

# Inadequate Insurance Coverage for Overweight/Obesity Management

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**O**besity is a significant health crisis affecting more than 123 million adults and children/adolescents in the US.<sup>1,2</sup> Although the health and economic consequences of obesity are well documented, public and private health care coverage for treating individuals with this condition is not keeping pace with the medical innovations and standards of clinical care.

The major contributors to the growing obesity epidemic are inadequate access to qualified health care providers due to racial disparities in obesity prevalence and treatment; lack of adequate health insurance coverage of necessary medical services; stigmatization of individuals with obesity by health care providers, policy makers, and society<sup>3-6</sup>; and failure of Medicare and most private insurance plans to provide widespread coverage for new medications that have been clearly demonstrated to be effective in achieving significant weight loss.<sup>7,8</sup>

Unwillingness to provide coverage is primarily due to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which prohibits Medicare Part D from covering weight loss medications, even those approved by the FDA for treating obesity.<sup>7</sup> As a result, insurance coverage for weight loss/management is commonly limited to counseling in primary care settings only and weight loss surgery for individuals with severe obesity. The newer weight loss therapies are available as options only for those who can afford to pay out of pocket.

In March 2021, the Treat and Reduce Obesity Act (TROA) of 2021 (S 596; HR 1577) was introduced in the US Senate and House of Representatives.<sup>9</sup> The objective of the bill is to expand Medicare coverage of intensive behavioral therapy (IBT) for obesity to include Medicare Part D coverage for antiobesity medications. However, economic concerns, pressure from the food and beverage industry, and lack of political support have prevented this bill from moving forward.<sup>10,11</sup>

The Diabetes Leadership Council (DLC) is a nonprofit patient advocacy organization that unites former leaders of national diabetes organizations dedicated to securing effective, affordable health care and a discrimination-free environment for every person with diabetes. On May 2, 2023, the DLC held a series of webinars that

## ABSTRACT

**OBJECTIVES:** To discuss the social, psychological, and access barriers that inhibit weight loss, and to propose steps and initiatives for addressing the growing obesity epidemic.

**STUDY DESIGN:** Narrative review of the obesity epidemic in the US and associated racial/ethnic and socioeconomic disparities.

**METHODS:** An internet search of relevant studies and government reports was conducted.

**RESULTS:** Obesity is a significant health crisis affecting more than 123 million adults and children/adolescents in the US. An estimated 1 in 5 deaths in Black and White individuals aged 40 to 85 years in the US is attributable to obesity. Obesity puts individuals at elevated risk for type 2 diabetes, cardiovascular disease, chronic kidney disease, gastrointestinal disorders, nonalcoholic fatty liver disease, cancer, respiratory ailments, dementia/Alzheimer disease, and other disorders. In the US, significantly more Black (49.9%) and Hispanic (45.6%) individuals are affected by obesity than White (41.4%) and Asian (16.1%) individuals. Health care costs for obesity account for more than \$260 billion of annual US health care spending—more than 50% greater in excess annual medical costs per person than individuals with normal weight.

**CONCLUSIONS:** Addressing the obesity epidemic will require a multifaceted approach that focuses on prevention, treatment, and reducing the impact of stigma. Continued advocacy and education efforts are necessary to make progress and improve the health and well-being of individuals affected by obesity.

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## TAKEAWAY POINTS

Obesity is a significant health crisis in the US that is driving adverse clinical outcomes and must be addressed.

- ▶ There are more than 123 million adults and children/adolescents in the US with obesity.
- ▶ Obesity is a leading contributor to the development of diabetes, cardiovascular disease, and other disorders.
- ▶ There are significant racial/ethnic and socioeconomic disparities in obesity prevalence.
- ▶ Obesity prevalence is primarily driven by inadequate access to qualified health care providers and services, environmental factors (eg, access to healthy food and safe exercise areas), stigma, and inadequate coverage for proven antiobesity medications and other therapies.

