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2025 ECONOMIC REPORT OF
THE PRESIDENT

CHAPTER 4 OF THE
CHAIRMAN'S VIEWS

An Update on
Obesity Trends

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CHAIRMAN DAVID SCHWEIKERT

CHAPTER 4: AN UPDATE ON OBESITY TRENDS

The Republican Response in the *2024 Joint Economic Report* (*Response*) outlined the United States' dire fiscal situation. Since January 2021, the total national debt has risen by $8.5 trillion largely due to outsized spending on Social Security and Medicare and the resulting net interest costs.[1] Of the two major mandatory programs, Medicare and Social Security, Medicare has the most unpredictable long-term costs due to changing health trends and variability in the costs of Medicare services. Chapter 4 of the *2024 Response* concluded that obesity is a primary driver of our medical spending, resulting in between $8.2 and $9.1 trillion in excess medical expenditures over the next ten years for those suffering from the disease.[2] Finding innovative solutions to improve Americans' health through reductions in obesity rates would have a large impact both on Americans' well-being and our fiscal situation. Since the *2024 Response*, there have been a number of legislative and medical developments relating to obesity. This Chapter will overview and analyze these changes, as well as provide recommendations for policymakers on how best to craft fiscally responsible policies to reduce obesity.

Obesity prevalence

Since the release of the *2024 Response*, there has been a notable update to a major health survey that measures obesity prevalence, the National Health and Nutrition Examination Survey

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[1] Bureau of the Fiscal Service, "Monthly Treasury Statement," U.S. Department of the Treasury (January 2025), https://www.fiscal.treasury.gov/files/reports-statements/mts/mts1224.pdf.

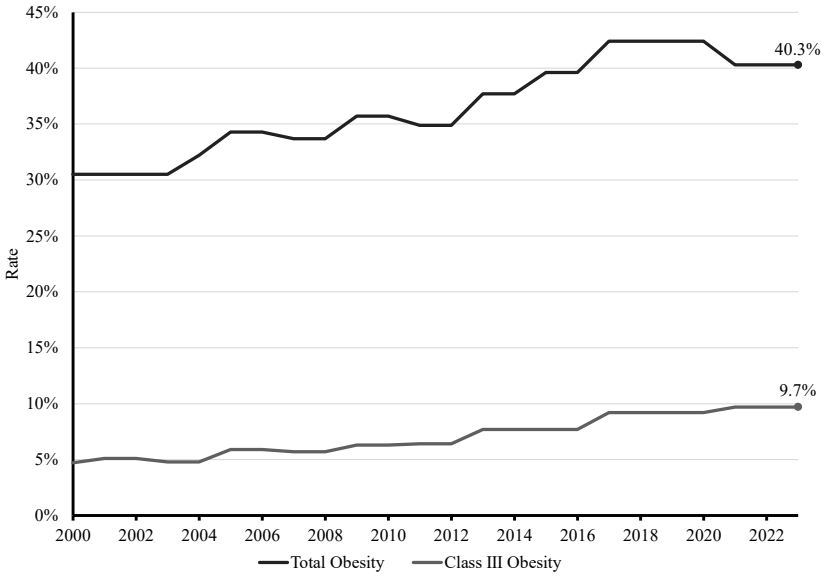
[2] Joint Economic Committee Republicans, "Chapter 4: Reaching Fiscal Solutions Through Healthcare Innovation," in *The 2024 Joint Economic Report, Republican Response* (U.S. Congress Joint Economic Committee, 2024), https://www.jec.senate.gov/public/vendor/_accounts/JEC-R/jer-chapters/2024JERChapter4.pdf.

