The State of Metabolic Health in America

An Independent Annual Policy Report

2026 Baseline Edition — Annual Policy Report

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The 2026 Baseline Edition contains ten chapters organized across the national baseline, payer systems, public health infrastructure, geographic variation, and health-system innovation. All ten chapters follow the finalized twelve-part structure (Key Findings, Introduction, Why This Matters, National Snapshot, Trends, Policy Implications, Baseline Metrics, Technical Considerations, Chapter Summary, Looking Ahead, Questions We Still Cannot Answer, and Sources).

Executive Summary

America has dozens of organizations measuring obesity, diabetes, hypertension, Medicare spending, employer costs, and public health performance. What has been missing is a single annual report that assembles these measurements into one objective baseline describing the metabolic health of the United States. This report attempts to establish that baseline. It is independently authored and published, and is not produced on behalf of, or at the direction of, any governmental agency, employer, health plan, pharmaceutical manufacturer, or commercial vendor.

Metabolic health was selected as this report's organizing subject, rather than the broader category of chronic disease generally, because it represents the common biological pathway linking many of the conditions responsible for the majority of American health care spending: obesity, diabetes, hypertension, chronic kidney disease, and their downstream cardiovascular consequences share overlapping physiology and frequently occur together in the same individuals, a clustering this report treats as its central organizing fact rather than as a coincidence of disease classification.

The State of Metabolic Health in America is not a treatise on any single disease, program, or company. It is a reference work, structured so that every chapter can be compared against the same chapter in next year's edition, and every statistic can be traced back to the federal surveillance system, professional medical society, or peer-reviewed study that produced it. This Executive Summary is written for the reader who may never reach Chapter 1: the congressional staffer preparing a briefing, the governor's policy director scanning for relevant figures, the CEO deciding whether to read further, the journalist on deadline. Everything in this summary is drawn directly from the chapters that follow, and nothing here should be read as advocacy for a particular policy, product, or point of view.

This report is intended for policymakers, employers, researchers, health systems, public health officials, journalists, and students, and it is written so that each of those audiences can read it without translation: no chapter assumes specialized clinical training, and no chapter assumes familiarity with any single audience's own professional vocabulary. Future editions will preserve this report's chapter structure, metric identifiers, and editorial standards whenever possible, precisely so that year-over-year comparison remains straightforward for every one of these audiences.

This edition includes 10 chapters, 98 baseline metrics carrying permanent identifiers, 25 figures and data visualizations, and nearly 300 cited primary sources. No original statistical modeling or proprietary datasets are used in this edition unless explicitly

identified. Wherever possible, this report relies upon publicly available governmental data, peer-reviewed literature, and nationally recognized professional organizations.

1. Why This Report Exists

Metabolic health in the United States is measured constantly, but never as a whole. Employers measure claims. CMS measures program spending. States measure Medicaid enrollment. The CDC measures disease prevalence. Each of these measurements is valuable, and each is the product of serious, careful work. None of them, on its own, answers a simple question: what is the state of metabolic health in America, considered as a single system rather than a collection of separately measured parts?

This report exists to answer that question, once a year, in one place. It does not introduce a new diagnostic category, a new payment model, or a new measurement framework. It assembles the best existing public evidence, chapter by chapter, into a single baseline against which every future edition can be measured. The 2026 Baseline Edition is the first of what this report intends to become: an annual institution rather than a one-time publication.

2. What We Learned

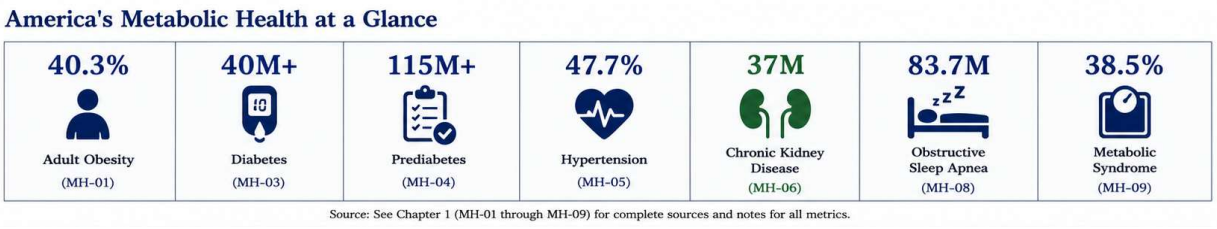
The individual statistics in this report are numerous; the conclusions they support are few, and they are the messages this Executive Summary most wants a reader to carry forward.

- Metabolic disease now touches nearly every major payer in the American health system, employer-sponsored insurance, Medicare, and Medicaid alike, rather than concentrating in any single financing channel.
- The burden extends far beyond obesity alone. Diabetes, prediabetes, hypertension, chronic kidney disease, steatotic liver disease, obstructive sleep apnea, and metabolic syndrome each affect tens of millions of Americans, and most of these conditions cluster within the same individuals rather than occurring in isolation.
- Undiagnosed disease remains extraordinarily common. Roughly nine in ten adults with chronic kidney disease, and more than four in five adults with obstructive sleep apnea, do not know they have the condition, meaning administrative and claims data substantially understate true prevalence for several of the conditions this report tracks.
- Employer health care costs continue rising faster than wages and general inflation, driven substantially by specialty pharmacy spending and, within it, by GLP-1

medications, forcing employers toward more deliberate, managed-access coverage designs rather than simple inclusion-or-exclusion decisions.

- Medicare contains a particularly high concentration of metabolic disease because of the age and clinical profile of its beneficiaries, with weight-related chronic conditions affecting the large majority of its more than 70 million enrollees, and its finances are under mounting strain as a result.
- Medicaid remains one of the nation's most significant opportunities for intervention, insuring a low-income population with a disproportionate share of the country's metabolic disease burden, even as the program itself enters a period of significant enrollment decline and financing uncertainty.
- Most existing interventions, in Medicaid, Medicare, and the employer market alike, are measured independently rather than as part of an integrated metabolic health framework, and this report repeatedly found that reduced cost or utilization does not necessarily mean improved clinical outcomes.

3. America's Metabolic Health at a Glance



Metric	National Figure
Adult obesity	40.3% of U.S. adults (MH-01)
Diabetes	More than 40 million people of all ages (MH-03)
Prediabetes	More than 115 million adults (MH-04)
Hypertension	47.7% of U.S. adults (MH-05)
Chronic kidney disease	Approximately 37 million adults; ~9 in 10 undiagnosed (MH-06)
Obstructive sleep apnea	An estimated 83.7 million adults; >80% undiagnosed (MH-08)
Metabolic syndrome	38.5% of U.S. adults (MH-09)

4. Economic Reality

The economic figures in this report tell the story of metabolic disease's cost faster than any narrative description can. U.S. national health expenditures reached **$5.3 trillion** in 2024, $15,474 per person, consuming **18.0%** of gross domestic product. Diagnosed diabetes alone costs the United States **$412.9 billion** annually, $306.6 billion in direct medical costs and $106.3 billion in indirect costs, and obesity accounts for nearly **$173 billion** in medical expenditures each year. Illness-related lost productivity costs U.S. employers an estimated **$575 billion** annually, equal to 61 cents in lost productivity for every dollar spent on health care benefits.

Employer-sponsored family health insurance premiums reached $26,993 in 2025, up 6% from 2024, the third consecutive year of premium growth at 6% or higher, the first time that has happened in two decades. Mercer projects average employer health benefit cost will rise a further 6.7% in 2026, to more than $18,500 per employee, the fastest projected increase in fifteen years, with prescription drug spending, and GLP-1 medications specifically, identified as the principal driver.

5. The Five Major Findings

Considered as a whole, rather than chapter by chapter, this report's evidence supports five findings.

- Finding 1. Metabolic disease is now one of America's defining public health challenges, measured by the sheer number of Americans affected and by how deeply it has embedded itself across every major public and private health financing system.
- Finding 2. The economic burden of metabolic disease extends well beyond health care spending itself, into lost workplace productivity, workers' compensation costs, disability, and early workforce exit, each of which this report found to be measured with less precision and less currency than direct medical spending.
- Finding 3. Large gaps remain in diagnosis and early detection, particularly for chronic kidney disease, obstructive sleep apnea, and metabolic dysfunction-associated steatotic liver disease, meaning the measured prevalence in this report likely understates the true burden for several conditions.
- Finding 4. Current measurement systems evaluate diseases, programs, and interventions separately rather than treating metabolic health as a single, interconnected system, a fragmentation this report found repeated across Medicaid, Medicare, public health infrastructure, and employer benefit design alike.

- Finding 5. Future policy and program evaluation should increasingly distinguish utilization and cost outcomes from clinical metabolic outcomes, and should favor longitudinal, multi-year measurement over single-year snapshots, a distinction this report found to be the single most consistent theme across its ten chapters.

6. What This Report Does NOT Say

This report's credibility depends as much on what it declines to do as on what it documents. This report does not:

- Recommend legislation, regulation, or any specific policy change.
- Endorse any specific medical treatment, clinical protocol, or course of care.
- Endorse any pharmaceutical manufacturer or pharmaceutical product.
- Endorse any commercial vendor, health plan, or condition-management program.
- Estimate future cost savings or return on investment for any program, policy, or intervention.
- Advocate for any proprietary measurement methodology or framework.

Instead, this report documents the current baseline, using publicly available, named, and independently verifiable sources, and states plainly where the evidence is strong, where it is mixed, and where it does not yet exist. That discipline is deliberate, and it is the reason this report can be read the same way by an employer, a state Medicaid director, a congressional staffer, and a journalist without any of them reasonably concluding that the report is arguing a case.

7. Why Annual Measurement Matters

One year of data is interesting. Five years of consistent, comparable data become a trend. Ten years become a basis for policy. Twenty years become history. This report is intended to become America's annual metabolic health report, published on the same schedule, using the same chapter structure and the same stable metric identifiers, so that a reader in 2036 can measure exactly how far the country has moved from the baseline established here.

That intention shapes this edition's editorial choices as much as any single statistic does. Every chapter follows the same twelve-part structure. Every metric carries a permanent identifier, MH-01 through MH-11, EI-01 through EI-08, and so on through this edition's ten chapters, that will never be renumbered or reused. Every chapter ends by naming the questions it cannot yet answer, precisely so that future editions have a standing

agenda to report against. None of this is bureaucratic formality; it is what makes annual comparison possible at all.

8. Opportunities Identified

This report identifies opportunities rather than recommendations, consistent with its decision not to advocate for any specific policy or program. The following areas emerged repeatedly across this edition's chapters as places where better measurement, not necessarily new spending, could meaningfully improve the country's understanding of its own metabolic health:

- Earlier diagnosis, particularly for chronic kidney disease, obstructive sleep apnea, and steatotic liver disease, where undiagnosed prevalence is large and where earlier detection is well understood clinically even where population-level screening remains limited.
- Employer prevention strategies that pair coverage decisions with outcome measurement, rather than coverage decisions alone, addressing the gap this report found between what employers expect from benefit design and what they can currently observe in their own claims data.
- Medicare innovation that extends the biomarker-based payment approach introduced in the ACCESS model beyond its initial scope, once evaluation data exists to show whether that approach works.
- Medicaid innovation that preserves the health-related social needs waiver infrastructure states have built, even where state budget pressure has interrupted specific programs such as North Carolina's Healthy Opportunities Pilots.
- Longitudinal measurement generally, extending this report's own annual structure to the state, county, and program levels where this edition found current data to be thinnest.
- Integrated metabolic management that treats obesity, diabetes, hypertension, and related conditions as components of one clinical picture rather than as separately managed diagnoses.
- Employer evaluation standards that would allow independent, non-vendor-funded verification of the condition-management vendors employers increasingly purchase, addressing the evidentiary gap this report documented in Chapter 10.

9. Questions Future Editions Should Answer

Each edition of this report will end, and the next will begin, with a standing set of unanswered questions. At the level of the report as a whole, rather than any single chapter, five questions stand out as the ones this report most wants to answer in future editions:

- Are Americans becoming metabolically healthier or less healthy over time, once measured consistently across the same conditions and the same population, year over year?
- Which employer condition-management and coverage strategies actually improve clinical outcomes, as opposed to reducing utilization or cost alone?
- Which Medicaid innovation models durably improve clinical metabolic outcomes, rather than utilization and cost outcomes only, once evaluated over a longer time horizon than this edition could examine?
- What happens to population-level obesity, diabetes, and related prevalence following widespread GLP-1 adoption, once enough years have passed to observe a durable population effect rather than an early adoption trend?
- Can integrated, cross-condition metabolic health measurement outperform the disease-specific measurement this report found to be the current norm, in the sense of producing better clinical outcomes at comparable or lower cost?

10. Looking Ahead

The 2026 Baseline Edition is intended to establish a fixed point of comparison for future years. It does not claim to be complete, and it states directly, chapter by chapter, where its own evidence is incomplete or its own measurement falls short. What it claims is narrower and, this report believes, more durable: that the United States now has a single, annual, source-transparent baseline against which its metabolic health, and the systems that finance and manage it, can be measured every year going forward. Every future edition of this report will measure change against this baseline, and this report's value will grow with each edition that does.

Key Metrics Dashboard

The figures below are this report's most frequently requested national metrics, consolidated here for quick reference. Each figure is drawn from, and cited in full within, the chapter noted.

Metric	Value	Chapter
Adult obesity prevalence	40.3%	Ch. 1 (MH-01)
Adults with diabetes	40+ million	Ch. 1 (MH-03)
Adults with prediabetes	115+ million	Ch. 1 (MH-04)
Adult hypertension prevalence	47.7%	Ch. 1 (MH-05)
National health expenditures (2024)	$5.3 trillion / 18.0% of GDP	Ch. 2 (EI-01)
Annual cost of diagnosed diabetes	$412.9 billion	Ch. 2 (EI-04)
Annual obesity medical expenditures	~$173 billion	Ch. 2 (EI-03)
Illness-related lost productivity	~$575 billion in 2019, modeled	Ch. 2 (EI-07)
Employer family premium (2025)	$26,993, up 6%	Ch. 2 (EI-05)
Employer-sponsored insurance, nonelderly	~154-165.6 million	Ch. 3 (EH-11)
Medicare beneficiaries with ≥1 selected weight-related chronic condition, excluding type 2 diabetes	76%–87%, depending on weight status	Ch. 4 (MA-07)
Medicare Advantage share of eligible beneficiaries	55%	Ch. 4 (MA-02)
Medicaid and CHIP enrollment (March 2026)	74.3 million	Ch. 5 (MD-01)
Medicaid beneficiaries in comprehensive risk-based MCOs	78%	Ch. 5 (MD-05)
States covering GLP-1s for obesity treatment under Medicaid fee-for-service	13 states	Ch. 5 (MD-07)
President's FY26 proposed CDC funding cut	~53% (TFAH estimate)	Ch. 6 (PH-01)
State obesity prevalence range, self-reported BRFSS (2024)	25.0% (CO) to 41.4% (WV)	Ch. 7 (SV-01/02)

Metric	Value	Chapter
HRSN- or SDOH-related Section 1115 demonstrations	25 approved / 6 pending (KFF classification, Feb. 2026)	Ch. 8 (MI-01)
NC Healthy Opportunities Pilots estimated expenditure impact	-$164 PMPM	Ch. 8 (MI-03)
ACO REACH PY2023 gross savings	~$1.643 billion	Ch. 9 (MV-04)
Firms requiring lifestyle program or clinician consult for GLP-1 coverage	34%	Ch. 10 (EN-01)

How to Read This Report

This report is organized so that any chapter can be read on its own, and so that every chapter can be compared directly against its counterpart in future editions. A few conventions recur throughout and are worth understanding before continuing.

Chapter structure

Every chapter follows the same twelve-part structure: Key Findings, Introduction, Why This Matters, National Snapshot, Trends, Policy Implications, Baseline Metrics, Technical Considerations, Chapter Summary, Looking Ahead, Questions We Still Cannot Answer, and Sources. A reader in a hurry can read only the Key Findings and Looking Ahead sections of every chapter and come away with an accurate, if compressed, understanding of the entire report. Readers interested in a specific topic may read individual chapters independently without losing context, as each chapter is designed to function as a stand-alone reference while remaining fully comparable across future editions.

Stable metric identifiers

Every chapter assigns a permanent, sequential identifier to its headline statistics, MH- for Chapter 1, EI- for Chapter 2, EH- for Chapter 3, and so on. These identifiers are never renumbered or reused, even across future editions. A reader who wants to track a specific metric, adult obesity prevalence (MH-01), for example, over several years' editions can locate it by its identifier regardless of how the surrounding prose changes from year to year.

Reading trends across editions

Because every chapter and every metric identifier is held constant year over year, comparing this edition to a future one is a matter of comparing the same identifier's value across editions, not re-reading each chapter in full. Beginning with the 2027 edition, this report intends to add a "What's Changed Since the Baseline" appendix summarizing exactly that comparison.

Technical Considerations and honest uncertainty

Every chapter includes a Technical Considerations section that states directly where the evidence is incomplete, where sources disagree, or where this report could not verify a claim to its own standard. This is a deliberate editorial choice, not a weakness in the underlying research: readers should treat these sections as some of the most important

in the report, since they define the boundaries of what this edition can and cannot responsibly claim.

About the Author

James M. Knox serves as Author and Editor of The State of Metabolic Health in America. He is Vice President at Eagles Benefits by Design, Inc., a third-party benefits administrator based in Tampa, Florida, and has spent his career working directly with self-funded employers, health plans, and benefits consultants on the financing and administration of employer-sponsored health coverage.

This report was conceived to fill a specific gap: the absence of a single, annual, source-transparent baseline describing the metabolic health of the United States, assembled from federal surveillance systems, professional medical societies, and peer-reviewed research rather than from any single organization's proprietary data or commercial interest. The editorial standards adopted for this report, including its commitment to naming a primary source for every statistic, distinguishing evidence from interpretation, and stating plainly what remains unknown, govern this edition and are intended to govern every edition that follows.

Correspondence regarding this report, including corrections, questions, and requests for underlying source citations, may be directed to James@CPS125.com.

Editorial Independence

The editorial content of The State of Metabolic Health in America is developed independently by the Author and Editor. Neither financial support, research participation, nor organizational cooperation confers editorial control, approval rights, or influence over the report's findings or conclusions.

Organizations providing data, participating in research, or reviewing draft sections do so in an advisory capacity only. Responsibility for all editorial decisions, including which sources to cite, which figures to report, and how findings are characterized, remains solely with the Editor. The author's conflict of interest disclosure appears in Appendix A.

Editorial Standards

Version 1.0 — Adopted for the 2026 Baseline Edition and All Subsequent Editions

This document establishes the editorial standards that govern The State of Metabolic Health in America across every edition. These standards exist to ensure the report earns and retains the trust of the employers, health plans, policymakers, researchers, and journalists who will come to rely on it as a consistent, credible reference over time. They apply equally to this inaugural 2026 Baseline Edition and to every edition that follows, and any departure from them in a future edition will be disclosed explicitly in that edition rather than made silently.

These standards are organized as seven numbered principles. Each is stated briefly and then explained in the paragraph that follows, so that the practical meaning of the standard, and not just its label, is clear to anyone applying it in the course of writing, reviewing, or citing this report.

The Seven Standards

Standard 1: Every statistic must cite a primary source.
Every prevalence figure, trend estimate, or economic statistic presented in this report must be traceable to a named primary source, such as a federal surveillance system, a professional medical society, or a peer-reviewed publication. Secondary summaries, general news coverage, and advocacy materials may be consulted for context and framing, but they are not acceptable as the sole citation for a statistic appearing in this report. Where a primary source itself relies on modeling or estimation rather than direct measurement, that fact will be stated alongside the figure rather than presented as a precise, directly observed count.

Standard 2: Every chapter must be written objectively.
This report is a work of description and analysis, not persuasion. Chapters will present prevalence, trend, and economic data in neutral, policy-register language, and will avoid promotional framing, marketing language, or advocacy for any particular commercial product, service, or company, including any affiliated with this report's publisher. Where interpretation is offered, such as in the Implications sections that follow each condition reviewed in this report, that interpretation will be clearly distinguished from the underlying data and framed as one reasonable reading of the evidence rather than the only possible one.

Standard 3: Public data and proprietary concepts must be clearly distinguished.

This report draws primarily on public, federally funded, and peer-reviewed data sources, and that will remain true in every edition. Where proprietary frameworks, tools, or concepts are discussed in any edition, they will be clearly labeled as such, distinguished explicitly from the public data surrounding them, and introduced only where they are directly relevant to a measurement gap already documented elsewhere in the report, never as an unlabeled extension of public surveillance findings.

Standard 4: Conclusions must be supported by cited evidence.
Any conclusion, interpretation, or forward-looking statement made in this report must be traceable to the evidence presented alongside it. This report will not present speculation as though it were an established finding, and will not draw conclusions that outrun what the underlying data can actually support, even where a broader or more dramatic conclusion might be more attention-getting or more persuasive to a particular audience.

Standard 5: Limit speculation; identify it explicitly when included.
Where this report includes forward-looking commentary, such as the Looking Ahead sections that close each chapter, that content will be clearly framed as anticipation of future developments rather than as settled fact, and will avoid presenting specific predictions as though they were certain outcomes. Any speculative content will be labeled as such at the point it appears in the text, rather than left for the reader to infer on their own.

Standard 6: Revise methodologies only when justified, and explain changes between editions.
Should this report change its methodology, data sources, or definitions in any future edition, whether due to a change in an underlying federal survey, an updated clinical definition, or an improvement in this report's own approach, that change will be disclosed explicitly in the edition where it occurs, along with an explanation of why the change was made and, where feasible, a comparison showing how the prior year's figures would look under the revised methodology.

Standard 7: Correct errors transparently in future editions.
Errors will occur in a publication of this scope, and when they are identified, whether through this report's own editorial review or by outside readers, they will be corrected openly in the next available edition, with a clear notation of what was corrected and why, rather than silently revised without acknowledgment.

Why These Standards Matter

These seven standards are not aspirational language; they are the operating discipline behind every chapter of this report, including the first. Adherence to them is what allows a report published by a single organization to be read, in good faith, as an objective account of American metabolic health rather than as an argument for any particular point of view. As this report grows into the kind of standing reference that employers, policymakers, journalists, and researchers cite year after year, these standards are the foundation that makes that kind of trust possible in the first place.

Adopted for The State of Metabolic Health in America, 2026 Baseline Edition, and all subsequent editions. Prepared by James M. Knox.

How to Cite This Report

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Glossary

This glossary defines recurring terms and acronyms used throughout this report. It is not exhaustive; terms specific to a single chapter are defined within that chapter at first use.

- ACO (Accountable Care Organization): a group of providers that accepts financial accountability for the total cost and quality of care for a defined population of patients.
- BRFSS (Behavioral Risk Factor Surveillance System): a CDC-administered, state-based telephone survey collecting self-reported health data, including many state-level prevalence estimates cited in this report.
- CKD (Chronic Kidney Disease): progressive loss of kidney function, frequently a downstream complication of diabetes and hypertension.
- CMMI (CMS Innovation Center): the CMS component responsible for designing and testing new Medicare and Medicaid payment and delivery models.
- CMS (Centers for Medicare & Medicaid Services): the federal agency administering Medicare, Medicaid, and CHIP.
- DSRIP (Delivery System Reform Incentive Payment): an earlier generation of Section 1115-authorized Medicaid payment reform programs.
- GLP-1 (Glucagon-Like Peptide-1 receptor agonist): a class of medications originally developed for type 2 diabetes that also produces substantial weight loss, marketed under brand names including Ozempic, Wegovy, Mounjaro, and Zepbound.
- HRSN (Health-Related Social Needs): social and economic conditions, such as housing instability or food insecurity, that affect health outcomes and that some Medicaid waivers now directly address.
- MASLD (Metabolic Dysfunction-Associated Steatotic Liver Disease): the current clinical term for what was formerly called non-alcoholic fatty liver disease.
- MCO (Managed Care Organization): a health plan that contracts with a state Medicaid program or other payer to deliver care to enrollees under a capitated or risk-based arrangement.
- Metabolic syndrome: a clinical designation applied when a patient has three or more of a specific set of risk factors, including abdominal obesity, elevated blood pressure, elevated blood sugar, and abnormal cholesterol levels.

- NHANES (National Health and Nutrition Examination Survey): a CDC survey combining interviews with direct physical examination and laboratory testing of a nationally representative sample, the source of this report's measured, rather than self-reported, prevalence estimates.
- PMPM (Per Member Per Month): a standard unit for expressing health care cost or savings on a per-enrollee, per-month basis.
- Section 1115 waiver: a provision of the Social Security Act allowing states to test Medicaid approaches that would otherwise violate certain federal program requirements, subject to budget neutrality and evaluation requirements.
- VBP (Value-Based Payment): payment arrangements that tie provider reimbursement, in whole or in part, to quality, outcomes, or total cost of care rather than to service volume alone.
- NHIS (National Health Interview Survey): a CDC survey collecting self-reported health data through in-person and telephone interviews with a nationally representative sample.
- MEPS (Medical Expenditure Panel Survey): a federal survey, administered by the Agency for Healthcare Research and Quality, that collects detailed data on health care use, expenditures, and insurance coverage.
- USPSTF (United States Preventive Services Task Force): an independent panel of experts that issues evidence-based recommendations on clinical preventive services, such as screening for chronic disease.
- HEDIS (Healthcare Effectiveness Data and Information Set): a standardized set of performance measures, maintained by the National Committee for Quality Assurance, used to evaluate health plan quality.
- Medicare Advantage: the private-plan alternative to traditional fee-for-service Medicare, in which beneficiaries enroll in a Medicare-approved health plan that typically offers supplemental benefits.
- ERISA (Employee Retirement Income Security Act): the federal law governing most employer-sponsored health and retirement benefit plans, including the framework that allows self-funded employer plans to operate under uniform federal rather than state regulation.
- Self-funded health plan: an employer-sponsored health plan in which the employer, rather than an insurance carrier, assumes the financial risk for enrollees' medical claims, often while contracting with a third-party administrator to process claims.

- PPO (Preferred Provider Organization): a health plan design offering a network of preferred providers while still allowing out-of-network care, typically at higher cost-sharing.
- HDHP (High-Deductible Health Plan): a health plan design with a higher deductible than a traditional plan, often paired with a health savings account.
- PBM (Pharmacy Benefit Manager): an organization that administers prescription drug benefits on behalf of health plans and employers, including formulary design, pharmacy network contracting, and rebate negotiation with manufacturers.

Chapter 1

America's Metabolic Health

Chapter 1 Key Findings

- 40.3% of U.S. adults have obesity, and severe obesity continues to rise even as the overall obesity rate has leveled off.
- More than 40 million Americans have diabetes, and over 115 million adults have prediabetes.
- Nearly half of U.S. adults, 47.7%, have hypertension.
- Approximately 37 million U.S. adults have chronic kidney disease, and CDC estimates that as many as nine in ten do not know it.
- Metabolic dysfunction-associated steatotic liver disease (MASLD), formerly known as fatty liver disease, affects an estimated 30% to 38% of U.S. adults.
- An estimated 83.7 million U.S. adults have obstructive sleep apnea, and published estimates suggest approximately 80% remain undiagnosed.
- Nearly four in ten adults, 38.5%, meet the clinical definition of metabolic syndrome.
- Approximately 35% of men over age 45 have testosterone deficiency, rising to as much as 50% among men with obesity or type 2 diabetes.
- Up to 80% of women experience vasomotor symptoms during the menopausal transition, with 34% experiencing moderate-to-severe symptoms.

Introduction

This chapter establishes the descriptive foundation for The State of Metabolic Health in America, 2026 Baseline Edition. It presents current, verifiable prevalence estimates for the principal conditions that define metabolic health status in the United States, drawing exclusively from federal surveillance systems, professional medical societies, and peer-reviewed research. Where multiple credible sources report different estimates due to differing methodologies or diagnostic thresholds, this chapter presents the most recent and most broadly cited figures and notes the range where appropriate.

Taken together, the data in this chapter describe a population in which several markers of metabolic health have continued to move in an unfavorable direction over the past two decades, even as public attention to metabolic disease has intensified. Severe obesity, metabolic syndrome, and the awareness gaps surrounding kidney and liver disease all show either continued increases or persistently high rates rather than meaningful improvement. These trends are consistent with an increasing public health burden. Establishing consistent, transparent, annual measurement of this kind is intended to make trajectories of this sort, whichever direction they take in future editions, easier to track and compare over time.

The remainder of this chapter proceeds condition by condition, beginning with obesity and severe obesity, the anchor measures against which most other metabolic conditions are commonly assessed, and continuing through diabetes and prediabetes, hypertension, chronic kidney disease, metabolic dysfunction-associated steatotic liver disease, obstructive sleep apnea, cardiovascular disease, metabolic syndrome, and the sex-specific burdens of testosterone deficiency in men and menopause-related symptom burden in women. Each section closes with a listing of the primary sources consulted, consistent with this report's commitment to full source transparency for every statistic presented.

Why This Matters

These conditions do not exist independently. They share common metabolic roots, and having one condition materially raises the likelihood of having several others. Treating them separately, as most health systems and health plans currently do, frequently produces fragmented care, fragmented measurement, and fragmented policy. Addressing metabolic health as a single, interconnected system rather than a collection of unrelated diagnoses is the organizing idea behind this entire report.

National Snapshot

This section presents current, verifiable prevalence estimates for the principal conditions that define metabolic health status in the United States, proceeding condition by condition. Each condition below is treated as a component of a single, interconnected metabolic health picture rather than as an isolated diagnosis, consistent with the organizing premise stated above.

Obesity and Severe Obesity

Obesity remains the most extensively measured marker of metabolic health in the United States, and the latest cycle of the National Health and Nutrition Examination Survey (NHANES), covering August 2021 through August 2023, found that the measured prevalence of obesity among adults age 20 and older was 40.3 percent, a figure that is the same whether reported as a crude or an age-adjusted estimate, with a prevalence of 39.2 percent in men and 41.3 percent in women, and no significant difference between men and women overall or within any individual age group. Obesity prevalence was highest among adults aged 40 to 59, at 46.4 percent, compared with adults aged 20 to 39 and those aged 60 and older. The condition remained well above the Healthy People 2030 national goal of 36.0 percent; readers comparing federal products should note that the Healthy People surveillance series reports 40.2 percent for this period under its own age-adjustment methodology, while NCHS Data Brief No. 508 reports 40.3 percent. and the overall adult obesity rate did not change significantly across the ten years spanning the 2013 to 2014 survey cycle through the most recent cycle.

The trend in severe obesity, defined as a body mass index of 40 or greater, has been less encouraging. Age-adjusted estimates place severe obesity at 9.7 percent of U.S. adults, with an additional 31.7 percent classified as overweight, and unadjusted figures for the same survey period show severe obesity at 9.4 percent. Unlike overall obesity, severe obesity prevalence continued to climb over the preceding decade, rising from 7.7 percent in the 2013 to 2014 NHANES cycle, with the largest increases occurring among women and among adults aged 40 to 59. This divergence, a stabilizing overall obesity rate alongside a still-rising severe obesity rate, is one of the more consequential findings in the current NHANES data, since severe obesity carries substantially higher risk for the downstream conditions addressed later in this chapter.

Geographic and socioeconomic patterns add further texture to the obesity picture. State-level surveillance places the Midwest and South as the regions with the highest adult obesity prevalence, and by 2024 every U.S. state and territory reported an obesity prevalence of at least 25 percent, with two states and one territory exceeding 40 percent. Obesity prevalence also varies inversely with educational attainment, and adults with a

bachelor's degree or higher consistently report lower obesity rates than adults with a high school diploma or less. These patterns matter for a report of this kind because they establish obesity not as a uniform national condition but as one shaped by geography, income, and access, a theme that recurs throughout the economic and employer-focused chapters that follow.

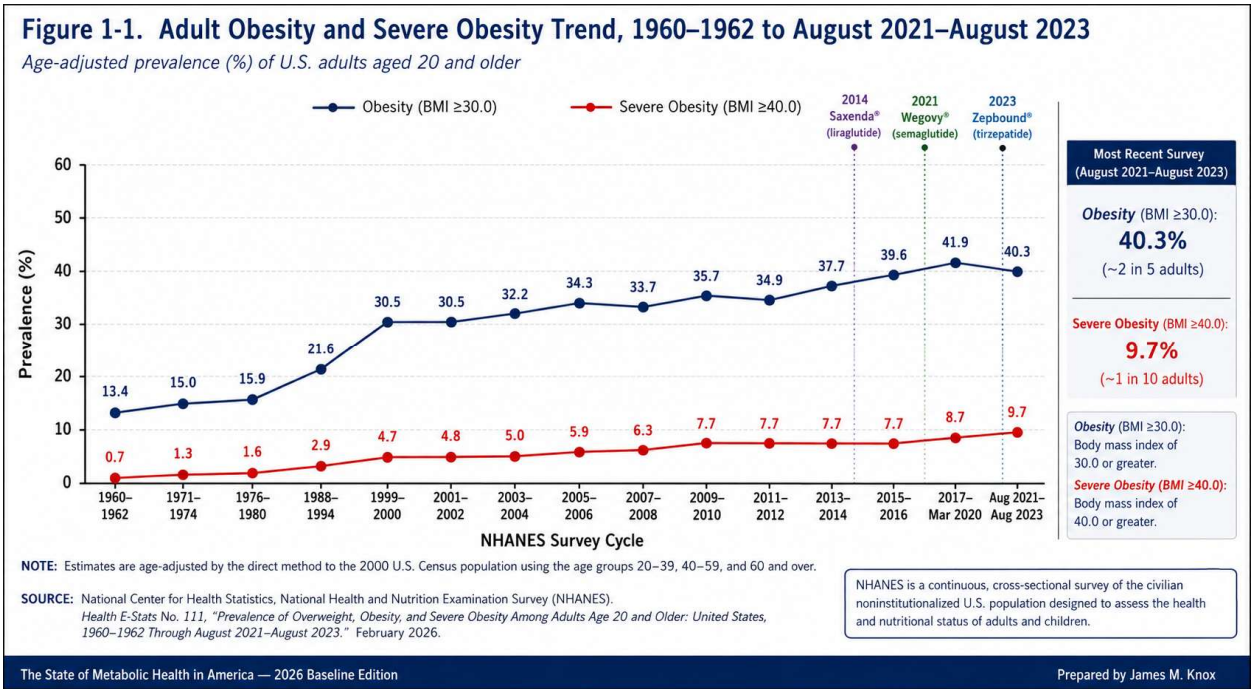


Figure 1-1. Adult Obesity and Severe Obesity Trend, 1960–1962 to August 2021–August 2023

Source: National Center for Health Statistics, National Health and Nutrition Examination Survey (NHANES). Health E-Stats No. 111, "Prevalence of Overweight, Obesity, and Severe Obesity Among Adults Age 20 and Older: United States, 1960–1962 Through August 2021–August 2023." February 2026.

Implications

Obesity prevalence above 40 percent, with severe obesity still rising, translates directly into higher medical claims costs for employers and health plans, greater utilization of specialty medications including GLP-1 therapies, and increased disability, absenteeism, and early retirement risk within the workforce. For Medicare and Medicaid, sustained high obesity prevalence among an aging population implies continued upward pressure on chronic disease spending for years to come. These figures are examined in direct economic terms in Chapter 2 and Chapter 3.

Sources: *Emmerich SD, Fryar CD, Stierman B, Ogden CL. Obesity and severe obesity prevalence in adults: United States, August 2021–August 2023. NCHS Data Brief No. 508. September 2024. doi:10.15620/cdc/159281; CDC Adult Obesity Prevalence Maps (updated December 2025); NCHS Health E-Stat 111.*

Diabetes and Prediabetes

The Centers for Disease Control and Prevention's National Diabetes Statistics Report, most recently updated in January 2026 using 2023 data, estimates that 40.1 million people of all ages, approximately 12.0 percent of the U.S. population, have diagnosed or undiagnosed diabetes. Of that total, 29.1 million people have been diagnosed, including 28.8 million adults aged 18 and older, while an estimated 11.0 million adults with diabetes remain undiagnosed, representing 27.6 percent of all adults living with the disease. Diabetes prevalence rises sharply with age, and adults aged 65 and older now show a diagnosed diabetes rate of 28.8 percent, underscoring the disease's disproportionate burden on an aging population.

Prediabetes represents a substantially larger population still. CDC surveillance estimates that more than 115 million American adults, more than two in five, have prediabetes, and among adults aged 65 and older, the CDC's most recent report places prediabetes prevalence at 52.1 percent, or roughly 31.3 million people. Because prediabetes frequently produces no symptoms and is detected only through laboratory testing, it remains substantially under-recognized relative to its true prevalence, a pattern consistent with the undiagnosed-diabetes gap described above.

Taken together, diabetes and prediabetes now affect a majority of the older adult population and a substantial share of working-age adults, which carries direct implications for the employer-sponsored health plans discussed in later chapters of this report. The scale of undiagnosed disease, more than one in four adults with diabetes, and likely a much larger share of adults with prediabetes, represents a measurement gap as much as a treatment gap, and it is precisely this kind of gap that population-level metabolic health measurement is intended to help close.

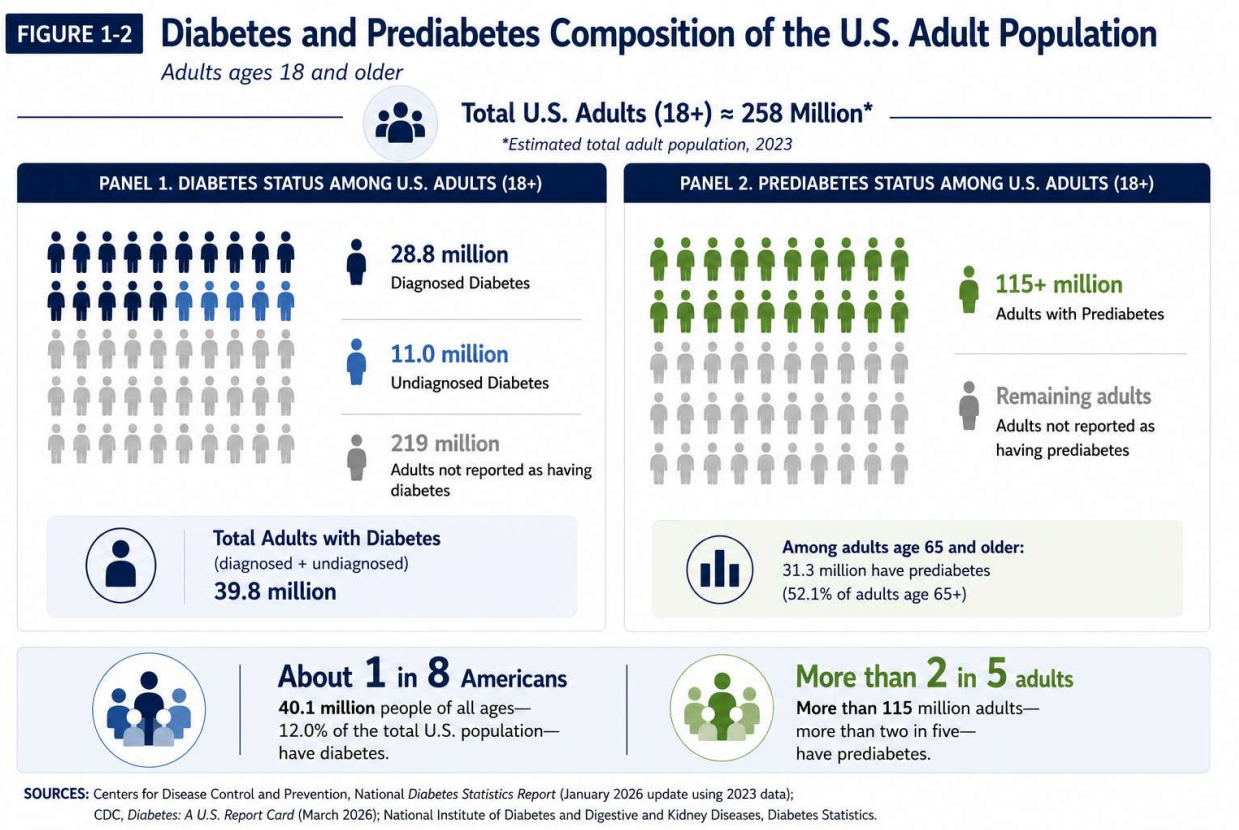


Figure 1-2. Diabetes and Prediabetes Composition of the U.S. Adult Population
Sources: Centers for Disease Control and Prevention, National Diabetes Statistics Report (updated January 21, 2026, using principally 2023 prevalence data); National Institute of Diabetes and Digestive and Kidney Diseases, Diabetes Statistics.

Implications

The scale of undiagnosed diabetes and prediabetes represents one of the largest opportunities in this entire report for earlier intervention: employers and health plans that identify prediabetes before progression to diabetes can meaningfully reduce long-term claims costs, while Medicare and Medicaid programs face a growing diagnosed population whose complications, including cardiovascular disease and chronic kidney disease, are the most expensive to treat once established. Screening and early identification, rather than late-stage disease management, are the highest-leverage levers available to policymakers and plan sponsors alike.

Sources: *Centers for Disease Control and Prevention, National Diabetes Statistics Report (updated January 21, 2026); National Institute of Diabetes and Digestive and Kidney Diseases, Diabetes Statistics.*

Hypertension

Hypertension affects nearly half of the U.S. adult population according to the most recent NHANES cycle. Hypertension prevalence in adults aged 18 and older was 47.7 percent, and was higher in men, at 50.8 percent, than in women, at 44.6 percent, with a separate CDC tabulation for adults aged 20 and older placing prevalence slightly higher, at 49.1 percent. Prevalence increases sharply with age, moving from 23.4 percent among adults aged 18 to 39 up to 52.5 percent among adults aged 40 to 59 and 71.6 percent among adults aged 60 and older.

Awareness, treatment, and control of hypertension remain incomplete even among those who carry the diagnosis. Among adults with hypertension, 59.2 percent were aware of their condition, 51.2 percent reported currently taking medication to lower their blood pressure, and only 20.7 percent had their blood pressure controlled to below 130/80 mm Hg, a pattern that has changed little over the past decade despite increased use of antihypertensive medication; awareness, treatment, and control showed no statistically significant change between the 2017 through March 2020 and August 2021 through August 2023 cycles. Approximately two in five adults with hypertension were unaware that they had the condition, which, combined with incomplete control among those who are aware and treated, means the true burden of uncontrolled hypertension in the United States is meaningfully understood only through population surveillance rather than through clinical records alone.

Hypertension's significance for this report extends well beyond its own prevalence, since it functions as both a component of the metabolic syndrome definition discussed later in this chapter and a primary driver of the cardiovascular and kidney disease burdens discussed in the sections that follow. Few single measurements connect as directly to downstream cost and mortality as blood pressure control, which is one reason hypertension trend data will be tracked consistently in every edition of this report going forward.

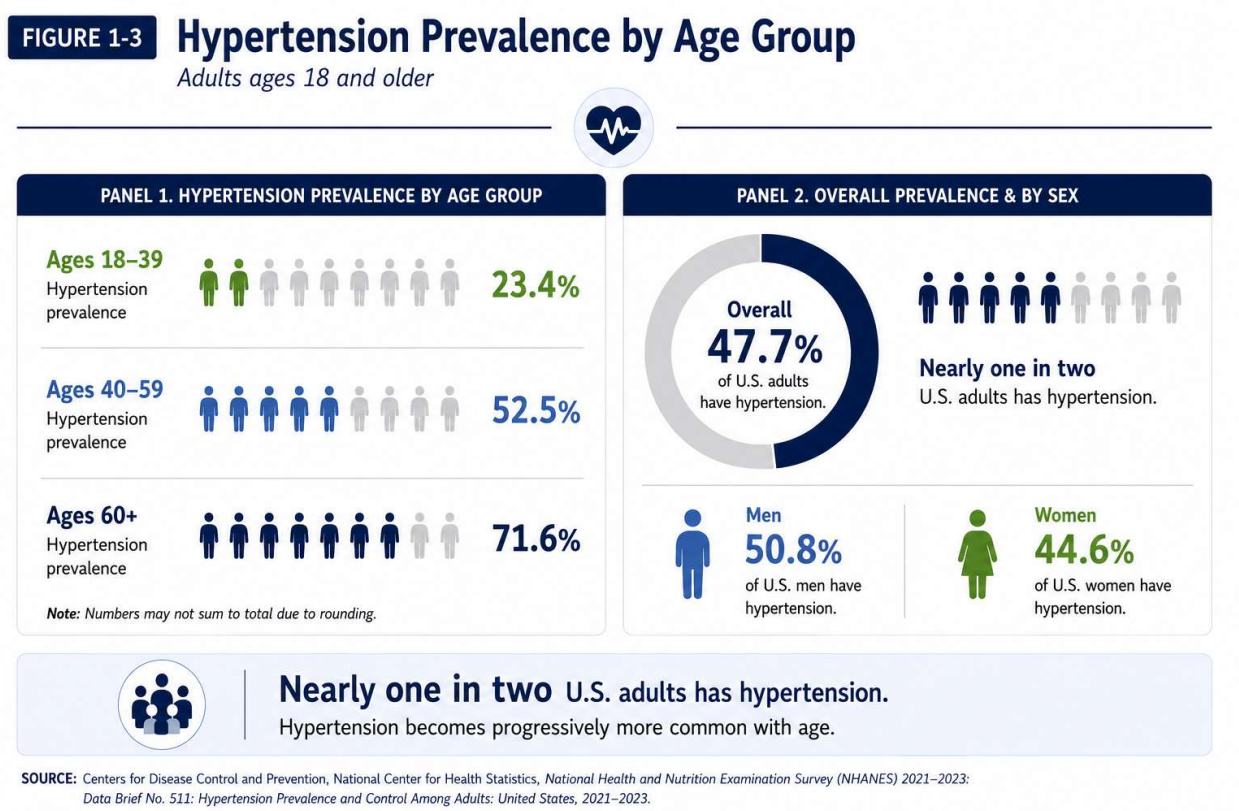


Figure 1-3. Hypertension Prevalence by Age Group

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Hypertension Prevalence, Awareness, Treatment, and Control Among Adults Age 18 and Older: United States, August 2021–August 2023. NCHS Data Brief No. 511. October 2024.

Implications

Because hypertension is inexpensive to screen for and treat relative to the downstream conditions it causes, the gap between prevalence (47.7 percent) and control (roughly one in five treated to target) represents one of the clearest cost-avoidance opportunities available to employers, health plans, Medicare, and Medicaid. Every percentage point improvement in blood pressure control has a direct, well-documented relationship to reduced rates of stroke, heart failure, and chronic kidney disease in the years that follow.

Sources: *Centers for Disease Control and Prevention, National Center for Health Statistics, Data Brief No. 511, "Hypertension Prevalence, Awareness, Treatment, and Control Among Adults Age 18 and Older: United States, August 2021–August 2023" (October 2024); CDC FastStats – Hypertension; CDC High Blood Pressure Facts.*

Chronic Kidney Disease

Chronic kidney disease affects a substantial and largely hidden share of the U.S. adult population. The CDC's most recent national estimate, updated in March 2026, places chronic kidney disease prevalence at approximately 14 percent of adults aged 18 and older, or roughly 37 million people. The disease is more common among adults aged 65 and older, among women relative to men, and among non-Hispanic Black adults relative to non-Hispanic Asian and non-Hispanic White adults.

The awareness gap in chronic kidney disease is more severe than in almost any other condition addressed in this chapter. CDC estimates that as many as nine in ten adults aged 20 and older with chronic kidney disease do not know they have it. Diabetes and hypertension are the two leading risk factors for chronic kidney disease, and the March 2026 CDC estimates quantify that overlap directly: approximately 38 percent of adults aged 18 and older with diagnosed or undiagnosed diabetes were estimated to have chronic kidney disease, rising to about 41 percent among adults with type 2 diabetes and about 49 percent among adults with type 1 diabetes, while roughly 21 percent of adults with high blood pressure and about 11 percent of adults with prediabetes were estimated to have the condition. Those figures place chronic kidney disease not at the periphery of metabolic disease but squarely inside it, and they are among the clearest available illustrations of why the conditions documented separately in this chapter are better understood as a single clustered burden. The National Kidney Foundation, a professional and patient-advocacy organization rather than a federal statistical agency, separately estimates that approximately one in three American adults, some 80 million people, carry at least one risk factor placing them at elevated future risk.

Chronic kidney disease's relationship to diabetes deserves particular attention in a report focused on metabolic health, since kidney disease is frequently a downstream consequence of years of poorly controlled blood glucose and blood pressure rather than a freestanding condition. The prevalence of chronic kidney disease among adults with diagnosed diabetes has been estimated at roughly 38 percent in the most recent pre-pandemic NHANES cycle, underscoring how closely the conditions in this chapter are linked to one another rather than existing as isolated statistics.

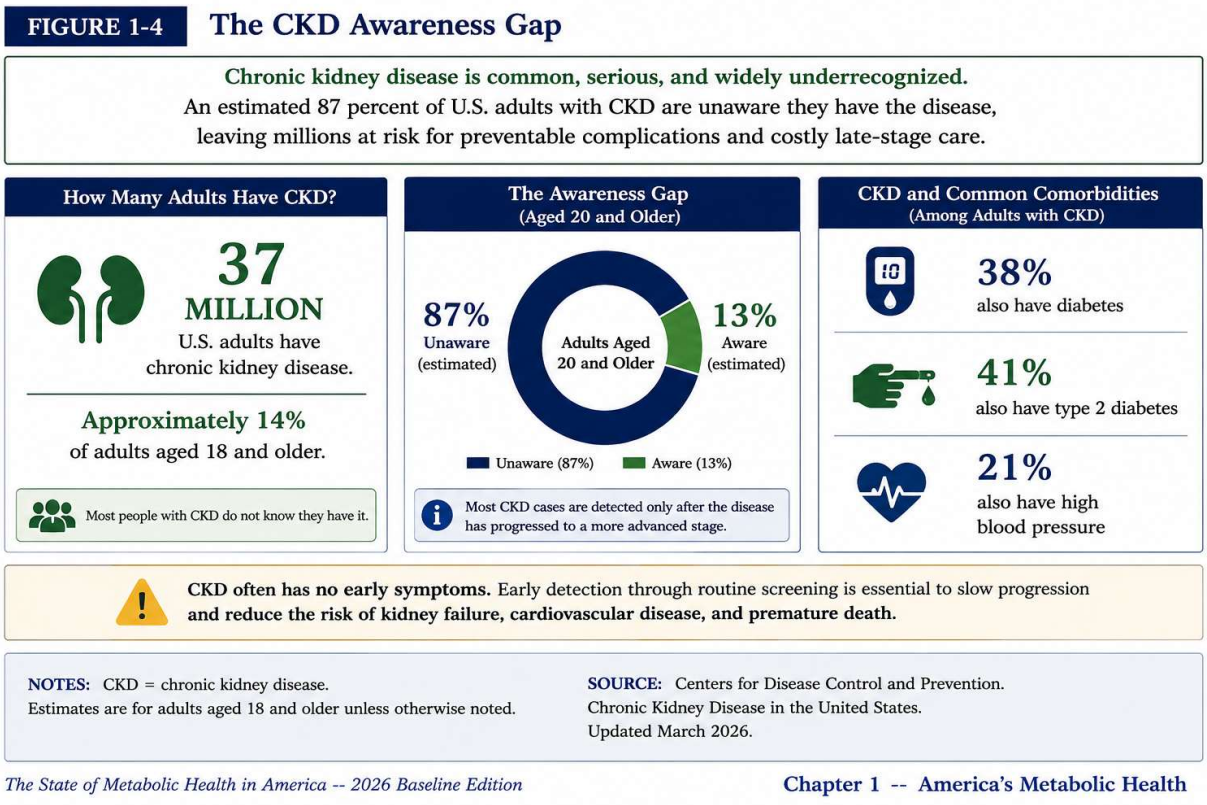


Figure 1-4. The CKD Awareness Gap

Sources: Centers for Disease Control and Prevention. Chronic Kidney Disease in the United States, March 2026 Update. National Kidney Foundation. Kidney Disease Statistics for the United States.

Implications

Chronic kidney disease's awareness gap, nine in ten adults with the condition unaware of their diagnosis, means most of its cost burden currently arrives late, in the form of dialysis and end-stage renal disease rather than earlier, far less expensive intervention. Employer health plans and Medicare both face outsized catastrophic claims exposure from this pattern, and expanded screening among adults with diabetes or hypertension, the two leading risk factors, represents one of the more direct paths to reducing that exposure over time.

Sources: *Centers for Disease Control and Prevention, "Chronic Kidney Disease in the United States" (updated March 2026); National Kidney Foundation, Kidney Disease Fact Sheet.*

Metabolic Dysfunction-Associated Steatotic Liver Disease

What was long known as nonalcoholic fatty liver disease has been renamed metabolic dysfunction-associated steatotic liver disease, or MASLD, to better reflect its underlying metabolic origins. Recent estimates place national prevalence in a range from roughly 30 percent to 38 percent of U.S. adults depending on diagnostic method and study population, with a review published in the American Diabetes Association's journal Diabetes Spectrum citing a U.S. prevalence of 38 percent, representing an increase of more than 50 percent over the past three decades.

The disease's connection to diabetes is especially pronounced. Among people with type 2 diabetes, MASLD prevalence has been estimated at 70 percent or higher in the American Diabetes Association's July 2025 consensus report on MASLD in people with diabetes; among those with both conditions, approximately half are estimated to have the more severe form known as metabolic dysfunction-associated steatohepatitis, and about one in five to have advanced liver fibrosis. These are cross-sectional prevalence estimates rather than measures of longitudinal progression. Cardiovascular disease, rather than liver failure itself, remains the leading cause of death among people with MASLD, which reinforces a broader theme running through this chapter: that these conditions rarely occur in isolation and instead compound one another's risk.

Public and clinical awareness of MASLD lags well behind its prevalence, and the condition receives comparatively little attention in mainstream discussions of metabolic health relative to obesity, diabetes, or hypertension. Given that it may affect more than one in four American adults and a substantial majority of adults with type 2 diabetes, this report will track MASLD prevalence and awareness in every future edition alongside the more commonly discussed metabolic conditions.

