

Women and Obesity

In this chapter, readers will learn about comprehensive obesity care, including the classifications for overweight and obesity, causes and risk factors, treatment and management, and what Medicare benefits and services are available for obesity care in older age.

Why Should Women Focus on Obesity?

Obesity is a complex chronic disease that results from the interaction of many different environmental and genetic factors. It can affect your health and quality of life and lead to high medical costs over time. It is associated with more than 200 health complications, such as cardiovascular disease, high blood pressure, Type 2 diabetes, certain cancers, polyendocrine metabolic ovarian syndrome (PMOS), worse menopause symptoms, and mental illness, among others.

In 2022, almost **4 out of 10 women 60 and over** in the U.S. were living with obesity. Obesity affects women of color more than other groups, with almost 6 out of 10 Black women and 5 out of 10 Hispanic women living with obesity. These differences show that everyone needs access to evidence-based prevention, treatment, and long-term care for obesity. This high level of obesity among women is partially because of changes in women's bodies that come with aging and menopause. Physical changes that happen during menopause — from **burning fewer calories to producing less estrogen** — can lead to excess body fat, especially in the belly. This can raise a woman's long-term **cardiovascular and metabolic risks**. Obesity has also been **linked** to higher rates of disability and poor overall health.

Managing obesity is important for general health and well-being, mobility, and improving quality of life. The best way to treat and manage obesity is with a personalized, evidence-based approach that may include a combination of nutrition strategies, physical activity, bariatric surgery, behavioral



therapy, and obesity medications. A plan that is tailored to each person's unique circumstances, lifestyle, and needs can help women maintain their strength, reduce the onset and seriousness of chronic conditions, and support healthy aging.

Breaking down BMI

Obesity is typically screened for using body mass index (BMI), a calculation to measure body composition based on a person's height and weight. The **U.S. Centers for Disease Control and Prevention** categorizes BMI for adults 20 years and older as:

- Underweight: BMI < 18.5 (kg/m²)
- Healthy Weight: BMI = 18.5 to less than 25
- Overweight: BMI = 25 to less than 30
- Obesity: BMI = 30 or greater
 - Class 1 Obesity: BMI = 30 to less than 35
 - Class 2 Obesity: BMI = 35 to less than 40
 - Class 3 Obesity (Severe Obesity): BMI = 40 or greater

Note: BMI is considered by many to be an **imperfect tool for diagnosing obesity**. It does not account for the location of or types of body fat and does not necessarily reflect someone's health or how factors like race or ethnicity may influence the link between their body composition and potential health risks.



Key Obesity Terms

- **Adiposity** – the state of having a high amount of adipose (fat) tissue in the body
- **Body mass index (BMI)** – a measure of body fat based on height and weight
- **Chronic disease** – a condition that lasts one year or more and requires ongoing medical attention, limits activities of daily living, or both
- **Comorbidity** – a disease or medical condition that occurs at the same time as one or more other conditions in a patient
- **Obesity** – a chronic disease that occurs when there is an increase in the size and amount of fat cells in the body that cause metabolic dysfunction (typically measured as having a BMI of 30 or higher)
- **Overweight** – a condition of excessive fat deposits (typically measured as having a BMI between 25 and 29.9)

Metabolic Health at Medicare Age: What to Know

Causes and Risk Factors

Obesity is regularly described as a complex disease because it can be caused by many factors from genetics to eating behaviors to the broader environment where people live. While some risk factors for obesity can be changed, many contributing factors are outside of a person's control or may be difficult to change. Causes of obesity may include:

- Family history
- Genetic factors
- Health conditions (e.g., metabolic syndrome, polycystic ovary syndrome (PCOS)/polyendocrine metabolic ovarian syndrome (PMOS))
- Lack of physical activity
- Psychological factors (e.g., stress)
- Poor sleep patterns
- Poor nutrition (e.g., lack of nutrient-dense foods and well-balanced diet)
- Certain medications (e.g., antidepressants, certain diabetes medications)
- Environmental factors (e.g., lack of access to healthy foods and safe recreational spaces)

Tips to Support Metabolic Health

While each person's journey with obesity looks different, there are evidence-based lifestyle choices, including following a healthy diet, engaging in regular physical activity, and getting enough sleep, that can have a positive influence on a person's weight and overall health.

Even a modest weight loss of 5%–10% can help lower blood pressure, cholesterol, and blood sugar levels, decreasing the risk for chronic diseases such as heart disease and Type 2 diabetes.