**TABLE 1.** Adults 20 Years or Older With Obesity/Extreme Obesity<sup>1,25,a</sup>

Characteristic	Obesity (n=4765)	Extreme obesity (n=8295)
Race		
Black (n=2213)	49.9%	14.0%
Hispanic (n=1806)	45.6%	7.5%
White (n=2866)	41.4%	9.5%
Asian (n=1014)	16.1%	1.8%
Income <sup>b</sup>		
≤ 130% of FPL (n=2019)	43.9%	10.9%
> 130%-350% of FPL (n=2815)	46.5%	11.8%
> 350% of FPL (n=2312)	39.0%	6.9%
Education		
Less than high school diploma (n=1538)	40.1%	7.6%
High school diploma or some college (n=4709)	46.4%	11.3%
College degree or above (n=2037)	34.2%	6.1%

BMI, body mass index; FPL, federal poverty level.

<sup>a</sup>Obesity, 30.0-39.9 BMI; extreme obesity, >40.0 BMI.

<sup>b</sup>Family income relative to FPL.

included recognized experts in obesity and diabetes who presented data regarding the prevalence, clinical consequences, and economic cost of obesity in the US and discussed access barriers to effective obesity medications and clinical care. This article summarizes many of the key points raised in these discussions and presents recommendations for addressing the obesity epidemic.

### Pathogenesis

Obesity is a chronic metabolic disease recognized by all major medical organizations.<sup>12-15</sup> The diagnosis of obesity is determined by an individual's body mass index (BMI): class 1, BMI of 30 to less than 35; class 2, BMI of 35 to less than 40; and class 3, BMI of 40 or greater.<sup>16</sup> However, a lower class 3 threshold (>27.5) for adults with Asian ancestry has been proposed because they have a higher prevalence of metabolic disorders at lower body weights compared with White adults.<sup>17</sup>

Historically, obesity has been perceived by society as the result of an individual's negative personal traits, which are often

described as “laziness,” “gluttony,” or “lack of willpower.” However, the pathogenesis of obesity is more complex, involving 2 distinct but related processes: (1) energy intake greater than energy output and (2) resetting the body weight “set point” at a higher level.<sup>18</sup> Although the mechanics of the first process are straightforward, the effects of genetic predisposition and access to virtually unlimited calories in modern society must also be considered. It has been hypothesized that particular gene variants evolved to favor efficient use when food sources are scarce.<sup>19</sup> Individuals who are strongly affected by these variants will tend to gain more weight than those who are not as affected. As weight increases, weight loss becomes increasingly difficult because the body defends the new, higher set point. This is why most weight loss programs that focus solely on diet and exercise fail over the long term.<sup>20</sup>

### Prevalence

According to the National Health and Nutrition Examination Survey 2017–March 2020 prepandemic data files, an estimated 41.9% of adults in the US 20 years or older had class 1 or 2 obesity, and 9.2% had class 3 obesity during the survey period.<sup>1</sup> The highest prevalence was seen in adults aged 40 to 59 years (44.3%).<sup>1</sup> Obesity increased by 3% during the first year of the COVID-19 pandemic.<sup>21</sup>

In children and adolescents aged 2 to 19 years in 2017-2020 in the US, the prevalence of obesity was 19.7%, and it was highest in adolescents aged 12 to 19 years (22.2%).<sup>22</sup> However, in a 2022 cohort study of 3110 children and adolescents, investigators reported that 66.9% had class 1 obesity or higher.<sup>23</sup>

Unpublished data from the University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics (USC Schaeffer Center) show that 30-year trajectories for obesity rates are significantly higher within the working-age population. In individuals younger than 65 years, the prevalence of obesity is expected to rise from 48% in 2023 to 55% in 2053, compared with an increase from 36% to 44% in individuals 65 years or older. (eAppendix Figure [eAppendix available at [ajmc.com](http://ajmc.com)]). Cawley et al reported that obesity raises absenteeism by 3.0 days per year due to associated illness and injury.<sup>24</sup>

### Racial/Ethnic Disparities

Across all age groups, investigators have observed significant racial/ethnic and socioeconomic disparities in obesity prevalence. As shown in **Table 1**,<sup>1,25</sup> survey results found that obesity was most

common in Black adults and adults with incomes from greater than 130% to 350% of the federal poverty level (FPL). Interestingly, the researchers noted that the prevalence was significantly higher among adults with a high school diploma/some college compared with those with no high school diploma and those with a college degree.

