	$10
Behavioral Counseling Services	$220	$100
Diabetes Prevention Program Services	$190	$70
Bariatric Procedures	N/A	$5,760

The estimated enrollee out-of-pocket cost impact (including both cost sharing and the cost of non-covered benefits at baseline) is shown in Exhibit 11. A portion of these newly covered benefits would be part of the premium cost post-benefit requirement. However, these services are not required to be covered with no cost sharing, so a portion of these newly covered benefits would be part of the patient out-of-pocket costs post-benefit requirement. Many of these services are likely to be subject to significant cost sharing. The increase in utilization of covered services results in the increase in out-of-pocket costs shown below after accounting for member cost sharing on newly covered benefits. The cost-sharing impacts below are spread across all enrollees and not just those utilizing the services.

- For individual insurance, we estimate a one-year (2027) total patient out-of-pocket increase of $2,386,000, a five-year (2026-2030) cumulative total patient out-of-pocket increase of $10,146,000, and a 10-year (2026-2035) cumulative total patient out-of-pocket increase of $25,356,000 or $0.71, $0.75, and $0.81 per member per month, respectively.
- For small group insurance, we estimate a one-year (2027) total patient out-of-pocket increase of $2,178,000, a five-year (2026-2030) cumulative total patient out-of-pocket increase of $9,252,000, and a 10-year (2026-2035) cumulative total patient out-of-pocket increase of $23,075,000 or $0.68, $0.71, and $0.76 per member per month, respectively.
- For large group insurance, we estimate a one-year (2026) total patient out-of-pocket increase of $2,432,000, a five-year (2026-2030) cumulative total patient out-of-pocket increase of $13,155,000, and a 10-year (2026-2035) cumulative total patient out-of-pocket increase of $28,878,000 or $0.40, $0.43, and $0.46 per member per month, respectively.

EXHIBIT 11: ESTIMATED ENROLLEE OUT-OF-POCKET IMPACT OF PROPOSED LEGISLATIVE LANGUAGE

	1-YEAR (2026) IMPACT	1-YEAR (2027) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
Individual - Total Dollars		$2,386,000	$10,146,000	$25,356,000
Individual - PMPM		$0.71	$0.75	$0.81
Small Group - Total Dollars		$2,178,000	$9,252,000	$23,075,000
Small Group - PMPM		$0.68	$0.71	$0.76
Large Group - Total Dollars	$2,432,000		$13,155,000	$28,878,000
Large Group - PMPM	$0.40		$0.43	$0.46

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
All Commercial - Total Dollars	**$6,996,000**	**$32,553,000**	**$77,309,000**
All Commercial – PMPM	**$0.55**	**$0.57**	**$0.62**

The total estimated cost of care impact, including out-of-pocket costs, from implementation of the proposed legislative language is in Exhibit 12.

- For individual insurance, we estimate a one-year (2027) total expenditure increase of $13,186,000, a five-year (2026-2030) cumulative total expenditure increase of $56,121,000, and a 10-year (2026-2035) cumulative total expenditure increase of $140,453,000 or $3.95, $4.14 and $4.48 per member per month, respectively. As a percentage, this increase ranges from 0.62% to 0.73% over the baseline period.
- For small group insurance, we estimate a one-year (2027) total expenditure increase of $14,042,000, a five-year (2026-2030) cumulative total expenditure increase of $59,670,000, and a 10-year (2026-2035) cumulative total expenditure increase of $148,943,000 or $4.35, $4.56, and $4.93 per member per month, respectively. As a percentage, this increase ranges from 0.50% to 0.59% over the baseline period.
- For large group insurance, we estimate a one-year (2026) total expenditure increase of $34,451,000, a five-year (2026-2030) cumulative total expenditure increase of $188,128,000, and a 10-year (2026-2035) cumulative total expenditure increase of $416,082,000 or $5.68, $6.08, and $6.56 per member per month, respectively. As a percentage, this increase ranges from 0.90% to 1.09% over the baseline period.

EXHIBIT 12: ESTIMATED TOTAL COST OF CARE IMPACT OF PROPOSED LEGISLATIVE LANGUAGE

	1-YEAR (2026) IMPACT	1-YEAR (2027) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
Individual - Total Dollars		$13,186,000	$56,121,000	$140,453,000
Individual – PMPM		$3.95	$4.14	$4.48
Individual - Percent Change		0.73%	0.69%	0.62%
Small Group - Total Dollars		$14,042,000	$59,670,000	$148,943,000
Small Group – PMPM		$4.35	$4.56	$4.93
Small Group - Percent Change		0.59%	0.56%	0.50%
Large Group - Total Dollars	$34,451,000		$188,128,000	$416,082,000
Large Group – PMPM	$5.68		$6.08	$6.56
Large Group - Percent Change	1.09%		1.01%	0.90%

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
All Commercial - Total Dollars	**$61,679,000**	**$303,919,000**	**$705,478,000**
All Commercial - PMPM	**$4.88**	**$5.28**	**$5.64**
All Commercial - Percent Change	**0.84%**	**0.81%**	**0.72%**

See Appendices E through J for more detailed information on PMPM and total cost of care.

LONG-TERM HEALTHCARE COST IMPACT

As mentioned in the Potential Health Benefits section, the durability of weight-loss results varies across services. People who lose weight through medication or intensive behavioral and lifestyle therapy will likely gain back at least some of the weight within months to years of treatment.[27,28] Additionally, over the course of time following any implementation of new coverage requirements, new people will become obese and prediabetic and seek treatment. To address this churn of people who are obese or prediabetic at various points in our analysis, we kept the diagnosed prevalence of obesity and prediabetes constant throughout time. This can be observed in the long-term impacts in Exhibit 12. The total cost-of-care impact as a percent change is relatively stable for the one-year impact, five-year cumulative total impact, and 10-year cumulative total impact. Because the diagnosed prevalence of obesity is assumed not to change, the resulting impacts do not compound with time.

