

THE WEIGHT OF STIGMA

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ABSTRACT

Many health care providers, both implicitly and explicitly, perpetuate stigma in their treatment of patients classified as obese. While medical professionals understand that a one-size-fits-all approach to treatment is ineffective, patients classified as obese are frequently offered limited treatment options that fail to account for their unique needs. Access to a range of effective treatment options has historically been limited, but new GLP-1 receptor agonist medicines like Wegovy (semaglutide) and Zepbound (tirzepatide), have shown incredible promise in addressing the obesity crisis. Unfortunately, these transformative drugs are costly, in high demand, and not widely covered by insurance, rendering them inaccessible for many Americans.

This Article reviews the history of weight loss medications, emphasizing how past problems have fueled skepticism toward obesity treatment while reinforcing societal stigma against overweight individuals. Medical understanding of obesity has evolved from an issue of personal responsibility to a recognized disease, yet stigma persists. GLP-1 receptor agonist medicines have the potential to reduce structural barriers, including stigma, that deter individuals classified as obese from seeking necessary medical care. Their effectiveness, however, in addressing these barriers depends on expanding access. GLP-1 receptor agonists will not be universally effective, so enhanced provider education on comprehensive obesity management remains paramount. Effective medicines with strong safety profiles are an important first step, but to improve outcomes and reduce obesity stigma, physicians must adopt individualized, multi-faceted treatment plans for patients classified as obese.

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INTRODUCTION

Obesity is among the most significant public health challenges in the United States, affecting over 40% of adults and contributing to substantial morbidity and mortality.¹ Despite its prevalence, individuals with obesity experience pervasive stigma and discrimination across nearly every facet of life, including health care, employment, and social interactions.² Stigma is heightened by deeply entrenched narratives that frame obesity as a personal failure rather than a complex medical condition influenced by genetic, biological, and environmental factors.³ These consequences are wide-ranging, spanning poorer health outcomes and reduced access to care, as well as psychological harm and broader socioeconomic disadvantage.⁴ While the medical community has begun to acknowledge the multifactorial nature of obesity, public policy has been slow to evolve, often reinforcing stigmatizing attitudes through laws and regulations that emphasize personal responsibility over medical intervention.⁵

The complex—and often fraught—history of weight-loss medications only adds to the modern challenge of obesity treatment. From the amphetamine-based pills of the mid-twentieth century to the rise and fall of Fen-Phen in the 1990s, the pharmaceutical treatment of obesity has been characterized by cycles of intense promotion followed by public backlash and regulatory retreat.⁶ These earlier generations of medications were initially heralded as miracle solutions, only to be withdrawn from the market due to serious safety concerns, such as addiction, life-threatening pulmonary hypertension, and heart valve damage.⁷ These cycles left lasting scars in both medical and public discourse. They also fostered skepticism toward

¹ Susannah Westbury, Oyinlola Oyeboode, Thijs van Rens & Thomas M. Barber, *Obesity Stigma: Causes, Consequences, and Potential Solutions*, 12 CURR. OBES. REP. 10, 10 (2023); *Adult Obesity Facts*, CDC (May 14, 2024), <https://www.cdc.gov/obesity/adult-obesity-facts/index.html> [https://perma.cc/GJY7-2BB5]. While recognizing the stigmatizing connotations associated with the term ‘obesity,’ this Article adopts its use solely in alignment with the standardized terminology employed in medical and clinical discourse.

² Westbury, Oyeboode, Rens & Barber, *supra* note 1 at 17.

³ *Id.* at 16; see also Eric Robinson, Ashleigh Haynes, Angelina Sutin & Michael Daly, *Self-Perception of Overweight and Obesity: A Review of Mental and Physical Outcomes*, 6 OBESITY SCI. & PRACT. 552, 553 (2020).

⁴ Westbury, Oyeboode, Rens & Barber, *supra* note 1 at 16; Leona Ryan, Fiona Quigley, Susie Birney, Michael Crotty, Owen Conlan & Jane C. Walsh, ‘Beyond the Scale’: *A Qualitative Exploration of the Impact of Weight Stigma Experienced by Patients With Obesity in General Practice*, 27 HEALTH EXPECTATIONS e14098, 1, 2 (2024).

⁵ Westbury, Oyeboode, Rens & Barber, *supra* note 1 at 15; *Adult Obesity Facts*, *supra* note 1.

⁶ Eric Colman, *Food and Drug Administration’s Obesity Drug Guidance Document: A Short History*, 125 CIRCULATION 2156, 2156-58 (2012); see also Susan Z. Yanovski & Jack A. Yanovski, *Progress in Pharmacotherapy for Obesity*, 326 J. AM. MED. ASS’N 129, 129 (2021).

⁷ Colman, *supra* note 6; Alexandra Brewis & Sarah Trainer, *No “Easy” Weight Loss: Don’t Overlook the Social Cost of Anti-Obesity Drugs*, 626 NATURE 258, 259 (2024).

pharmaceutical interventions and helped shape the view that such treatment is either dangerous or purely cosmetic, rather than a valid medical approach.⁸ This narrative continues to shape how new weight-loss medications are received by both the public and policymakers.

Notably, recent advances in medications approved by the U.S. Food and Drug Administration (“FDA”) for weight loss offer an opportunity to address obesity stigma through public health and law.⁹ Glucagon-like peptide-1 receptor agonists¹⁰ (“GLP-1s”), unlike their predecessors, have demonstrated unprecedented efficacy in promoting significant, sustained weight loss and improving related metabolic outcomes.¹¹ With robust clinical trial data, FDA approval for multiple indications, and support from leading medical organizations, GLP-1s represent a potential turning point in the treatment of obesity.¹² These medications have the potential to shift the paradigm away from the long-standing framing of obesity as an aesthetic issue tied to personal failure and lack of willpower, and toward a model that treats obesity as a chronic, biologically driven condition that merits medical intervention.¹³

Nonetheless, the emergence of GLP-1s has yet to fully escape the weight of earlier drug failures, which contributed to lingering public suspicion, leading even well-supported medications to be viewed with skepticism. Despite the increasing popularity of both branded and compounded GLP-1 drugs, public perception continues to reflect a deep ambivalence about weight loss medications, rooted not only in past medical missteps but also in the broader cultural framing of obesity as a matter of willpower.¹⁴ This framing reduces obesity to a behavioral flaw, obscuring

⁸ Brewis & Trainer, *supra* note 7, at 259-60.

⁹ Berit L. Heitmann, *The Impact of Novel Medications for Obesity on Weight Stigma and Societal Attitudes: A Narrative Review*, 14 CURR. OBES. REP. 18 (2025).

¹⁰ This class of medications works by mimicking the natural glucagon-like-peptide-1 (GLP-1) hormone. This hormone is released by the gut in response to eating and has several effects that help regulate blood sugar levels, reduce appetite, and slow digestion. Tirzepatide is a related drug that mimics GLP-1 as well as a hormone called a glucose-dependent insulinotropic polypeptide (GIP). See Jennifer Fisher, *How Does Ozempic Work? Understanding GLP-1s for Diabetes, Weight Loss, and Beyond*, HARV. HEALTH (Apr. 14, 2025), <https://www.health.harvard.edu/staying-healthy/how-does-ozempic-work-understanding-glp-1s-for-diabetes-weight-loss-and-beyond> [<https://perma.cc/T9Y7-DCSV>].

¹¹ GLP-1 medications work by mimicking the action of the glucagon-like peptide-1 hormone to regulate blood sugar and appetite. Haritha Darapaneni et al., *Shedding Light on Weight Loss: A Narrative Review of Medications for Treating Obesity*, 62 ROMANIAN J. INTERNAL MED. 3, 7 (2024).

¹² Brewis & Trainer, *supra* note 7, at 260; Yanovski & Yanovski, *supra* note 6, at 130.

¹³ See generally BRITTNEY M. GINSBURG, SHARON F. DALEY & AMY J. SHEER, *OVERCOMING STIGMA AND BIAS IN OBESITY MANAGEMENT* (2024).

¹⁴ Only 16% of Americans think weight-loss drugs will do “a great deal” or “quite a bit” to reduce obesity nationwide, while 35% expect “some” effect and 33% anticipate “not much” or “nothing at all.” See PEW RSCH. CTR., *HOW AMERICANS VIEW WEIGHT-LOSS DRUGS AND THEIR POTENTIAL IMPACT ON OBESITY IN THE U.S.* (2024).

its complex genetic, physiological, and environmental origins.¹⁵ As a result, even with compelling evidence of their effectiveness and safety, GLP-1s continue to face hurdles in perception, acceptance, and accessibility.¹⁶

Structural barriers further limit the reach of these medications. These include high costs, which often exceed \$1,000 per month, combined with limited insurance coverage, meaning that access to GLP-1s remains sharply stratified along socioeconomic lines.¹⁷ For low-income individuals and communities of color, who already bear a disproportionate burden of obesity-related illness, these barriers exacerbate existing health disparities.¹⁸ Medicare and Medicaid often exclude GLP-1s when prescribed for weight loss, reinforcing health care inequities.¹⁹ These limits on access reinforce longstanding inequities in health care delivery and sustain the very stigma these medications have the potential to disrupt.²⁰ Without deliberate legal and policy interventions to improve affordability, expand insurance coverage, and challenge cultural bias, the promise of GLP-1s may be

¹⁵ Obesity is a multifactorial condition shaped by genetic, environmental, and social determinants. Its prevalence is closely associated with socioeconomic status, racial and ethnic identity, and geographic location—factors that influence access to nutritious food, opportunities for physical activity, and exposure to environmental stressors such as neighborhood deprivation and crime. These systemic conditions contribute to disparities in energy intake and expenditure, disproportionately affecting individuals of lower social status and communities of color. See ALEXANDRA LEE, MICHELLE CARDEL & WILLIAM T. DONAHO, *SOCIAL AND ENVIRONMENTAL FACTORS INFLUENCING OBESITY* (Kenneth R. Feingold et al. eds., 2000).

¹⁶ Maneeha Naveed, Cecilie Perez, Ehtasham Ahmad, Laura Russell, Zoe Lees, & Catriona Maybury, *GLP-1 Medication and Weight Loss: Barriers and Motivators Among 1,659 Participants Managed in a Virtual Setting*, 27 *DIABETES, OBESITY & METABOLISM* 3780 (2025); Brewis & Trainer, *supra* note 7, at 260.

¹⁷ Jennifer Fink, *Weight Loss Medications: Stigma and Shortages*, 124 *AM. J. NURSING* 14, 15 (2024).

¹⁸ For instance, 56.8% of Black or African American men have hypertension, compared to 51.9% of white non-Hispanic men. 61.0% of Black or African American women have hypertension, compared to 47.7% of white non-Hispanic women. See *Health of White Non-Hispanic Population*, CDC (July 15, 2025), <https://www.cdc.gov/nchs/fastats/white-health.htm> [<https://perma.cc/9BG8-VZM6>]; see also *Health of Black or African American Non-Hispanic Population*, CDC (July 15, 2025), https://www.cdc.gov/nchs/fastats/black-health.htm?utm_source= [<https://perma.cc/9JX9-4TG5>]; see generally Inmaculada Hernandez, Davene R. Wright, Jingchuan Guo & William H. Shrank, *Medicare Part D Coverage of Anti-Obesity Medications: A Call for Forward-Looking Policy Reform*, 39 *J. GEN. INTERNAL MED.* 306, 307 (2023).

¹⁹ Hernandez, Wright, Guo & Shrank, *supra* note 18, at 307; Ezekiel J. Emanuel, Johan L. Dellgren, Matthew S. McCoy & Govind Persad, *Fair Allocation of GLP-1 and Dual GLP-1-GIP Receptor Agonists*, 390 *N. ENGL. J. MED.* 1839, 1842 (2024). Medicare is the federal health insurance program primarily serving individuals aged sixty-five and older, as well as certain younger individuals with disabilities; Medicaid is a joint federal–state program providing health coverage to low-income individuals and families; and private insurance refers to health coverage offered through employers or purchased directly from insurers or marketplaces. See *CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET, MEDICARE & MEDICAID BASICS* (2020), <https://www.cms.gov/files/document/medicare-and-medicare-basics.pdf> [<https://perma.cc/WXG6-69SC>].

²⁰ Fink *supra* note 17, at 15.

realized only for those who are already privileged, leaving behind those who could benefit the most.²¹

Section I examines the historical development of obesity stigma and its entrenchment within medical and societal narratives, before turning to the role of pharmacological interventions in shaping public perceptions. This section explores the history of FDA-approved weight-loss medications, emphasizing how past treatments, such as Fen-Phen and amphetamine-based medications, both reflected and reinforced existing biases against obesity. While these medications were initially heralded as solutions to the so-called “obesity epidemic,” their eventual withdrawal due to severe adverse effects fueled skepticism toward medical interventions and deepened the stigma surrounding obesity treatment.²²

Section II examines the medicalization of obesity and its role in shaping societal stigma, particularly in the context of emerging pharmacological treatments. The increasing recognition of obesity as a medical condition has, in some respects, legitimized treatment efforts, but it has also reinforced harmful narratives that frame larger bodies as inherently pathological.²³ This Section explores how the rise of GLP-1s both reflects and contributes to this evolving landscape. While these medications have the potential to reduce obesity stigma by positioning the condition as a treatable medical disorder, they also risk perpetuating the notion that weight loss is the only legitimate path to health.²⁴ Furthermore, public perception of GLP-1s as an “easy fix” may undermine their legitimacy and reinforce existing biases.²⁵

Finally, Section III explores how GLP-1s can be harnessed as tools to reduce obesity stigma through targeted legal and policy reforms. Expanding access to these treatments is essential to dismantling structural barriers that marginalize individuals classified as obese. To achieve meaningful progress, policymakers must address barriers in public and private insurance coverage of weight-loss treatments, as well as in medication pricing and patent policy. These changes are critical to lowering costs and improving access to effective treatments like GLP-1s, especially for uninsured individuals and those facing high out-of-pocket costs.

²¹ *Id.* at 15; Stephanie W. Waldrop, Veronica R. Johnson & Fatima Cody Stanford, *Inequalities in the Provision of GLP-1 Receptor Agonists for the Treatment of Obesity*, 30 NATURE MED. 22, 22 (2024).

