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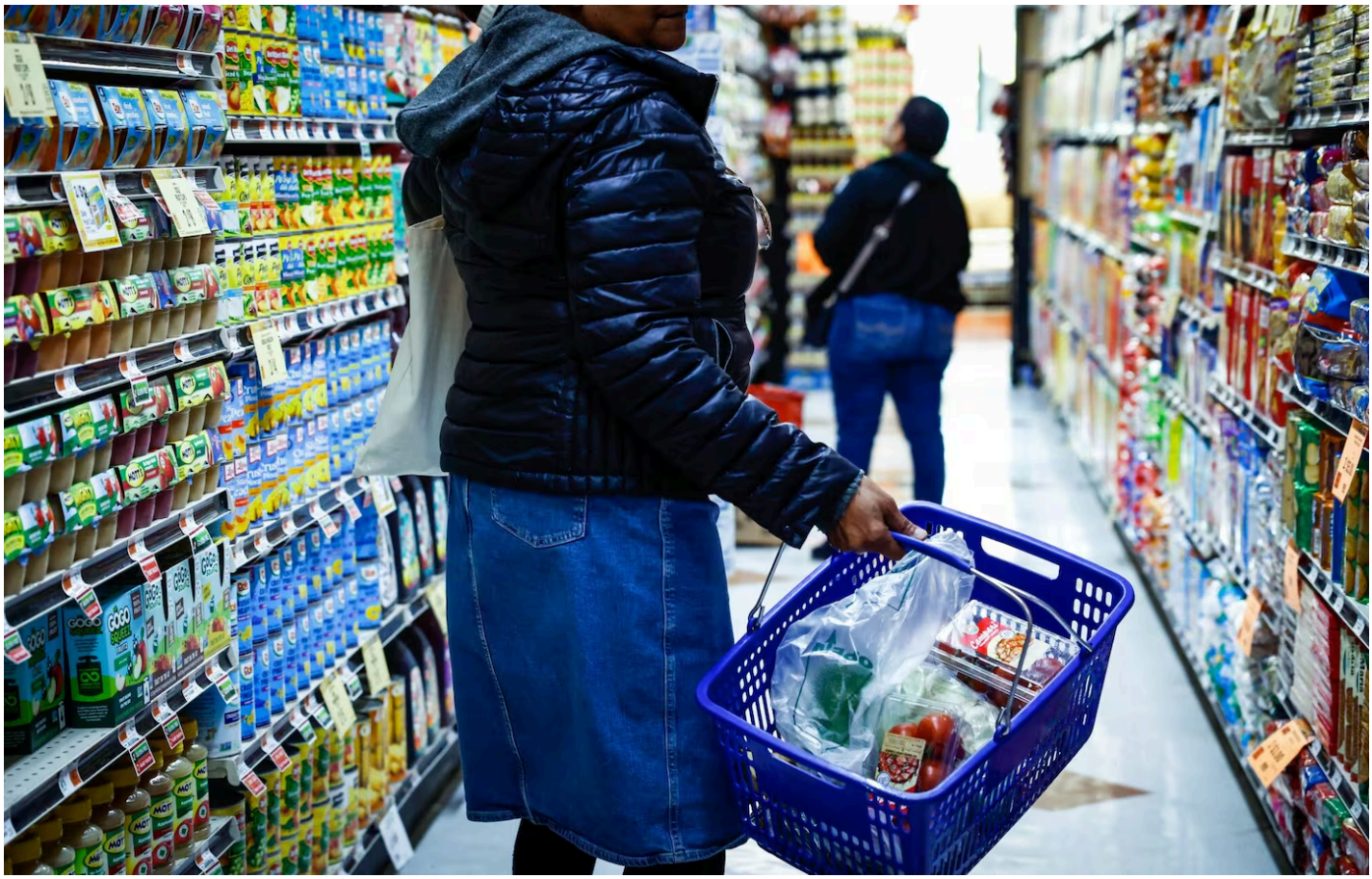
OPINION

The obesity curve finally bent. Now comes the hard part.

The decline in obesity rates is a medical triumph. But millions remain locked out by high costs, uneven insurance coverage, and bureaucratic barriers.

By Ashish K. Jha Updated June 29, 2026, 3:00 a.m.



Shoppers inside a grocery store in the Bronx in 2025. KENA BETANCUR/BLOOMBERG

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For four decades, American obesity moved in one direction: up. Menus were labeled. Sodas were taxed. School lunches were reformed. Doctors urged patients to eat less and move more. Public health campaigns came and went. Yet obesity kept climbing.