(NHANES).[3] When the *2024 Response* was published in June 2024, the most recent data available was from 2017–2018 due to a 16-month hiatus in data collection from April 2020 to July 2021, caused by the COVID-19 pandemic. The update in September 2024 expanded the prior data period from 2017–2018 to include data from January 2019–March 2020 as well as published new data from August 2021–August 2023. The most recent data shows a plateauing of the overall adult obesity rate, with the authors of the report stating that "from 2013–2014 through August 2021–August 2023, the age-adjusted prevalence of obesity in adults did not change significantly."[4]

[3] The survey is a nationally representative sample of around 5,000 individuals and uses both interviews and examinations to assess the health status of adults and children in the U.S. The survey provides a more accurate picture of obesity prevalence than other estimates due to the fact that weight and height are observed and not self-reported by individuals. Samuel D. Emmerich, Cheryl D. Fryar, Bryan Stierman, and Cynthia L. Ogden, "Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023," NCHS Data Brief no. 508 (National Center for Health Statistics, 2024), https://dx.doi.org/10.15620/cdc/159281; National Center for Health Statistics, "About NHANES," https://www.cdc.gov/nchs/nhanes/about/index.html.

[4] Emmerich, Fryar, Stierman, and Ogden, "Obesity and Severe Obesity Prevalence in Adults."

Figure 4-1: NHANES Adult (20+) Obesity Rates

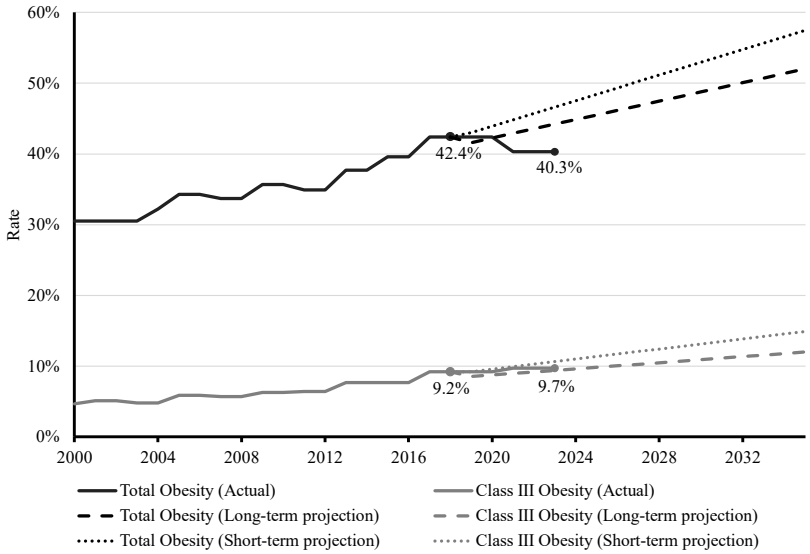


Source: National Center for Health Statistics[5]

This information represents a deviation from prior years' NHANES reports which showed a gradual increase in both the headline and severe obesity rate. Figure 4-1 displays the NHANES data on the overall and severe obesity rate from 2000 to 2023.

[5] Cheryl D. Fryar, Margaret D. Carroll, and Joseph Afful, "Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2017–2018," NCHS Health E-Stats (National Center for Health Statistics, 2020), Table 1, https://www.cdc.gov/nchs/data/hestat/obesity-adult-17-18/obesity-adult.htm; Bryan Stierman, Joseph Afful, Margaret D. Carroll, et al., "National Health and Nutrition Examination Survey 2017–March 2020 Prepandemic Data Files—Development of Files and Prevalence Estimates for Selected Health Outcomes," *National Health Statistics Reports*, no. 158 (June 2024), Tables 5 and 6, https://doi.org/10.15620/cdc:106273; Emmerich, Fryar, Stierman, and Ogden, "Obesity and Severe Obesity Prevalence in Adults."