Overall, the prevalence of obesity in children and adolescents aged 2 to 19 years was similar between males and females (Table 2).<sup>1,25</sup> Within this population, obesity prevalence increases with age.<sup>1</sup> Prevalence was highest in Hispanic males and Black females.<sup>1</sup> Unlike the adult population, obesity prevalence was more than 2 times greater in children and adolescents at 130% or less of the FPL than in those at more than 350%.<sup>1</sup>

The reasons for these disparities are complex and multifactorial, and they reflect differences in social and economic advantage related to racial factors. For example, the higher prevalence of obesity in Black and Hispanic populations is likely due to lower high school graduation rates, higher rates of unemployment, lower household incomes, poor access to health care, and/or lack of referrals to community organizations that can assist in accessing family management or self-management resources.<sup>26</sup> Compounding these factors is food insecurity, which is more prevalent among low-income populations and often leads to reliance on and overconsumption of inexpensive, high-carbohydrate foods.<sup>27</sup>

Another key contributor to obesity is the disproportionate focus on racial/ethnic minority group youth by US food and beverage companies. As recently reported by Harris et al, the promotion of unhealthy high-calorie products such as candy, sugary drinks, savory snacks, sugared cereal, and sweet snacks represented 75% of television advertising spending in 2021 targeted at Black individuals and individuals who speak Spanish.<sup>11</sup> Conversely, there was no advertising for fruits or vegetables directed at these populations. These targeted marketing efforts present significant barriers to reducing obesity and improving health in Black and Hispanic populations, along with populations living in food deserts.

### Clinical Impact

Second only to smoking, obesity is the next most preventable cause of death in the US. An estimated 1 in 5 deaths in Black and White Americans aged 40 to 85 years is attributable to obesity.<sup>28</sup> In an early study by Chang et al, investigators found that in individuals aged 40 to 49 years with BMI greater than 40, White men experienced 5.23 lost life-years (LLY), followed by Black women (5.04 LLY) and White women (4.7 LLY).<sup>29</sup> However, significant disparities were observed in younger individuals with extreme obesity aged 29 to 30 years, with the highest number of LLY occurring in Black men (11.65 LLY) and Black women (9.29 LLY) compared with White men (8.45 LLY) and White women (8.71 LLY).

Key drivers of early mortality are the myriad complications of obesity (Table 3).<sup>28</sup> Although obesity is considered a significant risk factor for developing type 2 diabetes (T2D), it is also the underlying factor driving many of these risk factors associated with T2D. Childhood obesity is also linked to the same range of

**TABLE 2.** Individuals Aged 2 to 19 Years With Obesity<sup>1,25,a</sup>

Characteristic	All (N=4749)	Male (n=2410)	Female (n=2339)
<b>Age</b>			
2-5 years (n=1141)	12.7%	13.6%	11.8%
6-11 years (n=1765)	20.7%	22.9%	18.5%
12-19 years (n=1843)	22.2%	22.6%	21.7%
<b>Race</b>			
Black (n=1270)	24.8%	18.8%	30.8%
Hispanic (n=1143)	26.2%	23.3%	23.0%
White (n=1471)	16.6%	17.6%	15.4%
Asian (n=420)	9.0%	13.1%	5.2%
<b>Income<sup>b</sup></b>			
≤ 130% FPL (n=1748)	25.8%	26.4%	25.2%
> 130%-350% FPL (n=1514)	21.2%	20.7%	21.7%
> 350% FPL (n=956)	11.5%	15.1%	8.2%

BMI, body mass index; FPL, federal poverty level.

<sup>a</sup>Obesity, 30.0-39.9 BMI; extreme obesity, > 40.0 BMI.

<sup>b</sup>Family income relative to FPL.