²² Gregory D. Curfman, *Diet Pills Redux*, 337 N. ENGL. J. MED. 629, 629-30 (1997); Marianna Papademetriou, Megan Riehl, & Allison R. Schulman, *Stigma, Bias, and the Shortfalls of Body Mass Index: A Reflection on the State of Weight Management*, 119 AM. J. GASTROENTEROLOGY 1023, 1025 (2024).

²³ Elise Paradis, “Obesity” as Process: *The Medicalization of Fatness by Canadian Researchers, 1971–2010*, in *OBESITY IN CANADA: CRITICAL PERSPS.* 56, 57 (JENNY ELLISON, DEBORAH MCPHAIL & WENDY MITCHINSON, EDS., UNIV. 2016).

²⁴ Brewis & Trainer, *supra* note 7, at 259.

²⁵ *Id.* at 259.

Access alone, however, is insufficient. Equally crucial is the enhancement of medical education to equip health care providers with a nuanced, evidence-based approach to obesity treatment. Moving beyond the reductive “eat less, exercise more” paradigm, provider training should emphasize the complex, multifactorial nature of obesity and the legitimacy of newer pharmacological interventions. Additionally, public health campaigns are needed alongside these medical education initiatives to combat implicit bias in health care settings and foster a more compassionate and scientifically informed understanding of obesity that ultimately mitigates stigma. Finally, further research into the long-term effects of GLP-1s is needed, which would build public trust in their effectiveness across populations.

I. THE HISTORY OF WEIGHT STIGMA AND ITS INFLUENCE ON WEIGHT LOSS MEDICATION DEMAND

Stigma, as conceptualized by sociologist Erving Goffman, refers to an attribute that deeply discredits an individual, reducing them from a whole and usual person to a tainted or discounted one.²⁶ Goffman categorized stigma into three main forms: those related to physical deformities, individual character blemishes (such as obesity), and tribal stigmas linked to race, religion, or nationality.²⁷ Stigma functions as a powerful social force, shaping the way individuals are perceived and treated within society.²⁸ Stigma is not merely a mark of difference but a mechanism through which social hierarchies are reinforced, often leading to discrimination, marginalization, and internalized shame.²⁹

Weight stigma, or the discrimination and bias against individuals based on their body weight, boasts deep historical roots and significant societal repercussions. In many premodern societies, body size was often associated with prosperity, fertility, class, and affluence.³⁰ In some contexts, a larger body was seen as a sign of prosperity, while in others, athleticism and physical fitness were more highly valued.³¹ In Western societies before the 19th century, plumpness was frequently linked to wealth and prosperity

²⁶ Martin M. Andersen, Somogy Varga, & Anna P. Folker, *On the Definition of Stigma*, 28 J. EVALUATION IN CLINICAL PRAC. 847, 848 (2022).

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ Frank Q. Nuttall, *Body Mass Index: Obesity, BMI, and Health: A Critical Review*, 50 NUTRITION TODAY 117 (2015); Somayeh Marghoub, Sarvin Sanaie, Mark J. M. Sullman, Seyed Aria Nejadghaderi, Saeid Safiri, & Reza Mohammadinasab, *Obesity From a Sign of Being Rich to a Disease of the New Age: A Historical Review*, 6 HEALTH SCI. REPS. 1, 2 (2023); Garabed Eknayan, *A History of Obesity, or How What Was Good Became Ugly and Then Bad*, 13 ADV. CHRONIC KIDNEY DISEASE 421, 421-23 (2006).

³¹ Marghoub et al., *supra* note 30, at 2; Nuttall, *supra* note 30, at 117.

because excess body fat signified access to abundant food in times of scarcity.³² This association was particularly evident during periods of famine or economic hardship, when only the affluent could afford to maintain a plump physique.³³

The Industrial Revolution, alongside the advent of modern medicine, contributed to a shift in attitudes toward body weight.³⁴ As industrialization advanced and food became more widely available, body size became less indicative of wealth.³⁵ Concurrently, cultural ideals began to shift, and thinness increasingly came to be associated with self-discipline, control, and moral superiority.³⁶ Public health campaigns and early medical literature reinforced these ideas by linking weight to personal responsibility and character.³⁷ As a result, body weight became an arena for moral judgment, with larger-bodied individuals facing growing societal scrutiny and stigma.

In the 20th century, the media increasingly promoted slender body ideals as the epitome of beauty and success.³⁸ This cultural shift further marginalized individuals with larger bodies by perpetuating stereotypes and reinforcing weight stigma.³⁹ At the same time, weight-loss methods, such as dieting, surgery, and medication, became heavily scrutinized.⁴⁰ Not only was thinness idealized, but those who achieved it “naturally” through diet and exercise were praised while those who relied upon medical interventions were criticized for taking the “easy way out.”⁴¹ This perception contributes to the widespread stigma surrounding weight loss medications, with the public discourse often focusing on their perceived dangers or morality regarding their use, rather than on their medical benefits.

³² Marghoub et al., *supra* note 30, at 2.

³³ Marghoub et al., *supra* note 30, at 2; Eknoyan, *supra* note 30, at 423.

³⁴ Eknoyan, *supra* note 30, at 423.

³⁵ *Id.*

³⁶ *Id.* at 425.

³⁷ *Id.* at 424.

³⁸ Danielle Couch, Samantha L. Thomas, Sophie Lewis, R. Warwick Blood, Kate Holland & Paul Komesaroff, *Obese People's Perceptions of the Thin Ideal*, 148 *SOCIAL SCIENCE & MEDICINE* 60, 60 (2016); Pilar Aparicio-Martinez, Alberto-Jesus Perea-Moreno, María Pilar Martinez-Jimenez, María Dolores Redel-Macias, Claudia Pagliari, & Manuel Vaquero-Abellan, *Social Media, Thin-Ideal, Body Dissatisfaction and Disordered Eating Attitudes: An Exploratory Analysis*, 16 *INT'L J. ENV'T'L. RES. & PUB. HEALTH* 4177, 4178 (2019).

³⁹ Couch et al., *supra* note 38, at 61; Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 *AM. J. PUBLIC HEALTH* 1019, 1020-21 (2010).

⁴⁰ Areeba N. Memon et al., *Have Our Attempts to Curb Obesity Done More Harm Than Good?*, 12 *CUREUS* e10275 (2020); Couch, et al., *supra* note 38, at 61; Aparicio-Martinez et al., *supra* note 38, at 4178.

⁴¹ Bruno Halpern & Alfredo Halpern, *Why Are Anti-Obesity Drugs Stigmatized?*, 14 *EXPERT OP. ON DRUG SAFETY* 185, 185-86 (2014).

The increasing societal stigma surrounding obesity fueled a growing demand for weight-loss medications that promised to restore bodies to their “ideal” form, even as American culture remained deeply ambivalent towards medical interventions that enabled weight loss.⁴² Early pharmacological interventions emerged as one such solution.⁴³ Beginning in the 1940s, amphetamines were introduced to the market for their appetite-suppressing qualities.⁴⁴ By the 1950s and 1960s, they were widely prescribed, especially to women, under the guise of enhancing productivity and maintaining socially acceptable body types.⁴⁵ Physicians frequently prescribed these drugs with minimal oversight, often pairing them with thyroid hormones or diuretics, even in patients without any underlying metabolic disorders.⁴⁶ Notwithstanding the well-known risks of dependency, cardiovascular complications, and psychological harm,⁴⁷ and the American Medical Association (“AMA”)’s conclusion that rainbow pills had “no rational therapeutic use,”⁴⁸ these medications were embraced by a society increasingly obsessed with thinness.

Despite growing awareness of the addictive potential of amphetamines, their use remained widespread well into the 1960s.⁴⁹ This era also saw the emergence of so-called “rainbow pills,” cocktails of multiple pharmaceuticals that were marketed and prescribed for rapid weight loss.⁵⁰ These combinations often included amphetamines, barbiturates, diuretics, thyroid hormones, and laxatives—administered with little oversight or understanding of their interactions or cumulative effects.⁵¹ The term “rainbow” referred to the pills’ array of bright colors, which were visually appealing but dangerously misleading to patients who had been marketed different colored pills as a form of “personalized medicine.”⁵² Patients were

⁴² Pieter A. Cohen, Alberto Goday, & John P. Swann, *The Return of Rainbow Diet Pills*, 102 AM. J. PUB. HEALTH 1676, 1676-77 (2012).

⁴³ Nicolas Rasmussen, *America’s First Amphetamine Epidemic 1929–1971*, 98 AM. J. PUB. HEALTH 974, 975 (2008).

⁴⁴ By the end of World War II in 1945, less than a decade after amphetamine tablets were introduced to medicine, over half a million civilians were using amphetamines psychiatrically or for weight loss. See Rasmussen, *supra* note 43, at 975.

⁴⁵ Rasmussen, *supra* note 43, at 975-6.

⁴⁶ Cohen, Goday & Swann, *supra* note 42, at 1676; GEORGE A. BRAY & JONATHAN Q. PURNELL, AN HISTORICAL REVIEW OF STEPS AND MISSTEPS IN THE DISCOVERY OF ANTI-OBESITY DRUGS (K. R. Feingold et al. eds., 2000), <https://www.ncbi.nlm.nih.gov/books/NBK581942> [<https://perma.cc/D2H7-TRDE>].

⁴⁷ BRAY & PURNELL, *supra* note 46.

⁴⁸ Cohen, Goday & Swann, *supra* note 42, at 1679.

⁴⁹ Rasmussen, *supra* note 43, at 975.

⁵⁰ Cohen, Goday, & Swann, *supra* note 42, at 1676-77.

⁵¹ *Id.*

⁵² The rainbow-colored nature of the pills was intended to avoid the perception of factory-line therapeutics. Instead, the rainbow colors suggested personalized treatment, uniquely crafted for the

often unaware of the complete list of substances they were prescribed or the collective health risks they posed.⁵³

The rainbow pill phenomenon reflected both a laissez-faire regulatory environment and the extent to which physicians profited from the desire to lose weight while compromising patient safety.⁵⁴ Marketed toward women under social pressure to maintain thinness, these regimens were normalized in medical settings despite the known risks of addiction, cardiac arrest, severe electrolyte imbalance, and death.⁵⁵ The effects of these drugs could also be very unpleasant; therefore, manufacturers offered more drugs to help combat those side effects.⁵⁶ Today, one might refer to this as polypharmacy, and it would generally be discouraged.⁵⁷ Back then, new drug companies sprang up to market these rainbow diet pills, and some doctors even opened clinics dedicated to prescribing them; the polypharmacy was the point.⁵⁸ By the late 1960s, a secret shopper study published by a reporter from *Life* magazine, coupled with high-profile cases of overdose and increasing concern over pharmaceutical misuse, led the FDA to scrutinize and eventually curtail such prescribing practices.⁵⁹ Nevertheless, the damage had been done: rainbow pills left behind a cultural and medical legacy of distrust, and weight loss medications became associated not with health but with recklessness and desperation.⁶⁰

This period of unregulated polypharmacy deepened the moral suspicion surrounding weight-loss medications.⁶¹ The initial medical acceptance of “quick fix” medications, rather than legitimate, evidence-based treatments, caused the association of pharmacological interventions with vanity, shortcuts, and abuse.⁶² Ultimately, it was this dynamic that laid critical groundwork for the public’s reaction to later treatments.

patient’s individual weight loss requirements, despite following no standard formulation. See Cohen, Goday, & Swann, *supra* note 42, at 1678.

⁵³ T. D. Müller, C. Clemmensen, B. Finan, R. D. DiMarchi & M. H. Tschöp, *Anti-Obesity Therapy: From Rainbow Pills to Polygonists*, 70 *PHARMACOLOGICAL REVS.* 712, 719 (2018).

⁵⁴ *Id.*; Cohen, Goday, & Swann, *supra* note 42, at 1682.

⁵⁵ Müller, Clemmensen, Finan, DiMarchi & Tschöp, *supra* note 53, at 717-19.

⁵⁶ BRAY & PURNELL, *supra* note 46; Cohen, Goday & Swann, *supra* note 42, at 1679.

⁵⁷ Polypharmacy is the practice of administering many different medicines, especially concurrently for the treatment of a single disease. See MERRIAM WEBSTER, <https://www.merriam-webster.com/dictionary/polypharmacy> [<https://perma.cc/99HL-H27D>]; see also Brewis & Trainer, *supra* note 7, at 259.

⁵⁸ Cohen, Goday & Swann, *supra* note 42, at 1678

⁵⁹ *Id.* at 1680. The FDA began seizing millions of tablets from manufacturers and worked in conjunction with Congress to increase accountability of the use of amphetamines in medical practice. See Müller, Clemmensen, Finan, DiMarchi & Tschöp, *supra* note 53, at 719.

⁶⁰ Müller, Clemmensen, Finan, DiMarchi & Tschöp, *supra* note 53, at 719.

⁶¹ Brewis & Trainer, *supra* note 7, at 259.

⁶² Insurance companies classify GLP-1 medications as “vanity drugs.” Gina Kolata, *The Doctor Prescribed an Obesity Drug. Her Insurer Called It ‘Vanity’*, N.Y. TIMES (May 31, 2021),

Possibly the most notorious of these later interventions was Fen-Phen, a combination of fenfluramine and phentermine, which gained popularity in the early 1990s.⁶³ Initially hailed as a breakthrough, with an impressive average of thirty-two pounds of weight lost, Fen-Phen was prescribed to millions of Americans and heavily marketed to physicians and consumers alike.⁶⁴ *Time* magazine referred to its derivative, dexfenfluramine [Redux], as a potential “miracle drug,” and patients were willing to cross state lines to gain access to it.⁶⁵ Like with rainbow pills, weight-loss clinics were a source for Redux; doctors prescribed them frequently (85,000 prescriptions a week within three months of its introduction to the American market); if those sources did not work, patients could obtain the drug over the Internet.⁶⁶ Wyeth, the company responsible for marketing Redux in the United States, launched a \$52 million marketing campaign.⁶⁷

By 1997, however, reports of life-threatening side effects, including pulmonary hypertension and heart valve damage, led the FDA to withdraw both fenfluramine and dexfenfluramine from the market.⁶⁸ The fallout was swift and widespread, with class-action lawsuits and billions in settlements that significantly tarnished the reputation of medications for weight loss.⁶⁹ Wyeth had 175,000 lawsuits filed against the company, leading to a \$21 billion settlement.⁷⁰

Fen-Phen became a cautionary tale, reinforcing public skepticism toward weight-loss pharmacotherapy. It deepened the stigmatizing narrative that such medications were not only physically dangerous but morally questionable.⁷¹ The idea that people should lose weight “naturally,” through willpower and self-control, became more deeply entrenched. Those who sought medical aid were often viewed as lazy or vain, and physicians became

<https://www.nytimes.com/2022/05/31/health/obesity-drugs-insurance.html> [https://perma.cc/XZ7G-TUDJ].

