



Obesity Groups Oppose New Virginia State Employee Health Plan Coverage Rules for FDA-Approved Obesity Management Medications

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The Obesity Action Coalition (OAC), The Obesity Society (TOS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) strongly object to the Virginia state employee health plan's new coverage policy surrounding "weight loss GLP-1 Prior Authorization criteria" detailed in the Virginia Department of Human Resource Management's (DHRM) ["Spotlight on Your Benefits" brochure](#). Under this new guidance, "a Body Mass Index (BMI) of 35 or higher is required to obtain a weight loss GLP-1 medication. Additional Prior Authorization guidelines and criteria will continue to be required and **current utilizers will be subject to the updated BMI criteria once their existing prior authorization (PA) expires.**"

Major Medical Society Guidelines Explicitly Recommend Against Discontinuation Based on BMI Reduction

While the state may be concerned regarding utilization and cost of maintaining GLP-1 coverage, requiring patients who have achieved successful weight reduction on GLP-1 therapy to meet the same BMI threshold used for treatment initiation is medically unsound, contradicts established clinical guidelines, and will predictably result in worse health outcomes and higher long-term costs for the plan. For example:

- The **American Diabetes Association (ADA) Standards of Care (2026)** states: "Obesity is a chronic, relapsing disease, similar to hypertension, and typically requires continuation of pharmacotherapy after weight reduction goals are achieved to sustain weight loss and health benefits." The ADA further notes that "sudden discontinuation of semaglutide and tirzepatide results in weight recurrence of one-half to two-thirds of the weight loss within 1 year with reversal of cardiometabolic improvements".¹
- A **JAMA Internal Medicine** review (2024) explicitly states: "It is not advisable to discontinue an AOM based solely on reduction in BMI to the 'normal weight' range given the high likelihood of weight regain after discontinuation." The authors draw a direct parallel to hypertension and dyslipidemia management, noting that "the concept of 'treating to target' using weight loss as a biomarker for reduced risk of complications is parallel to the use of drugs for hypertension or dyslipidemia, where drugs are not discontinued when the blood pressure or cholesterol reaches the normal range".²
- The **Obesity Society's Clinical Management of Obesity (2025)** states that "any medication that is started for the treatment of obesity should be considered a long-term medication" and that "discontinuing medications at the patient's desired goal weight may lead to weight regain and therefore is typically not recommended".³
- The **World Health Organization (2025)** recommends the long-term use of GLP-1 therapies for adults living with obesity, recognizing obesity as "a chronic, relapsing disease that requires lifelong care".⁴

¹ [Obesity and Weight Management for the Prevention and Treatment of Diabetes: Standards of Care in Diabetes-2026](#). Diabetes Care. 2026. American Diabetes Association Professional Practice Committee for Diabetes*.

² [Approach to Obesity Treatment in Primary Care: A Review](#). JAMA Internal Medicine. 2024. Yanovski SZ, Yanovski JA

³ [Clinical Management of Obesity – Third Edition](#). The Obesity Society (2025). 2025. Caroline M. Apovian MD, Louis Aronne MD, Sarah R. Barenbaum MD

⁴ [World Health Organization Guideline on the Use and Indications of Glucagon-Like Peptide-1 Therapies for the Treatment of Obesity in Adults](#). The Journal of the American Medical Association. 2025. Celletti F, Farrar J, De Regil L.

We respectfully request that DHRM implement a **grandfathering provision** for all patients currently receiving GLP-1 therapy, such that patients who were appropriately initiated on GLP-1 therapy under prior authorization criteria in effect at the time of prescribing are exempt from the new BMI ≥35 requirement for continued coverage. This approach balances the plan's interest in cost management with the overwhelming medical evidence supporting treatment continuation and aligns with the standard of care as defined by the ADA, the Obesity Society, the AGA, the WHO, and the broader medical community.

Robust State Employee Coverage for Obesity Medications is *also* Cost-Effective

It is also important to note that 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 October 29, 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 highly cost-effective at conventional thresholds with incremental cost-effectiveness ratios estimated at \$53,400 per quality-adjusted life year gained for tirzepatide, \$61,400 for injectable semaglutide, and \$69,300 for oral semaglutide.

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.

Finally, a recently published article in *Diabetes, Obesity and CardioMetabolic Care* entitled the [“Benefits and Costs of Treating Obesity Among Adults in the Medicaid Program,”](#) demonstrates that changes in body weight and cardiometabolic risk factors associated with providing specific obesity treatments would reduce the incidence of several chronic conditions generating multiple social benefits such as medical cost savings, productivity improvements, additional quality-adjusted life-years, and mortality reductions.

- Among people with no prior history of type 2 diabetes, results indicate that second-generation obesity medicines (GLP-1s) can prevent 45% of new cases compared with no treatment.
- Second generations obesity medicines also would reduce hypertension incidence by 45% and were the most effective across all interventions.
- Coronary heart disease, heart attack and stroke incidence would decline by rates of 18%, 31% and 27% respectively with use of second-generation OMs.

These studies demonstrate that while medical savings offset only a portion of treatment costs, obesity interventions generate substantial social value through improved long-term health and productivity. These findings support robust state employee coverage for obesity medications as a strategic investment in population health, demonstrating value that challenges conventional short-term, budget-focused coverage decisions that currently limit access to evidence-based obesity treatments for millions of adults.

Maintaining robust state employee coverage for FDA-approved obesity management medications is essential to ensuring that state employees 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.

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