Access, Affordability, and Obesity Care

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Disclosures

Conflict of Interest

- No conflict of interest
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Agenda

- Overview of Obesity in the U.S.
- Current Trends and Challenges
- Clinical Needs and Available Treatment Options
- Barriers to Accessing Obesity Care
- Study Objectives, Design, and Data Sources
- Key Findings: Access, Affordability, and Participant Demographics
- Discussion, Policy Implications, and Next Steps

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Executive Summary

Key Findings and Implications

This summary presents three key insights on access to care and affordability for adults with obesity.

Access to Care

- Adults with obesity are as likely as normal-weight individuals to have a usual source of healthcare, indicating stable primary care engagement despite higher medical needs.
- No significant differences were found in the ability to afford or timely access to medical care between obese and normal-weight groups, suggesting equitable healthcare access in this area.
- Maintaining primary care access is critical for managing obesity-related comorbidities and coordinating treatment.

Affordability Challenges

- Severely obese individuals (Class II and III) face significant financial barriers to affording prescription medications, with increased likelihood of delaying or forgoing drugs.
- Polypharmacy common in obesity worsens affordability issues, limiting access to effective weight management drugs like GLP-1 receptor agonists.
- These affordability challenges risk poorer clinical outcomes and increase disparities in chronic disease management.

Policy and Clinical Implications

- Insurance coverage gaps, including lack of Medicare Part D coverage for anti-obesity drugs, limit treatment access.
- Healthcare policies should improve prescription drug coverage and reduce out-of-pocket costs for severely obese individuals.
- Clinicians must consider financial barriers when prescribing and support integrated care approaches to improve medication affordability.

Our study reveals that adults with obesity generally maintain comparable access to primary care as those with normal weight, yet face significant affordability challenges, particularly with prescription medications. These findings emphasize the urgent need for healthcare policy reforms and clinical strategies to address financial barriers and improve treatment access for this vulnerable population.

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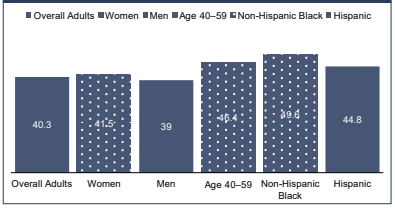
Background

Obesity in the United States: Current Landscape

Key Statistics and Public Health Context

- Approximately 40.3% of U.S. adults are classified as obese, with severe obesity affecting 9.4% (CDC, 2023).
- **BMI ≥ 40: Women** experience higher severe obesity rates **(12.1%)** compared to men (6.7%), indicating gender disparities.
- Obesity prevalence peaks in adults aged 40–59 years at 46.4%, underscoring middle age as a critical risk period.
- Non-Hispanic Black adults have the highest obesity rates at 49.6%, followed by Hispanic adults at 44.8%, reflecting significant racial disparities.
- These disparities contribute to increased healthcare needs and costs, emphasizing obesity as a major public health challenge.

Prevalence of Obesity and Severe Obesity in the U.S. by Age and Race/Ethnicity



Obesity affects over 40% of U.S. adults, with severe obesity disproportionately impacting women and middle-aged adults. Significant racial and ethnic disparities exist, highlighting the urgent need for targeted public health interventions. (CDC 2023)

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Treatment

Clinical Need and Treatment Options

Obesity is linked with multiple serious comorbidities that increase medical and pharmaceutical care needs. GLP-1 receptor agonists represent a highly effective pharmacologic treatment option.

Major Comorbidities Associated with Obesity

- Hypertension
- Type 2 Diabetes Mellitus (T2DM)
- Dyslipidemia
- Additional Conditions: Includes obstructive sleep apnea, osteoarthritis, certain cancers, and non-alcoholic fatty liver disease, all increasing healthcare utilization.
- Obesity exacerbates the complexity of managing these comorbidities, often requiring polypharmacy and multidisciplinary care.

Anti-Obesity Treatments and Clinical Indications

- GLP-1 receptor agonists (e.g., semaglutide) have demonstrated weight loss ranging from 10% to over 20% of body weight in clinical trials.
- Indicated for adults with BMI ≥ 30 kg/m² or BMI ≥ 27 kg/m² with weight-related comorbidities such as hypertension or T2DM.
- These medications improve weight-related metabolic parameters and may reduce the burden of obesity-related diseases.
- Despite clinical benefits, access is limited due to insurance restrictions and high costs, impacting treatment uptake.
- Other treatment options include lifestyle interventions, bariatric surgery, and emerging pharmacotherapies, but GLP-1s currently lead in efficacy.

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Access

Barriers to Accessing Obesity Treatment

Coverage limitations in Medicare Part D and private insurance policies create significant barriers to accessing effective obesity treatments like GLP-1 receptor agonists. Despite rising demand driven by obesity prevalence and GLP-1 clinical benefits, these policy and insurance result in a substantial gap between need and access.