**TABLE 3.** Complications Associated With Obesity<sup>28</sup>

• Type 2 diabetes	• Sleep apnea
• Hypertension	• Acute pancreatitis
• Hyperlipidemia	• Pancreatic cancer
• Dysglycemia	• Gallstone disease
• Cardiovascular disease	• Cancers (gastrointestinal, breast)
• Coronary heart disease	• Nonalcoholic fatty liver disease
• Stroke	• Osteoarthritis and joint replacement
• Gastrointestinal complications	• Respiratory ailments
• Polycystic ovary syndrome	• Dementia and Alzheimer disease
• Chronic kidney disease	• Psychosocial issues

complications, and children and adolescents with overweight or obesity often experience social and emotional challenges that can impact their overall well-being.

### Economic Impact

Obesity has a significant impact on health care spending, as well as the economy as a whole. The medical costs associated with its complications increase the economic burden on payers and health care systems by approximately 50% more than for individuals with normal weight.<sup>30,31</sup> In 2019, obesity accounted for almost \$173 billion of annual health care spending in the US.<sup>32</sup> Obesity was associated with a mean of \$2505 in excess annual medical costs per person compared with individuals with healthy weight (\$1861 for individuals with BMI 30-35 and \$3097 for those with BMI ≥ 40).<sup>33</sup> As discussed earlier, obesity also leads to lost productivity due to increased absenteeism and rising disability rates, further contributing to its economic impact. Early studies have reported increased absence

**TABLE 4.** Commonly Prescribed Medications for Obesity Treatment<sup>36-41</sup>

Medication	Mode of action	Adverse effects	Average weight loss
<b>Oral medications</b>			
Orlistat	Prevents absorption of fat in the gut	Oily stools, flatulence	2.9% at 120 mg 3 times daily <sup>39</sup>
Phentermine/topiramate	Suppresses appetite by reducing hunger signals to the brain (combination drug)	Dry mouth, constipation, insomnia	7.8% at 7.5/46 mg and 9.8% at 15/92 mg daily <sup>40</sup>
Bupropion/naltrexone	Reduces appetite and increases satiety (combination drug)	Nausea, constipation, headache	≥ 5% for ~30% of patients; ≥ 10% for ~8% of patients at 32/360 mg daily <sup>41</sup>
<b>Injectable medications<sup>a</sup></b>			
Liraglutide	Suppresses appetite and increases satiety	Nausea/vomiting, diarrhea, constipation, pancreatitis, gallbladder disease,	8.4% at 3 mg daily <sup>38</sup>
Semaglutide	Suppresses appetite and increases satiety	Nausea/vomiting, diarrhea, constipation, pancreatitis, gallbladder disease	15.8% at 2.4-3.0 mg daily <sup>36</sup>
Tirzepatide	Suppresses appetite and increases satiety	Nausea/vomiting, diarrhea, constipation, gallbladder disease, biliary disease	15.0% at 5 mg, 19.5% at 10 mg, and 20.9% at 15 mg weekly <sup>37</sup>

<sup>a</sup>In individuals with type 2 diabetes, the injectable medications increase insulin secretion (glucose dependent), inhibit glucagon release, suppress hepatic gluconeogenesis, and delay gastric emptying.

rates in employees with obesity, ranging from 25% to up to 200% compared with employees who are not obese.<sup>34,35</sup>

### Obesity Management

There are several treatments and medications available for obesity. Although a healthy diet and regular exercise are the most effective approaches to initial weight loss, a recent and early meta-analysis found that more than half of the lost weight was regained within 2 years, and by 5 years more than 80% of lost weight was regained.<sup>20</sup> This is why pharmacologic therapy is indicated for individuals with BMI of 30 or greater or those whose BMI is 27 or greater who have an obesity-related comorbidity such as T2D, hypertension, obstructive sleep apnea, or dyslipidemia.<sup>15</sup> **Table 4** lists some of the medications that are often prescribed for obesity.<sup>36-41</sup> The newest medications, semaglutide and tirzepatide, have been shown to have the largest reductions in body weight<sup>36,37</sup> compared with the earlier injectable medication, liraglutide,<sup>38</sup> and oral medications.<sup>39-41</sup> Moreover, 2 of the injectable medications, specifically, semaglutide and liraglutide, also have demonstrated cardiovascular and renal protective qualities, thereby reducing the risk of these obesity comorbidities.<sup>42-44</sup> Studies suggest that tirzepatide may offer similar protections,<sup>45,46</sup> and more definitive investigations are underway. Although tirzepatide was initially approved by the FDA for the treatment of T2D, it recently received FDA approval as an obesity treatment.<sup>47</sup>

