

Health Equity Coverage Recommendation Form

Title:	Health Equity in Obesity
Date of Last Review:	4/1/2026

Research Section

Background

According to the [World Health Organization](#) obesity is a chronic complex disease defined by excessive fat deposits that can impair health. Individuals who are classified as obese are more likely to suffer from high blood pressure, high levels of blood fats, diabetes and LDL cholesterol – all risk factors for heart disease and stroke.¹

Inequities discussed on the [Office of Minority Health Website](#)²

[Obesity and Black/African Americans:](#)³

- In 2024, Black/African American adults were **28% more likely** than U.S. adults overall to have obesity.
- In 2023, Black/African American high school boys were **8% more likely**, and girls were **55% more likely**, than their peers to have obesity.
- In 2018, Black/African American adults were **17% less likely** than U.S. adults overall to meet national guidelines for aerobic and muscle-strengthening activity.

[Obesity and American Indians/Alaska Natives:](#)⁴

- In 2024, American Indian/Alaska Native (AI/AN) adults were **22% more likely** than U.S. adults overall to have obesity.

[Obesity and Hispanic Americans:](#)⁵

- In 2024, Hispanic/Latino adults were **12% more likely** than U.S. adults overall to have obesity.
- In 2023, Hispanic/Latino high school boys were **35% more likely**, and girls were **4% more likely**, than their peers to have obesity.
- In 2018, Hispanic/Latino adults were **10% less likely** than U.S. adults overall to meet national guidelines for aerobic and muscle-strengthening activity.

Review of current, peer-reviewed evidence from established sources

- In 2021, [Min](#) et al published a systematic review on racial-ethnic disparities in obesity and biological, behavioral, and sociocultural influences in the United States.⁶ Forty-seven studies met the inclusion criteria and were systematically reviewed. After a short leveling-off during 2009–2012, the US national prevalence of obesity has steadily increased. Obesity and severe obesity prevalence increased in Mexican American (MA) men, MA boys, and MA girls and became similar to or surpassing non-Hispanic Black (NHB) groups. Substantial racial/ethnic disparities remained in the past decade. Even at the same level of BMI, MAs and non-Hispanic Asian Americans had a higher percent of body fat and metabolic syndrome than other ethnic/racial groups. NHB’s cultural preference for a large body significantly associated weight misperception and lower weight control practices. In addition to socioeconomic status, health behaviors, neighborhood environments, and early childhood health factors explained substantial racial/ethnic differences in obesity. Differences in biological, behavioral, and sociocultural characteristics should be considered in future public health intervention efforts to combat obesity in the USA. Modifiable health characteristics noted in the discussion include early education on reducing high sugar beverages, fast food intake, promote sufficient sleep, integrate physical activity daily, and have healthy food and beverage options.
- A review by [Hsu](#) et al found that Asian Americans have a higher prevalence of type 2 diabetes at relatively lower BMI cut points than white Americans.⁷ Given that established BMI cut points indicating elevated diabetes risk are inappropriate for Asian Americans, establishing a specific BMI cut point to identify Asian Americans with or at risk for future diabetes would be beneficial to the potential health of millions of Asian American individuals.

Review of clinical practices guidelines from professional associations and societies in regard to these findings

American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO):

In 2022, ASMBS and IFSO published [clinical guidelines](#) on indications for metabolic and bariatric surgery. They offer the following recommendations based on clinical evidence and expert opinion:⁸

- Metabolic and Bariatric Surgery (MBS) is recommended for individuals with BMI ≥ 35 kg/m², regardless of presence, absence, or severity of co-morbidities.
- MBS is recommended in patients with T2D and BMI ≥ 30 kg/m².
- MBS should be considered in individuals with BMI of 30–34.9 kg/m² who do not achieve substantial or durable weight loss or co-morbidity improvement using nonsurgical methods.
- Obesity definitions using BMI thresholds do not apply similarly to all populations. Clinical obesity in the Asian population is recognized in individuals with BMI >25 kg/m². Access to MBS should not be denied solely based on traditional BMI risk zones.