Coverage Limitations in Medicare and Private Insurance

- Medicare Part D explicitly excludes coverage for anti-obesity medications, including GLP-1 receptor agonists, limiting access for older adults dependent on this program.
- Private insurance plans often impose restrictive criteria, such as prior authorization requirements, high copayments, or exclusion of obesity drugs from formularies.
- Lack of coverage results in high out-of-pocket costs, making effective treatment unaffordable for many patients.
- Policy inertia and inconsistent insurer policies contribute to ongoing barriers despite demonstrated clinical benefits of GLP-1.

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Objective

Study Objective

Primary Objective and Focus

- Assess **accessibility**
  - Patient has a usual source of healthcare (yes / no).
- Assess **affordability**
  - Unable to afford or delay needed **medical care** in the past 12 months due to cost (yes / no).
  - Unable to afford or delay **prescribed medications** in the past 12 months due to cost (yes / no).

This study aims to evaluate the accessibility and affordability of medical care and prescription medications among adults with obesity in the United States.

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Methods

Study Design and Data Source

The study utilized a cross-sectional design analyzing 2022 MEPS Household Component data, which captures comprehensive healthcare usage, costs, and insurance coverage of non-institutionalized U.S. residents.

Study Design and Data Source Overview

- Cross-sectional analysis using the 2022 MEPS Household Component data, conducted annually by the Agency for Healthcare Research and Quality (AHRQ).
- MEPS employs a multistage, stratified sampling design representing the non-institutionalized U.S. civilian population, ensuring national representativeness.
- The 2022 Full-Year Consolidated File pools data from multiple rounds of Panel 24, 26, and 27, capturing detailed demographics, health conditions, healthcare utilization, costs, insurance coverage, and patient-reported outcomes.
- The survey's comprehensive scope enables evaluation of medical care access, prescription affordability, and sociodemographic factors critical to understanding obesity-related healthcare disparities.
- Use of MEPS data facilitates health economics and outcomes research by providing granular, nationally representative insights into healthcare patterns and financial barriers among adults with obesity.

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Methods

Sample Characteristics and Classification

Inclusion/Exclusion Criteria and BMI Categories

- Participants aged 18 years and older from the 2022 Medical Expenditure Panel Survey (MEPS) Household Component.
- Exclusion of participants with missing BMI data.
- BMI categories defined per CDC standards: Underweight (<18.5 kg/m²), Normal weight (18.5–24.9 kg/m²), Overweight (25–29.9 kg/m²), Obesity Class I (30–34.9 kg/m²), Class II (35–39.9 kg/m²), and Class III (≥40 kg/m²).
- Use of BMI categorization enables stratified analysis relative to obesity severity and related health outcomes.

Key Demographic Variables

- Age groups stratified as 18–25, 26–35, 36–45, 46–55, 56–65, 66–75, and ≥76.
- Sex.
- Race and ethnicity classified into Hispanic, Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Asian, and other groups, following standardized US demographic categories.
- Demographic variables allow analysis of disparities and associations between BMI categories and access to care.
- These variables contextualize findings within population subgroups relevant to health equity considerations.

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Methods

Statistical Methods

Analytic Approach and Tools

- Weighted chi-square tests -associations between access to care and categorical variables, accounting for complex survey design and population weights.
- Weighted logistic regression models enabled multivariable analysis to identify independent predictors of access and affordability outcomes among adults with obesity.
- Statistical significance: $p < 0.05$, $p < 0.01$, and $p < 0.001$.
- Analyses were conducted using RStudio (Version 2024.09.0+375).
- Results are reported as counts and weighted percentages to represent the non-institutionalized U.S. adult population accurately.

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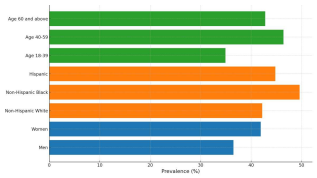
Results

Participant Demographics by BMI Category

Distribution of Participants by BMI Category and Demographics (MEPS 2022)



Demographic Breakdown

- Age distribution varies significantly by BMI category ($p < 0.001$), with higher obesity prevalence in middle-aged groups (40–59 years).
- Sex differences across BMI categories are significant ($p < 0.001$); females have higher prevalence in obesity classes II & III.
- Race/ethnicity - Non-Hispanic Black adults have the highest obesity rates (47.9%), with significant variation ($p < 0.001$).

Demographic Breakdown

The distribution of study participants across BMI categories reveals significant demographic variations. Age groups, sex, and race/ethnicity differ notably by BMI category, with important implications for targeted obesity interventions and healthcare planning.

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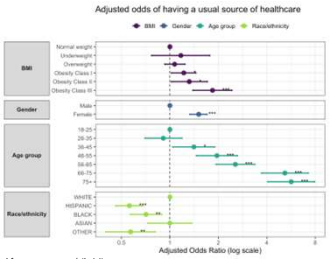
Results



* BMI adjusted for age, sex, race/ethnicity

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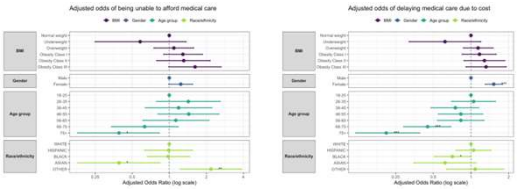
Results



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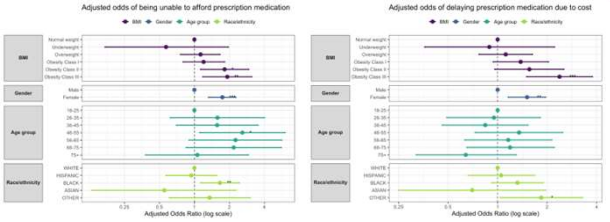
Results



* BMI adjusted for age, sex, race/ethnicity

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Results

Key Results: Access to Care and Affordability

Adults with obesity have comparable access to primary care and timely medical care compared to normal weight adults, but face significant challenges affording prescription medications, especially those with Class II and III obesity. These affordability barriers may hinder effective management of obesity and related comorbidities.

