OBESITY ACTION COALITION

ASMBS American Society for Metabolic and Bariatric Surgery

Obesity Treatment Access Scorecard

November 2026 White Paper

Your ZIP code should not determine your care.

A comprehensive, standardized framework examining access to evidence-based obesity care across all 50 states and the District of Columbia.

44	6	51	C-
metrics across the care journey	weighted tiers	jurisdictions scored	national average grade

A joint white paper of the Obesity Action Coalition and the American Society for Metabolic and Bariatric Surgery

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WHY WE BUILT THE SCORECARD

From conversation to a national access picture

A joint OAC + ASMBS framework for understanding where access works — and where barriers remain.

How this project began

The idea for the Obesity Treatment Access Scorecard (OTAS) grew out of the 2025 ASMBS Obesity Summit, where leaders across obesity care examined persistent barriers to comprehensive, evidence-based care. OAC and ASMBS turned that conversation into a practical state-level tool combining patient advocacy, clinical expertise and access-to-care experience.

What OTAS shows

- **Coverage is only the beginning.**
  A benefit can exist while authorization, cost, workforce or geography still limits access.
- **Access varies substantially by state.**
  OTAS measures 44 indicators across coverage, barriers, capacity, policy, equity and treatment use.
- **Medication coverage can be unstable.**
  Coverage can expand, narrow or end within a single reporting year.
- **Surgical access has multiple gates.**
  Coverage, authorization, qualified workforce, accredited facilities, travel and follow-up all matter.
- **Comprehensive care requires a system.**
  People need a holistic, patient-friendly system that supports them at every stage of the care journey.

Two perspectives. One shared purpose.

OAC centers the experiences and priorities of people affected by obesity. ASMBS contributes clinical, metabolic and bariatric, standards-of-care and access expertise. Together, the organizations seek a more comprehensive, respectful and usable system of care.

COMPREHENSIVE OBESITY CARE

Why comprehensive care matters

Dignity, choice and better health

Every person affected by obesity deserves respectful, evidence-based healthcare free from weight bias and discrimination. Obesity is a complex, chronic disease influenced by biological, genetic, environmental and social factors. Recognizing obesity as a chronic disease reinforces the need for individualized treatment, ongoing management and comprehensive care.[1,2]

People affected by obesity should be empowered to make informed decisions with their healthcare professionals based on clinical needs, preferences and health goals — without judgment or stigma. Body mass index (BMI) alone does not adequately describe a person's health, disease severity or treatment needs.[1,3]

Comprehensive assessment should consider obesity-related complications, physical functioning, quality of life and patient-reported outcomes. Shared decision-making should focus on improving overall health and well-being, not changes in body weight alone.[1,3]

Access to the full continuum of evidence-based treatment

No single treatment is appropriate for everyone. Evidence-based care may include medical nutrition therapy, behavioral interventions, psychological support, FDA-approved medications, endoscopic therapies, metabolic and bariatric surgery, and long-term follow-up. Treatment should reflect individual needs and preferences and may change over time.[1,4,5]

Insurance coverage should support the full continuum of clinically appropriate care, allowing patients and healthcare professionals to make decisions based on medical evidence rather than exclusions or unnecessary restrictions. Endoscopic therapies are an additional option for appropriately selected patients.[5]

What this means for OTAS
OTAS evaluates conditions for access. It does not determine which treatment is right for an individual. Dignity, choice and evidence should guide comprehensive care.

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Endoscopic-therapy guidance: reference 6.

44 MEASURES ACROSS SIX TIERS

A whole-person view of access

The scorecard combines coverage, barriers, capacity, policy, patient context and treatment use.

Tier	What we measure	Weight
T1	**Coverage and eligibility** Medicaid, marketplace, state employee and commercial coverage	25%
T2	**Barriers and cost** Authorization, thresholds, treatment limits and cost sharing	20%
T3	**Workforce and facilities** Clinicians, accredited centers and geographic access	17%
T4	**Policy environment** Disease recognition, telehealth and legislation	13%
T5	**Patient context and equity** Insurance, rurality, affordability and health literacy	10%
T6	**Treatment utilization** Whether covered treatments reach people	15%

The national picture

48.5 / 100

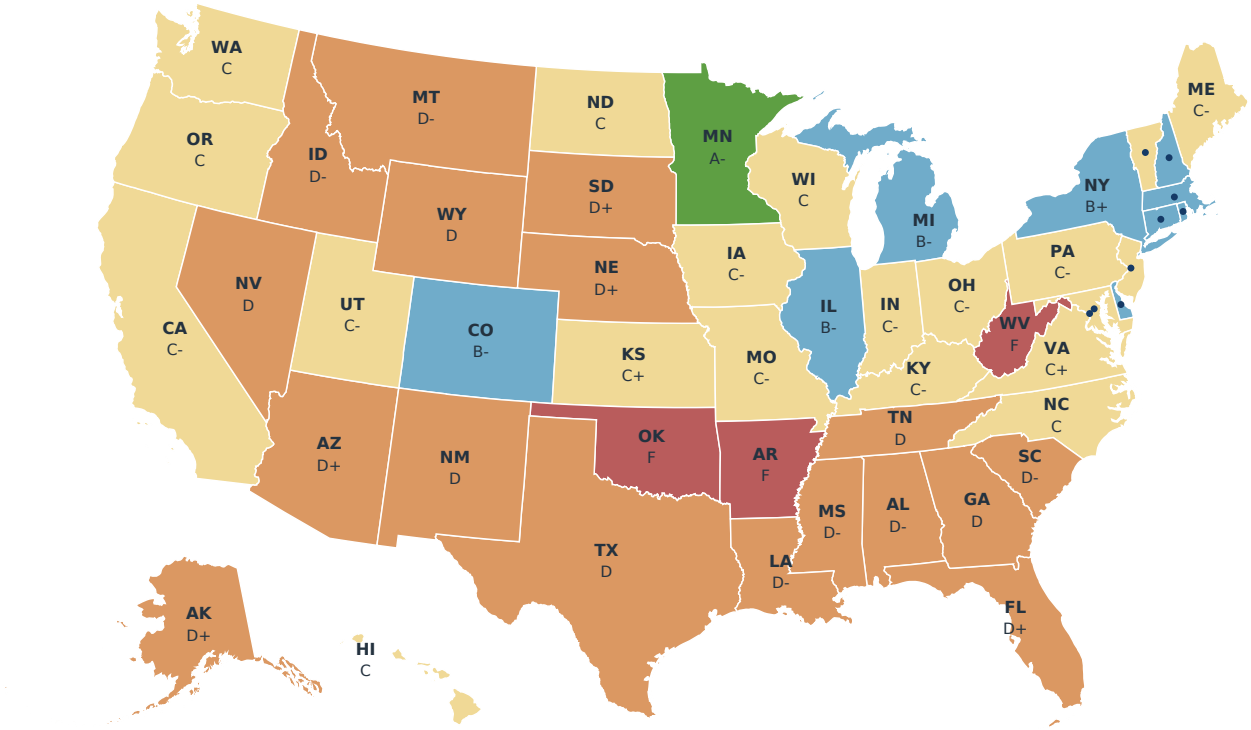
National average: C−

No state earned an A. Seventeen states received a D-range grade and three received an F. Minnesota led the country at 76.4 (A−). Every jurisdiction has opportunities to improve access.

Scoring: 44 measures across six weighted tiers; each metric is scored 0–4 against defined criteria.

SEPTEMBER 2026 COMPOSITE GRADES

Obesity treatment access across the U.S.



Alaska and Hawaii shown as insets; scales differ.

NORTHEAST + D.C.

VT C	NH B	MA B+
RI B	CT B	NJ C+
DE B+	MD C	DC C

A range **B range** **C range** **D range** **F**

Colors group the published letter grades. Exact scores and grades for all 51 jurisdictions appear in the rankings and individual scorecards. Grades measure the access environment, not people or their health.

Map geometry: U.S. Atlas, states-albers-10m (Albers USA projection). Scores: September 2026 OTAS ranking table.

THE EXPERIENCE OF SEEKING CARE

Coverage is not the same as access

A treatment on a benefit list is not necessarily a treatment a person can obtain.

The surgical access pathway

1. Coverage
2. Authorization
3. Workforce
4. Accredited care
5. Geography
6. Use + follow-up

Surgery illustrates why every gate matters

Research presented at the 2025 ASMBS Annual Meeting, using 2023 Medicaid plan data, found that 49 state Medicaid programs provided coverage for metabolic and bariatric surgery. Researchers also identified restrictions. Only four states in the study were classified as providing open access.



Laura G. | OAC Community Perspective
© Obesity Action Coalition

OAC COMMUNITY PERSPECTIVE | LAURA G.

**“For you, this may be policy.
For me, this is a matter of life and death.”**

In 2022, Laura’s healthcare team determined metabolic and bariatric surgery was medically necessary, but her employer-sponsored plan excluded obesity-related care. With advocacy support connected to OAC, ASMBS and The Obesity Society, she made the case for access. In October 2023, the school board expanded bariatric surgery coverage for eligible employees and families.

What Laura’s story shows

Coverage policy is not abstract. A treatment-specific exclusion can stop an evidence-based care pathway even after a healthcare team has identified an appropriate treatment.

Source: OAC Community Perspectives, Spring 2026.

Research source: 2025 ASMBS Annual Meeting abstract book (2023 Medicaid plan analysis).

THE 2026 ACCESS STORY

Coverage decisions change lives

A stable average can hide disrupted care

The national average remains near its March level, but individual coverage changes can have significant consequences for people receiving treatment. Seven Medicaid programs ended or scheduled an end to GLP-1 coverage for obesity during 2026, according to this edition.

Massachusetts: a substantial loss of access

MassHealth and the Group Insurance Commission ended GLP-1 coverage for obesity effective July 1. Major commercial carriers also discontinued coverage for obesity indications. Approximately 22,000 MassHealth members had relied on this care. Massachusetts moves from first place at baseline (77.7, A-) to third (71.5, B+). A relatively high overall grade does not erase the impact of losing treatment.

Coverage losses for GLP-1 obesity medications across states

California, New Hampshire, Pennsylvania and South Carolina ended coverage in January. Utah's Medicaid pilot expired June 30. Massachusetts followed July 1. Rhode Island enacted a termination effective October 1.

Utah: different pathways within the same state

The Medicaid weight management pilot expired June 30, while coverage for certain weight-related comorbidities continues under separate criteria. In the same legislative year, H.C.R. 8 renewed and expanded the state-employee pilot, adding a GLP-1 option alongside its bariatric surgery pathway for the July 2026 plan year. People living with the same disease face different options depending on their coverage.

What Utah's score does and does not show

Utah rises to 47.4 (C-), ranked 28th, because its state-employee plan measure improves. The Medicaid pilot was already scored at zero in the baseline because it was scheduled to end. That means the composite can rise even while Medicaid members lose a pathway to treatment. The priority is ensuring that Medicaid members have access to appropriate treatment and continuity of care.

STATE AND FEDERAL DEVELOPMENTS

Turn policy opportunities into care

Wisconsin: Reduce barriers to using coverage

BadgerCare Plus eased prior authorization requirements. Eligibility is described at BMI 30 or higher, or 27–29.9 with two or more risk factors. Other restrictions remain. Progress should be assessed by whether people experience fewer delays and interruptions.

Louisiana: Fund enacted coverage

Act 898, signed June 9, 2026, directs Medicaid coverage of medically necessary FDA-approved obesity medications, allows prior authorization and prohibits step therapy. Implementation remains contingent on legislative appropriation. Funding and implementation are necessary before the authorized benefit becomes available.

Indiana: Follow implementation through to patients

Indiana announced BALANCE participation July 30, 2026. Announced participation does not establish that an obesity medication benefit is available. Implementation timing and terms may depend on discussions with the administration. OTAS should reflect coverage when it takes effect.

Medicaid: Pricing is only one part of access

BALANCE creates a potential pathway to negotiated medication pricing, but state participation, timelines, benefit design, funding and implementation may vary. Initial administrative deadlines should not be presented as universally final. The measure of success is whether eligible people can begin and continue appropriate care.

Scope note: These developments provide policy context. An announced agreement or enacted statute should not be interpreted as implemented coverage until the relevant benefit is available.

MEDICATION ACCESS

Coverage can change — and continuity matters

Access is not only about starting an appropriate treatment. It is also about being able to continue it.

GLP-1 obesity medication coverage lost or scheduled to end

During 2026, several states ended or scheduled an end to Medicaid coverage for GLP-1 medications used for obesity. These changes illustrate how quickly the access environment can shift, even within a single reporting year.

OAC MEMBER PERSPECTIVE | MELADEE N.

“Access to that treatment was another, separate, part of the challenge.”

Meladee describes years of navigating obesity treatment and repeated medication-access barriers. Her experience included cash payment when insurance did not cover treatment, prior authorization, a denial after renewal paperwork problems, another coverage change and repeated coordination among her healthcare professional, pharmacy and insurer.



Meladee N. | OAC Member
© Obesity Action Coalition

What Meladee’s story shows

Administrative requirements, benefit changes and affordability can determine whether clinically appropriate care remains available over time.

A chronic disease requires continuity

OTAS tracks access conditions at a point in time. Coverage changes after the reporting cutoff should be read as important context rather than silently folded into earlier scores.

Source: OAC, “Finding the Right Obesity Treatment is Only the Beginning,” Sept. 1, 2026.