National Institute for Health and Care Excellence (NICE):

The 2025 evidence-based [NICE guideline](#) for the identification, assessment, and management of obesity gave the following recommendations for bariatric surgery:⁹

Bariatric surgery is a treatment option for people with obesity if all of the following criteria are fulfilled:

- They “have a BMI of 40 kg/m² or more, or between 35 kg/m² and 39.9 kg/m² with a significant health condition that could be improved if they lost weight **and**
- Consider referral for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background using a lower BMI threshold (reduced by 2.5 kg/m²) than in recommendation 1.10.1 to account for the fact that these groups are prone to central adiposity and their cardiometabolic risk occurs at a lower BMI.”

Do any of these findings relate to any of our current policies?

If race is known, lower BMI thresholds (usually reduced by 2.5 kg/m²) are used for people from South Asian, Chinese, other Asian, Middle Eastern, Black African, African-Caribbean, Native Hawaiian, Pacific Islanders, or American Indians/Alaska Natives family backgrounds.

This note is largely based on NICE guidelines, taking into account minority populations within the United States as well.

Summary

Medical Policy:

Obesity is a chronic complex disease that is associated with high blood pressure, high levels of blood fats, diabetes and LDL cholesterol – all risk factors for heart disease and stroke. Obesity disproportionately affects BIPOC populations especially individuals who identify as Black/African American, American Indians/Alaska Natives, and Hispanic American. Differences in obesity rates between unique racial and ethnic groups appear to be multifactorial and include variables such as socioeconomic status, health behaviors, neighborhood environments, and early childhood health factors. Considering these different rates in obesity due to racial and ethnic differences the National Institute for Health and Care Excellence (NICE) developed guidelines in 2023 with the recommendation that bariatric surgery be considered for individuals with South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds at lower BMI thresholds (usually reduced by 2.5 kg/m²) than other racial or ethnic groups. PHP plans to incorporate this guideline recommendation into the Company line of business of our Bariatric medical policy.

Pharmacy Policy:

Successful weight management relies heavily on lifestyle and behavioral modifications which are imperative for long-term success. Medications are used to supplement lifestyle changes and should not be relied upon as monotherapy for weight management. Historically the coverage of medications used for weight management have not been covered by most insurers due to the high cost and lack of clinical trials demonstrating efficacy in reducing weight-related health consequences. While coverage of medications used for weight management are still excluded by most groups, our policy has expanded to allow coverage (for those with the benefit) for weight loss, reduction of major adverse cardiovascular events in patients with established cardiovascular disease, and obstructive sleep apnea. For those without the weight management benefit, we allow coverage of injectable Wegovy for metabolic dysfunction associated steatohepatitis. Weight management benefit aside, our

policy criteria aligns with clinical trials and aims to target the individuals with demonstrated benefit in clinical trials.

According to the National Institute for Health and Care Excellence (NICE) overweight and obesity management guideline, individuals with South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family backgrounds are prone to central adiposity and cardiometabolic risk occurs at a lower BMI. The guideline recommends reducing the BMI threshold by 2.5 kg/m² when measuring overweight and obesity for these groups. The required BMI thresholds in our policies align with these recommendations.⁹

While opening up this benefit by reducing prior authorization barriers and cost-sharing individuals would aid in improving health equity in obesity, many of these drugs cost well over \$1000 per month which is not financially sustainable. Pharmacy will continue to monitor trials and evaluate the financial impact of weight loss on health-related outcomes. No changes to pharmacy policy at this time.¹⁰

Recommendation:

No recommended health equity updates to policies at this time. We will continue to review data and professional organization recommendations for future health equity updates.

References

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CORE Revision History Section

DATE	SUMMARY OF CHANGES
03/25/2024	Initial Review.
3/25/2025	Annual update. No recommended changes.

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The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP and PHA CORE forms will be resolved in favor of the coverage agreement.