Figure 4-2: 2024 Joint Economic Report Projection Compared to Updated NHANES Adult (20+) Obesity Rates



Source: National Center for Health Statistics[6]

The *2024 Response* used a linear regression of the past ten and 31 years of NHANES data to project obesity prevalence through 2034. Given that obesity prevalence had accelerated significantly faster in the prior ten years compared to the prior 31 years, two estimates were made, with the long-term projection representing the lower bound and the short-term projection representing the upper bound. As Figure 4-2 shows, especially in the case of the general obesity rate, there is a pronounced deviation from the earlier trend of obesity rates gradually increasing over the past 30+ years.[7] The change in this trend has led to a considerable amount

[6] Fryar, Carroll, and Afful, "Prevalence of Overweight, Obesity, and Severe Obesity," Table 1; Stierman, Afful, Carroll, et al., "National Health and Nutrition Examination Survey 2017–March 2020," Tables 5 and 6; Emmerich, Fryar, Stierman, and Ogden, "Obesity and Severe Obesity Prevalence in Adults."

[7] Joint Economic Committee Republicans, *The 2024 Joint Economic Report, Republican Response* (U.S. Congress Joint Economic Committee, 2024), p. 110, https://sen.gov/LVQNL.

of attention, with some claiming that the U.S. has passed its "peak obesity" and that this change may be due to the increased prevalence of anti-obesity medications (AOMs) such as GLP-1s.[8] While this change in the headline obesity rate is certainly a positive development, a more granular look into the data indicates that the plateauing observed may not indicate an improvement in the aggregate health of Americans and that the federal budget is still a long way away from reaping the benefits of this alleged reduction in the obesity rate.

Severe obesity rate

The *2024 Response* calculated the outsized impact that severe obesity (or Class 3 obesity), defined as a BMI greater than 40, has on health expenditures. The excess annual medical costs associated with Class 1 (BMI between 30.0 and 34.9) and Class 2 (BMI between 35.0 and 39.9) obesity were estimated to be $4,043 in 2024, while expenditures for those with Class 3 were more than double at $9,895.[9] Despite comprising less than a quarter of the overall obese population, Class 3 obesity accounted for over 44 percent of the total excess medical expenditures on obesity.[10] A significant portion of medical cost savings to both the federal government and private sector could be attributed to a large decline in the severe obesity rate. However, despite a drop in the overall obesity rate, the NHANES survey reports that severe obesity actually increased in 2021–23, rising from 9.2 percent in 2017–March 2020 to 9.7 percent in 2021–23.[11] Over the past ten

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[8] John Burn-Murdoch, "We may have passed peak obesity," *Financial Times*, October 4, 2024, https://www.ft.com/content/21bd0b9c-a3c4-4c7c-bc6e-7bb6c3556a56.

[9] Joint Economic Committee Republicans, *2024 Republican Response*, 114.

[10] Joint Economic Committee Republicans calculations; Joint Economic Committee Republicans, *2024 Republican Response*.

[11] Data for 2017-2020 only goes through March 2020 due to the onset of the COVID-19 pandemic.

years, the severe obesity rate has risen by 2 percentage points, which represents a significant share of the increase in the growth of excess medical expenditures. Given these factors, it is not clear that even if the trend of the overall obesity rate decreasing was permanent that it would translate to savings for the federal government if at the same time the severe obesity rate continues to rise.

Overall obesity rate

In addition to the rising severe obesity rate, it is unclear whether the recent NHANES data represents a permanent or temporary trend, or whether it is attributable to factors other than improved health. Prior to the pre-COVID impartial data from 2019–March 2020 being combined with 2017–2018 data, the 2017–2018 period had a 42.4 percent obesity rate and a 9.2 percent severe obesity rate.[12] After the merging of this data, the obesity rate fell slightly to 41.9 percent, while the severe obesity rate remained at 9.2 percent. The decline of the obesity rate in 2021–2023 to 40.3 percent is notable, but it is not clear this represents a permanent trend. Although the obesity rate has progressively increased over the past 25 years, similar short-term declines have occurred in the past.

Since 1999, there have been two other two-year periods where the obesity rate had fallen: 2007–2008 and 2011–2012.[13] Despite

[12] Craig M. Hales, Margaret D. Carroll, Cheryl D. Fryar, and Cynthia L. Ogden, "Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017–2018," NCHS Data Brief no. 360 (National Center for Health Statistics, 2020), https://www.cdc.gov/nchs/products/databriefs/db360.htm.