If expanded coverage of treatments meaningfully reduces the population prevalence of obesity and prediabetes, then the actual cost impacts would compound on each other and vary from what we modeled in our analysis.

There are likely to be medical cost offsets for treating obesity and prediabetes through weight-loss interventions, but developing estimates of medical cost offsets for treating obesity and prediabetes through weight-loss interventions is complex and involves modeling transitions of disease states considering starting BMI, comorbidities, adherence to treatment, amount of weight lost, and weight-loss intervention used. GLP-1 medication therapies are fairly new to the market, and research on these inputs is scant, as are studies estimating long-term effectiveness and resulting cost savings. Prime Therapeutics published a study in October of 2024 describing the real-world impact of two years of Ozempic or Wegovy use for obesity on healthcare costs and found no evidence of medical offsets after two

years.[69] We are not aware of any studies that quantify the long-term impact of anti-obesity medications on healthcare costs.

We have prepared the following illustrative scenarios estimating savings associated with the expansion of coverage of weight-loss services impacted by the proposed legislation. One study of employer-sponsored insureds indicated that weight loss of more than 5% of body weight and 25% of body weight resulted in average annual cost savings of $670 and $2,849, respectively.[70] Multiplying the marginal utilization resulting from this legislation by the effectiveness of each weight-loss intervention at achieving 5% weight loss by the savings assumptions above, we calculated the savings under two scenarios:

1. Low savings: Assume that health plan members achieving at least 5% weight loss save $670 annually. Each treatment type assumed a different effectiveness for the obese population using the specific treatment type:
    a. GLP-1 medications: 80%
    b. Non-GLP-1 medications: 50%
    c. Physical Activity Services: 20%
    d. Bariatric Procedures: 90%
2. High savings: Assume that 15% of the enrollees achieving at least 5% weight loss save $2,850 annually and the other 85% save $670 annually. Each treatment type assumed a different effectiveness for the obese population using the specific treatment type:
    a. GLP-1 medications: 12%
    b. Non-GLP-1 medications: 7.5%
    c. Physical Activity Services: 3%
    d. Bariatric Procedures: 13.5%

Please see the Medical Cost Offsets subsection of the Methodology and Assumptions section of the report for more details about effectiveness rates of each weight loss method.

These illustrative assumptions result in the amounts found in Exhibit 13. The illustrative medical costs offsets result in a savings of $0.41 to $0.61 PMPM on the estimated premium impact in the first year.

EXHIBIT 13: ESTIMATED PREMIUM IMPACT OF PROPOSED LEGISLATIVE LANGUAGE INCLUDING MEDICAL COST OFFSET SCENARIOS

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
No Savings - All Commercial - Total Dollars	$54,683,000	$271,366,000	$628,169,000
No Savings - All Commercial – PMPM	$4.33	$4.71	$5.03
No Savings - All Commercial - Percent Change	0.75%	0.73%	0.64%

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
Low Savings - All Commercial - Total Dollars	$49,517,000	$245,011,000	$560,879,000
Low Savings - All Commercial – PMPM	$3.92	$4.25	$4.49
Low Savings - All Commercial - Percent Change	0.68%	0.66%	0.57%

	1-YEAR (2026 LG, 2027 IND AND SG) IMPACT	5-YEAR (2026-2030) CUMULATIVE IMPACT	10-YEAR (2026-2035) CUMULATIVE IMPACT
High Savings - All Commercial - Total Dollars	$46,995,000	$232,149,000	$528,037,000
High Savings - All Commercial – PMPM	$3.72	$4.03	$4.22
High Savings - All Commercial - Percent Change	0.64%	0.62%	0.54%

SOCIAL AND ECONOMIC IMPACT

The proposed legislation would have financial impact for prediabetic or obese health plan members who currently do not have coverage for the specified services (Exhibit 3) but are seeking treatment. Coverage would be expanded across all markets for medication therapies and IBT-related services and among large group carriers for bariatric surgery. The increase in premiums across the population is $4.33 PMPM on average in the first year for the total covered population (see Exhibit 7). In addition, cost sharing for weight-management treatment may continue to present a financial burden to health plan members, especially for high-cost services such as bariatric surgery or GLP-1 medications. Higher cost sharing in bariatric surgery has been shown to be associated with lower utilization. A study of commercially insured members who had undergone bariatric surgery in the IBM MarketScan database found that every $1,000 increase in cost sharing was associated with five fewer bariatric operations/1,000 insured lives.[71] Cost sharing would be the greatest burden for low-income individuals. Higher cost sharing has also been shown to be associated with reduced medication adherence. A systematic literature review of 71 research articles relating adherence of medication and cost sharing showed a dose-response relationship, where larger differences in cost sharing were associated with worse medication adherence and increased cost sharing was associated with more patients discontinuing treatment.[72]

The high cost of GLP-1s has also been noted as a financial barrier, even for insured adults. A 2024 KFF survey found that 54% of respondents that ever took a GLP-1 for any reason found it difficult to afford, and 22% found it very difficult.[73]

Common insurance precertification criteria for bariatric surgery have been shown to reduce utilization. In a study of bariatric utilization by insurance type across five counties in Pennsylvania, an insurance requirement for three to six months of medically supervised weight management was associated with lower odds of undergoing surgery (odds ratio = 0.46).[74]

Societal stigma related to obesity has been shown to negatively impact access and utilization of weight-management healthcare services. Weight bias among healthcare providers has been shown to impact the quality of care for obese individuals.[75,76] For example, in a randomized prospective study of the relationship between patient obesity and

primary care experience, physicians were found to spend less time educating obese individuals about their health and less time building rapport.[77] Evidence from systematic literature reviews on weight bias in healthcare shows that providers often view patients with obesity as less adherent, more lazy, and less disciplined than patients without obesity.[75,76] This stigma can negatively impact an individual's self-esteem and trust with providers and can lead to care avoidance and low treatment adherence.[76,78] In a national survey about provider weight stigma consisting of 600 adults with a BMI of at least 25, patients who perceived judgment from their provider about their weight were less likely to achieve weight loss than those who did not perceive judgment.[79]