⁶³ BRAY & PURNELL, *supra* note 46, at 26-27.

⁶⁴ *Id.* at 27; Kate Cohen, *Fen Phen Nation*, FRONTLINE (Nov. 13, 2003), <https://www.pbs.org/wgbh/pages/frontline/shows/prescription/hazard/fenphen.html> [https://perma.cc/J8UT-FVM6].

⁶⁵ Cohen, *supra* note 64.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ In 1999, American Home Products, the maker of Fen-Phen, agreed to pay as much as \$3.75 billion in a class action settlement open to all individuals who took the medications. The settlement consisted of funds to cover refunds for medication, medical screening costs, cash payments to victims, education, research, and administration. Ruth SoRelle, *Diet Drug Maker Agrees to \$3.75 Billion Settlement*, 100 CIRCULATION 133 (1999); BRAY & PURNELL *supra* note 46 at 27.

⁶⁹ SoRelle, *supra* note 68, at 133-34; BRAY & PURNELL, *supra* note 46, at 48.

⁷⁰ John Fauber & Kristina Fiore, *Slippery Slope: Fen-Phen Users Recall a ‘Miracle’ Turned Nightmare*, MEDPAGETODAY (Apr. 19, 2015), <https://www.medpagetoday.com/special-reports/slipperyslope/51044> [https://perma.cc/YBZ2-2CX3].

⁷¹ Heitman, *supra* note 9, at 18; Curfman, *supra* note 22, at 630.

more reluctant to prescribe pharmacological treatments for fear of liability.⁷² In this way, the stigma surrounding obesity was extended to the very tools designed to treat it.

Subsequent pharmaceutical efforts fared little better. Orlistat, marketed as Xenical and later, over-the-counter as Alli, received FDA approval in 1999.⁷³ While it worked by inhibiting fat absorption, the medication quickly developed a reputation for unpleasant gastrointestinal side effects with stigmatizing effects on patients.⁷⁴ In 2012, the FDA approved lorcaserin (Belviq), a serotonin receptor agonist intended to suppress appetite.⁷⁵ Though initially promising, lorcaserin was voluntarily withdrawn from the market in 2020 after long-term studies showed a potential increase in cancer risk.⁷⁶

The repeated pattern of public enthusiasm, followed by medical retraction and public backlash, created a cultural script: pharmaceutical treatments for weight loss were suspect, shameful, and risky. These patterns fuel patient reluctance to engage in legitimate treatment options, even when they are effective and evidence-based.⁷⁷

Ultimately, the history of weight stigma in the United States is one of paradox: a society obsessed with thinness yet deeply distrustful of medical tools to achieve it. Breaking this paradox requires a cultural and legal reimagining of obesity treatment; one that moves beyond moralizing, embraces science, and centers the lived experiences of patients navigating obesity stigma, both past and present.

II. THE MEDICALIZATION OF OBESITY

The transition toward viewing obesity as a medical condition has been shaped by evolving public health perspectives and policy decisions. In the

⁷² Rebecca Nappi, *Fen-Phen? Just Say No to This Easy Way Out*, SPOKESMAN REV. (July 14, 1997), <https://www.spokesman.com/stories/1997/jul/14/fen-phen-just-say-no-to-this-easy-way-out> [<https://perma.cc/2WEZ-P7VS>].

⁷³ *Orlistat (Marketed as Alli and Xenical): Information, Postmarket Drug Safety Information for Patients and Providers*, U.S. FDA (July 8, 2015), <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/orlistat-marketed-alli-and-xenical-information> [<https://perma.cc/G4MM-9VHY>].

⁷⁴ K. M. Hvizdos & A. Markham, *Orlistat: A Review of Its Use in the Management of Obesity*, 58 DRUGS 743 (1999); BRAY & PURNELL, *supra* note 46.

⁷⁵ *Orlistat (marketed as Alli and Xenical): Information, Postmarket Drug Safety Information for Patients and Providers*, *supra* note 73.

⁷⁶ *FDA Requests Withdrawal of Weight-Loss Drug Belviq, Belviq XR (Lorcaserin) from the Market, Drug Safety and Availability*, U.S. FDA (Feb. 13, 2020), <https://www.fda.gov/drugs/drug-safety-and-availability/fda-requests-withdrawal-weight-loss-drug-belviq-belviq-xr-lorcaserin-market>.

⁷⁷ Jean Lee, *The Silent Struggle: Why Patients Hesitate to Ask About GLP-1 Medications*, INTAKE (July 23, 2025), <https://www.tebra.com/theintake/healthcare-reports/glp1-patient-hesitation> [<https://perma.cc/KKB4-ZQ5E>].

early twentieth century, obesity was largely framed as a behavioral issue tied to individual lifestyle choices.⁷⁸ However, beginning in the 1990s, public health officials increasingly emphasized environmental and systemic contributors, arguing that obesity was driven by factors beyond personal control.⁷⁹ This shift laid the foundation for the AMA's 2013 decision to officially classify obesity as a disease, a move that validated medical interventions while sparking fierce debate within the medical and public health communities.⁸⁰

The AMA's recognition of obesity as a medical condition reflected emerging evidence about the biological and genetic underpinnings of weight gain, along with research suggesting that stigma can undermine treatment outcomes. At the same time, some advocates feared that medicalizing obesity would detract from structural public health reforms, including food environments and socioeconomic determinants of health.⁸¹

Nonetheless, medicalization has expanded access to some treatments for obesity, such as bariatric surgery and pharmacotherapy, reinforcing the notion that obesity is a condition requiring clinical intervention.⁸² Still, critics argue that this clinical lens can also obscure the lived experiences of individuals in larger bodies, potentially pathologizing normal body diversity and further entrenching narrow ideals of health.⁸³ Additionally, while medicalization has the potential to alleviate stigma by reframing obesity as a health condition rather than a personal failing, it also carries the risk of further stigmatizing individuals by emphasizing the need for medical correction.⁸⁴

⁷⁸ Selena E. Ortiz, Ichiro Kawachi & Angie M. Boyce, *The Medicalization of Obesity, Bariatric Surgery, and Population Health*, 21 HEALTH (LONDON) 498, 502 (2016).

⁷⁹ Ortiz, Kawachi, & Boyce, *supra* note 78, at 502.

⁸⁰ *Id.* at 498-99.

⁸¹ It is critical to recognize the systemic drivers of obesity, outside of biological and genetic determinants. Changes in the global food system, such as the proliferation of cheap, convenient, energy-dense processed foods, aggressive marketing practices, and improved food distribution, have increased the supply and accessibility of obesogenic foods. Further, economic policies favoring consumption-based growth, further empower corporations to profit from rising demand, often ahead of public health safeguards. Socioeconomic determinants, such as poverty, income inequality, urbanization, and food environments that limit access to nutritious foods, act both as mediators and amplifiers of obesity risk, especially in marginalized populations. See Kevin D. Hall, *From Dearth to Excess: the Rise of Obesity in an Ultra-Processed Food System*, 11 PHILOSOPHICAL TRANSACTIONS OF THE ROYAL SOCIETY OF LONDON 378, 379-80 (2023); see also Ortiz, Kawachi, & Boyce, *supra* note 78, at 506-09.

⁸² Ortiz, Kawachi, & Boyce, *supra* note 78, at 506-09.

⁸³ Some scholars argue that the medicalization of obesity frames obesity as a personal and private problem, rather than a social and political systemic problem. See Ástriður Stefánsdóttir, *Three Positions on the Fat Body: Evaluating the Ethical Shortcomings of the Obesity Discourse*, 15 CLINICAL ETHICS 39, 40 (2020).

⁸⁴ George L. Blackburn, *Medicalizing Obesity: Individual, Economic, and Medical Consequences*, 13 AM. MED. ASSOC. J. OF ETHICS 890, 891 (2011).

The conflation of body mass index (“BMI”) classifications with the medical diagnosis of obesity is a clear example of a critical point of confusion that has directly contributed to the stigmatization of obesity within medicine. BMI, developed as a population-level statistical tool rather than a diagnostic measure for individual patients, is frequently used to categorize individuals as “overweight” or “obese” without accounting for variations in muscle mass, bone density, or other health indicators.⁸⁵ By contrast, medical obesity refers to a disease in which excess body weight results in measurable impairments to physical or metabolic health.⁸⁶ When these categories are blurred, individuals whose weight may not negatively impact their health are nonetheless labeled as diseased, thereby reinforcing perceptions that larger bodies are inherently pathological. This conflation sustains stigma by reducing diverse body types to a single flawed metric and obscuring the nuanced medical realities of obesity as a chronic condition.

Further, many health care providers still take a stigmatizing approach to obesity treatment, often interpreting obesity as a manifestation of moral failure or personal weakness.⁸⁷ This reflects a disconnect between the official medical recognition of obesity as a disease and the attitudes that continue to persist in medical practice. Physicians may suggest weight loss yet provide little guidance on exercise and diet, failing to offer a comprehensive treatment plan, consider other effective treatments, or engage patients in meaningful discussions about pharmacological or surgical interventions.⁸⁸ This approach is rooted in the belief that patients should be able to manage their weight independently, which reinforces the stigmatizing narrative that individuals with obesity are personally responsible for their condition and simply lack the discipline to lose weight.⁸⁹

This failure to treat obesity as a disease in both practice and culture contributes to the ongoing stigmatization of weight loss treatments.⁹⁰ If health care providers reinforce societal stigma by continuing to treat obesity as a problem of personal responsibility rather than a legitimate chronic disease that requires multi-faceted treatment approaches, patients with obesity may continue to experience delayed diagnoses, reduced quality of

⁸⁵ Rachel Pray & Suzanne Riskin, *The History and Faults of the Body Mass Index and Where It Should Go Next*, 15 CUREUS e48230 (2023).

⁸⁶ *Obesity and People with Higher Weight*, NAT’L INST. OF HEALTH (Nov. 1, 2025), <https://www.nih.gov/nih-style-guide/obesity-people-higher-weight> [<https://perma.cc/G4GC-K6EW>].

⁸⁷ Leona Ryan, Fiona Quigley, Susie Birney, Michael Crotty, Owen Conlan, Jane C. Walsh, ‘*Beyond the Scale*’: *A Qualitative Exploration of the Impact of Weight Stigma Experienced by Patients With Obesity in General Practice*, 27 HEALTH EXPECTATIONS e14098, 1, 2 (2024).

⁸⁸ Ryan et. al., *supra* note 87, at 1, 2.

⁸⁹ *Id.* at 1, 2.

⁹⁰ Westbury, Oyeboode, Rens & Barber, *supra* note 1 at 18; *Adult Obesity Facts*, *supra* note 1.

care, and worsening health outcomes.⁹¹ This cycle of bias not only hinders effective treatment but also discourages individuals from seeking help, fearing criticism and blame from health care professionals.⁹²

Medicalization has undoubtedly expanded the range of clinical interventions available to people with obesity, including bariatric surgery and an increasing array of medications.⁹³ But these treatments are not always delivered within a supportive or stigma-free environment. In fact, the medical model has often coexisted with lingering moral judgments. Providers may acknowledge that obesity is a disease while still treating it as a personal failure.⁹⁴

This inconsistency is evident in clinical encounters. Patients with obesity frequently report being dismissed or misdiagnosed by health care providers.⁹⁵ For example, patients with shortness of breath are more likely to receive lifestyle change recommendations if they are obese; patients who are perceived as being a normal weight are more likely to receive medication to manage their symptoms.⁹⁶

The medicalization of obesity has not occurred in a sociocultural vacuum; it is also deeply gendered and racialized. Women, particularly Black and Latina women, are disproportionately subjected to weight-related stigma in clinical and social settings, yet they remain underrepresented in clinical trials that inform pharmaceutical approvals and obesity treatment guidelines.⁹⁷ This exclusion both reflects and reinforces structural inequities,

⁹¹ Westbury, Oyebo, Rens & Barber, *supra* note 1 at 18.

⁹² *Id.*

⁹³ Blackburn, *supra* note 84, at 891.

⁹⁴ S.M. Phelan, D.J. Burgess, M.W. Yeazel, W.L. Hellerstedt, J.M. Griffin, & M. Van Ryn, *Impact of Weight Bias and Stigma on Quality of Care and Outcomes for Patients with Obesity*, 16 OBESITY REVIEWS 319, 320 (2015).

⁹⁵ *Id.* at 320-21. The literature is explicit about the downstream clinical effects of provider stigma: Physicians and other providers sometimes perceive those with obesity as noncompliant, overindulgent, lazy, and unsuccessful. They are less respected than patients who are not overweight, and some doctors report they would rather not care for those who are overweight. An inverse relationship has been reported between patient BMI and primary care physicians' patience, job satisfaction, and willingness to assist the patient. Doctors choose to spend less time with patients with obesity and order fewer preventive and diagnostic tests for them.

Ann Kennedy, Shannon Taylor, Carl Lavie, Steven Blair, *Ending the Stigma: Improving Care for Patients Who Are Overweight or Obese*, 29 FAM. PRAC. MGMT. 21, 22 (2022); see also Rich Schapiro, "An Ongoing Nightmare": People with Obesity Face Major Obstacles when Seeking Medical Care, NBC NEWS (June 27, 2021), <https://www.nbcnews.com/health/health-news/ongoing-nightmare-obese-people-face-major-obstacles-when-seeking-medical-n1272019> [<https://perma.cc/2PCS-XFB6>].

⁹⁶ Phelan, et al, *supra* note 94, at 320-21.

⁹⁷ 11.5% of women live with severe obesity, as opposed to 6.9% of men. See *Overweight & Obesity Statistics*, NAT'L INST. OF DIABETES & DIG. & KIDNEY DISEASES (last accessed Oct. 14, 2025), <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity> [<https://perma.cc/G94E-UJ5J>]; see also Crystal N. Johnson-Mann et. al., *A Systematic Review on*

limiting the applicability of research findings to those most affected by the condition. These disparities are further compounded by systemic barriers to health care access—including bias in medical encounters, gaps in insurance coverage, and provider distrust.⁹⁸ Popular media coverage, meanwhile, often centers affluent, white celebrities, reinforcing the perception that GLP-1s are cosmetic shortcuts rather than essential treatments for chronic disease.⁹⁹ Yet GLP-1s were initially approved to treat another chronic condition: type 2 diabetes mellitus.¹⁰⁰ This dissonance between medical promise and cultural framing underscores the need for inclusive research practices and equitable policy reforms that center the experiences of marginalized women. Together, these dynamics create a self-perpetuating cycle in which those most subject to bias become the least visible in research and media, thereby entrenching dismissive clinical practices and providing a rationale for restrictive coverage policies.