Access to Care and Medical Affordability

- Adults with obesity have slightly better odds of having a usual source of healthcare compared to normal weight adults, indicating comparable primary care access.
- Odds of being able to afford medical care in a timely manner do not significantly differ between obese and normal weight groups, suggesting equitable medical care affordability.
- Having a usual source of care supports ongoing management of obesity and its comorbidities, facilitating preventive care and monitoring.

Prescription Medication Affordability and Delays

- Individuals with Class II (BMI 35–39.9) and Class III (BMI ≥ 40) obesity have significantly lower odds of being able to afford their prescription medications compared to normal weight adults.
- The severely obese groups are also more likely to delay or forego prescribed medications due to cost, indicating substantial financial barriers.

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Implications

Discussion and Policy Implications

Affordability and Polypharmacy Burden Interpretation

- Severe obesity correlates with higher prescription drug costs due to multiple comorbidities requiring polypharmacy, increasing financial strain on patients.
- Despite similar access to primary care, severely obese individuals report greater difficulty affording prescription medications, highlighting a barrier due to medication affordability.
- Polypharmacy burden exacerbates challenges in accessing newer, effective treatments such as GLP-1 receptor agonists which may reduce the need for other medications.
- Financial barriers contribute to medication non-adherence and delayed treatment, adversely affecting obesity-related health outcomes.
- Addressing affordability is critical to reduce health disparities and improve long-term management of obesity and related comorbidities.

Insurance/Policy Limitations and Solutions

- Medicare Part D exclusion of GLP-1 medications and restrictive private insurance coverage limit patient access to effective obesity treatments.
- Current policy gaps create inequities, disproportionately affecting severely obese populations who would benefit most from these therapies.
- Potential solutions include expanding Medicare and private insurance coverage to include anti-obesity medications, reducing prior authorization hurdles.
- Innovative payment models and subsidy programs could alleviate out-of-pocket costs, improving medication adherence and health outcomes.
- Policy reforms should prioritize comprehensive obesity management, integrating treatment access with broader public health initiatives.

Severely obese individuals face increased financial challenges, impacting their ability to afford essential medications. Current insurance and policy frameworks limit access to effective obesity treatments like GLP-1 receptor agonists, necessitating reforms to improve affordability and coverage.

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Conclusion

Conclusions and Next Steps

Key Conclusions and Future Directions

- Severely obese individuals (Class II and III) encounter substantial financial challenges in affording prescription drugs.
- Polypharmacy common in obesity further exacerbates affordability issues, potentially reducing adherence and effectiveness of treatments.
- Current insurance policies, including Medicare Part D exclusions and private insurance restrictions, limit access to effective anti-obesity medications.
- Data is from 2022 - prior to substantial increase use of GLP-1s but patients with obesity already postponing necessary drug treatment.
- Improving access to highly effective GLP-1s may reduce the polypharmacy burden by improving obesity.
- Advocacy for policy change is essential to improve equitable access and reduce economic disparities in obesity care.

Severely obese adults face significantly higher financial burdens in affording prescription medications, which complicates clinical management and limits access to effective obesity treatments like GLP-1s. Addressing these affordability barriers through targeted policy reforms and expanded insurance coverage is critical. Future research should explore strategies to mitigate polypharmacy costs and improve equitable access to weight management therapies.

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Any questions?

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Measures of Access and Affordability

Key Binary Outcomes Evaluated

- **Usual source of healthcare**: Whether individuals have a consistent healthcare provider or facility they visit for medical needs (Yes/No).
- **Affordability of medical care**: Whether individuals were unable to afford or delayed needed medical care within the past 12 months due to cost constraints (Yes/No).
- **Affordability of prescription medications**: Whether individuals were unable to afford or delayed filling prescribed medications in the past 12 months due to cost (Yes/No).

Rationale for These Measures in Obesity Care

- A usual source of care is essential for effective chronic disease management and continuity in obesity-related healthcare.
- Obesity often requires frequent medical visits and monitoring of comorbidities, making timely access to care critical to prevent complications.
- High out-of-pocket costs for medical services and medications can lead to delayed or forgone care, worsening health outcomes in obese populations.
- Prescription medication affordability is particularly relevant given the polypharmacy common in obesity and the recent introduction of potentially costly treatments like GLP-1 receptor agonists.
- Assessing these outcomes provides insight into systemic barriers and financial challenges faced by adults with obesity, informing targeted interventions and policy decisions.

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