TREAT OR REFER

LEGISLATIVE BRIEF
JUNE 2026

The Cost of Coverage vs. the Cost of Inaction

Treating obesity as prevention — the near- and long-term case for Medicaid coverage in Arizona

PREPARED FOR THE ARIZONA STATE LEGISLATURE AND THE OFFICE OF THE GOVERNOR

1. The Federal Squeeze Is Real — We Acknowledge It

H.R. 1 (signed July 4, 2025) enacts the largest federal Medicaid reduction in the program's history — roughly **$800 billion to $1 trillion through 2034**. For Arizona, the JLBC projects approximately **$34 billion less federal Medicaid funding over the decade**, with General Fund revenue impacts of up to $438 million in FY 2026 and roughly $300 million annually thereafter. New provider-tax restrictions (frozen October 2026; the safe harbor steps down from 6% to 3.5% through FY 2034), twice-yearly eligibility redeterminations, and work requirements beginning January 2027 all shift costs onto the state.

Because federal law makes anti-obesity medications an **optional** Medicaid benefit, they are among the first places states look for savings. California, New Hampshire, Pennsylvania, and South Carolina ended coverage in late 2025 and January 2026; Massachusetts follows July 1, 2026. These are understandable responses to genuine fiscal pressure.

> *Arizona faces the same pressure — but obesity treatment actually offers financial and medical benefits. Treating obesity improves health immediately for people with medical complications, and it also provides prevention of disease (like vaccination or cancer screening). With new federal price cuts, the cost of coverage is small and largely offset by other savings. The cost of inaction compounds every year.*

2. The Cost of Coverage Is Now Much Smaller

$7.7M	~$8M/yr	<1%
Year-1 cost of expanded coverage (GlobalData model with estimated utilization rates)	General Fund savings from federal price negotiations on existing GLP-1 use in diabetes ($13M → $5M)	Projected Year-5 coverage cost as a share of current AHCCCS cardiometabolic spending

Year-1 expansion is approximately budget-neutral. The estimated ~$8 million in annual savings that federal price negotiations deliver on AHCCCS's *existing* GLP-1 spending for diabetes arrives in the same budget that would fund the $7.7 million first year of obesity coverage. Modeled costs grow to $20.9 million by Year 5 — still less than 1% of what AHCCCS already spends each year on obesity-driven cardiometabolic disease.

Federal price negotiations — now open — make the same discounted pricing the federal government secured available to state Medicaid programs. That gives Arizona a tool to keep per-member costs down that the states which cut coverage did not have when they acted.

Sources (Sections 1–2): JLBC, 2025 Federal Budget Reconciliation Bill — State Impact (9/18/2025); AHCCCS H.R. 1 Overview (azahcccs.gov); KFF, Medicaid: What to Watch in 2026; AHCCCS GLP-1 utilization data (Dec 2025); GlobalData DPTMM Arizona Medicaid model; federal Medicaid drug price negotiations (2026).

3. The Cost of Inaction Is Large — and Compounding

$2.45B	272,995	$8.8K→$24.5K	$11.1B
Annual AHCCCS spending on cardiometabolic disease, much of which is obesity-driven	AHCCCS members with an obesity diagnosis (2024)	Annual per-member cost for people without obesity vs people with obesity and diabetes	Annual economic activity impact of obesity and its complications — 1.8% of Arizona's output

More than **30% of Arizona adults (~1.5 million people)** live with obesity, on a trajectory toward ~38% by 2030. Obesity drives the state's costliest diseases: 88% of adults with diagnosed diabetes and over 80% of those with cardiovascular events have overweight or obesity. Each AHCCCS member who progresses from obesity to diabetes nearly triples the annual cost of care. Doing nothing is not free — it is the most expensive option on the table.

4. Treatment Is Prevention — in Both Directions

Like the prevention and wellness priorities the state is already investing in, treating obesity heads off disease before it gets more expensive — **lowering costs now** for members with active complications and **preventing the costlier complications still to come.**

- **Near term — events fall within months:** the SELECT trial showed semaglutide reduces major cardiovascular events beginning ~3 months into treatment, directly lowering the cost of members with active complications.
- **Long term — disease is headed off entirely:** tirzepatide reduced progression from prediabetes to diabetes by 94% (SURMOUNT-1), preventing the high-cost diagnoses before they start.
- **Mortality drops long-term:** 24-year follow-up shows a 23% reduction in all-cause mortality with effective obesity treatment (SOS Study).
- **The return is modeled:** every $1 of Medicaid obesity treatment generates an estimated **$8.57 in social and economic value** — and a non-partisan Dartmouth analysis found benefits exceed costs in *every* modeled coverage scenario.

5. Where Arizona Stands

Ten states currently cover GLP-1s for obesity in Medicaid. The states that cut coverage presumably acted under H.R. 1 pressure — but **Arizona has leverage they lacked**: the same federal-discount pricing now offered to states through the open negotiation window, plus ~$8 million in arriving savings on current GLP-1 use for diabetes. The American Diabetes Association, the Obesity Medicine Association, and The Obesity Society are unified in calling for Medicaid coverage of evidence-based obesity treatment.

Recommendations

1. **Include obesity-medication coverage in the FY 2027 budget** with phased utilization controls — prior authorization and BMI/comorbidity criteria — to keep Year-1 costs at or near the $7.7M estimate.
2. **Direct AHCCCS to secure the federal-discount pricing now open to state Medicaid programs**, holding per-member costs down as coverage expands.
3. **Pair coverage with fiscal guardrails and 5-year outcome monitoring**, so the Legislature can verify savings against the $2.45B cardiometabolic baseline.

The evidence is consistent across every payer and model examined: investing in prevention now costs far less than paying for the complications of inaction later.

Sources (Sections 3–5): ADHS BRFSS 2011–2024; AHCCCS 2024 claims data; ADOA Response to Obesity Study Committee (12/15/2025); GlobalData Arizona Infographic 2025; Lincoff et al., SELECT (NEJM 2023); Jastreboff et al., SURMOUNT-1; Sjöström et al., SOS Study; Livingston, Dall et al., Diabetes, Obesity, and Cardiometabolic CARE 2026; Dartmouth Rockefeller Center Policy Research Shop (March 2026); AOO State Medicaid GLP-1 Coverage Tracker (June 2026); ADA Standards of Care 2026; OMA Position Statement, Obesity Pillars 2026. Full evidence library: the Arizona Obesity Organization white paper, *The Cost of Inaction* (ArizonaObesity.org).

Disclosures and Funding: This paper was supported by sponsored research grants from Novo Nordisk, Eli Lilly and Company, and IntraSana; the funders had no role in design, analysis, writing, or approval. Dr. Maready has received speaker honoraria from these companies within the past 12 months and is the Board Chair of the Arizona Obesity Organization (AOO), a 501(c)(3) advocacy group.

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