Rankings: all 51 jurisdictions

Rank	State	Composite	Grade	Baseline	Status
#1	**Minnesota**	76.4	A-	#2 · 76.4 A-	Coverage at risk
#2	**New York**	71.6	B+	#3 · 71.6 B+	
#3	**Massachusetts**	71.5	B+	#1 · 77.7 A-	Coverage ended in July
#4	Delaware	70.6	B+	#4 · 70.6 B+	
#5	Rhode Island	67.9	B	#5 · 67.9 B	Coverage ends Oct. 1
#6	Connecticut	66.6	B	#6 · 66.6 B	
#7	New Hampshire	66.0	B	#7 · 66.0 B	Coverage ended in January
#8	Colorado	63.0	B-	#8 · 63.0 B-	
#9	Illinois	60.3	B-	#9 · 60.3 B-	
#10	Michigan	60.0	B-	#10 · 60.0 B-	Coverage restricted
#11	Virginia	59.8	C+	#11 · 59.8 C+	
#12	Kansas	56.8	C+	#12 · 56.8 C+	
#13	New Jersey	56.3	C+	#13 · 56.3 C+	
#14	Maryland	54.8	C	#14 · 54.8 C	
#15	**Wisconsin**	53.2	C	#17 · 52.6 C	Prior authorization eased
#16	**Vermont**	53.1	C	#15 · 53.1 C	
#17	**Oregon**	52.9	C	#16 · 52.9 C	
#18	District of Columbia	52.5	C	#18 · 52.5 C	
#19	North Dakota	52.4	C	#19 · 52.4 C	
#20	Washington	52.3	C	#20 · 52.3 C	
#21	North Carolina	50.9	C	#21 · 50.9 C	Coverage reinstated
#22	Hawaii	50.5	C	#22 · 50.5 C	
#23	California	49.8	C-	#23 · 49.8 C-	Coverage ended in January
#24	Kentucky	49.7	C-	#24 · 49.7 C-	
#25	Pennsylvania	49.0	C-	#25 · 49.0 C-	Coverage ended in January
#26	Maine	48.4	C-	#26 · 48.4 C-	
#27	Ohio	47.8	C-	#27 · 47.8 C-	
#28	**Utah**	47.4	C-	#29 · 46.7 C-	
#29	**Iowa**	47.2	C-	#28 · 47.2 C-	
#30	**Indiana**	47.0	C-	#31 · 46.1 C-	First-dollar coverage
#31	**Missouri**	46.2	C-	#30 · 46.2 C-	
#32	Arizona	44.1	D+	#32 · 44.1 D+	
#33	South Dakota	41.8	D+	#33 · 41.8 D+	

HOW TO READ THE RANKINGS

Bold rank: position changed since March 2026. Shaded row: a notable 2026 coverage or policy development, which may not yet affect the September score. Baseline: March 2026 rank, score and grade. Status: brief policy update, not a measure of treatment availability. Check each state's technical scorecard and current plan documents.

Rank	State	Composite	Grade	Baseline	Status
#37	New Mexico	39.7	D	#37 · 39.7 D	
#38	Georgia	39.5	D	#38 · 39.5 D	
#39	Nevada	39.2	D	#39 · 39.2 D	
#40	Texas	39.0	D	#40 · 39.0 D	
#41	Tennessee	37.7	D	#41 · 37.7 D	
#42	Wyoming	36.9	D	#42 · 36.9 D	
#43	Alabama	34.8	D-	#43 · 34.8 D-	
#44	Louisiana	34.8	D-	#44 · 33.9 D-	Act 898 enacted
#45	Montana	33.0	D-	#45 · 33.0 D-	
#46	Mississippi	32.1	D-	#46 · 32.1 D-	
#47	South Carolina	30.9	D-	#47 · 30.9 D-	Coverage ended in January
#48	Idaho	30.2	D-	#48 · 30.2 D-	
#49	West Virginia	28.9	F	#49 · 28.9 F	
#50	Oklahoma	28.5	F	#50 · 28.5 F	
#51	Arkansas	25.5	F	#51 · 25.5 F	

HOW TO READ THE RANKINGS

Bold rank: position changed since March 2026. Shaded row: a notable 2026 coverage or policy development, which may not yet affect the September score. Baseline: March 2026 rank, score and grade. Status: brief policy update, not a measure of treatment availability. Check each state's technical scorecard and current plan documents.

Treatment coverage indicators

Jurisdictions with a positive score on selected OTAS treatment measures

Nutrition counseling — 28 of 51

AL, AZ, CA, CO, DE, IA, IN, KS, KY, MA, MD, ME, MI, MN, MO, NC, NH, NM, OH, OR, RI, SC, UT, VA, VT, WA, WV, WY

Intensive behavioral therapy (IBT) — 50 of 51

AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

GLP-1 obesity medications — 16 of 51

CA, CT, DE, IL, KS, MI, MN, MS, NC, NH, NY, PA, RI, SC, VA, WI

Metabolic and bariatric surgery (MBS) — 49 of 51

AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY

Coverage scores are not the same as access

A positive measure score does not establish unrestricted coverage or timely access. Review benefit rules, authorization requirements and continuity of care.

How to interpret these coverage indicators

A positive OTAS score indicates some level of coverage or access under the measure evaluated, which may involve Medicaid, state employee health plans or other insurance coverage. It does not mean all insurance programs cover the treatment or guarantee access for every person. Coverage rules and restrictions vary by plan.

Source: OTAS September 2026 technical state scorecards, Appendix B.

OAC COMMUNITY PERSPECTIVE

Sarah's story: Access is more than an insurance card

> **"Access to care involves a lot more than an insurance card."**



SARAH B., MSHL

Sarah described a four-hour round trip to reach specialty care, transportation costs and the challenges distance creates for participating in post-operative support. Her account also highlights equipment and accommodation barriers in healthcare settings.

What Sarah's experience reveals

Coverage is only one part of access. Distance, affordability, accessible facilities and the ability to receive ongoing support all shape whether a person can obtain clinically appropriate care.

A meaningful measure of access must account for people's real experiences.

Source: OAC, "A Day in the Life without Access to Obesity Care: Sarah·s Story," June 17, 2019.

HOW TO READ OTAS

A grade is a starting point, not the whole access story

MASSACHUSETTS | A STRONG GRADE, A MAJOR COVERAGE LOSS

Massachusetts earned a B+ in September 2026 even as changes to MassHealth and state employee benefits restricted coverage of medications used to treat obesity.

OTAS captured the deterioration: its Coverage and Eligibility tier fell from 72.2 in March to 47.2 in September, a 25-point decline. The overall grade remained relatively strong because OTAS combines 44 measures across six weighted tiers.

For people who lost access to treatment, a strong overall grade offers little reassurance. A composite score cannot fully convey the consequences of a treatment-specific coverage loss.

Read state grades in context

Examine the underlying measures, current benefit documents and experiences of people affected by obesity. A grade describes an access environment, not any individual's coverage or care.

Use the scorecard to guide the next questions

Is clinically appropriate treatment covered? Are approval requirements workable? Can people reach qualified healthcare professionals and facilities? Is treatment affordable and continuous? Is care respectful, accessible and free from weight bias?

FROM EVIDENCE TO ACCESS

Six actions that can strengthen obesity care

The specific opportunity differs by state, but the access principles are consistent.

1. **Cover comprehensive care**
   Benefit design should reflect the continuum of evidence-based obesity care.

2. **Make coverage usable**
   Use workable authorization requirements and remove unnecessary barriers.

3. **Build care capacity**
   Strengthen obesity medicine, metabolic and bariatric surgery, behavioral health, nutrition and referral networks.

4. **Address geography**
   Improve referrals, accredited-center access, appropriate telehealth and travel support.

5. **Measure meaningful access**
   Track whether people can obtain care, not only whether a benefit technically exists.

6. **Eliminate weight bias**
   Build respectful systems and include people affected by obesity in policy evaluation.

Start with the barrier the data reveal.
Strengthen coverage, authorization, workforce, referral pathways, geographic access and continuity based on local needs.

FROM DATA TO MEANING

Different barriers can lead to the same access problem

Use OTAS to identify the question, then pair the score with current benefit documents and local experience.

THE DATA	THE ACCESS REALITY	THE OPPORTUNITY
What OTAS measures	**What the measures can mean**	**What stakeholders can examine**
Coverage, authorization, workforce, facilities, geography, policy and treatment use.	A covered benefit may still be difficult to use because of exclusions, approvals, distance, capacity or cost.	The specific policy, plan or delivery barrier that can be addressed to improve meaningful access.

Illustrative access barriers · examples to investigate

South Carolina The 2026 State Health Plan lists bariatric surgery among services it generally does not cover. A broad plan score can hide a treatment-specific exclusion.

Alaska and Montana Alaska shows how geographic and accredited-center access can remain weak even with strong Medicaid surgical coverage. Montana shows a different problem: weak Medicaid surgical coverage and authorization alongside geographic barriers.

The question behind every score

Can a person obtain appropriate care without unnecessary delay, cost, distance or administrative burden? Pair scorecard findings with current plan documents and the experiences of people affected by obesity and healthcare professionals.

Sources: S.C. PEBA 2026 State Health Plan Summary of Benefits and Coverage; OTAS technical scorecards for Alaska and Montana.

METHODS NOTE

How the November 2026 edition was built

Peer-reviewed methodology, a March baseline and a September data refresh.

Scoring framework

OTAS uses 44 metrics, scored 0-4 against defined criteria and organized into six weighted tiers: coverage and eligibility, 25%; barriers and cost, 20%; workforce and facilities, 17%; policy environment, 13%; patient context and equity, 10%; and treatment use, 15%. Tier scores are rescaled to 0-100; the composite is the weighted sum.

Peer-reviewed methodology and baseline analysis

Scott JD, Hale AL, Zvenyach T, Nadglowski J, Hilton LR. Obesity treatment access in the United States: a state-level scorecard. Surg Obes Relat Dis. Published online Sept. 28, 2026. Article S1550-7289(26)00926-3.

November 2026 edition and data vintage

State policy and administrative data were re-searched and verified in September 2026 unless a later effective date is specifically noted. The November edition distinguishes the publication date from the September data refresh.

September 2026 re-scores

Massachusetts, Wisconsin, Louisiana, Indiana and Utah were re-scored for verified changes. Rhode Island re-scores when its enacted termination takes effect Oct. 1. The report preserves the March 2026 baseline for comparison.

Verification

Changes were checked against primary sources, including state Medicaid and pharmacy materials, enacted legislation, federal program materials and current benefit documents. State fact sheets are interpretation tools and do not replace verification of an individual plan benefit.

Where to go next

National synthesis and call to action: pages 18-19. Key terms: page 21.

Appendix A - State Fact Sheets: pages 22-73.

Appendix B - Technical State Scorecards: pages 74-125.

ABOUT THE ORGANIZATIONS

A partnership built around meaningful access

Patient advocacy and clinical expertise working from the same evidence.

Obesity Action Coalition (OAC)

A national nonprofit organization giving a voice to people affected by obesity. OAC provides evidence-based education, advocates for comprehensive obesity care, works to eliminate weight bias and discrimination, and offers community support.

American Society for Metabolic and Bariatric Surgery (ASMBS)

The largest national society dedicated to metabolic and bariatric surgery. ASMBS advances research, professional education and standards of care and works to improve equitable access to obesity treatment.

What OTAS adds

OTAS connects national evidence with state-level conditions. It helps patients, advocates, healthcare professionals, health plans, employers and policymakers see where coverage exists, where barriers remain and where closer examination is needed.

From the 2025 ASMBS Obesity Summit to state-level understanding

The Summit called for greater collaboration and identified patient access and equity as a continuing workstream. OTAS carries that work forward with a common framework for examining access environments across all 50 states and the District of Columbia.

The goal is not a better score for its own sake.

The goal is meaningful access to appropriate care.

People affected by obesity deserve respectful, affordable, individualized care—and healthcare professionals need systems that allow them to provide it.

Patients and advocates: ObesityAction.org/action-center

Healthcare professionals: ASMBS.org/state-chapters

ASMBS source: 2025 Obesity Summit and Outcomes Report.

FROM FINDINGS TO ACTION

51 jurisdictions. One clear opportunity.

Turn what the scorecard reveals into meaningful access to obesity care.



© Obesity Action Coalition

A score can show where access breaks down.

People experience what happens next.

Across the country, people affected by obesity may encounter gaps in coverage, delays and authorization requirements, limited treatment options, shortages of trained healthcare professionals or long distances to appropriate care. No single score captures every experience.

What the national picture asks us to do

1. **Patients and advocates**

   Use your state fact sheet to identify a barrier. Share what access looks like in real life and take action through OAC.

2. **Healthcare professionals**

   Document delays and denials, strengthen referral pathways and connect with your ASMBS State Chapter or State Access to Care Representative.

3. **Policymakers, plans and employers**

   Move from coverage on paper to usable benefits. Examine the specific barrier in your state and commit to one concrete improvement.

Use the findings. Ask what is getting in the way.
Then take action to change it.

Patients and advocates: ObesityAction.org/action-center

Healthcare professionals: ASMBS.org/state-chapters

WHY ACTION MATTERS

The work is not finished

A current OAC story shows what it can take just to find a path to care.

CAROL | OAC COMMUNITY PERSPECTIVE

“I know I qualify for this program.”

OAC member story

OAC COMMUNITY PERSPECTIVE | CAROL

Her treatment worked.
Keeping access became the challenge.

Carol found a treatment that worked for her, then struggled to keep access when cost and Medicare GLP-1 Bridge requirements became barriers. She spent hours trying to understand the authorization process and is now working with a weight management clinic in hopes of finding a workable path forward. In the meantime, uncertainty remains.

Behind every access measure is a person trying to get care.

Carol’s experience is one example of what the scorecard cannot fully capture: the time, uncertainty and emotional burden created when coverage rules are difficult to understand or use. Access should not depend on a person becoming an expert in insurance policy.

This is why the score cannot be the end of the conversation.

Help turn these findings into meaningful access to care.

Patients and advocates

Share your experience. Contact decision-makers. Join OAC’s advocacy efforts.

ObesityAction.org/action-center

Healthcare professionals

Identify local barriers, strengthen referral pathways and connect with ASMBS access leaders.

ASMBS.org/state-chapters

Source: OAC, “Fighting to Maintain Access to the Care That Helped Her,” Sept. 9, 2026.

HOW TO READ OTAS

Key terms used in this report

Plain-language definitions for terms used throughout the white paper, state fact sheets and technical scorecards.

Baseline

The March 2026 OTAS measurement used for comparison with the September 2026 data refresh reported in this November 2026 edition.

Body mass index (BMI)

A measure calculated from height and weight. OTAS includes BMI-related policy and coverage criteria where they are part of the underlying access measure; BMI alone does not describe an individual's health or determine appropriate care.

Composite score

OTAS's combined measure of selected indicators related to obesity treatment access. It describes aspects of a state's access environment; it does not determine an individual's benefits or guarantee access to care.

GLP-1 obesity medications

A class of medications that includes some U.S. Food and Drug Administration-approved treatments for chronic weight management. OTAS evaluates insurance coverage and access conditions for these medications.

Intensive behavioral therapy

Structured behavioral support for obesity that may include counseling on nutrition, physical activity and behavior change.

Marketplace/qualified health plan (QHP)

Health insurance coverage offered through the Affordable Care Act Marketplace. A qualified health plan meets applicable Marketplace certification requirements.

MBSAQIP-accredited center

A metabolic and bariatric surgery center accredited through the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint program of the American College of Surgeons and ASMBS.

Metabolic and bariatric surgery

Evidence-based surgical treatment for obesity and related diseases. OTAS examines coverage, authorization, surgeon availability, accredited-center access, travel time and utilization.

Obesity medicine physician

A physician with specialized training or certification in obesity medicine. OTAS uses physician density as one indicator of clinical capacity.

Prior authorization

A health plan requirement that approval be obtained before it will cover a treatment or service. OTAS examines authorization because requirements can affect timely access to appropriate care.