Weight stigma has also been shown to impact utilization of exercise facilities. In a survey of gym experiences among individuals with BMI of at least 25, experiences with stigma at the gym were associated with negative attitudes toward gym attendance and poor self-reported physical and emotional health.[80]

Social determinants of health (SDOH) may also influence the ability for individuals to access weight-management treatment and contribute to health inequities among low-income individuals, people of color, and individuals living in rural areas.[47,81,82] SDOH are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.[83] Access to transportation, food insecurity, and schedule constraints such as childcare and work schedules can make it difficult to attend lifestyle or behavioral interventions.[47,82] In 2021, 9% of Coloradans experienced food insecurity, and in 2019, 5% of the population had limited access to healthy food.[84]

Methodology and assumptions

As noted in the prior section, the financial evaluation projects the population, cost of benefits, premium, and enrollee cost sharing for calendar year 2026 (for the large group market), calendar year 2027 (for individual and small group markets), calendar years 2026 through 2030, and calendar years 2026 through 2035 under the following two scenarios:

1. Baseline – Proposed legislation **does not** go into effect
2. Post-benefit requirement – Proposed legislation **does** go into effect

The difference between the baseline and post-benefit requirement values is the impact of the proposed legislation.

COLORADO POPULATION

We used 2023 enrollment data from the Colorado APCD to identify fully-insured commercial enrollment in preferred provider organization plans (PPO), point-of-service plans (POS), exclusive provider organization plans (EPO), and health maintenance organization plans (HMO). We limited the data to enrollment months with both medical and pharmacy coverage and placed each enrollment month into individual, small group, or large group based on their plan size. We then used Colorado population projections from the Department of Local Affairs to trend the 2023 enrollment data to 2026 through 2035. We did not separately account for the potential expiration of enhanced subsidies in the Affordable Care Act (ACA) market for 2026 or other potential future changes that could dramatically impact the number of individuals enrolled by market.

COLORADO CLAIMS AND PREMIUM

Using the data provided in the Colorado APCD, we summarized medical and pharmacy claims by individual, small group, and large group incurred during calendar year 2023 and paid through April 2024. Claims were adjusted to account for claims incurred but not paid using completion factors calculated using the development method. The resulting completion factors are in Exhibit 14. The medical factors range from 0.968 to 0.976 by market and the pharmacy completion factors range from 0.983 to 0.999.

EXHIBIT 14: 2023 COMPLETION FACTORS

	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Medical Completion Factor	0.968	0.976	0.975
Pharmacy Completion Factor	0.984	0.999	0.983

The completed 2023 medical and pharmacy paid claims were projected to represent 2026 through 2035 claims using a 6.5% annual claims trend with a 0.5% cost share leveraging factor. Claims trend was developed by reviewing historical individual, small group, and large group trend in Colorado and nationwide, as well as reviewing Colorado filing documents and unified rate review templates submitted by various insurance carriers to the DOI.

We applied administration expense ratios by individual, small group, and large group lines of business to the projected claims to develop premiums for 2026 through 2035. Exhibit 15 shows the assumed administration expenses as a percentage of total premium based on industry experience.

EXHIBIT 15: ADMINISTRATIVE COSTS INCLUDING PROFIT, AS A PERCENTAGE OF TOTAL PREMIUM

	INDIVIDUAL	SMALL GROUP	LARGE GROUP
Administration Ratio	15.0%	20.0%	12.0%

BENEFIT COVERAGE

As noted previously, the Colorado Division of Insurance surveyed insurance carriers in Colorado about current coverage of weight management treatments for obesity and prediabetes. We received responses from 13 carriers. The survey provided to respondents is in Appendix A.

There are varying levels of coverage for treatment options for obesity and prediabetes. In particular, medication therapies are the least commonly covered treatment. Exhibit 3 displays the percentage of enrollees who have coverage for each type of treatment based on survey responses received. Additionally, we assumed that 94% of enrollees currently have coverage for diabetes prevention programs (see the Insurance Coverage of Weight Management Treatment for Obesity and Prediabetes section for more details on the development of this assumption). The proposed language would cover all treatment types, and we have assumed 100% coverage for all treatment types post mandate.

UTILIZATION FOR ENROLLEES WITH COVERAGE AT BASELINE

We identified and summarized weight-management treatment services for obesity and prediabetes from the 2023 incurred claims data in Colorado APCD by commercial market. We first identified enrollees with obesity and/or prediabetes using ICD-10-CM diagnosis codes and diabetes prevention program service codes (only for prediabetes). Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS); and National Drug Code (NDC) codes were used to identify services for these enrollees from the following categories:

- Intensive behavioral or lifestyle therapy
  - Nutrition-related services (e.g., dietary counseling, medical nutrition therapy, weight-management class)
  - Physical-activity-related services (e.g., exercise counseling, exercise class, gym club membership)
  - Behavioral health therapies (e.g., health behavior assessment and intervention, preventive medicine counseling, and risk factor reduction)
    - Select services required a diagnosis code indicating that the service was related to obesity and/or prediabetes.
  - Diabetes prevention program services (for those with prediabetes)
- Bariatric surgery (e.g., laparoscopic bariatric surgery, gastric bypass surgery)
- FDA-approved anti-obesity medications – Brand names (generic)
  - Glucagon-like peptide 1 (GLP-1) receptor agonists
    - Saxenda (liraglutide)
    - Wegovy (semaglutide)
    - Zepbound (tirzepatide)
  - Non-GLP-1s
    - Contrave (bupropion and naltrexone)
    - Alli and Xenical (orlistat)
    - Qsymia (phentermine and topiramate)
    - Imcivree (setmelanotide)
    - Adipex-P (phentermine)

ICD-10-CM diagnosis, ICD-10-PCS, HCPCS, and NDC codes identified by Milliman clinicians were used to identify individuals with obesity and prediabetes and services representing the management, treatment, and monitoring of those conditions (physical activity, nutrition-related services, behavioral counseling for weight loss, bariatric surgery, weight-loss medications, diabetes prevention program services). While some codes were specific to treatments for obesity and prediabetes, regardless of the diagnosis codes on the encounter claims, other more general codes were attributed to treatments for obesity and prediabetes only if weight- or prediabetes-related diagnosis codes were observed on the claims for these services. Bariatric surgery included all claims on the day of the bariatric surgery (outpatient bariatric surgery) or during the full duration of the inpatient stay (inpatient bariatric surgery). The code lists and algorithms to identify the relevant medical conditions and treatments were developed to ensure that all services identified were for the diagnosis, treatment, appropriate management, or ongoing monitoring of obesity or prediabetes, consistent with the coverage required by the proposed legislation.