Then the curve bent. Gallup's tracking shows adult obesity peaked at 39.9 percent in 2022 and has fallen every year since, to 37 percent in 2025 — roughly 7.6 million fewer adults living with obesity. After 40 years of failure, something finally changed.

GLP-1 medications — Ozempic, Zepbound — appear to have done what no public health effort could. That is certainly what the data suggest: The steepest declines are among adults aged 50 to 64 and among women, exactly the groups using these drugs most. This is an achievement built on decades of basic science, including National Institutes of Health-supported research, and pharmaceutical development.

There is a familiar story here. For years, the fight against HIV leaned heavily on changing behavior. That work mattered and saved lives. But the epidemic was transformed by biomedical innovation: effective antiretroviral therapy. The hardest lesson came after the breakthrough. Having a treatment is not the same as getting it to the people who need it. Obesity has arrived at that same moment.

These drugs are not merely cosmetic. For many patients, especially those with obesity and diabetes or heart disease, they prevent heart attacks, strokes, and kidney failure. Despite their high costs, they are a great value using the same standards used for other treatments. The independent Institute for Clinical and Economic Review found that, at estimated net prices, GLP-1 drugs were highly cost effective by commonly used thresholds — roughly $53,000 to $69,000 for each year of healthy life they add. For context, Medicare has paid for end-stage kidney disease treatment, including dialysis and transplantation, since 1972, and these treatments cost nearly twice as much as GLP-1s for each additional life year saved. Dialysis is expensive but life-sustaining and rightly covered by Medicare. Obesity drugs should be covered by health insurance too.

Coverage should be broad and clinically grounded. It currently is not. Even among people with both obesity and diabetes, most are not receiving GLP-1 therapy. Among people with obesity but no diabetes, access is far lower still: In one large electronic health-record study, only about 2.3 percent of adults with obesity but without diabetes received a prescription for a GLP-1.

Employer coverage has grown but remains far from universal: Mercer found that 49 percent of large employers in the United States covered GLP-1 weight loss medications in 2025. Medicaid remains a patchwork, with only 13 states covering GLP-1s for obesity under fee-for-service.

The rationing follows patients into treatment, too. Many people who start these drugs do not stay on them. In a large claims-based study, most adults with overweight or obesity discontinued GLP-1 therapy within a year, especially those without diabetes. Cost is a

major reason people quit — a denied prior authorization, an expired coupon, a bill that suddenly becomes impossible to carry. Then insurers point to high dropout rates as a reason not to cover the drugs. The access problem becomes the excuse for the access problem.

The Trump administration has made some good moves here. Late last year, the administration negotiated deals to cut GLP-1 prices on Medicare and Medicaid, and beginning July 1, eligible Medicare patients can get these drugs for a $50 copay per month through the Medicare GLP-1 Bridge — the first time Medicare has offered broad access to obesity drugs.

The program wisely prioritizes patients at the highest cardiovascular and metabolic risk, where the value is clearest. But the bridge is a temporary demonstration that expires at the end of 2027, and it reaches only a limited subset of Medicare beneficiaries. What happens to Medicare patients after 2027 is currently unresolved.

The deeper fix: cover these drugs broadly, negotiate aggressively on price, and build in lower-cost maintenance once a patient stabilizes, so the choice is not a $1,000 injection forever or watching the weight return.

Coverage is the first test. The second is whether this moment can help change the food environment that helped create the epidemic in the first place.

For 40 years, prevention failed because individuals were asked to eat differently in an environment that made high-calorie foods abundant. The food industry did exactly what market incentives rewarded: make food cheaper, tastier, more convenient, more abundant. The outcome was never much in doubt.

But the incentives are now changing, and the same companies are following them. As tens of millions of people taking these drugs eat less and crave less, the businesses that feed them are responding. Circana projects that households with an adult using these drugs could account for 35 percent of US food and beverage sales by 2030. Nestlé has

launched a major new US brand, Vital Pursuit, aimed at these customers. Restaurant chains are testing smaller portions and GLP-1-friendly options. Across the grocery store, products are being remade around protein, fiber, and fewer empty calories.

This is not prevention in the old public health sense, and it will not automatically produce healthier food. Companies can just as easily sell a protein-packed candy bar, which is still a candy bar. But for the first time in decades, consumer demand may reward less volume, more satiety, and better nutrition. And as more consumers use GLP-1s, the pressure on the food industry will grow.

America has the tool that bends the obesity curve. But a tool is not a victory. The drugs reach too few people. The market that shaped how Americans eat is only beginning to adjust. HIV taught a hard lesson: the medicine was a milestone, not the finish line. The same is true here. The country finally has the means to reverse its oldest chronic epidemic. Whether its leaders are serious about using them is the only question that matters now.