For obesity to be effectively treated and for stigma to be reduced, doctors must fully accept and integrate the medical understanding of obesity into their practices.¹⁰¹ This includes moving beyond weight loss as the sole focus of treatment and toward the embrace of a holistic approach that considers medication, behavioral therapy, and lifestyle changes.¹⁰² Further, doctors must move beyond the inherently flawed BMI scale¹⁰³ and the

Participant Diversity in Clinical Trials—Have We Made Progress for the Management of Obesity and Its Metabolic Sequelae in Diet, Drug, and Surgical Trials, 10 J. RACIAL & ETHNIC HEALTH DISPARITIES 3140, 3140 (2023).

⁹⁸ NAT'L INST. OF DIABETES & DIG. & KIDNEY DISEASES, *Access to Healthcare and Disparities in Access*, in 2021 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT, <https://www.ncbi.nlm.nih.gov/books/NBK578537> [<https://perma.cc/VHR4-3YU5>].

⁹⁹ Mike Hollan, *Charles Barkley Is Ro's GLP-1 Celebrity Ambassador*, PHARM. EXEC. (May 2, 2025), <https://www.pharmexec.com/view/charles-barkley-ro-glp1-celebrity-ambassador> [<https://perma.cc/7TGN-AVUT>]; Emily Hutchinson, *12 Celebs Who Totally Transformed After Taking Ozempic Or Other GLP-1's*, WOMEN (May 18, 2025), <https://www.women.com/1857718/celebs-totally-transformed-taking-ozempic-other-glp-1> [<https://perma.cc/Q9E2-S35V>]; Sean Mandell, *Oprah Winfrey Reveals Taking GLP-1 Weight-Loss Drug Made Her Realize What She Got Wrong About 'Thin People'*, N.Y. POST (Jan. 22, 2025), <https://nypost.com/2025/01/22/entertainment/oprah-winfrey-reveals-taking-glp-1-weight-loss-drug-made-her-realize-what-she-got-wrong-about-thin-people> [<https://perma.cc/ETT6-MTYT>].

¹⁰⁰ FDA Approves Lilly's Mounjaro (Tirzepatide) Injection, the First and Only GIP and GLP-1 Receptor Agonist for the Treatment of Adults with Type 2 Diabetes, PR NEWswire (May 13, 2022), <https://www.prnewswire.com/news-releases/fda-approves-lillys-mounjaro-tirzepatide-injection-the-first-and-only-gip-and-glp-1-receptor-agonist-for-the-treatment-of-adults-with-type-2-diabetes-301547339.html> [<https://perma.cc/W4BN-FT9X>].

¹⁰¹ Phelan, et al., *supra* note 94, at 322-23.

¹⁰² *The Four Pillars of Obesity Treatment*, OBESITY MED. ASS'N, <https://obesitymedicine.org/about/four-pillars> [<https://perma.cc/9DR6-G69U>].

¹⁰³ Christian Nordqvist, *Why BMI is Inaccurate and Misleading*, MED. NEWS TODAY (Jan. 20, 2022), <https://www.medicalnewstoday.com/articles/265215> [<https://perma.cc/XC36-GCK5>]; *see also* Sabrina Strings, *How the Use of BMI Fetishizes White Embodiment and Racializes Fat Phobia*, 25 AMA J. ETHICS E535, E537-8 (2023).

idealization of what a “healthy” weight should be.¹⁰⁴ Doctors must also engage in bias-reduction training in order to ensure they are offering evidence-based, non-stigmatizing treatment options, including the use of medications like GLP-1s, which offer promising alternatives to traditional weight-loss treatments.¹⁰⁵

Ultimately, the successful medicalization of obesity depends not just on reclassification or diagnostic codes, but on whether the health care system treats patients with obesity with the same rigor, respect, and access to care as those with any other chronic disease.

III. GLP-1S AS ANTI-STIGMA TOOLS

As obesity stigma persists, the emergence and promise of GLP-1s in treating the condition is cause for optimism. Though not completely risk-free, GLP-1s lack the dangerous side effects that resulted in the market removal of their weight loss predecessors.¹⁰⁶ Moreover, GLP-1s stand to benefit millions of people in the United States, offering tremendous potential to reduce morbidity and mortality at a time when life expectancy is on the decline.¹⁰⁷ At best, GLP-1s can help meaningfully address the “obesity epidemic” while also serving as a tool to dismantle obesity stigma.¹⁰⁸ For GLP-1s to serve as a tool in reducing weight stigma, they must be equitably accessible to all individuals with obesity, rather than restricted only to those with the means to access them.¹⁰⁹

¹⁰⁴ Obesity does not inherently equate to poor health. Individuals classified as medically obese may maintain normal metabolic profiles over time—referred to as “metabolically healthy obese” (MHO). These individuals do not exhibit the metabolic abnormalities typically associated with obesity, such as insulin resistance or dyslipidemia. See Laura Perez-Campos Mayoral et. al., *Obesity Subtypes, Related Biomarkers & Heterogeneity*, 151 *INDIA J. MED. RES.* 11 (Jan. 2020)

¹⁰⁵ GINSBURG, DALEY, & SHEER, *supra* note 13, at 24.

¹⁰⁶ Common side effects include nausea and digestive problems, which are often manageable and decrease over time. There is no strong real-world evidence that GLP-1s cause severe side effects in many users. See Reimaer Thomsen, Aurelie Mailhac, Julie Lohde & Anton Pottgard, *Real-World Evidence on the Utilization, Clinical and Comparative Effectiveness, and Adverse Effects of Newer GLP-1RA-Based Weight-Loss Therapies*, 27 *DIABETES, OBESITY & METABOLISM* 66 (2025).

¹⁰⁷ Life expectancy in the United States has declined from pre-pandemic levels of 78.8 years to 78.4 years. Notably, the average life expectancy in comparable countries is 82.5 years. See Shameek Rakshit & Matthew McGough, *How Does U.S. Life Expectancy Compare to Other Countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Jan. 31, 2025), <https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries> [https://perma.cc/NSB6-8W3X].

¹⁰⁸ An “epidemic” is defined as “affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time. See *Epidemic*, MERRIAM-WEBSTER <https://www.merriam-webster.com/dictionary/epidemic> [https://perma.cc/8HGV-7TV7].

¹⁰⁹ Libby Green & Patty Taddei-Allen, *Shifting Paradigms: Reframing Coverage of Antiobesity for Plan Sponsors*, 29 *J. MANAGED CARE & SPECIALTY PHARM.* 564, 567 (2023).

A. *Affordability of GLP-1s*

Currently, one of the most significant barriers to obtaining GLP-1 agonist medications is their high cost, particularly when prescribed for weight management rather than diabetes.¹¹⁰ The patchwork of federal laws, insurance coverage exclusions, and regulatory loopholes restrict access to GLP-1s for many Americans, particularly those enrolled in Medicare, Medicaid, and those living without health insurance.¹¹¹ These limitations stem from outdated legislative frameworks, political instability surrounding preventive care mandates, and the strategic use of patent protections by pharmaceutical manufacturers to maintain high prices.

1. Public Insurance—Medicare Part D Coverage

Medicare¹¹² has historically been limited in its coverage of obesity treatments, primarily due to legislative and regulatory barriers. The Social Security Act (“SSA”) originally prohibited Medicare from covering weight loss treatments on the grounds that obesity was considered a lifestyle issue rather than a medical condition.¹¹³ In 2004, the Centers for Medicare & Medicaid Services (“CMS”) removed language that classified obesity as a non-disease, allowing for limited *coverage* of treatments related to obesity, but only when associated with other conditions such as diabetes or cardiovascular disease.¹¹⁴

¹¹⁰ John O.H. Wilding et al., *Once-Weekly Semaglutide in Adults with Overweight or Obesity*, 384 N. ENG. J. MED. 989, 990 (2021).

¹¹¹ Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, 89 Fed Reg. 99340 (proposed Dec. 10, 2024); Waldrop, Johnson & Stanford, *supra* note 21, at 24.

¹¹² Medicare was created in 1965 to provide health insurance for Americans aged 65 and older, addressing widespread lack of access to affordable health care for seniors. It has since expanded to cover younger individuals with certain disabilities. See *History of CMS*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/about-cms/who-we-are/history> [<https://perma.cc/X86N-QBLL>].

¹¹³ Hernandez, Wright, Guo & Shrank, *supra* note 18, at 307.

¹¹⁴ To be eligible for bariatric surgery under CMS, patients must have a BMI of 35 or higher, experience at least one co-morbidity related to obesity, such as type 2 diabetes, hypertension, sleep apnea, or hyperlipidemia, and the patient must have been previously unsuccessful with medical treatments for obesity. This includes active participation within the last twelve months prior to bariatric surgery in a weight-management program that is supervised by a health care professional for a minimum of four consecutive months. See Memorandum from the Ctr. for Medicare & Medicaid Servs. on Coverage Decision for Bariatric Surgery for the Treatment of Morbid Obesity (Sep. 24, 2013), <https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=266>; see also Theodore Kyle, Emily Dhurandhar, & David Allison, *Regarding Obesity as a Disease: Evolving Policies and Their Implications*, 45 ENDOCRINOLOGY & METABOLISM CLINICS N. AM. 511, 514 (2016).

Despite this change, Medicare Part D¹¹⁵ still excludes coverage of weight loss medications. This exclusion stems from the Medicare Modernization Act of 2003, which prohibits coverage of medications used for weight loss, cosmetic purposes, or fertility.¹¹⁶ CMS currently covers bariatric surgery for patients meeting specific criteria, but does not cover obesity medications, including GLP-1s.¹¹⁷ Because of this exclusion, millions of older adults and disabled individuals who rely on Medicare are currently unable to access these therapies, exacerbating health disparities and increasing long-term health care costs for millions of Americans.¹¹⁸

In November 2024, the Biden administration issued a proposed rule that would have allowed Medicare and required Medicaid to cover medications used to treat obesity, including GLP-1s.¹¹⁹ The proposed rule reflected the administration's understanding of obesity as a disease and the reality that weight loss provides real health benefits for people with obesity, rather than merely cosmetic benefits.¹²⁰ CMS received more than thirty thousand comments on the rule, many from individuals and physicians urging policymakers to expand coverage to include GLP-1s.¹²¹ But finalizing the

¹¹⁵ Medicare Part D provides coverage for outpatient prescription drugs through private insurance plans approved by Medicare. See *What's Medicare Drug Coverage (Part D)?*, MEDICARE, <https://www.medicare.gov/health-drug-plans/part-d> [<https://perma.cc/G9AN-EKPF>].

¹¹⁶ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §101, 117 Stat. 2066 (2003).

¹¹⁷ *Obesity Treatment and Medicare: A Guide to Understanding Coverage*, NAT'L COUNCIL ON AGING (Apr. 8, 2025), <https://www.ncoa.org/article/obesity-treatment-and-medicare-a-guide-to-understanding-coverage> [<https://perma.cc/R7BV-3PB4>].

¹¹⁸ OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION; OFF. OF HEALTH POL'Y, MEDICARE COVERAGE OF ANTI-OBESITY MEDICATION (2024), <https://aspe.hhs.gov/sites/default/files/documents/127bd5b3347b34be31ac5c6b5ed30e6a/medicare-coverage-anti-obesity-meds.pdf> [<https://perma.cc/E7JV-GQY8>].

¹¹⁹ Juliette Cubanski & Elizabeth Williams, *Proposed Coverage of Anti-Obesity Drugs in Medicare and Medicaid Would Expand Access to Millions of People with Obesity*, KAISER FAM. FOUND. (Nov. 26, 2024), <https://www.kff.org/medicare/proposed-coverage-of-anti-obesity-drugs-in-medicare-and-medicare-would-expand-access-to-millions-of-people-with-obesity> [<https://perma.cc/U2FS-FFWQ>].

¹²⁰ Cubanski & Williams, *supra* note 119.

¹²¹ Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, 89 Fed Reg. at 99340; see Ctrs. For Medicare & Medicaid Servs., Comment on Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, CMS-2024-0345-1533 (Jan. 27, 2025), <https://www.regulations.gov/comment/CMS-2024-0345-1533?utm> [<https://perma.cc/A3A4-EL3C>].

Obesity is a serious disease that affects millions of hard-working Americans, and it is not just a matter of lifestyle choice. Modern obesity medications, when combined with diet and exercise, provide proven health benefits by reducing the risks of heart disease, diabetes, stroke, and certain cancers. Without access to these life-changing treatments, many individuals—particularly those in working-class and minority communities—face higher risks of debilitating health conditions, leading to costly hospital stays and long-term care. Covering these medications under Medicare and Medicaid will save lives and reduce the financial strain on our healthcare system. The outdated rules prohibiting coverage for weight-loss medications fail to reflect our modern understanding of obesity as a disease.

proposed rule was left to the Trump administration, which took office in January 2025.

Following President Trump’s inauguration, the Trump administration’s messaging surrounding GLP-1 medications, public health, and the U.S. health care system was marked by inconsistency, reflecting shifting priorities and a lack of coherent direction on public health strategy.¹²² The Secretary of the Department of Health and Human Services (“HHS”) under the Trump administration, Robert F. Kennedy Jr., labeled GLP-1s as “miracle drugs” during his confirmation hearing, despite previously disparaging the medications, but expressed concern with the costs to the federal government of covering the medications.¹²³ The Director of CMS, Dr. Mehmet Oz, previously expressed an interest in coverage of GLP-1s, posting on social media that “I’ll respect you no matter what your weight might be, but for those who want to lose a few pounds, Ozempic and other semaglutide medications can be a big help. We need to make it as easy as possible for people to meet their health goals, period.”¹²⁴

In April 2025, however, the Trump administration declined to finalize the Biden administration’s proposed rule, opting not to extend Medicare Part D coverage to obesity medications, including GLP-1s.¹²⁵ The Trump administration did not explain its decision, simply stating that the Biden-era proposal was “not appropriate at this time.”¹²⁶ This decision stood in stark contrast to public opinion: a majority of Americans, about 61%, support Medicare coverage for GLP-1 medications when prescribed for weight loss.¹²⁷ Notably, this support cuts across political lines, reflecting a broad

The proposed rule is a step in the right direction, recognizing that obesity treatment is essential for improving health and reducing chronic illnesses. A recent Joint Economic Committee report shows obesity could cost our nation nearly \$9 trillion in excess medical expenses over the next decade. Expanding access to anti-obesity medications is not only the right thing to do but also a smart investment in healthier communities, a healthier workforce, and a more sustainable healthcare system.