State employee health plan

Health coverage offered to eligible state employees and, depending on the plan, their dependents. OTAS uses this as one indicator of public-sector benefit design.

Utilization

The measured use of a treatment or service within the population represented by the underlying data. Low utilization does not by itself explain why use is lower or indicate how many people should receive a particular treatment.

APPENDIX A

State Fact Sheets

Use these 51 fact sheets to explore how obesity treatment access differs across all 50 states and Washington, D.C. Each sheet highlights the jurisdiction’s overall score, selected access strengths and gaps, what the findings can mean for people affected by obesity, and opportunities for action.

Appendix B contains the corresponding detailed technical state scorecards.

November 2026

ALABAMA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

34.8/100
ACCESS RANK #43 OF 51
September 2026 score [1]

38.9%
Adults affected by obesity

45.5%
Hypertension

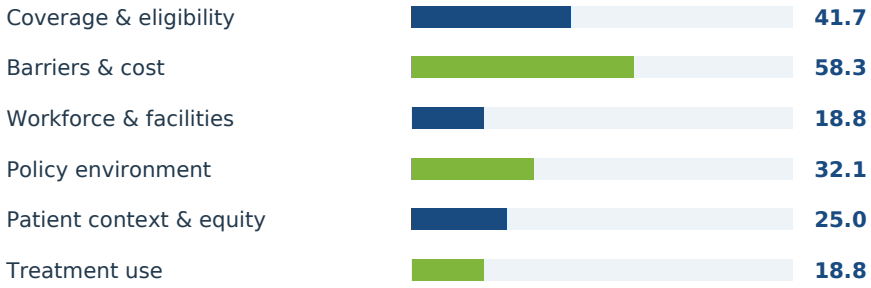
15.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build care capacity. Help people reach treatment.

Alabama scores 13.7 points below the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Finding a specialist

OTAS rates obesity medicine physician density at 1 of 4 and bariatric surgeon density at 0 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 1 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Three opportunities for action

1 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

2 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

3 State policymakers and health plans

Support appropriate telehealth payment and connect remote care with local services.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Alabama 2025 fact sheet (linked).

ALASKA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D+
OTAS GRADE

41.4/100
ACCESS RANK #35 OF 51
September 2026 score [1]

34.0%
Adults affected by obesity

34.4%
Hypertension

9.5%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Connect remote communities with comprehensive care.

Alaska scores 7.1 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	27.8
Barriers & cost	38.9
Workforce & facilities	28.1
Policy environment	60.7
Patient context & equity	46.4
Treatment use	62.5

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates Medicaid bariatric surgery at 4 of 4 and surgery authorization at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 0 of 4 and accredited center access at 0 of 4. Travel and referral support deserve attention alongside coverage. [1]

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 0 of 4. Local services can help people enter and stay connected to care. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referral pathways, travel support and appropriate telehealth follow-up so people can reach specialized obesity care.

2 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Alaska 2025 fact sheet (linked).

ARIZONA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D+
OTAS GRADE

44.1/100
ACCESS RANK #32 OF 51
September 2026 score [1]

33.3%
Adults affected by obesity

33.8%
Hypertension

11.9%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand treatment options and specialist access.

Arizona scores 4.4 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	33.3
Barriers & cost	58.3
Workforce & facilities	34.4
Policy environment	57.1
Patient context & equity	42.9
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Finding a specialist

OTAS rates obesity medicine physician density at 1 of 4 and bariatric surgeon density at 1 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Arizona 2025 fact sheet (linked).

ARKANSAS

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



F
OTAS GRADE

25.5/100
ACCESS RANK #51 OF 51
September 2026 score [1]

38.9%
Adults affected by obesity

43.2%
Hypertension

15.0%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build a stronger foundation for access.

Arkansas scores 23.0 points below the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	19.4
Barriers & cost	38.9
Workforce & facilities	18.8
Policy environment	39.3
Patient context & equity	17.9
Treatment use	18.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 3 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health systems and health plans

Reduce surgery authorization barriers and improve referral and travel pathways to accredited care.

3 State leaders and community partners

Improve coverage enrollment, benefit navigation and affordability support for patients.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Arkansas 2025 fact sheet (linked).

CALIFORNIA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

49.8/100
ACCESS RANK #23 OF 51
September 2026 score [1]

29.1%
Adults affected by obesity

31.1%
Hypertension

12.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make treatment affordable and continuity possible.

California scores 1.3 points above the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	52.8
Barriers & cost	25.0
Workforce & facilities	53.1
Policy environment	60.7
Patient context & equity	71.4
Treatment use	50.0

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care people can afford

OTAS rates patient cost sharing at 0 of 4. A covered treatment can still be difficult to afford. [1]

Keeping care consistent

OTAS rates treatment duration rules at 0 of 4 and discontinuation rules at 0 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Health plans and employers

Reduce out-of-pocket barriers and make treatment costs clear before care begins.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 Health plans and health systems

Improve access to accredited surgical care and investigate unmet need behind low utilization.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC California 2025 fact sheet (linked).

COLORADO

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

B-
OTAS GRADE

63.0/100
ACCESS RANK #8 OF 51
September 2026 score [1]

25.0%
Adults affected by obesity

27.5%
Hypertension

8.3%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Turn policy strengths into treatment access.

Colorado scores 14.5 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Eligibility that supports care

OTAS rates BMI thresholds at 1 of 4 and comorbidity requirements at 1 of 4. Eligibility should reflect clinical need and support individualized decisions. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Medicaid and health plans

Review restrictive eligibility rules and provide workable clinical exceptions.

3 Health systems and state leaders

Strengthen referral pathways to accredited metabolic and bariatric care and assess unmet surgical need.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Colorado 2025 fact sheet (linked).

CONNECTICUT

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B
OTAS GRADE

66.6/100
ACCESS RANK #6 OF 51
September 2026 score [1]

32.0%
Adults affected by obesity

33.1%
Hypertension

12.0%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Match clinical capacity with workable benefits.

Connecticut scores 18.1 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	58.3
Barriers & cost	52.8
Workforce & facilities	81.2
Policy environment	82.1
Patient context & equity	85.7
Treatment use	56.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 4 of 4 and telehealth parity at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Eligibility that supports care

OTAS rates BMI thresholds at 1 of 4 and comorbidity requirements at 1 of 4. Eligibility should reflect clinical need and support individualized decisions. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 Medicaid and health plans

Review restrictive eligibility rules and provide workable clinical exceptions.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Connecticut 2025 fact sheet (linked).

DELAWARE

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B+
OTAS GRADE

70.6/100
ACCESS RANK #4 OF 51
September 2026 score [1]

36.6%
Adults affected by obesity

38.5%
Hypertension

13.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Preserve benefits. Strengthen the care team.

Delaware scores 22.1 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Finding a specialist

OTAS rates obesity medicine physician density at 3 of 4 and bariatric surgeon density at 1 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Access to supportive teams

OTAS rates dietitian density at 1 of 4 and mental health workforce at 2 of 4. Patients need access to a team that can support their individual needs. [1]

Three opportunities for action

1 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

2 Health systems and health plans

Improve access to dietitians and behavioral health professionals within obesity care.

3 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Delaware 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

WASHINGTON, DC

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C
OTAS GRADE

52.5/100
ACCESS RANK #18 OF 51
September 2026 score [1]

25.5%
Adults affected by obesity

29.2%
Hypertension

8.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Connect strong clinical capacity with better coverage.

District of Columbia scores 4.0 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	22.2
Barriers & cost	36.1
Workforce & facilities	84.4
Policy environment	57.1
Patient context & equity	85.7
Treatment use	62.5

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates accredited center access at 4 of 4 and dietitian density at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Care people can afford

OTAS rates patient cost sharing at 1 of 4. A covered treatment can still be difficult to afford. [1]

Three opportunities for action

1 District policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health plans and employers

Reduce out-of-pocket barriers and make treatment costs clear before care begins.

3 Health plans

Review authorization requirements for metabolic and bariatric surgery and provide workable clinical exceptions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Washington, Dc 2025 fact sheet (linked).

FLORIDA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D+
OTAS GRADE

40.6/100
ACCESS RANK #36 OF 51
September 2026 score [1]

29.6%
Adults affected by obesity

37.0%
Hypertension

12.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand coverage. Make comprehensive care reachable.

Coverage is Florida's lowest-scoring tier. Its overall score is 7.9 points below the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	22.2
Barriers & cost	41.7
Workforce & facilities	46.9
Policy environment	46.4
Patient context & equity	42.9
Treatment use	56.2

Tier scores: 0–100; higher scores are better. [1]

Build on existing capacity

OTAS rates bariatric surgeon density and medical weight management programs at 3 of 4. Coverage expansion should connect patients with available expertise. [1]

What this means for patients

Limited coverage choices

OTAS assigns low scores to GLP-1 obesity medication and nutrition coverage. Patients may have fewer affordable treatment options. [1]

Access to the right team

Dietitian density scores 0 of 4, while obesity medicine physician density scores 1 of 4. Finding support deserves attention alongside coverage. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity treatment benefits, including medications and nutrition care.

2 Health plans and employers

Publish clear benefit criteria, simplify authorization and provide workable clinical exceptions.

3 Health systems and state leaders

Improve access to obesity medicine and dietitian services, including appropriate telehealth.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Florida 2025 fact sheet (linked).

GEORGIA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D
OTAS GRADE

39.5/100
ACCESS RANK #38 OF 51
September 2026 score [1]

35.4%
Adults affected by obesity

35.9%
Hypertension

13.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Close coverage gaps. Connect people with care.

Georgia scores 9.0 points below the national average of 48.5. Coverage is its lowest-scoring tier at 27.8. [1]

Access at a glance

Coverage & eligibility	27.8
Barriers & cost	50.0
Workforce & facilities	34.4
Policy environment	53.6
Patient context & equity	32.1
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

Build on surgical access

OTAS rates Medicaid bariatric surgery and accredited center access at 3 of 4. Preserve these strengths while addressing workforce gaps. [1]

What this means for patients

Missing pieces of comprehensive care

GLP-1 obesity coverage and nutrition counseling each score 0 of 4 in OTAS. These gaps can limit affordable treatment choices. [1]

A center is only part of access

Bariatric surgeon and dietitian density each score 0 of 4. A low density score does not mean no providers; it signals a need to improve reach. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand obesity medication and nutrition benefits with workable eligibility criteria.

2 Health systems and state leaders

Strengthen bariatric and dietitian capacity and referral pathways to accredited centers.

3 Health plans and employers

Remove unnecessary BMI and duration restrictions; support continuity of appropriate care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Georgia 2025 fact sheet (linked).

HAWAII

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

50.5/100
ACCESS RANK #22 OF 51
September 2026 score [1]

27.0%
Adults affected by obesity

32.8%
Hypertension

11.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand benefits and access to supportive care.

Hawaii scores 2.0 points above the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates behavioral treatment coverage at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 4 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Getting to the right care

OTAS rates travel time to accredited centers at 2 of 4 and accredited center access at 0 of 4. Travel and referral support deserve attention alongside coverage. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Hawaii 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

IDAHO

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

30.2/100
ACCESS RANK #48 OF 51
September 2026 score [1]

32.7%
Adults affected by obesity

31.8%
Hypertension

9.3%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build local capacity and broader treatment benefits.

Idaho scores 18.3 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	25.0
Barriers & cost	33.3
Workforce & facilities	21.9
Policy environment	35.7
Patient context & equity	42.9
Treatment use	31.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates Medicaid bariatric surgery at 3 of 4 and dietitian density at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 State policymakers and health plans

Support appropriate telehealth payment and connect remote care with local services.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Idaho 2025 fact sheet (linked).

ILLINOIS

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B-
OTAS GRADE

60.3/100
ACCESS RANK #9 OF 51
September 2026 score [1]

34.2%
Adults affected by obesity

33.9%
Hypertension

12.9%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make covered treatments reach more people.

Illinois scores 11.8 points above the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	52.8
Barriers & cost	86.1
Workforce & facilities	59.4
Policy environment	71.4
Patient context & equity	67.9
Treatment use	25.0

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 2 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Illinois 2025 fact sheet (linked).

INDIANA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

47.0/100
ACCESS RANK #30 OF 51
September 2026 score [1]

38.4%
Adults affected by obesity

38.4%
Hypertension

14.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Translate access opportunities into usable care.

Indiana scores 1.5 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	47.2
Barriers & cost	50.0
Workforce & facilities	40.6
Policy environment	57.1
Patient context & equity	42.9
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Access to supportive teams

OTAS rates dietitian density at 1 of 4 and mental health workforce at 1 of 4. Patients need access to a team that can support their individual needs. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health systems and health plans

Improve access to dietitians and behavioral health professionals within obesity care.

3 Medicaid and health plans

Review restrictive eligibility rules and provide workable clinical exceptions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Indiana 2025 fact sheet (linked).

IOWA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

47.2/100
ACCESS RANK #29 OF 51
September 2026 score [1]

36.6%
Adults affected by obesity

34.6%
Hypertension

11.4%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen local care and regional referrals.

Iowa scores 1.3 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	52.8
Barriers & cost	55.6
Workforce & facilities	31.2
Policy environment	60.7
Patient context & equity	50.0
Treatment use	31.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Getting to the right care

OTAS rates travel time to accredited centers at 1 of 4 and accredited center access at 1 of 4. Travel and referral support deserve attention alongside coverage. [1]

Three opportunities for action

1 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

2 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Iowa 2025 fact sheet (linked).

KANSAS

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C+
OTAS GRADE

56.8/100
ACCESS RANK #12 OF 51
September 2026 score [1]

37.6%
Adults affected by obesity

34.5%
Hypertension

12.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Reduce travel and improve the path to approval.

Kansas scores 8.3 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	61.1
Barriers & cost	52.8
Workforce & facilities	50.0
Policy environment	60.7
Patient context & equity	42.9
Treatment use	68.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 1 of 4 and accredited center access at 4 of 4. Travel and referral support deserve attention alongside coverage. [1]

Avoiding unnecessary hurdles

OTAS rates step therapy protections at 1 of 4. Patients need a path around requirements that do not fit their clinical needs. [1]

Three opportunities for action

1 Health systems and health plans

Reduce surgery authorization barriers and improve travel and referral pathways to accredited care.

2 State policymakers and health plans

Strengthen exceptions to inappropriate step therapy and avoid duplicative prerequisites.

3 State benefit administrators

Offer comprehensive obesity treatment benefits with affordable cost sharing and clear criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Kansas 2025 fact sheet (linked).

KENTUCKY

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C-
OTAS GRADE

49.7/100
ACCESS RANK #24 OF 51
September 2026 score [1]

37.2%
Adults affected by obesity

NR
Hypertension

16.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Bring care closer and address financial barriers.