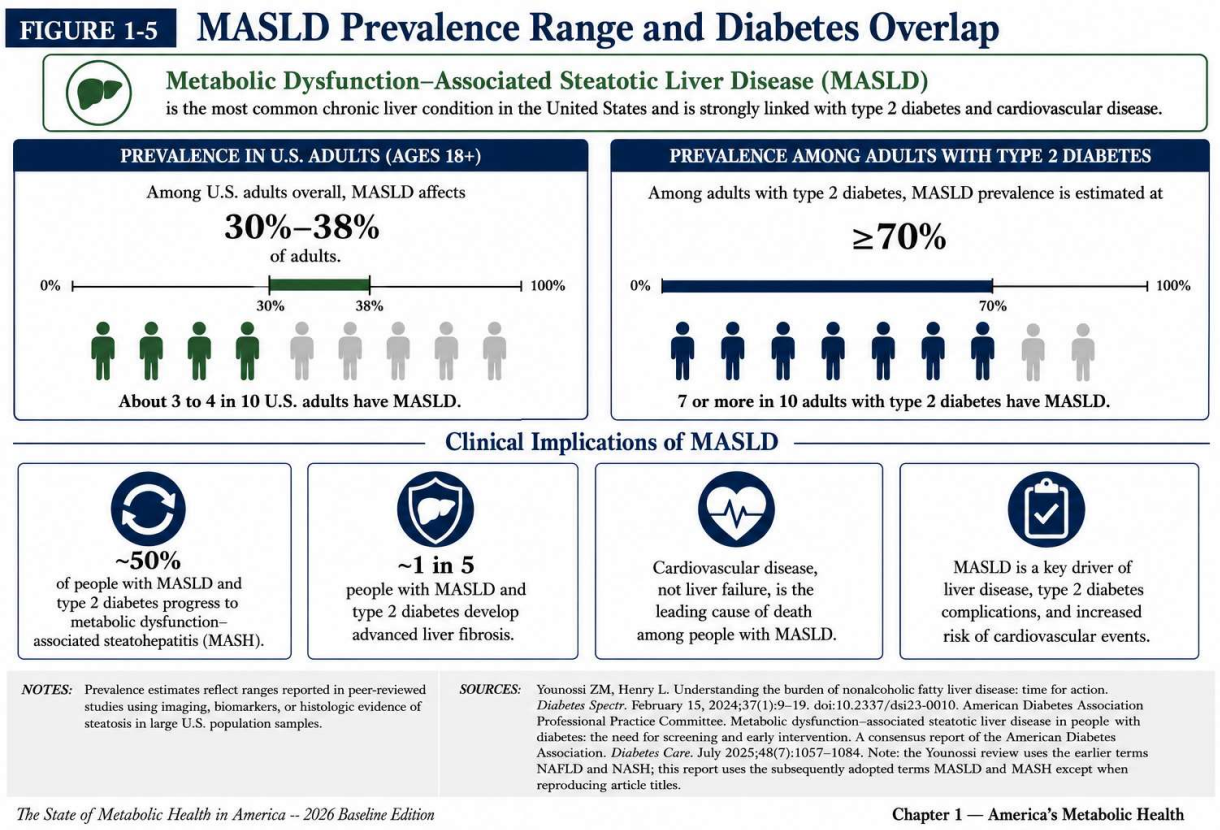


Figure 1-5. MASLD Prevalence Range and Diabetes Overlap

Sources: Younossi ZM, Henry L. Understanding the burden of nonalcoholic fatty liver disease: time for action. Diabetes Spectr. February 15, 2024;37(1):9–19. doi:10.2337/dsi23-0010. American Diabetes Association Professional Practice Committee. Metabolic dysfunction–associated steatotic liver disease in people with diabetes: the need for screening and early intervention. A consensus report of the American Diabetes Association. Diabetes Care. July 2025;48(7):1057–1084. Note: the Younossi review uses the earlier terms NAFLD and NASH; this report uses the subsequently adopted terms MASLD and MASH except when reproducing article titles.

Implications

MASLD is currently among the least screened-for conditions in this chapter relative to its prevalence, and it receives little dedicated attention in most employer wellness or disease management programs. As it becomes more clinically actionable, given emerging pharmacologic treatment options and its close relationship to obesity and diabetes management, MASLD screening is likely to become a more prominent feature of employer and health plan strategy in the years this report will track.

Sources: *American Diabetes Association, Diabetes Spectrum, "Understanding the Burden of Nonalcoholic Fatty Liver Disease: Time for Action" (2024); American Diabetes Association, Diabetes Care, Consensus Report on MASLD in People With Diabetes (2025).*

Obstructive Sleep Apnea

Obstructive sleep apnea is closely linked to obesity and has become substantially more prevalent as national obesity rates have risen. A peer-reviewed analysis published in 2025 in the journal Respiratory Medicine estimated that 83.7 million U.S. adults aged 20 and older, approximately 32.4 percent of the adult population, had obstructive sleep apnea as of 2024, a figure far higher than earlier estimates from the early 2010s, which placed prevalence closer to one in four adults.

The diagnostic gap in obstructive sleep apnea is among the largest of any condition addressed in this chapter. Published estimates cited in the 2025 prevalence analysis suggest that approximately 80 percent of people with the condition remain undiagnosed. The clinical literature also reports that underdiagnosis is disproportionately greater among women, among racial and ethnic minority populations, and among individuals in lower-income or rural communities, though this report was unable to identify a single primary source quantifying those differentials at the national level, and treats the pattern as a documented qualitative finding rather than a measured national estimate. Because untreated obstructive sleep apnea is strongly associated with hypertension, type 2 diabetes, cardiovascular disease, and reduced workplace productivity, this diagnostic gap has direct relevance for the employer and economic chapters later in this report.

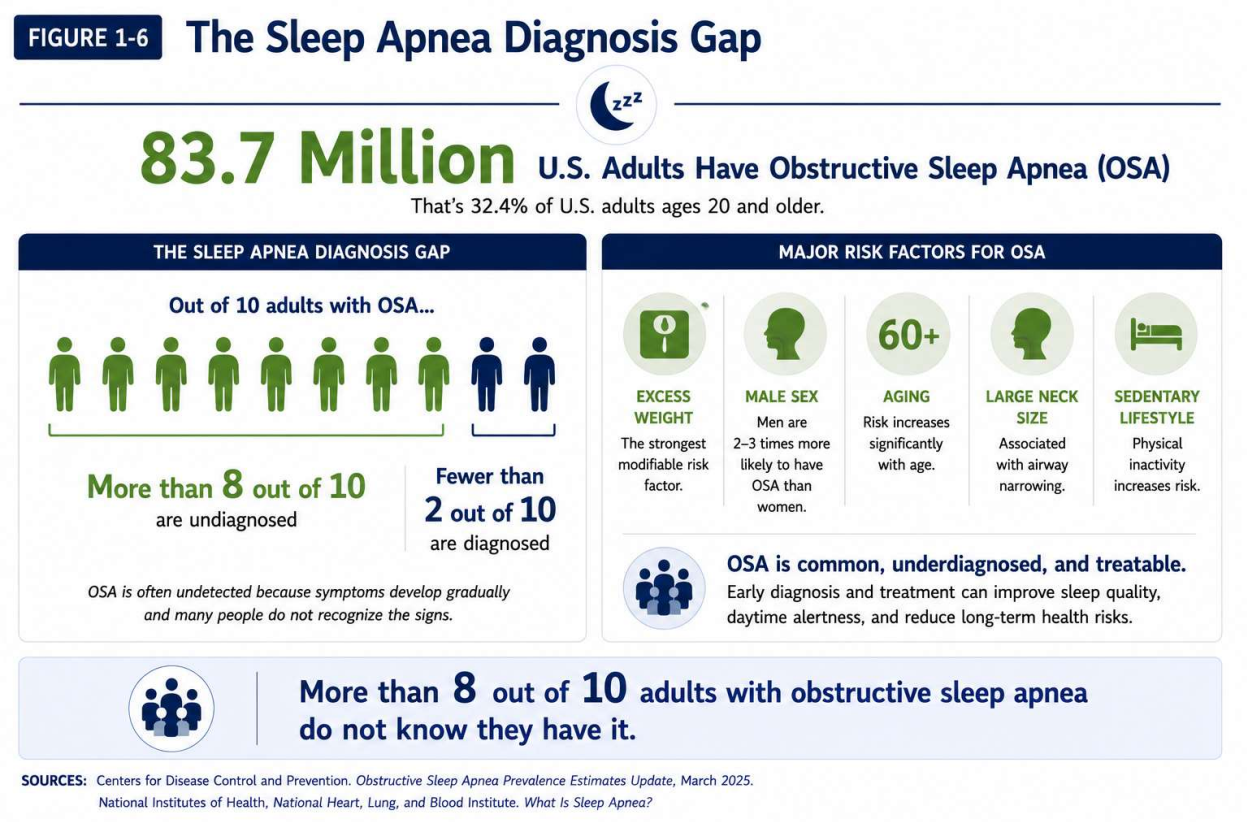


Figure 1-6. The Sleep Apnea Diagnosis Gap

Sources: Sönmez I, Vo Dupuy A, Yu KS, Cronin J, Yee J, Azarbarzin A. Unmasking obstructive sleep apnea: estimated prevalence and impact in the United States. Respir Med. November 2025;248:108348. Published online September 14, 2025. doi:10.1016/j.rmed.2025.108348. Condition definition: National Institutes of Health, National Heart, Lung, and Blood Institute. What Is Sleep Apnea?

Implications

Undiagnosed obstructive sleep apnea carries direct workplace safety implications, including elevated risk of drowsy-driving incidents and workplace accidents, in addition to its well-documented links to hypertension, diabetes, and cardiovascular disease. Employers in transportation, manufacturing, and other safety-sensitive industries have particular reason to treat sleep apnea screening as both a health cost issue and an occupational safety issue.

Sources: *Sönmez I, Vo Dupuy A, Yu KS, Cronin J, Yee J, Azarbarzin A. Unmasking obstructive sleep apnea: estimated prevalence and impact in the United States. Respir Med. November 2025;248:108348. Published online September 14, 2025. doi:10.1016/j.rmed.2025.108348.*

Cardiovascular Disease

Cardiovascular disease remains the leading cause of death in the United States. In 2023, diseases of heart, the National Center for Health Statistics category encompassing coronary heart disease, heart failure, and related conditions, accounted for 680,981 deaths, or 22.0 percent of all U.S. deaths, while stroke became the fourth-leading cause of death at 162,639 deaths, or 5.3 percent, with the two together accounting for 843,620 deaths, approximately 27.3 percent of all deaths and thus more than one-quarter of the national total. Coronary heart disease was the underlying cause of 349,470 deaths in 2023, a meaningful decline from 371,506 deaths the year before, continuing a long-term pattern of falling age-adjusted mortality even as overall prevalence continues to climb.

That apparent contradiction, falling death rates alongside rising prevalence, is one of the defining features of contemporary cardiovascular epidemiology. When hypertension is included within the broad American Heart Association definition of cardiovascular disease, nearly half of all U.S. adults now meet criteria for the condition. Longer survival after diagnosis, high prevalence of hypertension and metabolic risk factors, earlier onset of disrupted glucose metabolism, and population aging all contribute to the coexistence of declining age-adjusted mortality with a large and growing prevalent disease burden.

The 2026 American Heart Association update introduced a new chapter specifically addressing cardiovascular-kidney-metabolic syndrome, reflecting a growing consensus among cardiologists, endocrinologists, and nephrologists that heart disease, kidney disease, and metabolic dysfunction should be assessed as an interconnected system rather than as separate specialties. This report's own framework, treating obesity, diabetes, hypertension, kidney disease, liver disease, and cardiovascular disease as a single interrelated picture of metabolic health, reflects the same underlying logic that led the American Heart Association to formally adopt cardiovascular-kidney-metabolic syndrome as a surveillance category.

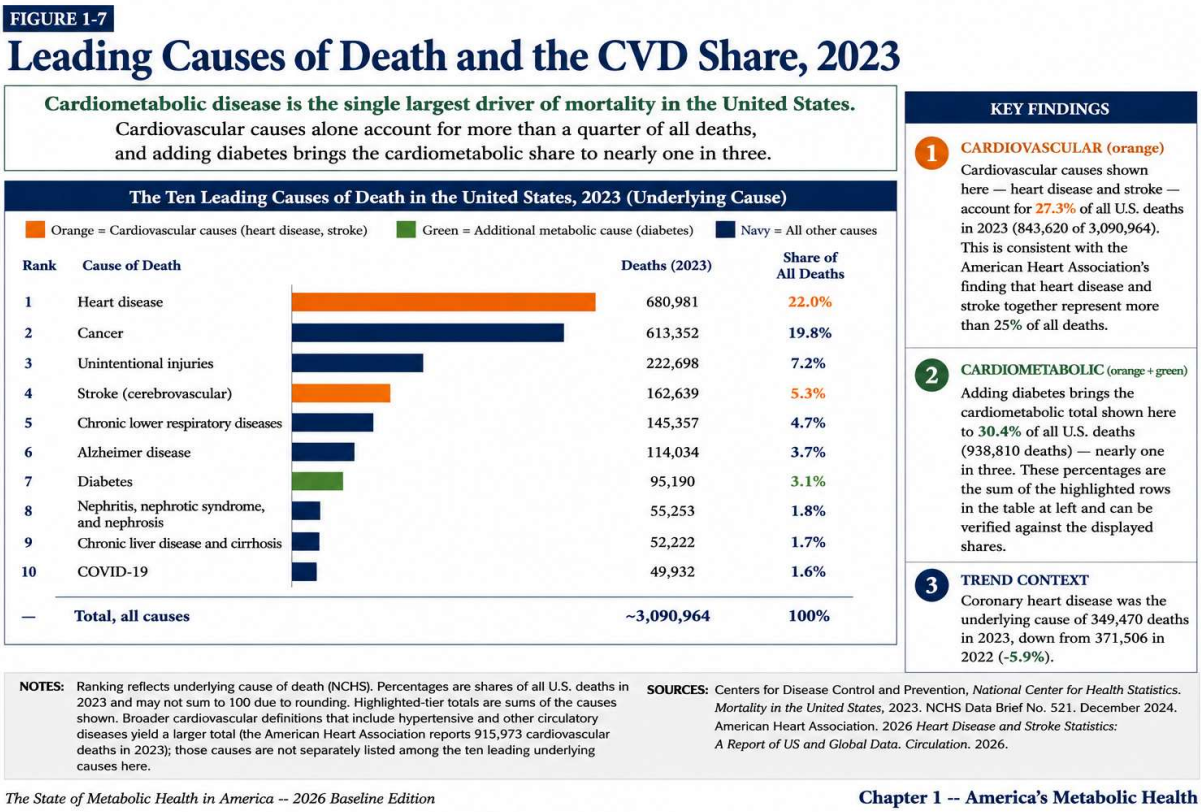


Figure 1-7. Leading Causes of Death and the CVD Share, 2023

Sources: Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2023. NCHS Data Brief. December 19, 2024;(521):1–13. doi:10.15620/cdc/170564. Palaniappan LP, Allen NB, Almarzooq ZI, et al. 2026 heart disease and stroke statistics: a report of US and global data from the American Heart Association. Circulation. March 3, 2026;153(9):e275–e906. doi:10.1161/CIR.0000000000001412.

Implications

Cardiovascular disease remains the single largest driver of mortality-related cost for employer health plans, Medicare, and Medicaid alike, and the American Heart Association's own adoption of cardiovascular-kidney-metabolic syndrome as a surveillance category signals that future cost and quality models will increasingly need to account for these conditions jointly rather than individually. Health plans and employers that continue to manage cardiovascular risk, diabetes risk, and kidney risk through separate, uncoordinated programs are likely to fall further behind this shift over time.

Sources: *Palaniappan LP, Allen NB, Almarzooq ZI, et al.; American Heart Association Council on Epidemiology and Prevention Statistics Committee and Stroke Statistics Committee. 2026 heart disease and stroke statistics: a report of US and global data from the American Heart Association. Circulation. March 3, 2026;153(9):e275–e906. Published online January 21, 2026. doi:10.1161/CIR.0000000000001412. Ndumele CE, Rodriguez F, Dixon DL, et al. 2026 AHA/ACC/ADA/ASN guideline for the prevention, detection, evaluation, and management of cardiovascular-kidney-metabolic syndrome. J Am Coll Cardiol. June 9, 2026;87(22S):e1889–e2007. doi:10.1016/j.jacc.2026.03.056.*

Metabolic Syndrome

Metabolic syndrome, defined as the presence of at least three of five specific risk factors including central obesity, elevated triglycerides, reduced HDL cholesterol, elevated blood pressure, and elevated fasting glucose, provides one of the most direct composite measures of population metabolic health available in the peer-reviewed literature. A recent analysis of NHANES data spanning 2013 through August 2023, published in JAMA, found a weighted prevalence of 38.7 percent, with the most recent survey cycle, August 2021 through August 2023, showing prevalence at 38.5 percent, meaning close to four in ten American adults now meet the clinical definition.

The trend over time, while not statistically significant as a single continuous increase across the full study period, has moved in a consistently unfavorable direction among specific subgroups. Prevalence among adults aged 60 and older rose from 50.2 percent in the 2013 to 2014 survey cycle to 62.4 percent in the most recent cycle, and a significant increase was also observed among non-Hispanic Black adults. Younger adults showed comparatively stable prevalence over the same period, suggesting the overall national increase is concentrated among older Americans rather than distributed evenly across age groups.

Because metabolic syndrome is a composite measure built directly from the same underlying risk factors, obesity, blood pressure, blood glucose, and lipid abnormalities, that appear individually throughout this chapter, it functions as something close to a summary statistic for the state of American metabolic health as a whole. A prevalence approaching 40 percent of all adults, concentrated most heavily among older Americans, is consistent with the broader pattern this chapter documents: a population in which multiple markers of metabolic dysfunction are common, interconnected, and, in several cases, still trending in the wrong direction.

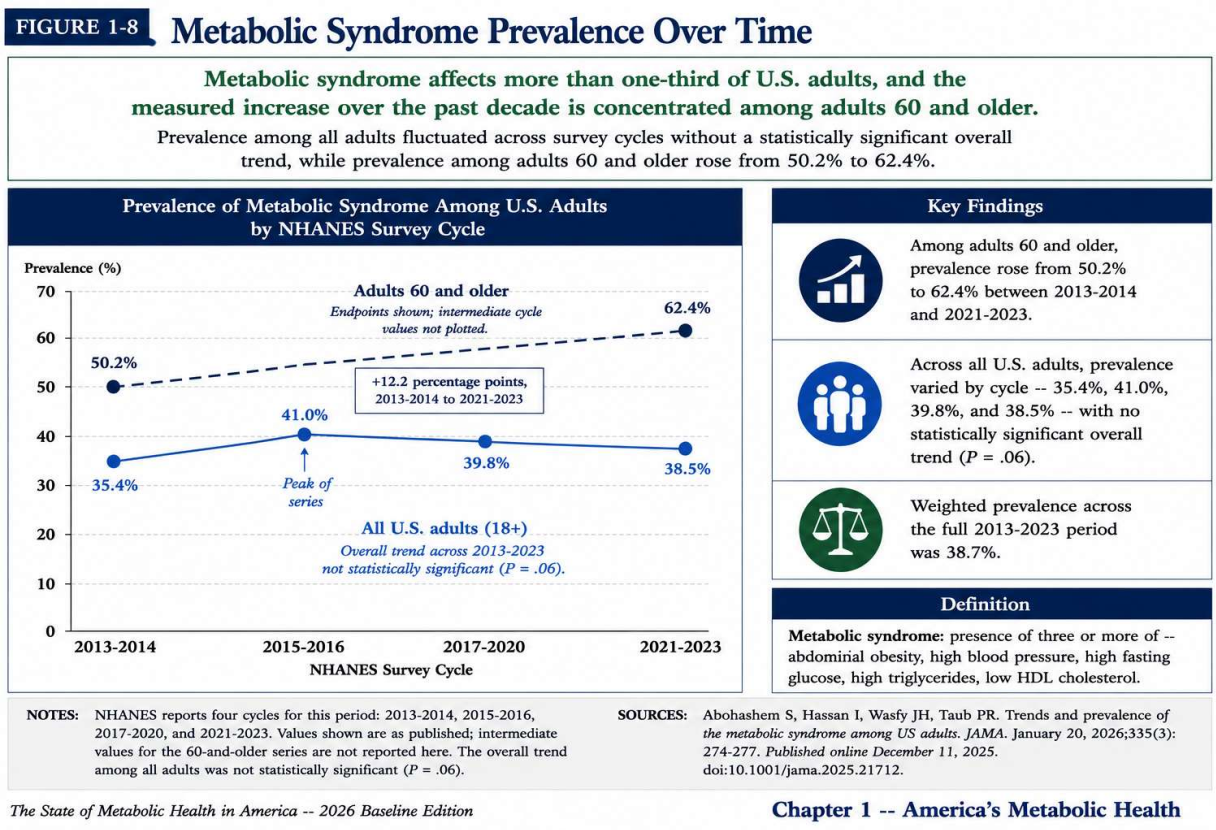


Figure 1-8. Metabolic Syndrome Prevalence Over Time

Source: Abohashem S, Hassan I, Wasfy JH, Taub PR. Trends and prevalence of the metabolic syndrome among US adults. JAMA. January 20, 2026;335(3):274–277. Published online December 11, 2025. doi:10.1001/jama.2025.21712.

Implications

Because metabolic syndrome combines several risk factors into a single diagnosis, it offers employers and health plans a practical, single screening target for identifying members at the highest composite risk, rather than managing each risk factor in isolation. Its concentration among older adults also has direct relevance for Medicare, where nearly two-thirds of the 60-and-older population now meets the clinical definition.

Sources: *Abohashem S, Hassan I, Wasfy JH, Taub PR. Trends and prevalence of the metabolic syndrome among US adults. JAMA. January 20, 2026;335(3):274–277. Published online December 11, 2025. doi:10.1001/jama.2025.21712. Additional context, not the source of the trend series reported here: Liang X, Or B, Tsoi MF, Cheung CL, Cheung BMY. Prevalence of metabolic syndrome in the United States National Health and Nutrition Examination Survey 2011–18. Postgrad Med J. August 22, 2023;99(1175):985–992. doi:10.1093/postmj/qgad008.*

Testosterone Deficiency in Men

Testosterone deficiency, also referred to clinically as male hypogonadism, is a common but comparatively under-measured component of metabolic health in men. The Endocrine Society, the leading U.S. professional society for hormone-related medicine, estimates that approximately 35 percent of men older than age 45 have hypogonadism, with prevalence rising further, to between 30 and 50 percent, among men who have obesity or type 2 diabetes.

The relationship between testosterone deficiency and the other conditions addressed in this chapter runs in both directions. Obesity and type 2 diabetes are established risk factors for low testosterone, while low testosterone itself is associated with increased visceral fat accumulation, reduced muscle mass, and further metabolic decline, creating a reinforcing cycle rather than a one-directional relationship. Because testosterone naturally declines with age even in the absence of disease, distinguishing age-related decline from clinically significant deficiency requires laboratory confirmation alongside symptom assessment, a standard the Endocrine Society and the American Urological Association both apply in their respective clinical guidelines.

Testosterone deficiency remains one of the more inconsistently diagnosed conditions in this chapter, in part because of variation across professional societies in the laboratory threshold used to define deficiency, and in part because symptoms such as fatigue, reduced libido, and mood changes are frequently attributed to aging generally rather than investigated as a distinct clinical entity. This report will track testosterone deficiency prevalence in future editions as more standardized national surveillance data become available.

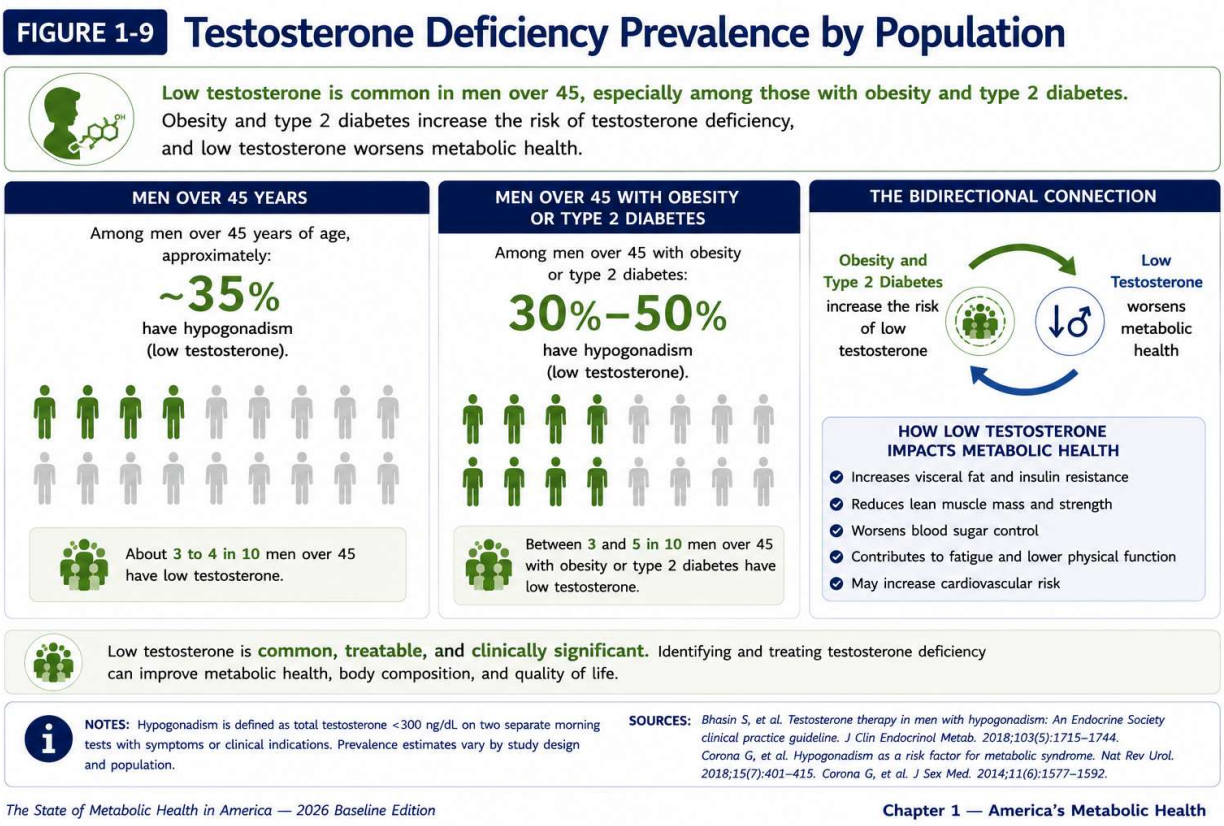


Figure 1-9. Testosterone Deficiency Prevalence by Population

Sources: Bhasin S, et al. Testosterone therapy in men with hypogonadism: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2018;103(5):1715–1744. Corona G, Rastrelli G, Morelli A, et al. Hypogonadism and metabolic syndrome. J Endocrinol Invest. 2011;34(7):557–567. doi:10.3275/7806. Corona G, Isidori AM, Buvat J, et al. Testosterone supplementation and sexual function: a meta-analysis study. J Sex Med. 2014;11(6):1577–1592. doi:10.1111/jsm.12536. Corona G, Rastrelli G, Di Pasquale G, Sforza A, Mannucci E, Maggi M. Endogenous testosterone levels and cardiovascular risk: meta-analysis of observational studies. J Sex Med. 2018;15(9):1260–1271. doi:10.1016/j.jsxm.2018.06.012. Rastrelli G, Filippi S, Sforza A, Maggi M, Corona G. Metabolic syndrome in male hypogonadism. Front Horm Res. 2018;49:131–155. doi:10.1159/000485999.

Implications

Testosterone deficiency's overlap with obesity and type 2 diabetes suggests that men's health programming addressing these conditions in isolation is likely missing a meaningful share of an interconnected problem. Employers with substantial male workforce populations, particularly in industries with older workforce demographics, may find value in incorporating testosterone screening into broader metabolic health initiatives rather than treating it as a separate, niche benefit.

Sources: *Endocrine Society, "Hypogonadism in Men," patient guidance; The American Journal of Medicine, review of testosterone deficiency.*

Menopause Symptom Burden in Women

Menopause is a universal biological transition for women, and its associated vasomotor symptoms, hot flashes and night sweats, are among the most common and disruptive symptoms addressed anywhere in this chapter. Peer-reviewed literature published in the journal Menopause estimates that vasomotor symptoms occur in up to 80 percent of women during the menopausal transition, with a global cross-sectional survey finding that moderate-to-severe vasomotor symptoms specifically affect approximately 34 percent of women in the United States.

The duration and impact of these symptoms are frequently underestimated in public discussion. Vasomotor symptoms can persist for an average of seven to ten years, and for a meaningful subset of women, symptoms continue for considerably longer. Beyond hot flashes and night sweats, women in the same survey commonly reported fatigue, joint and muscle aching, and difficulty sleeping as prominent menopausal symptoms, each of which carries independent implications for workplace productivity and quality of life.

Menopause-related symptom burden intersects with metabolic health in ways that are increasingly well documented, including a tendency toward increased central adiposity, unfavorable shifts in lipid profiles, and increased cardiovascular risk following the menopausal transition. Despite this, menopause remains comparatively underrepresented in employer wellness programming relative to its prevalence and its documented effect on the roughly half of the U.S. workforce that will pass through this transition during their working years, a gap this report intends to help address through consistent annual measurement.

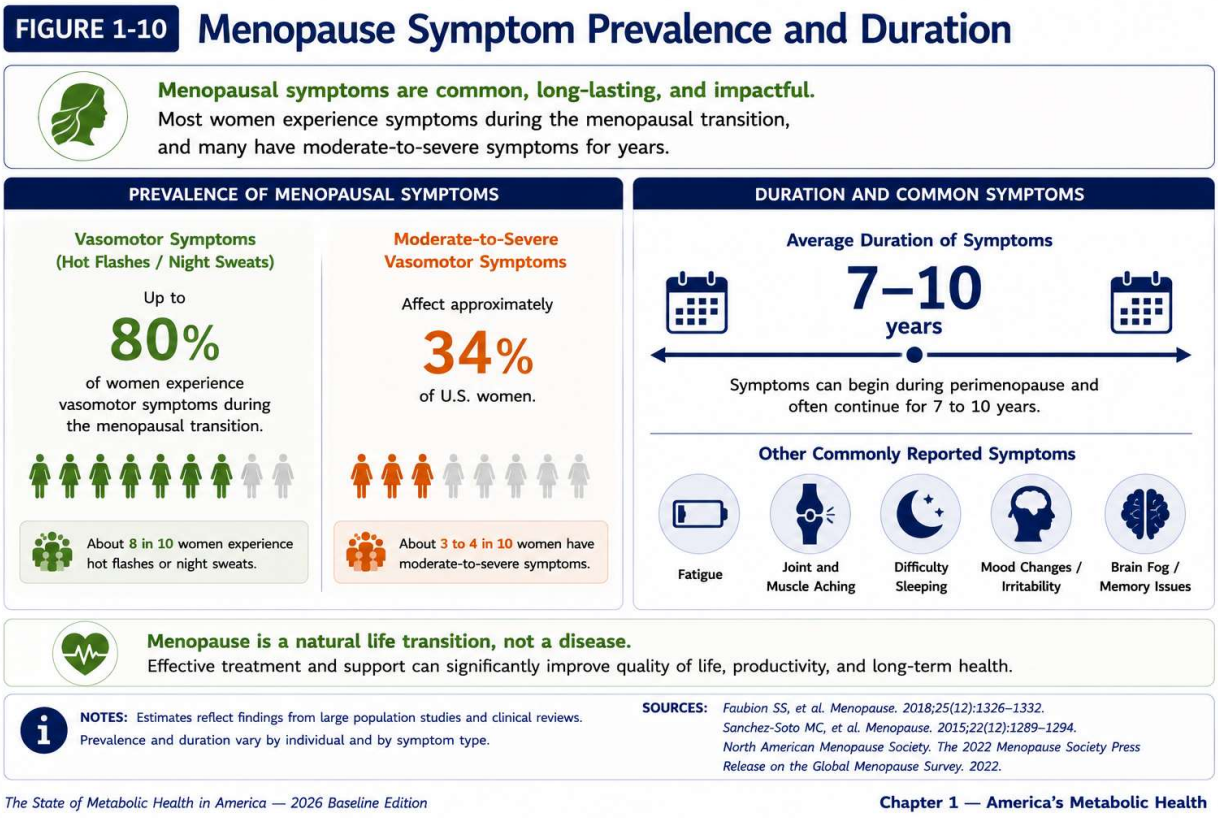


Figure 1-10. Menopause Symptom Prevalence and Duration

Sources: The North American Menopause Society Nonhormone Therapy Position Statement Advisory Panel. The 2023 nonhormone therapy position statement of The North American Menopause Society. Menopause. 2023;30(6):573–590. doi:10.1097/GME.0000000000002200. Avis NE, Crawford SL, Greendale G, et al. Duration of menopausal vasomotor symptoms over the menopause transition. JAMA Intern Med. 2015;175(4):531–539. doi:10.1001/jamainternmed.2014.8063. Williams RE, Kalilani L, DiBenedetti DB, et al. Frequency and severity of vasomotor symptoms among peri- and postmenopausal women in the United States. Climacteric. 2008;11(1):32–43. The North American Menopause Society 2022 Hormone Therapy Position Statement Advisory Panel. The 2022 hormone therapy position statement of The North American Menopause Society. Menopause. 2022;29(7):767–794. doi:10.1097/GME.0000000000002028. Santoro N, Epperson CN, Mathews SB. Menopausal symptoms and their management. Endocrinol Metab Clin North Am. 2015;44(3):497–515. doi:10.1016/j.ecl.2015.05.001. North American Menopause Society. The 2022 Menopause Society Press Release on the Global Menopause Survey. 2022.

Implications

With vasomotor symptoms affecting up to 80 percent of women for an average of seven to ten years, and with menopause's documented links to increased cardiovascular and metabolic risk, employers are increasingly likely to view menopause support as core to metabolic health strategy rather than as a separate, optional benefit. Given that roughly half of the workforce will pass through this transition, the current underrepresentation of menopause in employer wellness programming represents a substantial and largely unaddressed gap.

Sources: *Menopause, journal of The Menopause Society, global cross-sectional survey of vasomotor symptoms (2021); American Journal of Obstetrics & Gynecology, review of vasomotor symptoms in menopause.*

Trends

Several through-lines connect the individual conditions documented in the National Snapshot above. Over the past two decades, the overall adult obesity rate has risen substantially before leveling off in the most recent surveillance period, even as severe obesity, the category most closely associated with downstream metabolic complications, has continued to increase rather than plateau. Diabetes and prediabetes prevalence together now describe a majority-at-risk adult population, and several of the conditions in this chapter, chronic kidney disease, metabolic dysfunction-associated steatotic liver disease, and obstructive sleep apnea in particular, are characterized less by rising measured prevalence than by persistently large gaps between how many people have the condition and how many know it.

The most consistent trend across conditions is therefore not a single direction of change but a combination of high baseline prevalence, continued increases in the most severe categories, and large undiagnosed populations that make the true burden difficult to measure. This chapter treats that combination, rather than any one condition's trajectory, as the defining feature of America's current metabolic health status, and future editions will track whether the recent leveling in overall obesity prevalence proves durable or reverses, and whether the awareness gaps documented here narrow as screening and newer treatments expand.

Policy Implications

The prevalence figures in this chapter carry implications that later chapters examine in economic and programmatic terms. Because metabolic conditions cluster within the same individuals and share common physiological roots, a health system, employer, or public program that measures and manages each condition in isolation may systematically understate the true, combined burden any single person carries, and may fragment both care and accountability across conditions that are clinically interdependent. This chapter does not recommend any specific policy response; it establishes the descriptive baseline against which the cost, coverage, and intervention questions in Chapters 2 through 10 are measured.

The large undiagnosed populations documented for chronic kidney disease, steatotic liver disease, and obstructive sleep apnea in particular indicate that measured, diagnosis-based prevalence, the kind most administrative and claims data can capture, understates true prevalence for several conditions, a distinction directly relevant to how employers, Medicare, and Medicaid should interpret their own population data in later

chapters. Consistent, transparent measurement of these gaps is itself the principal contribution this chapter is intended to make.

2026 Baseline Metrics

The table below consolidates the headline prevalence figures presented throughout this chapter into a single reference point. Each metric is assigned a stable identifier, MH-01 through MH-11, that will remain unchanged in every future edition of this report. These identifiers are intended to make individual measures easy to cite consistently across editions, whether by readers, journalists, policymakers, or this report's own future chapters, without ambiguity about which measure is being referenced from one year to the next.

ID	Metric	2026 Baseline Value
MH-01	Adult obesity	40.3%
MH-02	Severe obesity	9.7% (age-adjusted)
MH-03	Diabetes (all ages)	40.1 million (12.0% of population)
MH-04	Prediabetes (adults)	115+ million (>2 in 5 adults)
MH-05	Hypertension (adults 18+)	47.7%
MH-06	Chronic kidney disease (adults)	~37 million (~14%)
MH-07	MASLD / fatty liver disease (adults)	30%–38%
MH-08	Obstructive sleep apnea (adults 20+)	83.7 million (32.4%)
MH-09	Metabolic syndrome (adults)	38.5%
MH-10	Testosterone deficiency (men 45+)	~35%
MH-11	Menopausal vasomotor symptoms (women)	up to 80% (34% moderate-to-severe)

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly. The prevalence estimates presented here draw on different surveillance systems with different methodologies: some, such as the obesity

and hypertension figures, derive from the National Health and Nutrition Examination Survey, which uses direct physical measurement of a nationally representative sample; others rely on self-reported diagnosis, claims data, or modeled estimates, each of which can understate true prevalence, particularly for conditions with large undiagnosed populations. Where this chapter reports a range rather than a single figure, that range typically reflects genuine methodological disagreement between credible sources rather than imprecision, and this chapter reports the range rather than silently selecting one figure.

Direct comparison of prevalence figures across conditions should also account for differences in diagnostic threshold and reference period. The hypertension figure in this chapter, for example, applies the lower diagnostic threshold in use since 2017 and reflects measured blood pressure, which is why it is substantially higher than self-reported, state-level hypertension figures reported later in this report in Chapter 7; this report flags that specific incompatibility directly rather than allowing the two figures to appear inconsistent. As a general matter, the figures in this chapter are most reliable as estimates of national prevalence and least reliable as precise counts, and should be read accordingly.

Chapter Summary

Considered together, the conditions surveyed in this chapter do not describe eleven separate health problems so much as one interconnected pattern of American metabolic health. Obesity, diabetes, hypertension, chronic kidney disease, fatty liver disease, sleep apnea, cardiovascular disease, and metabolic syndrome share overlapping risk factors, and in most cases, having one condition materially raises the likelihood of having several others. Testosterone deficiency and menopausal symptom burden, while distinct in their sex-specific presentation, sit within the same broader metabolic framework and deserve the same rigor of measurement historically reserved for more commonly discussed conditions.

The data reviewed in this chapter point toward a population in which several important markers, severe obesity, metabolic syndrome, and the awareness gaps surrounding kidney and liver disease in particular, have continued to move in an unfavorable direction over the past decade, even as overall obesity prevalence has shown signs of leveling off. These trends are consistent with an increasing public health burden across several of this

chapter's measures. Consistent, transparent, annual measurement of the kind presented here is intended to make trajectories of this sort, whatever direction they take, easier to track and compare across future editions.

The chapters that follow build directly on the prevalence data presented here. Chapter 2 quantifies the economic impact of these conditions in terms of direct healthcare spending and lost productivity, Chapter 3 examines how employer-sponsored health plans are responding, and subsequent chapters extend the analysis to Medicare, Medicaid, public health infrastructure, and state-by-state variation. Each of those chapters will return repeatedly to the baseline established in this chapter, which is the intended function of a baseline edition: to give every future edition of this report, and every reader who consults it, a fixed and well-documented point of comparison.

Looking Ahead to the 2027 Edition

Each edition of this report will close with a short list of developments worth watching before the next edition is published. These are not predictions; they are simply the specific data points and policy developments most likely to move the metrics established in this chapter, one way or the other, over the coming year.

- GLP-1 medication adoption rates and their measurable effect, if any, on population-level obesity and diabetes prevalence.
- Whether severe obesity prevalence continues its decade-long upward trend or begins to plateau alongside overall obesity.
- Chronic kidney disease awareness and screening initiatives, and whether the current nine-in-ten unawareness rate begins to narrow.
- MASLD screening guideline adoption among primary care providers and its effect on diagnosis rates.
- Medicare and Medicaid policy developments affecting coverage of metabolic health screening and treatment.
- State-level variation in obesity, diabetes, and hypertension prevalence, to be examined in full in Chapter 7 of this report.

Questions We Still Cannot Answer

Even a report of this depth cannot answer every question a serious reader might bring to it. Public surveillance data of the kind relied upon throughout this chapter is very strong at describing prevalence and trend, but it is considerably weaker at answering the harder causal and comparative questions that matter most to the people who must act on this information, including employers, health plans, policymakers, and clinicians. This section names those open questions directly, both as an honest accounting of this report's current limits and as a starting point for what future editions of this report might help address.

- Is the American population becoming more or less metabolically healthy over time, once measurement changes, survey redesigns, and diagnostic threshold shifts are properly accounted for?
- Which specific interventions, clinical, workplace, or policy, produce the largest measurable improvement in population-level metabolic health, as distinct from individual patient outcomes?
- Which employer benefit strategies produce durable, multi-year improvement in metabolic health outcomes, rather than short-term engagement or biometric screening participation alone?
- Which public health investments, at the federal, state, or local level, produce sustained population-level change rather than temporary improvement that reverses once funding or attention shifts elsewhere?
- How should a single, standardized measure of metabolic health be constructed and validated so that the same measure could be applied consistently across individuals, employer populations, and entire communities?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year. Where new measurement approaches, public or private, offer credible answers to any of them, this report will describe those approaches and evaluate the evidence behind them on their own merits.

Sources

Consistent with this report's commitment to full source transparency, the primary sources supporting each condition are listed at the close of that condition's discussion in the National Snapshot above. The principal sources for this chapter as a whole are consolidated here.

- Centers for Disease Control and Prevention, National Center for Health Statistics: NHANES prevalence data; Data Brief No. 508, "Obesity and Severe Obesity Prevalence in Adults: United States, August 2021-August 2023" (September 2024); Adult Obesity Prevalence Maps (updated December 2025); NCHS Health E-Stat 111.
- Centers for Disease Control and Prevention: National Diabetes Statistics Report; National Chronic Kidney Disease Fact Sheet; Behavioral Risk Factor Surveillance System.
- American Heart Association. Heart Disease and Stroke Statistics, 2025 Update.
- American Diabetes Association. Standards of Care in Diabetes.
- Peer-reviewed prevalence literature for metabolic dysfunction-associated steatotic liver disease (MASLD), obstructive sleep apnea, metabolic syndrome, testosterone deficiency, and menopausal vasomotor symptom burden, as cited within the corresponding sections of the National Snapshot.

Chapter 2

Economic Impact

Chapter 2 Key Findings

- U.S. national health expenditures reached $5.3 trillion in 2024, or $15,474 per person, consuming 18.0% of GDP.
- Obesity alone accounts for nearly $173 billion in U.S. medical expenditures annually.
- The total annual cost of diagnosed diabetes in the United States is $412.9 billion, including $306.6 billion in direct medical costs and $106.3 billion in indirect costs.
- Employer-sponsored family health insurance premiums reached $26,993 in 2025, up 6% from 2024, marking the third consecutive year of premium growth at 6% or higher, the first time that has happened in two decades.
- A modeled Integrated Benefits Institute analysis estimated $575 billion in illness-related employer productivity losses using 2019 data, equal to 61 cents in lost productivity for every dollar spent on health care benefits.
- Obesity raises job absenteeism by an estimated 3.0 days per employee per year, a 128% increase relative to normal weight, with national productivity losses estimated at $13.4 billion to $26.8 billion in 2016. No current, nationally representative dataset reports workers' compensation claim rates and costs stratified by body mass index.
- Reduced employment due to disability and reduced on-the-job performance together account for more than $64 billion of diabetes' annual indirect costs.

Introduction

This chapter translates the prevalence data established in Chapter 1 into direct economic terms. Where Chapter 1 asked how many Americans live with each metabolic condition, this chapter asks what those conditions cost: in national health care spending, in employer-sponsored insurance premiums, in lost workplace productivity, in workers' compensation claims, and in disability and early workforce exit. As in Chapter 1, every figure in this chapter is drawn from a named primary source, including the Centers for

Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the American Diabetes Association's quinquennial Economic Report, KFF's annual Employer Health Benefits Survey, and the Integrated Benefits Institute's Full Cost Estimator research.

Economic data of this kind carries an important limitation that this report states plainly and up front: the most comprehensive estimates are not always the most recent. The Integrated Benefits Institute's most recent full national estimate of lost productivity, for example, uses 2019 data, and the American Diabetes Association's Economic Report is published only once every five years, with the most recent edition covering 2022. Where this chapter relies on an estimate that is several years old, that vintage is stated explicitly alongside the figure, consistent with this report's editorial standards, rather than presented as a current-year number.

The remainder of this chapter proceeds through five economic categories: national health care spending, spending specifically attributable to obesity and diabetes, employer-sponsored health insurance cost trends, lost productivity through absenteeism and presenteeism, and workers' compensation and occupational injury. A final section addresses disability and early workforce exit, where the strongest available evidence currently comes from outside the United States, a gap this chapter identifies directly rather than overstating what the domestic data can support.

Why This Matters

The conditions measured in Chapter 1 do not remain confined to a doctor's office or a lab result. They move directly into national health spending, into the premiums employers and workers pay every month, into the workdays lost to illness and injury, and into the disability and workers' compensation systems that exist to catch workers when their health fails. Measuring prevalence without measuring cost tells only half the story; this chapter exists to tell the other half.

National Snapshot

This section proceeds through the principal economic categories in which metabolic disease imposes cost: national health care spending, spending specifically attributable to obesity and diabetes, the employer health care cost trend, lost productivity through

absenteeism and presenteeism, workers' compensation and occupational injury, and disability and early workforce exit. As in Chapter 1, these categories are treated as facets of a single economic burden rather than as unrelated line items.

The Economic Framework

Metabolic disease does not create a single cost. It creates cost through at least eight distinct channels, each measured differently, each falling on a different payer, and each addressed somewhere in this chapter or in a later chapter of this report. Naming these channels explicitly, before presenting any individual figure, gives readers a consistent framework for interpreting every dollar figure that follows, in this chapter and in every edition of this report to come.

- Direct medical spending: the cost of diagnosing and treating a condition and its complications.
- Pharmacy spending: medication costs specifically, including the growing category of GLP-1 and other specialty drugs.
- Insurance premiums: the price employers and workers pay to pool and finance the categories above.
- Lost productivity: absenteeism and presenteeism, meaning workdays missed entirely or worked at reduced performance.
- Disability: short-term and long-term disability leave taken as a direct result of a health condition.
- Workers' compensation: costs specifically tied to workplace injury or illness claims.
- Early retirement and workforce exit: permanent departure from the labor force earlier than would otherwise be expected.
- Mortality-related productivity loss: the economic value of working years lost to premature death.

Not every channel is measured with equal precision, and not every channel is addressed in this chapter alone. Insurance premiums are addressed both here and again in Chapter 3, and public program spending specific to Medicare and Medicaid is addressed in the chapters devoted to those programs later in this report. Readers should treat this list as the organizing structure for this report's economic analysis as a whole, not as a checklist unique to Chapter 2.

National Health Care Spending

U.S. national health expenditures reached $5.3 trillion in 2024, or $15,474 per person, and accounted for 18.0 percent of gross domestic product, according to the Centers for Medicare & Medicaid Services. Medicare spending grew 7.8 percent to $1,118.0 billion, representing 21 percent of total national health expenditures, while Medicaid spending grew 6.6 percent to $931.7 billion, representing 18 percent of the total. Private health insurance spending grew 8.8 percent to $1,644.6 billion, and out-of-pocket spending grew 5.9 percent to $556.6 billion.

Health spending growth has consistently outpaced growth in the broader economy, and CMS actuaries project that pattern will continue. National health expenditures are projected to grow at an average annual rate of 5.8 percent through 2033, compared with projected average GDP growth of 4.3 percent, which would push health spending's share of the economy from 18.0 percent in 2024 to roughly 20.3 percent by 2033. Medicare spending is projected to grow fastest among major payers, at an average of 7.7 to 7.8 percent annually, reflecting the continued aging of the population into the program.

This widening gap between health spending growth and economic growth is the backdrop against which every other figure in this chapter should be read. When a specific condition, such as obesity or diabetes, is shown to carry tens or hundreds of billions of dollars in annual cost, that cost is being added to a base that is already growing faster than the economy that must absorb it, which is precisely why the chronic, largely preventable conditions catalogued in Chapter 1 receive sustained attention throughout this report.

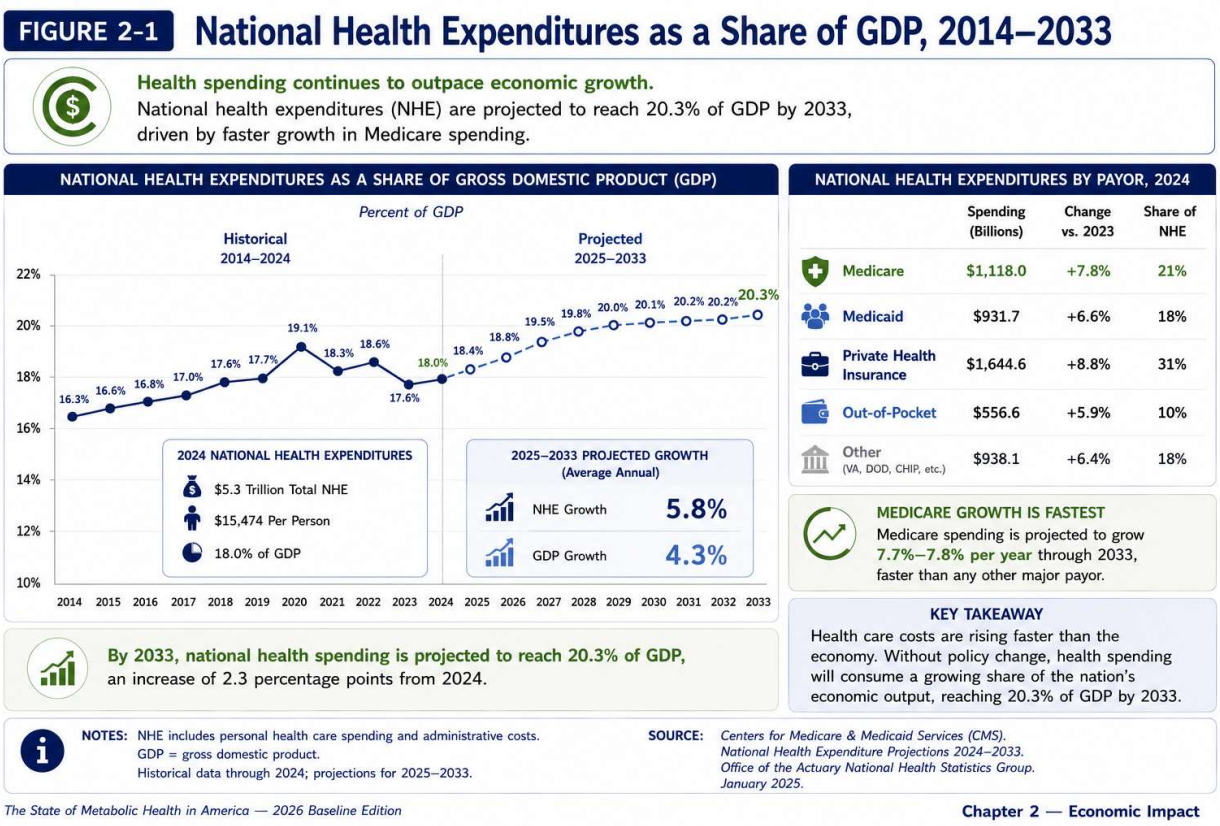


Figure 2-1. National Health Expenditures as a Share of GDP, 2014–2033

Sources: Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Accounts: Historical, 2024 (2024 values: $5.3 trillion, $15,474 per person, 18.0% of GDP, 7.2% growth). Keehan SP, et al. National Health Expenditure Projections, 2024–33. Health Affairs. 2025 (projected values, 2025–2033).

Implications

A health care sector projected to consume more than one-fifth of the U.S. economy within a decade has direct consequences for every other actor in this report: employers face continued premium growth, state Medicaid budgets face continued pressure, and Medicare's long-term financing faces continued strain from a payer base that is both aging and growing more expensive per beneficiary. Chronic, prevalence-driven conditions such as those catalogued in Chapter 1 are a substantial and controllable share of that growth, which is why measurement and early intervention carry outsized financial as well as clinical stakes.

Sources: *Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Data and NHE Fact Sheet (2024 data, released 2026); Health Affairs, "National Health Expenditure Projections, 2024–33" (2025).*

Spending Attributable to Obesity and Diabetes

The Centers for Disease Control and Prevention estimates that obesity accounts for nearly $173 billion in U.S. medical expenditures annually, in 2019 dollars, with adults who have obesity incurring $1,861 higher annual medical costs than adults at a healthy weight, and adults with severe obesity incurring $3,097 higher annual costs. A separate instrumental-variable analysis estimated $260.6 billion in adult obesity-attributable medical expenditures in 2016. The higher figure reflects a different analytic population and causal-estimation method and is not directly interchangeable with the CDC's $173 billion estimate. This report presents both rather than selecting one as more authoritative, and notes that the difference reflects methodology and data vintage rather than a factual dispute.

Diabetes carries a comparably large and more precisely documented burden. The American Diabetes Association's Economic Report, published in Diabetes Care and updated once every five years, found that the total annual cost of diagnosed diabetes in the United States in 2022 was $412.9 billion, consisting of $306.6 billion in direct medical costs and $106.3 billion in indirect costs. People with diagnosed diabetes account for one of every four health care dollars spent in the United States, and on average incur medical expenditures 2.6 times higher than would be expected without the disease.

Diabetes-attributable health care costs have risen steadily and substantially. National health care costs attributable to diabetes increased by $80 billion over the ten years spanning 2012 to 2022, from $227 billion to $307 billion in direct medical costs, and after adjusting for inflation, the direct medical cost of diabetes still increased by 7 percent between 2017 and 2022 alone. Glucose-lowering medications and diabetes supplies account for approximately 17 percent of total direct medical costs attributable to the disease, and the inflation-adjusted cost of insulin rose 24 percent between 2017 and 2022, making pharmacy costs one of the fastest-growing components of diabetes spending.

Obesity's cost trajectory follows a similar pattern. The aggregate direct medical cost of obesity more than doubled between 2001 and 2016, rising from $124.2 billion to $260.6 billion under the instrumental-variable estimate cited above. Both conditions, in short,

are not simply large fixed costs; they are costs that have grown consistently over the periods for which national estimates exist.

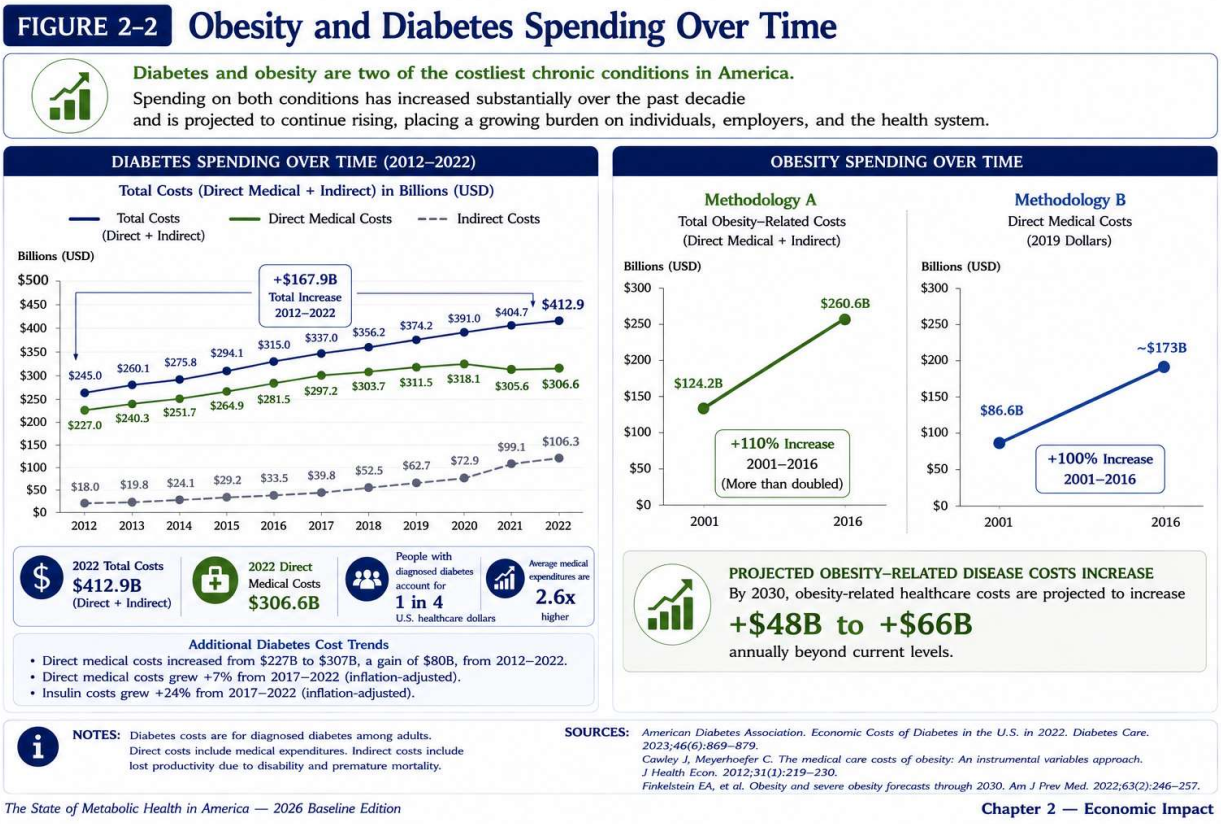


Figure 2-2. Obesity and Diabetes Spending Over Time

Sources: Parker ED, et al. Economic costs of diabetes in the U.S. in 2022. Diabetes Care. 2024;47(1):26–43. doi:10.2337/dci23-0085. Cawley J, Biener A, Meyerhoefer C, et al. Direct medical costs of obesity in the United States and the most populous states. J Manag Care Spec Pharm. 2021;27(3):354–366 (source of the $124.2 billion 2001 and $260.6 billion 2016 estimates). Centers for Disease Control and Prevention. Adult Obesity Facts (source of the ~$173 billion 2019-dollar estimate, $1,861 and $3,097 excess per-adult costs).