Where sufficient data existed, we leveraged the Colorado APCD to develop underlying baseline utilization estimates for those that currently have coverage. Details about the utilization of each service category are below.

To project 2023 through 2035 utilization, we applied secular utilization trend. Secular utilization trend is a measure of change in the number of services per member, resulting from only those factors that affect a static population with a fixed set of benefits. Exhibit 16 shows secular utilization trends used by service category. These trends were determined using the Milliman Health Cost Guidelines™. For medication therapies, we trended the 2023 utilization to 2026 using a 20% annualized trend, as experience in other markets suggests that utilization is high when coverage for medication therapies becomes available and tapers off over several years.

EXHIBIT 16: ASSUMED ANNUAL UTILIZATION TRENDS BY SERVICE CATEGORY

SERVICE CATEGORY	UTILIZATION TREND
Medication Therapies	20.00% (until 2026) 5.00% (2026-2027) 3.00% (after 2027)
Intensive Behavioral Therapies	0.50%
Bariatric Procedures	0.50%

Intensive behavioral or lifestyle therapy (IBT)

Sufficient data existed for nutrition-related services, behavioral health therapies, and diabetes prevention program services in the Colorado APCD to develop underlying baseline utilization estimates for those that currently have coverage. Since physical-activity-related services are often reimbursed outside of claims systems, we relied on participation rates and number of services from a study of community health center weight management programs that included exercise classes for obese participants to develop our baseline utilization assumptions.[54]

Working from the APCD data and the literature cited above, the estimated first-year baseline utilization for those that currently have coverage (2026 for large group and 2027 for individual and small group), including those who are not obese or prediabetic, is shown in Exhibit 17. Estimated utilization varies by market due to demographic and geographic variations by market.

EXHIBIT 17: BASELINE BENEFIT UTIL / 1,000 FOR THOSE CURRENTLY COVERED FOR IBT SERVICES

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
Nutrition-related Services	22.6	10.5	14.9
Physical Activity Services	66.0	48.6	52.7
Behavioral Counseling Services	79.1	44.8	57.4
Diabetes Prevention Program Services	73.0	36.8	43.4

Bariatric surgery

Sufficient data existed for bariatric surgeries in the Colorado APCD to develop underlying baseline utilization estimates for those that currently have coverage. We identified trigger procedures to construct bariatric surgery cases in order to develop underlying baseline utilization rates. Working from this data, we estimated baseline bariatric surgery utilization per 1,000 for those with current coverage to be 0.2, 0.4, and 0.4 for individual (calendar year 2027), small group (calendar year 2027), and large group (calendar year 2026) respectively.

Medication therapies

The utilization rate for medication therapies is based on the 2023 APCD utilization rate for large group enrollees with coverage for medication therapies. This rate is adjusted for prediabetes and obesity prevalence for the individual and small group markets. These assumptions resulted in overall baseline utilization for those with coverage for medication therapies (GLP-1s and non-GLP-1s) of 74.8, 57.5, and 62.4 prescriptions per 1,000 for large group (calendar year 2026), individual (calendar year 2027), and small group (calendar year 2027) respectively.

UTILIZATION FOR ENROLLEES WITHOUT COVERAGE AT BASELINE

At baseline, we assumed that there would be enrollees without coverage that are currently utilizing services and self-paying for these services. We assumed this self-pay utilization would be less than those currently with coverage and would vary by cost of the underlying service. We assumed that 19% of the total utilization of medication therapies at baseline is from enrollees without coverage at baseline. This assumption is based on a 2024 survey that found that 19% of people using GLP-1 drugs paid for the full cost of GLP-1s.[85] We assumed that self-pay utilization for bariatric surgery is 0 due to the high costs of these services. Our assumed IBT services reduced utilization factor for self-pay compared to currently covered utilization was informed by Milliman's commercial Health Cost Guidelines induced utilization factors and actuarial judgment.

Post-benefit requirement, we that assumed obese and prediabetic individuals who did not have coverage at baseline would use weight management treatment services at the same rate as enrollees with coverage.

COST PER SERVICE AND ENROLLEE COST SHARING

Similar to our analysis of current utilization, we identified and summarized average cost for weight-management treatment services for obese and prediabetic individuals from the 2023 incurred claims data in the Colorado APCD by commercial market. Where sufficient data existed, we leveraged this data to develop underlying baseline average cost estimates for those that currently have coverage.

We assumed the following annual unit cost trends by service category to project 2023 through 2035 average cost per service and reflect anticipated trends for various services (e.g., inpatient trends for bariatric surgery, professional trends for IBT). We assumed no cost trend for medication therapies, as we expect new drugs entering the market, increases in rebates, and the introduction of generics to counteract any price increases.

