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**OAC Supports House General Government Committee Passage of HB 388  
to Renew Access to Obesity Medications for Ohio State Employees**

**June 1, 2026**

On behalf of the Obesity Action Coalition (OAC), we would like to express our support for House General Government Committee passage of House Bill (HB) 388 – legislation introduced by Representative Josh Williams that would restore coverage of GLP-1 medications for obesity in the state employee health plan via a rebate reimbursement program.

OAC is a more than 95,000 member-strong 501(c)(3) National nonprofit organization dedicated to giving a voice to the individual affected by the disease of obesity and helping individuals along their journey toward better health through education, advocacy and support. Our core focuses are to raise awareness and improve access to the prevention and treatment of obesity, provide evidence-based education on obesity and its treatments, fight to eliminate weight bias and discrimination, elevate the conversation of weight and its impact on health and offer a community of support for the individual affected.

In late April of 2025, the Ohio Department of Administrative Services (DAS) announced, with little prior notice or explanation, that GLP-1 coverage for obesity as part of the state employee health plan would end on July 1, 2025. While most state employee programs negotiate directly with manufacturers for rebates on GLP-1s, our understanding is that DAS never explored this known cost-reducing option which would save the state millions of dollars.

The DAS announcement prompted Representative Josh Williams to introduce HB 388 to restore state employee coverage for these medications – especially given his personal experience with the life-changing success that GLP-1 coverage can bring. Since Representative Williams started taking GLP-1 medication, he has lost more than 100 pounds and, by his own account, his health has improved immeasurably.

This bipartisan legislation allows eligible state workers to apply for monthly reimbursements when they purchase GLP-1 medications directly from pharmacies. While OAC contends that GLP-1s should be covered by insurance in the same manner that medications for other chronic diseases, such as diabetes, cancer, and heart disease, we support HB 388 as a means for access and will continue working to restore the prior GLP-1 state employee coverage.

In addition, we encourage the Committee to make two amendments to the bill:

1. Eligibility for the second 24-month reimbursement period should be expanded to include a return to a BMI of 30, particularly since that is the threshold that must be met in order to be eligible for the first round of reimbursement. This change would allow a state employee who may not have gained back 20% of their weight loss, but did see their BMI return to at least 30, still be eligible for a second 24-month reimbursement period.
2. Additionally, there is no language in the bill that specifies the amount of reimbursement during that second 24-month reimbursement period. Would it continue to be as described in Lines 54-59 (up to \$250/month) or something different? We encourage the committee to add specificity to that section of the legislation.



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## **Reinstating State Employee Coverage for Obesity Medications is Cost-Effective**

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 reinstatement of 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.

Reinstating 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 Policy Consultant Chris Gallagher at [chris@potomaccurrents.com](mailto:chris@potomaccurrents.com).