[13] Cheryl D. Fryar, Margaret D. Carroll, and Joseph Afful, "Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2017–2018," NCHS Health E-Stats (National Center for Health Statistics, 2020), https://www.cdc.gov/nchs/data/hestat/obesity-adult-17-18/obesity-adult.htm.

declines in these periods, the obesity rate has risen by nearly 10 percentage points from 1999 to 2023.[14] It cannot be conclusively stated that the decline in 2021–2023 is a permanent trend that represents a change in the aggregate health of the U.S. population. It may instead be attributable to other factors such as increased mortality due to the COVID-19 pandemic or random fluctuations in the data.[15] Individuals with obesity were disproportionately impacted by the COVID-19 pandemic, and this, along with potential random variations in the sample population, may account for the observed decline in the obesity rate, rather than reflecting actual improvements in individuals' health.[16]

GLP-1s and the obesity rate

The theory that GLP-1 usage may have contributed to the most recent decline in obesity prevalence is difficult to state conclusively given the scarcity of data on usage and adherence, as well as granular trends in obesity data. Data on GLP-1 usage is scarce, but estimates from 2024 suggest that 12 percent of adults and 22 percent of individuals who are overweight or obese have used GLP-1s, which represents a significant growth from prior years.[17] Additionally, from 2019 to 2023, the number of prescriptions for GLP-1s is estimated to have more than

[14] From 30.5 percent to 40.3 percent.

[15] Bernard Arulanandam, Hamid Beladi, and Avik Chakrabarti, "Obesity and COVID-19 Mortality Are Correlated," *Scientific Reports* 13, no. 5895 (2023), https://doi.org/10.1038/s41598-023-33093-3.

[16] Romil Singh, Sawai Singh Rathore, Hira Khan, Smruti Karale, et al., "Association of Obesity with COVID-19 Severity and Mortality: An Updated Systematic Review, Meta-Analysis, and Meta-Regression," *Frontiers in Endocrinology* 13, no. 780872 (2022), https://doi.org/10.3389/fendo.2022.780872.

[17] KFF, "Poll: 1 in 8 Adults Say They've Taken a GLP-1 Drug, Including 4 in 10 of Those with Diabetes and 1 in 4 of Those with Heart Disease," May 10, 2024, https://www.kff.org/health-costs/press-release/poll-1-in-8-adults-say-theyve-taken-a-glp-1-drug-including-4-in-10-of-those-with-diabetes-and-1-in-4-of-those-with-heart-disease/.

quadrupled, which implies significant and growing demand for these medications.[18] Despite this explosion in demand and usage of these and other AOMs, evidence suggests that certain headwinds impact the potential of these medications.

In a study of Blue Cross Blue Shield patients, only 42 percent of individuals on GLP-1s adhered to the recommended treatment guideline of 12 weeks, while 30 percent of patients stopped usage within a month.[19] This falls in line with other research that suggests the overall one-year adherence to AOMs is only around 40 percent.[20] While effective for those who adhere to the medication plan, GLP-1s have a much smaller impact on BMI if patients stop taking them too early because a significant amount of weight lost can be regained if patients cease usage before the end of their treatment plan.[21] Reasons behind the low adherence are varied and not entirely clear, however, individuals who

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[18] Elizabeth Williams, Robin Rudowitz, and Clea Bell, "Medicaid Coverage of and Spending on GLP-1s," KFF, November 4, 2024, https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-and-spending-on-glp-1s/.

[19] Joshua P. Cohen, "58% Of Patients Discontinue Use Of Obesity Meds Before Reaching Meaningful Weight Loss, Study Shows," *Forbes*, June 20, 2024, https://www.forbes.com/sites/joshuacohen/2024/06/20/study-shows-58-of-patients-discontinue-use-of-obesity-meds-before-reaching-meaningful-weight-loss/.

[20] Hamlet Gasoyan, Elizabeth R. Pfoh, Rebecca Schulte, Phuc Le, and Michael B. Rothberg, "Early- and later-stage persistence with antiobesity medications: A retrospective cohort study," *Obesity* 32, no. 3 (2024): 486–93, https://doi.org/10.1002/oby.23952.