Id.

¹²² *Health Policy in Flux: Trump Administration Updates*, AM. J. MANAGED CARE (Mar. 28, 2025), <https://www.ajmc.com/view/health-policy-in-flux-trump-administration-updates> [<https://perma.cc/HRE7-74L2>].

¹²³ Anne Flaherty & Will McDuffie, *In Shift, RFK Jr. Now Says Weight-Loss Drugs ‘Have a Place,’* ABC NEWS (Dec. 12, 2024), <https://abcnews.go.com/politics/shift-rfk-jr-weight-loss-drugs-place/story> [<https://perma.cc/M3XZ-2ZS8>].

¹²⁴ @DrOz, X (Aug. 9, 2023, 12:37 PM), <https://x.com/DrOz/status/1689407885577441281> [<https://perma.cc/4D4M-PRM7>].

¹²⁵ The AGC News Team, *Anti-Obesity Drugs Will Not be Covered by Medicare and Medicaid in 2026*, AM. COLL. OF GASTROENTEROLOGY (Apr. 17, 2025), <https://gi.org/2025/04/17/anti-obesity-drugs-will-not-be-covered-by-medicare-and-medicare-in-2026> [<https://perma.cc/P4NK-EZU6>].

¹²⁶ *Id.*

¹²⁷ Alex Montero, Grace Sparks, Marley Presiado, & 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->

national consensus on the importance of ensuring access to these treatments.¹²⁸

Expanding Medicare Part D to include coverage of obesity treatments, including GLP-1s when prescribed for weight management, would yield significant health and economic benefits for Americans.¹²⁹ Not only would coverage reduce out-of-pocket costs for beneficiaries by up to 95%, but it would also yield substantial long-term cost savings for the Medicare program as well.¹³⁰ Coverage could generate approximately \$175 billion in cost offsets to Medicare over the first ten years, with potential savings increasing to \$700 billion over thirty years.¹³¹ These savings stem from reductions in obesity-related conditions, including diabetes, hypertension, and heart disease.¹³² Additionally, the Congressional Budget Office (“CBO”) estimated that providing the coverage for GLP-1s would only cost Medicare an additional \$35 billion from 2026 to 2034, suggesting that long-term health benefits would significantly outweigh initial expenditures.¹³³

The Inflation Reduction Act of 2022 marked a historic shift in U.S. pharmaceutical policy by, for the first time, empowering Medicare to directly negotiate the prices of certain high-cost prescription medications.¹³⁴ Under this legislation, HHS can identify select medications that have been on the market for several years without generic or biosimilar competition and negotiate lower prices on behalf of Medicare beneficiaries.¹³⁵ In January

costs/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs [https://perma.cc/RE44-B5RN].

¹²⁸ Montero, Sparks, Presiado, & Hamel, *supra* note 127.

¹²⁹ Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, 89 Fed Reg. at 99340; *see also* Hernandez, Wright, Guo & Shrank, *supra* note 18, at 307.

¹³⁰ U.S. Dep’t of Health & Human Servs., *supra* note 118.

¹³¹ USC Schaeffer Ctr., *Schaeffer Medicare Coverage of Weight Loss Drugs Could Significantly Reduce Costs*, USC LEONARD D. SCHAEFFER INSTITUTE FOR PUBLIC POLICY & GOV’T SERV. (Apr. 18, 2023), <https://schaeffer.usc.edu/research/medicare-coverage-of-weight-loss-drugs-could-significantly-reduce-costs> [https://perma.cc/4ZJA-MY92]. The U.S. healthcare system is largely reactionary, prioritizing treatment of existing disease rather than prevention, which perpetuates cycles of high-cost care. Coverage decisions, reimbursement structures, and provider incentives emphasize managing complications as they occur, rather than investing in upstream interventions that could reduce disease incidence. The reactive model contributes to long-term inefficiencies and escalating costs for Medicare and the broader healthcare system.

¹³² USC Schaeffer Center, *supra* note 131.

¹³³ *How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect the Federal Budget?*, CONG. BUDGET OFF. (Oct. 2024), <https://www.cbo.gov/publication/60816> [https://perma.cc/ZQ5L-JD4W].

¹³⁴ Juliette Cubanski, *FAQs About the Inflation Reduction Act’s Medicare Drug Price Negotiation Program*, KFF (Jan. 23, 2025), <https://www.kff.org/medicare/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program> [https://perma.cc/TJN3-4ZGV].

¹³⁵ *Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability*, CMS NEWSROOM (Aug. 15, 2024), <https://www.cms.gov/newsroom/fact-sheets/medicare-drug-price->

2024, the Biden administration added semaglutide-based GLP-1 medications¹³⁶ to the list of medications for price negotiations.¹³⁷

In April 2025, the Trump administration issued an executive order titled *Lowering Drug Prices By Once Again Putting Americans First*, aimed at modifying the Medicare drug price negotiation program established under the Inflation Reduction Act.¹³⁸ The order directs HHS to enhance transparency in the negotiation process, prioritize high-cost medications, and minimize any adverse effects on pharmaceutical innovation.¹³⁹ Additionally, the administration has renewed interest in implementing international reference pricing, which would tie Medicare drug payments to prices in other developed countries.¹⁴⁰ While these measures are intended to reduce drug costs, they may discourage pharmaceutical innovation and limit access to new therapies.¹⁴¹ The administration's actions reflect a complex balance

negotiation-program-negotiated-prices-initial-price-applicability-year-2026 [https://perma.cc/Y5YU-6AJ4].

¹³⁶ The GLP-1 medications included in the price negotiations by the Biden administration in January 2024 were Ozempic (semaglutide), Wegovy (semaglutide), and Rybelsus (semaglutide).

¹³⁷ *HHS Announces 15 Additional Drugs Selected for Medicare Drug Price Negotiations in Continued Effort to Lower Prescription Drug Costs for Seniors*, CMS NEWSROOM (Jan. 17, 2025), <https://www.cms.gov/newsroom/press-releases/hhs-announces-15-additional-drugs-selected-medicare-drug-price-negotiations-continued-effort-lower> [https://perma.cc/2A5N-GEZ9].

¹³⁸ Exec. Order No. 14273, 90 Fed. Reg. 16441 (Apr. 15, 2025).

¹³⁹ *Id.*

¹⁴⁰ In the United Kingdom, drug prices, including those for GLP-1 receptor agonists, are significantly lower due to centralized price negotiations conducted by the National Health Service (“NHS”) in collaboration with the National Institute for Health and Care Excellence (“NICE”). NICE evaluates the cost-effectiveness of medications based on health outcomes and determines whether they should be made available through the NHS. Pharmaceutical companies must agree to these prices to have their drugs included in the NHS formulary. This system allows the UK to negotiate much lower prices than the U.S., where there is no system for centralized and universal negotiation for all citizens and all medications. For example, Ozempic is estimated to cost the NHS less than half of what it costs U.S. consumers out of pocket. See Sarah McKeown, *Striving for Affordable Medicine: Lessons in Price Negotiation Learned from the United Kingdom*, 30 J. MANAGED CARE. & SPECIALTY PHARM. 259 (2024).

¹⁴¹ Pharmaceutical company sources warn that international reference pricing policies are a “existential threat to the industry and U.S. biosciences innovation.” Patrick Wingrove, *Trump Looking at Cutting US Drug Prices to International Levels, Sources Say*, REUTERS (Apr. 22, 2025), <https://www.reuters.com/business/healthcare-pharmaceuticals/trump-looking-cutting-us-drug-prices-international-levels-sources-say-2025-04-22> [https://perma.cc/DD2P-X8ZZ]. President Trump has announced plans to impose significant tariffs on pharmaceutical imports, potentially reaching up to 200%. Experts warn that such tariffs could substantially increase the cost of medications, including GLP-1s, exacerbating access disparities and financial burdens for patients. See Elsa Ohlen, *Trump Sets Pharma Tariffs Deadline. The Fallout for Lilly, Pfizer, Other Drugmakers*, BARRONS (May 6, 2025), <https://www.barrons.com/articles/trump-pharma-tariffs-eli-lilly-pfizer-18c67056> [https://perma.cc/232C-KRAS]; see also Nathaniel Meyersohn, *Trump Wants to Slash Drug Prices. His Plan Could Backfire*, CNN (Aug. 2, 2025), <https://www.cnn.com/2025/08/02/business/drug-prices-trump-us-manufacturing> [https://perma.cc/55WY-EN9S]; Aaron S. Kesselheim & Jerry Avorn, *Trump's Ongoing Tariff Chaos Will Make Medications Less Affordable and Harder to Find*, HEALTH AFFAIRS FOREFRONT (July 2, 2025), <https://www.healthaffairs.org/content/forefront/trump-s-ongoing-tariff-chaos-make-medications-less-affordable-and-harder-find> [https://perma.cc/C85F-ZDLC]; Berkeley Lovelace Jr., *How Will*

between lowering drug prices, maintaining incentives for drug development, and preserving favorable relationships with pharmaceutical manufacturers whose support is politically influential.¹⁴²

On November 5, 2025, the Trump administration announced a set of agreements with Eli Lilly and Company and Novo Nordisk to significantly reduce the cost of GLP-1 medications for individuals enrolled in Medicare and Medicaid.¹⁴³ Under the deal, the manufacturers agreed to offer GLP-1 medications to federal programs at prices that would permit Medicare beneficiaries to pay approximately \$50 per month in out-of-pocket costs.¹⁴⁴ On November 25, 2025, the next round of Medicare price negotiations under the Inflation Reduction Act was announced.¹⁴⁵ The negotiated price for semaglutide-containing products was “\$276.78 a month for commonly used doses of Ozempic and Rybelsus, and \$385.63 a month for the highest dose of Wegovy.” Perhaps not coincidentally, the IRA-negotiated Medicare prices are higher than the prices separately negotiated through President Trump’s new drug plan, TrumpRx, which boasts a Medicare price of \$245.00 a month for both semaglutide- and tirzepatide-based GLP-1s.¹⁴⁶

Trump’s E.U. Tariffs Affect Drug Prices?, NBC NEWS (July 29, 2025), <https://www.nbcnews.com/health/health-news/trump-eu-tariffs-drug-prices-ozempic-botox-wegovy-prescriptions-rcna221746> [<https://perma.cc/6ZU8-UKCS>]. While earlier reports suggested that Trump was considering benchmarking U.S. drug prices to international rates, the administration has since shifted its focus toward using tariffs as a lever to encourage domestic manufacturing and reduce reliance on foreign pharmaceutical supply chains. *Id.*

¹⁴² The pharmaceutical industry wields substantial influence over U.S. government policy through extensive lobbying, campaign contributions, and strategic partnerships. Between 1999 and 2018, the sector invested \$4.7 billion in federal lobbying, which is more than any other U.S. industry, and contributed an additional \$414 million to federal campaigns and \$877 million to state level political activities. See Olivier J. Wouters, *Lobbying Expenditures and Campaign Contributions by the Pharmaceutical and Health Product Industry in the United States, 1999-2018*, 180 JAMA INTERNAL MED. 688, 688 (2020).

¹⁴³ *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, THE WHITE HOUSE (Nov. 6, 2025), <https://www.whitehouse.gov/fact-sheets/2025/11/fact-sheet-president-donald-j-trump-announces-major-developments-in-bringing-most-favored-nation-pricing-to-american-patients> [<https://perma.cc/5X6P-KT4U>]; Rose McNulty, *Trump Announces Deals With Lilly, Novo to Cut Weight Loss Drug Prices*, AJMC (Nov. 6, 2025), <https://www.ajmc.com/view/trump-announces-deals-with-eli-lilly-novo-nordisk-for-lower-weight-loss-drug-prices> [<https://perma.cc/HJQ6-CVT7>].

¹⁴⁴ *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, *supra* note 143.

¹⁴⁵ See John Wilkerson & Elaine Chen, *Trump Administration Quietly Unveils New Round of Medicare-Negotiated Drug Prices*, STAT NEWS (Nov. 25, 2025), <https://www.statnews.com/2025/11/25/trump-administration-unveils-new-medicare-negotiated-drug-prices> [<https://perma.cc/92KQ-MLZT>].

¹⁴⁶ *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, *supra* note 143. One health policy scholar anticipates that, since TrumpRx-negotiated prices are non-binding, the companies will back out of the TrumpRx-negotiated prices in favor of the higher IRA Medicare-negotiated prices. Wilkerson & Chen, *supra* note 145.

To further ensure that GLP-1s become more affordable, policymakers should prioritize their inclusion in future rounds of Medicare price negotiations under the Inflation Reduction Act.¹⁴⁷ Additionally, lawmakers should resist efforts to weaken the negotiation program and instead expand its authority to lower costs for a broader range of medications more quickly, especially those with significant public health benefits like GLP-1s.

2. Public Insurance—Medicaid Coverage

Unlike Medicare, Medicaid is jointly administered by the federal and state governments, providing health coverage to low-income individuals and families.¹⁴⁸ This shared governance model results in varying state coverage of GLP-1 medications for obesity treatment.¹⁴⁹ While some states, including New York and California, have expanded coverage to include GLP-1s for weight management, other states continue to exclude them on the grounds that they are cosmetic or non-essential.¹⁵⁰

This patchwork approach to GLP-1 coverage undermines the effectiveness of Medicaid as a national safety net and further exacerbates health care disparities.¹⁵¹ Many Medicaid enrollees are at heightened risk

¹⁴⁷ The One Big Beautiful Bill Act of 2025 (signed into law in July 2025) could delay price negotiation for drugs that treat rare diseases, though it is not expected to affect Eli Lilly’s GLP-1 drug tirzepatide (marketed for weight loss as Zepbound). See Rebecca Robbins, *Drugmakers Notch a \$5 Billion Win in Republicans’ Policy Bill*, N.Y. TIMES (July 3, 2025), <https://www.nytimes.com/2025/07/03/health/trump-bill-medicare-drug-prices.html> [<https://perma.cc/MY5W-PUGZ>].