Kentucky scores 1.2 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Help navigating access

OTAS rates insurance context at 3 of 4 and income and cost burden at 1 of 4. These context measures highlight the need for practical access support. [1]

Three opportunities for action

1 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

2 State leaders and community partners

Improve coverage enrollment, benefit navigation and affordability support for patients.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Kentucky 2025 fact sheet (linked).

LOUISIANA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

34.8/100
ACCESS RANK #44 OF 51
September 2026 score [1]

39.2%
Adults affected by obesity

43.9%
Hypertension

15.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build benefits that support comprehensive care.

Louisiana scores 13.7 points below the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	22.2
Barriers & cost	41.7
Workforce & facilities	37.5
Policy environment	46.4
Patient context & equity	28.6
Treatment use	37.5

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 3 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Louisiana 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

MAINE

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

48.4/100
ACCESS RANK #26 OF 51
September 2026 score [1]

33.2%
Adults affected by obesity

36.2%
Hypertension

11.4%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Bring treatment within reach across communities.

Maine scores 0.1 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	38.9
Barriers & cost	50.0
Workforce & facilities	46.9
Policy environment	60.7
Patient context & equity	53.6
Treatment use	50.0

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 1 of 4 and accredited center access at 2 of 4. Travel and referral support deserve attention alongside coverage. [1]

Access through employment

OTAS rates state employee coverage at 1 of 4. Public employee benefits are one practical place to improve treatment access. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

2 State benefit administrators

Offer comprehensive obesity treatment benefits with affordable cost sharing and clear criteria.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Maine 2025 fact sheet (linked).

MARYLAND

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C
OTAS GRADE

54.8/100
ACCESS RANK #14 OF 51
September 2026 score [1]

32.7%
Adults affected by obesity

36.2%
Hypertension

12.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Improve surgical access and workable eligibility.

Maryland scores 6.3 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A path to surgical care

OTAS rates Medicaid bariatric surgery at 2 of 4 and surgery authorization at 1 of 4. Patients need both a benefit and a workable approval process. [1]

Eligibility that supports care

OTAS rates BMI thresholds at 1 of 4 and comorbidity requirements at 1 of 4. Eligibility should reflect clinical need and support individualized decisions. [1]

Three opportunities for action

1 **Medicaid and health plans**

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

2 **Medicaid and health plans**

Review restrictive eligibility rules and provide workable clinical exceptions.

3 **State policymakers and Medicaid**

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

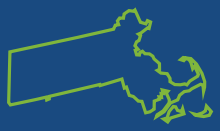
[1] Appendix B: Technical State Scorecards.

[2] OAC Maryland 2025 fact sheet (linked).

MASSACHUSETTS

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B+
OTAS GRADE

71.5/100
ACCESS RANK #3 OF 51
September 2026 score [1]

27.0%
Adults affected by obesity

31.5%
Hypertension

9.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Reconnect clinical strengths with treatment coverage.

Massachusetts scores 23.0 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	47.2
Barriers & cost	69.4
Workforce & facilities	93.8
Policy environment	78.6
Patient context & equity	92.9
Treatment use	68.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A lower coverage score

OTAS lowers GLP-1 obesity coverage from 4 to 0 of 4 and the composite from 77.7 to 71.5. Strong clinical capacity cannot replace an affordable benefit. [1]

Support across treatment

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Massachusetts 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

MICHIGAN

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B-
OTAS GRADE

60.0/100
ACCESS RANK #10 OF 51
September 2026 score [1]

36.1%
Adults affected by obesity

37.3%
Hypertension

13.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make covered care easier to start and continue.

Michigan is 11.5 points above the national average of 48.5. Barriers and cost remain its lowest-scoring tier. [1]

Access at a glance

Coverage & eligibility	72.2
Barriers & cost	41.7
Workforce & facilities	50.0
Policy environment	50.0
Patient context & equity	64.3
Treatment use	81.2

Tier scores: 0–100; higher scores are better. [1]

Preserve comprehensive benefits

OTAS gives Medicaid bariatric surgery, nutrition counseling and intensive behavioral therapy scores of 4 of 4. Protect those strengths. [1]

What this means for patients

New rules can affect ongoing care

Michigan's January 2026 GLP-1 restrictions apply to obesity-only requests, including continuation. Other covered indications were unchanged by that policy. [3]

Coverage does not remove every barrier

OTAS scores coverage at 72.2 but barriers and cost at 41.7. Patients need affordable care and a workable path to continued treatment. [1]

Three opportunities for action

1 Legislators and Medicaid

Revisit restrictive obesity-only GLP-1 requirements and protect clinically appropriate ongoing care.

2 Health plans and employers

Reduce patient cost barriers and avoid arbitrary treatment duration or discontinuation rules.

3 Health systems and state leaders

Expand access to obesity medicine and bariatric specialists while preserving supportive services.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Michigan 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

MINNESOTA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



A-
OTAS GRADE

76.4/100
ACCESS RANK #1 OF 51
September 2026 score [1]

32.3%
Adults affected by obesity

31.2%
Hypertension

10.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Protect strong benefits. Close remaining access gaps.

Minnesota scores 27.9 points above the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Finding a specialist

OTAS rates obesity medicine physician density at 2 of 4 and bariatric surgeon density at 0 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Are treatments reaching people?

OTAS rates obesity medication use at 4 of 4 and bariatric surgery use at 2 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Three opportunities for action

1 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

2 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

3 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Minnesota 2025 fact sheet (linked).

MISSISSIPPI

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

32.1/100
ACCESS RANK #46 OF 51
September 2026 score [1]

40.4%
Adults affected by obesity

46.8%
Hypertension

15.4%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make care affordable, reachable and supported.

Mississippi scores 16.4 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	25.0
Barriers & cost	33.3
Workforce & facilities	28.1
Policy environment	35.7
Patient context & equity	3.6
Treatment use	62.5

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates accredited center access at 4 of 4 and GLP-1 obesity coverage at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Help navigating access

OTAS rates insurance context at 1 of 4 and income and cost burden at 0 of 4. These context measures highlight the need for practical access support. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 State leaders and community partners

Improve coverage enrollment, benefit navigation and affordability support for patients.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

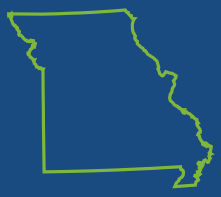
[1] Appendix B: Technical State Scorecards.

[2] OAC Mississippi 2025 fact sheet (linked).

MISSOURI

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

46.2/100
ACCESS RANK #31 OF 51
September 2026 score [1]

34.6%
Adults affected by obesity

37.0%
Hypertension

11.5%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Bring care closer. Simplify the path to treatment.

Missouri scores 2.3 points below the national average of 48.5. Workforce and patient context scores highlight access challenges. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

Preserve supportive care

OTAS rates nutrition counseling and intensive behavioral therapy at 4 of 4. Build on these strengths with access to the full range of treatments. [1]

What this means for patients

Distance and limited care options

OTAS scores drive time to accredited bariatric centers and medical weight management programs at 1 of 4. Travel and provider access merit attention. [1]

More steps before treatment

Medication and surgery authorization each score 1 of 4. Complicated approval processes can add work for patients and delay access to care. [1]

Three opportunities for action

1 Health systems and state leaders

Expand local obesity care, referral networks and appropriate telehealth to address travel barriers.

2 Health plans and Medicaid

Simplify medication and surgery authorization, with clear criteria and timely review.

3 State policymakers and employers

Broaden obesity medication benefits while protecting nutrition and behavioral support.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Missouri 2025 fact sheet (linked).

MONTANA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

33.0/100
ACCESS RANK #45 OF 51
September 2026 score [1]

31.0%
Adults affected by obesity

32.5%
Hypertension

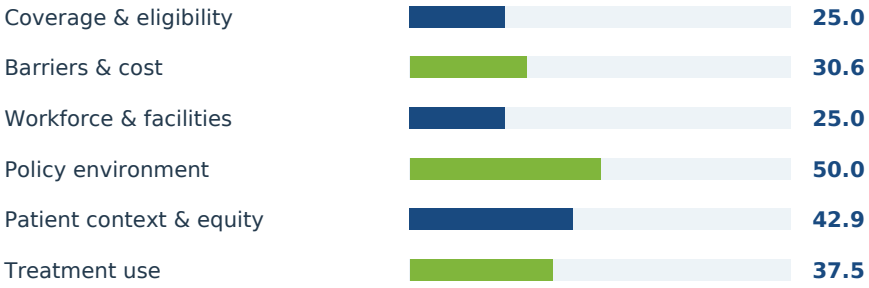
8.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen surgical pathways and regional access.

Montana scores 15.5 points below the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates behavioral treatment coverage at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A path to surgical care

OTAS rates Medicaid bariatric surgery at 0 of 4 and surgery authorization at 0 of 4. Patients need both a benefit and a workable approval process. [1]

Getting to the right care

OTAS rates travel time to accredited centers at 0 of 4 and accredited center access at 1 of 4. Travel and referral support deserve attention alongside coverage. [1]

Three opportunities for action

1 Medicaid and health plans

Address gaps in metabolic and bariatric surgery coverage and authorization so people who may benefit can access appropriate care.

2 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

3 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Montana 2025 fact sheet (linked).

NEBRASKA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D+
OTAS GRADE

41.5/100
ACCESS RANK #34 OF 51
September 2026 score [1]

37.6%
Adults affected by obesity

33.4%
Hypertension

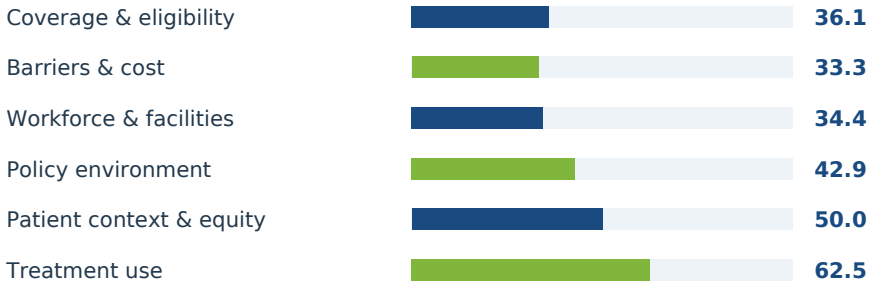
10.5%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Reduce treatment hurdles and strengthen local care.

Nebraska scores 7.0 points below the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates dietitian density at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Avoiding unnecessary hurdles

OTAS rates step therapy protections at 1 of 4. Patients need a path around requirements that do not fit their clinical needs. [1]

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Three opportunities for action

1 State policymakers and health plans

Strengthen exceptions to inappropriate step therapy and avoid duplicative prerequisites.

2 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

3 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Nebraska 2025 fact sheet (linked).

NEVADA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D
OTAS GRADE

39.2/100
ACCESS RANK #39 OF 51
September 2026 score [1]

34.2%
Adults affected by obesity

34.9%
Hypertension

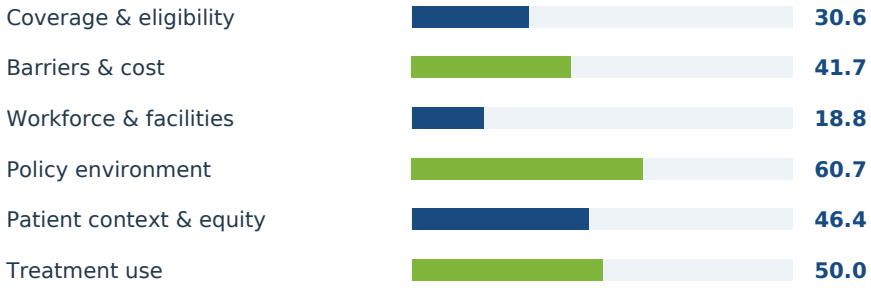
14.2%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build the workforce patients need to access care.

Nevada scores 9.3 points below the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates behavioral treatment coverage at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Finding a specialist

OTAS rates obesity medicine physician density at 1 of 4 and bariatric surgeon density at 1 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Three opportunities for action

1 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

2 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

3 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Nevada 2025 fact sheet (linked).

NEW HAMPSHIRE

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B
OTAS GRADE

66.0/100
ACCESS RANK #7 OF 51
September 2026 score [1]

31.1%
Adults affected by obesity

33.7%
Hypertension

10.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make benefits and approval processes work together.

New Hampshire scores 17.5 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	61.1
Barriers & cost	55.6
Workforce & facilities	68.8
Policy environment	60.7
Patient context & equity	78.6
Treatment use	81.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and accredited center access at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 1 of 4. This flags a gap to address when expanding affordable medication options. [1]

The work of getting approval

OTAS rates medication authorization at 1 of 4 and surgery authorization at 1 of 4. Complex approval processes can add work for patients and delay care. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

3 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC New Hampshire 2025 fact sheet (linked).

NEW JERSEY

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C+
OTAS GRADE

56.3/100
ACCESS RANK #13 OF 51
September 2026 score [1]

27.7%
Adults affected by obesity

34.4%
Hypertension

11.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Support comprehensive care and ongoing treatment.

New Jersey scores 7.8 points above the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates Medicaid bariatric surgery at 3 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Keeping care consistent

OTAS rates treatment duration rules at 1 of 4 and discontinuation rules at 1 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC New Jersey 2025 fact sheet (linked).

NEW MEXICO

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D
OTAS GRADE

39.7/100
ACCESS RANK #37 OF 51
September 2026 score [1]

34.5%
Adults affected by obesity

34.5%
Hypertension

12.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Build care teams and reduce the burden of travel.

New Mexico scores 8.8 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	30.6
Barriers & cost	52.8
Workforce & facilities	25.0
Policy environment	57.1
Patient context & equity	32.1
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Access to supportive teams

OTAS rates dietitian density at 0 of 4 and mental health workforce at 1 of 4. Patients need access to a team that can support their individual needs. [1]

Getting to the right care

OTAS rates travel time to accredited centers at 1 of 4 and accredited center access at 2 of 4. Travel and referral support deserve attention alongside coverage. [1]

Three opportunities for action

1 Health systems and health plans

Improve access to dietitians and behavioral health professionals within obesity care.

2 Health systems and state leaders

Strengthen metabolic and bariatric surgery capacity, referral pathways and travel support for people seeking care.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC New Mexico 2025 fact sheet (linked).

NEW YORK

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B+
OTAS GRADE

71.6/100
ACCESS RANK #2 OF 51
September 2026 score [1]

29.5%
Adults affected by obesity

32.6%
Hypertension

12.5%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Broaden supportive care and reach underserved need.