[21] Mojca Jensterle, Manfredi Rizzo, Martin Haluzík, and Andrej Janež, "Efficacy of GLP-1 RA Approved for Weight Management in Patients with or Without Diabetes: A Narrative Review," *Advances in Therapy* 39, no. 6 (2022): 2452–67, https://doi.org/10.1007/s12325-022-02153-x; John P. H. Wilding, Rachel L. Batterham, Melanie Davies, Luc F. Van Gaal, et al., "Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension," *Diabetes, Obesity & Metabolism* 24, no. 8 (2022): 1553–64, https://doi.org/10.1111/dom.14725.

experience shorter-term weight loss tend to stay on the medications longer.[22] Taken together, these factors suggest the effect of AOMs on the overall obesity rate may be smaller than anticipated due to suboptimal usage of these medications.

The difference in usage rates between men and women also suggests that GLP-1 usage may not have led to a decline in obesity rates. According to a Kaiser Family Foundation survey, an estimated 5 percent of women are currently using an AOM compared to only 2 percent of men.[23] An additional 13 percent of women say they have used an AOM in the past but are not currently compared to only 6 percent of men. This aligns with data from Blue Cross Blue Shield that states that 79 percent of its patients on GLP-1s are women.[24] These figures imply that any reductions in the overall obesity rate due to GLP-1s would likely be more pronounced in women. However, the NHANES data suggests that declines in the obesity rate were more strongly driven by men.

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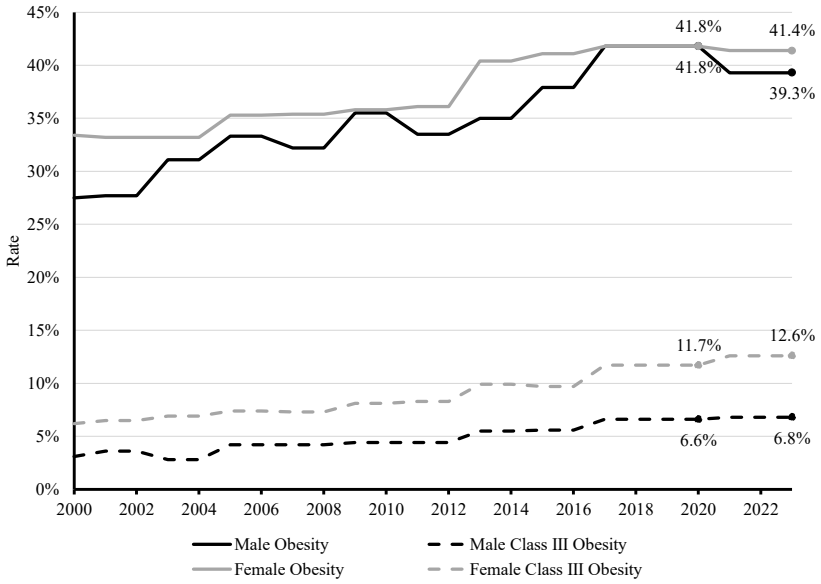
[22] Blue Cross Blue Shield, "Real-World Trends in GLP-1 Treatment Persistence and Prescribing for Weight Management," Blue Health Intelligence Issue Brief (May 2024), https://www.bcbs.com/media/pdf/BHI_Issue_Brief_GLP1_Trends.pdf; Gasoyan, Pfoh, Schulte, Le, and Rothberg, "Early- and later-stage persistence with antiobesity medications."

[23] Alex Montero, Grace Sparks, Ashley Kirzinger, Isabelle Valdes, and Liz Hamel, "KFF Health Tracking Poll July 2023: The Public's Views Of New Prescription Weight Loss Drugs And Prescription Drug Costs," KFF, August 4, 2023, https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/.

[24] Blue Cross Blue Shield, "Real-World Trends in GLP-1 Treatment Persistence."

