



Obesity Groups Urge OHIC to Address Harms of the Enacted FY2027 Budget to Eliminate Rhode Island Medicaid Coverage for FDA-Approved Obesity Management Medications

Statement for the Record for the September 16 Office of the Health Insurance Commissioner Public Hearing

The Obesity Action Coalition (OAC), The Obesity Society (TOS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) submitted a statement of opposition prior to passage of the Rhode Island Fiscal Year 2027 budget, which eliminates Medicaid coverage for GLP-1 medications for obesity effective October 1, 2026. The General Assembly enacted the Governor's proposal in June 2026, and it is no longer under consideration but is now settled law, projected to save the state \$6.3 million in general revenue and \$20.3 million from all funds in the Medicaid program. With the effective date now two weeks away, our organizations remain deeply concerned about the impact this policy will have on Rhode Islanders with obesity, and we urge OHIC to use this hearing to examine the health, cost, and health-equity consequences of this coverage elimination, including the risk that costs avoided by Medicaid will be shifted onto the commercial market and hospital and emergency systems that OHIC oversees.

Our organizations strongly support coverage of Food & Drug Administration (FDA) – approved obesity management medications in the context of comprehensive obesity care for Medicaid beneficiaries. Improved access to obesity treatments that have been proven safe and effective, including nutrition counseling, behavioral and lifestyle interventions, FDA-approved obesity management medications, endobariatric procedures, and metabolic and bariatric surgery is critical to ensuring the health and productivity of all state residents.

OHIC's own June 2026 primary care report found that Medicaid beneficiaries already have significantly less access to routine care than their commercially insured peers — fewer than half had a regular primary care wellness visit in 2024, compared to nearly seven in ten Rhode Islanders with commercial coverage — with the widest gaps among Hispanic and low-income residents, the same populations disproportionately affected by obesity. Eliminating GLP-1 coverage now, without a transition plan, moves in the opposite direction of the state's own stated primary care and access goals, at a moment when the state's plans for closing Medicaid access gaps are themselves in flux.

Rhode Island has been a leader in obesity care coverage throughout the last decade. For these reasons, we remain deeply disappointed that the enacted budget restricts GLP-1 coverage to type 2 diabetes only -- despite FDA approval for other conditions in addition to obesity such as cardiovascular disease, obstructive sleep apnea, and metabolic-associated steatohepatitis (MASH, or NASH with fibrosis). In our April statement, we asked whether there would be any grandfathering for individuals currently taking GLP-1 medications for obesity. The Executive Office of Health and Human Services has since confirmed that there will be no grandfathering or exemptions for existing patients, and that the drugs will simply be removed from the preferred drug list effective October 1, 2026. This means thousands of Rhode Islanders currently being treated for obesity, some of whom have been stabilized on these medications for months or years, will be involuntarily discontinued from their prescribed treatment with no transition plan. Abrupt discontinuation of GLP-1 therapy is associated with rapid weight regain and reversal of the cardiometabolic gains patients have achieved, compounding the harms of this

policy and creating exactly the kind of care disruption and cost-shifting that OHIC's mission is designed to prevent.

Rhode Island ranks 40th in states impacted by obesity with 30.8% of Rhode Island adults living with obesity and another 36.6 affected by overweight. Obesity and diabetes disproportionately affect people of color and of lower socioeconomic status which are important factors that often determine access to health care. Disparities further exacerbate Rhode Island obesity statistics and health outcomes with 38.5% of black and 33.9% of Hispanic state residents living with obesity compared to 29.5% of white residents. Persons with low incomes are more likely to be Medicaid recipients or uninsured, have poor-quality health care, and seek health care less often; when they do seek health care, it is more likely to be for an emergency. The American Diabetes Association has estimated that obesity costs Rhode Island's economy approximately \$1.7 billion annually, and that roughly 31% of Rhode Island adults are living with obesity today, a share the CDC projects will continue to rise. Since our April statement, Rhode Island's peer states have moved in both directions on this issue: as of mid-2026, only about a dozen state Medicaid programs nationally still cover GLP-1 medications for weight loss, and that number continues to shrink as states cite cost pressure, while at least one state that cut coverage for budget reasons has since reinstated it after weighing the costs of care disruption. Rhode Island's elimination of coverage, effective October 1, 2026, will move the state out of this shrinking group of leaders in obesity care coverage.

The total cost of obesity in the United States is \$1.7 trillion and healthcare costs are 34% higher for people with obesity. Expanding access to obesity care will help decrease the numerous illnesses and related medical problems that plague Rhode Islanders, while improving health outcomes and healthcare savings. It is important to remember that while some obesity management medications may be costly, state Medicaid programs receive very generous rebates and discounts from manufacturers and the Federal Government. In addition, creating a system where Medicaid beneficiaries will have access to the full range of obesity treatment services -- such as nutrition counseling, intensive behavioral therapy, obesity management medications, and metabolic and bariatric surgery -- will provide an avenue for addressing so many other costly obesity-related conditions such as Type II diabetes, hypertension and cardiovascular disease.