¹⁴⁸ Medicaid is jointly administered by the federal and state governments to balance national standards with state-specific needs. Established under the Social Security Amendments of 1965, this structure allows for federal oversight and funding through the Federal Medical Assistance Percentage (“FMAP”), which varies based on state income levels, while granting states the flexibility to design and implement programs tailored to their populations. This dual approach aims to ensure a consistent baseline of care across the nation while accommodating regional differences in healthcare delivery. See NAMA Staff, *Why Did They Do It That Way? Medicaid Financing*, NAT’L ASSOC. OF MEDICAID DIRS. (Apr. 28, 2025), https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-medicare-financing/?utm_ [<https://perma.cc/57KA-FACX>]; see also *What’s the Difference Between Medicare and Medicaid?*, U.S. DEP’T OF HEALTH AND HUMAN SERV. (Dec. 8, 2022), <https://www.hhs.gov/answers/medicare-and-medicare/what-is-the-difference-between-medicare-medicare/index.html> [<https://perma.cc/U9F4-JNRD>].

¹⁴⁹ As of August 2024, thirteen state Medicaid programs cover GLP-1 medications for obesity treatment, with twelve providing coverage under fee-for-service arrangements. These states often apply utilization controls such as prior authorization and body mass index requirements. Notably, all states are required to cover GLP-1s for treating type 2 diabetes. See Elizabeth Williams, Robin Rudowitz, & Clea Bell, *Medicaid Coverage of and Spending on GLP-1s*, KFF (Nov. 4, 2024), <https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s> [<https://perma.cc/H5KL-Q7R3>].

¹⁵⁰ *Id.*

¹⁵¹ Medicaid expansion decisions are correlated with state-level racial attitudes—lower racial sympathy and higher racial resentment are associated with stronger resistance to expansion. See Jamila D. Michener, *Politics, Pandemic, and Racial Justice Through the Lens of Medicaid*, 111 AM. J. PUB. HEALTH 643, 644 (2021).

for obesity-related illness due to systemic factors like food insecurity, housing instability, and reduced access to preventive care.¹⁵² Yet states that refuse to cover GLP-1s are denying individuals access to evidence-based treatment, often relying instead on over-the-counter products or unsupervised dieting.¹⁵³ The 2024 Biden-era rule would have created a uniform mandate requiring all state Medicaid programs to cover FDA-approved medications for obesity.¹⁵⁴ However, along with its Medicare provisions, the rule was shelved by the Trump administration.¹⁵⁵

Yet, as part of the Trump administration's November 2025 agreement with Eli Lilly and Novo Nordisk, manufacturers also agreed to provide semaglutide and tirzepatide based GLP-1s to state Medicaid programs at the same reduced net prices, enabling states to offer the medications with minimal or no cost-sharing for eligible enrollees.¹⁵⁶ The agreements incorporate "most-favored nation" pricing provisions, requiring that Medicaid receive pricing comparable to the lowest available rate internationally, and commit manufacturers to increased domestic production intended to stabilize nationwide supply.¹⁵⁷ Although the Trump administration rejected the Biden-era proposal that would have mandated Medicaid coverage of GLP-1s, the November 2025 agreements nonetheless represent an important expansion of practical access by lowering state costs and reducing administrative barriers to coverage, even as state-to-state variability in Medicaid policy remains a concern.¹⁵⁸ The anticipated disenrollment and program cuts stemming from the Medicaid provisions of

¹⁵² Medicaid enrollees with insulin-dependent diabetes; 44% were food insecure, over six times higher than their counterparts with private insurance. See James Kirby, Didem Bernard, & Lan Liang, *The Prevalence of Food Insecurity Is Highest Among Americans for Whom Diet Is Most Critical to Health*, 44 *DIABETES CARE* 131, 132 (2021); Angela Odoms-Young, Alison G M Brown, Tanya Agurs-Collins, & Karen Glanz, *Food Insecurity, Neighborhood Food Environment, and Health Disparities: State of the Science, Research Gaps, and Opportunities*, 119 *AM. J. CLINICAL NUTRITION* 850, 850-61 (2025).

¹⁵³ The use of over-the-counter laxatives, termed "budget Ozempic," to stimulate weight loss is on the rise in the United States. Laxative misuse is an extreme weight loss behavior and can be a sign of serious eating disorder. See Katie Kindelan, *Doctor Shares Warning on Dangerous 'Budget Ozempic' Weight Loss Trend*, ABC NEWS (Sep. 15, 2023), https://abcnews.go.com/GMA/Wellness/doctor-shares-warning-dangerous-budget-ozempic-weight-loss/story?id=103219998&utm_source=chatgpt.com [<https://perma.cc/ENG8-Q2J4>].

¹⁵⁴ *Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F)*, CMS NEWSROOM (Apr. 4, 2025), <https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-and-technical-changes-medicare-advantage-program-medicare-prescription-final> [<https://perma.cc/9TBG-DPTA>] (to be codified at 42 C.F.R. pts. 417, 422, 423, 460).

¹⁵⁵ AGC, *supra* note 125.

¹⁵⁶ *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, *supra* note 143; McNulty, *supra* note 143.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

the One Big Beautiful Bill Act of 2025 are likely to undermine the benefits of these negotiated prices to Medicaid enrollees.¹⁵⁹

3. Private Insurance

While Medicare has long excluded coverage of obesity treatments, private insurance coverage has also been inconsistent. Currently, a growing number of private insurers cover GLP-1s and other obesity treatments, particularly for individuals with comorbid conditions such as diabetes. In 2024, weight-loss medications were covered by 64% of employers with more than 20,000 employees, up from 56% in 2023.¹⁶⁰

However, many private insurance plans still exclude GLP-1s or impose significant cost-sharing requirements, effectively restricting access for lower-income Americans.¹⁶¹ Nearly 42% of working-age adults with private insurance could be eligible for a GLP-1 prescriptions,¹⁶² but because of the high cost this would have on private insurers, many remain hesitant to cover GLP-1s.¹⁶³

To ensure equitable access to effective treatments for obesity, including GLP-1s, policymakers could consider advocating for mandated coverage of these treatments by private insurers as part of essential health benefits under the Affordable Care Act (“ACA”).¹⁶⁴ The U.S. Preventative Services Task

¹⁵⁹ Kelly Hooper, *Why Medicaid patients can't celebrate Trump's deal on weight-loss drugs yet*, POLITICOPRO (Nov. 7, 2025), <https://subscriber.politicopro.com/article/2025/11/why-medicaid-patients-cant-celebrate-trumps-deal-on-weight-loss-drugs-yet-00641148> [<https://perma.cc/Z42S-G2QB>].

¹⁶⁰ *More Employers Cover Weight-Loss Drugs: Survey*, US-RX CARE (Jan. 1, 2025), <https://usrxcare.com/more-employers-cover-weight-loss-drugs-survey> [<https://perma.cc/SKG7-9TX4>].

¹⁶¹ Justin Lo & Cynthia Cox, *Insurer Strategies to Control Costs Associated with Weight Loss Drugs*, HEALTH SYS. TRACKER (June 12, 2024), <https://www.healthsystemtracker.org/brief/insurer-strategies-to-control-costs-associated-with-weight-loss-drugs> [<https://perma.cc/V54C-ZTWC>].

¹⁶² Matt McGough, Justin Lo, Delaney Tevis, Matthew Rae & Cynthia Cox, *How Many Adults with Private Health Insurance Could Use GLP-1 Drugs*, PETERSON-KFF HEALTH SYS. TRACKER (Sep. 5, 2024), <https://www.healthsystemtracker.org/brief/how-many-adults-with-private-health-insurance-could-use-glp-1-drugs> [<https://perma.cc/9LFG-K8SA>].

¹⁶³ Thirty-six percent of employers provide coverage for GLP-1s to treat diabetes and weight loss. See Kathryn Mayer, *How Much of Employers' Annual Claims Do GLP-1 Drugs Account For?*, SHRM (June 6, 2025), <https://www.shrm.org/topics-tools/news/benefits-compensation/glp1-drugs-employers-annual-claims-may-2025> [<https://perma.cc/U89M-KNCQ>]. Coverage of GLP-1s could cost companies \$650 per individual, per month. But patients who use GLP-1s can help employers lower medical costs in the long term, as patients taking GLP-1s experience a 44% reduction in major cardiovascular issues, less osteoporosis, fewer incidents of pneumonia, and various other decreased health risks. See *Can GLP-1s Help Shrink Employers' Medical Costs?*, THE CURRENCY (Mar. 29, 2025), <https://www.empower.com/the-currency/life/can-glp-1s-help-shrink-employers-medical-costs-news> [<https://perma.cc/AA96-8SE8>].

¹⁶⁴ Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL. POL'Y & L. 441, 442-7 (2014). In June 2025, the preventive care mandate was upheld as constitutional by the U.S. Supreme Court. *Kennedy v. Braidwood Mgmt, Inc.*, 143 S. Ct. 2404 (2025).

Force (“USPSTF”) is an independent, evidence-based panel that makes recommendations on clinical preventative services.¹⁶⁵ Under the Patient Protection and Affordable Care Act of 2010 (“ACA”), insurers must fully cover services rated “A” or “B” by the USPSTF without cost-sharing.¹⁶⁶ If the USPSTF were to determine that GLP-1s serve a preventive purpose, they would be recognized as essential health benefits and covered under the ACA.¹⁶⁷

Policymakers and DHHS ought to be prioritizing continued funding for USPSTF and advocating for support of the inclusion of GLP-1s as essential health benefits. In 2025, the U.S. Supreme Court issued its decision in *Kennedy v. Braidwood Management, Inc.*, upholding the ACA mandate that insurers must cover preventive services recommended by the USPSTF without cost-sharing.¹⁶⁸ The Court also rejected the argument that USPSTF members are unconstitutionally appointed, affirming that their recommendations remain binding because the Secretary of HHS retains authority to remove them.¹⁶⁹ While this decision preserved access to key preventive services like PrEP and cancer screenings for over a hundred million Americans, the ruling also introduced significant ambiguity about the USPSTF’s independence under Kennedy’s leadership.¹⁷⁰

The Court’s affirmation of removal authority means that political appointees could reshape the Task Force.¹⁷¹ This concern is not hypothetical. In 2025, HHS Secretary Robert F. Kennedy Jr. unilaterally dismissed the Centers for Disease Control and Prevention (“CDC”)’s Advisory Committee on Immunization Practices (“ACIP”) on ideological

¹⁶⁵ Home, USPSTF, <https://www.uspreventiveservicestaskforce.org/uspstf/home> [<https://perma.cc/GJ36-BQLF>].

¹⁶⁶ *Patient Protection and Affordable Care Act*, 42 U.S.C. § 18001; see also Bagley & Levy, *supra* note 164, at 443-44.

¹⁶⁷ Richard Hughes IV & William Walters, *New Anti-Obesity Medications Should Be Considered Preventive Health Care*, HEALTH AFFAIRS FOREFRONT (July 5, 2024), <https://www.healthaffairs.org/content/forefront/new-anti-obesity-medications-should-considered-preventive-health-care> [<https://perma.cc/26FU-KNN3>].

¹⁶⁸ The underlying dispute in *Kennedy* involved challenges brought by individuals and employers who objected, on religious and nondelegation grounds, to the ACA’s requirement that insurers cover certain preventative services, including preexposure prophylaxis (“PrEP”) drugs used to prevent HIV. The Fifth Circuit held that the USPSTF’s authority under the ACA violated the Appointments Clause because its members were not appointed by the President or confirmed by the Senate, raising constitutional concerns about the validity of its coverage recommendations. See *Kennedy*, 143 S. Ct. at 2404.

¹⁶⁹ *Id.*

¹⁷⁰ Laurie Sobel, Lindsey Dawson, & Alina Salganicoff, *Kennedy v. Braidwood: The Supreme Court Upheld ACA Preventive Services but that’s Not the End of the Story*, KFF (June 27, 2025), <https://www.kff.org/affordable-care-act/kennedy-v-braidwood-the-supreme-court-upheld-aca-preventive-services-but-thats-not-the-end-of-the-story> [<https://perma.cc/7CGK-5E6C>].

¹⁷¹ *Id.*

grounds.¹⁷² Critics of the administration warn that a similar purge of the USPSTF is plausible after *Kennedy v. Braidwood*, which would allow an administration to populate the Task Force with members who oppose certain pharmaceutical interventions such as vaccines.¹⁷³ Though GLP-1 medications do not appear to be a current political target, this development threatens to destabilize the preventive services framework of the ACA and makes the future of insurance coverage for anti-obesity medications particularly uncertain, even in the face of robust clinical evidence supporting their use.¹⁷⁴

4. People Without Health Insurance

For the growing number of uninsured Americans,¹⁷⁵ lowering the cost of GLP-1s and other obesity treatments will likely require incentivizing pharmaceutical companies to reduce prices through subsidies or tax incentives.¹⁷⁶ Further, current patent protections prevent the production and sale of generic versions of GLP-1 medications in the United States until at least 2030, unless the medications are deemed to be in “shortage,” which keeps prices high and supply limited.¹⁷⁷

In March and August 2022, the U.S. Food and Drug Administration (FDA) added GLP-1-injections¹⁷⁸ to the drug shortage list, allowing for

¹⁷² Sarah Owerhohle & Meg Tirrell, *RFK Jr. Removes All CDC Vaccine Advisers*, CNN (June 9, 2025), <https://www.cnn.com/2025/06/09/health/rfk-cdc-vaccine-advisers-removed> [<https://perma.cc/Q9VA-2B54>].

¹⁷³ Sobel, Dawson, & Salganicoff, *supra* note 170.

¹⁷⁴ Thomsen, Mailhac, Löhde & Pottegård, *supra* note 106.

¹⁷⁵ The Congressional Budget Office estimates that the One Big Beautiful Bill Act of 2025 (signed into law in July 2025) will remove at least 10.5 million people from Medicaid and associated children’s health insurance programs in the next decade. See Mia Ives-Rublee & Kim Musheno, *The Truth About the One Big Beautiful Bill Act’s Cuts to Medicaid and Medicare*, CTR. AMER. PROGRESS (July 3, 2025), <https://www.americanprogress.org/article/the-truth-about-the-one-big-beautiful-bill-acts-cuts-to-medicaid-and-medicare> [<https://perma.cc/KS29-L94W>].