Implications

Because obesity and diabetes are the two largest single-condition cost drivers documented in this chapter, and because both are tracked in detail among the metabolic health conditions surveyed in Chapter 1, employers, health plans, Medicare, and Medicaid all have a direct financial stake in the same prevalence and screening data presented in that chapter. Cost growth of this scale and consistency also helps explain why GLP-1 medication coverage, addressed in Chapter 3, has become one of the most closely watched line items in employer pharmacy spending.

Sources: *Centers for Disease Control and Prevention, Adult Obesity Facts (2024, using 2019 dollars); Cawley J, Biener A, Meyerhoefer C, et al., "Direct Medical Costs of Obesity in the United States and the Most Populous States," Journal of Managed Care & Specialty Pharmacy (2021); American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2022," Diabetes Care (2024).*

Employer Health Care Cost Trend

Employer-sponsored insurance covers approximately 154 million Americans under age 65, and KFF's 27th annual Employer Health Benefits Survey found that average annual premiums in 2025 reached $9,325 for single coverage and $26,993 for family coverage. Workers contributed an average of $1,440 toward single coverage and $6,850 toward family coverage, with employers paying the remainder. Sixty-seven percent of covered workers, including 80 percent at large firms, were enrolled in self-funded plans, meaning the employer itself, rather than an insurance carrier, bears the direct financial risk of its workforce's health care claims.

Family premiums rose 6 percent in 2025, following a 7 percent increase in each of the two prior years, marking the first time in two decades that family premiums have risen 6 percent or more for three consecutive years. Over the last five years, average family premiums have increased 24 to 26 percent, roughly in line with wage growth over the same period but outpacing it in the most recent year alone, when premiums rose 6 percent against 4 percent wage growth and 2.7 percent general inflation. Separate employer-focused surveys point to continued acceleration: Aon's analysis projected a 9 percent increase in employer health care costs for 2025, and the International Foundation of Employee Benefit Plans projected a median 8 percent increase, both higher than the 6 to 7 percent increases employers had projected in each of the two prior years.

Large employers increasingly cite specialty and weight-loss medications as a specific driver of this acceleration. In the 2025 KFF survey, 19 percent of large firms reported covering GLP-1 medications for weight loss, and 43 percent of firms with 5,000 or more employees did so, both increases from the prior year, even as 66 percent of the largest employers reported higher-than-expected utilization and some employers have since scaled back or eliminated that coverage in response to cost. More than one-third of large firms identified prescription drug prices generally as a major contributor to premium growth.

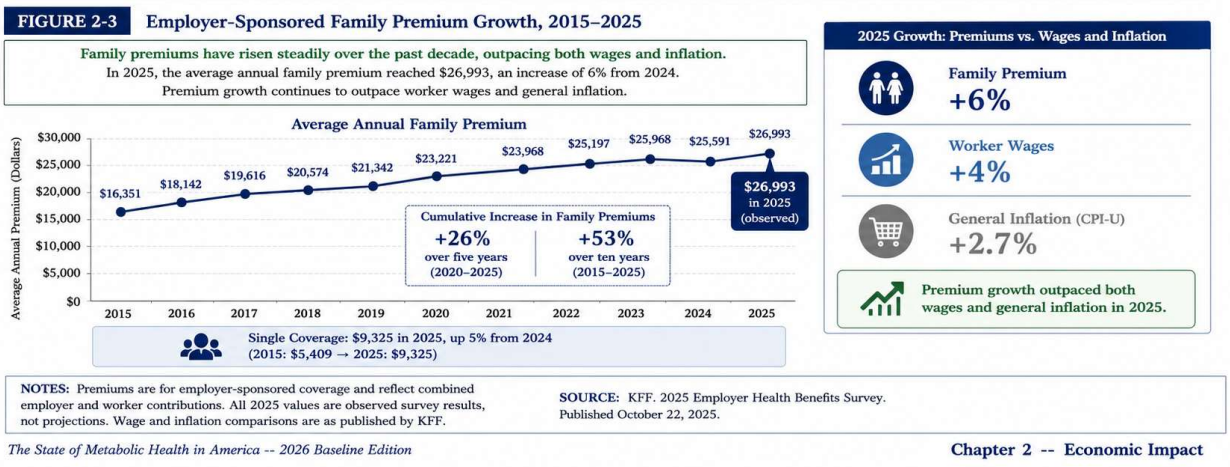


Figure 2-3. Employer-Sponsored Family Premium Growth, 2015–2025

Source: KFF. 2025 Employer Health Benefits Survey. Published October 22, 2025. All 2025 values are observed survey results rather than projections. Wage and general inflation comparisons are as published by KFF.

Implications

Three consecutive years of 6-percent-or-greater family premium growth, the first such stretch in two decades, means employers are increasingly likely to respond with higher deductibles and other cost-sharing measures, a dynamic KFF's own leadership has specifically flagged as a likely consequence of the current trend. Because self-funded employers bear claims risk directly, and 80 percent of large-firm workers are now in self-funded plans, the prevalence and severity of the metabolic conditions catalogued in Chapter 1 translate almost directly into employer financial exposure, which is the central subject of Chapter 3.

Sources: *KFF, 2025 Employer Health Benefits Survey (27th annual survey, released October 2025); Aon, Health Value Initiative analysis (2025); International Foundation of Employee Benefit Plans, employer cost projection survey (2025).*

Lost Productivity: Absenteeism and Presenteeism

The Integrated Benefits Institute, a nonprofit health and productivity research organization, estimated in its most recent comprehensive national analysis, using 2019 data, that illness-related lost productivity cost U.S. employers $575 billion in a single year, equal to 61 cents in lost productivity for every dollar employers spent on health care benefits. That total reflects approximately 978 million absence days due to illness and an estimated 540 million modeled equivalent workdays lost to impaired performance, or presenteeism, defined as reduced on-the-job performance among employees managing a chronic health condition, for a combined total of approximately 1.5 billion lost-

productivity days in 2019. The combined figure is not 1.5 billion actual missed workdays, and the estimate is generated by a proprietary modeling system rather than a published national accounting framework.

Diabetes alone illustrates how these categories break down for a single condition. Within the American Diabetes Association's $106.3 billion indirect cost estimate for diabetes in 2022, presenteeism accounted for $35.8 billion, reduced employment due to disability accounted for $28.3 billion, and lost productivity due to 338,526 premature deaths accounted for $32.4 billion, together making up the substantial majority of diabetes' total indirect cost burden.

The composition of lost-productivity costs has shifted meaningfully over time even where the aggregate totals have grown. A review of IBI's Full Cost Estimator data across 2015 through 2019 found that lost workdays attributable to workers' compensation claims declined by 13 percent per year on average, while workdays lost to short-term disability leave increased by 11 percent per year and long-term disability leave increased by 3 percent per year. This shift, away from workers' compensation and toward disability leave as the primary driver of lost time, suggests that chronic, non-occupational conditions, rather than workplace injuries specifically, are becoming a proportionally larger share of the lost-productivity burden, consistent with the chronic disease prevalence patterns documented throughout Chapter 1.

This report notes explicitly that $575 billion reflects 2019 data, the most recent year for which IBI has published a comprehensive national estimate using this methodology, and that more recent, narrower IBI analyses have focused on specific disruptions, such as the COVID-19 pandemic, rather than producing an updated comprehensive baseline. Future editions of this report will incorporate an updated aggregate estimate as soon as one becomes available, and will note explicitly if the underlying methodology changes between editions, consistent with this report's editorial standards.

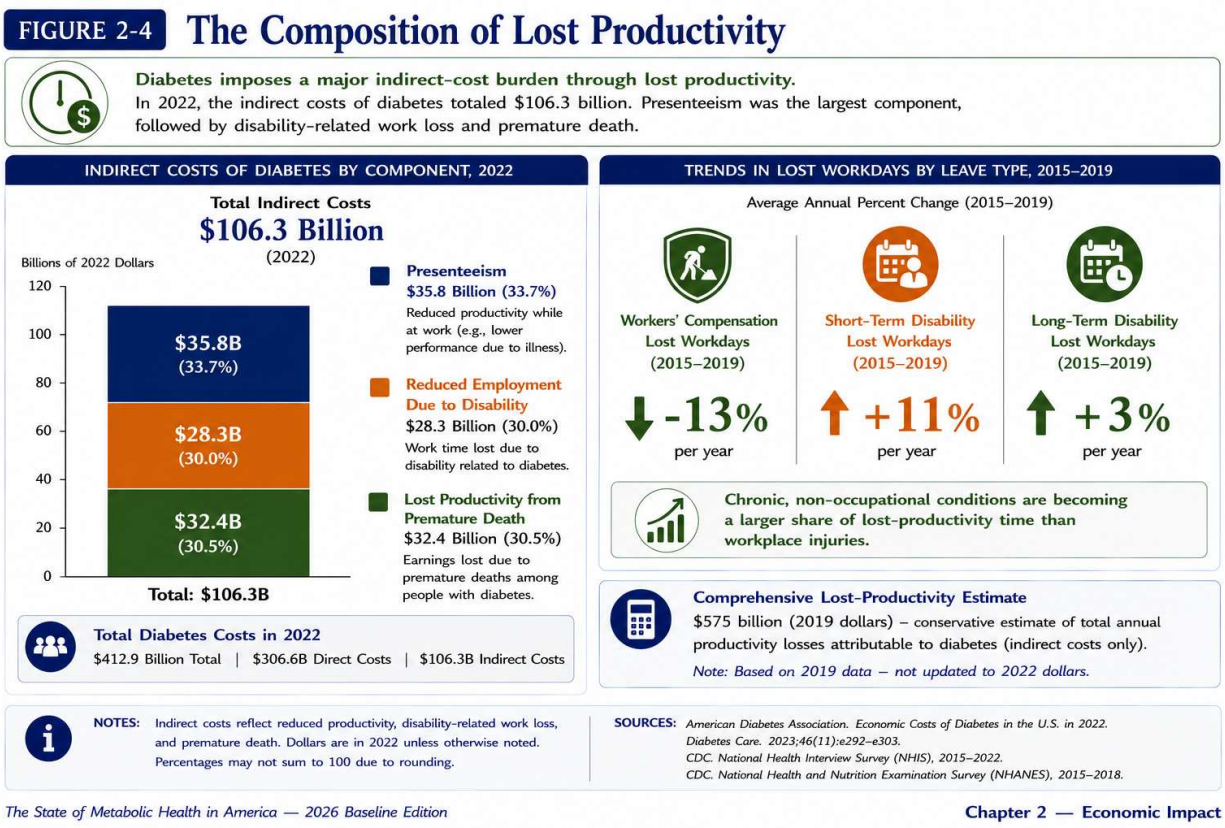


Figure 2-4. The Composition of Lost Productivity

Sources: Parker ED, et al. Economic costs of diabetes in the U.S. in 2022. Diabetes Care. 2024;47(1):26–43. doi:10.2337/dci23-0085. Integrated Benefits Institute. Poor Health Costs U.S. Employers $575 Billion and 1.5 Billion Days of Lost Productivity. December 8, 2020, using 2019 data and Full Cost Estimator trends for 2015–2019.

Implications

At 61 cents in lost productivity for every dollar spent on health care benefits, employers who focus exclusively on premium costs are seeing well under half of their total health-related financial exposure. The documented shift from workers' compensation toward short-term and long-term disability leave as the dominant driver of lost time suggests that employer strategies built primarily around workplace safety and injury prevention are addressing a shrinking share of the problem relative to strategies aimed at chronic condition management and prevention.

Sources: *Integrated Benefits Institute, "Poor Health Costs US Employers $575 Billion and 1.5 Billion Days of Lost Productivity" (2019 data, released December 2020); American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2022," Diabetes Care (2024).*

Absenteeism and Occupational Injury

The strongest available national evidence on the employment consequences of obesity concerns absenteeism rather than workers' compensation. Using nationally representative Medical Expenditure Panel Survey data from 2001 through 2016 and instrumental-variable methods, Cawley and colleagues estimated that obesity raises job absenteeism due to injury or illness by 3.0 days per employee per year, a 128 percent increase relative to normal weight, with annual productivity losses of $271 to $542 per employee with obesity and national productivity losses of $13.4 billion to $26.8 billion in 2016. Earlier employer-cohort research, notably a Duke University Medical Center analysis published in the Archives of Internal Medicine, found a clear linear relationship between body mass index and workers' compensation claims, costs, and lost workdays. Because that study examined a single university and health system during 1997 through 2004, this edition treats its findings as historical supporting evidence rather than as national baseline metrics.

That historical analysis also reported substantially higher lost workdays and identified the lower extremities, wrist or hand, and back as the injury sites most associated with elevated risk, consistent with the added physical strain that higher body weight places on the musculoskeletal system during workplace injury events. A 2024 employer-cost modeling study estimated a total obesity-attributable employer burden of $347.5 billion in 2023 across medical spending, absenteeism, presenteeism, disability, and workers' compensation. That estimate was generated through a proprietary microsimulation model, was authored entirely by consultants at a single commercial analytics firm, and was funded by Eli Lilly and Company; it is therefore presented here as a recent modeled industry estimate rather than as a national baseline measure.

The directional relationship between obesity and occupational injury cost has also been reported in insurer and state-level claims analyses, though none provides a nationally representative baseline. The National Council on Compensation Insurance has reported that claims involving workers with an obesity comorbidity diagnosis carry markedly higher indemnity and medical costs than otherwise comparable claims. A study of injured workers in Louisiana found that overweight or obese workers with major injuries were

roughly twice as likely to incur claims costing $100,000 or more, although body mass index showed no significant effect on costs for less severe or already-closed claims. A California Workers' Compensation Institute analysis similarly found that claims with an obesity comorbidity had higher rates of lost time from work, permanent disability determinations, and attorney involvement. These are insurer and single-state analyses rather than nationally representative research, and this report cites them as directionally consistent evidence rather than as baseline measurement.

Historical employer-cohort studies and selected commercial and state-level claims analyses generally report a higher workers' compensation burden among workers with obesity, and the underlying biological mechanism, greater physical strain and slower recovery, is well understood. However, differences in population, claim definition, obesity identification, and study period prevent those findings from supporting a current national baseline. The category remains consequential for employers because workers' compensation costs are, unlike many health care costs, borne directly and immediately by the employer in most states.

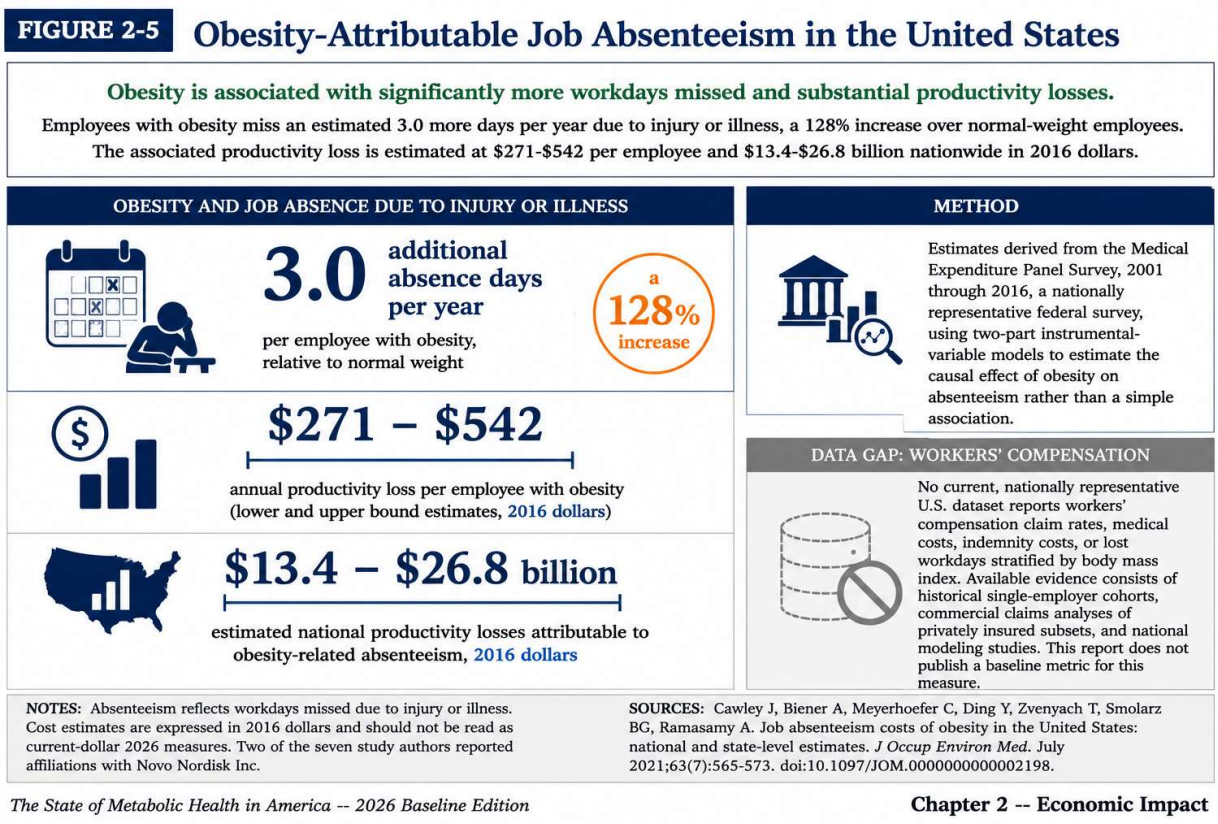


Figure 2-5. Obesity-Attributable Job Absenteeism in the United States

Source: Cawley J, Biener A, Meyerhoefer C, Ding Y, Zvenyach T, Smolarz BG, Ramasamy A. Job absenteeism costs of obesity in the United States: national and state-level estimates. J Occup Environ Med. July 2021;63(7):565–573. doi:10.1097/JOM.0000000000002198. Notes: Estimates derived from nationally representative Medical Expenditure Panel Survey data, 2001–2016, using two-part instrumental-variable models. National cost estimates are expressed in 2016 dollars and should not be read as current-dollar 2026 measures. Two of the seven authors reported affiliations with Novo Nordisk Inc. Historical comparison: Østbye T, Dement JM, Krause KM. Obesity and workers' compensation: results from the Duke Health and Safety Surveillance System. Arch Intern Med. 2007;167(8):766–773. doi:10.1001/archinte.167.8.766 (single employer, 1997–2004).

Implications

Absenteeism is one of the few cost categories in this chapter that the employer bears directly, immediately, and without the diffusion across a broader insurance pool that characterizes most health care spending, which is what makes a nationally representative estimate of obesity-attributable absence days useful to employer decision-making. Employers in physically demanding industries in particular have a direct financial incentive, independent of any broader health strategy, to treat obesity prevention and management as an occupational safety and workforce-continuity issue as much as a health benefits issue. This report notes, however, that the absence of a current national workers' compensation baseline stratified by body mass index means the occupational-injury component of that incentive cannot presently be quantified at the national level.

Sources: *Ostbye T, Dement JM, Krause KM, "Obesity and Workers' Compensation: Results From the Duke Health and Safety Surveillance System," Archives of Internal Medicine (2007); National Council on Compensation Insurance, obesity comorbidity claims analysis; California Workers' Compensation Institute, obesity comorbidity claims study (2013).*

Disability and Early Workforce Exit

The relationship between metabolic health and permanent workforce exit, through disability pension or early retirement, is less thoroughly documented in the United States than the cost categories addressed elsewhere in this chapter. The strongest available peer-reviewed evidence currently comes from national registry studies conducted outside the United States, particularly in Finland and the Netherlands, where universal health registries and pension systems allow researchers to track individuals over decades. This report states that distinction explicitly, consistent with its editorial standards, rather than presenting international findings as though they were confirmed for the U.S. population specifically.

A systematic review and meta-analysis of the influence of poor health on exit from paid employment found that poor health substantially increases the likelihood of leaving the workforce through disability pension, unemployment, and early retirement, with chronic disease among the consistent drivers across the studies reviewed. Metabolic conditions figure prominently in this literature: international registry and cohort research has repeatedly identified diabetes, hypertension, and obesity as independent contributors to work disability and early workforce exit, even after accounting for self-rated health and other chronic conditions.

At the population level, the Global Burden of Disease Study 2021 ranks high systolic blood pressure, high fasting plasma glucose, and high body-mass index among the leading metabolic contributors to global disability-adjusted life years (DALYs), underscoring the mechanism by which metabolic disease translates into reduced labor-force participation. Ranked against all risk factors the study evaluates, high systolic blood pressure stands highest of the three, followed by high fasting plasma glucose and then high body-mass index, with several non-metabolic risk factors interleaved among them. U.S.-based research in this specific area is considerably more limited, consisting primarily of individual cohort analyses of the association between obesity in early adulthood and earlier-than-expected retirement, rather than the comprehensive national registry data available in countries with linked health and pension systems. This report does not assign

a baseline metric to that relationship because it could not verify complete citations for the individual cohort studies concerned.

This is one of the more significant measurement gaps this report has identified in its first edition. The United States does not maintain the kind of linked, population-level health and pension registry that allows Nordic and Dutch researchers to trace a direct line from a metabolic health diagnosis to eventual workforce exit, which means employers and policymakers currently rely on international evidence, workers' compensation data, and shorter-term disability claims data to approximate a phenomenon that is better measured elsewhere.



Figure 2-6. International Evidence on Metabolic Health and Disability Pension Risk

Sources: GBD 2021 Risk Factors Collaborators. Global burden and strength of evidence for 88 risk factors in 204 countries and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. Lancet. 2024;403(10440):2162–2203. doi:10.1016/S0140-6736(24)00933-4. van Rijn RM, Robroek SJW, Brouwer S, Burdorf A. Influence of poor health on exit from paid employment: a systematic review. Occup Environ Med. 2014;71(4):295–301. doi:10.1136/oemed-2013-101591.

Implications

The absence of comparable U.S. registry data means that American employers and policymakers are currently working with a meaningfully incomplete picture of how metabolic health affects long-term workforce participation and disability pension risk. Until domestic longitudinal data of similar quality becomes available, employers should treat the international findings summarized here as directionally suggestive rather than as a precise estimate of U.S.-specific risk, an important distinction this report will continue to flag in every edition until better domestic data exists.

Sources: GBD 2021 Risk Factors Collaborators. Global burden and strength of evidence for 88 risk factors in 204 countries and 811 subnational locations, 1990-2021: a systematic analysis for the Global Burden of Disease Study 2021. The Lancet. 2024;403(10440):2162-2203. doi:10.1016/S0140-6736(24)00933-4. van Rijn RM, Robroek SJW, Brouwer S, Burdorf A. Influence of poor health on exit from paid employment: a systematic review. Occupational and Environmental Medicine. 2014;71(4):295-301. doi:10.1136/oemed-2013-101591. This report was unable to identify complete, verifiable citations for several individual national cohort analyses of metabolic disease and workforce exit, and has therefore relied on the systematic review and global burden analysis above rather than on individual cohort findings.

Trends

The economic categories documented above share a common trajectory: each has grown faster than general inflation over the past several years, and each is projected to continue rising. National health expenditures have grown as a share of gross domestic product, employer health care costs are rising at their fastest rate in more than a decade, and the productivity, disability, and workers' compensation costs attributable to metabolic disease compound the directly measured medical spending rather than substituting for it. The most important trend this chapter documents is therefore the breadth of the economic burden, spanning direct medical cost, employer cost, and lost productivity simultaneously, rather than the growth rate of any single category.

This breadth also means the total economic burden of metabolic disease is systematically understated by any single figure that captures only one category. Direct medical spending estimates omit productivity losses; employer cost trends omit disability and early workforce exit; and none fully capture the costs borne by individuals and families. Future editions will track whether the recent acceleration in employer cost trend and prescription drug spending, driven substantially by newer obesity treatments, continues, moderates, or reverses.

Policy Implications

The economic figures in this chapter establish the stakes for the coverage, program, and intervention decisions examined in the chapters that follow. Because the burden of metabolic disease is distributed across direct medical spending, employer costs, public program costs, and lost productivity, no single payer internalizes the full cost of the disease, and no single payer captures the full benefit of preventing or reversing it. This distribution of cost and benefit across payers is directly relevant to why individual employers, Medicare, and Medicaid may each underinvest in prevention relative to what the combined societal return would justify, a theme the intervention chapters later in this report examine in specific programmatic terms.

This chapter does not recommend a particular allocation of that cost or a particular policy response; it establishes the economic baseline against which later chapters' coverage and intervention questions are measured, and it emphasizes that cost and utilization figures, which are comparatively easy to measure, should not be mistaken for measures of health improvement, which are considerably harder to measure, a distinction that recurs throughout this report.

2026 Baseline Metrics

The table below consolidates the headline economic figures presented throughout this chapter into a single reference point, continuing the stable identifier system introduced in Chapter 1. Each metric is assigned an identifier, EI-01 through EI-08, that will remain unchanged in every future edition of this report, so that year-over-year comparisons can be made without ambiguity about which measure is being referenced.

ID	Metric	2026 Baseline Value
EI-01	National health expenditures (total)	$5.3 trillion (18.0% of GDP)
EI-02	National health expenditures per capita	$15,474
EI-03	Direct medical cost attributable to obesity	~$173 billion/year (2019 dollars)
EI-04	Total annual cost of diagnosed diabetes	$412.9 billion ($306.6B direct / $106.3B indirect)
EI-05	Average employer-sponsored family premium	$26,993/year (+6% YoY)

ID	Metric	2026 Baseline Value
EI-06	Average employer-sponsored single premium	$9,325/year (+5% YoY)
EI-07	Illness-related lost productivity cost to employers	~$575 billion in 2019 (modeled; IBI Full Cost Estimator)
EI-08	Modeled illness-related lost-productivity days	~1.5 billion in 2019, comprising ~978 million absence days and ~540 million equivalent workdays lost to impaired performance (modeled)

America's Metabolic Health Costs

The table below draws together the headline cost figures presented throughout this chapter into a single page, organized by economic channel rather than by condition, using the framework introduced at the start of this chapter.

Category	Annual Figure
National Health Expenditures (Total)	$5.3 trillion
Obesity (Direct Medical Cost)	~$173 billion (2019 dollars); ~$260.6B under an alternate peer-reviewed methodology
Diabetes (Total Annual Cost)	$412.9 billion ($306.6B direct / $106.3B indirect)
Illness-Related Lost Productivity	~$575 billion in 2019, modeled
Average Employer-Sponsored Family Premium	$26,993 per year
Workers' Compensation (Severe Obesity vs. Normal Weight)	No current national baseline by body mass index; see Data Gaps discussion

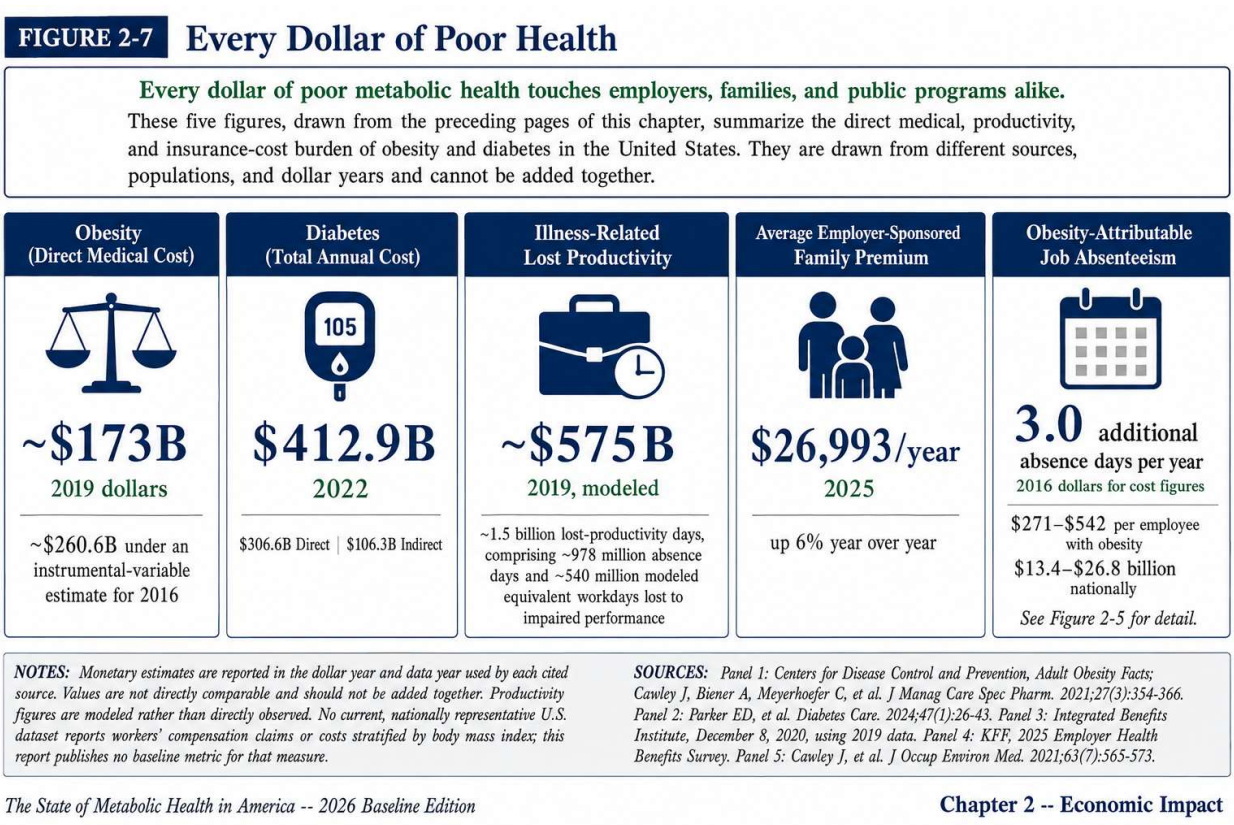


Figure 2-7. Every Dollar of Poor Health

Sources: Panel 1: Centers for Disease Control and Prevention, Adult Obesity Facts; Cawley J, Biener A, Meyerhoefer C, et al. J Manag Care Spec Pharm. 2021;27(3):354–366. Panel 2: Parker ED, et al. Diabetes Care. 2024;47(1):26–43. Panel 3: Integrated Benefits Institute, December 8, 2020, using 2019 data. Panel 4: KFF, 2025 Employer Health Benefits Survey. Panel 5: Cawley J, et al. J Occup Environ Med. 2021;63(7):565–573. Monetary estimates are reported in the dollar year and data year used by each cited source and are not directly comparable.

Important: Why These Figures Should Not Be Added Together

The figures in the table above should not be summed to produce a single 'total cost of poor metabolic health.' They measure overlapping and methodologically distinct dimensions of the same underlying burden: national health expenditures already include much of the direct medical spending attributable to obesity and diabetes, lost productivity is a separate category measured through an entirely different methodology, and the absenteeism estimate overlaps partly with the broader productivity figure while being derived from a different dataset and dollar year. Adding these figures together would substantially overstate the true economic burden by counting some dollars more than once. No single statistic captures the total economic burden of poor metabolic health, because each estimate measures a different dimension of cost.

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly. Cost estimates for metabolic disease vary widely across sources because they rely on different methods, attributable-fraction modeling, claims analysis, survey-based productivity estimates, and macroeconomic projection, each of which rests on different assumptions and captures a different slice of the total burden. Where this chapter reports a specific figure, it identifies the source and method; where sources disagree, it reports the range rather than silently selecting one estimate.

Productivity-loss estimates in particular, covering absenteeism and presenteeism, are inherently less precise than direct medical spending figures, because presenteeism, reduced productivity while at work, cannot be measured directly and must be inferred through survey instruments. This chapter reports these estimates because omitting them would understate the true economic burden, but flags that they carry greater uncertainty than the directly measured medical and employer cost figures, and should be read as informed estimates rather than precise accounting.

Chapter Summary

This chapter has traced the prevalence data established in Chapter 1 through five distinct economic channels: national health care spending, condition-specific spending on obesity and diabetes, employer-sponsored insurance premium growth, lost productivity through absenteeism and presenteeism, and workers' compensation. Across these channels the evidence consistently indicates a substantial burden, although the strength and currency of measurement vary materially. National health expenditures, employer premiums, and diagnosed-diabetes costs are documented through established national data systems. Absenteeism and presenteeism rely partly on modeling, while current national evidence on workers' compensation, disability, and early workforce exit remains incomplete. In most categories for which reliable series exist, costs are still growing faster than the broader economy or workforce that must absorb them.

The one meaningful exception to this pattern of strong documentation is disability and early workforce exit, where the best available evidence currently comes from outside the United States. This report views that gap as a genuine limitation rather than a minor footnote, and one of the more important contributions a future domestic dataset, public

or private, could make to this report's ongoing measurement of American metabolic health.

Chapter 3 builds directly on this chapter by examining how employer-sponsored health plans are specifically responding to these cost pressures, including GLP-1 coverage decisions, plan design changes, and the broader shift toward self-funded arrangements introduced in this chapter's discussion of employer health care cost trends.

Looking Ahead to the 2027 Edition

As in Chapter 1, this section closes the chapter with a short list of developments worth watching before the next edition of this report is published.

- KFF's 2026 Employer Health Benefits Survey, expected in October 2026, and whether family premium growth extends its current run of 6-percent-or-greater increases to a fourth consecutive year.
- CMS's next release of historical National Health Expenditure data, including the eventual 2025 estimate, and whether health spending's share of GDP continues its projected climb toward 20.3% by 2033.
- Whether the Integrated Benefits Institute or a comparable research organization publishes an updated comprehensive national lost-productivity estimate to replace the current 2019 baseline.
- Continued employer decisions on GLP-1 coverage for weight loss, including whether more employers scale back coverage in response to cost, as some have already begun to do.
- Whether any U.S. research effort begins to close the domestic evidence gap on metabolic health and long-term disability pension or early retirement risk identified in this chapter.

Questions We Still Cannot Answer

As in Chapter 1, this report closes with an honest accounting of what the current evidence base cannot yet tell us, both to be transparent about this report's limits and to identify where future measurement is most needed.

- How much of the recent acceleration in employer premium growth is directly attributable to metabolic conditions specifically, as opposed to other cost drivers such as specialty pharmacy generally, provider consolidation, or facility pricing?
- Does U.S.-specific longitudinal data confirm the disability pension and early workforce exit associations documented in the Finnish and Dutch registries discussed in this chapter, and if not yet, what would it take to build a comparable domestic dataset?
- What is the current, post-2022 total cost of illness-related lost productivity in the United States, given that the most comprehensive published estimate still relies on 2019 data?
- To what extent, if any, does increased GLP-1 medication spending offset downstream costs elsewhere in this chapter, including workers' compensation, disability claims, and cardiovascular events, and over what time horizon would that offset become measurable?
- How should the direct medical cost estimates for obesity, which currently range from roughly $173 billion to more than $260 billion depending on methodology, be reconciled into a single, consistently reported figure for use in future editions of this report?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

Sources

The primary sources supporting each economic category are listed at the close of that category's discussion in the National Snapshot above. The principal sources for this chapter as a whole are consolidated here.

- Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Accounts: Historical. 2024 data; updated January 2026. Source of the 2024 values reported in this chapter: $5.3 trillion in national health expenditures, $15,474 per person, 18.0% of gross domestic product, and 7.2% growth over 2023.
- Keehan SP, Fiore JA, Poisal JA, et al. National health expenditure projections, 2024–33. Health Affairs. 2025. doi:10.1377/hlthaff.2025.00545. Source of the projected values reported in this chapter for 2025 through 2033, including average annual growth of 5.8% and a projected 20.3% share of gross domestic product by 2033.

- Centers for Disease Control and Prevention. Adult Obesity Facts. Source of the approximately $173 billion adult obesity-attributable medical expenditure estimate in 2019 dollars, and of the $1,861 and $3,097 excess annual per-adult costs for obesity and severe obesity respectively.
- Cawley J, Biener A, Meyerhoefer C, et al. Direct medical costs of obesity in the United States and the most populous states. Journal of Managed Care & Specialty Pharmacy. 2021;27(3):354–366. Source of the $124.2 billion (2001) and $260.6 billion (2016) instrumental-variable estimates of adult obesity-attributable medical expenditures.
- Parker ED, Lin J, Mahoney T, et al. Economic costs of diabetes in the U.S. in 2022. Diabetes Care. 2024;47(1):26–43. doi:10.2337/dci23-0085. Source of the $412.9 billion total, $306.6 billion direct medical, and $106.3 billion indirect cost estimates, and of the disability, presenteeism, and premature-mortality components reported in this chapter.
- KFF. 2025 Employer Health Benefits Survey. Published October 2025. Source of the $26,993 average family premium and $9,325 average single premium for 2025, the 6% and 5% year-over-year increases, and the five- and ten-year cumulative premium growth figures.
- Integrated Benefits Institute. Poor Health Costs U.S. Employers $575 Billion and 1.5 Billion Days of Lost Productivity. December 8, 2020. Estimates based on 2019 data and the IBI Full Cost Estimator, drawing on Bureau of Labor Statistics data covering approximately 147 million workers and IBI benchmarking data from approximately 66,000 employers. Source of the modeled $575 billion productivity-loss estimate and the approximately 978 million absence days and 540 million presenteeism-equivalent workdays reported in this chapter.
- Cawley J, Biener A, Meyerhoefer C, Ding Y, Zvenyach T, Smolarz BG, Ramasamy A. Job absenteeism costs of obesity in the United States: national and state-level estimates. Journal of Occupational and Environmental Medicine. July 2021;63(7):565–573. doi:10.1097/JOM.0000000000002198. Source of the 3.0 additional absence days, 128% relative increase, $271 to $542 per-employee productivity loss, and $13.4 billion to $26.8 billion national estimates in 2016 dollars. Two of the seven authors reported affiliations with Novo Nordisk Inc.
- Østbye T, Dement JM, Krause KM. Obesity and workers' compensation: results from the Duke Health and Safety Surveillance System. Archives of Internal Medicine. 2007;167(8):766–773. doi:10.1001/archinte.167.8.766. Cited in this chapter as historical supporting evidence only. The study examined employees of a

single university and health system observed between 1997 and 2004 and does not support a contemporary national baseline. This report therefore does not publish baseline metrics for workers' compensation claims or costs stratified by body mass index.

- Dall TM, Sapra T, Natale Z, Livingston T, Chen F. Assessing the economic impact of obesity and overweight on employers: identifying opportunities to improve work force health and well-being. Nutrition & Diabetes. December 4, 2024;14:96. doi:10.1038/s41387-024-00352-9. Cited in this chapter as a recent modeled industry estimate only. The analysis was produced through a proprietary microsimulation model, all five authors were consultants to a single commercial analytics firm, and the study was funded by Eli Lilly and Company.
- GBD 2021 Risk Factors Collaborators. Global burden and strength of evidence for 88 risk factors in 204 countries and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. The Lancet. 2024;403(10440):2162–2203. doi:10.1016/S0140-6736(24)00933-4. Source of the relative standing of high systolic blood pressure, high fasting plasma glucose, and high body-mass index among leading global contributors to disability-adjusted life years.
- van Rijn RM, Robroek SJW, Brouwer S, Burdorf A. Influence of poor health on exit from paid employment: a systematic review. Occupational and Environmental Medicine. 2014;71(4):295–301. doi:10.1136/oemed-2013-101591. Source of the finding that poor health substantially increases the likelihood of leaving paid employment through disability pension, unemployment, and early retirement.

Chapter 3

Employer Healthcare

Chapter 3 Key Findings

- Employer-sponsored insurance remains the principal source of coverage for the nonelderly population. KFF estimates that approximately 154 million people under age 65 are covered by employer-sponsored insurance when coverage is assigned hierarchically; a broader measure that allows overlapping coverage yields about 165.6 million people in 2025.
- In 2025, 61% of firms with 10 or more workers offered health benefits. The offer rate was 97% among firms with 200 or more workers and 59% among firms with 10 to 199 workers. Because KFF restricted its 2025 survey universe to firms with at least 10 workers, excluding those with three to nine employees that earlier surveys included, this overall offer rate should not be compared directly with offer rates reported in prior years.
- Self-funding is the dominant financing model for large employers. Sixty-seven percent of covered workers were enrolled in self-funded plans in 2025, including 80% of covered workers at firms with 200 or more workers and 27% at firms with 10 to 199 workers.
- Employer health benefit costs are accelerating. Mercer reports that average health benefit cost reached $17,496 per employee in 2025 and projects a 6.7% increase in 2026, to more than $18,500 per employee. WTW projects a 9.1% increase before plan changes and 8.0% after plan changes for 2026.
- Prescription drug spending is rising faster than overall plan cost. Mercer reports a 9.4% increase in prescription drug spending among large employers, which Mercer defines as employers with 500 or more employees, in 2025. This differs from KFF's convention, under which large firms are those with 200 or more workers, and the two sets of figures are therefore not drawn from identical employer populations. Specialty drug cost per member per year rose from $1,333 in 2023 to $1,641 in 2024 in PSG's commercial book of business, although gross specialty trend slowed from 14.4% to 9.6%.
- GLP-1 coverage estimates vary materially by survey population. In 2026, IFEBP reported that 36% of surveyed plans covered GLP-1 drugs for both diabetes and weight loss; Business Group on Health reported 67% coverage for weight

management among 105 large-employer members; and WTW reported 66% coverage among 294 clients representing more than 2.8 million plan members.

- Employers are moving from stand-alone point solutions toward integrated strategies that combine benefit design, pharmacy contracting, clinical eligibility, care navigation, data integration, and outcome measurement. The policy challenge is not merely whether a benefit is offered, but whether employers can demonstrate improved health and economic value over a multi-year period.

Introduction

Chapter 2 documented the economic burden associated with poor metabolic health. This chapter examines how that burden is transmitted through employer-sponsored health coverage and how employers are responding through financing, plan design, pharmacy strategy, clinical programs, and measurement. The central policy issue is no longer whether employers recognize obesity, diabetes, cardiovascular risk, and related conditions as material cost drivers. It is whether the employer market has the data, contracting structures, and time horizon necessary to distinguish short-term benefit expense from long-term health investment.

The evidence base is drawn primarily from KFF's 2025 Employer Health Benefits Survey; Mercer's National Survey of Employer-Sponsored Health Plans and 2026 strategy research; WTW's 2025 Best Practices in Healthcare Survey and June 2026 Rx Pulse Survey; Business Group on Health's 2026 Employer Health Care Strategy Survey and 2026 GLP-1 survey; PwC's medical cost trend analyses; Aon's medical trend research; the International Foundation of Employee Benefit Plans' 2026 GLP-1 survey; Pharmaceutical Strategies Group's Artemetrx specialty-drug research; and federal guidance from the Centers for Medicare & Medicaid Services. Survey populations, denominators, and definitions differ. This chapter therefore reports results with their survey context and does not combine unlike estimates into a single national rate.

The chapter is organized around six policy questions: the scale and financing of employer coverage; the current cost environment; specialty pharmacy and PBM governance; GLP-1 coverage and obesity treatment strategy; consumer-directed plan design and affordability; and prevention, wellness, and population-health measurement.

Why This Matters

Employers are not passive intermediaries. In self-funded plans they directly finance claims, select vendors, establish formularies and utilization-management rules, determine employee cost sharing, and decide how much evidence is required before a program is expanded or discontinued. These decisions affect treatment access, household affordability, and the speed with which emerging therapies diffuse through the working-age population. Because large employers often move before federal policy changes, employer purchasing practices can also influence broader market norms for transparency, outcomes reporting, and value-based contracting.

National Snapshot

This section proceeds through the principal dimensions of employer metabolic health strategy: the overall shift from cost shifting toward measured value, the scale and financing of employer-sponsored insurance, the 2026 cost environment, specialty pharmacy and pharmacy benefit manager governance, GLP-1 coverage and obesity treatment strategy, consumer-directed plans and affordability, and prevention, wellness, and population-health measurement. As in the preceding chapters, these dimensions are treated as facets of a single employer strategy rather than as unrelated benefit decisions.

Employer Strategy: From Cost Shifting to Measured Value

Employer strategy has evolved in layers rather than through discrete replacement cycles. Deductibles and coinsurance remain important, but they increasingly coexist with virtual care, navigation, centers of excellence, pharmacy carve-outs, specialty-drug management, and condition-specific programs. The emerging policy direction is toward measured value: employers are asking not only whether a service is used, but whether it changes clinical risk, total cost of care, productivity, and employee experience.

Period	Dominant Emphasis	Policy Significance
Mid-2000s	Higher deductibles and coinsurance	Reduced employer premium growth partly by shifting more first-dollar exposure to workers.
2010–2014	HDHPs paired with HSAs	Used tax-favored accounts and consumer incentives to encourage price sensitivity.

Period	Dominant Emphasis	Policy Significance
2015–2019	Wellness, biometric screening, and health risk assessment	Expanded prevention and risk identification, but evidence of durable population-level savings remained mixed.
2020–2022	Virtual care and navigation	Accelerated access and vendor proliferation during and after the COVID-19 pandemic.
2023–2025	Specialty pharmacy and GLP-1 management	Focused attention on eligibility, prior authorization, formulary design, PBM contracting, and high-cost claimant management.
2026 and beyond	Integrated measurement and purchasing accountability	Links clinical eligibility, longitudinal outcomes, vendor performance, total-cost measurement, and workforce health strategy.

This framework is interpretive rather than a claim that all employers moved in the same sequence. The strongest evidence supports the underlying shift: cost trend is accelerating, pharmacy is a leading driver, and employers are increasing scrutiny of vendor performance and clinical outcomes. A policy paper should therefore avoid presenting any single intervention as a universal solution. The relevant question is which combinations of financing, access, clinical management, and measurement are effective for a defined workforce.

Employer-Sponsored Insurance: Scale, Financing, and Uneven Capacity

Employer-sponsored insurance remains the largest source of health coverage for people under age 65. KFF reports approximately 154 million covered people when each person is assigned to a single coverage category. KFF's 2026 policy overview also reports that about 165.6 million people, or 60% of the nonelderly population, had employment-sponsored coverage in 2025 when overlapping coverage is permitted. These figures are not contradictory; they reflect different counting methods and should not be used interchangeably without explanation.

Among firms with 10 or more workers, 61% offered health benefits in 2025. The rate was 97% among firms with 200 or more workers and 59% among firms with 10 to 199 workers. Among covered workers, 67% were in self-funded plans, including 80% at firms with 200 or more workers and 27% at firms with 10 to 199 workers. These figures demonstrate that

employer size is not merely a descriptive characteristic; it determines the degree of purchasing leverage, claims exposure, analytic capacity, and flexibility available to manage metabolic health risk.

Sources: *KFF, 2025 Employer Health Benefits Survey; KFF, "Employer-Sponsored Health Insurance 101," April 15, 2026.*

Policy Implications

Large self-funded employers can change formularies, contract directly with vendors, require data feeds, and evaluate outcomes using their own claims. Smaller employers are more likely to operate through fully insured or level-funded arrangements and may have less access to timely, integrated data. Policy proposals that depend on sophisticated longitudinal measurement should account for this capacity gap. Standardized reporting, portable metrics, and purchaser collaboratives may be necessary if smaller employers are to participate meaningfully in outcome-based metabolic health strategies.

The 2026 Employer Cost Environment

Multiple surveys point in the same direction even though they measure different concepts. Mercer reports that average employer-sponsored health benefit cost reached $17,496 per employee in 2025, up 6.0%, and projects a 6.7% increase in 2026 to more than $18,500 per employee. Mercer's preliminary strategy survey projected a 6.5% increase after plan changes and nearly 9% before employer actions. WTW projects a 9.1% increase before plan changes and 8.0% after plan changes in 2026. PwC projects an 8.5% medical cost trend for the 2026 group market, while its 2027 outlook projects 9.0%, the highest in 17 years. These are not directly comparable estimates: Mercer measures employer benefit cost, WTW reports employer projections before and after plan changes, and PwC estimates payer medical cost trend. Together, however, they show a sustained affordability problem rather than a one-year fluctuation.

Source	Measure	2026 Estimate	Interpretation
Mercer	Total employer health benefit cost per employee	6.7% increase; more than $18,500 per employee	Includes employer benefit cost and reflects planned employer actions.
WTW	Employer projected health care cost increase	9.1% before plan changes; 8.0% after	Shows the amount of trend employers expect to offset through benefit and vendor changes.
PwC	Group-market medical cost trend	8.5%	Payer-oriented medical cost trend; not the same denominator as employer benefit cost.
Business Group on Health	Large-employer strategy survey	Approximately 9% projected trend	Large-employer member population; emphasizes pharmacy and high-cost claims.
Aon	Medical trend research	Directionally elevated, with employer-specific variation	Useful for cross-market context; employers should apply their own claims experience rather than a global average.

Sources: *Mercer, National Survey of Employer-Sponsored Health Plans, 2025 results and 2026 projection; WTW, 2025 Best Practices in Healthcare Survey; PwC, "Future of Payers" and "Behind the Numbers 2027"; Business Group on Health, 2026 Employer Health Care Strategy Survey; Aon, 2026 Global Medical Trend Rates Report.*

Policy Implications

The key policy distinction is between trend avoidance and cost transfer. Employers can reduce their own increase by raising deductibles, narrowing networks, changing formularies, or increasing employee contributions, but these actions do not necessarily reduce the underlying price or volume of care. A stronger employer strategy separates four objectives: reducing unit prices, avoiding low-value utilization, improving clinical outcomes, and protecting employee affordability. Measurement systems should report each objective separately rather than treating any reduction in employer expense as evidence of improved health-system performance.

Specialty Pharmacy and PBM Governance

Specialty medications represent a small share of prescriptions but a disproportionate share of drug spending. Because definitions vary by PBM and data source, this chapter does not retain the prior unsupported claim that specialty drugs represented exactly 2%

of prescriptions and 50% to 60% of spending as a universal national statistic. The more defensible finding is that specialty spending is concentrated, rapidly growing, and increasingly distributed across both the pharmacy and medical benefits.

PSG's 2025 Artemetrx analysis found that specialty drug cost per member per year increased from $1,333 in 2023 to $1,641 in 2024 in its dataset. Gross specialty trend slowed from 14.4% to 9.6%, which PSG attributed in part to biosimilar adoption. The simultaneous increase in per-member cost and reduction in trend illustrates why plan sponsors need both level and rate-of-change measures. A lower trend rate does not mean specialty spending has become affordable; it means spending is increasing more slowly from an already high base.

PBM governance has also moved from a technical procurement issue to a fiduciary and public-policy issue. Employers are examining rebate retention, spread pricing, administrative fees, specialty pharmacy ownership, formulary incentives, and the allocation of savings between the plan and members. Public claims that "transparent" PBMs save a fixed percentage should be treated cautiously unless the comparison controls for formulary, utilization, specialty channel, rebates, and member cost sharing. The relevant policy standard is auditable net cost and aligned incentives, not a vendor's self-description.

A stronger employer pharmacy strategy includes: an integrated view of pharmacy and medical-benefit drug spending; contract definitions that permit independent audit; pass-through or otherwise fully disclosed economics; formulary and utilization-management rules tied to clinical evidence; biosimilar and site-of-care strategy; protection against cost shifting to members; and longitudinal reporting of adherence, discontinuation, adverse events, and total cost of care.

Sources: *Pharmaceutical Strategies Group, 2025 Artemetrx State of Specialty Spend and Trend Report; WTW, "The PBM Transparency Revolution," March 2026; FDA, Novel Drug Approvals for 2024 and 2025.*

GLP-1 Coverage and Obesity Treatment Strategy

GLP-1 medications have become a defining employer-benefit issue because they combine strong clinical demand, broad potential eligibility, high ongoing cost, and incomplete long-term employer ROI evidence. IFEBP reported that GLP-1 drugs for weight loss represented an average of 11.4% of total annual claims among responding corporate plans in its 2026 survey, based on 2025 claims experience, up from 6.9% in 2023. IFEBP's published materials describe this share against total annual claims rather than pharmacy claims specifically, and this report follows that denominator. The survey reported that 60% of respondents covered GLP-1s for diabetes only and 36% covered both diabetes and weight loss. Business Group on Health reported that 67% of 105 large-employer members covered GLP-1s for weight management. WTW's June 2026 pulse survey found 66% coverage among 294 clients representing more than 2.8 million members, while Mercer reported 49% coverage among large employers in 2025, up from 44% in 2024.

The variation is expected. IFEBP surveyed a broader mix of corporate employers and health plans; Business Group on Health surveyed large, sophisticated employer members; WTW surveyed its clients; and Mercer reports a nationally representative employer survey with separate large-employer results. The chapter therefore replaces the prior single "36%–67%" baseline with a survey-specific table and an explicit warning against treating the range as a confidence interval.

Survey	Population	Coverage Finding	Use in Policy Analysis
IFEBP 2026	Nearly 300 surveyed plans/employers	36% covered diabetes and weight loss; 60% diabetes only	Broad plan-sponsor perspective; not limited to very large employers.
Business Group on Health 2026	105 large-employer members	67% covered weight management	Best read as a large-employer member benchmark.
WTW Rx Pulse, June 2026	294 clients; >2.8 million members	66% covered obesity GLP-1s	Current client snapshot; 70% of covering employers intended to maintain coverage.
Mercer 2025	National employer survey; large-employer breakout	49% of large employers covered weight-loss GLP-1s	Useful nationally representative benchmark for large employers.

Sources: *IFEBP, 2026 GLP-1 Drugs Survey; Business Group on Health, 2026 GLP-1 Survey; WTW, June 2026 Rx Pulse Survey; Mercer, 2025 National Survey of Employer-Sponsored Health Plans.*

The evidence supports a conclusion of scrutiny and selective retrenchment, not a universal coverage collapse. Business Group on Health found that 72% of employers then covering GLP-1s for weight management were likely to continue in 2027, while 10% were unlikely to continue. WTW found that 70% intended to maintain coverage, 12% were likely or very likely to discontinue, and 18% were somewhat likely to discontinue. Mercer reported that some employers dropped or were considering dropping coverage, but its broader national data also showed large-employer coverage rising from 44% in 2024 to 49% in 2025. The appropriate baseline statement is that expansion has slowed and utilization controls are tightening, while coverage remains common among large employers.

Employers are increasingly requiring objective eligibility verification, prior authorization, participation in a weight-management program, prescribing through designated clinicians, and ongoing response criteria. These controls can improve clinical targeting, but they can also create access barriers or encourage discontinuation if requirements are burdensome. Policy evaluation should therefore include approval rates, time to therapy, persistence, discontinuation, adverse-event management, weight and cardiometabolic outcomes, and member out-of-pocket cost.