New York scores 23.1 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 4 of 4 and telehealth parity at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 4 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

3 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC New York 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

NORTH CAROLINA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

50.9/100
ACCESS RANK #21 OF 51
September 2026 score [1]

34.5%
Adults affected by obesity

38.4%
Hypertension

13.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen surgical access and continuity of care.

North Carolina scores 2.4 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	55.6
Barriers & cost	58.3
Workforce & facilities	46.9
Policy environment	50.0
Patient context & equity	42.9
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A path to surgical care

OTAS rates Medicaid bariatric surgery at 1 of 4 and surgery authorization at 3 of 4. Patients need both a benefit and a workable approval process. [1]

Keeping care consistent

OTAS rates treatment duration rules at 2 of 4 and discontinuation rules at 1 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 State benefit administrators

Offer comprehensive obesity treatment benefits with affordable cost sharing and clear criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC North Carolina 2025 fact sheet (linked).

NORTH DAKOTA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

52.4/100
ACCESS RANK #19 OF 51
September 2026 score [1]

36.8%
Adults affected by obesity

31.9%
Hypertension

10.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Connect rural patients with comprehensive care.

North Dakota scores 3.9 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	47.2
Barriers & cost	61.1
Workforce & facilities	46.9
Policy environment	67.9
Patient context & equity	50.0
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates accredited center access at 4 of 4 and dietitian density at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 1 of 4 and accredited center access at 4 of 4. Travel and referral support deserve attention alongside coverage. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC North Dakota 2025 fact sheet (linked).

OHIO

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

47.8/100
ACCESS RANK #27 OF 51
September 2026 score [1]

36.9%
Adults affected by obesity

37.3%
Hypertension

13.3%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand medication access and understand unmet need.

Ohio scores 0.7 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	44.4
Barriers & cost	52.8
Workforce & facilities	53.1
Policy environment	57.1
Patient context & equity	50.0
Treatment use	31.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and dietitian density at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 2 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

3 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Ohio 2025 fact sheet (linked).

OKLAHOMA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



F
OTAS GRADE

28.5/100
ACCESS RANK #50 OF 51
September 2026 score [1]

36.8%
Adults affected by obesity

39.2%
Hypertension

13.4%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen community care and practical support.

Oklahoma scores 20.0 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	25.0
Barriers & cost	38.9
Workforce & facilities	18.8
Policy environment	32.1
Patient context & equity	14.3
Treatment use	37.5

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates Medicaid bariatric surgery at 3 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Help navigating access

OTAS rates insurance context at 0 of 4 and income and cost burden at 1 of 4. These context measures highlight the need for practical access support. [1]

Three opportunities for action

1 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

2 State leaders and community partners

Improve coverage enrollment, benefit navigation and affordability support for patients.

3 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Oklahoma 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

OREGON

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

52.9/100
ACCESS RANK #17 OF 51
September 2026 score [1]

33.5%
Adults affected by obesity

33.7%
Hypertension

11.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Simplify approval and strengthen the care team.

Oregon scores 4.4 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	41.7
Barriers & cost	44.4
Workforce & facilities	40.6
Policy environment	71.4
Patient context & equity	71.4
Treatment use	68.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

The work of getting approval

OTAS rates medication authorization at 1 of 4 and surgery authorization at 1 of 4. Complex approval processes can add work for patients and delay care. [1]

Finding a specialist

OTAS rates obesity medicine physician density at 1 of 4 and bariatric surgeon density at 0 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Three opportunities for action

1 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

2 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

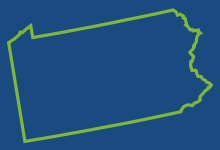
[1] Appendix B: Technical State Scorecards.

[2] OAC Oregon 2025 fact sheet (linked).

PENNSYLVANIA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C-
OTAS GRADE

49.0/100
ACCESS RANK #25 OF 51
September 2026 score [1]

34.2%
Adults affected by obesity

NR
Hypertension

13.3%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Reduce cost barriers and protect ongoing care.

Pennsylvania scores 0.5 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	41.7
Barriers & cost	30.6
Workforce & facilities	62.5
Policy environment	60.7
Patient context & equity	64.3
Treatment use	50.0

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates Medicaid bariatric surgery at 3 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Care people can afford

OTAS rates patient cost sharing at 0 of 4. A covered treatment can still be difficult to afford. [1]

Keeping care consistent

OTAS rates treatment duration rules at 0 of 4 and discontinuation rules at 0 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Health plans and employers

Reduce out-of-pocket barriers and make treatment costs clear before care begins.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Pennsylvania 2025 fact sheet (linked).

RHODE ISLAND

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



B
OTAS GRADE

67.9/100
ACCESS RANK #5 OF 51
September 2026 score [1]

31.1%
Adults affected by obesity

33.9%
Hypertension

11.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Protect access and simplify the path to surgery.

Rhode Island scores 19.4 points above the national average of 48.5.

Access at a glance

Coverage & eligibility	66.7
Barriers & cost	63.9
Workforce & facilities	62.5
Policy environment	71.4
Patient context & equity	82.1
Treatment use	68.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A path to surgical care

OTAS rates Medicaid bariatric surgery at 2 of 4 and surgery authorization at 1 of 4. Patients need both a benefit and a workable approval process. [1]

Protecting continuity

The white paper reports a coverage termination scheduled for October 1, after its reporting cutoff. The September score does not yet reflect that change. [1]

Three opportunities for action

1 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

2 State policymakers and Medicaid

Protect obesity treatment benefits and prevent avoidable interruptions as coverage rules change.

3 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Rhode Island 2025 fact sheet (linked).

OAC ASMBS American Society for Metabolic and Bariatric Surgery

SOUTH CAROLINA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D-
OTAS GRADE

30.9/100
ACCESS RANK #47 OF 51
September 2026 score [1]

34.6%
Adults affected by obesity

39.4%
Hypertension

14.1%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Remove treatment hurdles and build local capacity.

South Carolina scores 17.6 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	38.9
Barriers & cost	27.8
Workforce & facilities	25.0
Policy environment	32.1
Patient context & equity	25.0
Treatment use	31.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Avoiding unnecessary hurdles

OTAS rates step therapy protections at 1 of 4. Patients need a path around requirements that do not fit their clinical needs. [1]

A gap in state employee surgical coverage

South Carolina's 2026 State Health Plan lists bariatric surgery among services it generally does not cover. That exclusion can block access for state employees who may benefit from surgical treatment. [3]

Three opportunities for action

1 State policymakers and health plans

Strengthen exceptions to inappropriate step therapy and avoid duplicative prerequisites.

2 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

3 State employee health plan

Add metabolic and bariatric surgery coverage so state employees who may benefit have a pathway to care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC South Carolina 2025 fact sheet. [3] S.C. PEBA 2026 State Health Plan SBC.

OAC ASMBS American Society for Metabolic and Bariatric Surgery

SOUTH DAKOTA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D+
OTAS GRADE

41.8/100
ACCESS RANK #33 OF 51
September 2026 score [1]

37.0%
Adults affected by obesity

35.4%
Hypertension

11.7%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make rural care more accessible and comprehensive.

South Dakota scores 6.7 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	30.6
Barriers & cost	36.1
Workforce & facilities	34.4
Policy environment	42.9
Patient context & equity	42.9
Treatment use	75.0

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates accredited center access at 4 of 4 and Medicaid bariatric surgery at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 0 of 4 and accredited center access at 4 of 4. Travel and referral support deserve attention alongside coverage. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 State policymakers and health plans

Support appropriate telehealth payment and connect remote care with local services.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC South Dakota 2025 fact sheet (linked).

TENNESSEE

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D
OTAS GRADE

37.7/100
ACCESS RANK #41 OF 51
September 2026 score [1]

37.6%
Adults affected by obesity

41.1%
Hypertension

14.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand supportive benefits and practical access.

Tennessee scores 10.8 points below the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 3 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Help navigating access

OTAS rates insurance context at 1 of 4 and income and cost burden at 1 of 4. These context measures highlight the need for practical access support. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 State leaders and community partners

Improve coverage enrollment, benefit navigation and affordability support for patients.

3 Health systems and health plans

Improve surgical authorization and referral pathways to accredited care and assess unmet need.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Tennessee 2025 fact sheet (linked).

TEXAS

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



D
OTAS GRADE

39.0/100
ACCESS RANK #40 OF 51
September 2026 score [1]

35.6%
Adults affected by obesity

32.9%
Hypertension

13.6%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Broaden benefits and strengthen access to care teams.

Texas scores 9.5 points below the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates step therapy protections at 3 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Finding a specialist

OTAS rates obesity medicine physician density at 1 of 4 and bariatric surgeon density at 1 of 4. Low density scores signal a need to improve reach, not an absence of providers. [1]

Three opportunities for action

1 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

2 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Texas 2025 fact sheet (linked).

UTAH

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C-
OTAS GRADE

47.4/100
ACCESS RANK #28 OF 51
September 2026 score [1]

31.0%
Adults affected by obesity

27.7%
Hypertension

8.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Reduce approval hurdles and improve continuity.

Utah scores 1.1 points below the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

The work of getting approval

OTAS rates medication authorization at 1 of 4 and surgery authorization at 1 of 4. Complex approval processes can add work for patients and delay care. [1]

Keeping care consistent

OTAS rates treatment duration rules at 1 of 4 and discontinuation rules at 1 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Utah 2025 fact sheet (linked).

VERMONT

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

53.1/100
ACCESS RANK #16 OF 51
September 2026 score [1]

29.0%
Adults affected by obesity

32.4%
Hypertension

8.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen surgical reach and continuing care.

Vermont scores 4.6 points above the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 2 of 4 and accredited center access at 0 of 4. Travel and referral support deserve attention alongside coverage. [1]

Keeping care consistent

OTAS rates treatment duration rules at 1 of 4 and discontinuation rules at 1 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Vermont 2025 fact sheet (linked).

VIRGINIA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

C+
OTAS GRADE

59.8/100
ACCESS RANK #11 OF 51
September 2026 score [1]

32.3%
Adults affected by obesity

36.1%
Hypertension

13.0%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Make eligibility and ongoing treatment workable.

Virginia scores 11.3 points above the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	66.7
Barriers & cost	44.4
Workforce & facilities	56.2
Policy environment	60.7
Patient context & equity	64.3
Treatment use	68.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and behavioral treatment coverage at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Eligibility that supports care

OTAS rates BMI thresholds at 1 of 4 and comorbidity requirements at 1 of 4. Eligibility should reflect clinical need and support individualized decisions. [1]

Keeping care consistent

OTAS rates treatment duration rules at 1 of 4 and discontinuation rules at 2 of 4. Patients need predictable access to treatment that remains appropriate. [1]

Three opportunities for action

1 Medicaid and health plans

Review restrictive eligibility rules and provide workable clinical exceptions.

2 Health plans and employers

Remove arbitrary duration limits and protect clinically appropriate ongoing treatment.

3 Health plans

Review authorization requirements for metabolic and bariatric surgery and provide workable clinical exceptions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

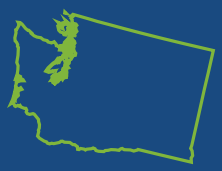
[1] Appendix B: Technical State Scorecards.

[2] OAC Virginia 2025 fact sheet (linked).

WASHINGTON

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

52.3/100
ACCESS RANK #20 OF 51
September 2026 score [1]

31.5%
Adults affected by obesity

31.2%
Hypertension

10.0%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Expand treatment options and assess unmet need.

Washington scores 3.8 points above the national average of 48.5.

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Medication access

OTAS rates GLP-1 obesity coverage at 0 of 4. This flags a gap to address when expanding affordable medication options. [1]

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 2 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Three opportunities for action

1 State policymakers and Medicaid

Expand evidence-based obesity medication benefits with clear, workable eligibility criteria.

2 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

3 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

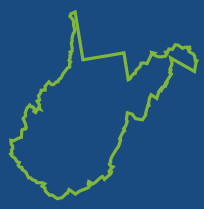
[1] Appendix B: Technical State Scorecards.

[2] OAC Washington 2025 fact sheet (linked).

WEST VIRGINIA

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



F
OTAS GRADE

28.9/100
ACCESS RANK #49 OF 51
September 2026 score [1]

41.4%
Adults affected by obesity

45.4%
Hypertension

18.4%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Connect people with treatment and local support.

West Virginia scores 19.6 points below the national average of 48.5.

Access at a glance

Coverage & eligibility	38.9
Barriers & cost	38.9
Workforce & facilities	21.9
Policy environment	35.7
Patient context & equity	21.4
Treatment use	6.2

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and step therapy protections at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Are treatments reaching people?

OTAS rates obesity medication use at 0 of 4 and bariatric surgery use at 0 of 4. These scores call for investigation of unmet need, not treatment quotas. [1]

Care closer to home

OTAS rates community health center services at 1 of 4 and medical weight management programs at 1 of 4. Local services can help people enter and stay connected to care. [1]

Three opportunities for action

1 Health plans and health systems

Study delays, denials and unmet need with patients; use findings to improve access.

2 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

3 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC West Virginia 2025 fact sheet (linked).

WISCONSIN

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET



C
OTAS GRADE

53.2/100
ACCESS RANK #15 OF 51
September 2026 score [1]

37.4%
Adults affected by obesity

33.5%
Hypertension

11.8%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Strengthen surgical pathways and supportive benefits.

Wisconsin scores 4.7 points above the national average of 48.5. [1]

Access at a glance

Coverage & eligibility	55.6
Barriers & cost	61.1
Workforce & facilities	43.8
Policy environment	53.6
Patient context & equity	60.7
Treatment use	43.8

Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates GLP-1 obesity coverage at 4 of 4 and dietitian density at 4 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

A path to surgical care

OTAS rates Medicaid bariatric surgery at 2 of 4 and surgery authorization at 1 of 4. Patients need both a benefit and a workable approval process. [1]

Support across treatment

OTAS rates nutrition counseling at 0 of 4 and behavioral treatment coverage at 1 of 4. Supportive care should be available alongside the treatment a patient chooses. [1]

Three opportunities for action

1 Medicaid and health plans

Improve access to appropriate metabolic and bariatric surgery through coverage and workable authorization requirements.

2 Health plans and employers

Strengthen nutrition and behavioral benefits as part of comprehensive obesity care.

3 Health systems and state leaders

Expand specialist capacity and referral networks so patients can reach appropriate care.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Wisconsin 2025 fact sheet (linked).