EXHIBIT 18: ASSUMED ANNUAL UNIT COST TREND BY SERVICE CATEGORY

SERVICE CATEGORY	UNIT COST TREND
Medication Therapies	0.00%
Intensive Behavioral Therapies	4.50%
Bariatric Procedures	1.00%

Intensive behavioral or lifestyle therapy (IBT)

The average cost for IBT will vary by type of therapy. Sufficient data existed for nutrition-related services, behavioral health therapies, and diabetes prevention program services in the Colorado APCD to develop underlying baseline average cost and patient cost-sharing estimates for those that currently have coverage. Since physical-activity-related services are often reimbursed outside of claims systems, we reviewed various prices for exercise classes from Colorado town recreation departments and universities as well as gyms and punch pass services to estimate the average cost per service. Patient cost sharing for physical activity services was calculated by applying the ratio of 2023 insurer paid amount per professional service for obese and prediabetic patients to 2023 average cost from the Colorado APCD to the 2026 through 2035 projected average allowed cost.

The estimated first-year (2026 for large group and 2027 for individual and small group) average cost per service for IBT services for those with current coverage is shown in Exhibit 19.

EXHIBIT 19 AVERAGE COST PER SERVICE FOR IBT SERVICES

	LARGE GROUP (2026)	INDIVIDUAL (2027)	SMALL GROUP (2027)
Nutrition-related Services	$232	$243	$243
Physical Activity Services	$16	$16	$16
Behavioral Counseling Services	$221	$231	$231
Diabetes Prevention Program Services	$183	$191	$191

Bariatric surgery

Sufficient data existed for bariatric surgeries in the Colorado APCD to develop underlying baseline average cost per service and patient cost-sharing estimates for those that currently have coverage. We identified trigger procedures to construct bariatric surgery cases in order to develop underlying baseline cost assumptions. We estimate that the average cost per bariatric procedure case for those who currently have coverage is approximately $34,800 in 2027 for individual plans and small group plans, and $34,400 in 2026 for large group plans.

Medication therapies

We considered separate baseline cost-per-service assumptions for GLP-1 drugs and non-GLP-1 drugs. We estimated an average 2026 unit cost net of rebates of $753 per prescription for GLP-1 drugs and $34 per prescription for non-GLP-1 drugs. The estimated unit cost is based on a 30-day supply and reflects pricing concessions from manufacturer rebates. Manufacturer rebates are highly confidential, but we assumed that they would be 40% based on a publicized 40% manufacturer rebate the North Carolina State Health Plan would have received for Wegovy and Saxenda from Novo Nordisk.[86] Unit cost was estimated from the Medi-Span drug database. Patient cost-sharing estimates for those who currently have coverage for medication therapies are based on Milliman pharmacy data.

We assumed no change in the average cost of weight-management treatments post benefit requirement.

For those without current coverage, we assumed that 100% of the average cost per service gross of rebates would be paid by the enrollee. We assumed the same cost sharing percentage as that seen by the population who currently have coverage at baseline after the implementation of the mandated benefit.

Patient cost sharing is calculated by observing the ratio of 2023 insurer paid amount per service to 2023 average cost per service in the Colorado APCD, then applying that ratio to the 2026 through 2035 projected average allowed cost.

SAVINGS ANALYSIS

While studies have shown that sustained weight loss for individuals with obesity can reduce health risks and improve health outcomes of treated comorbidities,[24,26,87] quantifying the impact in terms of impact to an individual's total healthcare costs is challenging, and published estimated impacts have varied. Please see the Potential Health Benefits of Treatment section for more details.

There are many factors to consider when quantifying the cost savings impact of these treatments, including starting BMI and comorbidities, adherence to treatment, amount of weight lost, weight-loss intervention used, and the duration of sustained weight loss. As mentioned in the Long-term Healthcare Cost Impact section, the durability of weight-loss results can also vary depending on treatment, which may influence long-term healthcare costs. Estimates of annual cost savings from surgical and non-surgical weight-loss interventions, excluding GLP-1s, ranged from $0 to $2,316, with greater cost reduction associated with greater weight loss.[88,89,90] In a study of cost savings and healthcare utilization from participation in a digital diabetes prevention program, commercially insured participants had a reduction in all-cause spending of $1,169 per participant per year, primarily driven by a reduction in inpatient admits and length of stay.[91] A longitudinal analysis comparing a bariatric surgery cohort with a matched non-surgical cohort enrolled in BlueCross BlueShield health insurance plans found that bariatric surgery does not reduce overall healthcare costs in the long term.[89]

A systematic literature review of comparing the relative costs of anti-obesity medication, including non-GLP-1s and semaglutide, found that medication resulted in $2,586 of direct medical costs savings per patient per year.[92] Yet, another study of changes to total cost of care after one year of GLP-1 weight-loss treatment found that the annual cost for those taking GLP-1 drugs was $7,727 higher per member as compared to a control group.[35]

We can see from these few examples that cost savings are highly variable. There may be medical cost offsets for treating obesity and prediabetes through weight-loss interventions, but quantifying these offsets is complex and involves modeling transitions of disease states considering starting BMI, comorbidities, adherence to treatment, amount of weight lost, and weight-loss intervention used. GLP-1 medication therapies are fairly new to the market, and research on these inputs is scant, as are studies estimating long-term effectiveness and resulting cost savings. Prime Therapeutics published a study in October of 2024 describing the real-world impact of two years of Ozempic or Wegovy use for obesity on healthcare costs and found no evidence of medical offsets after two years.[93] We are not aware of any studies that quantify the long-term impact of anti-obesity medications on healthcare costs.

We have prepared illustrative scenarios estimating savings associated with the expansion of coverage of weight-loss services impacted by the proposed legislation. One study of employer sponsored insureds indicated that weight loss of more than 5% of body weight and 25% of body weight resulted in average annual cost savings of $670 and $2,849, respectively.[70] Using these savings assumptions and the effectiveness of each weight-loss method at achieving at least 5% weight loss, we calculated the savings under two scenarios. The low-savings scenario assumes that health plan members achieving at least 5% weight loss save $670 annually. The high-savings scenario assumes that 15% of the enrollees achieving at least 5% weight loss save $2,850 annually and the other 85% save $670 annually. The 15% assumption is based on a study of long-term weight-loss thresholds and metabolic health, which found that of study participants who lost at least 5% of their body weight, approximately 15% lost more than 20% of their body weight.[94]

Exhibit 20 below shows the percentage of users achieving weight loss of 5% or more by weight loss intervention.