Figure 4-3: Adult (20+) Obesity Rates by Gender



Source: National Center for Health Statistics[25]

From the 2017–2020 period to the 2021–2023 period, the overall obesity rate fell by 2.5 percentage points for men but only 0.4 percentage points for women. At the same time, the severe obesity rate increased by 0.2 percentage points for men and 0.9 percentage points for women. Given that there is no measurable difference between the rate at which men and women adhere to their GLP-1 usage, this may imply that AOMs have had less of an impact on the overall obesity rate and that any declines may instead be attributable to other factors. More data is necessary to make conclusive statements, but this may indicate that the full impact of GLP-1s is not yet reflected in obesity data.

[25] Fryar, Carroll, and Afful, "Prevalence of Overweight, Obesity, and Severe Obesity," Table 1; Stierman, Afful, Carroll, et al., "National Health and Nutrition Examination Survey 2017–March 2020," Tables 5 and 6; Emmerich, Fryar, Stierman, and Ogden, "Obesity and Severe Obesity Prevalence in Adults."

Changes in GLP-1 usage

The potential for GLP-1 usage to impact obesity rates remains high over the near-to-long term. As previously mentioned, GLP-1s have a significant impact on BMI for those who adhere to their treatment plan, with those without diabetes experiencing an average weight loss ranging from 6.1 percent to 17.4 percent of their body weight while on semaglutides.[26] More adults report having heard about these drugs, and demand for them has been so strong that it has outpaced the available supply during the past two years.[27] Despite this, the cost of the drugs is still prohibitively high for most people, with the monthly price ranging from around $700 to over $1,000.[28] Even for those with insurance, the majority of adults on GLP-1s report that it is somewhat or very difficult to afford them.[29] The current high cost of the drugs is likely prohibiting individuals from using them who would otherwise be interested.

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[26] Jensterle, Rizzo, Haluzík, and Janež, "Efficacy of GLP-1 RA Approved for Weight Management."

[27] Alex Montero, Grace Sparks, Marley Presiado, and Liz Hamel, "KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs," KFF, May 10, 2024, https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/; Virta Health, "Demand for GLP-1s growing faster than expected," Fierce Healthcare, April 1, 2024, https://www.fiercehealthcare.com/sponsored/demand-glp-1s-growing-faster-expected.

[28] Inmaculada Hernandez and Sean D. Sullivan, "Net prices of new antiobesity medications," *Obesity* 32, no. 3 (2024): 472–5, https://doi.org/10.1002/oby.23973; Benedic N. Ippolito and Joseph F. Levy, "Estimating the Cost of New Treatments for Diabetes and Obesity," American Enterprise Institute Economic Perspectives (September 2023), https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf.

[29] Montero, Sparks, Presiado, and Hamel, "KFF Health Tracking Poll May 2024."

Fortunately, progress has been made over the course of the past year, and there are signs that the price of GLP-1s and other derivatives may soon decrease. The shortage of tirzepatide, a type of GLP-1, which had persisted since 2022 was recently declared by the FDA to be "resolved."[30] Additionally, semaglutides, which have been on the FDA drug shortage list since March 2022, recently changed from being "currently in shortage" to "available" as of November 2024.[31] Competition among pharmaceutical groups to create GLP-1s and other derivatives has also expanded in the past year.[32] The first generic GLP-1 recently hit the market and there has been a rapid increase in the development of AOMs to help match growing demand.[33] Lower cost versions of GLP-1s, such as those that come in vials rather than injector pens were also introduced in the latter half of 2024.[34] These versions have a significantly lower cost of approximately $400 to $530 for a month's supply. Increased competition and lower prices should

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[30] U.S. Food and Drug Administration, "FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize," December 19, 2024, https://www.fda.gov/drugs/drug-safety-and-availability/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize.

[31] U.S. Food and Drug Administration, "Current and Resolved Drug Shortages and Discontinuations Reported to FDA," accessed January 2025, https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Semaglutide%20Injection&st=c&tab=tabs-1.