### Barriers to Obesity Care

As with the causes of obesity, the barriers to treatment are multifactorial and often interrelated (**Table 5**).<sup>3-6,18,19,26,27,48-55</sup> Although

physiologic and environmental factors can be difficult to attenuate, the majority of factors can be modified through systemic changes in health care priorities (eg, improving access to qualified health care), expansion of coverage of all obesity treatments (behavioral and pharmacologic), and public awareness campaigns to reduce the stigma of obesity, which is often the driver of inadequate access to care and treatment. In addition to these barriers, individuals are often scammed by advertisers using telemarketing calls, text messages, social media, and internet banner advertisements that promise significant weight loss without making changes in diet and/or other health behaviors.<sup>56</sup>

### Stigma of Obesity Impacts Patient Outcomes, Provider Behaviors, and Health Policies

**Patient outcomes.** Obesity can cause stigma and discrimination toward individuals with obesity. In a 2016 meta-analysis, the prevalence of perceived obesity stigma was 19.2% in individuals with BMI of 30 to less than 35 and 41.8% in individuals with BMI 35 or greater.<sup>57</sup>

People often report feeling disgust, anger, blame, and dislike toward individuals with obesity.<sup>3,4</sup> The unfair presumption is that individuals with obesity are unintelligent, lazy, and lack the self-discipline necessary to achieve and maintain a healthy weight.<sup>4</sup> Individuals who experience obesity stigma are more likely to have poorer mental health, poor quality of life, disordered eating behaviors, excessive alcohol use, and weight gain, resulting in poor health outcomes.<sup>58</sup> Obesity stigma can also impact an individual's personal and professional lives, including employment, education, and housing discrimination.<sup>59</sup> This can further perpetuate socioeconomic disparities for individuals with obesity, leading to limited access to resources and opportunities.

The impact of obesity stigma is further compounded when the individual with obesity has T2D. Diabetes stigma refers to negative attitudes, discrimination, or prejudice against individuals with diabetes. These attitudes are based on the misguided assumption that individuals developed diabetes due to their unhealthy food and lifestyle choices, which resulted in their diagnosis.<sup>60</sup>

**Provider behaviors.** Many health care providers hold strong negative attitudes about their patients with obesity, which can influence the health care providers' perceptions, judgment, and decision-making.<sup>5</sup> Although obesity-related comorbidities are often addressed in primary care practices, obesity itself is frequently undertreated; only 40% of adults with obesity or overweight received counseling to lose weight.<sup>61</sup>

Implicit obesity bias can impact the level of support, care, and empathy that health care providers impart to their patients with

obesity.<sup>62,63</sup> As a result, patients' experiences and/or expectations can cause emotional stress, avoidance of care, and poor adherence to prescribed treatments.

**Health policies and insurance coverage.**

Despite evidence demonstrating the complex genetic, biological, and environmental drivers of obesity, policy makers often frame this condition as a personal responsibility, which absolves them of responsibility to address societal drivers appropriately.<sup>6</sup> Although economic factors associated with providing coverage for antiobesity medications play a major role in policy decisions—as evidenced by the failure to pass the TROA bill—the impact of obesity stigma cannot be ignored.

**Recommendations for Improving Obesity Management**

**Expand coverage for effective treatments.** Most medical organizations recommend the use of approved antiobesity medications in individuals with obesity (or perhaps with BMI > 27).<sup>12-15</sup> However, as discussed earlier, Medicare Part D does not cover medications approved by the FDA for obesity treatment despite mounting evidence that obesity leads to multiple comorbidities, including cardiovascular disease, chronic kidney disease, and T2D.