- **Nutrition:** A **healthy diet** prioritizes nutrient-dense protein foods, such as seafood and lean meats; a variety of fruits and vegetables; healthy fats found in dairy, avocados, and olives; and whole grains. A healthy diet also avoids processed foods, added sugars, sodium, and saturated fats and stays within a person's daily calorie needs.
- **Exercise:** The general **recommendation** for adults is to get at least 150 minutes of moderate-intensity aerobic activity each week. "Moderate-intensity aerobic activity" means that you're working hard enough to raise your heart rate and break a sweat, but you can still carry on a conversation. However, more physical activity may be needed to maintain a healthy weight. The exact amount will vary from person to person. If you have a chronic condition or a disability, you can **modify your physical activity routine** to match your abilities.
- **Sleep:** It is recommended that adults sleep seven to eight hours each night. A lack of sleep can lead to an **imbalance in the hormones** that regulate appetite and stress and can affect blood sugar levels.
- **Stress: Studies** show that a person's lived environment, including hardships and other social challenges, can affect the body in ways that make it harder to manage weight. While people can't always change their individual circumstances, they may be able to practice stress management through activities like meditation, journaling, and spending time outdoors. Stress can also negatively impact food choices and portion sizes.
- **Support:** There are many ways people can get positive support for managing overweight or obesity. One way is to reach out to trusted friends, family, or coworkers, especially those who may have similar goals. You can exercise together, encourage success, or share helpful tips or resources like healthy recipes. You can also seek help from a healthcare provider (HCP) that specializes in obesity and weight management

or an accredited weight-loss specialist or join a structured program with a support group.

It's important to remember that everyone's journey can look different, and there is no solution that works for everyone. Work with your HCP to discuss which options are right for you to help you manage overweight or obesity and safely maintain your weight. **Learn more from the National Institute of Diabetes and Digestive and Kidney Diseases.**



Featured Find!

Life's Essential 8 – How to Keep a Healthy Weight Fact Sheet

American Heart Association

A fact sheet sharing ideas for managing weight, such as increasing the amount of fiber you eat, and tips for success, including portion control.

Healthcare Providers

Several types of HCPs see people for obesity concerns and treatment management.

- A **primary care provider (PCP)** is an HCP who helps manage a person's general health over time and can refer patients for specialty care. They offer preventive care, screenings, and immunizations and also diagnose and treat a wide range of conditions.
- An **obesity medicine specialist/bariatrician/bariatric healthcare provider** is a doctor who specializes in the comprehensive management of obesity and its associated health conditions.
- A **bariatric surgeon** is a doctor who performs surgeries that are used in treating obesity by making changes to your digestive system, such as gastric bypass and gastric sleeves.
- An **endocrinologist** is a doctor who specializes in the diagnosis and treatment of disorders of the endocrine system (the organs and glands that make hormones).
- A **gastroenterologist** is a doctor who specializes in the diagnosis and treatment of disorders of the digestive system.
- A **registered dietitian**, also known as a registered dietitian nutritionist, is a credentialed HCP who specializes in diet and nutrition. They often work in coordination with primary care and specialty

care teams to help people with diet-related matters, such as improving diabetes management.

- A **physician assistant/physician associate (PA)** is a licensed clinician who practices medicine across different specialties and healthcare settings. PAs are important members of a care team, developing care plans, and providing ongoing support and education to patients and families.
- A **nurse practitioner (NP)**, a type of advanced practice registered nurse (APRN), is a registered nurse with advanced training in administering patient care. NPs diagnose, treat, and manage acute and chronic diseases while emphasizing health promotion and disease prevention.

In addition to these HCPs, there are other types of providers who may see people for conditions related to obesity. These include, but are not limited to, cardiologists (who can diagnose and treat problems related to the heart and blood vessels), dermatologists, nephrologists (doctors who specialize in kidney care), psychologists, pulmonologists (doctors who specialize in the respiratory system and treat conditions like sleep apnea), ophthalmologists and optometrists (who may see patients for obesity-related eye diseases, such as diabetic retinopathy), and podiatrists (foot health specialists).

While Medicare generally covers visits for PCPs, coverage and deductibles may vary depending on factors such as the type of Medicare plan and provider participation. Those with Medicare Advantage will likely have to stay within the plan's network and may require a referral to see specialists. Coverage for visits with other specialists may be dependent on whether the specialist participates in Medicare. Checking with your plan to confirm what is covered in advance is important and could prevent unexpected bills.