EXHIBIT 20: ASSUMED EFFECTIVENESS BY WEIGHT LOSS INTERVENTION

SERVICE CATEGORY	EFFECTIVENESS
Medication Therapies: GLP-1s	80%[95]
Medication Therapies: Non GLP-1s	50%[96]
IBT: Nutrition-related Services	20%[97]
IBT: Physical Activity Services	20%[97]
IBT: Behavioral Counseling Services	0%
IBT: Diabetes Prevention Program Services	30%[98]
Bariatric Procedures	90%[99]

ADMINISTRATIVE COSTS

We assumed no undue burden from administering this additional benefit. Administration costs will increase in proportion to the cost of additional mandated benefits.

CONSIDERATIONS AND LIMITATIONS

As stated in the Obesity and Prediabetes Utilization and Cost section above, we relied on data from the Colorado APCD as well as available research to develop cost and utilization assumptions for this analysis. To the extent that the assumed cost and utilization of weight-management treatments varies from these assumptions, then some components of our analysis could be materially different.

For purposes of our analysis, we are relying on diagnosed prevalence rates to inform our utilization assumptions, since a diagnosis would be required to determine appropriateness and medical necessity of treatments. As stated in the Financial Analysis section, administrative diagnoses coded in the claims data may meaningfully underestimate the prevalence of obesity. It is possible that the diagnosed prevalence rates may increase as a result of this proposed legislation. We have not assumed an increase in diagnosed prevalence rates in our analysis, as this increase in prevalence rate would be hypothetical. As such, our analysis represents a low-end estimate of the impact of the proposed legislation.

Any offsets modeled in the form of reduced medical costs due to effective weight-management treatments are highly theoretical. Due to the emerging use of GLP-1 medications, these long-term effects have not been observed. Actual effects could be materially different.

Variability of results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Model and data reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of proposed legislation related to the comprehensive coverage of obesity and prediabetes. We have reviewed these models, including inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without a systematic audit. To the extent that the data and information provided are not accurate, or are not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman’s data and information reliance includes:

- Data from Colorado’s All Payer Claims Database (APCD)
- Colorado census data and projections
- Published papers, reports, and articles listed in the references section
- All other sources mentioned inline and in references, including the carrier surveys and studies

The models, including all input, calculations, and output may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Qualifications to perform analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Casey Hammer is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.

Distribution and usage

Milliman's work is prepared solely for the use and benefit of Colorado Department of Regulatory Agencies in accordance with its statutory and regulatory requirements. Milliman recognizes that this report will be public record subject to disclosure to third parties. To the extent that the information contained in this report is provided to any third parties, the report should be distributed in its entirety. We do not intend this information to benefit, or create a legal liability to, any third party, even if Milliman consents to the release of its work product to such third party. Similarly, third parties are instructed to place no reliance upon this report prepared by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any recipient of this report to make an independent determination as to the adequacy of the proposed results for their organization.

Appendix A: Carrier coverage survey

COLORADO
Department of Regulatory Agencies

COVERAGE SURVEY FOR OBESITY TREATMENT

Please return this survey via email to Riley De Valois (riley.devalois@state.co.us) and Tara Smith (tara.smith@state.co.us) by December9, 2024.

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1) What is the name of the insurance carrier?

2) Please complete the following table with how many people are enrolled in the following lines of business as of October 31, 2024? Please exclude all self-insured or administrative services only plans in your responses.

Individual Market	Small Group Market	Large Group Market

3) Please complete the following table with the % of members that have coverage of the listed benefits for obesity treatment.

	Individual Market	Small Group Market	Large Group Market
Screening for obesity			
Screening for obesity-related complications in obese individuals			
Medication therapies (e.g., bupropion-naltrexone, liraglutide, orlistat, semaglutide, setmelanotide)			
Nutrition-related services (e.g., dietary counseling, nutrition class, weight-management class)			
Physical-activity-related services (e.g., physical therapy education, exercise class)			
Behavioral health therapies (e.g., cognitive behavioral therapy, exposure and response prevention therapy) to manage neuropsychiatric symptoms			

4) Are there currently specific cost-sharing requirements for enrollees with coverage for obesity that differ from standard cost sharing for other benefits (e.g., generic/brand drugs, lab tests, mental health therapy visits, etc.)?

5) For obesity treatments, are there any limitations such as dollar limits or frequency limits on treatment that can be received?

6) Is there any additional information you would like to share about coverage for obesity treatment as defined above?

Appendix B: Large group enrollees impacted by benefit requirement

Large Group Market	1-Year (2026)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	505,569	2,577,736	5,287,177
Total Population Affected	505,569	2,577,736	5,287,177
Baseline Utilization per 1,000			
Medication Therapies	10.3	11.1	12.1
Intensive Behavioral Therapies	217.3	219.5	222.4
Bariatric Procedures	0.4	0.4	0.4
Baseline Cost per Procedure			
Medication Therapies	$755	$755	$755
Intensive Behavioral Therapies	$155	$170	$195
Bariatric Procedures	$34,445	$35,150	$36,080
Baseline Patient Cost Sharing per Procedure			
Medication Therapies	$160	$160	$160
Intensive Behavioral Therapies	$70	$75	$85
Bariatric Procedures	$5,760	$5,880	$6,035
Post-benefit Requirement Utilization per 1,000			
Medication Therapies	74.8	80.7	87.5
Intensive Behavioral Therapies	240.8	243.2	246.3
Bariatric Procedures	0.7	0.8	0.8
Post-benefit Requirement Cost per Procedure			
Medication Therapies	$710	$710	$710
Intensive Behavioral Therapies	$155	$170	$190
Bariatric Procedures	$34,445	$35,150	$36,080
Post-benefit Requirement Cost Sharing per Procedure			
Medication Therapies	$55	$55	$55
Intensive Behavioral Therapies	$65	$70	$80
Bariatric Procedures	$5,760	$5,880	$6,035