The unresolved economic question is the time horizon. Employers often evaluate a one- to three-year budget period, while some avoided complications may accrue over longer periods or after an employee changes jobs. This creates a structural underinvestment problem: the employer paying for treatment may not capture all future savings. For that reason, a credible policy framework should distinguish clinical value from employer-specific short-term ROI and should consider portability, risk adjustment, manufacturer contracting, and multi-year outcome guarantees.

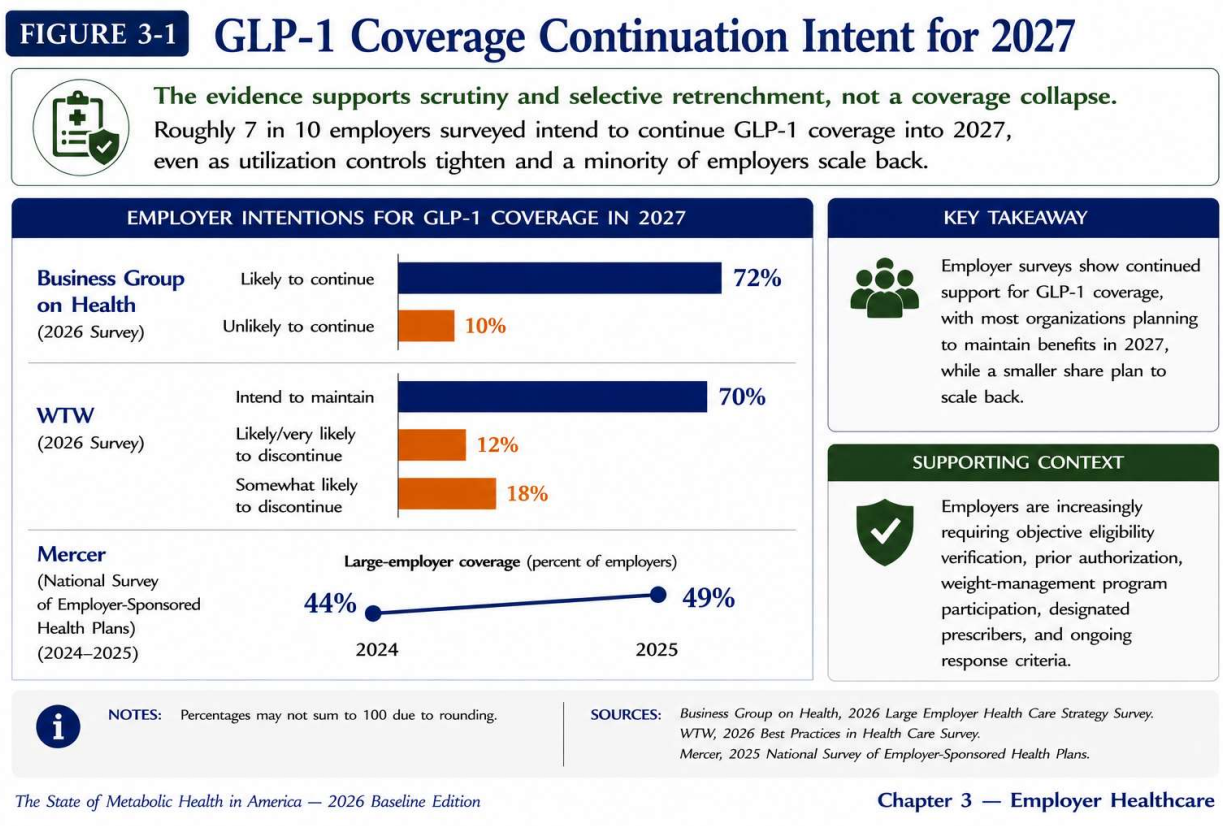


Figure 3-1. GLP-1 Coverage Continuation Intent for 2027

Sources: Business Group on Health, 2026 Large Employer Health Care Strategy Survey. WTW, 2026 Best Practices in Health Care Survey. Mercer, 2025 National Survey of Employer-Sponsored Health Plans.

Policy Implications

GLP-1 coverage decisions sit at the direct intersection of this report's central subject and its economic analysis in Chapter 2, since these medications treat the obesity and diabetes documented in Chapter 1 while simultaneously driving a substantial share of the pharmacy cost growth documented in Chapter 2. The unresolved time-horizon problem, in which the employer bears near-term cost while any long-term savings may accrue to a future employer or to Medicare, is one of the more structurally important findings in this chapter, and one this report will track closely as portability and multi-year outcome data become available.

Consumer-Directed Plans, HSAs, and Affordability

In 2025, 33% of covered workers were enrolled in a high-deductible health plan with a savings option, compared with 46% in preferred provider organization plans. The average single-coverage deductible among workers with a general annual deductible was $1,886. Thirty-four percent of covered workers were in a plan with a single deductible of $2,000

or more. The average deductible increased 17% over five years and 43% over ten years; the share facing a deductible of at least $2,000 increased 32% over five years and 77% over ten years.

Beginning in 2026, Bronze and Catastrophic Marketplace plans available through an Exchange are HSA-compatible regardless of whether they satisfy the general statutory definition of a high-deductible health plan (HDHP), per CMS guidance.

Federal changes also expanded the policy relevance of HSAs by preserving pre-deductible telehealth treatment and permitting HSA use for qualifying direct primary care arrangements. These changes may improve access, but they do not resolve the central equity issue: tax-favored accounts provide the greatest benefit to households with sufficient income to contribute and absorb high deductibles. Employer strategy should therefore evaluate the distribution of HSA contributions, not only enrollment, and should consider targeted employer funding for lower-wage workers and chronic-condition populations.

Sources: *KFF, 2025 Employer Health Benefits Survey; CMS, 2026 Marketplace Open Enrollment materials and Plans and Benefits FAQs; KFF, 2026 analysis of policy changes affecting HDHPs and HSAs.*

Prevention, Wellness, and Population-Health Measurement

KFF reports that 83% of large firms and 56% of small firms offered at least one wellness promotion program in 2025, including smoking cessation, weight management, or behavioral/lifestyle coaching. These offer rates establish prevalence, not effectiveness. The evidence base does not support a general claim that wellness programs reliably reduce total medical spending. Program evaluations must distinguish participation, satisfaction, biometric change, preventive-care completion, and claims outcomes.

The employer market is therefore moving toward a more disciplined measurement model. A useful population-health framework should: define a stable denominator; risk-adjust

or stratify results without masking disparities; use claims, laboratory, pharmacy, and engagement data where legally and operationally feasible; measure both process and outcome; preserve individual privacy; identify vendor attribution limits; and report results over a sufficiently long period. It should also separate changes caused by workforce turnover from changes in the health of a stable cohort.

For metabolic health specifically, employers should track preventive-care completion, obesity prevalence and severity, diabetes and prediabetes identification, blood pressure control, lipid management, medication adherence, avoidable emergency and inpatient use, and total medical and pharmacy cost. No single composite score should replace the underlying measures. A composite can support communication and longitudinal benchmarking only when its methodology, weighting, data completeness, and limitations are transparent to purchasers and policymakers.

Sources: *KFF, 2025 Employer Health Benefits Survey; Aon, 2026 medical trend research emphasizing employer-specific data and analytics; Business Group on Health, 2026 Employer Health Care Strategy Survey.*

Trends

Two trends define the employer metabolic health environment this chapter documents. First, employer health care costs are rising at their fastest rate in more than a decade, driven substantially by specialty pharmacy spending and, within it, by GLP-1 medications, forcing employers to make more deliberate coverage and utilization management decisions than the largely passive cost-shifting posture of prior years. Second, employers are moving, unevenly and with varying sophistication, from managing cost alone toward attempting to measure value, though this chapter documents that the capacity and data infrastructure required to measure health outcomes, as opposed to spending, remain underdeveloped across most employers.

The interaction of these two trends is the defining feature of the current employer environment: rising cost pressure is pushing employers toward more active management at precisely the moment when the tools to distinguish effective from ineffective spending remain immature. This chapter treats that gap between the sophistication of cost management and the sophistication of outcome measurement as the central employer challenge, and later chapters, particularly Chapter 10 on employer innovation, return to it directly.

Policy Implications

This report does not prescribe a single employer strategy, but the dimensions documented above point toward a set of implications that a stronger employer metabolic health approach would reflect. The following discussion, carried forward from this chapter's original analysis, outlines those implications; it describes what a more measured, value-oriented employer strategy would entail rather than endorsing any specific vendor, product, or plan design.

The evidence reviewed in this chapter supports a six-part employer strategy. It is presented as a policy framework, not as a proprietary program design or a recommendation that every employer adopt the same vendors.

Element	Employer Action	Policy Test
1. Define the population	Establish eligibility, baseline risk, and stable cohort rules.	Can results be interpreted despite turnover, missing data, and changing benefit eligibility?
2. Protect access and affordability	Design cost sharing, HSA contributions, and navigation around the needs of lower-wage and high-risk workers.	Does the strategy reduce barriers or merely transfer expense to employees?
3. Integrate clinical and pharmacy strategy	Align obesity, diabetes, cardiovascular, renal, behavioral-health, and primary-care pathways.	Are programs coordinated, or are they separate point solutions with duplicative fees and data silos?
4. Contract for auditable economics	Require transparent pricing, rebate and fee disclosure, independent audit rights, and defined performance guarantees.	Can the employer reconcile gross cost, rebates, net cost, and member cost sharing?
5. Measure longitudinal outcomes	Track clinical process, outcomes, utilization, total cost, persistence, and disparities.	Are outcomes measured over enough time and against an appropriate comparison or baseline?
6. Govern and reassess	Use a cross-functional committee with benefits, finance, clinical, legal, privacy, and employee representation.	Are continuation and expansion decisions based on predefined evidence rather than vendor narratives or short-term budget pressure alone?

This framework strengthens the prior chapter by shifting from a catalog of benefit tools to a purchasing and governance model. It also keeps the discussion within the boundaries of a policy paper: the objective is to identify market failures, evidence requirements, and policy-relevant employer practices rather than to prescribe a consumer wellness regimen.

2026 Baseline Metrics

The revised baseline uses metrics that are directly supported by named sources and that can be reproduced in future editions. Survey-specific GLP-1 results are separated rather than collapsed into a single range.

ID	Metric	2026 Baseline Value
EH-01	Employer health benefit offer rate, firms with 10+ workers	61% overall; 97% large firms; 59% small firms (KFF 2025)
EH-02	Self-funded plan enrollment	67% of covered workers; 80% large firms; 27% small firms (KFF 2025)
EH-03	Average employer health benefit cost per employee	$17,496 in 2025; projected to exceed $18,500 in 2026 (Mercer)
EH-04	Projected 2026 employer health cost increase	6.7% Mercer; 9.1% before / 8.0% after plan changes WTW
EH-05	Specialty drug cost per member per year	$1,641 in 2024, up from $1,333 in 2023 (PSG Artemetrx)
EH-06	GLP-1 share of total annual claims (weight-loss indication)	11.4% among IFEBP 2026 respondents, up from 6.9% in 2023
EH-07A	GLP-1 coverage for diabetes and weight loss	36% in IFEBP 2026 survey
EH-07B	GLP-1 coverage for weight management, large-employer member survey	67% in Business Group on Health 2026 survey
EH-07C	GLP-1 coverage for obesity, WTW client survey	66% in June 2026 WTW Rx Pulse survey
EH-08	HDHP with savings option enrollment	33% of covered workers (KFF 2025)
EH-09	Average single deductible	$1,886 among workers with a general annual deductible (KFF 2025)
EH-10	Employer wellness promotion offer rate	83% large firms; 56% small firms (KFF 2025)

ID	Metric	2026 Baseline Value
EH-11	Employer-sponsored insurance covered lives, nonelderly	~154 million (hierarchical assignment) / ~165.6 million (overlapping coverage permitted), KFF 2025

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly. The employer benefit design figures in this chapter derive primarily from large employer surveys, principally KFF's and Mercer's, which rely on employer self-report rather than claims audit, and which sample large employers more completely than small ones; figures should therefore be read as most representative of large-employer practice. Two further caveats apply to this chapter's productivity and occupational figures. First, the Integrated Benefits Institute estimates reported as EI-07 and EI-08 are generated by a proprietary modeling tool rather than a published peer-reviewed national accounting system; they combine employer claims benchmarks, federal workforce data, employee self-reports, and modeled presenteeism, and should be interpreted as national burden estimates rather than audited employer expenditures. The 1.5 billion figure is not solely days employees were absent from work; it combines approximately 978 million actual absence days with approximately 540 million equivalent workdays modeled as lost through reduced on-the-job performance. Second, no current, nationally representative U.S. dataset provides directly observed workers' compensation claim rates, medical costs, indemnity costs, and lost workdays stratified by body mass index. Available evidence consists of historical single-employer cohorts, commercial claims analyses of privately insured subsets, and national modeling studies. For that reason this edition does not publish a baseline metric for workers' compensation claims or costs by body mass index, rather than substituting a differently limited estimate, and reports obesity-attributable absenteeism instead, for which a nationally representative peer-reviewed estimate exists. The detailed source and fact-check record that follows, carried forward from this chapter's original preparation, documents the specific verification applied to the chapter's key figures.

This record documents the principal verification and editorial decisions applied to the uploaded draft. It is included to make the chapter's evidentiary treatment transparent and reproducible.

Original Claim or Treatment	Finding	Revision
154 million people covered by employer-sponsored insurance	Verified, but counting method required clarification.	Retained and distinguished from KFF's 165.6 million overlapping-coverage estimate for 2025.
61% offer rate; 97% large; 59% small	Verified in KFF 2025.	Retained.
67% self-funded; 80% large; 27% small	Verified in KFF 2025.	Retained and added small-firm figure.
Specialty drugs equal about 2% of prescriptions and 50%–60% of spending	Common industry formulation, but not adequately anchored to a single neutral national source in the draft.	Removed as a headline baseline and replaced with PSG's directly documented PMPY and trend figures.
$92.5B in 2023 to nearly $130B in 2024 specialty market	Could not be verified from an accessible primary report with a clear market definition.	Removed.
70% of new FDA approvals were specialty drugs	FDA confirms 50 novel approvals in 2024 but does not support this percentage in the cited material.	Removed.
PBM market share fell 72% to 61%; transparent PBM use rose 12% to 31%; savings up to 30%	Appeared to rely on vendor marketing and lacked a sufficiently neutral methodology for a baseline policy paper.	Removed; replaced with governance standards and qualified discussion of transparency.
9.1% employer cost increase in 2026 before plan changes	Verified in WTW 2025 Best Practices in Healthcare Survey.	Retained and paired with 8.0% after plan changes.
GLP-1 claims share 11.4%, up from 6.9%	Verified in IFEBP 2026.	Retained with survey context.
36%, 67%, and 48% GLP-1 coverage estimates	36% IFEBP and 67% Business Group on Health verified; 48% Brown & Brown was not needed once stronger current benchmarks were available.	Replaced range with separate IFEBP, Business Group on Health, WTW, and Mercer metrics.
Coverage has plateaued or is declining	Directionally supported, but too categorical.	Revised to "expansion has slowed and utilization controls are tightening," with survey-specific continuation findings.
All Bronze and Catastrophic Marketplace plans are HDHPs in 2026	Imprecise under CMS wording.	Revised to HSA-compatible regardless of whether the plan meets the general HDHP definition.

Original Claim or Treatment	Finding	Revision
Wellness offer rates 83% large and 56% small	Verified in KFF 2025.	Retained; effectiveness claims were narrowed.
More than doubling of biometric screening among small firms	Not retained because the exact comparison and denominator were not sufficiently clear in the draft citation.	Removed pending direct table-level verification.
Employer strategy timeline	Interpretive, not a statistical claim.	Retained with explicit characterization as an analytic framework, not a sourced chronology.

Chapter Summary

Employer-sponsored insurance is the principal financing mechanism for working-age health coverage, but the capacity to manage metabolic health risk is distributed unevenly. Large self-funded employers have the strongest purchasing leverage and the most direct exposure to claims, while smaller employers face greater data and administrative constraints. Across the market, cost growth is accelerating, prescription drug spending is rising rapidly, and specialty and GLP-1 therapies are forcing employers to make explicit decisions about access, evidence, and affordability.

The policy response should not be reduced to either broad coverage or broad restriction. Employers need auditable pharmacy economics, clinically defensible eligibility standards, protection against employee cost transfer, integrated care pathways, and longitudinal outcome measurement. The central evidence gap is whether current employer interventions produce durable improvements in metabolic health and total cost of care over a time horizon that matches employer decision-making. Future editions should track not only coverage rates, but also approval, persistence, outcomes, member affordability, and the distribution of benefits across workforce groups.

Looking Ahead to the 2027 Edition

- Whether 2027 medical cost trend reaches PwC's projected 9.0% and how much of that increase employers offset through plan changes versus true reductions in underlying cost.
- Whether large-employer GLP-1 coverage remains stable, contracts, or shifts toward direct manufacturer, designated-provider, or outcomes-based arrangements.
- Whether oral obesity therapies materially change adherence, price competition, and employer coverage policy.
- Whether PBM transparency initiatives produce measurable reductions in net plan and member cost after controlling for formulary and utilization differences.
- Whether employers adopt standardized longitudinal measures of metabolic health and whether those measures are independently validated.
- Whether the gap between large and small employers narrows through standardized reporting, purchasing collaboratives, public policy, or insurer-led programs.
- KFF's 2026 Employer Health Benefits Survey and updated Mercer, WTW, Business Group on Health, PwC, Aon, IFEBP, and PSG results.

Questions We Still Cannot Answer

- Do employer-sponsored GLP-1 programs produce net medical and productivity offsets within the period that an employer can reasonably observe and capture?
- Which utilization-management designs improve clinical targeting without creating inequitable delays or excessive discontinuation?
- How much of reported PBM savings reflects genuine net-cost reduction rather than changes in formulary, utilization, rebates, or member cost sharing?
- Which employer wellness and metabolic health programs improve stable-cohort clinical outcomes rather than engagement alone?
- What minimum data set and governance standard are necessary for a credible employer population-health measure?
- How should policy account for the fact that workers change employers before many long-term benefits of preventive treatment accrue?

Future editions of this report will return to these questions directly and report honestly on what has and has not been learned in the intervening year.

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Chapter 4

Medicare and the Concentration of Metabolic Disease

Chapter 4 Key Findings

- Medicare represents the nation's largest concentration of metabolic disease burden: among its more than 70 million beneficiaries, weight-related chronic conditions affect 76% of beneficiaries even at a normal weight, rising to 83% among those who are overweight and 87% among those with obesity.
- Claims-based prevalence of chronic kidney disease among Medicare beneficiaries has risen sharply in recent years, alongside continued high and rising prevalence of hypertension, diabetes, and heart failure, though this chapter notes explicitly that claims-based detection improvements may account for part of that rise.
- Adults aged 60 to 64, in the years just before Medicare eligibility, had meaningfully higher rates of anti-obesity GLP-1 prescribing and prescription-filling than beneficiaries 65 and older in the same eligible population, a gap a peer-reviewed analysis found held across every body-mass-index category, suggesting a treatment access cliff at the point of Medicare enrollment.
- Medicare Advantage, now covering 55% of eligible beneficiaries, has become the principal delivery infrastructure through which metabolic disease is increasingly managed, through supplemental benefits, risk adjustment, and value-based purchasing arrangements, rather than a side option alongside traditional fee-for-service Medicare.
- The Medicare Diabetes Prevention Program, CMS's flagship prevention initiative aimed at beneficiaries with prediabetes, had only 941 active participants nationally as of its most recently published participation count, a strikingly small number set against the 17.7 million or more beneficiaries already diagnosed with diabetes.
- Food, transportation, and other social-needs supplemental benefits directly relevant to metabolic health remain narrowly available outside of Special Needs Plans: only 11% of individual Medicare Advantage plans offer a food and produce benefit, compared with 85% of Special Needs Plans.
- CBO's February 2026 baseline projects Medicare spending will grow 88% between 2026 and 2036, and the Hospital Insurance Trust Fund is now projected to be depleted by 2040, twelve years sooner than the prior baseline projected.

- Beginning July 1, 2026, the Medicare GLP-1 Bridge provides temporary coverage of select GLP-1 medications for weight loss at a $50 monthly copayment, the first instance of Medicare covering an anti-obesity medication for weight loss specifically.
- The Inflation Reduction Act's Medicare Part D redesign capped beneficiary out-of-pocket drug costs at $2,100 for 2026, and the first ten drugs selected for Medicare price negotiation, several of which treat cardiometabolic conditions, took effect at negotiated prices on January 1, 2026.
- Average Medicare Advantage Star Ratings for 2026 were reported at 3.65 to 3.66 on an unweighted, per-contract basis, and at approximately 3.98 on an enrollment-weighted basis by a separate industry estimate; these figures use different methodologies and are not directly comparable.

Introduction

This chapter is not, at its core, a chapter about Medicare as a program. It is a chapter about metabolic health as it concentrates, ages, and compounds within Medicare, and about the cost drivers that concentration produces for the federal budget and for tens of millions of older Americans. Medicare enrolls essentially the entire U.S. population aged 65 and older, along with younger people with qualifying disabilities, which means it enrolls the population in which decades of obesity, diabetes, hypertension, and related conditions have had the longest possible time to compound into diagnosed disease, comorbidity, and cost. Where Chapter 3 examined how employers manage metabolic health risk in a working-age population, this chapter examines what happens to that same risk once it has had forty, fifty, or sixty years to accumulate.

This edition substantially expands the Medicare chapter beyond its prior scope, in direct response to editorial review, to examine the full landscape through which Medicare intersects with metabolic health: the chronic disease burden itself; the population approaching Medicare eligibility and the coverage discontinuities it faces; Medicare Advantage as a delivery and financing infrastructure, including its supplemental benefits, risk adjustment, and quality measurement; value-based care models such as the Medicare Shared Savings Program and ACO REACH; the prevention infrastructure Medicare funds and beneficiaries' use of it; social determinants of health and health equity initiatives; and

pharmaceutical policy under the Inflation Reduction Act. Each of these areas is examined specifically for what it reveals about metabolic health, not as a general survey of Medicare policy for its own sake.

The evidence base for this chapter draws on CMS enrollment, National Health Expenditure, Chronic Conditions Data Warehouse, and Innovation Center data; the Congressional Budget Office's February 2026 baseline and its 2024 anti-obesity medication analysis; KFF's Medicare Advantage research; peer-reviewed literature on chronic disease prevalence and GLP-1 access among Medicare and near-Medicare populations; and supporting analysis from ASPE, AHRQ, and the American Diabetes Association. As in prior chapters, figures are reported with their specific source and methodology attached, and this chapter does not collapse estimates that use different denominators, populations, or measurement approaches into a single number.

Why This Matters

Medicare is where metabolic health outcomes ultimately arrive. A person's obesity, diabetes, or hypertension does not begin at age 65, but Medicare is where the federal government, and the taxpaying public, begins paying its share of the accumulated consequences at national scale. Understanding Medicare through a metabolic health lens, rather than treating it as a generic backdrop of enrollment and spending statistics, is what allows this report to connect the prevalence data in Chapter 1 and the cost data in Chapter 2 all the way through to the program that ultimately finances most of the care that results.

National Snapshot

Medicare as the Nation's Largest Concentration of Metabolic Disease Burden

Medicare covered more than 70 million beneficiaries as of early 2026. Within that population, weight-related chronic disease is not a subgroup phenomenon but a near-universal one. CBO's analysis of the Medicare Current Beneficiary Survey found that among beneficiaries who are overweight but do not have type 2 diabetes, 83% have at least one other weight-related chronic condition, including various cancers and heart conditions; among beneficiaries with obesity and without type 2 diabetes, that figure rises

to 87%. Even beneficiaries at a normal weight and without type 2 diabetes have a 76% prevalence of weight-related chronic conditions. These figures reframe how this report understands Medicare: it is not a population in which some beneficiaries happen to have metabolic disease, but a population in which the near-total majority carries measurable weight-related risk regardless of visible body size.

Diabetes prevalence estimates vary by data source and methodology, a discrepancy this chapter addresses directly in its Technical Considerations section rather than resolving by selecting a single preferred figure. ASPE analysis places diagnosed diabetes prevalence at 26% of all Medicare beneficiaries, or approximately 17.7 million people. A separate claims-based analysis using CMS Chronic Conditions Data Warehouse definitions found overall prevalence closer to 20%, with prevalence somewhat higher among beneficiaries aged 18 to 64 who qualify for Medicare through disability (23.0%) than among beneficiaries 65 and older (19.5%). CMS's own 2022 Medicare Current Beneficiary Survey, which relies on beneficiary self-report rather than claims, found diagnosed diabetes prevalence ranging from 27% among higher-income beneficiaries to 38% among lower-income beneficiaries. Regardless of which specific figure is used, diabetes affects a substantial minority to near-majority of the Medicare population, and its prevalence is consistently higher among lower-income beneficiaries across every data source this report reviewed.

Chronic Disease Burden Across Conditions

Diabetes is only one of several metabolically driven chronic conditions with high and, in some cases, rapidly rising prevalence among Medicare beneficiaries. Claims-based analysis of the CMS Chronic Conditions Data Warehouse found that most tracked comorbidities, including hypertension, hyperlipidemia, diabetes, atrial fibrillation, and dementia or Alzheimer's disease, show a low-magnitude but consistent upward prevalence trend over time. Chronic kidney disease stands out as an exception with a large-magnitude increase: one recent claims-based analysis found CKD prevalence rising from roughly 22% to roughly 46% among traditional Medicare beneficiaries, and from roughly 8% to roughly 14% among Medicare Advantage beneficiaries, over the comparison period studied. This report presents that finding with an explicit caveat: because CKD staging and detection have both improved over the same period, part of this

apparent increase likely reflects better claims-based identification of existing disease rather than a true increase in incidence, a distinction this chapter's data cannot fully separate.

Condition	Reported Prevalence	Source and Vintage
Diabetes (all beneficiaries)	20%–26%, depending on data source	ASPE; CCW claims analysis
Diabetes, self-reported (2022)	27%–38%, by income	CMS Medicare Current Beneficiary Survey
Chronic kidney disease, traditional Medicare	~22% rising to ~46%	Claims-based comparative analysis
Chronic kidney disease, Medicare Advantage	~8% rising to ~14%	Claims-based comparative analysis
Obesity (fee-for-service claims diagnosis)	21%	CMS Office of Minority Health (2019 data)
Weight-related chronic condition, obese beneficiaries without diabetes	87%	CBO analysis of Medicare Current Beneficiary Survey
Weight-related chronic condition, normal-weight beneficiaries without diabetes	76%	CBO analysis of Medicare Current Beneficiary Survey
Heart disease among beneficiaries 65+ with diabetes	~70%	American Heart Association, cited 2018 data

Hypertension, heart failure, chronic kidney disease, and ischemic heart disease are all disproportionately concentrated among Medicare's oldest beneficiaries, meaning these conditions cluster in the latter half of Medicare enrollment rather than distributing evenly across the entire 65-and-older population. This review did not, however, identify a current, nationally representative CMS estimate of the percentage of all Medicare beneficiaries with either heart failure or chronic kidney disease who are age 75 or older, and this edition therefore reports the age concentration qualitatively rather than assigning it a baseline value. This age concentration has direct implications for how this report's later chapters on Medicaid and public policy should interpret cost growth: a

substantial share of Medicare's chronic disease burden is concentrated among the very old, whose care needs and cost profile differ from those of beneficiaries who have only recently become eligible.

Medicare Spending Concentrated by Condition

Medicare accounted for $1,118.0 billion in national health expenditures in 2024, 21% of total NHE, and CBO's February 2026 baseline projects Medicare spending will grow 88% between 2026 and 2036, faster than any other major federal health program. This report was unable to identify a single, current, authoritative federal breakdown of total Medicare spending by individual chronic condition comparable to the condition-specific cost figures presented in Chapter 2 for the broader economy; CMS and CBO both report spending primarily by service category (inpatient, physician, Part D, and so on) rather than by diagnosis. Where condition-specific Medicare cost figures do exist in the peer-reviewed and federal literature, such as the historical finding that CKD and COPD beneficiaries had the highest annual inpatient-day counts among tracked chronic conditions, this chapter reports them, but this report identifies the absence of a comprehensive, current, Medicare-specific spending-by-condition breakdown as a genuine data gap rather than presenting an approximated or dated figure as though it were current.

The Population Approaching Medicare Eligibility

This report's prior editions have not directly examined the population immediately below Medicare's eligibility age, a gap this edition corrects at the reviewing editor's specific request. Adults aged 50 to 64, sometimes described in the research literature as "near-older adults," already carry a substantial chronic disease burden: 2014 National Health Interview Survey data found that 32.1% of adults aged 45 to 64 had two or more chronic conditions, compared with 7.3% of adults aged 18 to 44. Unlike the Medicare population, this group faces meaningfully uneven insurance coverage. National Health Interview Survey data for 2024 found 11.1% of adults aged 18 to 64 uninsured, compared with just 0.6% of adults 65 and older, reflecting Medicare's near-universal coverage of the older population. Uninsured near-older adults face substantially worse access to care than their insured counterparts: one analysis found uninsured adults aged 50 to 64 were at least seven times more likely to have postponed or foregone needed health care due to cost,

and only 15% to 23% as likely to have seen a health care professional in the preceding year, compared with adults of the same age with private or public coverage.

A preprint analysis of anti-obesity GLP-1 access, not yet certified by peer review, found a striking and specific discontinuity at the Medicare eligibility threshold itself. Comparing eligible patients without type 2 diabetes just below Medicare age (60 to 64) with those at Medicare age and older, the study found that prescribing of anti-obesity GLP-1 medications was 0.37% among the younger group compared with 0.24% among the Medicare-aged group, and that among patients who were prescribed such a medication, 60-day dispensing was 22.7% for the younger group compared with 15.2% for the Medicare-aged group. Both differences were statistically significant and held consistently across every body-mass-index category examined. Because standard Medicare Part D coverage excludes anti-obesity medications used for weight loss alone, this finding suggests that some beneficiaries who had access to such medications immediately before turning 65, through employer or marketplace coverage, may lose that access precisely at the point they age into Medicare, a coverage discontinuity this report considers a significant and previously under-examined finding. The temporary Medicare GLP-1 Bridge described later in this chapter is layered over this unchanged statutory exclusion rather than replacing it, and the prescribing and dispensing data shown here predate the Bridge, so the eligibility cliff illustrated below reflects the standing Part D exclusion that the Bridge only partially and temporarily offsets.

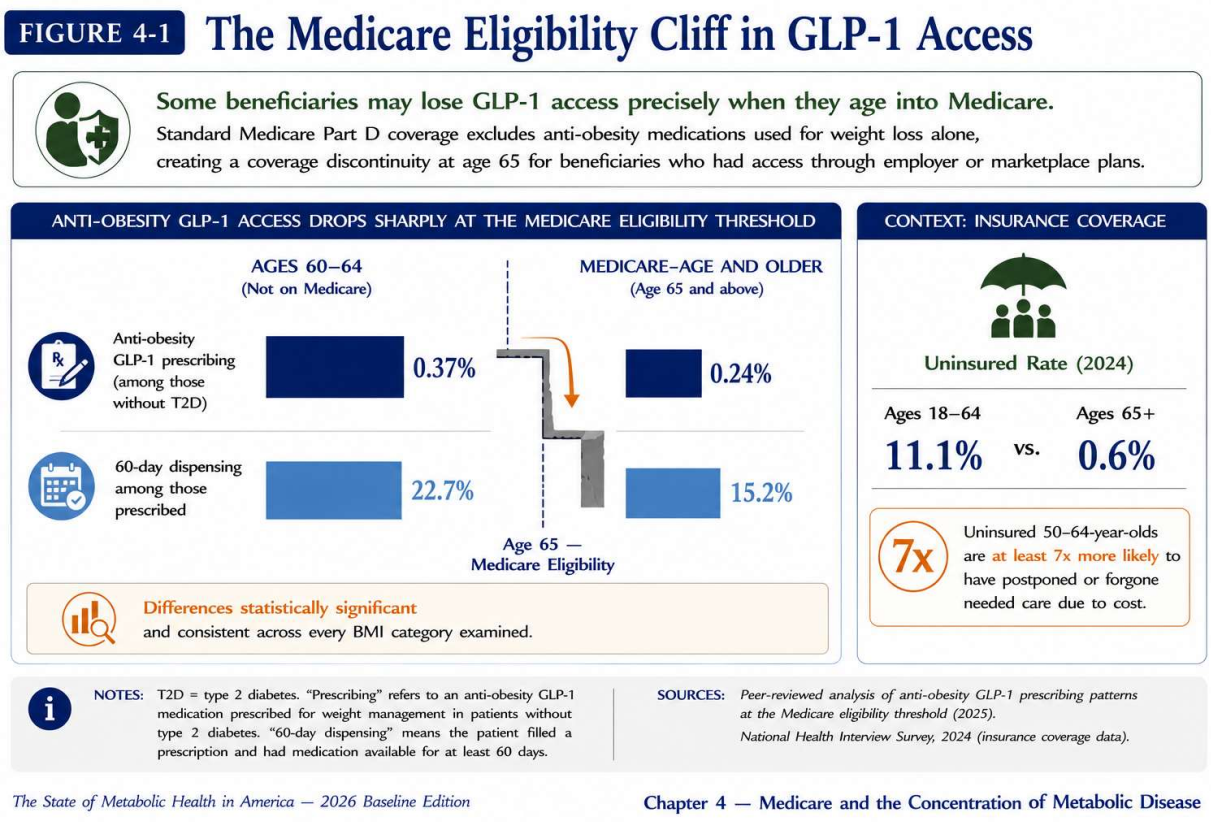


Figure 4-1. The Medicare Eligibility Cliff in GLP-1 Access

Sources: Peer-reviewed analysis of anti-obesity GLP-1 prescribing patterns at the Medicare eligibility threshold (2025). National Health Interview Survey, 2024 (insurance coverage data).

Medicare Advantage as Metabolic Health Delivery Infrastructure

Medicare Advantage has grown from 19% of eligible beneficiaries in 2007 to 55% in 2026, an enrollment of approximately 36 million people, and CBO projects this share will reach 63% by 2034. That growth means Medicare Advantage should now be understood as the principal delivery system through which metabolic disease is managed for most Medicare beneficiaries, rather than as an alternative arrangement alongside a traditional-Medicare default. Medicare Advantage plans finance supplemental benefits, including many directly relevant to metabolic health, through rebate dollars generated by bidding below CMS's county-level benchmark; virtually all individual-plan enrollees are in plans offering a fitness benefit (91%), and CMS's expanded definition of Special Supplemental Benefits for the Chronically Ill allows plans to offer food and produce benefits, transportation for non-medical needs, and other social-needs supports to beneficiaries with qualifying chronic conditions such as diabetes or heart failure.

These social-needs supplemental benefits remain concentrated in Special Needs Plans rather than broadly available. In 2026, food and produce benefits were offered by only 11% of individual Medicare Advantage plans compared with 85% of Special Needs Plans; general supports for living, such as housing and utility assistance, by 8% of individual plans compared with 72% of Special Needs Plans; and transportation for non-medical needs by 5% of individual plans compared with 36% to 37% of Special Needs Plans. The Value-Based Insurance Design Model, which had allowed broader targeting of these benefits by socioeconomic status rather than diagnosis alone, was discontinued by CMS at the end of the 2025 plan year due to what CMS described as unprecedented cost. Industry analysis also found that availability of several supplemental benefit categories, including transportation, meals, fitness, and over-the-counter allowances, declined modestly from a 2023 peak, even as food and produce and other home-focused benefits continued incremental growth, a pattern one analyst described as plans "recalibrating" rather than continuing to expand across every benefit category.

Quality measurement and payment for Medicare Advantage remain sources of active dispute relevant to metabolic health financing. Average Star Ratings for 2026 were reported at 3.65 to 3.66 on an unweighted, per-contract basis, and at approximately 3.98 on an enrollment-weighted basis by a separate industry estimate, following several years of decline beginning in 2022 that CMS attributes to legitimately tightened quality standards and that some industry participants attribute to methodology changes. Separately, KFF analysis found that Medicare Advantage payments per beneficiary ran approximately 14% higher than comparable traditional Medicare costs in 2026, translating to an estimated $76 billion in additional federal spending, a gap the Medicare Payment Advisory Commission and industry groups including the Healthcare Leadership Council and Better Medicare Alliance dispute on methodological grounds that this report does not adjudicate.

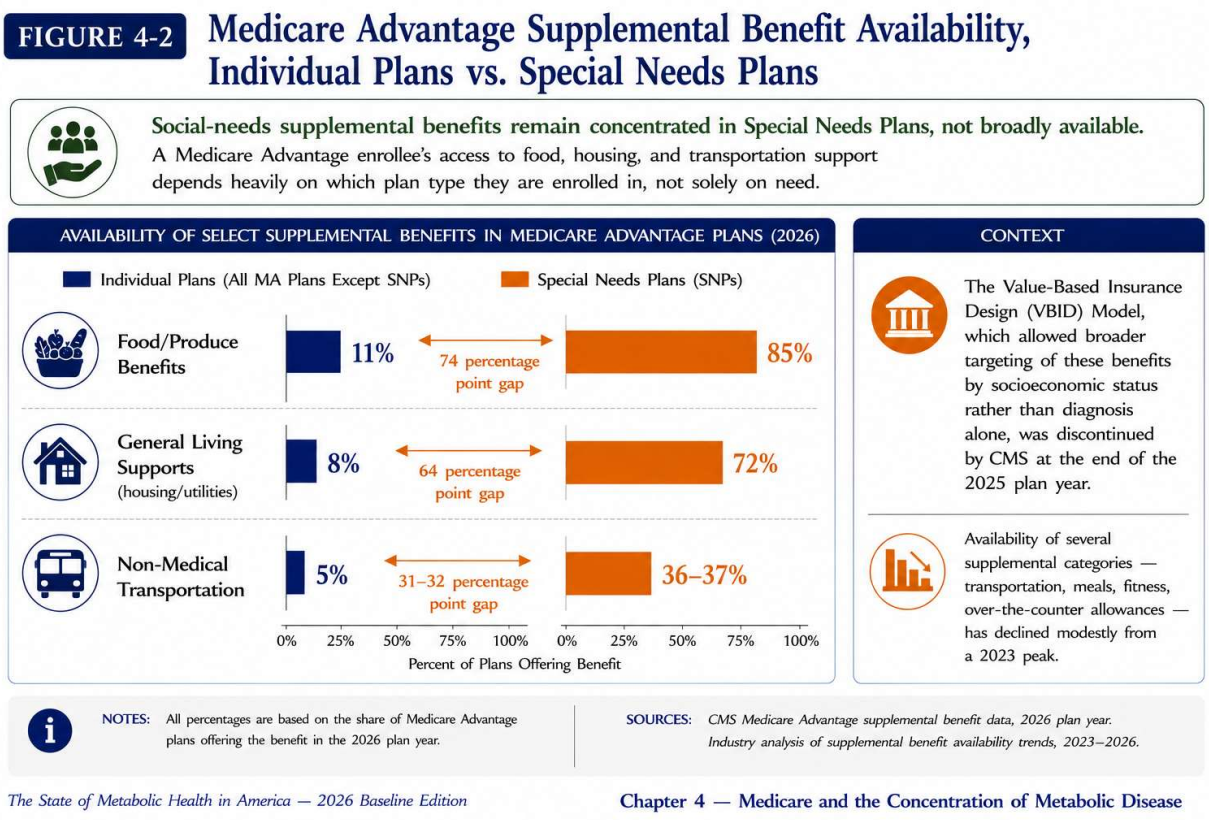


Figure 4-2. Medicare Advantage Supplemental Benefit Availability, Individual Plans vs. Special Needs Plans

Sources: CMS Medicare Advantage supplemental benefit data, 2026 plan year. Industry analysis of supplemental benefit availability trends, 2023–2026.

Value-Based Care Models

Medicare increasingly finances care for beneficiaries with metabolic disease through value-based arrangements rather than pure fee-for-service payment. The Medicare Shared Savings Program, the largest such arrangement, groups physicians, hospitals, and other providers into Accountable Care Organizations that share in savings achieved through coordinated, lower-cost, high-quality care, with CMS releasing updated participation and financial results for each performance year. ACO REACH, a CMMI model with a stronger emphasis on health equity and beneficiary risk adjustment than its predecessor models, and newer CMMI models including Making Care Primary and the TEAM episode-payment model, extend this value-based logic further into primary care and specific surgical or medical episodes. Because chronic, metabolically driven conditions such as diabetes, hypertension, and heart failure are exactly the kind of costly, long-duration conditions that coordinated, accountable care is designed to manage more

efficiently, these models are directly relevant to this report's subject even though none is designed around metabolic health specifically.

Prevention Infrastructure

Medicare funds a range of prevention services directly relevant to metabolic health, including the Annual Wellness Visit, obesity screening and behavioral counseling under Part B for beneficiaries with a body mass index of 30 or higher, medical nutrition therapy for beneficiaries with diabetes or kidney disease, and no-cost coverage of ACIP-recommended adult vaccines under the Part D redesign. The most direct prevention program aimed at this report's subject, however, shows a striking utilization gap. The Medicare Diabetes Prevention Program, an evidence-based, CDC-curriculum program intended to prevent or delay type 2 diabetes onset among beneficiaries with prediabetes, had only 941 active participants nationally as of its most recently published CMS Innovation Center count. Set against the 17.7 million or more beneficiaries already diagnosed with diabetes, and a considerably larger undiagnosed prediabetic population, this participation level represents a rounding error relative to the scale of the underlying risk the program is intended to address. CMS has recently expanded programmatic flexibility, including permitting asynchronous, fully online program delivery through 2029, in an apparent effort to improve access and participation.

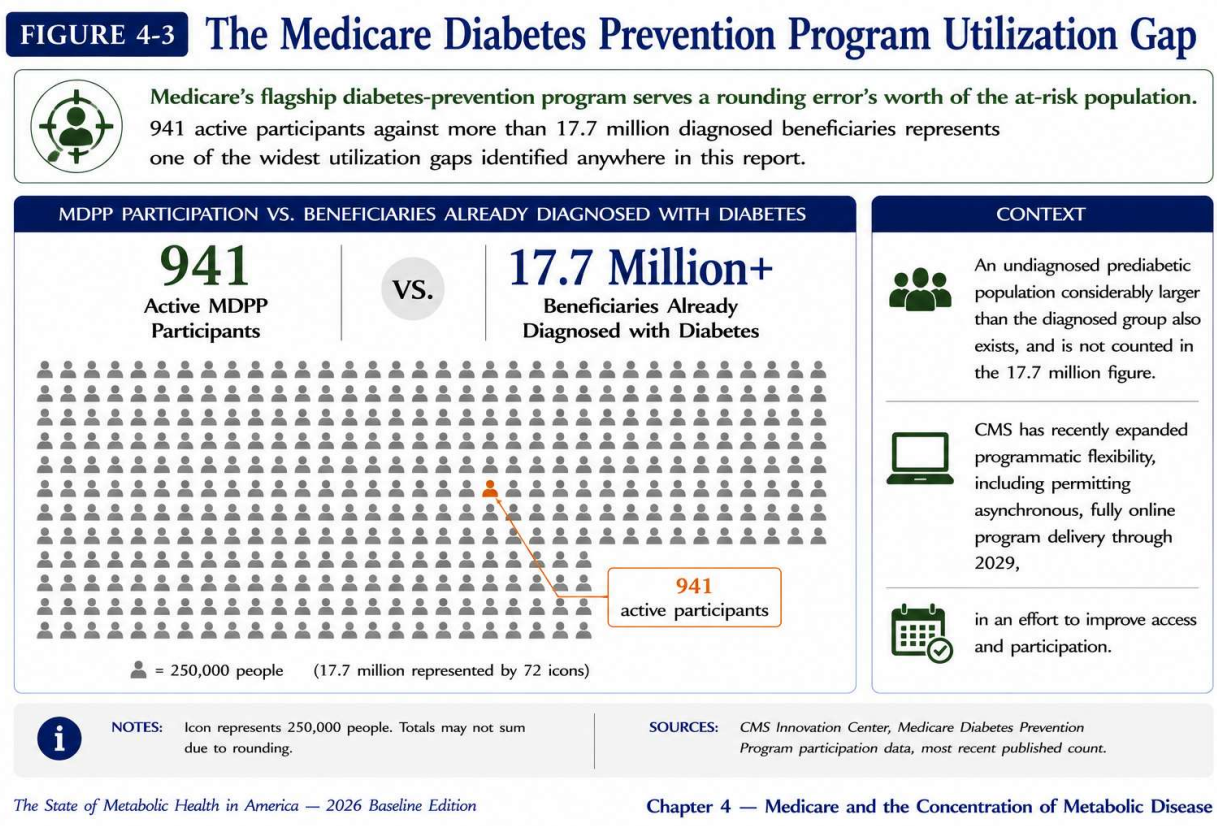


Figure 4-3. The Medicare Diabetes Prevention Program Utilization Gap

Sources: CMS Innovation Center, Medicare Diabetes Prevention Program participation data, most recent published count.

Social Determinants and Health Equity

CMS has placed growing emphasis on social determinants of health, including food insecurity, housing instability, transportation access, and caregiver burden, as factors materially affecting both cost and outcomes for Medicare beneficiaries managing chronic disease. That emphasis appears concretely in Medicare Advantage's expanded supplemental benefit categories discussed above, in ACO REACH's explicit health equity benchmark adjustments, and in CMS's broader health equity framework for quality measurement. As with prevention infrastructure, however, this report finds a consistent gap between stated policy emphasis and beneficiary-level reach: social-needs supplemental benefits remain concentrated in Special Needs Plans serving beneficiaries who are dually eligible for Medicare and Medicaid or who have qualifying chronic conditions, rather than being broadly available across the Medicare Advantage market or in traditional Medicare.

Pharmaceutical Policy and the Inflation Reduction Act

The Inflation Reduction Act has produced the most significant changes to Medicare's prescription drug benefit since Part D's creation, with direct relevance to metabolic health given how many cardiometabolic medications are among the highest-cost drugs in the program. The redesigned Part D benefit capped beneficiary out-of-pocket costs at $2,000 in 2025 and $2,100 in 2026, eliminated the former coverage gap, and introduced a Medicare Prescription Payment Plan allowing beneficiaries to spread out-of-pocket costs into monthly installments rather than facing large costs early in the year. Separately, the Medicare Drug Price Negotiation Program produced negotiated Maximum Fair Prices for an initial set of ten high-cost drugs, several of which treat cardiometabolic conditions, effective January 1, 2026, with discounts ranging from 38% to 79% off 2023 list prices. CMS projects that beneficiaries will save approximately $1.5 billion in out-of-pocket costs in 2026. CMS separately estimates that the Medicare program would have saved approximately $6 billion, or roughly 22% net on these drugs, had the negotiated prices been in effect in 2023; that figure is a retrospective estimate applied to a prior year rather than a projection of 2026 program savings, and the two amounts should not be read as a single combined forward-looking total. The 2026 Part D benefit also carries a maximum deductible of $615. An additional 15 drugs will be added to negotiation for 2027, for which CMS estimates savings of approximately $12 billion relative to 2024 net prices, amounting to roughly 44% net savings on those medications, along with approximately $685 million in beneficiary out-of-pocket savings. In January 2026 CMS announced a further 15 Part D and Part B drugs with negotiated prices effective in 2028. Separately, insulin cost-sharing under Part D is now capped at the lesser of $35 per month or 25% of the negotiated or applicable price, and all ACIP-recommended adult vaccines are covered at no cost-sharing.

These changes carry real trade-offs that this report presents without resolving. Research from the University of Southern California's Schaeffer Center found that, even as the redesigned benefit protects the minority of beneficiaries who reach the out-of-pocket cap, average deductibles and coinsurance requirements in Medicare Advantage Prescription Drug plans rose sharply in 2025, suggesting that most beneficiaries who do not reach the

cap may see increased, rather than decreased, out-of-pocket costs under the new plan designs insurers have adopted in response to the IRA's changed liability structure.

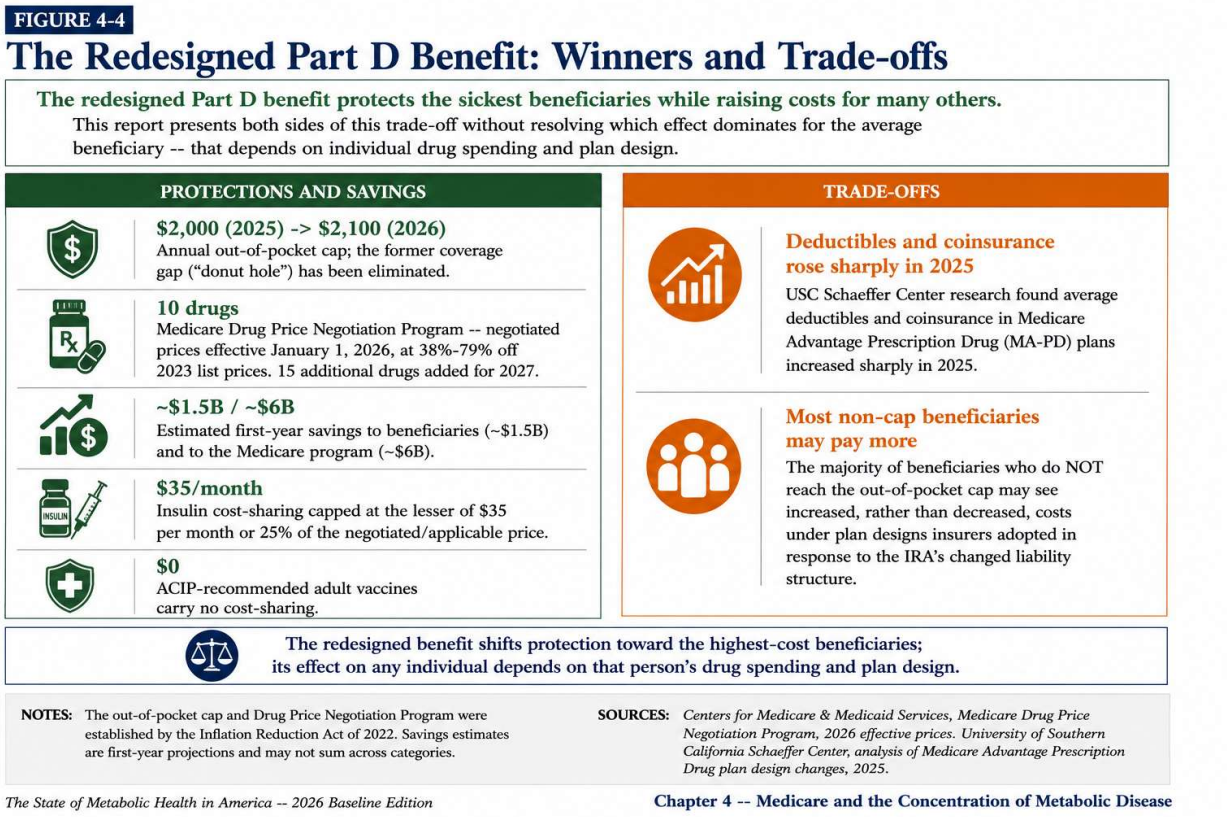


Figure 4-4. The Redesigned Part D Benefit: Winners and Trade-offs

Sources: Centers for Medicare & Medicaid Services, Medicare Drug Price Negotiation Program, 2026 effective prices. University of Southern California Schaeffer Center, analysis of Medicare Advantage Prescription Drug plan design changes, 2025.

Emerging CMS Quality Measurement

CMS has signaled continued movement toward patient-reported outcomes, digital quality measures, interoperable data reporting, and a "universal foundation" of aligned quality measures intended to reduce reporting burden and improve comparability across Medicare's various value-based programs. Because these measurement frameworks will determine which aspects of metabolic health, such as blood pressure control, glycemic control, or weight management, are formally tracked and financially incentivized across Medicare Advantage, Accountable Care Organizations, and other value-based arrangements, their continued development is directly relevant to this report's subject

even though the specific technical details remain in active development and are not yet finalized in a form this report can report as settled policy.

Trends

Every trend this report has tracked in Medicare points toward increasing concentration and increasing cost pressure. CBO's February 2026 baseline increased projected Medicare mandatory outlays for 2026 through 2035 by roughly $1 trillion compared with its January 2025 baseline, driven substantially by Medicare Part D, where private insurers' 2026 bids anticipated a 35% increase in per-enrollee costs against a 5% increase CBO had expected before those bids were submitted; CBO attributed part of that unexpected growth to continued spending increases on GLP-1 medications. Under the current baseline, Medicare spending is projected to grow 88% between 2026 and 2036, and the Hospital Insurance Trust Fund is now projected to be depleted by 2040, twelve years sooner than the prior baseline projected.

Chronic disease prevalence trends compound this fiscal pressure rather than offsetting it. Claims-based prevalence has risen, to varying degrees, across nearly every metabolically relevant condition this chapter tracked, from a low-magnitude but consistent increase in hypertension and diabetes to a much sharper claims-based increase in chronic kidney disease. Medicare Advantage's continued growth, now covering 55% of eligible beneficiaries and projected to reach 63% by 2034, means an increasing share of this chronic disease burden is managed through Medicare Advantage's supplemental benefit and risk-adjustment infrastructure, even as that infrastructure's most socially relevant benefits, food, housing, and transportation support, remain concentrated in Special Needs Plans rather than the broader market.

Medicare's near-term pharmaceutical and prevention landscape is shifting rapidly but unevenly. The Medicare GLP-1 Bridge and the IRA's drug price negotiation and Part D redesign represent the most significant near-term policy interventions aimed at the cost and access dimensions of metabolic health, yet the Medicare Diabetes Prevention Program, Medicare's primary upstream prevention tool for the same underlying disease,

remains dramatically underutilized. Meanwhile, the population immediately below Medicare eligibility appears to lose meaningful access to anti-obesity treatment precisely at the point of Medicare enrollment, a discontinuity that current policy does not yet address and that this report is unaware of any pending CMS or Congressional action to resolve.