Although concerns about cost have been a major impediment to providing coverage, these concerns may be unfounded. In a recent analysis by the USC Schaeffer Center, investigators found that the cumulative social benefits from Medicare coverage for the new antiobesity medications would reach almost \$1.0 trillion over the next 10 years, and that Medicare coverage would save federal taxpayers up to \$248 billion in the first 10 years if private insurers followed Medicare's lead.<sup>64</sup> Most of the cost savings to Medicare—more than 60%—would flow to Medicare Part A, which covers hospitalizations, hospice care, nursing facilities, and home care. Moreover, after 20 years of Medicare coverage, investigators calculated that diabetes prevalence would decrease by 7.7% and by as much as 24% if private insurers also provided coverage.

Medicare also needs to expand access to lifestyle approaches to obesity treatment under Part B, such as IBT and medical nutritional therapy (MNT). For example, Medicare requires that IBT be provided by primary care clinicians who have the expertise to counsel patients following a rigorous schedule. Moreover, the average time spent with patients is only 18 minutes per visit.<sup>65</sup> Researchers in a recent study<sup>66</sup> found that physicians would require 26.7 hours per day to comply with national recommendation guidelines for preventive care, chronic disease care, and acute care. Medicare also stipulates

**TABLE 5.** Common Barriers to Treatment<sup>3-6,18,19,26,27,48-55</sup>

Lack of access to qualified health care	<ul style="list-style-type: none"> <li>Some communities lack the necessary health facilities and professionals, making it challenging for individuals with obesity to access medical care.<sup>26</sup></li> <li>Lack of qualified health care professionals (eg, nutritionists, therapists, specialized health care centers) further limits access to treatment.<sup>26</sup></li> </ul>
Physiologic factors	<ul style="list-style-type: none"> <li>Certain genetic variants can increase obesity risk, which establishes an elevated set point and makes it more difficult for individuals to lose weight, even with recommended diet and exercise regimens.<sup>18,19</sup></li> <li>Hormonal imbalances, such as thyroid disorders and polycystic ovary syndrome, increase obesity risk and difficulty losing weight.<sup>48</sup></li> <li>Certain medications, including insulin, antidepressants, antipsychotics, gabapentin, antihistamines, and corticosteroids, may cause weight gain as an adverse effect.<sup>49</sup></li> </ul>
Psychological factors	<ul style="list-style-type: none"> <li>Psychological factors such as stress, anxiety, or depression can affect weight management. Individuals may turn to food as a coping mechanism or experience changes in appetite and energy levels.<sup>50</sup></li> <li>Obesity can negatively impact quality of life, resulting from self-blame, poor body image, and the feeling of being ostracized.<sup>51</sup></li> <li>Treatment plans that are too complicated or time-consuming may discourage individuals from following these regimens.<sup>52</sup></li> <li>Obesity treatments such as weight loss surgeries or medications may have risks that individuals are not willing or able to take.<sup>53</sup></li> </ul>
Environmental factors	<ul style="list-style-type: none"> <li>Access to healthy food options, safe places to exercise, affordable health care, and weight loss programs may be limited in certain areas, making it difficult for individuals to manage their weight.<sup>27</sup></li> </ul>
Sociological factors	<ul style="list-style-type: none"> <li>Weight bias and discrimination [stigma] can discourage individuals from seeking treatment or persisting with their efforts, making it harder for them to achieve their weight loss goals.<sup>3-6</sup></li> <li>Obesity stigma can result in unfair hiring practices, lower wages (compared with individuals who are not obese), lack of advancement opportunities, and wrongful termination.<sup>3-6</sup></li> </ul>
Economic factors	<ul style="list-style-type: none"> <li>Some treatments require individuals to invest in exercise equipment, gym memberships, healthy food, and medical services, which may prove to be costly and difficult for some.<sup>26</sup></li> <li>Public and private insurance coverage is not keeping pace with innovation and standards of care.<sup>54,55</sup></li> </ul>

that IBT be provided by primary care clinicians despite their limited training. Registered dietitians, pharmacists, health coaches, behavioral psychologists, and others are significantly more qualified to provide this type of therapy. Although the use of these professionals was recommended during the public comment period that preceded the coverage decision, Medicare refused to reconsider its position.<sup>67</sup>

Moreover, current coverage eligibility for MNT requires that patients obtain a referral from a primary care provider and have 1 of the following conditions: diabetes, chronic kidney disease, or a kidney transplant within the past 3 years.<sup>68</sup> In other words, an individual must first develop a recognized comorbidity of obesity to receive treatment for obesity.