Appendix C: Individual enrollees impacted by benefit requirement

Individual Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	278,473	1,130,940	2,610,682
Total Population Affected	278,473	1,130,940	2,610,682
Baseline Utilization per 1,000			
Medication Therapies	1.2	1.2	1.3
Intensive Behavioral Therapies	120.2	121.1	122.6
Bariatric Procedures	0.2	0.2	0.2
Baseline Cost per Procedure			
Medication Therapies	$1,185	$1,185	$1,185
Intensive Behavioral Therapies	$155	$165	$185
Bariatric Procedures	$34,790	$35,320	$36,250
Baseline Patient Cost Sharing per Procedure			
Medication Therapies	$1,185	$1,185	$1,185
Intensive Behavioral Therapies	$70	$75	$85
Bariatric Procedures	$5,820	$5,910	$6,065
Post-benefit Requirement Utilization per 1,000			
Medication Therapies	57.5	60.2	65.0
Intensive Behavioral Therapies	140.7	141.8	143.6
Bariatric Procedures	0.2	0.2	0.2
Post-benefit Requirement Cost per Procedure			
Medication Therapies	$710	$710	$710
Intensive Behavioral Therapies	$145	$160	$180
Bariatric Procedures	$34,790	$35,320	$36,250
Post-benefit Requirement Cost Sharing per Procedure			
Medication Therapies	$170	$170	$170
Intensive Behavioral Therapies	$60	$65	$75
Bariatric Procedures	$5,820	$5,910	$6,065

Appendix D: Small group enrollees impacted by benefit requirement

Small Group Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	268,821	1,091,396	2,518,476
Total Population Affected	268,821	1,091,396	2,518,476
Baseline Utilization per 1,000			
Medication Therapies	1.2	1.2	1.3
Intensive Behavioral Therapies	156.7	157.9	159.9
Bariatric Procedures	0.4	0.4	0.4
Baseline Cost per Procedure			
Medication Therapies	$1,185	$1,185	$1,185
Intensive Behavioral Therapies	$165	$175	$195
Bariatric Procedures	$34,790	$35,320	$36,250
Baseline Patient Cost Sharing per Procedure			
Medication Therapies	$1,185	$1,185	$1,185
Intensive Behavioral Therapies	$70	$75	$80
Bariatric Procedures	$5,820	$5,910	$6,065
Post-benefit Requirement Utilization per 1,000			
Medication Therapies	62.4	65.3	70.6
Intensive Behavioral Therapies	168.4	169.7	171.9
Bariatric Procedures	0.4	0.4	0.4
Post-benefit Requirement Cost per Procedure			
Medication Therapies	$710	$710	$710
Intensive Behavioral Therapies	$155	$165	$185
Bariatric Procedures	$34,790	$35,320	$36,250
Post-benefit Requirement Cost Sharing per Procedure			
Medication Therapies	$150	$150	$150
Intensive Behavioral Therapies	$65	$70	$75
Bariatric Procedures	$5,820	$5,910	$6,065

Appendix E: Large group enrollee PMPM

Large Group Market	1-Year (2026)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	505,569	2,577,736	5,287,177
Total Population Affected	505,569	2,577,736	5,287,177
Baseline PMPM			
Insurer Premium	$519.40	$599.50	$724.39
Enrollee Cost Sharing	$1.35	$1.48	$1.67
Enrollee Non-covered	$0.23	$0.25	$0.28
Total Baseline PMPM	**$520.98**	**$601.23**	**$726.34**
Post-benefit Requirement PMPM			
Insurer Premium	$524.68	$605.16	$730.49
Enrollee Cost Sharing	$1.98	$2.16	$2.41
Enrollee Non-covered	$0.00	$0.00	$0.00
Total Post-benefit Requirement PMPM	**$526.66**	**$607.31**	**$732.90**
Change Attributable to Required Benefits			
Insurer Premium	$5.28	$5.66	$6.10
Enrollee Cost Sharing	$0.63	$0.68	$0.74
Enrollee Non-covered	-$0.23	-$0.25	-$0.28
Total Change PMPM	**$5.68**	**$6.08**	**$6.56**
Percent Change Attributable to Required Benefits			
Insurer Premium	1.0%	0.9%	0.8%
Enrollee Cost Sharing	46.6%	45.6%	44.1%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**1.1%**	**1.0%**	**0.9%**

Appendix F: Individual enrollee PMPM

Individual Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	278,473	1,130,940	2,610,682
Total Population Affected	278,473	1,130,940	2,610,682
Baseline PMPM			
Insurer Premium	$536.47	$596.45	$718.43
Enrollee Cost Sharing	$0.72	$0.77	$0.86
Enrollee Non-covered	$0.21	$0.22	$0.25
Total Baseline PMPM	**$537.39**	**$597.44**	**$719.53**
Post-benefit Requirement PMPM			
Insurer Premium	$539.70	$599.84	$722.10
Enrollee Cost Sharing	$1.64	$1.74	$1.92
Enrollee Non-covered	$0.00	$0.00	$0.00
Total Post-benefit Requirement PMPM	**$541.34**	**$601.58**	**$724.02**
Change Attributable to Required Benefits			
Insurer Premium	$3.23	$3.39	$3.67
Enrollee Cost Sharing	$0.92	$0.97	$1.06
Enrollee Non-covered	-$0.21	-$0.22	-$0.25
Total change PMPM	**$3.95**	**$4.14**	**$4.48**
Percent Change Attributable to Required Benefits			
Insurer Premium	0.6%	0.6%	0.5%
Enrollee Cost Sharing	129.1%	126.8%	122.6%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.7%**	**0.7%**	**0.6%**