A Reminder: Healthcare Provider and Hospital Choice

Original Medicare	Medicare Advantage
You can visit any HCP or hospital in the United States that accepts Medicare.	These plans often require you to use HCPs and hospitals within the plan's network.
In most cases, referrals are not needed to see a specialist.	A referral from your PCP may be needed to see a specialist.

**Adapted from Medicare.gov.*

Taking Charge: My Health Management Habit Tracker

Regardless of your stage of life, you can take steps now to support your overall health. This daily health management habit tracker can help ensure you're taking steps from week to week to lead a healthy lifestyle.

- ☒ I was mindful of portion size at each meal
- ☒ I ate a good variety of fruits and vegetables
- ☒ I chose whole grains (e.g., oats, brown rice)
- ☒ I limited salt and added sugars
- ☒ I drank at least 8 cups of water
- ☒ I got at least 30 minutes of moderate-intensity physical activity
- ☒ I got quality sleep
- ☒ I practiced stress management
- ☒ I tracked my habits (e.g., daily steps, duration of activity, active vs. sedentary time)



Care Considerations With Original Medicare and Medicare Advantage

As you think about which coverage pathway between Original Medicare and Medicare Advantage is right for you, you'll have to consider your unique circumstances and which path provides services that are most important to you.

For example, a 2022 **analysis of Medicare beneficiaries** found that Medicare Advantage enrollees were in a plan that included about half (48%) of the physicians available to Original Medicare beneficiaries. The narrower network of providers available with Medicare Advantage could significantly limit timely and consistent access to specialists, such as obesity medicine doctors, unless the enrollees were to go out-of-network and pay more. Additionally, under Medicare Advantage, beneficiaries are not always able to buy or afford supplemental coverage to help pay out-of-pocket costs (Medigap) if they decide to disenroll from their Medicare Advantage plan and move to Original Medicare.

Yet, Medicare Advantage plans may offer additional benefits that could be valuable for someone with obesity, including limits for out-of-pocket costs. Most Medicare Advantage plans also include Medicare Part D, or prescription drug coverage, as part of their overall health benefits. As described below, some Medicare Advantage plans may offer additional services to assist with exercise and weight management.

It's important to understand your coverage needs and what will save you the most on costs.

Medicare Coverage for Obesity

Eligibility

While most people start Medicare at age 65, people with a qualifying disability who have been receiving Social Security Disability Insurance (SSDI) benefits for more than 24 months **may be able to receive Medicare coverage earlier**.

While obesity alone does not qualify a person for disability benefits, the **Social Security Administration (SSA)** does recognize obesity as a **medically**

determinable impairment (MDI) and considers its combined effects with other conditions when evaluating disability claims. In evaluating claims, the SSA will review medical records from your HCP, such as laboratory findings, and your medical history to review whether there is a consistent pattern of obesity. The SSA will also consider whether someone living with obesity is experiencing functional limitations in their ability to work (e.g., sitting, standing, walking).

Coverage

Both Original Medicare and Medicare Advantage provide the following types of coverage that can help support women in managing their weight and for women affected by obesity:

- **Preventive and Screening Services:** Medicare Part B covers many preventive services, including health exams and screenings, programs for health monitoring, and counseling and education to help women take care of their health as they age. These include:
 - **“Welcome to Medicare” Visit:** An initial, one-time visit that takes place within the first 12 months of enrolling in Medicare Part B.
 - **Annual Wellness Visit:** Available every 12 months after the first year on Medicare Part B and focused on prevention, including a health risk assessment, review of current providers and medications, and creation of a screening checklist.

Note: Medicare does not cover routine physical exams. [Learn more about yearly wellness visits.](#)

- **Obesity behavioral therapy:** Includes an initial screening for BMI and behavioral therapy sessions that include a dietary assessment and counseling. Medicare Part B covers this type of counseling for people with a BMI of 30 or more whose PCP provides the counseling in a primary care setting. Medicare will cover counseling visits for up to 12 months. Receiving these services from another specialist, such as a registered dietitian, could mean having to pay for services out of pocket. Individuals who qualify and have their appointments within a primary care setting pay nothing for this service if the provider [accepts the assignment](#) (meaning the HCP accepts Medicare and agrees to the Medicare-approved payment for the service). [Learn more about obesity behavioral therapy.](#)
- **Thyroid testing:** Includes up to two thyroid tests, including the TSH, T3, and T4 blood tests, per year for clinically stable patients if an HCP deems them medically necessary for diagnosing or treating thyroid dysfunction. Medicare Part B covers these tests once the Part B plan’s deductible has been met. Costs may vary for those with Medicare Advantage plans, and Medicare Advantage plans may offer additional testing. Tests done during an inpatient hospital stay are covered under Medicare Part A. [Learn more about thyroid testing.](#)