[32] Clara Rodriguez Fernandez, "Competitors race to launch GLP-1 drugs amid soaring weight loss demand," OutsourcingPharma, October 31, 2024, https://www.outsourcing-pharma.com/Article/2024/10/31/glp-1-market-heats-up-as-companies-vie-for-next-gen-obesity-drugs/.

[33] Nancy Schimelpfening, "Victoza: Generic GLP-1 Drug Similar to Ozempic Now Available," *Healthline*, June 24, 2024, https://www.healthline.com/health-news/victoza-generic-glp1-drug-available; Jakob Emerson, "Inside the GLP-1 'price war,'" Becker's Hospital Review, September 23, 2024, https://www.beckershospitalreview.com/pharmacy/inside-the-glp-1-price-war.html.

[34] Deidre McPhillips, "Lilly launches lower-price weight loss drug without injector pen," *CNN*, August 27, 2024, https://www.cnn.com/2024/08/27/health/zepbound-tirzepatide-new-vials/index.html.

lead to GLP-1s being more accessible for a larger population, resulting in greater uptake and potentially lower obesity rates in the long run.

Obesity legislation and recommendations

In the past year, there has also been a major push for the federal government to expand access to GLP-1s. The *Treat and Reduce Obesity Act*, reintroduced in the 118th Congress, would expand Medicare coverage of behavioral therapy to treat obesity as well as allow for Medicare Part D to cover AOMs for individuals with at least one comorbidity.[35] Additionally, the Biden Administration proposed a rule change in November 2024 that would expand coverage of AOMs to both Medicare and Medicaid, but this proposed rule has since been suspended.[36] Concerns about the growing rates of obesity—which were projected in the *2024 Response* to eclipse 50 percent by 2032 in the best-case scenario—have driven lawmakers to more aggressively pursue solutions, but many proposals currently entail a high fiscal cost.

The Congressional Budget Office estimates that the fiscal cost of expanding Medicare Part D to cover AOMs would be about $35

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[35] Congress.gov, "H.R.4818—118th Congress (2023–2024): Treat and Reduce Obesity Act of 2023," December 27, 2024, https://www.congress.gov/bill/118th-congress/house-bill/4818.

[36] The White House, "FACT SHEET: Biden-Harris Administration Takes Latest Step to Lower Prescription Drug Costs by Proposing Expanded Coverage of Anti-Obesity Medications for Americans with Medicare and Medicaid," November 26, 2024, https://bidenwhitehouse.archives.gov/briefing-room/statements-releases/2024/11/26/fact-sheet-biden-harris-administration-takes-latest-step-to-lower-prescription-drug-costs-by-proposing-expanded-coverage-of-anti-obesity-medications-for-americans-with-medicare-and-medicaid/; The White House, "Regulatory Freeze Pending Review," January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/regulatory-freeze-pending-review/.

billion over the nine-year window from 2026 to 2034.[37] This is largely driven by high direct costs from the prescriptions, with the average cost to the federal government per user estimated to be $5,600 in 2026.[38] Savings per user associated with improved health are limited over the nine-year window following the implementation of the policy, with direct savings starting at $50 in 2026 and rising to $650 in 2034.[39] Despite these high initial costs to the federal government and limited savings to individuals, CBO does note that there are conditions that could change and reduce the fiscal impact of this policy.

First, competition, the development of generics, or other developments may lead GLP-1s to fall in price. CBO states that prices for AOMs are projected to fall, especially in the second decade following the policy change.[40] The introduction of new formulas and versions with different methods of administration may somewhat offset any cost reductions as newer versions tend to be more expensive. However, improved effectiveness of these new technologies, for example through increased adherence, may also result in greater fiscal savings through improved health. This would reduce federal government health outlays and increase labor force participation, which would lead to higher tax receipts.

Even assuming the best-case scenario for price reductions, current policy proposals would still have a net negative fiscal impact on the budget in the ten-year budget window. Cost savings from reductions in obesity through improved health grow gradually as

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[37] Congressional Budget Office, *How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect the Federal Budget?* CBO report (October 8, 2024), https://www.cbo.gov/publication/60441.