Advocacy groups can promote expanded coverage for antiobesity medications as essential health benefits in the Affordable Care Act and coverage under state Medicaid programs, state employee plans, and the Federal Employees Health Benefits Program. These measures may prompt private insurers that provide limited coverage for obesity treatment to reassess their coverage policies.

**Resolve barriers in primary care.** In a recent survey of 107 primary care clinicians, less than 10% of participants reported using evidence-based guidelines to inform obesity treatment decisions.<sup>69</sup> When asked to identify opportunities to improve obesity care, respondents provided a list of requisite resources, including education on local obesity treatment resources (73%), evidence-based dietary counseling strategies (63%), effective self-help resources (70%), enhanced team-based care with support from clinic staff (46%), peers trained in obesity medicine (44%), and dietitians (54%).

Respondents also identified the need for simplification of coding and increased reimbursement for obesity treatment. As reported by Avalere Health, electronic health record (EHR) systems are often not conducive to identifying correct diagnostic codes for obesity, and the process of scrolling through codes is both tedious and time-consuming.<sup>70</sup> Moreover, a few respondents indicated that some payers do not cover services for patients with a primary diagnosis of obesity, thereby disincentivizing appropriate health care coding for obesity.

Expanding coverage for antiobesity medications and collaborating with EHR developers to improve the functionality of their systems would alleviate many of the barriers to providing effective obesity care. However, health care systems must invest in expanding access to quality care within communities of lower socioeconomic status and racial/ethnic minority groups, providing resources that meet primary care centers' educational and staffing needs. This would improve the overall quality of patient care while addressing the disparities in obesity and diabetes management.

**Dispel obesity stigma.** It is critical that we acknowledge the implicit and explicit negative biases on both the local and national levels against individuals with obesity. A preemptive approach would be to target students in medical school to dispel the perception of controllability in obesity.<sup>71</sup> This information should also be added to the curriculum/training for other health care professionals, such as nurses, pharmacists, and dietitians. Educational initiatives in medical schools and clinical practices must address reducing stigma and utilizing behavioral interventions and antiobesity medications with patients.

On a national level, we are seeing increased attention paid to eliminating obesity stigma driven by advocacy groups, such as the Obesity Action Coalition,<sup>72</sup> Obesity Care Advocacy Network,<sup>73</sup> and Diabetes Patient Advocacy Coalition,<sup>74</sup> that create public awareness for this problem and promote legislation to support coverage of obesity treatments. We are also seeing increasing support from public health incubators such as the Strategic Training Initiative for the Prevention of Eating Disorders, which provides training and educational resources for medical students and practicing health care providers.<sup>75</sup>

Training students and providers on how to talk to patients about weight is key; it is not just what they say but how they say it. Other health care targets for reducing stigma include using respectful weighing (eg, asking permission to weigh, having a private space), using nonstigmatizing language to describe weight, prohibiting the

use of BMI cutoffs to deny patients care, and ensuring the clinic environment is safe and inclusive for all body types (eg, having high-capacity scales, blood pressure cuffs, and gowns).

## Conclusions

Obesity is a significant health crisis affecting more than 123 million adults and children/adolescents in the US.<sup>1,2</sup> Significant racial and socioeconomic disparities have been observed, and higher percentages of Black and Hispanic American individuals are affected by obesity. The reasons for these disparities are complex and multifactorial, involving inadequate access to qualified health care providers and services, environmental factors (eg, access to healthy food, safe exercise areas), stigma, and inadequate coverage for proven antiobesity medications and other therapies. Addressing the obesity epidemic will require a multifaceted approach that focuses on prevention, treatment, and reducing the impact of stigma. Continued advocacy and education efforts are necessary to make progress and improve the health and well-being of individuals affected by obesity. ■

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**eAppendix Figure.** Obesity Prevalence: 30-Year Projection by Age Group (Unpublished Observations)