Policy Implications

Policy Implications

This chapter's findings raise several policy questions that this report poses descriptively, in keeping with its editorial commitment to remain a reference document rather than an advocacy paper. How should Medicare measure metabolic health at a population level, given that its own claims-based chronic condition data is acknowledged to undercount true prevalence, particularly among Medicare Advantage beneficiaries whose encounter data is systematically less complete than fee-for-service claims? Should obesity and prediabetes be identified and treated earlier, potentially before Medicare eligibility, given the apparent coverage discontinuity this chapter documents at the Medicare eligibility threshold? How should Medicare's quality measurement infrastructure, currently subject to open dispute over Star Ratings methodology and Medicare Advantage payment accuracy, evolve to more directly capture metabolic health outcomes rather than proxies for them? What financial incentives currently exist for prevention, such as the Medicare Diabetes Prevention Program, and why have they produced such limited beneficiary reach relative to the scale of diagnosed and undiagnosed disease? How should prevention, rather than treatment after diagnosis, be financed within a program whose payment infrastructure has historically been built around treating disease that has already occurred? This report does not answer these questions, but considers naming them clearly to be among its most useful contributions in this chapter.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using the MA- identifier series established in this report's prior edition, now expanded to MA-15 to accommodate this chapter's broader scope. As with prior series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
MA-01	Total Medicare enrollment	Approximately 70 million beneficiaries (CBO February 2026 baseline: Part A average monthly enrollment of 69.96 million in FY2026, rising to 71.5 million in FY2027). Related but non-identical measures: 64.2 million enrolled in Part B, and 66.6 million covered per the 2024 National Health Expenditure Accounts.
MA-02	Medicare Advantage enrollment and penetration	35.2 million, or 55% of the 64.2 million beneficiaries with both Parts A and B (KFF, February 2026, point-in-time). CBO's February 2026 baseline reports a modestly higher figure of approximately 36.2 million in group plans for FY2026 on an average-monthly basis that includes employer group waiver plans; the two measures are not directly comparable.
MA-03	Medicare share of national health expenditures	$1,118.0 billion; 21% of NHE (CMS, 2024)
MA-04	Projected Medicare spending growth, 2026–2036	Medicare alone: 88% (CBO February 2026 baseline, gross outlays rising from $1,295 billion in FY2026 to $2,433 billion in FY2036; the same 88% growth holds for mandatory outlays and total benefits, while the net-outlays basis yields 85%). All federal health programs combined, comprising Medicare, Medicaid, CHIP, and premium tax credits: 63%, from $1.9 trillion in 2026 to $3.1 trillion in 2036. The two figures measure different scopes and are not interchangeable.
MA-05	Hospital Insurance Trust Fund depletion projection	2040 (CBO, February 2026 baseline), revised from 2052 in the prior year's baseline; the Medicare Board of Trustees separately projects 2033

ID	Metric	2026 Baseline Value
MA-06	Type 2 diabetes prevalence among Medicare beneficiaries	More than 26%; ~17.7 million beneficiaries with type 2 diabetes (ASPE Issue Brief HP-2024-25, November 2024); range 20%–38% across sources depending on data type and population (see Technical Considerations)
MA-07	Weight-related chronic condition prevalence, beneficiaries without diabetes by weight status	76% normal weight / 83% overweight / 87% obesity (CBO analysis of Medicare Current Beneficiary Survey, 2015–2019)
MA-08	Average 2026 MA Star Rating	3.65–3.66 unweighted (CMS); ~3.98 enrollment-weighted (industry estimate)
MA-09	Medicare GLP-1 claims and gross spending, 2024	21.8 million claims; $27.5 billion (KFF)
MA-10	Medicare GLP-1 Bridge copay and duration	$50/month; July 1, 2026–December 31, 2027 (CMS)
MA-11	Medicare Diabetes Prevention Program active participants	941 nationally (CMS Innovation Center, most recent count)
MA-12	GLP-1 anti-obesity prescribing rate, ages 60–64 vs. Medicare-aged	0.37% vs. 0.24% of eligible patients (peer-reviewed analysis)
MA-13	MA supplemental food/produce benefit availability	11% individual plans vs. 85% Special Needs Plans (KFF, 2026)
MA-14	Part D out-of-pocket cap and initial negotiated-drug discounts	$2,100 cap; 38%–79% off 2023 list prices for first 10 negotiated drugs (CMS)
MA-15	Medicare Advantage payment relative to traditional Medicare	~14% higher per beneficiary; ~$76 billion in added 2026 federal spending (KFF); methodology disputed by MedPAC and industry groups

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

- Type 2 diabetes prevalence among Medicare beneficiaries is reported across this chapter in a range from 20% to 38%, depending on whether the underlying source uses claims-based diagnosis or self-report, which years of data are used, and whether the population includes only fee-for-service beneficiaries, only beneficiaries 65 and older, or the full Medicare population including younger beneficiaries who qualify through disability. This report presents the range explicitly rather than selecting a single figure as authoritative, and anchors its stable MA-06 baseline metric to the ASPE estimate (26%; 17.7 million) used in this report's prior edition, consistent with this report's editorial standard against revising established baseline figures without explicit justification.
- Chronic kidney disease prevalence trends reported in this chapter reflect claims-based detection, which has likely improved over the comparison period examined, alongside any true change in incidence. This report cannot separate these two effects with the data available and states this limitation explicitly rather than presenting the reported increase as if it were driven solely by a true rise in disease incidence.
- Chronic condition prevalence for Medicare Advantage beneficiaries is very likely systematically undercounted relative to traditional Medicare beneficiaries in claims-based data sources such as the Chronic Conditions Data Warehouse, because Medicare Advantage encounter data is submitted through managed care organizations rather than directly to CMS in the same manner as fee-for-service claims. Peer-reviewed research specifically attributes at least part of the apparent difference in chronic condition prevalence between Medicare Advantage and traditional Medicare to this data completeness gap rather than to a true difference in beneficiary health status.
- Average Medicare Advantage Star Ratings for 2026 are reported at both 3.65–3.66 (an unweighted average across individual contracts) and approximately 3.98 (an enrollment-weighted estimate from an industry analyst). This report presents both because they answer different questions: the unweighted figure describes the typical contract, while the enrollment-weighted figure describes the typical beneficiary's experience.
- This report was unable to identify a single, current, authoritative federal breakdown of total Medicare spending by individual chronic condition comparable to the condition-specific figures presented in Chapter 2 for the broader economy. Where this chapter cites condition-specific Medicare cost or utilization findings, it

attributes them to their specific, sometimes dated, source rather than presenting them as a comprehensive current breakdown.

- The dispute between the Medicare Payment Advisory Commission and industry groups including the Healthcare Leadership Council and Better Medicare Alliance over Medicare Advantage payment methodology, referenced in this chapter's discussion of Medicare Advantage financing, is not adjudicated by this report. Both the approximately 14% payment differential figure and the methodological objections to how it is calculated are presented for the reader's own evaluation.

Chapter Summary

Reframed through a metabolic health lens rather than a general Medicare policy lens, this chapter's findings describe a program managing a near-universal burden of weight-related chronic disease, a fiscal trajectory deteriorating faster than previously projected, a delivery infrastructure, Medicare Advantage, that is expanding its role in managing that burden unevenly across its market, and a prevention infrastructure that remains dramatically underused relative to the scale of the risk it is meant to address. The population immediately below Medicare eligibility appears to face a specific and previously under-examined coverage discontinuity in anti-obesity treatment access precisely at the point of Medicare enrollment, a finding this report considers one of its more significant contributions in this edition.

Taken together with Chapters 1 through 3, this chapter completes a throughline this report has built deliberately: prevalence, documented in Chapter 1; cost, documented in Chapter 2; employer response, documented in Chapter 3; and now, in this chapter, the concentration of that same prevalence and cost within the nation's largest single health care purchaser as its beneficiaries age. The next chapter turns to Medicaid, a program that shares much of Medicare's chronic disease burden but differs sharply in its financing structure, its beneficiary population, and its own approach to metabolic health coverage.

Looking Ahead to the 2027 Edition

- Medicare GLP-1 coverage policy specifically is politically salient and has changed rapidly across multiple editions of this report already; this section should be

expected to require substantive annual updating, and future editions will track any changes to the Bridge program's eligibility, copayment structure, or duration alongside any new coverage action from CMS or Congress.

- Whether the Medicare GLP-1 Bridge's actual utilization and cost, once 2026–2027 data become available, come in near CBO's earlier modeled estimates for a broader coverage policy, and whether utilization is higher among beneficiaries who lost prior GLP-1 coverage upon aging into Medicare.
- Whether CMS or Congress takes any action to address the apparent GLP-1 access discontinuity at the Medicare eligibility threshold documented in this chapter.
- Whether Medicare Diabetes Prevention Program participation increases materially following CMS's expanded online-delivery flexibility, or remains a marginal program relative to the scale of diagnosed and undiagnosed diabetes and prediabetes.
- Whether Medicare Advantage supplemental benefits addressing food, housing, and transportation needs expand beyond Special Needs Plans, or whether the discontinuation of the Value-Based Insurance Design Model further concentrates these benefits among beneficiaries who already qualify through diagnosis or dual eligibility.
- Whether 2027 Star Ratings continue their marginal 2026 stabilization or resume decline, and whether the dispute over Medicare Advantage payment methodology is resolved, narrowed, or affects future payment policy.
- CBO's next annual baseline update and CMS's 2027 National Health Expenditure release, both expected to provide updated Medicare spending and Trust Fund solvency projections.

Questions We Still Cannot Answer

- Does the apparent decline in anti-obesity GLP-1 access at the Medicare eligibility threshold reflect a true loss of coverage for beneficiaries transitioning from other insurance, reduced clinical urgency perceived by prescribers for older patients, or some combination of both, and how many beneficiaries are affected nationally?
- Will the Medicare GLP-1 Bridge measurably reduce downstream cardiovascular, renal, or long-term-care costs within its eighteen-month window, or is that period too short to detect such effects even if they exist?

- Why has the Medicare Diabetes Prevention Program achieved such limited participation relative to the scale of diagnosed and undiagnosed diabetes and prediabetes, and would expanded online delivery, different beneficiary outreach, or different provider incentives meaningfully change that outcome?
- How much of the claims-based increase in chronic kidney disease prevalence among Medicare beneficiaries reflects true rising incidence versus improved detection and staging, and would a population-representative clinical survey, rather than claims data, produce a materially different estimate?
- Does claims-based chronic condition prevalence in Medicare Advantage understate true prevalence relative to traditional Medicare by a large enough margin to distort comparative analyses of the two programs' beneficiary health status, and if so, by how much?
- Which reconciliation of the competing Medicare Advantage payment-accuracy estimates, MedPAC's or those offered by industry groups, best reflects the program's true cost relative to traditional Medicare?

Future editions of this report will return to these questions directly and report honestly on what has and has not been learned in the intervening year.

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Chapter 5
Medicaid

Chapter 5 Key Findings

- Medicaid and CHIP covered 74.3 million people nationally as of March 2026, of whom 67.1 million were enrolled in Medicaid and 7.2 million in separate CHIP programs, according to CMS's monthly Performance Indicator reporting.
- Medicaid enrollment has fallen sharply following the end of the pandemic-era continuous enrollment provision. Total Medicaid and CHIP enrollment fell from 78.6 million in March 2025 to 74.3 million in March 2026, a decline of approximately 4.3 million people, or 5.5%. Medicaid enrollment alone fell from 71.3 million to 67.1 million over the same period, a decline of approximately 4.2 million, or 5.9%. Enrollment has fallen by a considerably larger margin from its 2023 peak.
- Nearly three in ten non-elderly Medicaid adults, 29.7%, have cardiometabolic multimorbidity, meaning two or more of obesity, hypertension, hyperlipidemia, diabetes, or cardiovascular disease, with an additional 29.3% carrying exactly one such condition, according to a peer-reviewed analysis of 2018–2022 national survey data.
- Seventy-eight percent of Medicaid beneficiaries nationally, more than 66 million people as of July 1, 2024, receive their care through comprehensive risk-based managed care organizations rather than fee-for-service Medicaid, making MCO contracting and quality oversight the primary lever through which most Medicaid metabolic health care is actually delivered.
- Only 13 state Medicaid programs covered GLP-1 medications for obesity treatment under fee-for-service as of January 2026, down from 16 as recently as October 2025, after California, New Hampshire, Pennsylvania, and South Carolina eliminated the benefit and Michigan sharply restricted eligibility.
- Federal law requires every state Medicaid program to cover GLP-1 medications for their original indication, type 2 diabetes; coverage for the same medications when prescribed for obesity or weight management is an optional state benefit, and it is this optional benefit that is contracting.
- The 2025 federal budget reconciliation law, as enacted, is projected by the Congressional Budget Office to reduce federal Medicaid spending by approximately $911 billion over ten years and to increase the uninsured population by roughly 7.5 million people through its Medicaid and CHIP provisions by 2034, driven primarily

by new work requirements, more frequent eligibility redeterminations, and restrictions on state provider-tax financing.

- CMS's new BALANCE model, announced in December 2025, is a voluntary five-year initiative under which the agency will negotiate lower GLP-1 prices directly with manufacturers on behalf of participating state Medicaid programs; Medicaid coverage under the model could begin as early as May 2026, but participation by states, and coverage for any individual beneficiary, is not guaranteed.
- Ten states have still not adopted the ACA's Medicaid expansion as of 2026, and the temporary five-percentage-point enhanced federal match that had encouraged additional states to expand ended in 2026 under the reconciliation law, removing a financial incentive for those states to reconsider.

Introduction

Chapters 1 through 4 established the prevalence of metabolic health conditions among Americans generally, the economic burden those conditions carry, how employers are responding within the working-age, employer-sponsored population, and how that same burden concentrates within Medicare as beneficiaries age. This chapter turns to Medicaid, the nation's other major public health insurance program. Medicaid and CHIP together cover more people than Medicare and constitute the largest publicly financed health-coverage population in the United States, covering low-income children, parents, pregnant women, adults who qualify through the Affordable Care Act's expansion pathway, and people with disabilities. Medicaid's relationship to metabolic health differs from Medicare's in almost every structural respect: its financing is shared between the federal government and the states rather than financed federally alone, its beneficiary population skews younger and lower-income, its benefits and coverage policy vary substantially from state to state, and it is now the subject of the largest federal funding reduction in the program's history.

This chapter is being published at an unusually consequential moment for Medicaid. The 2025 federal budget reconciliation law, commonly known as the One Big Beautiful Bill Act, enacted the largest projected reduction in federal Medicaid spending in the program's sixty-year history, phasing in new work requirements, more frequent eligibility redeterminations, and new restrictions on how states finance their share of the program, over the next several years. At the same time, and largely independent of that law, a substantial number of states have been actively narrowing or eliminating Medicaid coverage of GLP-1 medications for obesity specifically, citing cost, even as a new voluntary federal model announced in December 2025 aims to expand access

through negotiated pricing. This chapter documents both the underlying metabolic health burden within the Medicaid population and this fast-moving policy environment, and it does so with an explicit acknowledgment that the coverage and financing picture it describes will look different by the time the next edition of this report is published.

The evidence base for this chapter draws on CMS's Medicaid and CHIP enrollment and expenditure reporting, including the Performance Indicator Project, the Medicaid Budget and Expenditure System, and the National Health Expenditure Accounts; the Medicaid and CHIP Payment and Access Commission's MACStats; KFF's Medicaid enrollment tracker, GLP-1 coverage survey, and Medicaid managed care market tracker; the Congressional Budget Office's analysis of the 2025 reconciliation law; the CMS Innovation Center's BALANCE model materials; Health Management Associates' analysis of CMS-64 expenditure data; and a peer-reviewed analysis of national survey data on cardiometabolic multimorbidity among Medicaid enrollees. As in prior chapters, figures are reported with their specific source and methodology attached, and where sources disagree because they measure enrollment or spending at different points in time or through different reporting systems, that disagreement is stated directly rather than resolved by silently choosing one figure.

Why This Matters

Medicaid insures more Americans than any other single health program, and it does so for a population with a disproportionate share of the country's chronic disease burden, lower average incomes, and less consistent access to the preventive care that can catch metabolic conditions early. Because Medicaid is financed jointly by the federal government and the states, and because most Medicaid beneficiaries now receive care through contracted managed care organizations rather than directly from the state, decisions made in state capitals, in managed care contracts, and in Washington all bear directly on whether this population's metabolic health is measured, managed, and financed well. Understanding Medicaid through a metabolic health lens is what allows this report to extend the throughline built across Chapters 1 through 4, prevalence, cost, employer response, and Medicare concentration, to the public program that insures the country's low-income population.

National Snapshot

Medicaid and CHIP together covered 74.3 million people in the fifty states and the District of Columbia as of the last day of March 2026, according to CMS's monthly

Performance Indicator reporting, with 67.1 million enrolled in Medicaid and 7.2 million enrolled in CHIP. Separately, 35.6 million children were enrolled in either Medicaid or CHIP. These are point-in-time, unduplicated counts covering people eligible for comprehensive benefits; limited-benefit categories such as emergency Medicaid and family-planning-only coverage are excluded. This figure, and the reporting system that produces it, differs in scope and timing from other commonly cited Medicaid enrollment figures, a discrepancy this chapter addresses directly in its Technical Considerations section rather than silently reconciling. CMS's National Health Expenditure Accounts, for example, reported that Medicaid coverage peaked at 92.2 million people in 2023 before falling 7.9% to 84.3 million in 2024, using a different, calendar-year-average counting methodology, and CMS's own September 2025 Medicaid and CHIP Beneficiary Profile placed combined enrollment at approximately 77.1 million using yet another point-in-time measure.

Medicaid financing is shared between the federal government and the states, and in federal fiscal year 2025, federal funds accounted for 64.2% of total Medicaid spending, with state matching funds covering the remaining 35.8%, according to Health Management Associates' analysis of CMS-64 preliminary expenditure data. Total Medicaid medical services expenditures reached $971.4 billion across all states and territories in federal fiscal year 2025, up 6.9% from the prior year. Managed care has become the dominant delivery model within that spending: total Medicaid managed care spending, combining federal and state shares, reached $550.5 billion in federal fiscal year 2025, up from $517.5 billion in federal fiscal year 2024, and KFF's Medicaid Managed Care Tracker reports that more than three-quarters of all Medicaid beneficiaries nationally now receive most or all of their care through risk-based managed care organizations that contract with state Medicaid programs, rather than through traditional fee-for-service arrangements.

The metabolic health burden within the Medicaid population is substantial, though, as this chapter's Technical Considerations section discusses, it is measured less completely and less currently than the corresponding burden within Medicare. The most recent peer-reviewed analysis available, drawing on 2018 through 2022 National Health Interview Survey data for 11,090 non-elderly adults with Medicaid coverage, found that 29.3% had exactly one cardiometabolic condition, defined as hypertension, hyperlipidemia, coronary heart disease, angina, heart attack, stroke, diabetes, or obesity, and 29.7% had cardiometabolic multimorbidity, meaning two or more such conditions: 14.5% had two conditions, 8.0% had three, and 7.1% had four or more. Obesity, hypertension, and hyperlipidemia were the most commonly occurring conditions, individually and in combination, and multimorbidity was more common among older,

non-working, and less educated Medicaid enrollees. An older KFF analysis of 2015 survey data, now roughly a decade old and cited here with its vintage stated explicitly rather than presented as current, found that seven in ten low-income Medicaid adult enrollees were overweight or had obesity, a somewhat higher rate than the 65% figure the same analysis reported for low-income adults with private insurance.

Trends

Three distinct trends define the current Medicaid policy environment, and this chapter addresses each in turn: a large, ongoing decline in enrollment following the end of pandemic-era continuous coverage protections; a state-by-state retrenchment in optional coverage of GLP-1 medications for obesity specifically, running in parallel with a new voluntary federal model intended to expand access through negotiated pricing; and the phased implementation of the largest federal Medicaid funding reduction in the program's history.

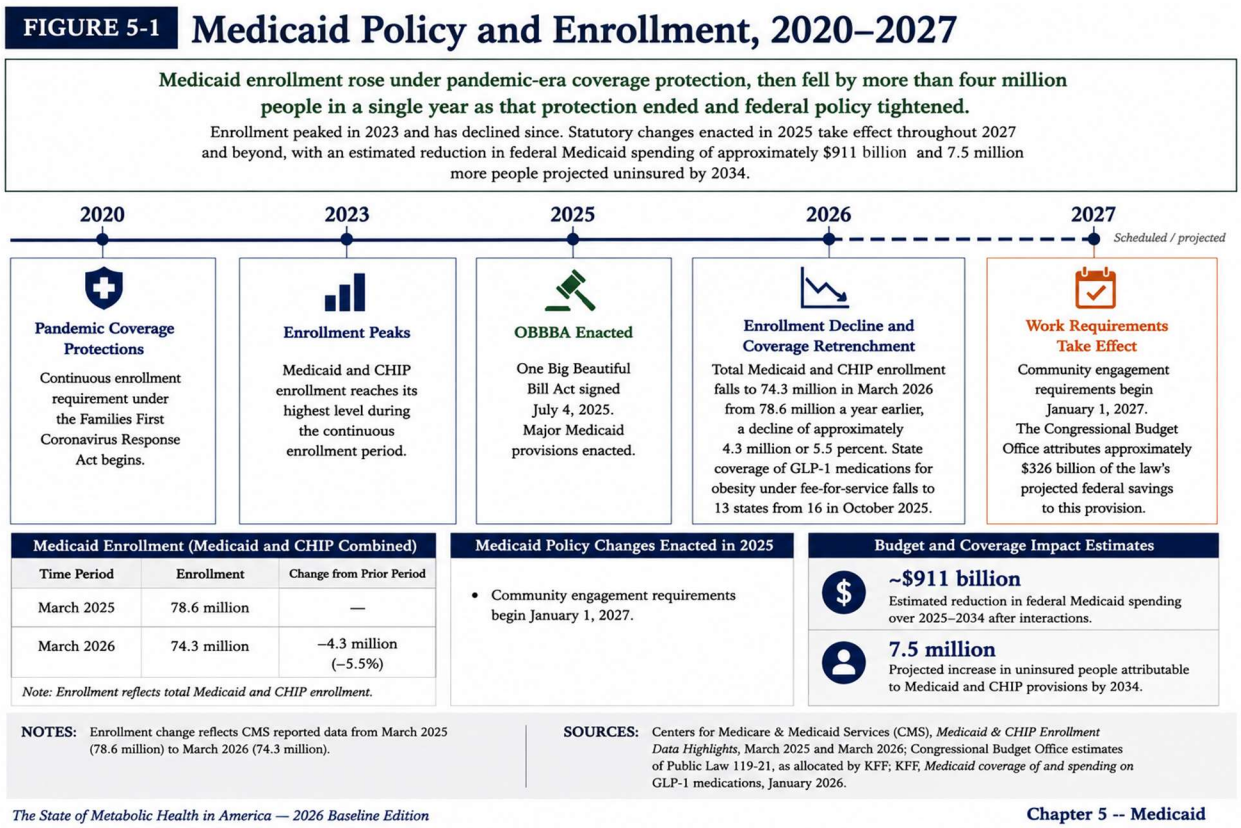


Figure 5-1. Medicaid Policy and Enrollment, 2020–2027

Sources: Centers for Medicare & Medicaid Services, Medicaid and CHIP Monthly Performance Indicator data, March 2025 and March 2026. Congressional Budget Office estimates of Public Law 119-21, as allocated by KFF. KFF, Medicaid coverage of and spending on GLP-1 medications, January 2026.

Medicaid enrollment has fallen substantially since the expiration of the continuous enrollment provision that had prohibited states from disenrolling beneficiaries during the COVID-19 public health emergency. CMS Performance Indicator data show that total Medicaid and CHIP enrollment decreased by approximately 4.3 million people, or 5.5%, between March 2025 and March 2026, falling from 78.6 million to 74.3 million, with Medicaid enrollment declining in all fifty states over that period and CHIP enrollment increasing in nineteen states, a divergence that likely reflects some children moving from Medicaid to separate CHIP coverage as family income or eligibility circumstances changed. The pace of decline has varied widely by state, from a 20% decrease in Indiana to a decrease of less than 1% in Iowa over the same period. Total Medicaid and CHIP enrollment nonetheless remained 4% higher in March 2026 than in February 2020, immediately before the pandemic, indicating that the post-unwinding decline has not yet fully returned the program to its pre-pandemic size.

State Medicaid coverage of GLP-1 medications for obesity has been contracting since late 2025, even as federal law continues to require every state to cover the same medications when prescribed for their original indication of type 2 diabetes. KFF's tracking found that 16 state Medicaid programs covered GLP-1s for obesity treatment under fee-for-service as of October 2025, falling to 13 states by January 2026 after California, New Hampshire, Pennsylvania, and South Carolina eliminated the benefit; North Carolina had also dropped coverage in October 2025 during a state budget stalemate but reinstated it in December 2025. Michigan did not eliminate coverage outright but sharply restricted it, effective January 1, 2026, limiting eligibility to beneficiaries with a body mass index of 40 or greater who have documented failure of other weight-loss interventions and are using the medication specifically to avoid bariatric surgery, a change the state projects will save $240 million in 2026 and that outside physician researchers estimate could affect up to one million Michigan Medicaid beneficiaries who are overweight or have obesity. States that continue to cover GLP-1s for obesity, including Delaware, Kansas, Minnesota, Mississippi, Missouri, Tennessee, Utah, Virginia, and Wisconsin according to KFF's survey, typically pair that coverage with prior authorization and body-mass-index-based clinical criteria. Several additional states, including Rhode Island, were considering further restrictions or elimination of the benefit as of this chapter's preparation, and state interest in expanding obesity drug coverage was described by KFF's own survey as waning, with states citing cost as the primary factor in coverage decisions.

Running in parallel with this state-level retrenchment, CMS announced the BALANCE model in December 2025, a voluntary five-year initiative under the CMS Innovation Center in which the federal government will negotiate lower GLP-1 prices directly with manufacturers on behalf of participating state Medicaid agencies and Medicare Part D plans, and will pair covered access with a manufacturer-funded lifestyle support program for beneficiaries. Participation is voluntary for manufacturers, states, and Part D plans alike, and states could begin joining the model in May 2026 through January 1, 2027. The model's Medicare Part D component, however, has since been delayed indefinitely, so the Medicaid arm is for now the only operative path through which the model can affect obesity drug coverage. Even for a participating state, the model does not guarantee coverage for any individual beneficiary, since access still depends on the specific eligibility criteria negotiated between CMS and each participating manufacturer. Whether the BALANCE model meaningfully reverses the recent state-level retrenchment in obesity drug coverage, or whether states that have already eliminated or restricted the benefit choose to participate, is a genuinely open question this chapter cannot yet answer and that future editions of this report will track directly.

The 2025 federal budget reconciliation law enacted the largest projected reduction in federal Medicaid spending in the program's history, though nearly all of its major provisions phase in over the next several years rather than taking effect immediately. The Congressional Budget Office's estimate of the law as enacted projects a reduction in federal Medicaid spending of approximately $911 billion over the ten-year period from federal fiscal year 2025 through 2034, after accounting for interactions that produce overlapping reductions across provisions, and an increase of approximately 7.5 million in the number of people without health insurance attributable to the law's Medicaid and CHIP provisions by 2034. Earlier estimates prepared for the House-passed version of the bill projected a smaller Medicaid outlay reduction of $840.2 billion and a coverage loss of 7.8 million; because both sets of figures remain in circulation, readers comparing estimates across sources should confirm which version of the legislation a given figure reflects. New work requirements, sometimes described as community engagement requirements, are projected to account for the largest single share of those savings, an estimated $326 billion, and take effect January 1, 2027, requiring most non-exempt adults enrolled through the ACA expansion group to complete at least 80 hours per month of qualifying work, education, or volunteer activity and to verify that status at least every six months. A prior state-level pilot of similar work requirements in Arkansas is frequently cited as evidence of implementation risk: an estimated 18,000 Arkansas Medicaid beneficiaries lost coverage under that pilot primarily due to paperwork and reporting problems rather than a documented failure to meet the underlying work

activity standard. Separately, the law restricts states' ability to use provider taxes, a financing mechanism nearly every state currently uses to help fund its share of Medicaid costs, an estimated $191 billion reduction in federal outlays, and restricts state-directed payments to providers, a further estimated $149 billion reduction, both of which will reduce the financing tools states have available to sustain current Medicaid spending levels without raising other revenue or cutting the program directly.

Policy Implications

The combination of a large, ongoing enrollment decline, a phased-in reduction in federal financing, and a state-by-state retreat from optional obesity drug coverage creates a specific policy risk for metabolic health outcomes within the Medicaid population: precisely the population most likely to carry undiagnosed or poorly managed metabolic disease may be the population most exposed to coverage instability over the next several years, at the same moment this report's data shows nearly three in ten non-elderly Medicaid adults already carry two or more cardiometabolic conditions. New six-month eligibility redeterminations and work-requirement verification, even when a beneficiary remains technically eligible, create administrative friction that the Arkansas experience suggests can produce coverage loss independent of actual eligibility, a risk with particular relevance for beneficiaries managing chronic conditions who depend on continuous medication access and provider relationships.

State-level GLP-1 coverage decisions illustrate a broader structural feature of Medicaid that this chapter documents directly rather than treats as a footnote: because states retain broad discretion over optional benefits, and because state budgets face acute near-term pressure from the financing changes enacted in the 2025 reconciliation law, an individual Medicaid beneficiary's access to an FDA-approved treatment for obesity now depends substantially on the state in which that beneficiary happens to reside, a pattern with few close parallels in Medicare's more centrally administered supplemental benefit structure. The BALANCE model's voluntary, negotiated-pricing design represents one federal policy response to that variation, but its reliance on voluntary state and manufacturer participation means it may not reach beneficiaries in states that have already made a contrary policy choice on cost grounds.

Because more than three-quarters of Medicaid beneficiaries now receive care through risk-based managed care organizations, MCO contract terms, quality measurement requirements, and network adequacy standards function as a primary lever through which state Medicaid agencies could, in principle, address metabolic health at scale, whether or not a given state also elects to cover GLP-1 medications for obesity specifically. This report does not evaluate the effectiveness of any specific MCO

contracting approach, but notes that the concentration of the Medicaid population within a relatively small number of managed care organizations, several of which operate in multiple states, creates a scale at which measurement and quality standards adopted by one state, or by CMS itself, could plausibly extend across state lines through the same parent organizations. Because managed care organizations often operate across multiple states, innovations in quality measurement or metabolic health adopted within one Medicaid program may influence care delivery beyond that state's borders.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, MD-01 through MD-10, continuing the stable-identifier convention established in Chapters 1 through 4. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
MD-01	Total Medicaid and CHIP enrollment	74.3 million (67.1M Medicaid / 7.2M CHIP), point-in-time count as of the last day of March 2026 (CMS Performance Indicator Project); comprehensive-benefit enrollees only
MD-02	Medicaid share of national health expenditures	$931.7 billion in calendar year 2024; 18% of national health expenditures (CMS National Health Expenditure Accounts). Calendar-year NHEA basis, not interchangeable with CMS-64 federal-fiscal-year expenditures
MD-03	Federal and nonfederal shares of Medicaid spending	Estimated 64.2% federal / 35.8% nonfederal, FFY2025, based on a Health Management Associates Information Services analysis of preliminary CMS-64 expenditure reports. These are HMAIS-calculated shares rather than percentages published directly by CMS. The nonfederal share may include qualifying local-government and other permissible public funds, not solely state general revenue.
MD-04	Medicaid managed-care spending	Estimated $550.5 billion (FFY2025), up from $517.5 billion (FFY2024), a 6.4% annual increase representing 56.7% of total Medicaid spending, based on a Health Management Associates Information Services analysis of

ID	Metric	2026 Baseline Value
		preliminary CMS-64 expenditure reports. The estimate includes comprehensive risk-based managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, and excludes fee-based arrangements such as primary-care case management.
MD-05	Medicaid beneficiaries in comprehensive risk-based MCOs	78%, representing more than 66 million beneficiaries, as of July 1, 2024 (KFF, published March 2026). Applies specifically to comprehensive risk-based MCOs and excludes prepaid inpatient health plans, prepaid ambulatory health plans, primary-care case management, and PACE
MD-06	Cardiometabolic multimorbidity, Medicaid-covered adults ages 19–64	29.7% with two or more selected cardiometabolic conditions; 29.3% with one condition. Pooled 2018–2022 National Health Interview Survey data, 11,090 adults ages 19–64 with Medicaid coverage. Conditions counted: hypertension, hyperlipidemia, coronary heart disease, angina, heart attack, stroke, diabetes, and obesity. Cross-sectional and largely self-reported, including reported height and weight; not a claims-based prevalence measure
MD-07	States covering GLP-1s for obesity treatment under Medicaid fee-for-service	13 states as of January 2026, down from 16 states as of October 1, 2025 (KFF). Applies to GLP-1 use for obesity treatment under fee-for-service only; coverage for other medically accepted indications such as diabetes is governed separately under the Medicaid Drug Rebate Program, and covered drugs commonly remain subject to prior authorization and other utilization controls
MD-08	Projected federal Medicaid/CHIP outlay reduction, OBBBA (FY2025–FY2034)	~$911 billion, Medicaid spending, law as enacted, after interactions (CBO; KFF allocation)
MD-09	Projected increase in uninsured people from OBBBA Medicaid provisions by 2034	7.5 million people, Medicaid/CHIP provisions, after interactions (CBO). This is the projected net increase in the uninsured population, not the number of people losing Medicaid coverage. CBO

ID	Metric	2026 Baseline Value
		separately projects a substantially larger reduction in Medicaid enrollment, approximately 12.9 million in its February 2026 analysis, because some people who lose Medicaid obtain other insurance and some enrollment reductions reflect duplicate records and related effects.
MD-10	States not adopting ACA Medicaid expansion	10 states as of March 2026 (CMS enrollment map; 41 expansion jurisdictions including the District of Columbia)

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

Medicaid enrollment figures vary substantially depending on the reporting system and measurement convention used, a data gap this chapter states directly rather than papering over. CMS's Performance Indicator Project reports a point-in-time count of 74.3 million people as of March 2026; CMS's National Health Expenditure Accounts reported a calendar-year average of 84.3 million people for 2024, using a different counting methodology and a different reporting period, after finding enrollment had peaked at 92.2 million in 2023; and CMS's own September 2025 Medicaid and CHIP Beneficiary Profile reported approximately 77.1 million covered individuals using yet a third measure. These figures are not inconsistent so much as differently defined, but this report is not aware of a single, comprehensive, continuously updated public data source that reconciles Medicaid enrollment across these differing definitions, and readers who wish to track Medicaid enrollment over time should be attentive to which measure a given source is actually using.

This report could not identify a single, current, comprehensive administrative data source measuring obesity, diabetes, or broader cardiometabolic disease prevalence specifically among the national Medicaid population, comparable to the Chronic Conditions Data Warehouse this report relied on for Medicare in Chapter 4. The most current peer-reviewed estimate available, the 29.7% cardiometabolic multimorbidity figure drawn from 2018 through 2022 National Health Interview Survey data, is a nationally representative survey estimate based on self-report from a sample of 11,090

non-elderly adults, not a claims-based census of the full Medicaid population, and it excludes Medicaid beneficiaries aged 65 and older, most of whom are also enrolled in Medicare and captured in this report's Chapter 4 Medicare data instead. The next-most-recent figure this report could locate, the seven-in-ten overweight-or-obesity estimate, comes from an analysis of 2015 survey data published in 2017, and is presented here with its vintage stated explicitly because a decade-old estimate should not be read as describing the Medicaid population as it exists today.

This report also could not verify, from a primary federal source meeting this report's citation standard, a single current total for national Medicaid spending on GLP-1 medications across all indications and all states. KFF's analysis of State Drug Utilization Data, a genuine primary source, documents that both the number of Medicaid GLP-1 prescriptions and gross spending before rebates have increased substantially since 2019, and that this data cannot currently distinguish utilization for diabetes, cardiovascular disease, or sleep apnea from utilization for obesity specifically. Several secondary, consumer-facing sources report a specific current national total in the low single-digit billions of dollars, but this report was unable to trace that figure to a primary source with a clearly stated methodology, and accordingly declines to reproduce it here. This is a genuine measurement gap rather than a minor omission: a program-wide, indication-specific total for Medicaid GLP-1 spending, updated on a regular cadence, would materially improve future editions of this chapter's ability to track this fast-moving cost category.

The spending figures reported in this chapter are drawn from different accounting systems and do not form a single continuous series. MD-02 is a calendar-year measure from CMS's National Health Expenditure Accounts. MD-03 and MD-04 derive from federal-fiscal-year CMS-64 expenditure reporting, the instrument states use to claim federal financial participation, and both are Health Management Associates Information Services calculations from preliminary CMS-64 data rather than figures CMS itself published. None of the three is directly interchangeable with the others, nor with state budget figures, managed-care capitation totals, or MACPAC benefit-spending measures. MD-04 and MD-05 also use different managed-care definitions and should not be read as two views of one measure: MD-04 reports spending across comprehensive managed care organizations together with prepaid inpatient and prepaid ambulatory health plans, while MD-05 reports beneficiary enrollment in comprehensive risk-based MCOs only. KFF separately reports that comprehensive MCO payments accounted for roughly 50% of total Medicaid spending in FY2024, a narrower measure than MD-04. MD-06 is a pooled survey estimate rather than a claims measure, and its component values as published sum to 29.6% against a stated headline estimate of 29.7%; this report retains

the article's headline figure and records the difference as rounding rather than error. Where finalized CMS or MACPAC national totals for FFY2025 become available, this report will replace MD-03 and MD-04 with official amounts and show the derivation. Finally, published estimates of the total coverage loss attributable to the 2025 reconciliation law vary depending on both scope and which version of the legislation an estimate reflects. This chapter's MD-09 figure, 7.5 million people, reflects the Congressional Budget Office's estimate for the enacted law's Medicaid and CHIP provisions specifically, after accounting for interactions among provisions. The Congressional Budget Office separately estimates that the enacted law increases the total number of uninsured people by approximately 10 million by 2034, a figure that combines the Medicaid and CHIP effect with projected losses from the law's Affordable Care Act marketplace provisions. Still other frequently cited totals add the scheduled expiration of enhanced ACA premium tax credits at the end of 2025, and figures drawn from analyses of the earlier House-passed bill, including a Medicaid-specific coverage loss of 7.8 million and a health-provisions total of 9.1 million, remain in circulation despite having been superseded. None of these are directly comparable to one another. Readers encountering a different total in another source should confirm both which combination of provisions that total reflects and whether it describes the enacted law or an earlier version of the bill.

Chapter Summary

This chapter has extended the throughline this report has built deliberately across its first four chapters, prevalence, cost, employer response, and Medicare concentration, to Medicaid, the public program that insures the largest number of Americans and that carries a disproportionate share of the country's chronic disease burden among a lower-income population. Nearly three in ten non-elderly Medicaid adults already carry two or more cardiometabolic conditions, and more than three-quarters of all Medicaid beneficiaries now receive their care through risk-based managed care organizations rather than directly from the state, a structural fact that shapes how, and whether, metabolic health is measured and managed at scale within this program.

This chapter has also documented a genuinely unsettled policy environment rather than a stable baseline. Medicaid enrollment is declining sharply following the end of pandemic-era continuous coverage protections, state coverage of GLP-1 medications for obesity is contracting even as a new voluntary federal model aims to expand access through negotiated pricing, and the largest federal Medicaid funding reduction in the program's history is only beginning to phase in. Each of these developments will look substantially different by the time this report's next edition is published, and this chapter has aimed to describe the current moment honestly rather than to predict how it resolves.

The next chapter turns to public health infrastructure, the federal, state, and local systems responsible for surveillance, prevention, and population-level intervention that sit alongside, and in some cases attempt to reduce reliance on, the insurance-based systems this report has examined in Chapters 3 through 5.

Looking Ahead to the 2027 Edition

- Whether the BALANCE model achieves meaningful state Medicaid participation when enrollment opens in May 2026, and whether any state that has already eliminated or restricted GLP-1 coverage for obesity chooses to reverse that decision through the model.
- Whether additional states move to restrict or eliminate Medicaid coverage of GLP-1 medications for obesity in state fiscal year 2027, following the pattern set by California, Michigan, New Hampshire, North Carolina, Pennsylvania, and South Carolina in the current fiscal year.

- Early implementation data on Medicaid work requirements as states begin complying with the January 1, 2027 deadline, including whether procedural coverage losses resemble the Arkansas pilot's experience at national scale.
- Whether CMS or an independent research organization publishes an updated, comprehensive estimate of obesity, diabetes, or broader cardiometabolic disease prevalence specifically within the Medicaid population, addressing the data gap this chapter identifies in its Technical Considerations section.
- The first full federal fiscal year of state provider tax restrictions and state-directed payment limits under the 2025 reconciliation law, and initial evidence of how states are adjusting Medicaid financing or benefits in response.
- Updated Medicaid enrollment and expenditure data from CMS's Performance Indicator Project, the National Health Expenditure Accounts, and MACPAC's MACStats, which may narrow or further illustrate the measurement discrepancy this chapter documents between those sources.

Questions We Still Cannot Answer

- What is the current, national, claims-based prevalence of obesity, diabetes, and related metabolic conditions specifically within the Medicaid population, measured with the same rigor this report was able to apply to Medicare in Chapter 4?
- How many Medicaid beneficiaries who lose GLP-1 coverage for obesity due to a state policy change, as in Michigan or Pennsylvania, subsequently discontinue treatment entirely, switch to an alternative intervention, or regain the weight the medication had helped them lose?
- How much of the projected Medicaid enrollment decline associated with new work requirements will reflect beneficiaries who are genuinely ineligible under the new standard, as opposed to eligible beneficiaries who lose coverage due to administrative or reporting friction, as the Arkansas pilot suggests occurred there?
- Will the BALANCE model's negotiated pricing meaningfully change state Medicaid coverage decisions on GLP-1s for obesity, or will states that have already restricted or eliminated the benefit on cost grounds decline to participate regardless of price?
- What is the total, current, program-wide Medicaid expenditure on GLP-1 medications across all indications, and can that total be reliably disaggregated by indication, obesity, diabetes, cardiovascular disease, or sleep apnea, using existing administrative data?

- How does metabolic health management, and metabolic health outcome measurement specifically, vary across the managed care organizations that now serve more than three-quarters of the Medicaid population, and does that variation track differences in state contract requirements, parent-company practice, or other factors?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

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Chapter 6
Public Health Infrastructure and Prevention

Chapter 6 Key Findings

- The federal government's fiscal year 2026 budget request proposed reducing the Centers for Disease Control and Prevention's funding by approximately 53%, from roughly $9 billion to roughly $4 billion, and proposed eliminating the National Center for Chronic Disease Prevention and Health Promotion entirely, the CDC center that houses the divisions most directly responsible for national diabetes and obesity prevention infrastructure.
- Congress did not adopt that proposal. The combined appropriations legislation passed in early February 2026 provided CDC with funding described by independent trackers as "mostly level" relative to fiscal year 2025, and included no funding for the newly proposed Administration for a Healthy America.
- Despite that enacted funding, independent tracking organizations report that HHS has taken administrative actions consistent with the proposed reorganization regardless, including delaying fiscal year 2026 grant funding announcements for chronic disease programs, terminating CDC grants to at least four states, and reducing chronic disease center leadership to roughly one-fifth of its prior number of center directors.
- The CDC's Division of Nutrition, Physical Activity, and Obesity, the primary federal channel for community-level obesity prevention funding, had distributed more than $65 million in grants to 83 grantees across 42 states as of the most recent public accounting, funding that was proposed for elimination in the fiscal year 2026 budget request.
- Roughly 80% of CDC's domestic resources appropriated by Congress flow directly to states and localities rather than being spent directly by the federal government, with substantial additional funding provided to tribal, territorial, and nonprofit partners, and federal funding accounts for approximately half of state and local health department budgets on average, meaning that federal-level funding changes translate mechanically into state and local public health budget changes.
- State and local governmental public health agencies lost nearly half of their workforce between 2017 and 2021, according to peer-reviewed analysis, and independent estimates place the additional staffing needed to deliver a basic

package of public health services nationally at approximately 80,000 full-time positions, 54,000 at the local level and 26,000 at the state level.

- A 2026 analysis found public sector health workforce departures accelerating again in late 2024 and 2025, with federal health workforce exit rates rising to approximately 8%, converging with the exit rates long observed among state and local public health workers.
- The Prevention and Public Health Fund, a mandatory, ACA-created funding stream that has historically provided several hundred million to just over a billion dollars annually to CDC and other federal prevention programs, was proposed for full elimination in the fiscal year 2026 budget request; separate legislation proposing to restore and expand the fund to $2 billion annually has been introduced but not enacted.
- Over $12 billion in COVID-era supplemental public health infrastructure grants, funds that had been intended to build lasting state and local public health capacity beyond the pandemic response itself, were terminated during 2025.

Introduction

Chapters 1 through 5 examined metabolic health through the lens of insurance coverage, financing, and delivery: how many Americans carry metabolic disease, what it costs, and how employers, Medicare, and Medicaid each respond. This chapter turns to a different layer of the system entirely, the federal, state, local, and tribal public health infrastructure responsible for surveillance, prevention, and population-level intervention that sits alongside, and is intended in part to reduce reliance on, the insurance-based systems examined in the preceding chapters. Public health infrastructure is where population-level obesity and diabetes prevention programs, nutrition assistance, chronic disease surveillance systems, and the state and local health department workforce all reside, and it is currently undergoing the most significant federal restructuring attempt in decades.

This chapter is being published during a period of substantial uncertainty about the size and structure of that infrastructure going forward. The federal government's fiscal year 2026 budget request proposed a major reorganization of the Department of Health and Human Services, including elimination of the CDC center most directly responsible for chronic disease prevention. Congress did not enact that proposal, and instead funded CDC at levels much closer to the prior year. Yet independent trackers report that federal agencies have taken administrative steps consistent with the proposed reorganization despite Congress's decision not to fund it, creating a genuinely unsettled picture of what

public health infrastructure for chronic disease prevention will actually look like in practice over the coming year. This chapter documents the proposal, the enacted outcome, and the gap between them, rather than treating any single one of those three as the full story.

This chapter also documents the state and local public health workforce, a foundational input to nearly every prevention and surveillance function this chapter describes, and one that entered this period of federal uncertainty already substantially depleted by departures that began well before the current restructuring effort. The evidence base for this chapter draws on CDC and HHS budget justification documents; Trust for America's Health's annual public health funding reports; the CDC Data Project's independent tracking of enacted versus proposed federal public health funding; the de Beaumont Foundation's public health workforce staffing estimates; peer-reviewed workforce research published in Health Affairs and Health Affairs Scholar; the American Diabetes Association's public statements on federal diabetes prevention funding; and federal statutory and legislative text governing the Prevention and Public Health Fund. As in prior chapters, this chapter does not take a position on whether the proposed restructuring is desirable; it reports what was proposed, what was enacted, and what independent sources report has actually occurred on the ground, and it identifies directly where those three pictures diverge.

Public Health Infrastructure, Defined

For purposes of this report, public health infrastructure includes the governmental systems, workforce, surveillance programs, laboratories, data systems, grant programs, and community partnerships responsible for preventing disease, monitoring population health, and supporting state, local, tribal, and territorial public health activities.

Why This Matters

Public health infrastructure is the layer of the system responsible for reaching people before they become patients: community-level obesity and diabetes prevention programs, chronic disease surveillance that produces much of the prevalence data this report relies on in every other chapter, and the state and local health department workforce that carries out both functions. Unlike Medicare or Medicaid, this

infrastructure does not show up as a line item on an individual's insurance card, which can make it easy to overlook even as changes to its funding and staffing directly shape how much metabolic disease is prevented before it reaches the insurance-financed systems examined in Chapters 3 through 5. A report that measured only insurance-based spending and coverage, without also tracking the public health infrastructure upstream of it, would be describing only part of the system responsible for the country's metabolic health.

National Snapshot

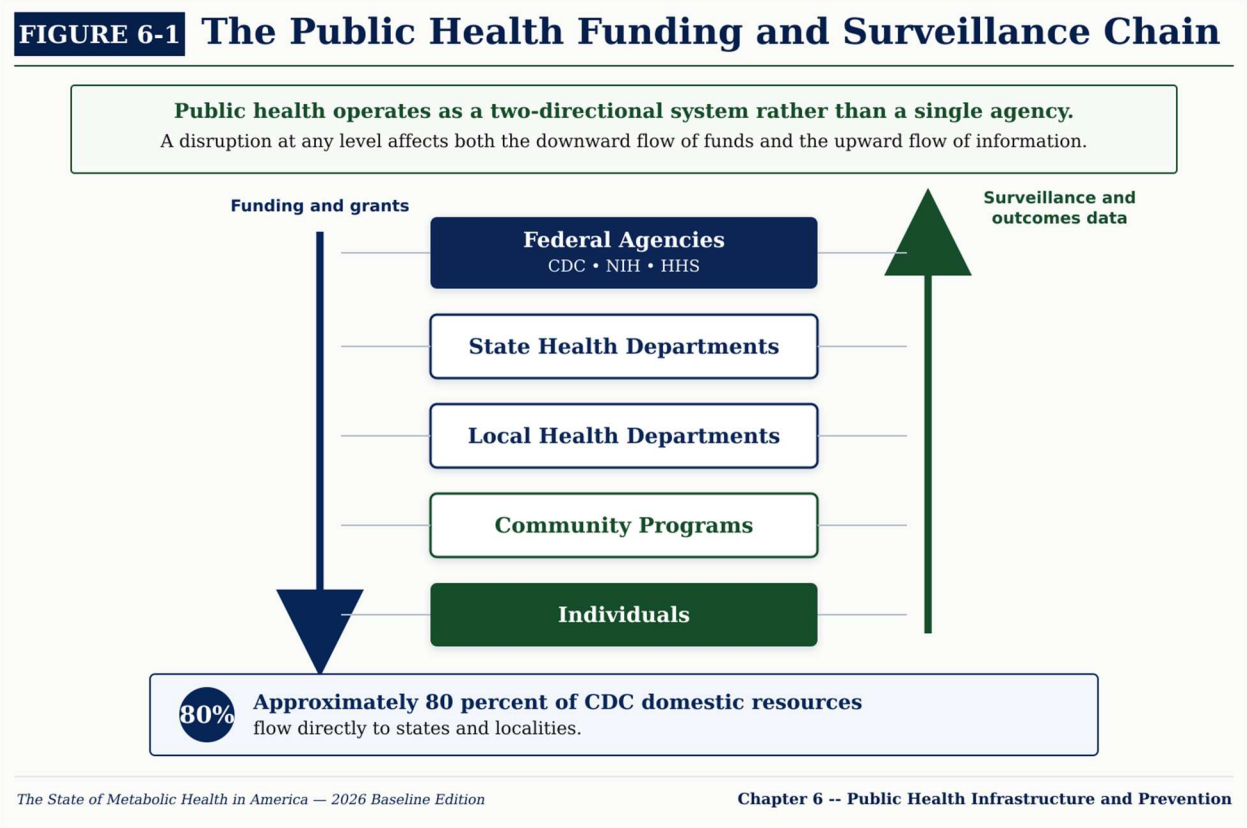


Figure 6-1. The Public Health Funding and Surveillance Chain

Sources: Centers for Disease Control and Prevention, congressional testimony, July 2024 and November 2024.
Notes: The funding share reflects CDC domestic resources appropriated by Congress and flowing directly to state and local health departments. CDC also provides substantial direct funding to tribal, territorial, and nonprofit partners, which is not depicted in this simplified chain.

The federal government's fiscal year 2026 budget request, released in detailed form in May 2025, proposed consolidating the Department of Health and Human Services' 28

operating divisions into 15 and creating a new agency, the Administration for a Healthy America, built substantially from programs previously housed at the CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Office of the Assistant Secretary for Health. For the CDC specifically, the proposal reduced the agency's budget from just over $9 billion to approximately $4 billion, according to the American Action Forum's analysis of the budget submission, a reduction Trust for America's Health calculated at 53% relative to fiscal year 2024 levels once CDC's sister agency, the Agency for Toxic Substances and Disease Registry, is included. The proposal explicitly eliminated the National Center for Chronic Disease Prevention and Health Promotion, the CDC center that houses the Division of Diabetes Translation and the Division of Nutrition, Physical Activity, and Obesity, the two divisions most directly responsible for the federal government's national diabetes and obesity prevention infrastructure, along with named elimination of cancer, heart disease, and stroke prevention programs.

Congress did not adopt this proposal. According to the CDC Data Project, an independent tracker of federal public health appropriations, the Senate Appropriations Committee had originally proposed nearly level CDC funding while the House had proposed a 19% reduction concentrated in HIV/AIDS, global health, and chronic disease prevention; the two chambers reached a combined recommendation on January 20, 2026, that provided CDC with funding the tracker describes as mostly level relative to the prior year, and this funding was signed into law on February 3, 2026. Congress did not appropriate any funding for the proposed Administration for a Healthy America in this legislation.

The enacted appropriation, however, does not appear to have fully resolved the uncertainty this chapter describes. The CDC Data Project reports that HHS has taken a series of administrative actions consistent with the reorganization proposed in the President's budget despite Congress's decision not to fund it, including not posting fiscal year 2026 grant funding announcements for chronic disease, HIV/AIDS, viral hepatitis, and tuberculosis prevention programs; halting or disrupting normal funding cycles for programs that had been slated for elimination in the President's budget; terminating CDC grants specifically in California, Minnesota, Colorado, and Illinois; and reducing chronic disease center leadership to approximately 20% of its original number of center directors. The enacted appropriations bill, House Resolution 7148, included statutory language directing HHS to maintain staffing levels necessary to carry out its funded programs and to provide 60 days' advance notice before moving CDC functions to another component of the department, a provision that reflects Congress's own effort to

constrain exactly this kind of divergence between enacted funding and actual agency practice.

This divergence matters concretely for metabolic health infrastructure specifically. The CDC's Division of Nutrition, Physical Activity, and Obesity had distributed more than $65 million in grants to 83 grantees across 42 states for obesity prevention and lifestyle-change programs as of the most recent public accounting cited by the American Diabetes Association, funding that supports community-level nutrition and physical activity interventions and that was named explicitly for elimination in the fiscal year 2026 budget request. A related but analytically distinct federal action, unconnected to the CDC budget proposal, is the National Institutes of Health's March 2025 cancellation of funding for the Diabetes Prevention Program Outcomes Study, the roughly thirty-year-old research cohort, numbering approximately 1,700 remaining participants, that originally established the evidence base showing that intensive lifestyle change could reduce type 2 diabetes incidence by 58%. This research cohort is distinct from the CDC's National Diabetes Prevention Program, the separate, ongoing operational network of more than 2,300 CDC-recognized organizations that deliver the lifestyle-change program to the public and that remains in operation; this chapter is careful to distinguish the two because they are frequently conflated in public reporting.

Trends

Beyond the current federal budget dispute, this chapter documents two longer-running trends that predate the current restructuring effort and that will shape public health infrastructure regardless of how that dispute is ultimately resolved: a sustained decline in the state and local governmental public health workforce, and repeated reductions to the Prevention and Public Health Fund, the ACA-created mandatory funding stream that has been a recurring target for cuts since its creation in 2010.

Peer-reviewed research published in Health Affairs found that nearly half of all employees in state and local public health agencies left their positions between 2017 and 2021, a proportion that rose to roughly three-quarters among employees younger than 35 or with shorter tenures, and the same analysis projected that continued separation at that rate would produce more than 100,000 total departures, as much as half of the governmental public health workforce, by 2025. The de Beaumont Foundation and Trust for America's Health separately estimate that state and local health departments need approximately 80,000 additional full-time positions nationally, 54,000 at the local level and 26,000 at the state level, to deliver a minimum package of foundational public health services, an estimate that reflects staffing shortfalls that predate both the pandemic-era exodus and the current federal budget dispute. A more recent analysis

from the University of Minnesota, examining Census Bureau and Bureau of Labor Statistics data through mid-2025, found that departures among government health and behavioral health workers accelerated again beginning in late 2024, and that federal health workforce exit rates, historically the lowest among the three levels of government, rose to approximately 8%, converging with the exit rates long observed among state and local public health workers.

The Prevention and Public Health Fund has faced recurring funding reductions in nearly every year since its creation, according to ASTHO's tracking, with actual annual funding to CDC and other federal agencies ranging from roughly $800 million to just over $1 billion in recent years against a statutory schedule that called for higher amounts before subsequent legislation repeatedly reduced it. The fiscal year 2026 budget request proposed eliminating funding from the Fund entirely. Separate legislation introduced in the current Congress, the Public Health Funding Restoration Act, would instead increase the Fund's annual appropriation to $2 billion beginning in fiscal year 2026, but as of this chapter's preparation that legislation had not been enacted, leaving the Fund's actual fiscal year 2026 funding level, like much of the rest of this chapter's subject matter, unresolved.

Underlying both trends is a structural feature of American public health financing that this chapter states directly: approximately 80% of CDC's domestic resources appropriated by Congress flow directly to states and localities rather than being spent directly by the federal government, with substantial additional funding provided to tribal, territorial, and nonprofit partners, and federal funding accounts for roughly half of the average state or local health department's total budget. This means that federal funding decisions, whether enacted through appropriations or implemented administratively as described earlier in this chapter, translate mechanically into state and local public health budget changes rather than remaining a purely federal matter, a dynamic with few close parallels among the other programs this report has examined.

Policy Implications

The gap this chapter documents between the President's proposed budget, Congress's enacted appropriation, and independently reported agency practice creates a specific measurement problem for a report of this kind: the funding level that best predicts what actually happens to a given obesity or diabetes prevention grant program in fiscal year 2026 may be neither the amount proposed nor the amount Congress appropriated, but rather a third figure, HHS's actual administrative implementation, that this report can document only through independent tracking organizations rather than through primary federal budget documents alone. Future editions of this report will need to

continue relying on organizations such as the CDC Data Project and Trust for America's Health specifically because primary federal sources describe the enacted appropriation but not necessarily the administrative reality on the ground.