¹⁷⁶ Kathryn Nagel, Reshma Ramachandran & Kasia Lipska, *Lessons from Insulin: Policy Prescriptions for Affordable Diabetes and Obesity Medications*, 47 *DIABETES CARE* 1246, 1250 (July 2024).

¹⁷⁷ The U.S. patent for the semaglutide compound in the popular GLP-1 medication ‘Ozempic’ is expected to expire in 2031. Other patents for GLP-1 compounds, such as ‘Wegovy,’ will not expire until 2038. See Rasha Alhiary et al., *Patents and Regulatory Exclusivities on GLP-1 Receptor Agonists*, 330 *JAMA* 650 (Aug. 15, 2023); Karen Berger, *Are There Generic GLP-1 Drugs?*, *THE CHECKUP* (Mar. 14, 2025), <https://www.singlecare.com/blog/generic-glp-1> [<https://perma.cc/2CHA-V5SQ>].

¹⁷⁸ Letter from Jacqueline Corrigan-Curay, Acting Dir., of Ctr. For Drug Evaluation and Rsch. to Robert Fischer, Dir., Reg. Aff’s, Novo Nordisk Inc., Declaratory Order: Resolution of Shortages of Semaglutide Injection Products (Ozempic and Wegovy), U.S. FOOD AND DRUG ADMIN. (Feb. 21, 2025), <https://www.fda.gov/media/185526/download> [<https://perma.cc/N2VP-5R4W>] (“Ozempic was approved by FDA in December 2017 (NDA 209637) and added to FDA’s drug shortage list on August 23, 2022 . . . Wegovy was approved by FDA in June 2021 (NDA 215256) and added to FDA’s drug shortage list on March 31, 2022.”).

compounding pharmacies to create similar medications and sell them at a lower price.¹⁷⁹ As of early 2025, the prolonged shortage of GLP-1s officially ended.¹⁸⁰ In December 2024, the FDA issued a Declaratory Order affirming that the supply of these medications now meets or exceeds both current and projected demand.¹⁸¹ This development follows major capacity expansions by Novo Nordisk and Eli Lilly, who have invested billions to scale up production and distribution of their GLP-1 medications.¹⁸²

Consequently, these medications have been removed from the FDA's drug shortage list, signaling a return to stable availability, albeit at premium prices.¹⁸³ During the shortage, compounding pharmacies such as Hims & Hers filled the shortage gap by offering compounded, "off-brand" versions of these medications.¹⁸⁴ With the official resolution of the shortage, however, these compounding pharmacies are required to halt production unless a specific clinical necessity is established.¹⁸⁵

For companies like Hims & Hers, the FDA's action marks a significant regulatory and commercial shift. The companies announced they would discontinue their compounded GLP-1 offerings and advise customers to consider alternatives, such as the company's expanding portfolio of oral

¹⁷⁹ *Compounding When Drugs Are on FDA's Drug Shortages List*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/human-drug-compounding/compounding-when-drugs-are-fdas-drug-shortages-list> [<https://perma.cc/F6UH-ZPQJ>].

¹⁸⁰ Letter from Patrizia Cavazzoni, Dir. of Ctr. for Drug Evaluation and Rsch. to Patty Donnelly, Senior V.P., Glob. Quality, Eli Lilly Co., Declaratory Order: Resolution of Shortages of Tirzepatide Injection Products (Mounjaro and Zepbound), U.S. FOOD & DRUG ADMIN. (Dec. 19, 2024), <https://www.fda.gov/media/184606/download> [<https://perma.cc/ZBY6-NE8K>].

¹⁸¹ *Compounding When Drugs Are on FDA's Drug Shortages List*, *supra* note 179; Letter from Patrizia Cavazzoni, *supra* note 180.

¹⁸² Annalee Armstrong, *Lilly and Novo Spend Billions to Expand Obesity Pipelines Beyond GLP-1s*, BIOSPACE (Sep. 25, 2024), <https://www.biospace.com/business/lilly-and-novo-spend-billions-to-expand-obesity-pipelines-beyond-glp-1s> [<https://perma.cc/8URB-5HM8>].

¹⁸³ Letter from Patrizia Cavazzoni *supra* note 180.

¹⁸⁴ Sneha S K, *Hims & Hers Warns It May Stop Selling Compounded Weight-Loss Drugs*, REUTERS (Feb. 24, 2025), <https://www.reuters.com/business/healthcare-pharmaceuticals/hims-hers-warns-its-supply-compounded-weight-loss-drugs-could-be-constrained-2025-02-24> [<https://perma.cc/3BSH-7CSN>]; HIMS, https://www.hims.com/lp/wl-start-hims-glp1-injections?utm_source=google&utm_medium=cpc&utm_campaign=21310658838&utm_term=166443638127--kwd-892331878516&utm_content=768834435482&mt=e&utm_platform=c&utm_product=b_demeter&gad_source=1&gad_campaignid=21310658 [<https://perma.cc/QN79-HC5S>]; HERS, <https://www.forhers.com> [<https://perma.cc/4CPP-9W7K>].

¹⁸⁵ S K, *supra* note 184.

weight-loss medications or other injectable GLP-1s like liraglutide¹⁸⁶, which remain permissible under existing regulations.¹⁸⁷

While branded GLP-1 manufacturers, namely Eli Lilly and Novo Nordisk, continue to dominate and demand remains strong, the stricter regulatory environment presents challenges, particularly for affordability and accessibility. The abrupt cessation of compounded GLP-1s has had serious repercussions for uninsured individuals who previously relied on these lower-cost options.¹⁸⁸ Initially priced significantly below branded alternatives, compounded semaglutide often ranged from \$250 to \$600 per month, compared to the \$900 to \$1,400 price tag for brand-name versions like Ozempic and Wegovy.¹⁸⁹ Eli Lilly and Novo Nordisk now offer direct-to-consumer purchase programs for uninsured individuals, and despite recent

¹⁸⁶ Liraglutide, also known as Novo Nordisk's 'Victoza,' is a first-generation GLP-1 that requires a once-daily injection. Demand for Liraglutide has declined with the availability of once-weekly injections and tablet-based treatments. Victoza's patent protection expired in 2023, allowing pharmaceutical manufacturers to launch generic versions of the liraglutide injection. Because liraglutide is no longer patent protected and is available as a generic, telehealth companies like Hims & Hers can incorporate it into their model without running into exclusivity barriers that still protect the newer generation of GLP-1s, like Wegovy and Zepbound. See Reuters, *Teva Launches Generic Version of Novo Nordisk's Diabetes Drug Victoza*, REUTERS (June 24, 2024), <https://www.reuters.com/business/healthcare-pharmaceuticals/teva-launches-generic-version-novo-nordisks-diabetes-drug-victoza-2024-06-24> [<https://perma.cc/LU5Z-TUQG>].

¹⁸⁷ *Weight Loss Treatment Medication Kits*, HERS, <https://www.forhers.com/weight-loss/oral-weight-loss-medication-kits> [<https://perma.cc/XV58-PLV5>]; *What to Expect With RYBELSUS (semaglutide) Tablets*, RYBELSUS, <https://www.rybelsus.com/taking-rybelsus/what-to-expect-with-rybelsus.html> [<https://perma.cc/HB8Z-9LKN>]. See also Eli Lilly and Co., *Lilly's Oral GLP-1, Orforglipron, Demonstrated Statistically Significant Efficacy Results*, <https://investor.lilly.com/news-releases/news-release-details/lillys-oral-glp-1-orphorglipron-demonstrated-statistically> [<https://perma.cc/BR34-XLDL>]. Oral treatments refer to weight-loss medications that are taken by mouth, as opposed to injectable therapies. *Id.* These include existing medications such as phentermine-topiramate (Qsymia) and newer drugs currently undergoing FDA review. Notably, Novo Nordisk and Eli Lilly are developing oral formulations of GLP-1 receptor agonists, such as oral semaglutide (Rybelsus) and investigational candidates like orforglipron, which early clinical trials suggest may offer comparable efficacy to injectables. *Id.* These developments could significantly expand access and adherence, especially for patients averse to injections. *Id.*

¹⁸⁸ While compounded GLP-1 medications provided a more affordable alternative during the national shortage, the FDA has repeatedly emphasized concerns about their safety and quality. Unlike FDA-approved drugs, compounded medications are not subject to the same rigorous premarket review, testing, or manufacturing standards. In 2023, the FDA issued warnings noting that some compounded semaglutide products may contain incorrect salt forms or inconsistent dosages, potentially posing health risks to patients. Prior to ending the shortage, the agency stated that compounded versions should only be used when FDA-approved options are unavailable or a patient has a specific medical need that cannot be met by commercial products. See *FDA's Concerns with Unapproved GLP-1 Drugs Used for Weight Loss*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fdas-concerns-unapproved-glp-1-drugs-used-weight-loss> (last updated Sep. 25, 2025) [<https://perma.cc/5G8D-VS6J>].

¹⁸⁹ Sara Shikhman, *Ozempic: \$1,400/Month—Compounded Version: \$250/Month*, INC. (Feb. 19, 2025), <https://www.inc.com/sarashikman/ozempic-1400-month-compounded-version-250-month/91150136> [<https://perma.cc/UJ37-LCNH>].

price negotiations with the Trump administration, these channels remain almost entirely controlled by the manufacturers themselves, allowing significant discretion in pricing.¹⁹⁰ In effect, manufacturers currently have disproportionate gatekeeping power over who receives GLP-1s and at what cost, further highlighting the need for policy solutions that reduce patient reliance on industry goodwill to access treatment.¹⁹¹

For uninsured patients, this shift has created an untenable dilemma: absorb the steep out-of-pocket costs of branded medications or forgo effective treatment. Many low-income individuals, regardless of insurance coverage, turned to compounded versions as their only viable means of managing obesity or type 2 diabetes.¹⁹² Now, faced with dramatically higher costs, these patients may be forced to rely on less effective alternatives or go without treatment.¹⁹³

Moreover, structural features of the pharmaceutical patent system threaten to prolong access barriers to GLP-1s for uninsured Americans, even after market exclusivity ends. While the primary patents for GLP-1 medications may expire around 2030, manufacturers often file dozens of overlapping patents covering delivery devices, dosing regimens, or manufacturing techniques.¹⁹⁴ This tactic, known as “patent thickening,” effectively extends exclusivity for years past the expiration of the drug’s active ingredient patent.¹⁹⁵

¹⁹⁰ Michelle Onder & Michael S. Sinha, *Pharmaceutical-Telehealth Confederacies*, 12 EMORY CORP. GOVERNANCE & ACCOUNTABILITY REV. ____ (forthcoming 2025) (on file with author); see also *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, *supra* note 143.

¹⁹¹ One in two Americans assume GLP-1s are too expensive and do not bring up the treatment option with their doctors. See Jean Lee, *The Silent Struggle: Why Patients Hesitate to Ask About GLP-1 Medications*, THE INTAKE (July 23, 2025), <https://www.tebra.com/theintake/healthcare-reports/glp1-patient-hesitation> [<https://perma.cc/KKB4-ZQ5E>].

¹⁹² See Meg Tirrell, *The End of a Shortage of Popular Weight-Loss Drugs May Mean Many People Lose Access to Them*, CNN HEALTH (Oct. 9, 2024), <https://www.cnn.com/2024/10/09/health/tirzepatide-compounded-weight-loss-drugs/index.html> [<https://perma.cc/N96V-B4Y2>] (“Some estimates put prescriptions for compounded versions [of GLP-1s] as high as 20% of all prescriptions for the drugs.”); see also Shweta Kumar, *Compounding Inequities Through Drug IP and Unfair Competition*, 102 WASH. U. L. REV. 371, 379-80 (2024).

¹⁹³ One in five GLP-1 users report microdosing, and one in three report rationing or skipping doses due to cost. Lee, *supra* note 191.

¹⁹⁴ Rasha Alhiary et al., *Delivery Device Patents on GLP-1 Receptor Agonists*, 331 JAMA 794, 795 (2024).

¹⁹⁵ Stefan Wagner, *Are ‘Patent Thickets’ Smothering Innovation?*, YALE INSIGHTS (Apr. 22, 2015), <https://insights.som.yale.edu/insights/are-patent-thickets-smothering-innovation> [<https://perma.cc/P5T8-PN4G>] (“A ‘patent thicket’ is defined as a dense web of overlapping intellectual property rights that a company must hack its way through in order to actually commercialize new technology.”); see also Michael A. Carrier & S. Sean Tu, *Why Pharmaceutical Patent Thickets are Unique*, 32 TEX. INTELL. PROP. L. J. 79, 82-3 (2023).

For GLP-1s, the injector pen delivery mechanism is a primary target for secondary delivery device patent filings.¹⁹⁶ These device patents create formidable hurdles: under current FDA guidelines, generic manufacturers must replicate both the drug and its delivery system before entering the market as a generic.¹⁹⁷ This delays competition and keeps prices high long after clinical exclusivity has ended.¹⁹⁸

Lawmakers must scrutinize the structural forces that keep GLP-1s and many other medications artificially expensive, particularly those at the intersection of current FDA regulatory frameworks and the U.S. patent system. Congress should consider reforms that curtail patent thicket and evergreening practices¹⁹⁹, such as increased U.S. Patent and Trademark Office (“USPTO”) scrutiny of “secondary patents”²⁰⁰ or the expansion of FDA approval pathways for generics and biosimilars when public health demand is high.²⁰¹ Additionally, the FDA, the USPTO, and other interested stakeholders should continue to assess the public health impact of delayed generic competition. Without such reforms, GLP-1s risk becoming emblematic of the broader failures of American health care: transformative innovation in medicines, but accessible only to the privileged few.

B. Integration of GLP-1s into Comprehensive Obesity Care

Integrating GLP-1 medications into a comprehensive obesity care model is essential for addressing obesity as a chronic condition rather than merely a weight-loss issue.²⁰² Policymakers should encourage health care providers to incorporate GLP-1s as one component of a patient-centered treatment strategy that includes behavioral therapy, nutritional counseling, and structured physical activity programs.²⁰³ Such strategies might also mitigate the disproportionate harms of obesity that arise from systemic

¹⁹⁶ Alhiary et al., *supra* note 194, at 651.

¹⁹⁷ *Id.* at 651; see also Michael S. Sinha, *Costly Gadgets: Barriers to Market Entry and Price Competition for Generic Drug-Device Combinations in the United States*, 23 MINN. J. L. SCI. TECH. 293, 314 (2022).