Appendix G: Small group enrollee PMPM

Small Group Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	268,821	1,091,396	2,518,476
Total Population Affected	268,821	1,091,396	2,518,476
Baseline PMPM			
Insurer Premium	$732.74	$814.89	$981.78
Enrollee Cost Sharing	$1.05	$1.12	$1.26
Enrollee Non-covered	$0.14	$0.15	$0.16
Total Baseline PMPM	**$733.93**	**$816.16**	**$983.21**
Post-benefit Requirement PMPM			
Insurer Premium	$736.42	$818.74	$985.95
Enrollee Cost Sharing	$1.87	$1.98	$2.19
Enrollee Non-covered	$0.00	$0.00	$0.00
Total Post-benefit Requirement PMPM	**$738.28**	**$820.72**	**$988.13**
Change Attributable to Required Benefits			
Insurer Premium	$3.68	$3.85	$4.16
Enrollee Cost Sharing	$0.82	$0.86	$0.93
Enrollee Non-covered	-$0.14	-$0.15	-$0.16
Total Change PMPM	**$4.35**	**$4.56**	**$4.93**
Percent Change Attributable to Required Benefits			
Insurer Premium	0.5%	0.5%	0.4%
Enrollee Cost Sharing	78.0%	76.4%	73.6%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.6%**	**0.6%**	**0.5%**

Appendix H: Large group enrollee total dollars

Large Group Market	1-Year (2026)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	505,569	2,577,736	5,287,177
Total Population Affected	505,569	2,577,736	5,287,177
Baseline Total Dollars			
Insurer Premium	$3,151,111,000	$18,544,201,000	$45,959,754,000
Enrollee Cost Sharing	$8,207,000	$45,830,000	$105,932,000
Enrollee Non-covered	$1,390,000	$7,761,000	$17,793,000
Total Baseline Dollars	**$3,160,708,000**	**$18,597,792,000**	**$46,083,479,000**
Post-benefit Requirement Total Dollars			
Insurer Premium	$3,183,130,000	$18,719,174,000	$46,346,958,000
Enrollee Cost Sharing	$12,029,000	$66,746,000	$152,603,000
Enrollee Non-covered	$0	$0	$0
Total Post-benefit Requirement Dollars	**$3,195,159,000**	**$18,785,920,000**	**$46,499,561,000**
Change Attributable to Required Benefits			
InsurerP	$32,019,000	$174,973,000	$387,204,000
Enrollee Cost Sharing	$3,822,000	$20,916,000	$46,671,000
Enrollee Non-covered	-$1,390,000	-$7,761,000	-$17,793,000
Total Change	**$34,451,000**	**$188,128,000**	**$416,082,000**
Percent Change Attributable to Required Benefits			
Insurer Premium	1.0%	0.9%	0.8%
Enrollee Cost Sharing	46.6%	45.6%	44.1%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**1.1%**	**1.0%**	**0.9%**

Appendix I: Individual enrollee total dollars

Individual Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	278,473	1,130,940	2,610,682
Total Population Affected	278,473	1,130,940	2,610,682
Baseline Total Dollars			
Insurer Premium	$1,792,703,000	$8,094,633,000	$22,507,012,000
Enrollee Cost Sharing	$2,391,000	$10,387,000	$26,982,000
Enrollee Non-covered	$701,000	$3,019,000	$7,722,000
Total Baseline Dollars	**$1,795,795,000**	**$8,108,039,000**	**$22,541,716,000**
Post-benefit Requirement Total Dollars			
Insurer Premium	$1,803,503,000	$8,140,608,000	$22,622,109,000
Enrollee Cost Sharing	$5,478,000	$23,552,000	$60,060,000
Enrollee Non-covered	$0	$0	$0
Total Post-benefit Requirement Dollars	**$1,808,981,000**	**$8,164,160,000**	**$22,682,169,000**
Change Attributable to Required Benefits			
Insurer Premium	$10,800,000	$45,975,000	$115,097,000
Enrollee Cost Sharing	$3,087,000	$13,165,000	$33,078,000
Enrollee Non-covered	-$701,000	-$3,019,000	-$7,722,000
Total Change	**$13,186,000**	**$56,121,000**	**$140,453,000**
Percent Change Attributable to Required Benefits			
Insurer Premium	0.6%	0.6%	0.5%
Enrollee Cost Sharing	129.1%	126.7%	122.6%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.7%**	**0.7%**	**0.6%**

Appendix J: Small group enrollee total dollars

Small Group Market	1-Year (2027)	5-Year (2026-2030)	10-Year (2026-2035)
Total Enrollment Subject to State Benefit Requirements	268,821	1,091,396	2,518,476
Total Population Affected	268,821	1,091,396	2,518,476
Baseline Total Dollars			
Insurer Premium	$2,363,703,000	$10,672,441,000	$29,671,149,000
Enrollee Cost Sharing	$3,382,000	$14,677,000	$38,061,000
Enrollee Non-covered	$460,000	$1,965,000	$4,953,000
Total Baseline Dollars	**$2,367,545,000**	**$10,689,083,000**	**$29,714,163,000**
Post-benefit Requirement Total Dollars			
Insurer Premium	$2,375,567,000	$10,722,859,000	$29,797,017,000
Enrollee Cost Sharing	$6,020,000	$25,894,000	$66,089,000
Enrollee Non-covered	$0	$0	$0
Total Post-benefit Requirement Dollars	**$2,381,587,000**	**$10,748,753,000**	**$29,863,106,000**
Change Attributable to Required Benefits			
Insurer Premium	$11,864,000	$50,418,000	$125,868,000
Enrollee Cost Sharing	$2,638,000	$11,217,000	$28,028,000
Enrollee Non-covered	-$460,000	-$1,965,000	-$4,953,000
Total Change	**$14,042,000**	**$59,670,000**	**$148,943,000**
Percent Change Attributable to Required Benefits			
Insurer Premium	0.5%	0.5%	0.4%
Enrollee Cost Sharing	78.0%	76.4%	73.6%
Enrollee Non-covered	-100.0%	-100.0%	-100.0%
Total Percent Change	**0.6%**	**0.6%**	**0.5%**

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