WYOMING

OBESITY CARE & ACCESS

OAC + ASMBS | STATE FACT SHEET

D
OTAS GRADE

36.9/100
ACCESS RANK #42 OF 51
September 2026 score [1]

32.5%
Adults affected by obesity

31.7%
Hypertension

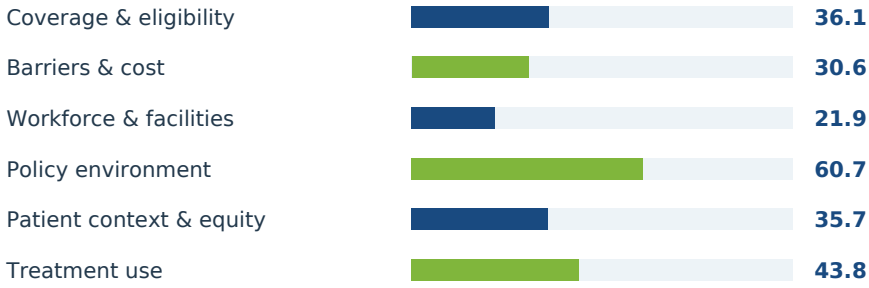
10.0%
Diabetes

Adult figures: OAC 2025 fact sheet [2]

Bring care within reach and simplify approval.

Wyoming scores 11.6 points below the national average of 48.5. [1]

Access at a glance



Tier scores: 0–100; higher scores are better. [1]

A foundation to build on

OTAS rates nutrition counseling at 4 of 4 and telehealth parity at 3 of 4. Preserve these relative strengths while addressing the gaps below. [1]

What this means for patients

Getting to the right care

OTAS rates travel time to accredited centers at 0 of 4 and accredited center access at 0 of 4. Travel and referral support deserve attention alongside coverage. [1]

The work of getting approval

OTAS rates medication authorization at 1 of 4 and surgery authorization at 1 of 4. Complex approval processes can add work for patients and delay care. [1]

Three opportunities for action

1 Health systems and state leaders

Strengthen regional referrals, travel support and appropriate telehealth follow-up.

2 Medicaid and health plans

Simplify medication and surgery authorization, with clear criteria and timely decisions.

3 Health systems and community clinics

Build local obesity care services with referral pathways and ongoing follow-up.

People deserve respectful, affordable, individualized obesity care.

Patients and advocates: ObesityAction.org/action-center | Healthcare professionals: ASMBS.org/state-chapters

[1] Appendix B: Technical State Scorecards.

[2] OAC Wyoming 2025 fact sheet (linked).

APPENDIX B

Technical State Scorecards

These detailed scorecards preserve the underlying OTAS measures used to evaluate each jurisdiction, including tier results, metric values and changes from the March 2026 baseline. They are intended to support deeper review of the evidence behind the reader-facing state fact sheets.

Use Appendix A for the reader-facing state summaries.

November 2026

Minnesota

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #2 · 76.4 A- Mid-Year (July): #1 · 76.4 A-

#1

76.4 · A-

GLP-1 obesity medication coverage at risk — repeal bill laid over in committee

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	86.1	86.1	**86.1**	—
T2 Access Barriers & Cost (20%)	83.3	83.3	**83.3**	—
T3 Workforce & Facilities (17%)	59.4	59.4	**59.4**	—
T4 Regulatory Environment (13%)	85.7	85.7	**85.7**	—
T5 Patient Context & Equity (10%)	85.7	85.7	**85.7**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	4
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	4
Marketplace/QHP coverage	3
State employee health plan	4
Private insurance mandate	0
Commercial penetration	4
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	3
PA burden (surgery)	4
Step therapy protections	4
BMI thresholds	4
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	4
Formulary placement	3
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	0
MBSAQIP center access	2
Registered dietitian density	4
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	4
Active legislation	3
Pilot programs	4
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	4
Rural population (inverse)	2
Income/OOP burden	3
Health literacy	4
Insurance complaint burden	4
Surgery caps	4
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	4
Comorbidity burden (inverse)	3
MCO quality	0

New York

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #3 · 71.6 B+ **Mid-Year (July): #2 · 71.6 B+**

#2

71.6 · B+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	71.9	71.9	**71.9**	—
T4 Regulatory Environment (13%)	89.3	89.3	**89.3**	—
T5 Patient Context & Equity (10%)	75.0	75.0	**75.0**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	3
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	4
PA burden (surgery)	3
Step therapy protections	4
BMI thresholds	4
Duration limits	4
Copay/coinsurance burden	4
Comorbidity requirements	4
Formulary placement	3
Discontinuation rules	4
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	1
MBSAQIP center access	4
Registered dietitian density	3
Drive time to MBSAQIP	3
Medical weight mgmt programs	4
Mental health workforce	3
FQHC obesity services	3
T4 — Regulatory Environment	
Obesity disease recognition	4
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	4
Active legislation	3
Pilot programs	2
GLP-1 Rx restrictions	4
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	3
Rural population (inverse)	3
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	0
Comorbidity burden (inverse)	3
MCO quality	4

Massachusetts

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #1 · 77.7 A- Mid-Year (July): #3 · 71.5 B+

#3

71.5 · B+

GLP-1 obesity medication coverage ended July 2026

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	72.2	47.2	**47.2**	**-25.0**
T2 Access Barriers & Cost (20%)	69.4	69.4	**69.4**	—
T3 Workforce & Facilities (17%)	93.8	93.8	**93.8**	—
T4 Regulatory Environment (13%)	78.6	78.6	**78.6**	—
T5 Patient Context & Equity (10%)	92.9	92.9	**92.9**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	**0 (4→0)**
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	**2 (3→2)**
State employee health plan	**2 (4→2)**
Private insurance mandate	2
Commercial penetration	**2 (4→2)**
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	3
PA burden (surgery)	1
Step therapy protections	4
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	3
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	4
MBSAQIP center access	4
Registered dietitian density	4
Drive time to MBSAQIP	4
Medical weight mgmt programs	4
Mental health workforce	4
FQHC obesity services	3
T4 — Regulatory Environment	
Obesity disease recognition	4
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	4
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	4
Rural population (inverse)	4
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	3
Comorbidity burden (inverse)	4
MCO quality	0

Delaware

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #4 · 70.6 B+ **Mid-Year (July): #4 · 70.6 B+**

#4

70.6 · B+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	56.2	56.2	**56.2**	—
T4 Regulatory Environment (13%)	75.0	75.0	**75.0**	—
T5 Patient Context & Equity (10%)	71.4	71.4	**71.4**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	4
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	4
Marketplace/QHP coverage	2
State employee health plan	4
Private insurance mandate	2
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	4
PA burden (surgery)	4
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	3
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	1
MBSAQIP center access	4
Registered dietitian density	1
Drive time to MBSAQIP	3
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	3
GLP-1 Rx restrictions	4
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	3
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	2
Surgery caps	4
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	3
Comorbidity burden (inverse)	2
MCO quality	0

Rhode Island

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #5 · 67.9 B Mid-Year (July): #5 · 67.9 B

#5

67.9 · B

Medicaid GLP-1 obesity medication coverage ends October 1, 2026 — enacted

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	66.7	66.7	**66.7**	—
T2 Access Barriers & Cost (20%)	63.9	63.9	**63.9**	—
T3 Workforce & Facilities (17%)	62.5	62.5	**62.5**	—
T4 Regulatory Environment (13%)	71.4	71.4	**71.4**	—
T5 Patient Context & Equity (10%)	82.1	82.1	**82.1**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	4
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	3
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	3
MBSAQIP center access	2
Registered dietitian density	3
Drive time to MBSAQIP	3
Medical weight mgmt programs	2
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	4
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	4
Rural population (inverse)	4
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	4

Connecticut

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #6 · 66.6 B Mid-Year (July): #6 · 66.6 B

#6

66.6 · B

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	81.2	81.2	**81.2**	—
T4 Regulatory Environment (13%)	82.1	82.1	**82.1**	—
T5 Patient Context & Equity (10%)	85.7	85.7	**85.7**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	3
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	4
Private insurance mandate	2
Commercial penetration	4
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	3
PA burden (surgery)	1
Step therapy protections	4
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	3
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	4
MBSAQIP center access	4
Registered dietitian density	4
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	4
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	4
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	4
Rural population (inverse)	3
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	1
Comorbidity burden (inverse)	3
MCO quality	1

New Hampshire

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #7 · 66.0 B Mid-Year (July): #7 · 66.0 B

#7

66.0 · B

Medicaid GLP-1 obesity medication coverage ended January 2026

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	61.1	61.1	**61.1**	—
T2 Access Barriers & Cost (20%)	55.6	55.6	**55.6**	—
T3 Workforce & Facilities (17%)	68.8	68.8	**68.8**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	78.6	78.6	**78.6**	—
T6 Treatment Utilization (15%)	81.2	81.2	**81.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	1
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	1
Private insurance mandate	3
Commercial penetration	4
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	2
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	4
MBSAQIP center access	4
Registered dietitian density	4
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	3
Rural population (inverse)	1
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	3
Comorbidity burden (inverse)	3
MCO quality	3

Colorado

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #8 · 63.0 B- Mid-Year (July): #8 · 63.0 B-

#8

63.0 · B-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	62.5	62.5	**62.5**	—
T4 Regulatory Environment (13%)	85.7	85.7	**85.7**	—
T5 Patient Context & Equity (10%)	71.4	71.4	**71.4**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	2
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	4
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	2
MBSAQIP center access	1
Registered dietitian density	4
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	4
Active legislation	4
Pilot programs	3
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	2
Rural population (inverse)	3
Income/OOP burden	3
Health literacy	4
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	2
Comorbidity burden (inverse)	4
MCO quality	4

Illinois

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #9 · 60.3 B- Mid-Year (July): #9 · 60.3 B-

#9

60.3 · B-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	59.4	59.4	**59.4**	—
T4 Regulatory Environment (13%)	71.4	71.4	**71.4**	—
T5 Patient Context & Equity (10%)	67.9	67.9	**67.9**	—
T6 Treatment Utilization (15%)	25.0	25.0	**25.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	2
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	2
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	4
PA burden (surgery)	3
Step therapy protections	4
BMI thresholds	4
Duration limits	4
Copay/coinsurance burden	2
Comorbidity requirements	4
Formulary placement	3
Discontinuation rules	3
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	4
MBSAQIP center access	2
Registered dietitian density	2
Drive time to MBSAQIP	2
Medical weight mgmt programs	3
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	4
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	4
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	3
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	0
Comorbidity burden (inverse)	2
MCO quality	0

Michigan

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #10 · 60.0 B- **Mid-Year (July): #10 · 60.0 B-**

#10

60.0 · B-

Medicaid GLP-1 obesity medication coverage restricted to BMI 40 or higher — in effect

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	72.2	72.2	**72.2**	—
T2 Access Barriers & Cost (20%)	41.7	41.7	**41.7**	—
T3 Workforce & Facilities (17%)	50.0	50.0	**50.0**	—
T4 Regulatory Environment (13%)	50.0	50.0	**50.0**	—
T5 Patient Context & Equity (10%)	64.3	64.3	**64.3**	—
T6 Treatment Utilization (15%)	81.2	81.2	**81.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	2
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	4
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	3
PA burden (surgery)	4
Step therapy protections	3
BMI thresholds	1
Duration limits	0
Copay/coinsurance burden	0
Comorbidity requirements	1
Formulary placement	3
Discontinuation rules	0
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	1
MBSAQIP center access	3
Registered dietitian density	3
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	3
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	4
Surgery caps	4
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	4
Comorbidity burden (inverse)	2
MCO quality	4

Virginia

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #11 · 59.8 C+ **Mid-Year (July): #11 · 59.8 C+**

#11

59.8 · C+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	56.2	56.2	**56.2**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	64.3	64.3	**64.3**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	2
GLP-1 obesity coverage	4	Medical weight mgmt programs	3
GLP-1 comorbidity coverage	2	Mental health workforce	2
Medicaid bariatric surgery	2	FQHC obesity services	2
Marketplace/QHP coverage	2	**T4 — Regulatory Environment**	
State employee health plan	3	Obesity disease recognition	3
Private insurance mandate	0	NP/PA scope of practice	1
Commercial penetration	3	Telehealth parity	4
Nutrition counseling	4	Admin code restrictions	3
Intensive behavioral therapy	4	Active legislation	2
T2 — Access Barriers & Cost		Pilot programs	2
PA burden (medications)	2	GLP-1 Rx restrictions	2
PA burden (surgery)	1	**T5 — Patient Context & Equity**	
Step therapy protections	3	Obesity prevalence (inverse)	2
BMI thresholds	1	Uninsured rate (inverse)	2
Duration limits	1	Rural population (inverse)	2
Copay/coinsurance burden	3	Income/OOP burden	4
Comorbidity requirements	1	Health literacy	4
Formulary placement	2	Insurance complaint burden	2
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	2	Bariatric surgery utilization	3
Bariatric surgeon density	3	Obesity Rx utilization	3
MBSAQIP center access	3	Comorbidity burden (inverse)	3
Registered dietitian density	1	MCO quality	2

Kansas

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #12 · 56.8 C+ **Mid-Year (July): #12 · 56.8 C+**

#12

56.8 · C+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	50.0	50.0	**50.0**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	1
GLP-1 obesity coverage	3	Medical weight mgmt programs	1
GLP-1 comorbidity coverage	4	Mental health workforce	1
Medicaid bariatric surgery	2	FQHC obesity services	1
Marketplace/QHP coverage	1	**T4 — Regulatory Environment**	
State employee health plan	1	Obesity disease recognition	2
Private insurance mandate	0	NP/PA scope of practice	4
Commercial penetration	3	Telehealth parity	3
Nutrition counseling	4	Admin code restrictions	3
Intensive behavioral therapy	4	Active legislation	1
T2 — Access Barriers & Cost		Pilot programs	1
PA burden (medications)	3	GLP-1 Rx restrictions	3
PA burden (surgery)	1	**T5 — Patient Context & Equity**	
Step therapy protections	1	Obesity prevalence (inverse)	1
BMI thresholds	2	Uninsured rate (inverse)	2
Duration limits	2	Rural population (inverse)	2
Copay/coinsurance burden	3	Income/OOP burden	2
Comorbidity requirements	2	Health literacy	2
Formulary placement	3	Insurance complaint burden	1
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	1	Bariatric surgery utilization	4
Bariatric surgeon density	4	Obesity Rx utilization	4
MBSAQIP center access	4	Comorbidity burden (inverse)	2
Registered dietitian density	3	MCO quality	1

New Jersey

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #13 · 56.3 C+ **Mid-Year (July): #13 · 56.3 C+**

#13

56.3 · C+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	71.9	71.9	**71.9**	—
T4 Regulatory Environment (13%)	64.3	64.3	**64.3**	—
T5 Patient Context & Equity (10%)	82.1	82.1	**82.1**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	2
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	3
MBSAQIP center access	3
Registered dietitian density	3
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	2
Rural population (inverse)	4
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	0
Comorbidity burden (inverse)	3
MCO quality	2