[38] This estimate excludes increase in Part D premiums. Congressional Budget Office, "How Would Authorizing Medicare," 8.

[39] Congressional Budget Office, "How Would Authorizing Medicare," 9.

[40] Congressional Budget Office, "How Would Authorizing Medicare," 9.

both more individuals take up these drugs and as their health improves over time. CBO estimates that per-capita Medicare savings as a share of total Medicare spending for individuals on AOMs gradually grows from 0.2 percent in 2026 to 2.8 percent in 2034, which represents $50 and $650 per Medicare patient using AOMs, respectively.[41] CBO notes that these savings would be higher if individuals use the medications for longer, or if they start using them before receiving them through Medicare.[42] A reduction in prices would have a two-fold impact; it both reduces the direct cost to the federal government and grows demand for these medications from individuals who are not yet of Medicare age.

Under CBO's assumptions, even in the most optimal case where there is a high take-up rate, effectiveness of AOMs increases, and prices fall due to increased competition, it is not likely that current proposals for Medicare to cover these drugs would have a positive fiscal impact, at least within a ten-year window. Nevertheless, these medications would undoubtedly improve individuals' health, mortality outcomes, and well-being.

Targeting GLP-1 coverage to specific populations fares better under a cost-benefit analysis than broad coverage. As previously discussed, excess healthcare expenditures for those who are severely obese are more than double the costs of those who are classified as having Class 1 or Class 2 obesity. CBO notes that Medicare spending is substantially higher for those with severe obesity, even when compared to other obese individuals, and that these costs progressively increase as individuals' BMI increases above 40.[43] Given that the greatest potential cost savings come

[41] Congressional Budget Office, "How Would Authorizing Medicare," 9.
[42] Congressional Budget Office, "How Would Authorizing Medicare," 12.
[43] Congressional Budget Office, "How Would Authorizing Medicare," 2-3.

from this group, policymakers should consider targeting coverage for those with certain comorbidities and a BMI over 40, at least initially. This would substantially reduce the present cost of the prescription coverage as the severely obese population generally is at most only 25 percent of the overall obese population.[44]

As outlined in the *2024 Response*, reductions in the obesity rate that improve the aggregate health of the U.S. population would have benefits that extend well beyond CBO's ten-year window, including greater employment and lower dependency on health services earlier in life. As CBO mentions in their analysis as well, benefits extend over time as more individuals take up these medications, especially among those not yet on Medicare.[45] Specifically, they state that "savings also could be larger if greater-than-expected AOM use among the current non-Medicare population resulted in lower obesity rates and less spending to treat health complications for those people as they aged, became eligible for Medicare, and enrolled in the program."[46] For these reasons, policymakers should consider targeting coverage towards a younger population that could have decades' worth of savings if certain comorbidities were avoided. The Medicaid population—which is significantly younger than the Medicare population, with almost 75 percent of enrollees being under the age of 65—could be reformed to allow coverage to individuals who would have the highest lifetime health expenditures.[47] A combination of targeting

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[44] JEC Republicans calculations; Joint Economic Committee Republicans, *2024 Republican Response*.

[45] Congressional Budget Office, "How Would Authorizing Medicare," 12.

[46] Congressional Budget Office, "How Would Authorizing Medicare," 12.

[47] Medicaid programs in 13 states currently cover GLP-1s as of August 2024. KFF, "Medicaid Enrollees by Age," KFF State Health Facts, https://www.kff.org/medicaid/state-indicator/medicaid-enrollees-by-age/; Williams, Rudowitz, and Bell, "Medicaid Coverage of and Spending on GLP-1s."

those who are younger and have a high BMI could lead to large health savings at a fraction of the cost it would take to cover the entire Medicare and Medicaid population. More analysis should be conducted to determine the exact fiscal impact of such policies but targeting anti-obesity policy towards a younger and less healthy population could be a more fiscally responsible way to address the obesity crisis.