Because roughly 80% of CDC's domestic budget flows through to states and localities, any sustained reduction in federal chronic disease prevention funding, whether achieved through the budget process or through administrative action, falls most directly on the same state and local health departments already documented in this chapter as having lost nearly half of their workforce over the preceding several years. A workforce already reduced by pandemic-era departures has less capacity to absorb further funding instability than a fully staffed one would, a compounding dynamic this chapter surfaces rather than resolves.

The distinction this chapter draws between the CDC's operational National Diabetes Prevention Program and the NIH-funded Diabetes Prevention Program Outcomes Study research cohort illustrates a broader point relevant to how this report, and other observers, should track federal chronic disease prevention policy going forward: federal funding actions affecting metabolic health prevention infrastructure arrive through multiple, only loosely coordinated channels, CDC grant funding, NIH research funding, and Medicaid or Medicare program funding among them, and a single federal funding action, such as the 2025 research funding cancellation, does not necessarily indicate a parallel action in a different channel, such as the operational lifestyle-change program network the CDC continues to operate.

The enacted FY2026 appropriation also permits a comparison this report has not previously been able to make: how federal chronic disease prevention funding is distributed across the conditions documented in Chapter 1. Within the National Center for Chronic Disease Prevention and Health Promotion's $1.433 billion FY2026 budget, Diabetes receives $163.13 million and Heart Disease and Stroke $156.105 million, while Chronic Kidney Disease receives $4.5 million. Chapter 1 documents chronic kidney disease affecting approximately 37 million U.S. adults, roughly 14% of the adult population, with CDC estimating that as many as nine in ten are unaware they have it, and the March 2026 CDC estimates place chronic kidney disease among approximately 38% of adults with diabetes and 21% of adults with high blood pressure. This report does not evaluate whether any particular allocation is correct, since appropriations reflect statutory history, program maturity, congressional priorities, and administrative capacity rather than prevalence alone. It does observe that the condition with the widest documented awareness gap in Chapter 1 receives roughly one thirty-sixth the appropriation of diabetes, and that a prevention strategy organized around the clustered

nature of metabolic disease would need to account for that distribution explicitly rather than by default.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, PH-01 through PH-09, continuing the stable-identifier convention established in Chapters 1 through 5. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
PH-01	President's FY2026 budget proposed CDC funding reduction	Estimated ~53% reduction versus FY2024, based on Trust for America's Health analysis accounting for the Administration's proposed transfer of programs out of CDC and ATSDR. This is a TFAH analytic estimate rather than an official federal budget percentage; alternative presentations yield different figures depending on whether FY2025 is restated on a comparable organizational basis
PH-02	CDC FY2026 enacted funding, as passed by Congress (Feb. 2026)	$9.227 billion enacted core public health program level, approximately 0.2% ($21 million) below the comparable FY2025 final level (CRS analysis of P.L. 119-75, Division B, enacted February 3, 2026). On a basis inclusive of mandatory funding, CDC is estimated to receive $16.266 billion, a decrease of $459 million or 2.7%. Congress did not enact the Administration's proposed transfer of major CDC functions to a new Administration for a Healthy America
PH-03	Share of CDC's domestic resources flowing directly to states and localities	~80%
PH-04	DNPAO nutrition, physical-activity, and obesity-prevention grant funding (proposed for elimination in the FY2026 request; elimination not enacted)	$54.32 million enacted for Nutrition, Physical Activity, and Obesity in FY2026, including $16.5 million for High Obesity Rate Counties (CDC NCCDPHP FY2026 Operating Budget). The FY2026 request proposed eliminating this funding; Congress did not do so. A prior grant accounting cited by the American

ID	Metric	2026 Baseline Value
		Diabetes Association reported $65+ million across 83 grantees in 42 states
PH-05	COVID-era public health grants targeted for termination by HHS, March 2025	More than $11 billion targeted for termination effective March 24, 2025; Trust for America's Health estimated more than $12 billion when combining affected CDC and SAMHSA awards. Litigation subsequently blocked the action: the U.S. District Court for the District of Rhode Island issued a temporary restraining order on April 3, 2025 and a preliminary injunction on May 16, 2025 in Colorado v. HHS, and portions of the funding were restored or protected for the plaintiff states. This was not a completed permanent reduction
PH-06	Estimated additional state and local public health FTEs needed for minimum foundational public health services (2021 modeled estimate)	~80,000 (54,000 local / 26,000 state), a roughly 80% workforce increase (de Beaumont Foundation and Public Health National Center for Innovations, Staffing Up, 2021). A modeled estimate of staffing required to deliver a minimum package of foundational public health services; it excludes temporary surge staffing for pandemics or other emergencies and is not a measured 2026 vacancy count
PH-07	Employee turnover in health departments participating in both the 2017 and 2021 PH WINS survey waves	Approximately 50% employee turnover by the end of 2021; nearly 75% among workers who in 2017 were under age 35 and/or had less than five years of tenure in their health department. Longitudinal analysis of employees from 96 state and local health departments participating in both the 2017 and 2021 PH WINS survey waves. Turnover is not equivalent to net national workforce loss, since departing employees may have moved to another public health agency, another government position, retired, or left the sector
PH-08	Prevention and Public Health Fund, FY2026 proposed versus enacted status	Elimination was proposed in the FY2026 President's budget request but was not enacted; Congress continued the Fund in enacted FY2026 appropriations, and it is actively

ID	Metric	2026 Baseline Value
		financing FY2026 chronic disease programs. CDC's NCCDPHP FY2026 operating budget draws $448.985 million of its $1.433 billion total from the Prevention and Public Health Fund, including $118.13 million for Diabetes, $111.105 million for Heart Disease and Stroke, and $200 million for Tobacco. Separately, the Public Health Funding Restoration Act (S. 786 and H.R. 1715), introduced February 27, 2025, would have provided $2.0 billion for FY2026 and each fiscal year thereafter; neither bill advanced beyond referral and neither was enacted
PH-09	Public health/chronic-disease programs proposed for elimination in the FY2026 budget request (proposal not enacted)	More than 100 programs and funding lines, including 61 at CDC and 40 at SAMHSA, according to Trust for America's Health analysis of the FY2026 proposal, covering named diabetes, obesity, cardiovascular disease, and stroke programs. Congress did not enact the proposed eliminations wholesale; the enacted FY2026 appropriation funded Nutrition, Physical Activity, and Obesity at $54.32 million, Heart Disease and Stroke at $156.105 million, Diabetes at $163.13 million, the National Diabetes Prevention Program at $37.3 million, and REACH at $68.95 million

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

This chapter relies more heavily on independent tracking organizations, rather than primary federal budget documents alone, than any prior chapter in this report, and it does so deliberately. One consequence is visible in PH-01. Federal budget documents present different percentage reductions depending on whether funding is compared before or after adjusting for the Administration's proposed transfer of programs out of CDC. Trust for America's Health estimated an approximately 53% reduction versus

FY2024 using its own reorganization-adjusted methodology; CDC's FY2026 Congressional Justification reports a substantially smaller reduction when FY2025 is restated on a comparable organizational basis, and the House Appropriations report produces a third figure using unadjusted program levels. This report presents the TFAH estimate because it captures the full proposed effect on CDC and ATSDR functions, but labels it as an analytic estimate rather than an official budget percentage. Primary federal sources, the President's budget request and CDC's own congressional budget justification documents, describe what was proposed. Congressional appropriations legislation describes what was enacted. Neither source, on its own, reliably describes what federal agencies are actually doing on the ground in a given month, which is the specific gap organizations such as the CDC Data Project and Trust for America's Health are attempting to track through public records requests, grant announcement monitoring, and direct outreach to affected state programs. This report treats that tracking as a genuine, if imperfect, primary source for the specific claims in this chapter attributed to it, consistent with this report's standard that every statistic cite a named source, but readers should understand that the administrative-implementation figures in this chapter carry more inherent uncertainty than the enacted-appropriation figures drawn directly from federal budget documents.

Congress did not enact the President's proposed eliminations. The Consolidated Appropriations Act, 2026, enacted February 3, 2026, funded CDC at a core public health program level of $9.227 billion, approximately 0.2% below the comparable FY2025 level, and maintained the agency's existing chronic disease funding structure, including appropriations under the Chronic Disease Prevention and Health Promotion heading that funds the National Center for Chronic Disease Prevention and Health Promotion. CDC's National Center for Chronic Disease Prevention and Health Promotion reports a total FY2026 operating budget of $1.433 billion, of which the metabolic-health-relevant lines include $163.13 million for Diabetes, $156.105 million for Heart Disease and Stroke, $54.32 million for Nutrition, Physical Activity, and Obesity including $16.5 million for High Obesity Rate Counties, $37.3 million for the National Diabetes Prevention Program, $68.95 million for Racial and Ethnic Approaches to Community Health, and $4.5 million for Chronic Kidney Disease. A measurement gap nonetheless remains between appropriated and disbursed funds. The $65 million, 83-grantee, 42-state figure this chapter reports for the Division of Nutrition, Physical Activity, and Obesity reflects a grant accounting cited by the American Diabetes Association, and this report cannot confirm whether that specific award level continued unchanged following enactment, because appropriation at the

program level does not establish that individual grant awards were renewed at prior amounts or that funds were obligated on the prior schedule. A program-by-program reconciliation of proposed, enacted, and actually disbursed chronic disease prevention funding would materially improve future editions of this chapter.

The public health workforce estimates in this chapter draw on data collected before the current federal budget dispute: the Health Affairs analysis of departures covers 2017 through 2021, and the de Beaumont Foundation and Trust for America's Health staffing-need estimate is likewise based on data that predates 2025's federal funding and staffing actions. This report could not identify an updated, comprehensive national estimate of the state and local public health workforce staffing gap that incorporates the workforce reductions and departures reported during 2025 and 2026 specifically, meaning the 80,000-FTE figure this chapter reports likely understates the current gap rather than overstating it, though this report cannot quantify by how much.

Chapter Summary

This chapter has extended this report's throughline, prevalence, cost, employer response, Medicare concentration, and Medicaid, to the public health infrastructure that sits upstream of the insurance-based systems examined in Chapters 3 through 5. That infrastructure enters 2026 in a state of genuine uncertainty: a federal budget proposal that would have eliminated the CDC's chronic disease prevention center entirely, a congressional appropriation that rejected that proposal and funded CDC at levels much closer to the prior year, and independent reporting that federal agencies have nonetheless taken steps consistent with the rejected proposal. Layered on top of that immediate dispute is a state and local public health workforce that had already lost close to half its staff before this dispute began, and a Prevention and Public Health Fund that has faced recurring reductions since its creation and is now proposed for full elimination.

This chapter has aimed to document that uncertainty honestly rather than resolve it artificially. Where this report could identify a clear, enacted outcome, it has reported that outcome; where the outcome remains genuinely contested between what was proposed, what was funded, and what independent trackers report is actually occurring, this chapter has said so directly. That approach will matter most in the 2027 edition of this report, when it should be possible to report which of these three pictures, the proposal, the appropriation, or the administrative practice, actually determined the funding that reached obesity and diabetes prevention programs on the ground in fiscal year 2026.

Because public health authority, funding, and implementation vary substantially across states, the national infrastructure described in this chapter is experienced differently across the country. The next chapter examines those differences.

Looking Ahead to the 2027 Edition

- Whether the divergence this chapter documents between Congress's enacted CDC appropriation and reported administrative implementation narrows, persists, or widens over the remainder of fiscal year 2026, and which of the three pictures, proposed, enacted, or implemented, best predicted actual program funding.
- Whether the Division of Nutrition, Physical Activity, and Obesity's grant funding to states continues, is reduced, or is eliminated in practice following the February 2026 appropriations act.

- Whether Congress enacts the proposed Public Health Funding Restoration Act or any other legislative vehicle addressing the Prevention and Public Health Fund's fiscal year 2026 and future funding levels.
- Updated, current data on state and local public health workforce staffing levels and departures covering 2025 and 2026 specifically, which would allow this report to state the current staffing gap directly rather than relying on pre-2025 estimates.
- Whether the Administration for a Healthy America is ultimately authorized and funded by Congress in a future appropriations cycle, restructured further, or abandoned as a proposal.
- Whether independent tracking organizations identify additional state-specific CDC grant terminations beyond the four states, California, Minnesota, Colorado, and Illinois, identified as of this chapter's preparation.

Questions We Still Cannot Answer

- What is the actual, current funding level reaching state and local obesity and diabetes prevention programs, as distinct from the amount Congress appropriated to CDC in February 2026?
- How many, and which, state or local chronic disease prevention programs have had grant funding delayed, reduced, or terminated as a result of the administrative actions this chapter describes, beyond the four states identified by independent trackers as of this chapter's preparation?
- Will the CDC's National Diabetes Prevention Program network of recognized organizations be affected by the funding and leadership changes described in this chapter, even though it is analytically distinct from the NIH-funded research cohort whose funding was separately cancelled in 2025?
- How much of the projected further decline in the state and local public health workforce, if any, is attributable specifically to 2025 and 2026 federal funding and reorganization actions, as opposed to the longer-running attrition trend this chapter documents dating to 2017?
- Will Congress restore or expand funding for the Prevention and Public Health Fund, and if so, at what level relative to the $2 billion proposed in pending legislation or the fund's historical annual funding range?
- Does the specific combination of proposed elimination, enacted continuation, and reported administrative restructuring documented in this chapter represent a

temporary transitional state, or a durable new normal in which enacted appropriations and actual federal agency practice diverge on a sustained basis?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

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Chapter 7
State-by-State Variation

Chapter 7 Key Findings

- Adult obesity prevalence in 2024 ranged from a low of 25.0% in Colorado to a high of 41.4% in West Virginia, a difference of more than 16 percentage points between the least and most affected states, according to CDC's Behavioral Risk Factor Surveillance System.
- Nineteen states had adult obesity prevalence at or above 35% in 2024, down from 23 states the prior year, the first recorded decline in the number of states at this threshold since Trust for America's Health began tracking this measure in 2011.
- Obesity prevalence varies sharply by region: the Midwest (35.9%) and South (34.5%) carry the highest regional burden, compared with the West (30.2%) and Northeast (30.3%), a gap of roughly six percentage points between the highest and lowest regions.
- Rural adults have meaningfully higher diagnosed diabetes prevalence than urban adults nationally, 12.3% versus 9.3% according to national survey data, and this gap persists across most income, education, and racial and ethnic groups, disappearing only among adults 65 and older.
- State-level rural diabetes prevalence in 2021 ranged from 8.4% in Colorado to 21.3% in North Carolina, and urban diabetes prevalence ranged from 6.9% in Colorado to 15.5% in West Virginia, showing that both the rural-urban gap and the overall state baseline vary independently of one another.
- Self-reported, diagnosed hypertension prevalence varied by state in 2021 from 24.6% in Colorado to 40.6% in Mississippi, against a national age-standardized prevalence of 30.1%, and is consistently highest in the Southeastern and Appalachian states, a regional pattern often referred to as the nation's "Stroke Belt."
- Diabetes- and hypertension-related mortality was substantially higher in rural than urban areas in 2020, 85.6 versus 71.7 age-adjusted deaths per 100,000 among adults aged 25 and older, and is highest in the South among the four census regions. Rural and urban rates were not available for 2021 through 2023 in the published analysis.
- Colorado appears at or near the most favorable end of nearly every metabolic health measure examined in this chapter, obesity, rural and urban diabetes prevalence

alike, while West Virginia and, in several measures, Mississippi, Louisiana, and North Carolina, appear at or near the least favorable end.

Introduction

The preceding six chapters have described metabolic health, its cost, and its financing and public health infrastructure primarily at the national level. This chapter examines how those same national figures obscure substantial variation across individual states, a pattern already introduced briefly in Chapter 1 and referenced again in Chapter 5's discussion of state-level Medicaid GLP-1 coverage decisions and Chapter 6's discussion of how public health funding and authority is distributed across states, localities, tribes, and territories. This chapter draws those threads together and adds a dimension not yet examined in depth: the underlying prevalence gap between states, and specifically between rural and urban areas within states, that exists independently of any single policy decision.

This chapter deliberately does not re-examine the state-level Medicaid coverage variation already documented in Chapter 5 or the state and local public health funding and workforce dynamics already documented in Chapter 6. Instead, it focuses on a question those chapters did not directly answer: how much does the underlying metabolic health burden itself, obesity, diabetes, and hypertension prevalence, vary from state to state and between rural and urban areas within the same state, and what accounts for that variation. The evidence base for this chapter draws primarily on CDC's Behavioral Risk Factor Surveillance System and Adult Obesity Prevalence Maps, Trust for America's Health's annual State of Obesity report, the CDC's National Health Interview Survey, and peer-reviewed rural-urban disparity research published in Preventing Chronic Disease, a CDC-affiliated journal.

This chapter also states directly, rather than glossing over, a definitional complication that follows from using state-level surveillance data alongside the national prevalence figures established in Chapter 1. Chapter 1 reported that 47.7% of U.S. adults have hypertension, a figure drawn from NHANES measured blood pressure data applying the current, lower diagnostic threshold recommended since 2017. Most state-level hypertension surveillance, by contrast, relies on self-reported, previously diagnosed hypertension collected through BRFSS, which this chapter's Technical Considerations section addresses directly rather than allowing the two figures to appear inconsistent without explanation.

Why This Matters

A single national prevalence figure can obscure as much as it reveals. An employer, health plan, or policymaker operating in West Virginia or North Carolina faces a materially different metabolic health burden than one operating in Colorado, and a rural county within almost any state faces a different burden than a nearby urban center. Understanding that variation, and what appears to explain it, matters for the same reason this report exists in the first place: measurement that is accurate only in the aggregate is of limited use to the specific employer, state Medicaid program, or public health department that must actually act on it.

National Snapshot

Adult obesity prevalence in 2024 ranged from 25.0% in Colorado, the lowest rate of any state, to 41.4% in West Virginia, the highest, according to CDC's Behavioral Risk Factor Surveillance System as compiled in the 2024 Adult Obesity Prevalence Maps and Trust for America's Health's State of Obesity 2025 report. Mississippi (40.4%) and Louisiana (39.2%) followed closely behind West Virginia, while the District of Columbia (25.5%) and Hawaii and Massachusetts (27.0% each) followed closely behind Colorado at the low end. Every state and territory had an obesity prevalence of at least 25% in 2024, meaning no part of the country falls outside the range this chapter describes as elevated, even as the range within that elevated band spans more than sixteen percentage points.

Regional patterns are pronounced and consistent with the individual state figures: the Midwest (35.9%) and South (34.5%) carry the highest regional obesity burden, while the West (30.2%) and Northeast (30.3%) carry the lowest, a gap of roughly six percentage points between the highest and lowest regions. Nineteen states had obesity prevalence at or above 35% in 2024, down from 23 the year before, the first decline in the number of states at this threshold since Trust for America's Health began tracking the measure in 2011; Alaska, Illinois, Missouri, and New Mexico each fell below the 35% threshold for the first time. Obesity prevalence also varies sharply by race and ethnicity nationally, at 49.9% among Black adults and 45.6% among Hispanic adults, compared with 41.4% among white adults and 16.1% among Asian adults, and by geography within states, with rural areas consistently showing higher rates than metropolitan areas.

Diabetes prevalence shows a comparable rural-urban pattern at the national level: pooled 2021 through 2024 National Health Interview Survey data found overall diagnosed diabetes prevalence of 9.8%, with rural adults at 12.3% compared with 9.3% among urban adults, a gap that persisted across most income, education, and racial and ethnic subgroups and disappeared only among adults 65 and older. A separate, state-specific analysis of 2021 BRFSS data found rural diabetes prevalence ranging from 8.4% in Colorado to 21.3% in North Carolina, and urban diabetes prevalence ranging from 6.9% in Colorado to 15.5% in West Virginia, indicating that both a state's overall diabetes burden and the size of its internal rural-urban gap vary independently from state to state rather than moving together in a single, predictable pattern.

Hypertension prevalence follows a similar regional pattern to obesity and diabetes, concentrated in the Southeastern and Appalachian states. CDC's analysis of 2017 through 2021 BRFSS data found a national age-standardized self-reported hypertension prevalence of 30.1% in 2021, ranging across states from 24.6% in Colorado to 40.6% in Mississippi, with the highest rates generally found in the Southeastern and Appalachian states and the lowest rates found in the Mountain West, a geographic pattern long associated with the region informally referred to as the nation's Stroke Belt. Combined diabetes and hypertension mortality shows the same rural and regional concentration: a peer-reviewed analysis of mortality trends from 1999 through 2023 found age-adjusted diabetes- and hypertension-related mortality of 85.6 deaths per 100,000 in rural areas compared with 71.7 in urban areas in 2020, the most recent year for which that analysis reported rural and urban rates separately, with the South recording the highest regional mortality rate among the four census regions.

Trends

The single most notable trend this chapter can report is a modest but genuine reversal in one part of the obesity picture: the number of states with obesity prevalence at or above 35% fell from 23 to 19 between 2023 and 2024, the first decline since Trust for America's Health began tracking this specific threshold in 2011. Four states, Alaska, Illinois, Missouri, and New Mexico, moved below the 35% threshold during this period. Trust for America's Health's own report cautions that this progress is limited and potentially fragile, citing the federal public health funding reductions and reorganization documented in this report's Chapter 6 as a specific risk to continued improvement, since many of the community-level obesity prevention programs most directly tied to state

and local outcomes are financed through the same federal grant lines examined in that chapter.

Beneath this modest national improvement, the underlying regional and rural-urban structure of metabolic disease prevalence appears durable rather than newly emerging. The concentration of high obesity, diabetes, and hypertension prevalence in the Southeastern and Appalachian states, and the persistence of a rural-urban gap in diabetes prevalence across nearly every demographic subgroup examined, both reflect patterns that have been documented in federal surveillance data for well over a decade rather than a recent development. This chapter treats that durability as itself a finding: whatever is producing the gap between Colorado and West Virginia, or between rural and urban North Carolina, has proven resistant to whatever combination of national trends, medical advances, and public health investment has been brought to bear on it so far.

Policy Implications

The scale of state-level variation documented in this chapter has direct implications for how the employer, Medicare, Medicaid, and public health infrastructure findings in Chapters 3 through 6 should be read. A national employer with locations in both Colorado and West Virginia, for example, is managing two materially different underlying risk populations under a single national benefit strategy, and a state Medicaid program in a high-prevalence state carries a different baseline burden than one in a low-prevalence state before any policy choice, such as the GLP-1 coverage decisions examined in Chapter 5, is made at all.

The persistence of a rural-urban gap within states, independent of each state's overall prevalence level, suggests that state-level averages themselves can obscure meaningful within-state variation in the same way this chapter's introduction noted that national averages obscure state-level variation. A state health department, employer, or health plan operating only from a state-level figure may materially misjudge the burden facing its rural service areas or workforce specifically, a consideration directly relevant to the public health infrastructure and workforce distribution questions raised in Chapter 6.

This chapter does not attempt to adjudicate which specific factors, climate, food environment, healthcare access, income, education, or public health investment, best explain the state and rural-urban patterns it documents, consistent with this report's standing practice of distinguishing description from causal claims that the underlying data cannot support. What this chapter can state directly is that geographic disparities are evident across obesity, diagnosed diabetes, self-reported hypertension, and diabetes-

and hypertension-related mortality, although the magnitude and drivers of those disparities vary by condition, dataset, and period. The state-level gap in adult obesity prevalence alone spans roughly sixteen percentage points between the highest and lowest states in 2024. These patterns argue against any single, narrow explanation and for continued, geographically resolved surveillance of the kind this chapter relies on, while cautioning against treating the four measures as one uniform geographic gradient, since they rest on different surveillance instruments, observation periods, and rural-urban classifications.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, SV-01 through SV-09, continuing the stable-identifier convention established in Chapters 1 through 6. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
SV-01	Highest state adult obesity prevalence, self-reported BRFSS (2024)	West Virginia, 41.4% (CDC 2024 Adult Obesity Prevalence Maps, BRFSS; TFAH State of Obesity 2025 provides secondary synthesis). Derived from self-reported height and weight, not measured as in NHANES
SV-02	Lowest state adult obesity prevalence, self-reported BRFSS (2024)	Colorado, 25.0% (95% CI 24.0%–26.0%; CDC 2024 Adult Obesity Prevalence Maps, BRFSS). The District of Columbia was 25.5%. Derived from self-reported height and weight, not measured as in NHANES
SV-03	States with self-reported adult obesity prevalence ≥35% (2024)	19 states (17 at 35% to under 40%, plus 2 at 40% or greater), down from 23 states in 2023. Both counts derived from CDC BRFSS; TFAH State of Obesity 2025 provides secondary synthesis
SV-04	Regional self-reported adult obesity prevalence range (2024)	Midwest 35.9% (highest) vs. West 30.2% (lowest); South 34.5%, Northeast 30.3% (CDC BRFSS). The West and Northeast differ by only 0.1 percentage point
SV-05	Diagnosed diabetes prevalence by rurality, national (NHIS 2021–2024)	12.3% rural vs. 9.3% urban (overall 9.8%), P < .001. Pooled 2021–2024

ID	Metric	2026 Baseline Value
		National Health Interview Survey, 119,160 adults (20,393 rural, 98,767 urban). Respondent-reported physician diagnosis; estimates are crude and not age-adjusted, and no rural–urban difference was observed among adults aged 65 and older
SV-06	State rural diagnosed-diabetes prevalence range, 41 reporting states (BRFSS 2021)	8.4% (Colorado) to 21.3% (North Carolina), among 41 states with reportable rural BRFSS estimates; median 13.2%, combined rural prevalence 14.3%. Not a 50-state comparison
SV-07	State urban diagnosed-diabetes prevalence range, 41 reporting states (BRFSS 2021)	6.9% (Colorado) to 15.5% (West Virginia), among the same 41 states; combined urban prevalence 11.2%. Not a 50-state comparison
SV-08	State self-reported diagnosed hypertension prevalence range (BRFSS 2021)	24.6% in Colorado to 40.6% in Mississippi, age-standardized, 2021; national age-standardized prevalence 30.1%. Self-reported diagnosed hypertension from BRFSS, which CDC notes likely underestimates actual prevalence; not comparable to the measured NHANES prevalence reported in Chapter 1. Florida was excluded from the 2021 public-use data set
SV-09	Diabetes- and hypertension-related mortality, rural versus urban (2020)	85.6 versus 71.7 age-adjusted deaths per 100,000 adults aged 25 and older, 2020. Derived from CDC WONDER death-certificate data where diabetes and hypertension met the study's cause-of-death coding criteria; rural and urban rates were unavailable for 2021 through 2023 in the published analysis, so this is a 2020 observation rather than a 2023 endpoint

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

This chapter's state-level hypertension figures, a 2021 state range of 24.6% to 40.6% against a 30.1% national age-standardized prevalence, are not directly comparable to the 47.7% national hypertension figure this report established in Chapter 1, and this report states that difference directly rather than leaving readers to reconcile it themselves. The Chapter 1 figure derives from NHANES clinically measured blood pressure data applying the lower diagnostic threshold recommended since 2017. The state-level figures in this chapter derive from BRFSS self-reported, previously diagnosed hypertension, which will understate true prevalence both because it relies on diagnosis rather than direct measurement and because some state surveillance may not fully reflect the updated diagnostic threshold. This report is not aware of a comprehensive, current, state-by-state hypertension surveillance dataset using clinically measured blood pressure and the updated diagnostic threshold consistently across all fifty states, which would be necessary to produce state-level figures directly comparable to this report's national hypertension baseline.

The state-specific rural and urban diabetes prevalence figures this chapter reports, drawn from a single peer-reviewed analysis of 2021 BRFSS data, cover 41 states with sufficient sample size for rural-urban comparison rather than all fifty states and the District of Columbia, and reflect a single survey year rather than a multi-year average, which the source study itself notes can limit the reliability of rural-specific estimates in lower-population states. This report presents the 2021 figures as the most current state-specific rural-urban diabetes breakdown it could identify, while noting that a more recent, multi-year, full-state update would improve the precision of future editions of this chapter. The national and state-level rural–urban diabetes estimates in this chapter also come from different surveillance systems and should not be compared directly. SV-05 uses pooled 2021–2024 National Health Interview Survey data and reports 12.3% rural versus 9.3% urban. SV-06 and SV-07 use 2021 Behavioral Risk Factor Surveillance System data from the 41 states with reportable rural and urban estimates; that study reported combined prevalences of 14.3% rural and 11.2% urban. The difference between 12.3% and 14.3% reflects survey design, observation period, and included populations rather than conflicting measurements of the same sample. A further caution applies to interpretation. The state-level analysis found rural diabetes odds significantly higher in 19 states before adjustment; after adjusting for age, sex, race, and ethnicity the disparity remained significant in 7 states, and after additionally adjusting for education, income, and obesity it remained significant in only North Carolina and Oregon. The national analysis likewise reports crude rather than age-adjusted estimates, and its authors state that findings are descriptive and should not be interpreted as age-independent contrasts. This report therefore states that rural populations show higher observed

diagnosed-diabetes prevalence, and does not treat rural residence itself as an independent causal factor. The mortality analysis reported as SV-09 uses the 2013 NCHS Urban–Rural Classification Scheme, under which rural comprises micropolitan and noncore counties and urban comprises large central metro, large fringe metro, medium metro, and small metro counties. That definition differs from the classification used in the diabetes prevalence analyses, and the two should not be treated as interchangeable geographic categories.

This chapter also does not attempt a comprehensive state-by-state accounting of the public health funding and Medicaid coverage variation examined in Chapters 5 and 6, and readers seeking to connect a specific state's prevalence figures in this chapter to that state's Medicaid GLP-1 coverage status or public health funding exposure should consult those chapters directly rather than assume this chapter's regional prevalence patterns and those chapters' policy patterns necessarily move together; this report has not verified that they do.

Chapter Summary

This chapter has shown that the national prevalence figures established in Chapter 1 conceal substantial variation, both between states and between rural and urban areas within the same state. A more than sixteen-percentage-point gap in adult obesity prevalence separates the least and most affected states, a comparable gap separates rural and urban diabetes prevalence within individual states, and hypertension and combined diabetes-hypertension mortality both concentrate in the same Southeastern, Appalachian, and rural areas that carry the highest obesity and diabetes burden. Colorado sits at or near the favorable end of nearly every measure this chapter examined, while West Virginia, and in several measures Mississippi, Louisiana, and North Carolina, sit at or near the unfavorable end.

This chapter has also identified one piece of genuinely encouraging news, a first-ever decline in the number of states with obesity prevalence at or above 35%, while stating directly the risk that this progress could prove fragile given the federal public health funding pressures documented in Chapter 6. As with every chapter in this report, this chapter has aimed to report what the data show, and what they do not yet show, rather than to draw a firmer conclusion than the evidence supports.

Because public health authority, funding, and implementation vary substantially across states, the national infrastructure described in Chapter 6 is experienced differently across the country, and the state and rural-urban prevalence gaps documented in this chapter are the population-level outcomes against which that varied infrastructure, and the varied Medicaid and employer policy choices documented in Chapters 3 and 5, ultimately need to be measured.

Looking Ahead to the 2027 Edition

- Whether the first-ever decline in the number of states with obesity prevalence at or above 35% continues, stalls, or reverses when 2025 BRFSS data become available.
- Whether an updated, full-state, multi-year rural-urban diabetes prevalence analysis becomes available to replace the single-year, 41-state 2021 estimate this chapter relies on.
- Whether the federal public health funding and reorganization dynamics documented in Chapter 6 measurably affect state-level obesity, diabetes, or hypertension trends in the states most dependent on the federal grant lines discussed in that chapter.

- Whether a comprehensive, state-by-state, clinically measured hypertension dataset using the current diagnostic threshold becomes available, allowing this chapter's state-level hypertension figures to be made directly comparable to this report's national Chapter 1 baseline.
- Whether the states currently at the most favorable end of this chapter's measures, particularly Colorado, continue to diverge from the states at the least favorable end, or whether the gap narrows.

Questions We Still Cannot Answer

- What combination of factors, food environment, healthcare access, income, education, climate, or public health investment, best explains the persistent gap between states such as Colorado and West Virginia, and can that combination be disentangled with existing data?
- Why does the rural-urban diabetes gap persist across most demographic subgroups but disappear among adults 65 and older, and what does that convergence in later life suggest about the factors driving the gap at younger ages?
- Does the 2023-to-2024 decline in the number of high-obesity-prevalence states reflect a genuine change in population health trajectory, normal year-to-year survey variation, or early effects of GLP-1 medication adoption, and how would this report distinguish among those explanations with another year or two of data?
- To what extent do state-level Medicaid GLP-1 coverage decisions, examined in Chapter 5, and state-level public health funding exposure, examined in Chapter 6, correlate with the prevalence patterns documented in this chapter, and would a formal cross-chapter analysis in a future edition be feasible?
- Would a full fifty-state, multi-year, clinically measured hypertension surveillance system, rather than the self-reported BRFSS data this chapter relies on, substantially change the state rankings this chapter reports?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

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Chapter 8
Medicaid Innovation

Chapter 8 Key Findings

- As of February 2026, 25 Section 1115 Medicaid demonstration waivers addressing beneficiaries' health-related social needs were approved nationally, with 6 more pending, covering services including housing supports (23 waivers), nutrition supports (12), medical respite care (11), and employment support (7).
- North Carolina's Healthy Opportunities Pilots, the largest and most closely studied state test of non-medical, social-needs-focused Medicaid interventions, was associated with an estimated reduction in health care spending of $164 per Medicaid beneficiary per month among 31,597 enrollees studied between March 15, 2022 and November 30, 2024, according to a summative evaluation released in June 2026.
- That same evaluation demonstrated no clear statistically significant improvement in hemoglobin A1c or blood pressure, the two most direct clinical markers of metabolic health among the outcomes it examined, with point estimates generally directionally favorable but small and imprecise and drawn from a non-random subset of participants with clinical data available in the state health information exchange, even as it found clear reductions in emergency department visits, hospitalizations, and overall cost.
- Despite these results, the North Carolina General Assembly did not appropriate continued state funding for the Healthy Opportunities Pilots beyond July 1, 2025, causing the program to suspend operations, even though CMS has authorized the underlying waiver to continue through December 2029.
- Federal posture toward Medicaid social-needs waivers shifted in 2025: the current administration rescinded prior guidance, announced that new Section 1115 waivers may no longer include employment support or job training components, and has not cancelled existing approved waivers but is considered unlikely to approve new ones of the kind most common among the 25 currently in effect.
- A prior Massachusetts Section 1115 waiver evaluation found that Food Is Medicine nutritional interventions delivered through Medicaid were associated with a 23% reduction in hospitalizations and a 13% reduction in emergency department visits among eligible beneficiaries.

- Medicaid value-based payment adoption has grown unevenly across states over the past decade, with individual state targets for provider payments made through alternative payment models ranging as high as 50% of total payments in states such as Texas and Colorado, though this report could not identify a single, current, comprehensive national accounting of value-based payment adoption across all state Medicaid programs.
- Delivery System Reform Incentive Payment programs, an earlier generation of Section 1115-authorized payment reform, were implemented in 13 states with $48.6 billion in approved state and federal funding as of a 2017 accounting, establishing much of the infrastructure and provider relationships that current health-related social needs waivers now build upon.

Introduction

Chapter 5 examined Medicaid's core financing, enrollment, and GLP-1 coverage decisions. This chapter examines a different, more experimental layer of the same program: the demonstration waivers, payment reforms, and non-medical interventions that a growing number of states have used to test whether Medicaid can address the social and economic conditions that contribute to metabolic disease, food insecurity, housing instability, and transportation barriers among them, rather than financing only clinical treatment after those conditions have already produced diagnosed disease. This chapter's central case study, North Carolina's Healthy Opportunities Pilots, illustrates both the promise and the current fragility of this approach: rigorous evaluation found real cost and utilization benefits, but found no measurable effect on the clinical metabolic markers, hemoglobin A1c and blood pressure, that this report has tracked since Chapter 1, and the program itself has been suspended for lack of continued state funding despite those results.

This chapter's evidence base draws primarily on the KFF Medicaid Waiver Tracker and its associated Section 1115 Waiver Watch briefs; the Health Affairs brief examining health-related social needs waivers; North Carolina's Healthy Opportunities Pilots summative evaluation, conducted by the University of North Carolina's Cecil G. Sheps Center for Health Services Research; federal guidance from the Office of Disease Prevention and Health Promotion's Food Is Medicine resource hub; and MACPAC's tracking of state Medicaid value-based payment adoption. As in prior chapters, this chapter reports what the evidence shows, including where that evidence is mixed or incomplete, rather than presenting Medicaid innovation initiatives as a settled success or failure.

Why This Matters

Chapters 1 through 7 have largely examined Medicaid, Medicare, and employer coverage as systems that finance clinical care for metabolic disease once it is diagnosed. The waivers and payment reforms this chapter examines represent a different premise: that some portion of the metabolic disease burden this report has documented is itself downstream of unmet social and economic needs, and that Medicaid, as the insurer of last resort for the low-income population carrying a disproportionate share of that burden, may be a viable vehicle for addressing those needs directly. Whether that premise holds is an empirical question this report can only partially answer with the evidence currently available, and this chapter states plainly where the evidence is strong and where it is not.

FIGURE 8-1 The Medicaid Innovation Framework

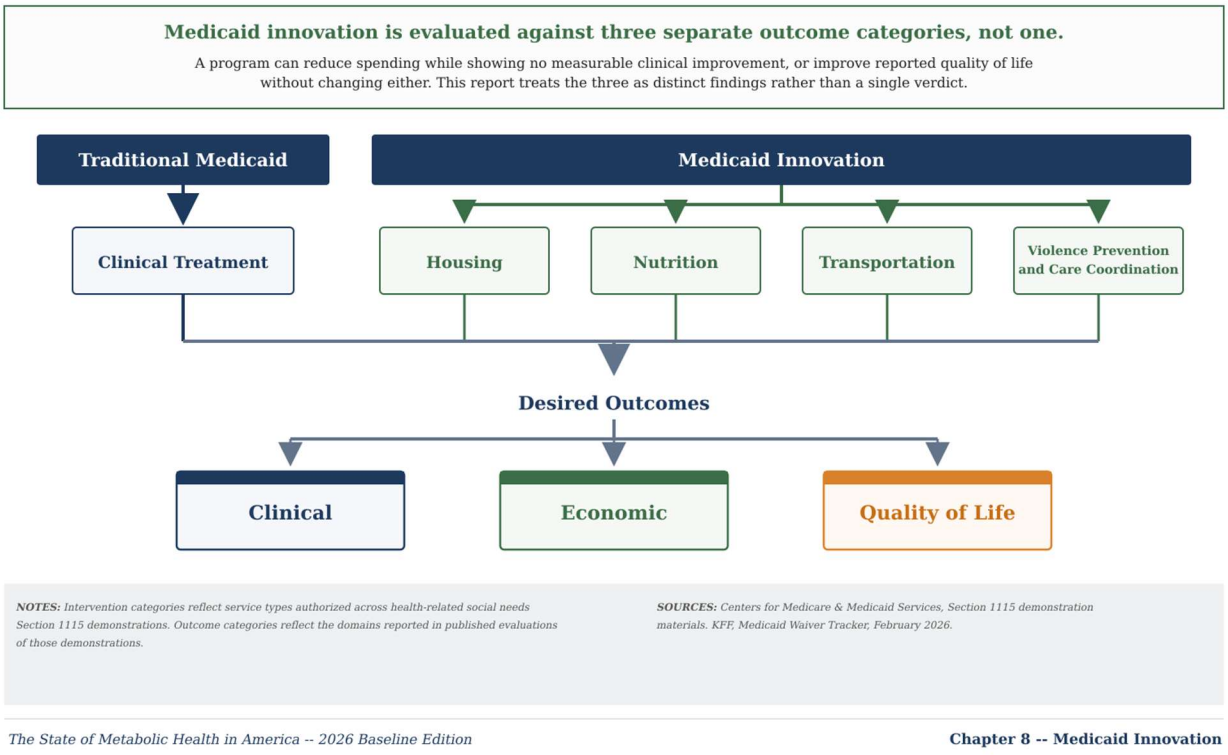


Figure 8-1. The Medicaid Innovation Framework

Sources: Centers for Medicare & Medicaid Services, Section 1115 demonstration materials. KFF, Medicaid Waiver Tracker, February 2026. Notes: Intervention categories reflect service types authorized across health-related social needs Section 1115 demonstrations. Outcome categories reflect the domains reported in published evaluations of those demonstrations.

National Snapshot

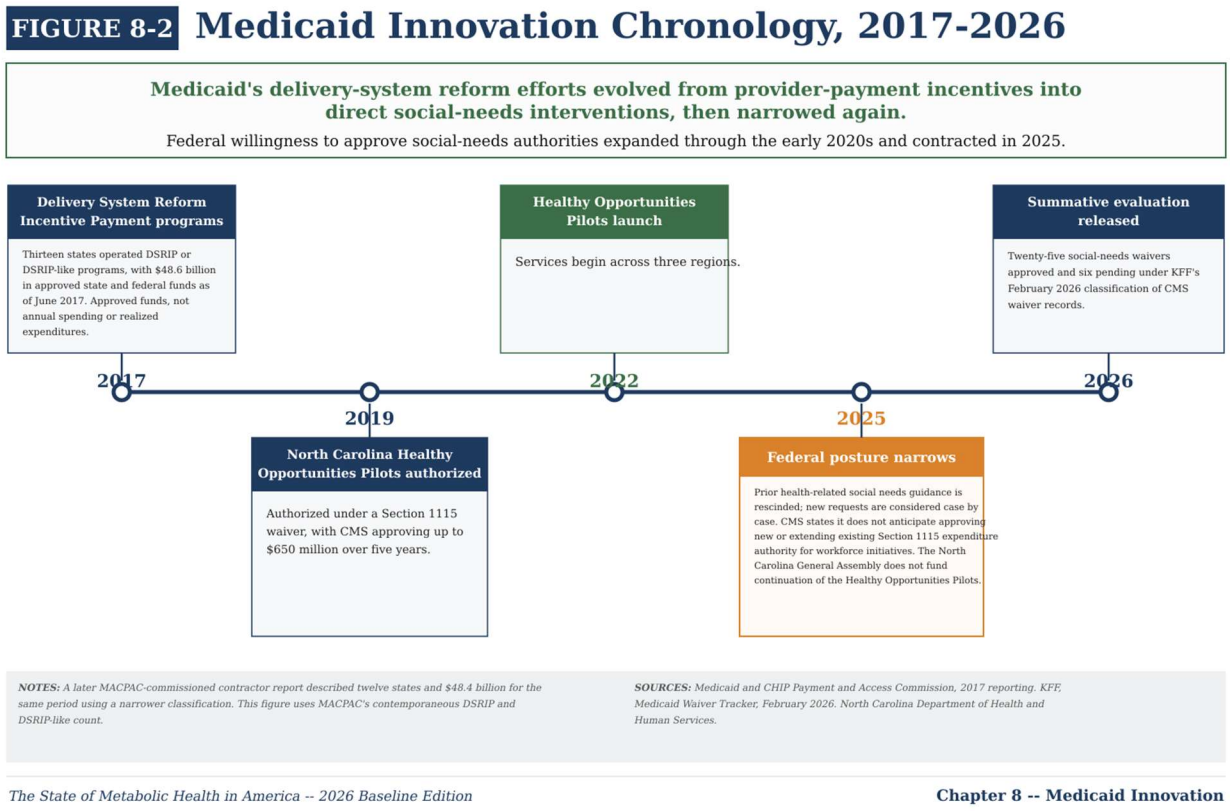


Figure 8-2. Medicaid Innovation Chronology, 2017–2026

Sources: Medicaid and CHIP Payment and Access Commission, 2017 reporting. KFF, Medicaid Waiver Tracker, February 2026. North Carolina Department of Health and Human Services. Notes: A later MACPAC-commissioned contractor report described twelve states and $48.4 billion for the same period using a narrower classification. This figure uses MACPAC's contemporaneous DSRIP and DSRIP-like count.

Section 1115 of the Social Security Act allows the HHS Secretary to waive certain federal Medicaid requirements so that states can test approaches likely to promote the program's objectives, subject to a requirement that waivers be budget neutral to the federal government and that states conduct rigorous, CMS-approved evaluations. As of February 26, 2026, KFF's Medicaid Waiver Tracker reported 25 approved waivers addressing beneficiaries' health-related social needs, with 6 more pending. Housing supports appear in 23 of these waivers, nutrition supports in 12, medical respite care in 11, and employment support in 7, and most current waivers target beneficiaries who are homeless or at high risk of homelessness in combination with a qualifying medical or

behavioral health condition. States including California, through its CalAIM initiative, and New York, Massachusetts, Arizona, and North Carolina have been among the most active in this space, building on an earlier generation of Section 1115-authorized Delivery System Reform Incentive Payment programs that operated in 13 states with $48.6 billion in approved state and federal funding as of a 2017 accounting.

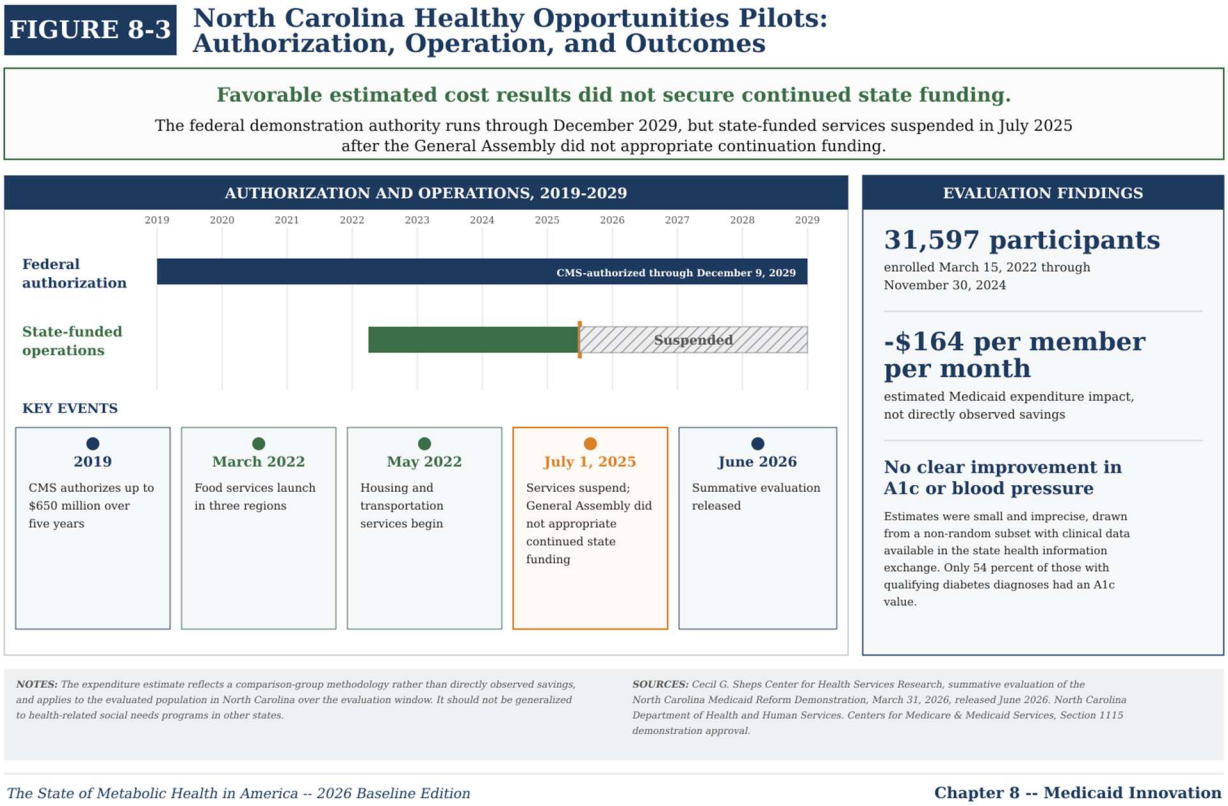


Figure 8-3. North Carolina Healthy Opportunities Pilots: Authorization, Operation, and Outcomes

Sources: Cecil G. Sheps Center for Health Services Research, summative evaluation of the North Carolina Medicaid Reform Demonstration, March 31, 2026, released June 2026. North Carolina Department of Health and Human Services. Centers for Medicare & Medicaid Services, Section 1115 demonstration approval. Notes: The expenditure estimate reflects a comparison-group methodology rather than directly observed savings, and applies to the evaluated population in North Carolina over the evaluation window. It should not be generalized to health-related social needs programs in other states.

North Carolina's Healthy Opportunities Pilots, authorized under a Section 1115 waiver in 2019 with up to $650 million in federal Medicaid funding over five years, is this report's most closely studied example of a state test of non-medical interventions delivered at meaningful scale through Medicaid managed care. The Pilots launched in March 2022 across three regions of the state, delivering 29 evidence-based services addressing housing instability, food insecurity, transportation barriers, and interpersonal violence

through networks of contracted community-based organizations. A summative evaluation released in June 2026 by the University of North Carolina's Cecil G. Sheps Center for Health Services Research, covering 31,597 enrollees from the program's March 2022 launch through November 2024, estimated that the program was associated with $164 per member per month less Medicaid health care spending than would otherwise have been expected, driven by fewer emergency department visits and hospital stays and more visits to lower-cost outpatient and primary care settings. The same evaluation, however, demonstrated no clear statistically significant improvement in hemoglobin A1c or blood pressure among the subset of beneficiaries with data available in the state's health information exchange, a non-random subset in which only 54% of those with qualifying diabetes diagnoses had an A1c value and 81% of those with qualifying hypertension diagnoses had a blood-pressure value, limitations the evaluators state make definitive conclusions difficult, and found inconclusive, statistically uncertain effects on participant-reported health-related quality of life, even as participants themselves rated their experience with the program positively in interviews and surveys.

Despite these evaluation results, the North Carolina General Assembly did not appropriate continued state funding for the Pilots beyond July 1, 2025, and the program suspended operations at that time even though CMS has authorized the underlying waiver to continue through December 2029. The majority of program funding is federal, with the state responsible for the remaining share, meaning the suspension reflects a state budgeting decision rather than a federal funding withdrawal or a negative evaluation finding. North Carolina continues to negotiate a waiver renewal request that would extend the program for an additional five years and expand it statewide, but as of this chapter's preparation, that renewal had not been finalized and the program remained suspended.

A separate, earlier Massachusetts Section 1115 waiver evaluation, cited by researchers as part of the evidence base supporting Food Is Medicine interventions generally, found that Medicaid beneficiaries receiving nutritional services and supports experienced a 23% reduction in hospitalizations and a 13% reduction in emergency department visits, results the Health Affairs brief characterizes as emerging rather than conclusive evidence, alongside a stronger evidence base for housing-related interventions specifically.

Trends

The federal policy environment for Medicaid social-needs waivers shifted materially during 2025. The current administration rescinded prior CMS guidance that had

encouraged health-related social needs waivers, announced that new Section 1115 waivers may no longer include employment support or job training components, and issued a related executive order affecting federal support for supportive housing approaches associated with a "housing first" model. The administration has not cancelled any of the 25 currently approved waivers addressing social needs, but given that the large majority of those waivers involve employment supports or supportive housing interventions, independent analysis concludes that approval of new waivers resembling the current cohort, while still technically possible, is unlikely for the remainder of the current administration.

Medicaid value-based payment adoption, the broader payment-reform trend within which many of these waivers sit, has grown over the past decade but remains unevenly documented across states. Individual state targets for the share of Medicaid managed care payments made through alternative payment models range as high as 50% in states such as Texas and Colorado, with a portion of those payments required to carry downside financial risk for providers. This report could not identify a single, current, comprehensive national data source tracking value-based payment adoption across all state Medicaid programs on a comparable basis, a measurement gap this chapter's Technical Considerations section addresses directly.

Taken together, these trends suggest a Medicaid innovation landscape that is contracting in one dimension, new federal approvals of employment- and housing-focused social needs waivers, while continuing, unevenly, in another, state-level value-based payment adoption and existing waiver implementation. North Carolina's experience, strong evaluation results paired with a state funding lapse, illustrates that federal authorization and evaluation success do not guarantee program continuity when state budget priorities shift.

Policy Implications

The Healthy Opportunities Pilots evaluation carries a specific implication for how this report, and other observers, should interpret Medicaid social-needs interventions going forward: cost and utilization outcomes and clinical metabolic outcomes are not the same thing and do not necessarily move together over the two-and-a-half-year window this evaluation examined. A program can meaningfully reduce emergency department visits and hospitalizations, and correspondingly reduce Medicaid costs, without yet producing a measurable change in hemoglobin A1c or blood pressure among the same population. Future editions of this report should track whether longer follow-up, a larger evaluated population, or program refinement narrows this gap between utilization and clinical

outcomes, rather than treating the absence of a clinical effect in this evaluation window as a final verdict on the underlying approach.

North Carolina's funding lapse illustrates a structural vulnerability specific to Section 1115 waiver financing: because most such waivers require a state matching contribution alongside federal funds, a program's continuity depends on sustained state legislative appropriation in addition to federal authorization, and a state budget decision unrelated to the program's own evaluated performance can suspend it regardless of the strength of that performance. This dynamic has a direct parallel to the state-level Medicaid GLP-1 coverage retrenchment documented in Chapter 5, where several states narrowed or eliminated an optional Medicaid benefit primarily citing cost rather than evaluated effectiveness.