Maryland

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #14 · 54.8 C Mid-Year (July): #14 · 54.8 C

#14

54.8 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	53.1	53.1	**53.1**	—
T4 Regulatory Environment (13%)	67.9	67.9	**67.9**	—
T5 Patient Context & Equity (10%)	78.6	78.6	**78.6**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	4
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	1
MBSAQIP center access	1
Registered dietitian density	2
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	4
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	0

Wisconsin

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #17 · 52.6 C Mid-Year (July): #15 · 53.2 C

#15

53.2 · C

Prior authorization requirements eased — in effect

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	55.6	55.6	**55.6**	—
T2 Access Barriers & Cost (20%)	58.3	61.1	**61.1**	+2.8
T3 Workforce & Facilities (17%)	43.8	43.8	**43.8**	—
T4 Regulatory Environment (13%)	53.6	53.6	**53.6**	—
T5 Patient Context & Equity (10%)	60.7	60.7	**60.7**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	4
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	0
Commercial penetration	4
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	**2 (1→2)**
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	1
MBSAQIP center access	0
Registered dietitian density	4
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	3
Comorbidity burden (inverse)	2
MCO quality	2

Vermont

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #15 · 53.1 C Mid-Year (July): #16 · 53.1 C

#16

53.1 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	43.8	43.8	**43.8**	—
T4 Regulatory Environment (13%)	64.3	64.3	**64.3**	—
T5 Patient Context & Equity (10%)	75.0	75.0	**75.0**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	2
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	4
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	0
Registered dietitian density	4
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	3
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	4
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	4
Rural population (inverse)	0
Income/OOP burden	3
Health literacy	4
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	1

Oregon

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #16 · 52.9 C Mid-Year (July): #17 · 52.9 C

#17

52.9 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	40.6	40.6	**40.6**	—
T4 Regulatory Environment (13%)	71.4	71.4	**71.4**	—
T5 Patient Context & Equity (10%)	71.4	71.4	**71.4**	—
T6 Treatment Utilization (15%)	68.8	68.8	**68.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	2
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	4
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	3
Registered dietitian density	1
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	3
Rural population (inverse)	3
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	3

District of Columbia

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #18 · 52.5 C Mid-Year (July): #18 · 52.5 C

#18

52.5 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	84.4	84.4	**84.4**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	85.7	85.7	**85.7**	—
T6 Treatment Utilization (15%)	62.5	62.5	**62.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	2
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	0
Intensive behavioral therapy	0
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	1
BMI thresholds	2
Duration limits	2
Copay/coinsurance burden	1
Comorbidity requirements	2
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	3
Bariatric surgeon density	4
MBSAQIP center access	4
Registered dietitian density	3
Drive time to MBSAQIP	4
Medical weight mgmt programs	3
Mental health workforce	4
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	1
Admin code restrictions	4
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	4
Rural population (inverse)	4
Income/OOP burden	4
Health literacy	2
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	0
Comorbidity burden (inverse)	3
MCO quality	3

North Dakota

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #19 · 52.4 C Mid-Year (July): #19 · 52.4 C

#19

52.4 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	46.9	46.9	**46.9**	—
T4 Regulatory Environment (13%)	67.9	67.9	**67.9**	—
T5 Patient Context & Equity (10%)	50.0	50.0	**50.0**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	2
Private insurance mandate	4
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	4
Duration limits	3
Copay/coinsurance burden	2
Comorbidity requirements	4
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	4
Registered dietitian density	4
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	4
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	2
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	4
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	0
Comorbidity burden (inverse)	3
MCO quality	0

Washington

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #20 · 52.3 C Mid-Year (July): #20 · 52.3 C

#20

52.3 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	53.1	53.1	**53.1**	—
T4 Regulatory Environment (13%)	71.4	71.4	**71.4**	—
T5 Patient Context & Equity (10%)	78.6	78.6	**78.6**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	2
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	1
Step therapy protections	4
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	2
MBSAQIP center access	2
Registered dietitian density	2
Drive time to MBSAQIP	2
Medical weight mgmt programs	3
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	4
Telehealth parity	4
Admin code restrictions	3
Active legislation	1
Pilot programs	3
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	3
Rural population (inverse)	3
Income/OOP burden	4
Health literacy	4
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	0
Comorbidity burden (inverse)	3
MCO quality	1

North Carolina

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #21 · 50.9 C Mid-Year (July): #21 · 50.9 C

#21

50.9 · C

GLP-1 obesity medication coverage reinstated December 2025

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	55.6	55.6	**55.6**	—
T2 Access Barriers & Cost (20%)	58.3	58.3	**58.3**	—
T3 Workforce & Facilities (17%)	46.9	46.9	**46.9**	—
T4 Regulatory Environment (13%)	50.0	50.0	**50.0**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	3
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	1
Marketplace/QHP coverage	2
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	3
Duration limits	2
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	1
Registered dietitian density	2
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	1
Surgery caps	4
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	0
Comorbidity burden (inverse)	2
MCO quality	4

Hawaii

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #22 · 50.5 C Mid-Year (July): #22 · 50.5 C

#22

50.5 · C

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	43.8	43.8	**43.8**	—
T4 Regulatory Environment (13%)	64.3	64.3	**64.3**	—
T5 Patient Context & Equity (10%)	89.3	89.3	**89.3**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	2
GLP-1 obesity coverage	0	Medical weight mgmt programs	2
GLP-1 comorbidity coverage	1	Mental health workforce	2
Medicaid bariatric surgery	3	FQHC obesity services	1
Marketplace/QHP coverage	1	**T4 — Regulatory Environment**	
State employee health plan	1	Obesity disease recognition	3
Private insurance mandate	0	NP/PA scope of practice	4
Commercial penetration	4	Telehealth parity	3
Nutrition counseling	0	Admin code restrictions	4
Intensive behavioral therapy	4	Active legislation	1
T2 — Access Barriers & Cost		Pilot programs	1
PA burden (medications)	1	GLP-1 Rx restrictions	2
PA burden (surgery)	3	**T5 — Patient Context & Equity**	
Step therapy protections	3	Obesity prevalence (inverse)	4
BMI thresholds	1	Uninsured rate (inverse)	4
Duration limits	1	Rural population (inverse)	4
Copay/coinsurance burden	3	Income/OOP burden	4
Comorbidity requirements	1	Health literacy	3
Formulary placement	2	Insurance complaint burden	4
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	3	Bariatric surgery utilization	0
Bariatric surgeon density	3	Obesity Rx utilization	2
MBSAQIP center access	0	Comorbidity burden (inverse)	4
Registered dietitian density	1	MCO quality	1

California

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #23 · 49.8 C- **Mid-Year (July): #23 · 49.8 C-**

#23

49.8 · C-

Medicaid GLP-1 obesity medication coverage ended January 2026

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	52.8	52.8	**52.8**	—
T2 Access Barriers & Cost (20%)	25.0	25.0	**25.0**	—
T3 Workforce & Facilities (17%)	53.1	53.1	**53.1**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	71.4	71.4	**71.4**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	1
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	2
Marketplace/QHP coverage	2
State employee health plan	3
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	1
Step therapy protections	4
BMI thresholds	0
Duration limits	0
Copay/coinsurance burden	0
Comorbidity requirements	0
Formulary placement	2
Discontinuation rules	0
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	2
MBSAQIP center access	0
Registered dietitian density	1
Drive time to MBSAQIP	3
Medical weight mgmt programs	3
Mental health workforce	3
FQHC obesity services	3
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	4
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	3
Rural population (inverse)	4
Income/OOP burden	4
Health literacy	1
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	3
Comorbidity burden (inverse)	3
MCO quality	2

Kentucky

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #24 · 49.7 C- **Mid-Year (July): #24 · 49.7 C-**

#24

49.7 · C-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	28.6	28.6	**28.6**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	3
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	3
Registered dietitian density	1
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	0
Uninsured rate (inverse)	3
Rural population (inverse)	1
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	3
Comorbidity burden (inverse)	1
MCO quality	2

Pennsylvania

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #25 · 49.0 C- **Mid-Year (July): #25 · 49.0 C-**

#25

49.0 · C-

Medicaid GLP-1 obesity medication coverage ended January 2026

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	41.7	41.7	**41.7**	—
T2 Access Barriers & Cost (20%)	30.6	30.6	**30.6**	—
T3 Workforce & Facilities (17%)	62.5	62.5	**62.5**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	64.3	64.3	**64.3**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	1
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	3
Marketplace/QHP coverage	2
State employee health plan	1
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	0
Duration limits	0
Copay/coinsurance burden	0
Comorbidity requirements	0
Formulary placement	3
Discontinuation rules	0
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	4
MBSAQIP center access	2
Registered dietitian density	3
Drive time to MBSAQIP	2
Medical weight mgmt programs	3
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	3
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	2
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	4
Comorbidity burden (inverse)	2
MCO quality	0

Maine

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #26 · 48.4 C- **Mid-Year (July): #26 · 48.4 C-**

#26

48.4 · C-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	46.9	46.9	**46.9**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	53.6	53.6	**53.6**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	2
Duration limits	2
Copay/coinsurance burden	3
Comorbidity requirements	2
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	4
MBSAQIP center access	2
Registered dietitian density	2
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	2
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	3
Rural population (inverse)	0
Income/OOP burden	2
Health literacy	3
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	1

Ohio

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #27 · 47.8 C- Mid-Year (July): #27 · 47.8 C-

#27

47.8 · C-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	53.1	53.1	**53.1**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	50.0	50.0	**50.0**	—
T6 Treatment Utilization (15%)	31.2	31.2	**31.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	2
Duration limits	2
Copay/coinsurance burden	2
Comorbidity requirements	2
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	2
Registered dietitian density	4
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	3
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	0
Comorbidity burden (inverse)	1
MCO quality	2

Utah

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #29 · 46.7 C- **Mid-Year (July): #29 · 46.7 C-**

#28

47.4 · C-

Medicaid GLP-1 obesity medication pilot ended June 30, 2026; state employee pilot renewed

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	50.0	50.0	**52.8**	+2.8
T2 Access Barriers & Cost (20%)	30.6	30.6	**30.6**	—
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	67.9	67.9	**67.9**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	**2 (1→2)**
Private insurance mandate	0
Commercial penetration	4
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	0
Registered dietitian density	2
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	2
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	4
Uninsured rate (inverse)	1
Rural population (inverse)	4
Income/OOP burden	3
Health literacy	3
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	2
Comorbidity burden (inverse)	4
MCO quality	2

Iowa

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #28 · 47.2 C- Mid-Year (July): #28 · 47.2 C-

#29

47.2 · C-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	31.2	31.2	**31.2**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	50.0	50.0	**50.0**	—
T6 Treatment Utilization (15%)	31.2	31.2	**31.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	4
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	2
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	1
MBSAQIP center access	1
Registered dietitian density	3
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	3
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	3
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	2
Comorbidity burden (inverse)	2
MCO quality	0

Indiana

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #31 · 46.1 C- **Mid-Year (July): #31 · 46.1 C-**

#30

47.0 · C-

BALANCE participation announced July 30, 2026 — medication coverage implementation pending

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	47.2	47.2	**47.2**	—
T2 Access Barriers & Cost (20%)	50.0	50.0	**50.0**	—
T3 Workforce & Facilities (17%)	40.6	40.6	**40.6**	—
T4 Regulatory Environment (13%)	50.0	50.0	**57.1**	+7.1
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	4
MBSAQIP center access	1
Registered dietitian density	1
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	**3 (1→3)**
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	2
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	2
Comorbidity burden (inverse)	1
MCO quality	3

Missouri

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #30 · 46.2 C- Mid-Year (July): #30 · 46.2 C-

#31

46.2 · C-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	46.4	46.4	**46.4**	—
T5 Patient Context & Equity (10%)	35.7	35.7	**35.7**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	2
Duration limits	2
Copay/coinsurance burden	3
Comorbidity requirements	2
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	3
Registered dietitian density	2
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	1
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	2
Comorbidity burden (inverse)	2
MCO quality	2

Arizona

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #32 · 44.1 D+ Mid-Year (July): #32 · 44.1 D+

#32

44.1 · D+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	34.4	34.4	**34.4**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	2
GLP-1 obesity coverage	0	Medical weight mgmt programs	2
GLP-1 comorbidity coverage	1	Mental health workforce	2
Medicaid bariatric surgery	2	FQHC obesity services	2
Marketplace/QHP coverage	1	**T4 — Regulatory Environment**	
State employee health plan	1	Obesity disease recognition	2
Private insurance mandate	0	NP/PA scope of practice	4
Commercial penetration	2	Telehealth parity	3
Nutrition counseling	4	Admin code restrictions	3
Intensive behavioral therapy	1	Active legislation	1
T2 — Access Barriers & Cost		Pilot programs	1
PA burden (medications)	1	GLP-1 Rx restrictions	2
PA burden (surgery)	1	**T5 — Patient Context & Equity**	
Step therapy protections	3	Obesity prevalence (inverse)	3
BMI thresholds	3	Uninsured rate (inverse)	1
Duration limits	3	Rural population (inverse)	3
Copay/coinsurance burden	3	Income/OOP burden	2
Comorbidity requirements	3	Health literacy	1
Formulary placement	2	Insurance complaint burden	0
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	1	Bariatric surgery utilization	1
Bariatric surgeon density	1	Obesity Rx utilization	2
MBSAQIP center access	1	Comorbidity burden (inverse)	2
Registered dietitian density	0	MCO quality	2

South Dakota

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #33 · 41.8 D+ Mid-Year (July): #33 · 41.8 D+

#33

41.8 · D+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	34.4	34.4	**34.4**	—
T4 Regulatory Environment (13%)	42.9	42.9	**42.9**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	75.0	75.0	**75.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	2
Bariatric surgeon density	0
MBSAQIP center access	4
Registered dietitian density	2
Drive time to MBSAQIP	0
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	4
Telehealth parity	1
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	2
Comorbidity burden (inverse)	3
MCO quality	3

Nebraska

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #34 · 41.5 D+ Mid-Year (July): #34 · 41.5 D+

#34

41.5 · D+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	34.4	34.4	**34.4**	—
T4 Regulatory Environment (13%)	42.9	42.9	**42.9**	—
T5 Patient Context & Equity (10%)	50.0	50.0	**50.0**	—
T6 Treatment Utilization (15%)	62.5	62.5	**62.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	3
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	2
Registered dietitian density	4
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	2
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	2
Comorbidity burden (inverse)	2
MCO quality	4

Alaska

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #35 · 41.4 D+ **Mid-Year (July): #35 · 41.4 D+**