Throughout the last 5 years, there have been numerous studies and reports issued on the cost effectiveness of providing coverage for obesity treatment, such as the release of the December 16, 2025, Institute for Clinical and Economic Review (ICER) Evidence Report assessing the comparative clinical effectiveness and value of semaglutide and tirzepatide. ICER found all three medications to be cost-effective at the \$100,000 per quality-adjusted life year threshold.

Another example is the October 2025 report from Global Data, entitled the "Economic Benefits of Obesity Treatment," which assessed previous literature findings on the value of obesity treatments to help policymakers be better informed regarding coverage and policy decisions. This included 31 studies (2012–2025) on the economic value of four major interventions -- lifestyle programs, first-generation medications, modern medications, and metabolic and bariatric surgery. The report's key take away was that investing in effective obesity treatments not only improves health outcomes and quality of life but also delivers meaningful savings. The estimated annual medical savings (adjusted to 2025 dollars; varies by insurance type) would be as follows: \$200-\$1,220 for lifestyle programs and first-gen medications; \$760-\$4,720 for modern medications; and \$940-\$5,830 for metabolic and bariatric surgery.

In addition, a recent [AON study](#) of 139,000 U.S. employees revealed that patients treated with GLP-1 medications experienced a 7% lower medical cost trend by year two compared to similar patients who did not receive treatment for their obesity. In contrast, the untreated group saw their medical cost trend rise to 14%. This is a 50% reduction in health care spending for patients taking obesity management medications. Most notably, GLP-1 use led to a greater than 40% reduction in major adverse cardiac events such as heart attacks and strokes and significantly reduced the incidence of diabetes—outcomes that directly benefit both patient lives and the state's healthcare expenditures. The study was so impactful that the benefits consulting firm started a program to cover these obesity medications for their own employees.

Finally, the Centers for Medicare and Medicaid Services has invited states to participate in the [BALANCE \(Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth\)](#) model, which broadens access to evidence-based obesity treatments at lower costs through federal negotiations. Meanwhile, increased competition and innovation continue to place downward pressure on GLP-1 prices and manufacturers have shown a willingness to negotiate directly with states.

Reduced GLP-1 Medication Costs

The cost of GLP-1 medications has significantly declined in the past year. Unfortunately, we believe that Rhode Island policymakers did not fully account for the magnitude of these reductions when this decision was made, and continue to rely on outdated cost information. For example, manufacturers are now offering states substantial discounts on many GLP-1 medications. For Medicaid programs, federal government payments in accordance with the Federal Medical Assistance Percentage (FMAP) further reduce state expenditures for GLP-1s by 50% to 77%. Many state estimates of GLP-1 costs neglect to account for these federal funds paid to the state Medicaid program.

Breaking Down the Numbers for Rhode Island Medicaid

Manufacturers have publicly agreed to provide a 30-day supply of all formulations of Foundayo®, Wegovy®, and Zepbound® Kwikpen for \$245. The State's Medicaid cost for the GLP-1 medication is then further reduced by the Federal Medical Assistance Percentage (FMAP) payment, which for Rhode Island is 57.81% for federal fiscal year 2027, resulting in a 30-day cost of \$103.37 for the state – less than \$3.50 a day!

Maintaining Medicaid coverage for FDA-approved obesity management medications is essential to ensuring that Medicaid beneficiaries who are affected by obesity have access to affordable, individualized medical coverage for science-based treatments in the same way other chronic diseases are managed, allowing them to be treated with dignity, respect, and equality that is offered to their peers. We collectively believe that access to all obesity treatment avenues will not only improve health outcomes for state residents but will also reduce healthcare costs to the state.

Because the Fiscal Year 2027 budget is now enacted, our organizations recognize that reversing this policy is outside OHIC's direct authority. We nonetheless urge the Commissioner to use the tools available to this office to: (1) formally request that the Executive Office of Health and Human Services adopt a clinically appropriate transition period or continuity-of-care exception for the thousands of current Medicaid beneficiaries who will otherwise be involuntarily discontinued from GLP-1 therapy on October 1, 2026; and (2) request that the Executive Office of Health and Human Services publicly clarify, in writing, whether Medicaid coverage will continue for GLP-1 medications prescribed for other FDA-approved, non-weight-loss indications -- such as cardiovascular risk reduction, moderate-to-severe obstructive sleep apnea, and metabolic dysfunction-associated steatohepatitis (MASH) -- and ensure that providers, pharmacies, and beneficiaries are clearly notified before October 1, 2026 to prevent erroneous denials for these federally non-excludable indications. We would welcome the opportunity to serve as a resource to OHIC as it considers these issues.

For more information, please contact OAC, TOS, ASMBS Public Policy Advisor Chris Gallagher via email at chris@potomaccurrents.com.