The federal narrowing of permissible social-needs waiver components, specifically CMS's July 2025 statement that it does not anticipate approving new or extending existing Section 1115 expenditure authority for workforce initiatives, does not by itself affect the nutrition, housing, and medical respite components most directly relevant to metabolic health that this chapter has documented, since those waivers appear to have concentrated in housing and nutrition supports rather than employment supports specifically among the current 25 approved waivers. Whether new waiver approvals narrow further, or whether existing approved waivers are renewed on comparable terms as they come up for renewal, remains an open question this chapter cannot yet answer.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, MI-01 through MI-09, continuing the stable-identifier convention established in Chapters 1 through 7. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
MI-01	Section 1115 demonstrations with approved HRSN- or SDOH-related authorities	25 approved and 6 pending as of the February 2026 KFF Medicaid Waiver Tracker. This is a KFF classification of CMS waiver records rather than a national total published by CMS, and reflects the broader universe of demonstrations addressing beneficiary social needs rather than only those approved under the 2023 HRSN framework. Existing approvals

ID	Metric	2026 Baseline Value
		remained in effect while federal policy toward new HRSN requests shifted during 2025 and 2026
MI-02	Service categories authorized across HRSN- or SDOH-related Section 1115 demonstrations	Housing 23; nutrition 12; medical respite 11; employment supports 7, based on KFF classification of approved waivers. Categories overlap, since a single demonstration may authorize more than one, and must not be summed to infer a total number of waivers or states. Employment-support authorities reflect previously approved demonstrations; CMS announced in July 2025 that it did not anticipate approving new or extending existing Section 1115 expenditure authority for workforce initiatives
MI-03	NC Healthy Opportunities Pilots, estimated Medicaid expenditure impact	−$164 per member per month, estimated rather than directly observed savings, from the Cecil G. Sheps Center summative evaluation of the North Carolina Medicaid Reform Demonstration (report dated March 31, 2026; released June 2026). The estimate applies to the evaluated Healthy Opportunities Pilots population, in North Carolina, over the evaluation window, using the study's comparison methodology, and should not be generalized to health-related social needs programs in other states
MI-04	NC HOP participants enrolled during the evaluation period	31,597 individuals enrolled between March 15, 2022 and November 30, 2024; 31,084 remained actively enrolled at the end of the reporting period
MI-05	NC HOP operational status versus federal authorization	Services suspended beginning July 1, 2025 because the General Assembly did not appropriate continued state funding; the underlying Section 1115 demonstration remains CMS-approved through December 9, 2029
MI-06	NC HOP effect on hemoglobin A1c and blood pressure	No clear statistically significant improvement demonstrated. Estimated A1c differences at 6, 12, and 18 months were −0.06, −0.04, and −0.02 percentage points, with

ID	Metric	2026 Baseline Value
		confidence intervals crossing zero at every time point, and blood-pressure estimates generally included the null. Point estimates were usually directionally favorable but small and imprecise. Analyses relied on a non-random subset of participants with clinical data available in NC HealthConnex: 81% of those with qualifying hypertension diagnoses had at least one blood-pressure value, but only 54% of those with qualifying diabetes diagnoses had an A1c value. The evaluators state that these limitations make definitive conclusions difficult
MI-07	Federal posture on Section 1115 workforce-initiative expenditure authority	CMS stated in July 2025 that it does not anticipate approving new or extending existing Section 1115 expenditure authority for workforce initiatives; previously approved initiatives continue to be monitored. New approvals of the current-cohort HRSN type are considered unlikely
MI-08	MassHealth Flexible Services nutrition-support evaluation (Massachusetts)	Associated with 23% lower hospitalization rates and 13% lower emergency department visit rates among participants receiving nutrition supports compared with eligible nonparticipants. More than 20,000 MassHealth members offered nutrition services between January 2020 and March 2023 under the 2017–2022 Section 1115 demonstration. The evaluation used comparison groups rather than randomized assignment, so these are associations rather than demonstrated causal effects
MI-09	Historical scale of DSRIP and DSRIP-like Medicaid programs (historical context, not a current program count)	13 states and $48.6 billion in approved state and federal funds as of June 2017, according to contemporaneous MACPAC reporting. The figure represents approved funds rather than annual spending or realized expenditures. A later MACPAC-commissioned contractor report described 12 states and $48.4 billion using a somewhat narrower

ID	Metric	2026 Baseline Value
		classification; this report uses MACPAC's contemporaneous DSRIP and DSRIP-like count

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

The Healthy Opportunities Pilots' null finding on hemoglobin A1c and blood pressure was limited to the subset of enrollees with data available in North Carolina's health information exchange, NC HealthConnex, which the evaluation itself notes is not the full enrolled population, and the evaluation covered services delivered through November 2024, a period the evaluators note was shorter than originally intended because of a delayed program launch tied to the state's separate transition to Medicaid managed care. This report presents the null clinical finding as reported, while noting that a longer observation window or more complete clinical data linkage could plausibly change this specific result in either direction, and this report cannot predict which. A separate definitional discrepancy applies to MI-09. MACPAC's contemporaneous 2017 materials report 13 states and $48.6 billion in approved state and federal funds for Delivery System Reform Incentive Payment and DSRIP-like programs as of June 2017, while a MACPAC-commissioned contractor report published in March 2018 describes 12 states and $48.4 billion for the same period using a somewhat narrower classification. This report uses the contemporaneous MACPAC DSRIP and DSRIP-like count and notes that the $48.6 billion figure represents approved rather than realized funds. MI-09 is included as historical context for the delivery-system and social-needs waiver approaches examined elsewhere in this chapter, not as a count of programs currently operating.

This report could not identify a single, current, comprehensive national data source tracking Medicaid value-based payment adoption across all state Medicaid programs on a directly comparable basis. The state -specific figures this chapter reports, drawn from individual state managed care contracts and program documentation, use varying definitions of what qualifies as a value-based or alternative payment model, varying baseline years, and varying methods of counting risk-based versus non-risk-based arrangements, making cross-state comparison imprecise. A consolidated, methodologically consistent national tracking source, comparable to what MACPAC has

periodically produced through targeted state studies, would materially improve future editions of this chapter's ability to describe the pace and scale of Medicaid payment reform nationally.

This chapter's account of the 2025 federal policy shift on employment-support waiver components draws on secondary academic and policy-brief sources describing rescinded guidance and administration statements, rather than a single, consolidated federal notice this report could cite directly; this report is not aware of a single comprehensive federal document stating the current administration's complete waiver policy in one place, and instead relies on the pattern of individual approvals, denials, and public statements that independent trackers such as KFF have compiled.

Chapter Summary

This chapter has examined Medicaid's experimental edge: Section 1115 waivers and value-based payment reforms intended to address the social and economic conditions that contribute to metabolic disease directly, rather than financing only its clinical treatment after diagnosis. The evidence to date is genuinely mixed rather than uniformly encouraging or discouraging. North Carolina's Healthy Opportunities Pilots produced real, measured reductions in cost and acute care utilization, but no measurable change in the clinical metabolic markers this report has tracked since Chapter 1, and the program was suspended for lack of continued state funding despite those results, a pattern that illustrates the structural fragility of state-matched waiver financing more broadly.

This chapter has also documented a federal policy environment narrowing new approvals of the employment-support and supportive-housing waiver components that have made up the largest share of the current cohort of health-related social needs waivers, even as existing approved waivers, including those most directly relevant to metabolic health through nutrition and Food Is Medicine components, remain in place. As with every chapter in this report, this chapter has aimed to report what the evidence currently shows, including its genuine limitations, rather than to advocate for or against the broader premise that Medicaid can effectively address social determinants of metabolic health.

Having now examined the national baseline, cost, employer response, Medicare, Medicaid, public health infrastructure, state variation, and Medicaid innovation specifically, this report's next edition will need to determine which additional dimensions of the metabolic health system most warrant sustained, annual measurement.

Looking Ahead to the 2027 Edition

- Whether North Carolina's Healthy Opportunities Pilots resume operations following a waiver renewal and restored state funding, and if so, whether a longer follow-up period shows a measurable effect on hemoglobin A1c or blood pressure that the current evaluation window did not detect.
- Whether other states with approved health-related social needs waivers publish comparable summative evaluations, and whether their findings on clinical metabolic outcomes specifically resemble North Carolina's mixed result.

- Whether the federal administration approves any new Section 1115 health-related social needs waivers during 2026, and if so, whether they include nutrition or Food Is Medicine components specifically.
- Whether a consolidated, comparable national data source on state Medicaid value-based payment adoption becomes available, addressing the measurement gap this chapter identifies in its Technical Considerations section.
- Whether California's CalAIM initiative, New York's renewed 1115 waiver, or other large-state programs not examined in depth in this edition publish evaluation results bearing on metabolic health outcomes specifically.

Questions We Still Cannot Answer

- Why did the Healthy Opportunities Pilots reduce cost and acute care utilization without a measurable effect on hemoglobin A1c or blood pressure, and would a longer follow-up period, larger clinical data linkage, or program refinement change that specific finding?
- Do Medicaid health-related social needs interventions produce measurable clinical metabolic improvement in any state with comparable evaluation rigor to North Carolina's, or does the utilization-without-clinical-effect pattern generalize across states?
- How many Medicaid beneficiaries nationally have lost access to a health-related social needs intervention specifically because of a state funding decision, as opposed to a federal policy change, and is North Carolina's experience typical or unusual among states that have implemented these waivers?
- What share of Medicaid managed care payments nationally are currently made through value-based or alternative payment models, using a single, consistent definition applied across all states?
- Will the current federal narrowing of employment-support waiver components extend to nutrition or housing components specifically relevant to metabolic health, or will those components continue to be approved on a case-by-case basis as they have been to date?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

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- Lantz PM, Hiltner S. Addressing Health-Related Social Needs Through Medicaid Section 1115 Waivers: Challenges and Opportunities. Health Affairs Health Policy Brief. January 8, 2026. doi:10.1377/hpb20260108.28767.
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- Centers for Medicare & Medicaid Services. State Medicaid Director (SMD) Letter #20-004, Value-Based Care Opportunities in Medicaid; Accelerating the Adoption of Value-Based Payment in Medicaid (2019).

Chapter 9
Medicare Innovation

Chapter 9 Key Findings

- The CMS Innovation Center has undergone substantial model consolidation since March 2025, terminating the Primary Care First, Making Care Primary, ESRD Treatment Choices, and Maryland Total Cost of Care models early to achieve an estimated $750 million in savings, and ending the Medicare Advantage Value-Based Insurance Design model ahead of schedule in December 2024.
- ACO REACH, Medicare's primary total-cost-of-care accountable care model since 2023, will end on December 31, 2026, and will be succeeded on January 1, 2027 by the LEAD model, a new 10-year accountable care design; ACO REACH is not accepting new participants for its remaining duration.
- ACO REACH generated approximately $1.643 billion in gross savings relative to model benchmarks in Performance Year 2023, a 5.8% gross savings rate, of which $694.6 million was retained by CMS as net savings and $948.4 million accrued to participating ACOs, but 27% of participating ACOs recorded net financial losses in the same year, indicating that implementation at national scale has not translated into uniformly positive financial results for participants.
- The most metabolic-health-relevant Medicare payment innovation to date is the new ACCESS model, a 10-year, voluntary payment model launched July 5, 2026 that creates dedicated payment tracks organized explicitly around cardio-kidney-metabolic risk, the first Medicare payment model to define eligibility and required outcome measures directly in terms of blood pressure, weight, hemoglobin A1c, LDL cholesterol, and kidney function markers.
- Because the ACCESS model launched on July 5, 2026, no utilization or clinical outcome data yet exist for it; this chapter can currently assess only whether the model has been successfully designed and launched, the first tier of this report's evidence hierarchy for innovation programs, and not yet whether it improves utilization or clinical metabolic outcomes.
- Under the ACCESS model, an organization earns its full Outcome-Aligned Payment only if at least half of its relevant beneficiaries meet all required clinical outcome targets in the first model year, with payment reduced proportionally below that threshold and the reduction capped at half of the gross payment amount, the most

direct link between Medicare payment and metabolic biomarker achievement CMS has implemented in traditional fee-for-service Medicare to date.

- The Kidney Care Choices model, which addresses late-stage chronic kidney disease, a common downstream complication of diabetes and hypertension, was not affected by CMMI's March 2025 model terminations and continues through 2026.
- CMS has stated that ACCESS payments will not be incorporated into Medicare Shared Savings Program or ACO REACH benchmark calculations through 2027, but will begin to be incorporated in 2028, meaning the financial interaction between Medicare's population-based ACO models and its new individual-provider chronic care payment model remains only partially defined.

Introduction

Chapter 4 examined Medicare's core coverage and the concentration of metabolic disease among its beneficiaries. Chapter 8 examined Medicaid's experimental use of Section 1115 waivers to test non-medical, social-needs interventions. This chapter turns to a parallel question within Medicare: how is the CMS Innovation Center testing new payment models intended to improve chronic disease management, and specifically metabolic disease management, within traditional, fee-for-service Medicare? At this stage, the available evidence permits assessment only of the model's design and implementation. This chapter documents what has been designed and implemented, distinguishes that clearly from what has been shown to work, and applies this report's evidence hierarchy for innovation programs, whether a program was implemented successfully, whether it improved utilization, whether it improved clinical outcomes, and whether any improvement proved durable, exactly as Chapter 8 did for Medicaid. As demonstrated in Chapter 1, nearly half of U.S. adults have hypertension and a substantial share carry obesity, diabetes, or prediabetes as well, meaning most beneficiaries enter Medicare already carrying at least one of the biomarker-defined risk factors the ACCESS model targets, which is what makes a payment model organized explicitly around those biomarkers particularly relevant to this report's subject matter.

This chapter's evidence base draws on CMS Innovation Center model pages and Requests for Applications; CMS's Performance Year 2023 ACO REACH financial and quality results; industry and legal analysis of CMMI's 2025 model terminations from Hogan Lovells and other firms tracking CMS Innovation Center activity; and trade press coverage of the ACCESS model's launch from the American Health Care Association, the American Hospital Association, and specialty publications covering value-based care operations. Several of this chapter's claims describe models that have been announced

or have just begun, rather than models with completed evaluations, and this chapter states that distinction plainly rather than describing an announced model in the same terms as an evaluated one.

Why This Matters

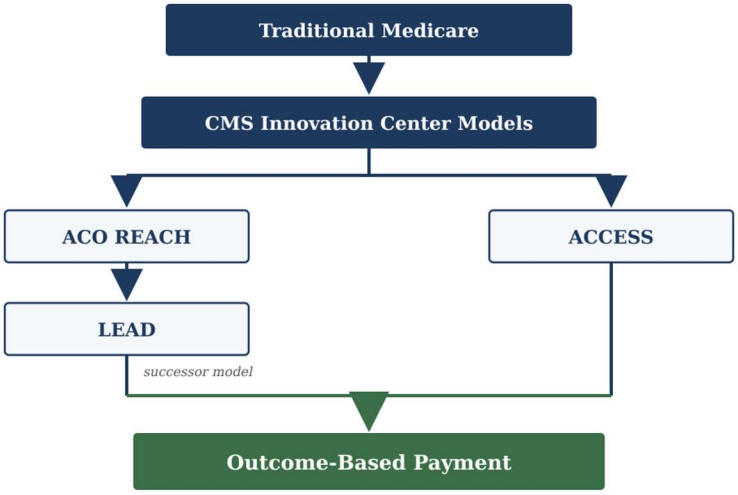
Medicare's fee-for-service payment structure has historically paid for office visits and procedures rather than for sustained improvement in a beneficiary's blood pressure, weight, or blood sugar between visits. The models this chapter examines represent CMS's attempt to change that, either by shifting financial responsibility to accountable care organizations for a beneficiary's total cost of care, or, in the ACCESS model's case, by paying directly for demonstrated achievement of specific metabolic biomarker targets. Whether either approach measurably improves metabolic health outcomes for Medicare beneficiaries is an empirical question this report can only begin to answer in this edition, and will need to revisit directly as these models mature.

National Snapshot

FIGURE 9-1 **From Traditional Medicare to Outcome-Based Payment**

Medicare payment reform is consolidating around fewer, longer-duration models that tie payment to measured clinical outcomes.

This figure shows the direction of that shift. Model dates, durations and status appear separately in Figure 9-2.



NOTES: *This figure depicts the structural direction of Medicare payment reform. Model timelines, durations, and current status are shown in Figure 9-2.*

SOURCES: *Centers for Medicare & Medicaid Services, CMS Innovation Center. ACO REACH, LEAD, and ACCESS model program materials.*

Figure 9-1. From Traditional Medicare to Outcome-Based Payment

Sources: Centers for Medicare & Medicaid Services, CMS Innovation Center. ACO REACH, LEAD, and ACCESS model program materials. Notes: This figure depicts the structural direction of Medicare payment reform. Model timelines, durations, and current status are shown in Figure 9-2.

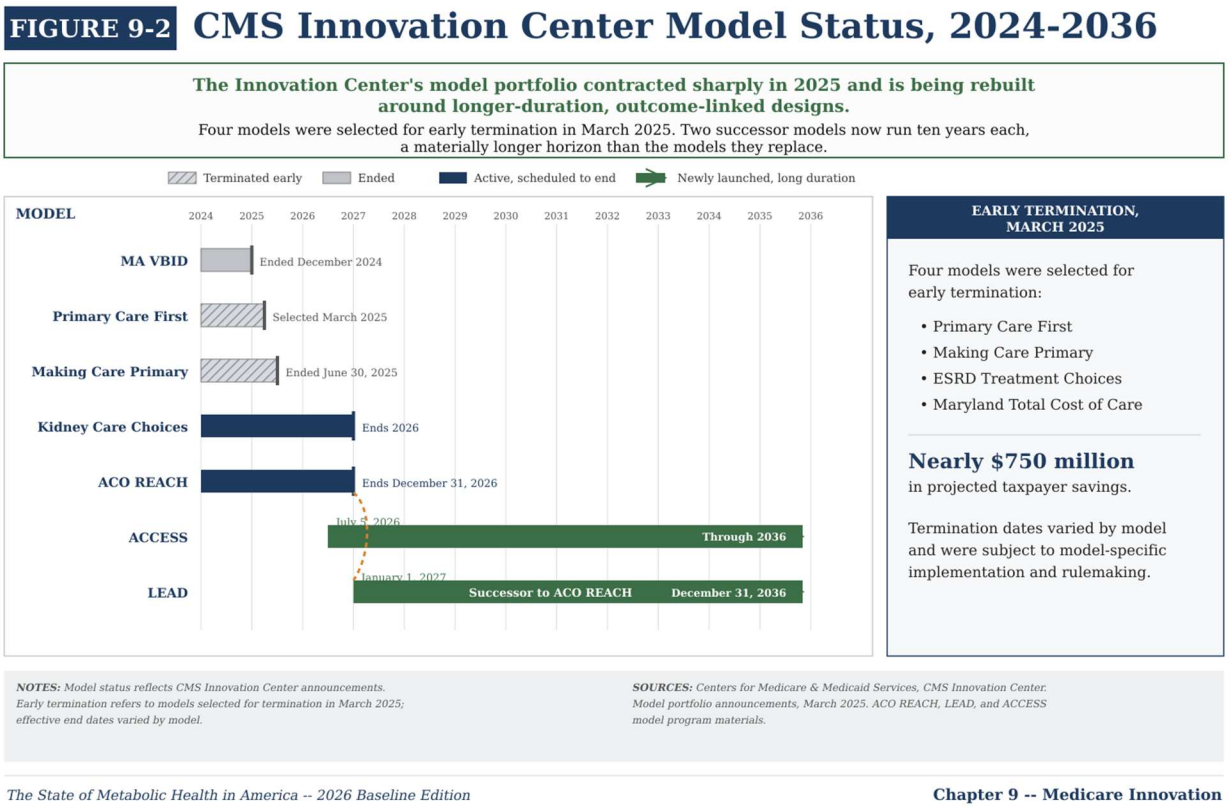


Figure 9-2. CMS Innovation Center Model Status, 2024–2036

Sources: Centers for Medicare & Medicaid Services, CMS Innovation Center. Model portfolio announcements, March 2025. ACO REACH, LEAD, and ACCESS model program materials. Notes: Model status reflects CMS Innovation Center announcements. Early termination refers to models selected for termination in March 2025; effective end dates varied by model.

The CMS Innovation Center announced in March 2025 that it would terminate four payment models early, the Primary Care First model, the Making Care Primary model, the mandatory ESRD Treatment Choices model, and the Maryland Total Cost of Care model, to achieve an estimated $750 million in savings, and separately declined to move forward with two previously announced models. This followed the earlier-than-scheduled termination of the Medicare Advantage Value-Based Insurance Design model in December 2024. The Innovation Center's ACO PC Flex model, its most recent primary-care-centered accountable care model, drew substantially fewer participants than CMS's original planning estimate, 24 ACOs in its first performance year and 23 in performance year 2026, against the roughly 130 CMS had initially expected to select. That figure was a planning estimate rather than a statutory target or minimum threshold. CMS does not intend to offer a second application round. Taken together, independent legal and policy analysis characterizes this period as an atypical,

simultaneous consolidation of the CMS Innovation Center's model portfolio rather than a routine, one-off program closure.

ACO REACH, the successor to the Global and Professional Direct Contracting model and Medicare's primary total-cost-of-care accountable care model since its first performance year began in 2023, will end on December 31, 2026 after four performance years, and is not accepting new applications for its remaining duration. In performance year 2026, 74 ACOs were participating in the model; in performance year 2025, 103 ACOs and 161,765 participating providers and organizations served an estimated 2.5 million Traditional Medicare beneficiaries. CMS's Performance Year 2023 financial and quality results found that ACO REACH generated approximately $1.643 billion in gross savings relative to model benchmarks in Performance Year 2023, a 5.8% gross savings rate, of which $694.6 million was retained by CMS as net savings and $948.4 million accrued to participating ACOs, though 36 ACOs, approximately 27% of participants, recorded net financial losses relative to their benchmarks in the same year, indicating a wide distribution of financial outcomes beneath the aggregate savings figure. Beginning in performance year 2026, CMS adjusted ACO REACH's financial methodology in response to findings in its own preview of the performance year 2023 evaluation report, aiming to improve the model's sustainability for its final year. CMS announced in December 2025 that ACO REACH will be succeeded on January 1, 2027 by the LEAD model, a new accountable care design with a 10-year performance period, the longest CMS has tested to date, intended in part to expand ACO participation among smaller, rural, and independent providers and to build a framework for coordinating Medicare and Medicaid services for dually eligible beneficiaries.

CMS's stated rationale for LEAD draws directly on the participation pattern this chapter has already described: ACO REACH, like the ACO PC Flex model before it, drew fewer smaller, rural, and independent provider organizations than CMS had hoped, in part because ACO models have historically required providers to accept meaningful financial risk within a comparatively short benchmark cycle, three to five years, that resets and can penalize an ACO for its own prior savings. LEAD's central design change is its 10-year performance period, offering participating ACOs a longer window without rebasing and, CMS argues, a more predictable path toward sustainable long-term benchmarks than shorter models have provided. LEAD also introduces CMS-Administered Risk Arrangements, a digital data-sharing and payment platform intended to support episode-based risk arrangements between ACOs and specialists, and a dedicated Medicare-Medicaid integration component under which CMS will work with two selected states, beginning with a planning phase running from March 2026 through December 2027, to develop a framework for ACO-Medicaid partnership arrangements

serving dually eligible beneficiaries. Whether a decade-long benchmark cycle succeeds in attracting the smaller and rural provider organizations that ACO REACH and ACO PC Flex did not, and whether it produces more consistent financial results than ACO REACH's mixed performance year 2023 results, are questions this report cannot yet answer but will track as LEAD's first performance year approaches in 2027.

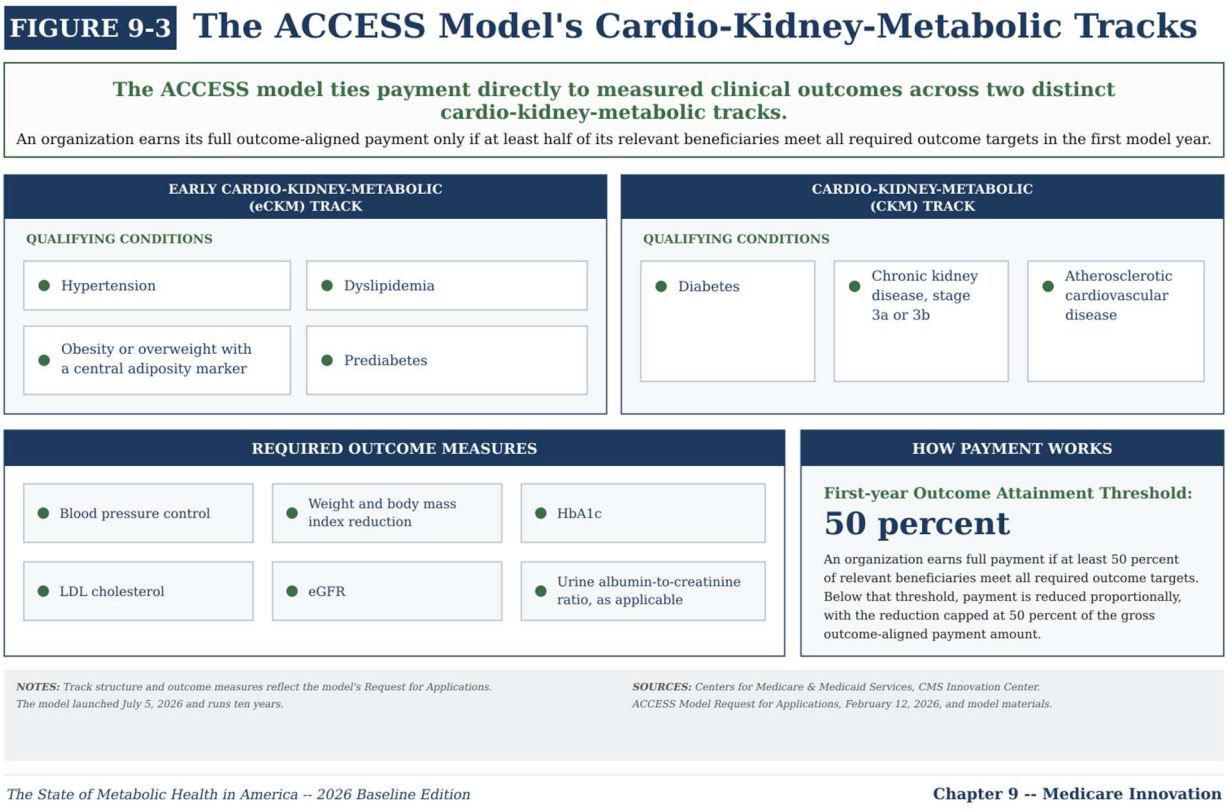


Figure 9-3. The ACCESS Model's Cardio-Kidney-Metabolic Tracks

Sources: Centers for Medicare & Medicaid Services, CMS Innovation Center. ACCESS Model Request for Applications, February 12, 2026, and model materials. Notes: Track structure and outcome measures reflect the model's Request for Applications. The model launched July 5, 2026 and runs ten years.

The ACCESS model, formally the Advancing Chronic Care with Effective, Scalable Solutions model, is this chapter's most directly relevant development for metabolic health specifically. Announced in December 2025 and launching July 5, 2026, ACCESS is a 10-year, voluntary model, running through 2036, that introduces Outcome-Aligned Payments, a recurring, per-beneficiary payment intended to support technology-enabled chronic care management, with payment reduced proportionally, up to a maximum reduction of half the gross amount, where an organization falls short of the model's Outcome Attainment Threshold. ACCESS organizes eligibility and outcome

measurement into four clinical tracks, two of which map directly onto this report's subject matter: an Early Cardio-Kidney-Metabolic track for beneficiaries with hypertension, dyslipidemia, obesity or overweight with a marker of central adiposity, or prediabetes, and a more advanced Cardio-Kidney-Metabolic track for beneficiaries with diabetes, chronic kidney disease at stage 3a or 3b, or atherosclerotic cardiovascular disease. Required outcome measures include blood pressure control or reduction, weight or BMI reduction, hemoglobin A1c control among beneficiaries with prediabetes or diabetes, LDL cholesterol management among beneficiaries with dyslipidemia, and kidney function measures, estimated glomerular filtration rate and urine albumin-to-creatinine ratio, among beneficiaries with chronic kidney disease. CMS has stated that ACCESS-related payments will not affect Medicare Shared Savings Program or ACO REACH benchmark calculations through 2027, but will begin to be incorporated into those calculations starting in 2028.

The Kidney Care Choices model, a continuing CMMI model addressing late-stage chronic kidney disease through financial risk arrangements with Kidney Care Entities, was not among the models terminated in March 2025 and continues through 2026. Because chronic kidney disease is frequently a downstream complication of the diabetes and hypertension prevalence this report documented in Chapter 1, Kidney Care Choices sits adjacent to, though distinct from, the metabolic-health-specific focus of the new ACCESS model, and this report treats it as a related but separate line of Medicare innovation activity rather than conflating the two.

Trends

Two trends define the current Medicare innovation landscape relevant to metabolic health. First, CMMI's model portfolio has contracted and consolidated since early 2025, with several primary-care- and population-health-oriented models ended ahead of schedule and a signature accountable care model, ACO REACH, set to conclude at the end of 2026 in favor of a single, longer-duration successor. Second, and distinct from that contraction, CMS has simultaneously introduced its most granular and most explicitly metabolic-health-focused payment model to date, ACCESS, which ties payment directly to biomarker-level outcomes rather than to total cost of care or utilization alone. These two trends are not in tension so much as reflective of a broader shift in the Innovation Center's approach: fewer, longer-duration, more targeted models, rather than a larger number of shorter, narrower demonstrations.

Because ACCESS has not yet completed a performance period, this report cannot yet apply the second, third, or fourth tiers of its evidence hierarchy for innovation programs, whether the model improved utilization, whether it improved clinical

outcomes, and whether any improvement proved durable, to this specific model. This chapter instead documents the first tier directly: the model has been formally announced, its Request for Applications has been published, and CMS has begun accepting rolling applications with performance periods beginning July 5, 2026 and continuing into 2027 for later applicants under the rolling start structure. Whether ACCESS achieves meaningful provider participation at a scale comparable to, or different from, ACO REACH's 103 ACOs, and whether it produces the biomarker-level improvements its outcome measures target, are the central questions this report will need to track beginning with its 2027 edition.

Policy Implications

ACO REACH's performance year 2023 results, substantial aggregate savings alongside a meaningful minority of participants recording net losses, illustrate a pattern this report has now observed across multiple innovation programs in both Medicare and Medicaid: population-level, aggregate results can obscure considerable variation in outcomes for individual participants or beneficiaries. Any assessment of Medicare innovation models that relies solely on an aggregate savings or spending figure, without examining the distribution of results beneath it, risks overstating how uniformly beneficial a given model has been.

The ACCESS model's design, tying up to half of a participant's payment directly to biomarker achievement, represents a more direct test than this report has yet documented of whether financial incentives aimed squarely at metabolic outcomes change provider behavior and, ultimately, beneficiary health. Because this is a genuinely new payment mechanism in traditional Medicare, this report takes no position on whether it will prove effective, consistent with this report's standing practice of describing rather than predicting the outcome of programs that have not yet been evaluated.

The unresolved interaction between ACCESS payments and ACO benchmark calculations, not counted through 2027 but incorporated beginning in 2028, illustrates a coordination question specific to a period in which Medicare is simultaneously running population-based, total-cost-of-care models such as ACO REACH and LEAD alongside a condition-specific, individual-provider payment model such as ACCESS. How CMS ultimately resolves overlapping accountability between these model types, particularly for beneficiaries who could plausibly be aligned to both an ACO and an ACCESS-participating provider simultaneously, is not yet fully specified in the sources available to this report.

Although ACCESS applies only to Medicare fee-for-service beneficiaries, it represents a notable policy signal beyond Medicare itself. CMS is explicitly tying provider payment to measurable improvement in metabolic biomarkers, blood pressure, weight, HbA1c, and kidney function, rather than solely to utilization or total cost of care. If this approach proves effective, comparable outcome-based payment structures could plausibly influence commercial employer-sponsored health plans, Medicare Advantage contracts, and Medicaid managed care arrangements in later years, connecting this chapter's subject matter back to the employer-sponsored coverage examined in Chapter 3 and the Medicaid managed care landscape examined in Chapters 5 and 8, even though this report takes no position on whether that broader influence will in fact materialize.

This chapter also notes, descriptively rather than as a policy judgment, that ACCESS launches amid a broader federal emphasis on chronic disease prevention and metabolic health specifically, an emphasis reflected in the Administration for a Healthy America proposal discussed in Chapter 6 and in public statements from federal health officials associated with the current administration's chronic disease agenda. Whether that broader federal emphasis increases the attention, funding, or provider participation ACCESS ultimately receives, relative to a model introduced in a different policy environment, is not a question this report can answer with the evidence currently available, but it is a contextual factor this report will continue to monitor.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, MV-01 through MV-08, continuing the stable-identifier convention established in Chapters 1 through 8. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
MV-01	CMMI models selected for early termination, March 2025	4 models selected (Primary Care First, Making Care Primary, ESRD Treatment Choices, Maryland Total Cost of Care); CMS projected nearly $750 million in taxpayer savings. Termination dates varied by model and were subject to model-specific implementation and rulemaking; Making Care Primary ended June 30, 2025

ID	Metric	2026 Baseline Value
MV-02	ACO REACH end date / successor	Ends Dec. 31, 2026; succeeded by LEAD (Jan. 2027-2036)
MV-03	ACO REACH participation	74 ACOs in PY2026; 103 ACOs and 161,765 participating providers and organizations serving an estimated 2.5 million Traditional Medicare beneficiaries in PY2025; 132 ACOs in PY2023
MV-04	ACO REACH PY2023 gross savings relative to model benchmarks	Approximately $1.643 billion, a 5.8% gross savings rate relative to retrospective adjusted performance-year benchmarks. Financial settlement divided this into $694.6 million in net savings to CMS (2.6%) and $948.4 million in net savings to participating ACOs (3.4%)
MV-05	ACO REACH PY2023 ACOs with net losses	36 of 132 participating ACOs (27%) accrued net losses; 96 (73%) earned net savings from financial settlement
MV-06	ACCESS model launch / duration	Launched July 5, 2026; 10-year model running through 2036, with rolling participant start dates including August 17 and October 1, 2026
MV-07	ACCESS first-year Outcome Attainment Threshold and maximum payment reduction	First-year Outcome Attainment Threshold of 50%: an organization earns full payment if at least 50% of relevant beneficiaries meet all required outcome targets, with payment reduced proportionally below that threshold and the reduction capped at 50% of the gross Outcome-Aligned Payment amount. CMS does not withhold half of every payment and later return it; the reduction applies only to the extent performance falls short of the threshold
MV-08	ACO PC Flex participation versus original CMS planning estimate	24 participating ACOs at the January 1, 2025 launch, serving approximately 349,000 Traditional Medicare beneficiaries, and 23 in PY2026, against approximately 130 ACOs CMS originally planned to select. The 130 figure was an initial planning estimate rather than a statutory target or minimum threshold. No additional application round is currently planned

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

This chapter can report only the first tier of its own evidence hierarchy for innovation programs for the ACCESS model: that it has been announced, specified in detail, and has begun accepting participants. This report has not identified, and given the model's July 2026 launch could not plausibly identify, any utilization or clinical outcome data for ACCESS at the time of this chapter's preparation. Readers should not infer from this chapter's detailed description of the model's design that its effectiveness has been demonstrated; design and demonstrated effectiveness are, per this report's evidence hierarchy, two separate questions, and only the first can currently be answered.

The ACO REACH savings and loss figures in this chapter reflect performance year 2023 results specifically, the most recent full-year results this report could identify at the time of preparation, and may not reflect the financial methodology changes CMS implemented beginning in performance year 2026 in response to its own evaluation findings. This report cannot yet assess whether those methodology changes narrow or widen the share of participating ACOs recording net losses. A further and more consequential distinction applies to MV-04. CMS calculates the financial and quality results reported here against benchmarks set for model participants, whereas the model's formal evaluation measures spending relative to a control group, estimating what would have occurred absent the model. CMS states that the evaluation results typically reflect more conservative financial findings, and the two approaches have diverged in sign: for performance year 2022, the evaluation identified $632.2 million in losses against $855.6 million in savings measured relative to benchmarks. The gross and net savings figures in MV-04 are therefore benchmark-relative settlement amounts and should not be read as CMS's estimate of net savings to Medicare attributable to the model. CMS released updated evaluation information on July 10, 2026 reporting improved quality and reduced gross spending across the model's first four performance years, and stated that results for 2025 and 2026 will reflect methodology changes intended to improve the likelihood of net Medicare savings.

This chapter's account of CMMI's March 2025 model terminations draws on legal and policy analysis rather than a single consolidated CMS notice enumerating the full rationale for each termination; this report is not aware of a single public CMS document providing a comprehensive, program-by-program accounting of the evidence basis for each of the four terminations described in this chapter.

Chapter Summary

This chapter has examined Medicare's innovation activity most relevant to metabolic health during a period of substantial change in the CMS Innovation Center's model portfolio. Several models have ended ahead of schedule since early 2025, Medicare's flagship total-cost-of-care ACO model, ACO REACH, will conclude at the end of 2026 in favor of the longer-duration LEAD model, and CMS has introduced its most explicitly metabolic-health-focused payment model to date, ACCESS, which ties Medicare payment directly to blood pressure, weight, HbA1c, LDL cholesterol, and kidney function targets. This chapter has applied the same evidence hierarchy this report established in Chapter 8 for Medicaid innovation programs, and has found that ACCESS, the model most central to this chapter's subject matter, can currently be assessed only on its first tier, successful design and launch, with utilization, clinical outcome, and durability evidence necessarily unavailable this early in the model's life.

This chapter has aimed to describe what Medicare has built, rather than to anticipate what it will achieve. The 2027 edition of this report will be the first opportunity to examine whether the ACCESS model has begun to generate the kind of utilization and clinical outcome evidence this chapter could not yet report, and whether the transition from ACO REACH to LEAD proceeds as CMS currently anticipates.

Having now examined Medicaid innovation in Chapter 8 and Medicare innovation in this chapter, this report's next editions will need to determine whether a comparable innovation lens applied to employer health benefit design, the subject of Chapter 3, would extend this report's interventions-focused analysis to the private-sector side of the system as well.

Looking Ahead to the 2027 Edition

- Whether the ACCESS model achieves meaningful provider participation across its eCKM and CKM tracks specifically, and whether early operational or enrollment data become available before a full performance period concludes.
- Whether CMS publishes any preliminary utilization or process data for ACCESS ahead of its first full clinical outcome evaluation, and if so, what it shows.
- How the transition from ACO REACH to the LEAD model proceeds during 2026 and into LEAD's first performance year in 2027, including whether currently participating ACO REACH organizations move to LEAD, to the Medicare Shared Savings Program, or exit federal ACO models entirely.

- Whether CMS finalizes the specific mechanism for incorporating ACCESS payments into ACO benchmark calculations beginning in 2028, and what that mechanism means for beneficiaries potentially aligned to both an ACO and an ACCESS participant.
- Whether Kidney Care Choices is renewed, allowed to conclude, or succeeded by a new model when its current authorization ends, given its relevance to diabetes- and hypertension-related chronic kidney disease.

Questions We Still Cannot Answer

- Will the ACCESS model's outcome-aligned payment structure produce measurable improvement in blood pressure, weight, HbA1c, or kidney function among enrolled beneficiaries, and if so, how quickly?
- Will provider participation in ACCESS concentrate in the eCKM and CKM tracks most relevant to metabolic health, or in the musculoskeletal and behavioral health tracks, and what would that distribution suggest about which chronic conditions technology-enabled, outcome-based payment is best suited to address?
- Why did roughly 27% of ACO REACH participants record net financial losses in performance year 2023 despite substantial aggregate model savings, and does the financial methodology CMS adopted for performance year 2026 change that distribution?
- Will the LEAD model's 10-year performance horizon produce more stable participation and more consistent financial results than ACO REACH's four-year cycle, and is model duration itself a meaningful driver of participant success?
- How will CMS resolve accountability for beneficiaries potentially aligned to both a total-cost-of-care ACO model and an outcome-based, condition-specific model like ACCESS simultaneously?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

Sources

- Centers for Medicare & Medicaid Services, CMS Innovation Center. ACO REACH Model program materials; PY2024 and PY2023 ACO REACH Financial and Quality Results; ACO REACH Model Performance Year 2026 Model Update.

- Centers for Medicare & Medicaid Services, CMS Innovation Center. Long-term Enhanced ACO Design (LEAD) Model. Announced December 18, 2025; model overview available at cms.gov/priorities/innovation/innovation-models/lead.
- Centers for Medicare & Medicaid Services, CMS Innovation Center. Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model: Request for Applications. February 12, 2026. Model materials available at cms.gov/priorities/innovation/innovation-models/access.
- Centers for Medicare & Medicaid Services, CMS Innovation Center. Kidney Care Choices (KCC) Model program materials.
- Secondary commentary and trade coverage, cited for contemporaneous interpretation and industry reaction only; model design, timing, and financial parameters in this chapter are drawn from the CMS Innovation Center materials above rather than from these sources: Hogan Lovells, "Center for Medicare and Medicaid Innovation (CMMI) to End Four Payment Models in Cost-Cutting Effort" (March 2025); Epstein Becker Green, "ACCESS Model: CMMI's New Technology-Enabled Chronic Care Model"; ArentFox Schiff, "CMS Innovation Center Unveils ACCESS Model to Expand Technology-Supported Care for Chronic Disease"; Bass, Berry & Sims PLC, "Taking the LEAD: CMS Unveils the New LEAD Model, Focused on Long-Term Primary Care Success"; ATI Advisory, "ACO REACH Sunset: Operational Scenarios and Strategic Considerations for 2027"; Healthcare Brew, "Potential End of ACO REACH Brings 'Question Mark' to Value-Based Care" (September 2025); American Hospital Association News, "CMS to Launch Payment Model for Expansion of Technology-Supported Care Access" (December 2025); American Health Care Association, "CMS Launches ACCESS Model to Improve Chronic Care in Medicare FFS Through Technology."

Chapter 10
Employer Innovation

Chapter 10 Key Findings

- Employer GLP-1 coverage design has shifted decisively away from simple inclusion or exclusion decisions and toward managed-access models: KFF's 2025 Employer Health Benefits Survey found that approximately 34% of firms covering GLP-1 medications for weight loss now require enrollees to meet with a dietitian, case manager, or therapist, or to participate in a lifestyle program, in order to have the medications covered. KFF's 2024 survey reported these requirements in separate categories rather than as a single combined measure, so a clean year-over-year comparison is not available.
- KFF's 2025 Employer Health Benefits Survey found that 19% of firms with 200 or more workers cover GLP-1 medications when used primarily for weight loss, rising to 43% among firms with 5,000 or more workers, with many reporting that utilization and cost impact exceeded their initial projections.
- Major pharmacy benefit managers have introduced employer-facing GLP-1 utilization management programs that combine negotiated pricing with clinical guardrails; Cigna's EncircleRx program, one of the largest, had enrolled approximately nine million lives by 2026 according to the company's own investor disclosures, up from roughly five million in late 2024.
- Virta Health, a vendor-based, intensive lifestyle and nutritional intervention for type 2 diabetes offered by a number of self-funded employers, has published peer-reviewed, company-sponsored outcomes showing that among the 122 participants who completed five years of continuous engagement, 20% achieved diabetes remission and 61.3% sustained at least 5% weight loss, among this report's few examples of multi-year, durability-stage evidence for an employer-available metabolic health intervention.
- Those Virta Health outcomes derive from a non-randomized, single-arm, company-funded and company-authored study design without an independent control group, a methodological limitation distinct from, but comparable in kind to, the sponsorship and design considerations this report has flagged for other interventions in prior chapters.
- Independent long-term evidence remains limited. During preparation of the 2026 Baseline Edition, this review did not identify a multi-year evaluation of a major

employer condition-management vendor that was both independently funded and independently authored and that reported longitudinal clinical and economic outcomes in an employer-sponsored population. This finding reflects the literature search conducted for this edition and should not be interpreted as proof that no such study exists. It is reported here as a documented gap rather than as a baseline metric. The practical consequence is that the evidence base for this entire category of employer-purchased metabolic health intervention remains substantially vendor-reported rather than independently verified.

- Employer benefit consultants and pharmacy benefit managers broadly agree that pairing GLP-1 coverage with mandatory lifestyle program participation is intended to both improve outcomes and satisfy IRS guidance on eligible medical expenses, though this report could not identify independent evidence quantifying how much of the outcome difference between paired and unpaired coverage designs is attributable to the lifestyle program itself.

Introduction

Chapter 3 examined employer-sponsored health coverage broadly: enrollment, cost, and the general shape of employer benefit design as it relates to metabolic health. Chapter 8 examined Medicaid's experimental use of Section 1115 waivers, and Chapter 9 examined Medicare's newest payment models. This chapter completes that interventions-focused sequence by asking the same question of the employer-sponsored system: what specific innovations are self-funded and fully insured employers adopting to manage metabolic health, and what evidence exists that those innovations work? This chapter applies the same evidence hierarchy this report established in Chapter 8 and applied again in Chapter 9, whether a program was implemented, whether it improved utilization, whether it improved clinical outcomes, and whether any improvement is durable, to the employer-sponsored side of the system for the first time.

This chapter's central finding differs in kind from Chapters 8 and 9. Where Medicaid's Healthy Opportunities Pilots offered independent evaluation results and Medicare's ACCESS model offered a program too new to evaluate at all, the employer-sponsored condition-management vendor market offers a third pattern: multi-year outcome data exists for at least one prominent vendor, but that data is company-sponsored and company-authored rather than independently evaluated. This chapter treats that distinction as itself an important finding, since it means the evidentiary reliability, not merely the existence, of outcome data varies across the interventions this report has now examined in Chapters 8 through 10.

This chapter's evidence base draws on Mercer's National Survey of Employer-Sponsored Health Plans, KFF's 2025 Employer Health Benefits Survey, the Business Group on Health's 2026 employer surveys, pharmacy-benefit-manager and insurer disclosures of their own program enrollment and design, and Virta Health's peer-reviewed published outcomes literature, including its five-year extension study published in Diabetes Research and Clinical Practice. This report has not independently verified any vendor's proprietary outcome claims beyond what has been published in peer-reviewed literature, and states plainly, as it does throughout this report, where a claim rests on a vendor's own publication rather than independent verification. Employer prior-authorization criteria for weight-management GLP-1 coverage vary materially by plan and pharmacy benefit manager, and this report did not identify a single national employer standard. The threshold reported as EN-04 is specific to one program, Evernorth's EncircleRx, and is stricter than the general FDA-approved obesity-treatment eligibility criteria of a body mass index of 30, or 27 with one qualifying weight-related condition, which are clinical treatment criteria rather than an employer coverage rule. Readers should not treat any single threshold as representative of employer practice generally.

Why This Matters

Employers occupy a distinct position in the metabolic health system this report has examined: unlike Medicare and Medicaid, which operate under substantial statutory and regulatory constraint, employers have considerable latitude to design benefits, select vendors, and structure coverage conditions largely as they see fit, subject to general nondiscrimination and ERISA requirements. That latitude means employer-sponsored innovation can move faster than public program innovation, but it also means the evidence base behind a given employer's benefit design decision may rest more heavily on vendor marketing materials than on independent evaluation, a distinction this report considers directly relevant to any employer, consultant, or benefits administrator relying on this report to inform purchasing decisions.

National Snapshot

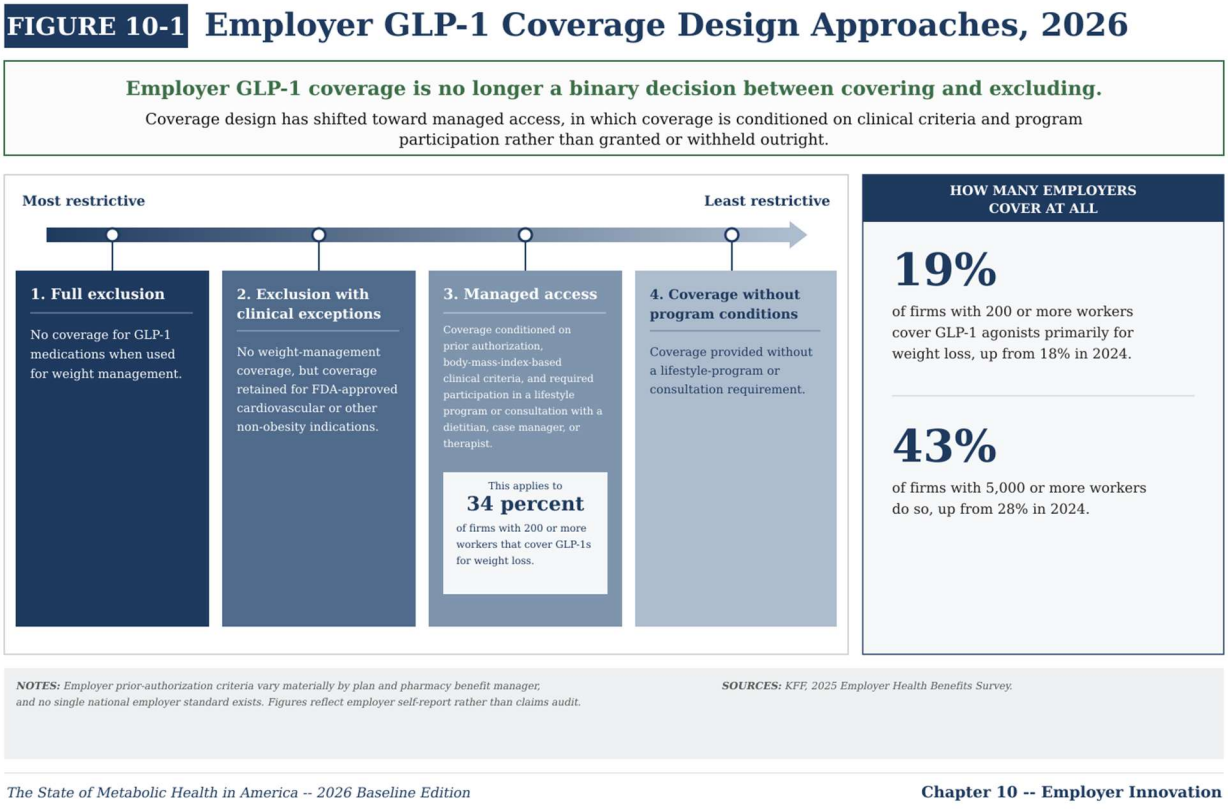


Figure 10-1. Employer GLP-1 Coverage Design Approaches, 2026

Source: KFF, 2025 Employer Health Benefits Survey. Notes: Employer prior-authorization criteria vary materially by plan and pharmacy benefit manager, and no single national employer standard exists. Figures reflect employer self-report rather than claims audit.

Employer approaches to GLP-1 coverage have converged, over 2025 and 2026, on a small number of recurring design patterns rather than the binary include-or-exclude decisions common in 2023 and 2024. According to KFF's 2025 Employer Health Benefits Survey, approximately 34% of firms that cover GLP-1 medications for weight loss now require enrollees to meet with a dietitian, case manager, or therapist, or to participate in a lifestyle program, as a condition of coverage among firms with 200 or more workers, typically alongside prior authorization, body-mass-index-based clinical eligibility criteria above the FDA label, and periodic reauthorization tied to documented weight loss or continued clinical need. KFF's 2025 Employer Health Benefits Survey found that 19% of firms with 200 or more workers cover GLP-1 medications when used primarily for weight loss, rising to 43% among firms with 5,000 or more workers, and many respondents reporting that utilization and cost exceeded their initial projections. Coverage for GLP-1 medications used for their original, FDA-approved indications, principally type 2 diabetes, and for later-approved indications such as cardiovascular

risk reduction, is substantially more widespread and less contested than coverage for weight management specifically.

Business Group on Health, whose annual survey draws on very large employers and asks detailed benefit strategy questions, provides a complementary and largely consistent picture. Its 2026 survey found that employers projected a median health care cost trend of 9% for 2026, falling to 7.6% after planned plan design changes, and that 79% of employers were already seeing increased utilization of obesity medications. Among the surveyed employers covering GLP-1s for weight management, 67% did so as of early 2026, though only 72% of those said they were likely to continue that coverage into 2027, and utilization management was near-universal, with the large majority applying prior authorization, requiring participation in a weight management program, or imposing clinical eligibility criteria beyond the FDA label. The single most consequential Business Group on Health finding for this report's purposes, however, concerns the gap between expectation and observed result: while more than half of employers covering GLP-1s for weight management expect the medications to produce significant clinical benefit, few have yet observed measurable improvement, such as lower obesity prevalence or reduced bariatric surgery volume, in their own aggregated claims data. This directly reinforces a theme recurring throughout this report, that utilization is easier to measure than health improvement, and that the two should not be assumed to move together over short observation windows.

The same survey data also indicate that employers are becoming more active purchasers rather than passive buyers of these programs: a substantial share of employers report changing vendors or issuing new requests for proposals as they reassess vendor performance, a shift consistent with the growing employer scrutiny of benefit value this chapter documents throughout. This report cites Business Group on Health, Mercer, and KFF as industry survey sources, distinct in kind from independent peer-reviewed evaluation, and treats their employer-reported figures as credible evidence of what employers are doing and observing, rather than as independent verification of whether a given intervention improves health.

Major national health plans and their affiliated pharmacy benefit managers have built employer-facing utilization management programs specifically around GLP-1 medications, combining negotiated manufacturer pricing with clinical guardrails intended to concentrate spending on beneficiaries most likely to benefit. Cigna's EncircleRx program, offered to employer clients through its pharmacy benefit management operation, had enrolled approximately nine million lives by 2026 according to the company's own investor disclosures, up from roughly five million in

late 2024, and pairs GLP-1 utilization management with negotiated pricing and outcomes guarantees. Elevance Health's CarelonRx and UnitedHealthcare's Optum Rx apply comparable prior authorization frameworks combining body-mass-index thresholds, comorbidity requirements, and documented trial of lifestyle intervention, for employer groups that elect to cover GLP-1s for weight management specifically. Benefits consultants generally advise that self-funded employers with transparent pharmacy benefit manager contracts, rather than fully bundled or opaque contracts, are better positioned to capture the negotiated savings these programs are designed to generate, though this report has not independently verified the magnitude of that difference across employers.



Figure 10-2. Virta Health Five-Year Outcomes Among Study Completers

Sources: McKenzie AL, Volk BM, Phinney SD, et al. 5-Year effects of a novel continuous remote care model with carbohydrate-restricted nutrition therapy including nutritional ketosis in type 2 diabetes: an extension study. Diabetes Res Clin Pract. 2024;217:111898. doi:10.1016/j.diabres.2024.111898. Notes: Remission and reversal are distinct measures. Remission excludes all glucose-lowering medication; reversal permits metformin.

Vendor-based condition-management programs represent a second major category of employer innovation this chapter examines, and the market is considerably larger than any single company. Employers selecting digital or virtual metabolic health vendors in 2026 choose among a substantial field that includes, among others, Omada Health, Vida Health, Teladoc Health, Lark, and Twin Health, alongside the diabetes-management programs formerly operated under the Livongo brand now absorbed into larger platforms. This report does not evaluate these vendors individually and does not endorse or rank any of them; naming them here is intended only to acknowledge that the employer metabolic health vendor market is broad rather than to single any company out. This chapter examines Virta Health in detail not because it is the only, the largest, or a recommended vendor, but because it currently offers the most mature publicly available durability data, a five-year, peer-reviewed outcomes record, of any vendor this report could identify, which makes it the most useful available illustration of both the promise and the evidentiary limits of this category as a whole.

Virta Health, an intensive nutritional and lifestyle intervention for type 2 diabetes offered by a number of self-funded employers, offers this report's most complete published outcomes record among such vendors. A five-year extension study, published in 2024 in Diabetes Research and Clinical Practice, followed participants originally enrolled in a two-year comparison of Virta's continuous care intervention against usual diabetes care; among the 122 participants who remained in the study for the full five years, 20% achieved diabetes remission, defined as sub-diabetic blood sugar levels without diabetes medication for at least three months, 33% achieved diabetes reversal, a related but distinct measure allowing continued metformin use, and 61.3% sustained at least 5% weight loss. Earlier company-published results from the same research program reported an average hemoglobin A1c reduction of 1.3% at one year alongside significant reductions in diabetes medication use. This combination of clinical outcome data and multi-year durability data is, among the interventions this report has examined across Chapters 8 through 10, comparatively rare.

The scale of employer investment underlying these coverage and vendor decisions is substantial and growing. Mercer's 2025 National Survey of Employer-Sponsored Health Plans, which draws on responses from more than 2,000 employers and is among the largest statistically representative employer health benefits surveys conducted in the United States, found that total health benefit cost reached an average of $17,496 per employee in 2025 and is projected to rise 6.7% to more than $18,500 per employee in 2026, the largest projected increase in fifteen years, with prescription drug spending, up 9.4% among large employers, and GLP-1 medications specifically identified as a central driver. The table below summarizes the principal categories of employer metabolic-

health-related investment this chapter and Chapter 3 have examined, drawn principally from Mercer survey data, with the coverage-condition figure drawn from KFF; it is intended to convey relative scale and prevalence rather than precise per-employer spending, which varies widely by employer size, funding structure, and benefit design.

Investment category	Prevalence / scale among large employers	Source
GLP-1 coverage for weight management	~49-50% of large employers cover; 77% call managing GLP-1 cost a top concern	Mercer 2025-2026
Prescription drug spending growth	+9.4% in 2025; ~9% projected 2026 (fastest-growing category)	Mercer 2025-2026
Standalone specialized diabetes program	~32% of large employers (2025)	Mercer 2025
Standalone musculoskeletal program	~28% of large employers (2025)	Mercer 2025
Lifestyle program or clinician consultation required for GLP-1 coverage	34% of covering firms with 200+ workers	KFF 2025 EHBS
Independent / transparent pharmacy management program	23% in 2026, up from 18% in 2025	Mercer 2026
GLP-1 coverage dropped or tightened	6% dropped in 2026; ~27-30% tightened utilization controls	Mercer 2026

This report notes a genuine discrepancy in the underlying survey data that it does not attempt to resolve: Mercer's survey reports that roughly half of large employers cover GLP-1 medications for weight management, while KFF's 2025 Employer Health Benefits Survey reports 19% of firms with 200 or more workers, and 43% of those with 5,000 or more workers, do so. This difference likely reflects differences in survey population, employer size thresholds, question wording, and the distinction between offering coverage and covering weight-loss use specifically, but this report cannot fully reconcile the two figures and presents both with their respective sources attached rather than choosing one.