#35

41.4 · D+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	28.1	28.1	**28.1**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	46.4	46.4	**46.4**	—
T6 Treatment Utilization (15%)	62.5	62.5	**62.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	4
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	4
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	4
MBSAQIP center access	0
Registered dietitian density	2
Drive time to MBSAQIP	0
Medical weight mgmt programs	0
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	0
Rural population (inverse)	1
Income/OOP burden	3
Health literacy	2
Insurance complaint burden	1
Surgery caps	4
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	2
Comorbidity burden (inverse)	4
MCO quality	4

Florida

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #36 · 40.6 D+ **Mid-Year (July): #36 · 40.6 D+**

#36

40.6 · D+

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	46.9	46.9	**46.9**	—
T4 Regulatory Environment (13%)	46.4	46.4	**46.4**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	2
Registered dietitian density	0
Drive time to MBSAQIP	2
Medical weight mgmt programs	3
Mental health workforce	2
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	1
Telehealth parity	1
Admin code restrictions	3
Active legislation	2
Pilot programs	2
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	0
Rural population (inverse)	4
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	1
Comorbidity burden (inverse)	2
MCO quality	4

New Mexico

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #37 · 39.7 D Mid-Year (July): #37 · 39.7 D

#37

39.7 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	25.0	25.0	**25.0**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	32.1	32.1	**32.1**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	0
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	1
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	2
Registered dietitian density	0
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	1
Rural population (inverse)	2
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	2
Obesity Rx utilization	1
Comorbidity burden (inverse)	2
MCO quality	2

Georgia

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #38 · 39.5 D Mid-Year (July): #38 · 39.5 D

#38

39.5 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	34.4	34.4	**34.4**	—
T4 Regulatory Environment (13%)	53.6	53.6	**53.6**	—
T5 Patient Context & Equity (10%)	32.1	32.1	**32.1**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	2
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	3
Registered dietitian density	0
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	1
FQHC obesity services	2
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	2
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	0
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	0
Comorbidity burden (inverse)	1
MCO quality	3

Nevada

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #39 · 39.2 D Mid-Year (July): #39 · 39.2 D

#39

39.2 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	18.8	18.8	**18.8**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	46.4	46.4	**46.4**	—
T6 Treatment Utilization (15%)	50.0	50.0	**50.0**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	1
MBSAQIP center access	0
Registered dietitian density	0
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	1
Rural population (inverse)	4
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	2
Comorbidity burden (inverse)	2
MCO quality	4

Texas

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #40 · 39.0 D Mid-Year (July): #40 · 39.0 D

#40

39.0 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	57.1	57.1	**57.1**	—
T5 Patient Context & Equity (10%)	28.6	28.6	**28.6**	—
T6 Treatment Utilization (15%)	56.2	56.2	**56.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	2
GLP-1 obesity coverage	0	Medical weight mgmt programs	2
GLP-1 comorbidity coverage	1	Mental health workforce	1
Medicaid bariatric surgery	2	FQHC obesity services	2
Marketplace/QHP coverage	1	**T4 — Regulatory Environment**	
State employee health plan	1	Obesity disease recognition	2
Private insurance mandate	0	NP/PA scope of practice	1
Commercial penetration	2	Telehealth parity	3
Nutrition counseling	0	Admin code restrictions	3
Intensive behavioral therapy	1	Active legislation	3
T2 — Access Barriers & Cost		Pilot programs	2
PA burden (medications)	1	GLP-1 Rx restrictions	2
PA burden (surgery)	1	**T5 — Patient Context & Equity**	
Step therapy protections	3	Obesity prevalence (inverse)	1
BMI thresholds	1	Uninsured rate (inverse)	0
Duration limits	1	Rural population (inverse)	3
Copay/coinsurance burden	3	Income/OOP burden	2
Comorbidity requirements	1	Health literacy	0
Formulary placement	2	Insurance complaint burden	0
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	1	Bariatric surgery utilization	3
Bariatric surgeon density	1	Obesity Rx utilization	1
MBSAQIP center access	3	Comorbidity burden (inverse)	2
Registered dietitian density	0	MCO quality	3

Tennessee

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #41 · 37.7 D Mid-Year (July): #41 · 37.7 D

#41

37.7 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	53.6	53.6	**53.6**	—
T5 Patient Context & Equity (10%)	25.0	25.0	**25.0**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	1
Registered dietitian density	2
Drive time to MBSAQIP	2
Medical weight mgmt programs	2
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	3
Active legislation	2
Pilot programs	1
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	2
Comorbidity burden (inverse)	1
MCO quality	3

Wyoming

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #42 · 36.9 D Mid-Year (July): #42 · 36.9 D

#42

36.9 · D

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	21.9	21.9	**21.9**	—
T4 Regulatory Environment (13%)	60.7	60.7	**60.7**	—
T5 Patient Context & Equity (10%)	35.7	35.7	**35.7**	—
T6 Treatment Utilization (15%)	43.8	43.8	**43.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	0
Registered dietitian density	1
Drive time to MBSAQIP	0
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	0
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	3
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	3
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	0
Comorbidity burden (inverse)	4
MCO quality	3

Alabama

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #43 · 34.8 D- Mid-Year (July): #43 · 34.8 D-

#43

34.8 · D-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	18.8	18.8	**18.8**	—
T4 Regulatory Environment (13%)	32.1	32.1	**32.1**	—
T5 Patient Context & Equity (10%)	25.0	25.0	**25.0**	—
T6 Treatment Utilization (15%)	18.8	18.8	**18.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	3
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	1
BMI thresholds	3
Duration limits	3
Copay/coinsurance burden	3
Comorbidity requirements	3
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	1
Registered dietitian density	0
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	2
Telehealth parity	1
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	2
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	0
Comorbidity burden (inverse)	0
MCO quality	2

Louisiana

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #44 · 33.9 D- **Mid-Year (July): #44 · 33.9 D-**

#44

34.8 · D-

Obesity medication coverage expansion enacted — Act 898; implementation contingent on appropriation

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	22.2	22.2	**22.2**	—
T2 Access Barriers & Cost (20%)	41.7	41.7	**41.7**	—
T3 Workforce & Facilities (17%)	37.5	37.5	**37.5**	—
T4 Regulatory Environment (13%)	39.3	39.3	**46.4**	+7.1
T5 Patient Context & Equity (10%)	28.6	28.6	**28.6**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	2
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	3
Registered dietitian density	1
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	2
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	1
Active legislation	**3 (1→3)**
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	0
Uninsured rate (inverse)	2
Rural population (inverse)	2
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	3
Obesity Rx utilization	1
Comorbidity burden (inverse)	1
MCO quality	1

Montana

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #45 · 33.0 D- Mid-Year (July): #45 · 33.0 D-

#45

33.0 · D-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	25.0	25.0	**25.0**	—
T4 Regulatory Environment (13%)	50.0	50.0	**50.0**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	0
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	4
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	0
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	0
MBSAQIP center access	1
Registered dietitian density	3
Drive time to MBSAQIP	0
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	4
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	3
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	3
Uninsured rate (inverse)	2
Rural population (inverse)	1
Income/OOP burden	2
Health literacy	2
Insurance complaint burden	2
Surgery caps	0
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	0
Comorbidity burden (inverse)	4
MCO quality	1

Mississippi

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #46 · 32.1 D- **Mid-Year (July): #46 · 32.1 D-**

#46

32.1 · D-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	28.1	28.1	**28.1**	—
T4 Regulatory Environment (13%)	35.7	35.7	**35.7**	—
T5 Patient Context & Equity (10%)	3.6	3.6	**3.6**	—
T6 Treatment Utilization (15%)	62.5	62.5	**62.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	3
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	0
Marketplace/QHP coverage	1
State employee health plan	2
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	0
Step therapy protections	1
BMI thresholds	2
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	2
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	0
Bariatric surgeon density	2
MBSAQIP center access	4
Registered dietitian density	0
Drive time to MBSAQIP	0
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	0
Uninsured rate (inverse)	1
Rural population (inverse)	0
Income/OOP burden	0
Health literacy	0
Insurance complaint burden	0
Surgery caps	0
T6 — Treatment Utilization	
Bariatric surgery utilization	4
Obesity Rx utilization	2
Comorbidity burden (inverse)	0
MCO quality	4

South Carolina

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #47 · 30.9 D- **Mid-Year (July): #47 · 30.9 D-**

#47

30.9 · D-

Medicaid GLP-1 obesity medication coverage ended January 2026

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)	38.9	38.9	**38.9**	—
T2 Access Barriers & Cost (20%)	27.8	27.8	**27.8**	—
T3 Workforce & Facilities (17%)	25.0	25.0	**25.0**	—
T4 Regulatory Environment (13%)	32.1	32.1	**32.1**	—
T5 Patient Context & Equity (10%)	25.0	25.0	**25.0**	—
T6 Treatment Utilization (15%)	31.2	31.2	**31.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	1
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	2
MBSAQIP center access	1
Registered dietitian density	0
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	1
Uninsured rate (inverse)	1
Rural population (inverse)	1
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	1
Obesity Rx utilization	3
Comorbidity burden (inverse)	1
MCO quality	0

Idaho

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #48 · 30.2 D- Mid-Year (July): #48 · 30.2 D-

#48

30.2 · D-

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	21.9	21.9	**21.9**	—
T4 Regulatory Environment (13%)	35.7	35.7	**35.7**	—
T5 Patient Context & Equity (10%)	42.9	42.9	**42.9**	—
T6 Treatment Utilization (15%)	31.2	31.2	**31.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	1
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	2
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	1
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	0
Bariatric surgeon density	0
MBSAQIP center access	0
Registered dietitian density	3
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	4
Telehealth parity	1
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	2
Uninsured rate (inverse)	1
Rural population (inverse)	2
Income/OOP burden	2
Health literacy	1
Insurance complaint burden	2
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	0
Comorbidity burden (inverse)	4
MCO quality	1

West Virginia

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #49 · 28.9 F Mid-Year (July): #49 · 28.9 F

#49

28.9 · F

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	21.9	21.9	**21.9**	—
T4 Regulatory Environment (13%)	35.7	35.7	**35.7**	—
T5 Patient Context & Equity (10%)	21.4	21.4	**21.4**	—
T6 Treatment Utilization (15%)	6.2	6.2	**6.2**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	4
Medicaid bariatric surgery	2
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	4
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	1
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	3
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	2
T3 — Workforce & Facilities	
ABOM diplomate density	1
Bariatric surgeon density	3
MBSAQIP center access	0
Registered dietitian density	0
Drive time to MBSAQIP	0
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	2
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	0
Uninsured rate (inverse)	3
Rural population (inverse)	0
Income/OOP burden	0
Health literacy	0
Insurance complaint burden	1
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	0
Comorbidity burden (inverse)	0
MCO quality	1

Oklahoma

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #50 · 28.5 F Mid-Year (July): #50 · 28.5 F

#50

28.5 · F

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	18.8	18.8	**18.8**	—
T4 Regulatory Environment (13%)	32.1	32.1	**32.1**	—
T5 Patient Context & Equity (10%)	14.3	14.3	**14.3**	—
T6 Treatment Utilization (15%)	37.5	37.5	**37.5**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility	
GLP-1 obesity coverage	0
GLP-1 comorbidity coverage	2
Medicaid bariatric surgery	3
Marketplace/QHP coverage	1
State employee health plan	1
Private insurance mandate	0
Commercial penetration	1
Nutrition counseling	0
Intensive behavioral therapy	1
T2 — Access Barriers & Cost	
PA burden (medications)	1
PA burden (surgery)	3
Step therapy protections	3
BMI thresholds	1
Duration limits	1
Copay/coinsurance burden	2
Comorbidity requirements	1
Formulary placement	1
Discontinuation rules	1
T3 — Workforce & Facilities	
ABOM diplomate density	0
Bariatric surgeon density	1
MBSAQIP center access	0
Registered dietitian density	1
Drive time to MBSAQIP	1
Medical weight mgmt programs	1
Mental health workforce	1
FQHC obesity services	1
T4 — Regulatory Environment	
Obesity disease recognition	1
NP/PA scope of practice	1
Telehealth parity	3
Admin code restrictions	1
Active legislation	1
Pilot programs	1
GLP-1 Rx restrictions	1
T5 — Patient Context & Equity	
Obesity prevalence (inverse)	0
Uninsured rate (inverse)	0
Rural population (inverse)	1
Income/OOP burden	1
Health literacy	0
Insurance complaint burden	0
Surgery caps	2
T6 — Treatment Utilization	
Bariatric surgery utilization	0
Obesity Rx utilization	2
Comorbidity burden (inverse)	1
MCO quality	3

Arkansas

OBESITY TREATMENT ACCESS SCORECARD · SEPTEMBER 2026 · OAC + ASMBS

Baseline (March 2026): #51 · 25.5 F Mid-Year (July): #51 · 25.5 F

#51

25.5 · F

Tier scores

	March	July	September	Δ March→September
T1 Coverage & Eligibility (25%)				
T2 Access Barriers & Cost (20%)				
T3 Workforce & Facilities (17%)	18.8	18.8	**18.8**	—
T4 Regulatory Environment (13%)	39.3	39.3	**39.3**	—
T5 Patient Context & Equity (10%)	17.9	17.9	**17.9**	—
T6 Treatment Utilization (15%)	18.8	18.8	**18.8**	—

Metric detail (0–4)

red = changed since March baseline

T1 — Coverage & Eligibility		Drive time to MBSAQIP	0
GLP-1 obesity coverage	0	Medical weight mgmt programs	1
GLP-1 comorbidity coverage	1	Mental health workforce	1
Medicaid bariatric surgery	2	FQHC obesity services	1
Marketplace/QHP coverage	1	**T4 — Regulatory Environment**	
State employee health plan	1	Obesity disease recognition	1
Private insurance mandate	0	NP/PA scope of practice	2
Commercial penetration	1	Telehealth parity	3
Nutrition counseling	0	Admin code restrictions	1
Intensive behavioral therapy	1	Active legislation	2
T2 — Access Barriers & Cost		Pilot programs	1
PA burden (medications)	1	GLP-1 Rx restrictions	1
PA burden (surgery)	1	**T5 — Patient Context & Equity**	
Step therapy protections	3	Obesity prevalence (inverse)	0
BMI thresholds	1	Uninsured rate (inverse)	1
Duration limits	1	Rural population (inverse)	1
Copay/coinsurance burden	3	Income/OOP burden	1
Comorbidity requirements	1	Health literacy	0
Formulary placement	1	Insurance complaint burden	0
Discontinuation rules	2	Surgery caps	2
T3 — Workforce & Facilities		**T6 — Treatment Utilization**	
ABOM diplomate density	0	Bariatric surgery utilization	3
Bariatric surgeon density	0	Obesity Rx utilization	0
MBSAQIP center access	3	Comorbidity burden (inverse)	0
Registered dietitian density	0	MCO quality	0