¹⁹⁸ Alhiary et al., *supra* note 194, at 651.

¹⁹⁹ See Ruth Feldman, *May Your Drug Price Be Evergreen*, 5 J. L. & BIOSCIENCES 590, 596 (2018) (“‘Evergreening’ can be defined as artificially extending the life of a patent or other exclusivity by obtaining additional protections to extend the monopoly period.”).

²⁰⁰ Michael S. Sinha, *Unpatenting Product Hops*, 15 U. C. IRVINE L. REV. 769, 798-99 (2025).

²⁰¹ Michael S. Sinha, *Public Health Product Hops*, 73 AM. U. L. REV. 395, 446 (2023) (“Shorter patent extensions, scaled on the basis of previous year sales, could be granted for follow-on products deemed ‘public health product hops.’”).

²⁰² John Moorman, *GLP-1 Medications and Weight Loss: Helping Patients Navigate Beyond the Trends*, WOLTERS KLUWER, <https://www.wolterskluwer.com/en/expert-insights/glp-1-medications-and-weight-loss-help-patients-navigate-beyond-trends> [<https://perma.cc/JGT5-SUKH>].

²⁰³ *The Four Pillars of Obesity Treatment*, *supra* note 102.

racism.²⁰⁴ By embedding these medications into a broader framework of obesity care, providers can ensure that patients receive well-rounded support tailored to their specific health needs.

Importantly, a holistic approach to obesity treatment recognizes that medication alone is not a complete solution. Integrating GLP-1s into existing obesity care frameworks would help patients achieve sustainable health improvements rather than focusing solely on short-term weight loss.²⁰⁵ This shift in perspective could also lead to better long-term health outcomes by addressing the underlying behavioral and metabolic components of obesity.²⁰⁶

Moreover, normalizing GLP-1s as part of an evidence-based obesity treatment plan can help reduce stigma associated with their use.²⁰⁷ Many individuals with obesity face societal and medical bias, often being told to simply eat less and move more rather than being offered comprehensive, science-backed treatment options.²⁰⁸ When GLP-1s are positioned within a broader care model, they become part of a legitimate medical strategy rather than being viewed as the “easy way out.”

To build on existing progress, policymakers should continue to work with medical organizations, insurers, and public health officials to develop obesity treatment protocols that integrate GLP-1s with other supportive services. Expanding access to comprehensive care will enable a more effective and equitable approach to obesity management, ultimately improving patient outcomes and reducing the long-term health burdens associated with untreated obesity.

C. Education of Health Care Providers about Weight Bias

Educating health care providers about weight bias is crucial for improving the quality of care for patients with obesity and decreasing weight stigma for patients.²⁰⁹ Weight bias among medical professionals can lead to poorer patient interactions, reduced quality of care, and negative health outcomes.²¹⁰ Many individuals with obesity report feeling dismissed or judged by their health care providers, which discourages them from seeking

²⁰⁴ Daniel G. Aaron & Fatima C. Stanford, *Is Obesity a Manifestation of Systemic Racism? A Ten-Point Strategy for Study and Intervention*, 290 J. INTERN. MED. 416, 418 (2021).

²⁰⁵ Simon Birk Kjær Jensen et al., *Healthy Weight Loss Maintenance with Exercise, GLP-1 Receptor Agonist, or Both Combined Followed by One Year Without Treatment: A Post-Treatment Analysis of a Randomised Placebo- Controlled Trial*, 69 CLINICAL MED. 1, 9-10 (2024).

²⁰⁶ Sarah Froom, Lee Johnston, Carrie Matteson & Diane Finegood, *Obesity, Complexity, and the Role of the Health System*, 2 CURR. OBESITY REPTS. 320, 323-24 (2013).

²⁰⁷ Heitman, *supra* note 9, at 6.

²⁰⁸ GINSBURG, DALEY, & SHEER, *supra* note 13, at 24.

²⁰⁹ *Id.*

²¹⁰ *Id.*

necessary medical care.²¹¹ By integrating anti-bias training into medical education and continuing education programs, providers can become more aware of their implicit biases and learn how to offer compassionate, evidence-based treatment.²¹²

Weight bias training should emphasize obesity's complex, multifactorial causes, moving beyond narratives that reduce weight to individual choice. Training should educate providers on the role of food environments; the prevalence of calorie dense, ultra-processed foods; socioeconomic barriers to healthy food and safe exercise; environmental exposure to endocrine-disrupting chemicals (including from plastics and drinking water);²¹³ genetic predispositions; and individual psychological factors, such as chronic stress. Further, training should emphasize how structural determinants of health, such as poverty, racial inequities, and insurance coverage gaps, affect obesity prevalence and health outcomes. By contextualizing obesity within these broader social and biological frameworks, providers can appreciate why lifestyle modification may be insufficient for patients. When providers approach obesity management with empathy for each patient and an understanding of alternative treatments, patients are more likely to adhere to treatment plans and feel supported in their health journeys.

Effective weight-bias education should be interactive, evidence-based, and skills-focused. In-person workshop trainings that integrate cognitive, affective, and psychomotor learning domains are more successful in reducing weight-biased attitudes and beliefs in health care providers compared to more passive learning approaches.²¹⁴ Asynchronous training modules—such as videos, podcasts, or computer-based programs—can also improve weight-biased attitudes.²¹⁵ Notably, asynchronous learning models are more successful when paired with interactive discussions or reinforced through repeated intervention sessions.²¹⁶

Policymakers and medical institutions should prioritize integrating in-person, interactive weight-bias education into health care training at all

²¹¹ Westbury, Oyebode, Rens & Barber, *supra* note 1 at 10. This is part of the reason why the direct-to-consumer programs have such broad appeal—the short telemedicine visit is usually depersonalized, and therefore, less subject to judgment. See Onder & Sinha, *supra* note 190.

²¹² Julie Fricke, Shazia Mehmood Siddique, Jaya Aysola, Margot E. Cohen, & Nikhil K. Mull, *Healthcare Worker Implicit Bias Training and Education*, in MAKING HEALTHCARE SAFER IV: A CONTINUOUS UPDATING OF PATIENT SAFETY HARMS AND PRACTICES (2024).

²¹³ Breanna Booker & Michael S. Sinha, *Dirty Water*, 15 WM. & MARY ENVTL L. & POL'Y REV. 677, 685 (2025).

²¹⁴ Gregory S. Marler et al., *Weight Bias Interventions for Healthcare Professionals: An Integrative Review*, J. ADV. NURS. 1, 8 (2025).

²¹⁵ Marler et al., *supra* note 214, at 8.

²¹⁶ *Id.*

levels, from medical school curriculum²¹⁷ to ongoing professional development. By fostering a more inclusive and evidence-based approach to obesity care, the health-care system can ensure that all patients receive respectful, high-quality treatment that supports their long-term health and well-being.

D. Promotion of Inclusive Health Policies

Promoting inclusive health policies is essential to creating a health care environment where patients with obesity feel respected and supported in seeking treatment. Many individuals with obesity face stigma in medical settings, which can lead to avoidance of care and poorer health outcomes.²¹⁸ For example, obese women less frequently seek recommended screening for certain types of cancers due to a perception that their body weight will be a source of embarrassment in that setting.²¹⁹ Further, individuals who are stigmatized may withdraw from full participation in a medical encounter.²²⁰ After withdrawal, patients are less likely to recall advice or instructions given by the provider, resulting in reduced adherence to prescribed treatment.²²¹ Ultimately, patients who report feeling judged by their primary care provider are less likely to seek or achieve successful weight loss.²²²

Implementing policies that emphasize non-stigmatizing language, promote body diversity, and provide clear guidelines for respectful patient interactions can help reduce patient hesitation and ensure that patients adhere to provider recommendations. Health care institutions and policymakers should work together to establish frameworks that encourage compassionate, patient-centered approaches to obesity care.

One key aspect of inclusive policy is training providers to use language that is supportive rather than judgmental. The way obesity is discussed in clinical settings can significantly impact a patient's willingness to engage in treatment. For instance, using person-first language, such as "a person with obesity" rather than "an obese person," can help shift focus from blame

²¹⁷ Bias training in medical education varies significantly across institutions. Importantly, the didactic curriculum represents only one component of medical training; much of professional socialization occurs in clinical settings through direct interactions with patients and supervising physicians. Evidence suggests that greater exposure to faculty members who model discriminatory behaviors or make derogatory remarks about patients with higher body weights is associated with increased implicit and explicit weight bias among trainees. See Erin L.M. Bowden & Elizabeth M. Petty, *Perspectives on Weight Stigma and Bias in Medical Education: Implications for Improving Health Outcomes*, 123 WIS. MED. J. 160, 161 (2024).

²¹⁸ AMY J. SHEER & MARGARET C. LO, COUNSELING PATIENTS WITH OBESITY (2023).

²¹⁹ Phelan, et al., *supra* note 94, at 321.

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.* at 322.

to treatment by centering the individual rather than their medical condition.²²³

Beyond language, health care environments should be designed to accommodate patients of all body sizes. This includes ensuring that waiting room chairs, examination tables, and medical equipment are accessible and comfortable for individuals with higher body weights.²²⁴ Without such measures, patients with obesity may feel alienated or discouraged from seeking necessary medical interventions. Addressing weight stigma at a systemic level ensures that all individuals, regardless of body size, receive high-quality care in an environment that prioritizes dignity and respect.

E. Support Long-Term Research on GLP-1 Medications

Supporting long-term research on GLP-1s is critical to advancing obesity treatment and addressing public concerns about their safety and effectiveness. These medications have demonstrated significant benefits for weight management and metabolic health, but because GLP-1s are not intended as short-term treatments, ongoing studies are needed to assess their long-term impacts on patients' overall health and well-being.²²⁵ Continued investment in research can help refine treatment guidelines, optimize dosing strategies, and identify any potential risks associated with prolonged use.²²⁶

One of the key areas of continued study should be the long-term safety and efficacy of GLP-1s. Researchers have highlighted the effectiveness of GLP-1s in promoting weight loss and improving metabolic markers, but further studies are needed to evaluate their impacts over extended periods.²²⁷ Understanding factors such as sustained weight-loss maintenance, potential side effects, and effects on cardiovascular health will be essential for fully integrating these medications into standard obesity care.²²⁸

²²³ Charlotte Albury et al., *The Importance of Language in Engagement Between Health-Care Professionals and People Living With Obesity: A Joint Consensus Statement*, 8 *LANCET DIABETES & ENDOCRINOLOGY* 447, 448 (2020).

²²⁴ Alison Mosier-Mills, Meghana Vagwala, Jennifer Potter & Sadie Elisseou, *Respecting Body-Size Diversity in Patients: A Trauma-Informed Approach for Clinicians*, 28 *PERMANETE J.* 206, 209-10 (2024).

²²⁵ Shanzay Haider & Kasia J. Lipska, *Glucagon-Like Peptide-1 Receptor Agonists—How Safe Are They?*, 182 *J. AM. MED. ASS'N INTERN. MED.* 520 (2022).

²²⁶ Areesha Moiz, Kristian B. Filion, Michael A. Tsoukas, Oriana H.Y. Yu, Tricia M. Peters, & Mark J. Eisenberg, *The Expanding Role of GLP-1 Receptor Agonists: A Narrative Review of Current Evidence and Future Directions*, *ECLINICALMEDICINE*, July 2025 at 18.

²²⁷ John O. Olukorode et al., *Recent Advances and Therapeutic Benefits of Glucagon-Like Peptide-1 (GLP-1) Agonists in the Management of Type 2 Diabetes and Associated Metabolic Disorders*, 1 *CUREUS J. MED. SCI.* 9 (2024).

²²⁸ Ariana M. Chao, Thomas A. Wadden, Robert I. Berkowitz, Kerry Quigley & Frank Silvestry, *The Risk of Cardiovascular Complications With Current Obesity Drugs*, 19 *EXPERT OPIN. DRUG SAFETY* 1095, 1106 (2020).

Transparent communication of research findings by pharmaceutical companies, the FDA, and researchers will also be equally important in building public confidence in GLP-1 treatments. Misinformation and skepticism about weight loss medications have historically contributed to stigma and reluctance among both patients and health care providers.²²⁹ By ensuring that study results are widely disseminated and easily accessible, policymakers and medical professionals can reinforce the legitimacy of GLP-1s as a safe and effective component of obesity treatment.

Investing in long-term research not only benefits individual patients but also informs broader public health strategies. Comprehensive data on GLP-1s can guide policy decisions regarding insurance coverage, clinical best practices, and patient eligibility criteria. As scientific understanding of obesity continues to evolve, prioritizing research on GLP-1s will help shape a future where evidence-based, stigma-free treatment of obesity is available to all who need it.

CONCLUSION

The advent of FDA-approved GLP-1s offers a pivotal opportunity to reimagine not only the clinical treatment of obesity, but also the legal and policy frameworks that shape access to care. If leveraged thoughtfully, these medications could serve as powerful tools in advancing health equity and dismantling deeply rooted weight stigma. Inaction risks entrenching existing disparities and allowing stigma to persist under the guise of scientific progress.

To truly reduce weight stigma through the medicalization of obesity, GLP-1 medications must be more than clinically effective; they must be equitably accessible. Policymakers must act swiftly to reduce critical barriers to access. At the federal level, Congress should amend the Medicare Modernization Act to allow for Medicare Part D coverage of anti-obesity medications, aligning statutory language with contemporary understandings of obesity as a chronic disease rather than a cosmetic issue. In tandem, federal regulators should collaborate with the USPSTF to evaluate whether GLP-1s meet the criteria for a “B” rating or higher, potentially qualifying them as essential health benefits under the Affordable Care Act and triggering mandatory coverage without cost-sharing by most private insurers. For uninsured populations, lawmakers should pursue subsidies, tax incentives, and reforms that encourage timely competition and innovation when there are patent-protected medications with a high demand and significant public health benefits. Without such action, GLP-1s risk becoming another example of medical progress accessible only to those who

²²⁹ Halpern & Halpern, *supra* note 41, at 202.

can afford it. Beyond access, reforms must also address the broader systems in which these medications are deployed. This includes integrating GLP-1s into comprehensive obesity care, training providers to recognize and counteract weight bias, enacting inclusive health policies, and investing in long-term research on emerging treatments.

GLP-1s hold promise in reducing the longstanding stigma associated with obesity, but without equitable access to both medication and inclusive care, they risk becoming not a catalyst for change, but a stark reminder of how deeply stigma remains embedded in the American health-care system.