Trends

Two trends define employer-sponsored metabolic health innovation as this report observes it in 2026. First, employer GLP-1 coverage design has matured from a binary coverage decision into a more granular set of clinical and behavioral conditions,

mirroring, though independently of, the Medicaid-level retrenchment in optional GLP-1 coverage this report documented in Chapter 5; employers, like state Medicaid programs, appear to be converging on managed-access models that pair coverage with clinical criteria and lifestyle program participation rather than choosing between unconditional coverage and exclusion. Second, the evidentiary basis for the vendor-based condition-management programs employers increasingly purchase alongside or instead of pharmaceutical coverage remains substantially vendor-generated; this report identified published, peer-reviewed, multi-year outcome data for at least one major vendor, but that data comes from a company-funded, company-authored study design, and this report could not identify a comparable independent evaluation for this vendor or any other in this category.

These two trends interact in a way this chapter considers noteworthy: the same roughly one-third of employers pairing GLP-1 coverage with mandatory lifestyle program participation are, in many cases, purchasing that lifestyle program from vendors whose outcome evidence has not been independently verified, meaning an employer's coverage design decision and its vendor selection decision may both rest on evidence of comparable, and comparably limited, independent verification.

Policy Implications

The pairing of GLP-1 coverage with mandatory lifestyle program participation, now practiced by approximately 34% of firms offering coverage according to KFF, represents a specific and increasingly common employer answer to a question this report has raised in multiple chapters: whether utilization and cost outcomes can be distinguished from clinical outcomes. Employers adopting this design are, in effect, betting that combining pharmacological and behavioral intervention produces better clinical results than either alone, a reasonable clinical hypothesis this report is not aware of independent, employer-population-level evidence directly testing.

The gap this chapter identifies between Virta Health's published outcomes and the absence of comparable independent evaluation is not a criticism specific to that vendor; this report could not identify a materially more rigorously, independently evaluated alternative anywhere in the employer condition-management vendor market. This gap instead reflects a broader structural feature of employer-purchased health interventions relative to the Medicaid and Medicare programs examined in Chapters 8 and 9: Medicaid's Section 1115 waivers require CMS-approved, typically independent, evaluation as a condition of waiver authority, and Medicare's Innovation Center models are evaluated by CMS or CMS-contracted evaluators; no comparable, generally applicable evaluation requirement governs employer-purchased condition-management

vendors, leaving employers more dependent on vendor-reported evidence than public payers are.

Employers, benefits consultants, and health plan sponsors relying on this report to inform purchasing or coverage design decisions should treat the distinction this chapter draws, between published outcome data and independently verified outcome data, as directly relevant to how much weight a given vendor's reported results should carry in a purchasing decision, independent of whether this report takes any position on that vendor's underlying clinical approach, which it does not.

Several plausible factors may explain why independent evaluation of employer-purchased metabolic health vendors has not developed at a pace comparable to the CMS-required evaluation governing Medicaid and Medicare innovation, though this report can identify these factors without claiming to know their relative weight: employer procurement timelines often move faster than the multi-year horizon an independent randomized evaluation requires; independent evaluations are costly and no single party in the employer market has a clear obligation to fund them; vendors may regard detailed outcome data as proprietary and competitively sensitive; and no regulatory body imposes an evaluation requirement on employer-purchased condition-management programs comparable to the one CMS imposes on Section 1115 waivers. Whichever of these factors predominate, the practical result is the evidentiary gap this chapter documents.

More broadly, the employer market has historically rewarded innovation more quickly than it has rewarded independent validation. Vendors frequently introduce new programs years before independent evaluations become available, a pattern that is not unique to metabolic health and that has characterized many areas of employer-sponsored healthcare innovation. As employer investment in obesity treatment, diabetes management, and metabolic health continues to expand, independent evaluation may itself become an increasingly important differentiator among competing vendors, a development this report will track in future editions but cannot yet report as underway.

The Independent Evidence Gap

Despite billions of dollars in annual employer spending on condition-management vendors, digital therapeutics, navigation services, and obesity interventions, this report identified relatively few independently funded, peer-reviewed, multi-year evaluations of commercially available employer programs. Much of the published evidence continues to originate from the vendors themselves. This observation should not be interpreted as

evidence that these programs are ineffective; rather, it reflects a gap between commercial adoption and independent scientific evaluation.

This gap is the single most important finding of this chapter, and it distinguishes the employer-sponsored side of the metabolic health system from the Medicaid and Medicare programs examined in Chapters 8 and 9, where CMS-required, generally independent evaluation is a condition of program authority. It is also the gap that the research agenda in the following section is intended to address.

Research Needs

Because this chapter has identified a persistent gap between the existence of vendor-reported outcome data and the availability of independent verification, this report notes the specific categories of research that would most improve future editions' ability to evaluate employer-sponsored metabolic health interventions. This section is intended as a standing research agenda that future editions can update rather than a one-time list.

- Independent, randomized controlled trials of employer-available metabolic health vendors, funded and conducted without vendor sponsorship or authorship.
- Multi-employer evaluations that pool outcomes across employers using the same vendor, rather than single-employer or vendor-aggregated results.
- Five-year and longer follow-up establishing durability of clinical outcomes beyond the intervention period, for vendors of all types rather than a single company.
- Economic outcome evaluation, including total cost of care, return on investment, and pharmacy versus medical spending offsets, conducted independently of vendor financial modeling.
- Workforce outcome evaluation, including absenteeism and presenteeism effects, which employers frequently cite as purchasing rationale but which are rarely independently measured.
- Comparative effectiveness research directly comparing pharmacological coverage, lifestyle program participation, and their combination within the same employer population.

2026 Baseline Metrics

The table below consolidates this chapter's headline figures using a new identifier series, EN-01 through EN-06, continuing the stable-identifier convention established in Chapters 1 through 9. As with those series, these identifiers will remain unchanged in every future edition of this report.

ID	Metric	2026 Baseline Value
EN-01	Firms requiring lifestyle program or clinician consultation as a condition of GLP-1 coverage	34% of firms with 200 or more workers that cover GLP-1 agonists for weight loss require enrollees to meet with a dietitian, case manager, or therapist, or to participate in a lifestyle program, in order to receive coverage (KFF 2025 Employer Health Benefits Survey)
EN-02	Firms with 200 or more workers covering GLP-1 agonists primarily for weight loss	19% in 2025, up from 18% in 2024; among firms with 5,000 or more workers, 43%, up from 28% in 2024 (KFF 2025 Employer Health Benefits Survey)
EN-03	Lives enrolled in or eligible for Evernorth's EncircleRx GLP-1 management program	More than 9 million enrolled or eligible lives (Cigna Group investor disclosures, 2025; Evernorth program materials). This counts lives in client populations covered by the program, not people actively receiving GLP-1 medications
EN-04	EncircleRx weight-management GLP-1 coverage threshold	BMI ≥32, or BMI ≥27 with two qualifying weight-related conditions, plus required participation in an approved lifestyle-modification program (Evernorth). This is a program-specific threshold; employer prior-authorization criteria vary materially by plan and pharmacy benefit manager and no single national employer standard was identified
EN-05	Type 2 diabetes remission among Virta five-year study completers (vendor-sponsored study)	20% (n=24) of the 122 participants who completed five years of follow-up. Remission was defined as HbA1c below 6.5% without any glucose-lowering medication for at least three months, consistent with the international consensus definition; metformin was not permitted under this definition. A separate and broader measure, HbA1c below 6.5% on no glucose-lowering medication or only metformin, was met by 32.5% (n=39) of completers, or 23.1% on

ID	Metric	2026 Baseline Value
		an intention-to-treat basis carrying the worst observation forward. Derived from a non-randomized, open-label, company-funded and company-authored extension study; the 122 completers represent approximately 47% of the 262 participants originally enrolled in the intervention arm
EN-06	Sustained ≥5% weight loss among Virta five-year study completers (vendor-sponsored study)	61.3% of the 122 five-year completers sustained at least 5% weight loss, and 39.5% sustained at least 10%. Applies to participants with five-year follow-up data, not to the full original enrollment cohort

Technical Considerations

Several figures in this chapter require methodological caveats that a reference-quality treatment should state explicitly rather than resolve by silent selection of one number over another.

Virta Health's five-year outcomes derive from a study that Virta Health funded and whose authorship includes Virta Health employees, following a two-year, open-label, non-randomized comparison against usual care, with participants who chose to continue followed through an extension period. This design differs materially from an independent, randomized, controlled evaluation: participants were not randomly assigned, the comparison group was not followed on the same schedule as the intervention group through the full five years, and the study's sponsor had a direct commercial interest in favorable results. This report reports the results as published in a peer-reviewed journal, which provides a meaningful, though not equivalent, level of external methodological scrutiny compared to non-peer-reviewed vendor marketing claims, but readers should not treat peer review of a company-funded, company-authored study as equivalent to independent verification.

This report conducted a reasonably thorough search for independent, peer-reviewed, multi-year outcome evaluations of employer-purchased metabolic health condition-management vendors generally, not limited to Virta Health, and could not identify one. This absence may reflect a genuine gap in the independent research literature, the relative youth of many vendors in this category, or limitations in this report's search

rather than definitive proof that no such evaluation exists anywhere; this report states its search process honestly rather than asserting a negative with more confidence than is warranted.

The 34% figure for firms pairing GLP-1 coverage with a lifestyle-program or clinician-consultation requirement, and the roughly one-in-five figure for large employers covering GLP-1s for weight loss, both derive from KFF's employer survey methodology, which rely on employer self-report rather than claims data audit, and which this report cannot independently verify beyond citing the surveying organizations directly.

Chapter Summary

This chapter has completed the interventions-focused sequence begun in Chapter 8, examining how self-funded and fully insured employers are innovating in metabolic health benefit design and vendor selection. Employer GLP-1 coverage has converged on managed-access models pairing pharmacological coverage with lifestyle program requirements, a pattern with a direct parallel to the state-level Medicaid coverage retrenchment documented in Chapter 5. This chapter's most consequential finding, however, concerns evidence quality rather than coverage design: at least one major condition-management vendor has published genuine multi-year clinical and durability outcome data, a rarity among the interventions this report has examined, but that data is company-sponsored rather than independently evaluated, and this report could not identify a more rigorously evaluated alternative anywhere in this vendor category.

This chapter has aimed to state that evidentiary gap plainly rather than either dismissing vendor-published outcomes as worthless or treating them as equivalent to independent evaluation. Both would misrepresent what this report was actually able to verify. Future editions of this report will continue to monitor whether independent evaluations of employer-purchased metabolic health vendors emerge, and will apply the same evidence hierarchy consistently as that evidence base develops.

Having now examined Medicaid innovation, Medicare innovation, and employer innovation in Chapters 8 through 10, this report's next editions will need to determine whether further chapters addressing food systems, community health, or measurement itself would extend this interventions-focused analysis further, a decision this report's editorial team has not yet made.

Looking Ahead to the 2027 Edition

- Whether an independent, peer-reviewed, multi-year evaluation of any employer-purchased metabolic health condition-management vendor is published, addressing the evidentiary gap this chapter identifies.
- Whether the share of employers pairing GLP-1 coverage with mandatory lifestyle program participation continues to rise beyond the approximately 34% KFF identified in 2025, and whether that trend converges further with the Medicaid coverage design patterns documented in Chapter 5.
- Whether major pharmacy benefit manager GLP-1 utilization management programs, such as Cigna's EncircleRx, publish independent outcomes data beyond enrollment and coverage figures.

- Whether new entrants to the employer condition-management vendor market adopt independent evaluation as a market differentiator, given the evidentiary gap this chapter documents across the category generally.
- Whether KFF's and Mercer's next annual employer benefits surveys show continued growth, plateau, or reversal in employer GLP-1 coverage for weight management specifically.

Questions We Still Cannot Answer

- How much of the clinical benefit reported in company-sponsored vendor outcome studies would persist under an independent, randomized evaluation design, and is there any category of employer-purchased metabolic health vendor for which such an evaluation currently exists?
- Does pairing GLP-1 coverage with mandatory lifestyle program participation produce better clinical outcomes than GLP-1 coverage alone, and if so, by how much, at the population level across employers generally rather than within a single vendor's own reported results?
- Why has independent, non-vendor-funded evaluation of employer condition-management vendors not developed at a pace comparable to CMS-required evaluation of Medicaid and Medicare innovation models, and what would need to change for it to do so?
- How consistent are employer GLP-1 coverage design decisions, lifestyle program pairing, BMI thresholds, and reauthorization requirements, across employers of different sizes and industries, and does that consistency affect outcomes?
- Will employers increasingly demand independent evaluation as a condition of vendor selection, comparable to how CMS requires evaluation as a condition of Section 1115 waiver authority, and would that demand measurably improve the evidence base this chapter found lacking?

Future editions of this report will return to these questions directly and will report honestly on what has and has not been learned in the intervening year.

Sources

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- KFF. 2025 Employer Health Benefits Survey.

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Technical Appendix A
Source & Evidence Guide

This appendix consolidates the sourcing and evidentiary standards applied throughout this report into a single technical reference, rather than repeating the same methodological explanation in every chapter where it becomes relevant. It has two parts: a master source table classifying the recurring data sources this report relies on by confidence level, and an Evidence Classification Framework used, primarily in Chapters 8 through 10, to classify the strength of evidence behind a specific program, model, or intervention's claimed effectiveness. These are related but distinct systems: the source table below classifies how reliable a data source is for establishing a fact; the Evidence Classification Framework classifies how reliable the evidence is that a specific intervention works. A single chapter can, and often does, draw on a High Confidence source, such as CMS claims data, to report that a Level D or Level E outcome, such as a vendor's self-published marketing claim, is what a specific vendor asserts about its own product.

Guiding Principles

The purpose of this appendix is to ensure that every statistic, trend, and conclusion presented in this report is based upon transparent, reproducible, and consistently evaluated evidence. These standards are intended to remain stable across future editions so that year-to-year comparisons reflect changes in the underlying data rather than changes in editorial methodology.

Scope of the Report

This report is intended to describe the current state of metabolic health in the United States using the best publicly available evidence. Unless explicitly stated otherwise, the report does not attempt to establish causality, make clinical recommendations, or endorse specific health care interventions. Program evaluations are presented separately from population surveillance data and are evaluated under the Evidence Classification Framework contained in this appendix.

Version Control

Because this appendix is intended to govern every future edition of this report, changes to it are tracked explicitly rather than made silently.

Field	Value
Appendix Version	1.0
Effective Edition	2026 Baseline Edition
Date Adopted	August 2026
Last Revised	August 2026 (original adoption; no revisions yet)
Summary of Changes	Not applicable; this is the initial version adopted with the 2026 Baseline Edition.
DOI (if assigned)	10.5281/zenodo.22772957

Confidence Classifications

Every recurring source in the table below is assigned one of three confidence classifications, used consistently across all ten chapters of this report.

High Confidence

Federal administrative data, nationally representative surveys using direct measurement or comprehensive enrollment records, or well-established recurring publications from bodies such as the Congressional Budget Office or the Medicaid and CHIP Payment and Access Commission, with transparent, publicly documented methodology.

Moderate Confidence

Reputable employer or industry surveys, independent policy organization analyses, or peer-reviewed studies with recognized limitations, narrower populations, or reliance on self-report rather than direct measurement.

Emerging Evidence

Early research, single-arm or company-sponsored studies, demonstration projects and pilots without completed independent evaluation, preprints, or findings that require further validation before this report would treat them as established.

Master Source Table

The table below classifies the sources this report relies on most frequently across multiple chapters. It is not a complete bibliography; each chapter's own Sources section provides the complete citation list for that chapter's specific claims.

Source	Type	Update Frequency	Geographic Scope	Confidence
CDC / NHANES	Federal survey (physical exam + labs)	~2-year cycles	National	High
CDC / BRFSS	Federal survey (self-report)	Annual	State/national	High
CMS National Health Expenditure Accounts	Federal administrative	Annual	National	High
CMS Medicaid/Medicare claims & enrollment (CMS-64, MBES, CCW)	Federal administrative	Monthly/annual	National/state	High
CMS Innovation Center (CMMI) model materials	Federal program documentation	Per model	National	High
Congressional Budget Office (CBO)	Federal budget/policy analysis	Per legislative cycle	National	High
MACPAC (Medicaid and CHIP Payment and Access Commission)	Federal advisory body analysis	Ongoing/annual	National/state	High
U.S. Food and Drug Administration	Federal regulatory	Per approval/action	National	High
American Diabetes Association Economic Report	Professional society, quinquennial	Every 5 years	National	High

Source	Type	Update Frequency	Geographic Scope	Confidence
American Heart Association Statistical Update	Professional society	Annual	National	High
KFF (Employer Health Benefits Survey, trackers)	Nonprofit research organization survey/tracker	Annual	National	High
Health Affairs (peer-reviewed literature)	Peer-reviewed journal	Per study	Varies	High
Mercer National Survey of Employer-Sponsored Health Plans	Employer survey	Annual	National	Moderate
WTW / Aon / PwC employer surveys	Employer/consulting survey	Annual	National	Moderate
Business Group on Health surveys	Large-employer member survey	Annual	National (large employers)	Moderate
Trust for America's Health (State of Obesity, funding reports)	Nonprofit policy analysis of federal data	Annual	National/state	Moderate
de Beaumont Foundation workforce estimates	Nonprofit workforce research	Periodic	National	Moderate
CDC Data Project (independent appropriations tracker)	Independent tracking organization	Ongoing	National	Moderate
American Action Forum / think tank budget analyses	Policy institute analysis	Per event	National	Moderate
Vendor-published outcomes (e.g., Virta Health)	Company-sponsored, peer-reviewed	Per study	Vendor population	Emerging

Note: Inclusion in this registry does not imply that every publication produced by an organization is used or receives the same confidence classification; classifications apply only to the specific recurring source types identified above.

The table below extends the same source registry with two additional dimensions: each source's primary purpose within this report, and the typical limitation a reader should

bear in mind when relying on it. This second table is presented separately from the table above, rather than as additional columns on the same table, purely for legibility; the two tables share the same source order and should be read together.

Source	Primary Purpose	Typical Limitations
CDC / NHANES	Clinical prevalence (measured)	Smaller subgroup sample sizes; ~2-year lag to publication
CDC / BRFSS	State-level prevalence (self-report)	Self-report; understates true prevalence for underdiagnosed conditions
CMS National Health Expenditure Accounts	National spending	Aggregate only; not disaggregated by specific condition
CMS Medicaid/Medicare claims & enrollment	Enrollment, cost, utilization	Claims-based; misses undiagnosed conditions and non-billed care
CMS Innovation Center (CMMI) model materials	Program design and status	Describes design, not independently evaluated outcomes
Congressional Budget Office (CBO)	Budget and coverage projections	Modeled projections, not observed outcomes
MACPAC	Medicaid policy analysis	Advisory body analysis; not primary data collection
U.S. Food and Drug Administration	Regulatory status/approvals	Approval status only; not effectiveness in general practice
American Diabetes Association Economic Report	Diabetes cost estimates	Published only every 5 years; can be several years stale
American Heart Association Statistical Update	Cardiovascular prevalence/cost	Aggregates multiple underlying sources of varying vintage
KFF	Employer benefit design and cost	Employer self-report; large-employer skew
Health Affairs	Peer-reviewed policy research	Individual study limitations vary; check each study
Mercer	Employer benefit cost trend	Employer self-report survey
WTW / Aon / PwC	Employer benefit cost trend	Employer self-report survey; methodology varies by firm
Business Group on Health	Large-employer strategy	Limited to large-employer membership; smaller sample

Source	Primary Purpose	Typical Limitations
Trust for America's Health	Obesity/public health policy tracking	Secondary analysis of federal data, not primary collection
de Beaumont Foundation	Public health workforce	Periodic rather than annual; estimates predate recent disruption
CDC Data Project	Federal appropriations tracking	Independent tracker, not an official federal accounting
American Action Forum	Budget/policy analysis	Policy institute perspective; verify against primary budget documents
Vendor-published outcomes (e.g., Virta Health)	Intervention outcome claims	Company-funded/authored; no independent control group

Methodological Notes

The following methodological distinctions recur across this report's chapters and are consolidated here rather than re-explained at each occurrence. Chapters refer back to this appendix when one of these distinctions becomes relevant to a specific figure.

- Administrative claims vs. clinical prevalence. Claims-based counts capture only diagnosed, billed encounters and will understate true prevalence for any condition with a meaningful undiagnosed population, such as chronic kidney disease or obstructive sleep apnea, both examined in Chapter 1.
- Self-reported vs. measured data. Survey data relying on self-reported diagnosis, such as BRFSS hypertension figures, will generally understate prevalence relative to data from direct physical measurement, such as NHANES, a distinction addressed directly in Chapter 7's reconciliation of its state-level hypertension figures against Chapter 1's national figure.
- Enrollment-weighted vs. contract-weighted averages. Aggregate figures describing Medicare Advantage or Medicaid managed care performance can differ substantially depending on whether they are weighted by enrollee count or averaged across contracts or plans without regard to size.
- Cross-sectional vs. longitudinal analyses. A single-year snapshot, such as a one-year cost comparison, cannot establish durability or trend, a distinction this report applies throughout its treatment of innovation programs in Chapters 8 through 10.
- National estimates vs. modeled projections. Figures describing future spending, such as CBO's Medicare spending growth projections in Chapter 4, are modeled

projections built on stated assumptions, not observed outcomes, and should be read with the uncertainty that any multi-year projection carries.

- Statistical projections vs. observed outcomes. Related to the point above: this report distinguishes what a model projects will happen from what has actually been observed to happen, and states which of the two a given figure represents.
- Differences between Medicare, Medicaid, commercial, and employer populations. A prevalence or cost figure drawn from one population, for example Medicare's older, sicker beneficiary population, should not be assumed to generalize to a younger, employer-insured population without adjustment, a distinction this report maintains by keeping its national baseline, Medicare, Medicaid, and employer chapters analytically separate rather than blending their populations together.

Hierarchy of Conflict Resolution

The Methodological Notes above distinguish claims data from measured data, self-reported from directly measured data, cross-sectional from longitudinal analyses, and enrollment-weighted from contract-weighted averages. Those distinctions describe why sources can disagree; the policy below states what this report does when they do.

- Prefer directly measured clinical data over self-reported data.
- Prefer nationally representative datasets over convenience samples.
- Prefer federal surveillance systems over secondary summaries.
- When equally credible sources disagree, explain the methodological differences rather than forcing a single estimate.
- Preserve consistency with prior editions unless there is a compelling scientific reason to change.

This report has applied this hierarchy directly in several places readers can check against the policy above: Chapter 7 reports both NHANES-measured and BRFSS self-reported hypertension figures rather than reconciling them into one number, consistent with the fourth principle; and this report's stable metric identifiers exist specifically to operationalize the fifth principle, preserving prior figures rather than silently restating them under new methodology.

Citation Standards

- Primary sources are preferred whenever available.
- Secondary citations are used only when the primary source is unavailable.

- Every numerical claim should be traceable to its original publication.
- Estimates are labeled as estimates.
- Forecasts and projections are never presented as observed data.

Limitations

Every chapter's Technical Considerations section documents limitations specific to that chapter's figures. This section consolidates the limitations that recur across the report as a whole, so that a reader evaluating this publication's overall reliability can see them gathered in one place rather than inferring them from ten separate discussions.

- Lagging federal datasets. Several of this report's most authoritative sources, including NHANES and the American Diabetes Association's quinquennial Economic Report, update on multi-year cycles, meaning some figures in this edition are necessarily several years old even though they remain the best available measured data.
- Claims-based limitations. Administrative and claims data, used throughout Chapters 4 through 9, capture only diagnosed, billed encounters and systematically understate prevalence for conditions with large undiagnosed populations, a limitation this report has flagged repeatedly rather than corrected for, since no reliable correction factor exists.
- Self-report bias. Survey-based figures, including most state-level and employer-level data in this report, rely on respondent self-report rather than direct measurement or audit, and are subject to the reporting biases inherent in any survey instrument.
- Definitional inconsistency across sources. Terms such as "obesity," "food insecurity," and "value-based payment" are not defined identically across the federal agencies, employer surveys, and state programs this report draws upon, complicating direct comparison even when sources appear to measure the same thing.
- State and regional variability in underlying data quality. Chapter 7 documents that some state-level estimates, particularly rural subgroup estimates, rest on smaller samples than national figures and carry correspondingly wider uncertainty.
- Missing biomarkers in most administrative data. Outside of NHANES, most of this report's data sources do not include direct biomarker measurement, meaning this report frequently relies on diagnosis codes or self-report as a proxy for underlying clinical status.

- Single-edition baseline. Because this is this report's first edition, it cannot yet report trend data for its own metrics; every figure in this edition is a single-year snapshot rather than part of an established time series, a limitation only future editions can resolve.

Strengths

This report's central strengths are structural rather than substantive: they describe how the report is built, not what any single chapter concludes.

- The largest single synthesis of federal, employer, and program-level metabolic health data assembled in one publication to date, spanning national prevalence, Medicare, Medicaid, public health infrastructure, state variation, and innovation programs within a single, consistently structured document.
- Primary-source discipline. Every statistic in this report is traceable to a named source, and this report declines to reproduce a claim it cannot trace to a primary or credible secondary source.
- A transparent, three-tier source confidence classification and a five-level evidence classification framework, both defined explicitly in this appendix and applied consistently across every chapter, rather than left implicit.
- Independent authorship and editorial control, documented in this report's Editorial Independence & Conflict of Interest statement, distinguishing this report from vendor-funded or advocacy-funded publications covering similar subject matter.
- Stable, permanent metric identifiers across 98 baseline metrics, documented in Appendix B, enabling exact year-over-year comparison in future editions without ambiguity about which figure is being referenced.
- An explicit annual update commitment, with this report's chapter structure, identifiers, and editorial standards designed from this first edition forward to support direct comparison across future editions rather than requiring readers to reconcile changing methodology each year.

The Evidence Classification Framework

Beginning with the interventions examined in Chapters 8 through 10, this report classifies the strength of evidence behind a specific program, model, or vendor's claimed effectiveness using a five-level scale. This framework addresses a different question than the source confidence classifications above: it asks not how reliable the underlying data source is, but how rigorously a specific claim of effectiveness has been tested. Evidence

level reflects the strength of available evidence rather than the magnitude of an intervention's reported effect: a program can report dramatic outcomes while still being supported only by Level C evidence, and this report treats those as two separate questions rather than allowing a large reported effect to substitute for rigorous evaluation.

Level	Description	Example from this report
A	Multiple independent randomized controlled trials, independent meta-analyses, or completed government-sponsored evaluations.	Not yet observed for any single intervention examined in this edition.
B	Independent observational studies or independent, peer-reviewed prospective cohort evaluations.	North Carolina's Healthy Opportunities Pilots summative evaluation (Ch. 8), conducted by an independent academic research center.
C	Peer-reviewed, but company-sponsored or company-authored, studies.	Virta Health's 5-year outcomes study (Ch. 10), peer-reviewed but company-funded and company-authored, without an independent control group.
D	Company white papers, conference abstracts, or internal analyses not subject to independent peer review.	Vendor-published claims this report identified but declined to cite as evidence of effectiveness (Ch. 10).
E	Marketing claims without publicly available methodology.	Not cited as evidence anywhere in this report; excluded from every chapter’s evidentiary claims.

This report cites Level D and Level E material only to describe what a vendor or program claims about itself, never as evidence that the underlying claim is true. Where this report's Technical Considerations sections note that independent evaluation does not yet exist for a given program, that observation should be read as placing the program's evidence at Level C or below on this scale, regardless of how favorable the available Level C, D, or E evidence may appear.

This framework will be applied consistently to every new intervention, model, or vendor program examined in future editions of this report, whether it originates in Medicaid, Medicare, employer benefit design, or a category not yet covered by this edition.

Editorial Independence & Conflict of Interest

Editorial conclusions presented in this report are developed independently by the author and are not influenced by funding sources, commercial organizations, healthcare vendors, pharmaceutical manufacturers, or entities discussed within the report. Source selection follows the methodological standards described in this appendix.

Disclosure: The author is Vice President at Eagles Benefits by Design, Inc., a third-party administrator of employee benefit plans for large, self-funded employers. The author is also the named inventor on a pending U.S. provisional patent application covering Health Dividend 360, the Metabolic Health Index, and Grapefruit Wellness, a proprietary metabolic health measurement and wellness program assigned to and offered commercially through Eagles Benefits by Design, Inc. None of these programs, their underlying methodology, or their proprietary metric framework is described, referenced, endorsed, or promoted anywhere in this report. This report's editorial content, source selection, and findings are developed independently of that commercial work.

Reproducibility Statement

Unless prohibited by licensing restrictions, all calculations contained in this report are reproducible using publicly available source data and the methodology described throughout this report.

Appendix B
Metric Registry

This appendix consolidates every stable metric identifier used across this report's ten chapters into a single registry. Each identifier is permanent: it will never be renumbered or reused in a future edition, even if the surrounding chapter text changes, a data source is superseded, or a figure is later revised. Where a future edition revises a value, the identifier stays the same and the revision is noted in that edition's registry rather than treated as a new metric. This is the same discipline this report has applied since Chapter 1, made explicit and complete here in one place.

Each entry below lists the identifier, a short description of what the metric measures, its 2026 Baseline Edition value, its primary source, and the first edition in which it was reported. Because this is the report's first edition, every metric's first-reported edition is the 2026 Baseline Edition and no revisions yet exist; future editions will add a revision history to any metric whose figure, definition, or source changes materially from the value recorded here. Full source citations for every metric appear in the Sources section of the chapter in which it originates; this registry is a locator and definition reference, not a replacement for those citations.

Chapter 1 — America's Metabolic Health (MH- series)

ID	Metric	2026 Baseline Value
MH-01	Adult obesity prevalence	40.3%
MH-02	Adult severe obesity prevalence (age-adjusted)	9.7%
MH-03	Diabetes prevalence, all ages	40.1 million (12.0% of population)
MH-04	Prediabetes prevalence, adults	115+ million (>2 in 5 adults)
MH-05	Hypertension prevalence, adults 18+	47.7%
MH-06	Chronic kidney disease prevalence, adults	~37 million (~14%)
MH-07	MASLD / fatty liver disease prevalence, adults	30%–38%

ID	Metric	2026 Baseline Value
MH-08	Obstructive sleep apnea prevalence, adults 20+	83.7 million (32.4%)
MH-09	Metabolic syndrome prevalence, adults	38.5%
MH-10	Testosterone deficiency prevalence, men 45+	~35%
MH-11	Menopausal vasomotor symptom prevalence, women	Up to 80% (34% moderate-to-severe)

Chapter 2 — Economic Impact (EI- series)

ID	Metric	2026 Baseline Value
EI-01	National health expenditures, total	$5.3 trillion (18.0% of GDP)
EI-02	National health expenditures per capita	$15,474
EI-03	Direct medical cost attributable to obesity	~$173 billion/year (2019 dollars)
EI-04	Total annual cost of diagnosed diabetes	$412.9 billion ($306.6B direct / $106.3B indirect)
EI-05	Average employer-sponsored family premium	$26,993/year (+6% YoY)
EI-06	Average employer-sponsored single premium	$9,325/year (+5% YoY)
EI-07	Illness-related lost productivity cost to employers	~$575 billion in 2019 (modeled; IBI Full Cost Estimator)
EI-08	Illness-related lost workdays, employer-covered	~1.5 billion in 2019, comprising ~978 million absence days and ~540 million equivalent workdays lost to impaired performance (modeled)

Chapter 3 — Employer Healthcare (EH- series)

ID	Metric	2026 Baseline Value
EH-01	Employer health benefit offer rate, firms with 10+ workers	61% overall; 97% large firms; 59% small firms
EH-02	Self-funded plan enrollment	67% of covered workers; 80% large firms; 27% small firms

ID	Metric	2026 Baseline Value
EH-03	Average employer health benefit cost per employee	$17,496 in 2025; projected to exceed $18,500 in 2026
EH-04	Projected 2026 employer health cost increase	6.7% Mercer; 9.1% before / 8.0% after plan changes (WTW)
EH-05	Specialty drug cost per member per year	$1,641 in 2024, up from $1,333 in 2023
EH-06	GLP-1 share of total annual claims (weight-loss indication)	11.4% (IFEBP 2026), up from 6.9% in 2023
EH-07A	GLP-1 coverage for diabetes and weight loss	36% (IFEBP 2026 survey)
EH-07B	GLP-1 coverage for weight management, large employers	67% (Business Group on Health 2026 survey)
EH-07C	GLP-1 coverage for obesity, WTW client survey	66% (WTW Rx Pulse survey, June 2026)
EH-08	HDHP with savings option enrollment	33% of covered workers
EH-09	Average single deductible (general annual deductible)	$1,886
EH-10	Employer wellness promotion offer rate	83% large firms; 56% small firms
EH-11	Employer-sponsored insurance covered lives, nonelderly	~154 million (hierarchical assignment) / ~165.6 million (overlapping coverage permitted), KFF 2025

Chapter 4 — Medicare (MA- series)

ID	Metric	2026 Baseline Value
MA-01	Total Medicare enrollment	~70 million (Part A, FY2026 average monthly); 64.2 million in Part B
MA-02	Medicare Advantage enrollment and penetration	35.2 million; 55% of beneficiaries with both Parts A and B (KFF); ~36.2 million average monthly (CBO)
MA-03	Medicare share of national health expenditures	$1,118.0 billion; 21% of NHE
MA-04	Projected Medicare spending growth, 2026–2036	Medicare alone: 88% (gross outlays, $1,295B FY2026 to $2,433B FY2036); all

ID	Metric	2026 Baseline Value
		federal health programs: 63% (CBO, Feb. 2026)
MA-05	Hospital Insurance Trust Fund depletion projection	2040 (CBO, Feb. 2026); Trustees project 2033
MA-06	Type 2 diabetes prevalence among Medicare beneficiaries	More than 26%; ~17.7 million with type 2 diabetes (ASPE); range 20%–38% across sources
MA-07	Weight-related chronic condition prevalence, beneficiaries without diabetes by weight status	76% / 83% / 87% (normal / overweight / obese, CBO)
MA-08	Average 2026 Medicare Advantage Star Rating	3.65–3.66 unweighted; ~3.98 enrollment-weighted
MA-09	Medicare GLP-1 claims and gross spending, 2024	21.8 million claims; $27.5 billion
MA-10	Medicare GLP-1 Bridge copay and duration	$50/month; July 1, 2026–Dec. 31, 2027
MA-11	Medicare Diabetes Prevention Program active participants	941 nationally
MA-12	GLP-1 anti-obesity prescribing rate, ages 60–64 vs. Medicare-aged	0.37% vs. 0.24% of eligible patients
MA-13	MA supplemental food/produce benefit availability	11% individual plans vs. 85% Special Needs Plans
MA-14	Part D out-of-pocket cap and initial negotiated-drug discounts	$2,100 cap; 38%–79% off 2023 list prices
MA-15	Medicare Advantage payment relative to traditional Medicare	~14% higher per beneficiary; ~$76 billion added 2026 federal spending

Chapter 5 — Medicaid (MD- series)

ID	Metric	2026 Baseline Value
MD-01	Total Medicaid and CHIP enrollment	74.3 million (67.1M Medicaid / 7.2M CHIP), point-in-time, last day of March 2026
MD-02	Medicaid share of national health expenditures	$931.7 billion, calendar year 2024; 18% of NHE (NHEA basis)

ID	Metric	2026 Baseline Value
MD-03	Federal and nonfederal shares of Medicaid spending	Estimated 64.2% federal / 35.8% nonfederal, FFY2025 (HMAIS analysis, preliminary CMS-64)
MD-04	Medicaid managed-care spending	Estimated $550.5 billion (FFY2025), up from $517.5B, a 6.4% increase and 56.7% of total Medicaid spending (HMAIS analysis, preliminary CMS-64; MCOs, PIHPs, PAHPs only)
MD-05	Medicaid beneficiaries in comprehensive risk-based MCOs	78%; >66 million beneficiaries, as of July 1, 2024 (comprehensive MCOs only)
MD-06	Cardiometabolic multimorbidity, Medicaid-covered adults ages 19–64	29.7% with 2+ selected conditions; 29.3% with 1 (pooled NHIS 2018–2022, ages 19–64, self-reported)
MD-07	States covering GLP-1s for obesity treatment under Medicaid fee-for-service	13 states, Jan. 2026, down from 16 in Oct. 2025 (obesity indication, FFS only)
MD-08	Projected federal Medicaid/CHIP outlay reduction, OBBBA	~$911 billion
MD-09	Projected increase in uninsured people from OBBBA Medicaid provisions by 2034	7.5 million (net increase in uninsured, not Medicaid enrollment loss)
MD-10	States not adopting ACA Medicaid expansion	10 states

Chapter 6 — Public Health Infrastructure and Prevention (PH-series)

ID	Metric	2026 Baseline Value
PH-01	President's FY2026 budget proposed CDC funding reduction	Estimated ~53% vs. FY2024 (TFAH reorganization-adjusted analysis; not an official federal budget percentage)
PH-02	CDC FY2026 enacted funding, as passed by Congress	$9.227 billion core program level, −0.2% vs. FY2025 (P.L. 119-75); $16.266 billion inclusive of mandatory funding, −2.7%; proposed AHA restructuring not enacted
PH-03	Share of CDC's domestic resources flowing directly to states and localities	~80%
PH-04	DNPAO nutrition, physical-activity, and obesity-prevention grant funding (proposed for elimination; not enacted)	$54.32 million enacted FY2026, incl. $16.5M High Obesity Rate Counties (elimination proposed, not enacted)

ID	Metric	2026 Baseline Value
PH-05	COVID-era public health grants targeted for termination by HHS, March 2025	>$11 billion targeted March 2025 (TFAH est. >$12B incl. SAMHSA); blocked by injunction, portions restored
PH-06	Additional public health workforce FTEs needed nationally	~80,000 (54,000 local / 26,000 state), 2021 Staffing Up modeled estimate; excludes emergency surge capacity
PH-07	State/local public health workforce attrition, 2017–2021	~50% turnover; ~75% among staff under 35 and/or under 5 years tenure in 2017 (96-department PH WINS longitudinal cohort; turnover, not net national loss)
PH-08	Prevention and Public Health Fund, FY2026 proposed versus enacted status	Elimination proposed but not enacted; Fund continued in FY2026 appropriations ($448.985M to NCCDPHP); separate $2B/yr restoration bill (S. 786 / H.R. 1715) not enacted
PH-09	Public health/chronic-disease programs proposed for elimination in the FY2026 budget request (proposal not enacted)	100+ total (61 CDC, 40 SAMHSA) per TFAH analysis of the proposal; eliminations not enacted wholesale

Chapter 7 — State-by-State Variation (SV- series)

ID	Metric	2026 Baseline Value
SV-01	Highest state adult obesity prevalence, self-reported BRFSS (2024)	West Virginia, 41.4% (CDC BRFSS, self-reported)
SV-02	Lowest state adult obesity prevalence, self-reported BRFSS (2024)	Colorado, 25.0% (CDC BRFSS, self-reported)
SV-03	States with self-reported adult obesity prevalence ≥35% (2024)	19 states, down from 23 in 2023 (CDC BRFSS)
SV-04	Regional self-reported adult obesity prevalence range (2024)	Midwest 35.9% (high) vs. West 30.2% (low); South 34.5%, Northeast 30.3% (CDC BRFSS)
SV-05	Diagnosed diabetes prevalence by rurality, national (NHIS 2021–2024)	12.3% rural vs. 9.3% urban (NHIS 2021–2024, crude, diagnosed)
SV-06	State rural diagnosed-diabetes prevalence range, 41 reporting states (BRFSS 2021)	8.4% (CO) to 21.3% (NC), 41 reporting states (BRFSS 2021)
SV-07	State urban diagnosed-diabetes prevalence range, 41 reporting states (BRFSS 2021)	6.9% (CO) to 15.5% (WV), 41 reporting states (BRFSS 2021)

ID	Metric	2026 Baseline Value
SV-08	State self-reported diagnosed hypertension prevalence range (BRFSS 2021)	24.6% (CO) to 40.6% (MS), age-standardized, BRFSS 2021
SV-09	Diabetes- and hypertension-related mortality, rural versus urban (2020)	85.6 vs. 71.7 age-adjusted deaths per 100,000, adults 25+, 2020

Chapter 8 — Medicaid Innovation (MI- series)

ID	Metric	2026 Baseline Value
MI-01	Section 1115 demonstrations with approved HRSN- or SDOH-related authorities	25 approved; 6 pending (KFF classification of CMS records, Feb. 2026)
MI-02	Service categories authorized across HRSN- or SDOH-related Section 1115 demonstrations	Housing 23; nutrition 12; medical respite 11; employment supports 7 (KFF classification; categories overlap, do not sum)
MI-03	NC Healthy Opportunities Pilots, estimated Medicaid expenditure impact	−$164 PMPM estimated expenditure impact (NC-specific; Sheps Center evaluation)
MI-04	NC HOP participants enrolled during the evaluation period	31,597 (Mar. 15, 2022–Nov. 30, 2024)
MI-05	NC HOP operational status versus federal authorization	Suspended July 1, 2025 (state funding lapse); demonstration CMS-approved through December 9, 2029
MI-06	NC HOP effect on hemoglobin A1c and blood pressure	No clear statistically significant improvement demonstrated. Estimated A1c differences at 6, 12, and 18 months were −0.06, −0.04, and −0.02 percentage points, with confidence intervals crossing zero at every time point, and blood-pressure estimates generally included the null. Point estimates were usually directionally favorable but small and imprecise. Analyses relied on a non-random subset of participants with clinical data available in NC HealthConnex: 81% of those with qualifying hypertension diagnoses had at least one blood-pressure value, but only 54% of those with qualifying diabetes diagnoses had an A1c value. The evaluators state that these limitations make definitive conclusions difficult

ID	Metric	2026 Baseline Value
MI-07	Federal posture on Section 1115 workforce-initiative expenditure authority	CMS does not anticipate approving new or extending existing Section 1115 workforce-initiative expenditure authority (July 2025); existing initiatives monitored
MI-08	MassHealth Flexible Services nutrition-support evaluation (Massachusetts)	Associated with 23% lower hospitalizations and 13% lower ED visits vs. eligible nonparticipants (comparison-group design)
MI-09	Historical scale of DSRIP and DSRIP-like Medicaid programs (historical context, not a current program count)	13 states; $48.6B approved state and federal funds as of June 2017 (MACPAC; approved not realized)

Chapter 9 — Medicare Innovation (MV- series)

ID	Metric	2026 Baseline Value
MV-01	CMMI models selected for early termination, March 2025	4 models selected; ~$750M projected savings (termination dates varied by model)
MV-02	ACO REACH end date / successor	Ends Dec. 31, 2026; succeeded by LEAD
MV-03	ACO REACH participation	74 ACOs in PY2026; 103 ACOs and 161,765 participating providers and organizations serving an estimated 2.5 million Traditional Medicare beneficiaries in PY2025; 132 ACOs in PY2023
MV-04	ACO REACH PY2023 gross savings relative to model benchmarks	~$1.643B gross ($694.6M net to CMS; $948.4M net to ACOs)
MV-05	ACO REACH PY2023 ACOs with net losses	36 of 132 participating ACOs (27%) accrued net losses; 96 (73%) earned net savings from financial settlement
MV-06	ACCESS model launch / duration	Launched July 5, 2026; 10-year model through 2036 (rolling start dates)
MV-07	ACCESS first-year Outcome Attainment Threshold and maximum payment reduction	First-year Outcome Attainment Threshold of 50%: an organization earns full payment if at least 50% of relevant beneficiaries meet all required outcome targets, with payment reduced proportionally below that threshold and the reduction capped at 50% of the gross Outcome-Aligned Payment amount. CMS does not withhold

ID	Metric	2026 Baseline Value
		half of every payment and later return it; the reduction applies only to the extent performance falls short of the threshold
MV-08	ACO PC Flex participation versus original CMS planning estimate	24 participating ACOs at launch (23 in PY2026) vs. ~130 originally planned (planning estimate, not a target)

Chapter 10 — Employer Innovation (EN- series)

ID	Metric	2026 Baseline Value
EN-01	Firms requiring lifestyle program or clinician consultation as a condition of GLP-1 coverage	34% of covering firms with 200+ workers (KFF 2025)
EN-02	Firms with 200 or more workers covering GLP-1 agonists primarily for weight loss	19% of firms with 200+ workers; 43% of firms with 5,000+ workers (KFF 2025)
EN-03	Lives enrolled in or eligible for Evernorth's EncircleRx GLP-1 management program	More than 9 million enrolled or eligible lives (Cigna Group investor disclosures, 2025; Evernorth program materials). This counts lives in client populations covered by the program, not people actively receiving GLP-1 medications
EN-04	EncircleRx weight-management GLP-1 coverage threshold	BMI ≥32, or BMI ≥27 with two qualifying weight-related conditions, plus required participation in an approved lifestyle-modification program (Evernorth). This is a program-specific threshold; employer prior-authorization criteria vary materially by plan and pharmacy benefit manager and no single national employer standard was identified
EN-05	Type 2 diabetes remission among Virta five-year study completers (vendor-sponsored study)	20% (n=24) of 122 five-year completers; remission = HbA1c below 6.5% off all glucose-lowering medication for ≥3 months (vendor-sponsored, non-randomized)
EN-06	Sustained ≥5% weight loss among Virta five-year study completers (vendor-sponsored study)	61.3% of the 122 five-year completers sustained at least 5% weight loss, and 39.5% sustained at least 10%. Applies to participants with five-year follow-up data, not to the full original enrollment cohort

Registry Conventions

First year reported: every metric in this registry carries a first-reported edition of 2026 Baseline Edition, since this is the report's inaugural edition. Beginning with the 2027 edition, this field will distinguish metrics carried forward from this baseline from any new metrics introduced in that edition.

Revisions: no metric in this registry has yet been revised. Beginning with the 2027 edition, any metric whose value, definition, or source changes materially from the figure recorded here will carry a brief revision note in that edition's registry, consistent with the version-control discipline established in Technical Appendix A.

Retired metrics: this report does not currently retire metric identifiers. If a future edition determines that a metric should no longer be tracked, this registry will mark it as retired, along with the edition and reason, rather than deleting or reusing its identifier.

Appendix C: Policy Maker Brief

Selected findings for legislators, governors' policy offices, and congressional staff

This brief summarizes selected findings from the 2026 Baseline Edition of The State of Metabolic Health in America, an independently authored annual reference report. It does not recommend legislation, regulation, or any specific policy action, and nothing here should be read as advocacy for a particular position.

The National Baseline

- **40.3%** of U.S. adults have obesity; severe obesity continues to rise even as the overall rate has leveled off.
- **More than 40 million** Americans have diabetes; **more than 115 million** adults have prediabetes.
- **47.7%** of U.S. adults have hypertension.
- **~37 million** adults have chronic kidney disease; an estimated **9 in 10** do not know it.
- **83.7 million** adults have obstructive sleep apnea; more than **80%** are undiagnosed.
- **38.5%** of adults meet the clinical definition of metabolic syndrome.

Medicaid

- Enrollment fell from 78.6 million (March 2025) to 74.3 million (March 2026), a 5.5% decline, following the end of the pandemic-era continuous enrollment provision.
- The enacted 2025 federal budget reconciliation law is projected by CBO to reduce federal Medicaid spending by approximately $911 billion over ten years and increase the uninsured population by roughly 7.5 million people by 2034.
- Only 13 states covered GLP-1 medications for obesity under fee-for-service Medicaid as of January 2026, down from 16 in October 2025.
- 25 Section 1115 health-related social needs waivers are approved nationally (6 more pending); federal posture toward approving new waivers of this kind narrowed in 2025.
- North Carolina's Healthy Opportunities Pilots — the largest evaluated state test of this model — showed an estimated $164/member/month reduction in Medicaid expenditure but no clear, statistically significant improvement in A1c or blood pressure. The state legislature did not fund its continuation despite federal authorization through December 2029.

Medicare

- Weight-related chronic conditions affect 76% of beneficiaries at normal weight, rising to 87% among beneficiaries with obesity.
- CBO's February 2026 baseline projects Medicare spending will grow 88% between 2026 and 2036; the Hospital Insurance Trust Fund is now projected to be depleted by 2040 — twelve years sooner than the prior baseline.
- The Medicare GLP-1 Bridge, effective July 1, 2026, provides temporary coverage of select GLP-1 medications for weight loss at a $50 monthly copayment — the first instance of Medicare covering an anti-obesity medication for weight loss specifically.
- The ACCESS model, a 10-year Medicare payment model launched July 5, 2026, is the first to define eligibility and outcome measures directly around cardio-kidney-metabolic risk. No utilization or outcome data yet exist for it.
- The Medicare Diabetes Prevention Program had only 941 active participants nationally as of its most recent count, against more than 17.7 million beneficiaries already diagnosed with diabetes.

State Variation

- Adult obesity prevalence ranges from 25.0% (Colorado) to 41.4% (West Virginia).
- Rural adults have meaningfully higher diagnosed diabetes prevalence than urban adults nationally (12.3% vs. 9.3%).
- Hypertension prevalence ranges from 24.6% (Colorado) to 40.6% (Mississippi), concentrated in the Southeast and Appalachia.

What This Report Does Not Say

This report does not recommend legislation, regulation, or policy change; endorse any treatment, product, vendor, or health plan; or estimate return on investment for any program. It documents opportunities for better measurement, not policy prescriptions.

Derived from: Knox, James M. The State of Metabolic Health in America — 2026 Baseline Edition. Tampa, Florida: Eagles Benefits by Design, Inc.; August 2026. Full sourcing, methodology, and data-gap disclosures for every figure above appear in the complete report.

Questions, corrections, or requests for underlying source citations: James@CPS125.com | Appendix C of the 2026 Baseline Edition

Appendix D: Employer Brief

Selected findings for CEOs, benefits leaders, and plan sponsors

This brief summarizes selected findings from the 2026 Baseline Edition of The State of Metabolic Health in America for benefits and financial decision-makers. It does not recommend any vendor, program, or plan design, and does not estimate return on investment for any intervention.

Cost Trajectory

- **$5.3 trillion** — U.S. national health expenditures in 2024 ($15,474 per person; 18.0% of GDP).
- **$26,993** — average employer-sponsored family premium in 2025, up 6%: the third consecutive year of 6%+ growth, the first time that's happened in two decades.
- Mercer projects a further 6.7% increase in 2026 (to more than $18,500/employee) — the fastest projected increase in fifteen years — with prescription drug spending, and GLP-1 medications specifically, identified as the principal driver. WTW projects a 9.1% increase before plan changes, 8.0% after, for 2026.
- Specialty drug cost per member per year rose from $1,333 (2023) to $1,641 (2024) in PSG's commercial book of business, though gross specialty trend slowed from 14.4% to 9.6%.

Coverage Design Is Shifting

- 61% of firms with 10+ workers offered health benefits in 2025 (97% among firms with 200+ workers); 67% of covered workers were enrolled in self-funded plans (80% at firms with 200+ workers).
- GLP-1 coverage estimates vary materially by survey population: IFEBP reported 36%, Business Group on Health 67% (weight management, 105 large-employer members), and WTW 66% (294 clients, 2.8 million+ members). This range reflects differences in who was surveyed, not necessarily disagreement.
- Approximately 34% of firms covering GLP-1s for weight loss now condition coverage on a lifestyle program, dietitian visit, or case manager — a shift from the binary include/exclude decisions common through 2024.
- 19% of firms with 200+ workers cover GLP-1s primarily for weight loss, rising to 43% among firms with 5,000+ workers.

The Cost of Doing Nothing

- A modeled Integrated Benefits Institute analysis (2019 data) estimated $575 billion in illness-related employer productivity losses annually — 61 cents lost for every dollar spent on health benefits.
- Obesity raises absenteeism by an estimated 3.0 days/employee/year (a 128% increase vs. normal weight); national productivity losses were estimated at $13.4–$26.8 billion (2016 data).
- Reduced employment and on-the-job performance together account for more than $64 billion of diabetes' annual indirect costs.

Evidence Quality — What to Watch For

- This report's only example of durable, multi-year employer-vendor outcome data — Virta Health's 5-year type 2 diabetes results — is company-funded and company-authored, with no independent control group. That doesn't make the results meaningless, but it hasn't been independently verified.
- This report could not identify a comparable independent, multi-year evaluation for any employer condition-management vendor category. The evidence base for this entire purchasing category remains substantially vendor-reported.
- Before relying on vendor outcome claims, ask whether the data is independently authored, whether it reports beyond one year, and whether it distinguishes cost/utilization change from clinical outcome change — this report found these frequently conflated across the industry.

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Questions, corrections, or requests for underlying source citations: James@CPS125.com | Appendix D of the 2026 Baseline Edition

Appendix E: Media Brief

Key facts and reporting context for journalists

This brief highlights findings likely to be of interest for news coverage, along with context necessary to report them accurately. The full report contains complete sourcing, methodology, and caveats for every figure below. This report does not advocate for any policy, product, or point of view.

Numbers Worth Reporting

- **40.3%** of U.S. adults have obesity; **38.5%** meet the clinical definition of metabolic syndrome.
- **More than 40 million** Americans have diabetes; **more than 115 million** adults have prediabetes.
- **47.7%** of U.S. adults — nearly half — have hypertension.
- **9 in 10** adults with chronic kidney disease, and more than **80%** of the 83.7 million adults with obstructive sleep apnea, don't know they have it.
- **$5.3 trillion** — U.S. national health expenditures in 2024 (18.0% of GDP); employer family premiums hit **$26,993** in 2025, the third straight year of 6%+ growth — the first time that's happened in two decades.

State-Level Story Angles

- Adult obesity ranges from 25.0% in Colorado to 41.4% in West Virginia.
- Rural Americans have meaningfully higher diagnosed diabetes rates than urban Americans nationally (12.3% vs. 9.3%).
- Hypertension is concentrated in the Southeast and Appalachia (the "Stroke Belt"), ranging from 24.6% in Colorado to 40.6% in Mississippi.
- 19 states had obesity prevalence at or above 35% in 2024 — down from 23 the year before, the first recorded decline since tracking began in 2011.

Developing Policy Stories

- Medicare's Hospital Insurance Trust Fund is now projected to be depleted by 2040 — twelve years sooner than the prior baseline (CBO, February 2026).

- The Medicare GLP-1 Bridge (effective July 1, 2026) is the first time Medicare has covered an anti-obesity medication for weight loss specifically — a $50/month copay for select drugs.
- Medicaid enrollment fell by roughly 4.3 million people (5.5%) in the year following the end of pandemic-era continuous enrollment.
- North Carolina's Healthy Opportunities Pilots showed a real cost reduction but no clear clinical improvement — and lost state funding despite federal authorization running through 2029. This is a genuinely mixed result, not a clean success or failure story.

Reporting Accurately — Common Pitfalls

- **Proposed vs. enacted:** this report tracks federal and state actions as announced, proposed, and enacted separately — a program's status can change quickly.
- **Vendor-sponsored data isn't independent evaluation:** this report's most-cited employer-vendor outcome data (Virta Health) is company-funded and company-authored. That doesn't make it false, but it hasn't been independently verified.
- **Cost reduction ≠ clinical improvement:** multiple programs in this report reduced spending or utilization without a matching, statistically clear improvement in clinical markers — this report treats these as separate findings, not one outcome.
- **Undiagnosed-prevalence estimates are modeled, not counted:** figures like "9 in 10 undiagnosed" for CKD come from statistical estimation, not a headcount, and carry more uncertainty than diagnosed-prevalence figures.

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