- **Lifestyle Support:** Medicare Part B offers several resources related to lifestyle and nutrition that could be beneficial in a person’s obesity management journey:
 - **Diabetes self-management training,** which provides tips for eating healthy and being active, monitoring blood sugar, and taking prescription drugs, for those who have been diagnosed with diabetes. An HCP must provide a written order for this training, and exceptions may apply based on the individual’s needs or whether services (i.e., group sessions) aren’t available where you live. [Learn more about diabetes self-management training.](#)
 - **Durable medical equipment,** when prescribed by an HCP and considered medically necessary. Coverage for certain medical equipment, such as walkers and canes, may be based on functional need, such as difficulty moving around the home. Approved equipment is likely to cost 20% of the Medicare-approved amount after the Part B plan’s deductible has been met. Medicare Advantage plans must cover the same medically necessary categories of durable medical equipment items as Original Medicare, but the suppliers of the equipment and costs will depend on an individual’s specific Medicare Advantage plan. [Learn more about durable medical equipment coverage at Medicare.gov](#) and in the official government booklet, [“Medicare Coverage of Durable Medical Equipment & Other Devices.”](#)
 - **Lymphedema compression treatment items** (gradient compression garments and gradient compression wraps with adjustable straps and compression bandaging supplies) for those diagnosed with lymphedema and who have been prescribed the treatment items by an HCP. Additional items to treat lymphedema are covered by Medicare, such as pneumatic compression pumps (covered under durable medical equipment) and manual lymphedema drainage (covered under occupational or physical therapy). Individuals will pay 20% of the Medicare-approved cost after the Part B plan’s deductible has been met. [Learn more about lymphedema compression treatment items.](#)
 - **Medical nutrition therapy** for those with diabetes or kidney disease or those who have had a kidney transplant in the last 36 months. Only a treating physician or a primary care physician can refer an individual for this service,

which is provided by a registered dietitian. Individuals pay nothing for these services if they qualify and if they received the service from dietitians who accept Medicare rates. **Learn more about medical nutrition therapy services.**

- **Occupational therapy** to help improve or maintain current capabilities for daily living (e.g., getting dressed) for people who need it. An HCP must certify that this care is needed. Individuals pay 20% of the Medicare-approved amount after the Part B plan's deductible has been met. Medigap plans will generally cover the 20% payment, so people with those plans should check their [explanation of benefits](#) to see if the service will be covered. **Learn more about occupational therapy services.**
- **Physical therapy** to improve or maintain current function for people who qualify. Individuals pay 20% of the Medicare-approved amount after the Part B plan's deductible has been met. Medigap plans will generally cover the 20% payment, so people with those plans should check their [explanation of benefits](#) to see if the service will be covered. **Learn more about physical therapy services.**

Coverage Extras Under Medicare Advantage

Some Medicare Advantage plans may provide coverage for additional health and wellness services that can support obesity management or weight-loss efforts. This could include coverage for gym memberships or fitness programs, such as SilverSneakers, a fitness and lifestyle program for adults ages 65 and older. SilverSneakers may also be available through a Medicare Supplement Plan. Other programs that may be offered as an alternative include Renew Active, Silver&Fit, and Golden Sneakers.

Some Medicare Advantage plans may also offer food delivery services. For those with a chronic medical condition, such as diabetes, plans may pay for meals tailored to the condition. These services will vary from plan to plan and will have different costs and eligibility criteria. Check with your specific Medicare Advantage plans to determine benefits.

Learn more from the National Council on Aging.

- **Medication Coverage:** Medicare coverage for obesity medications can vary depending on individual circumstances. Drugs may be covered under Medicare Part B or Medicare Part D when other chronic conditions are present in addition to obesity. Medications include:
 - **Glucagon-like-peptide-1 (GLP-1) medications:** Certain semaglutide treatments (such as Ozempic and Wegovy) and tirzepatide treatments (such as Mounjaro and Zepbound) are covered by Medicare when they are prescribed for U.S. Food and Drug Administration (FDA)-approved conditions such as Type 2 diabetes, moderate-to-severe sleep apnea, and metabolic dysfunction-associated steatohepatitis (MASH, formerly called non-alcoholic steatohepatitis or NASH), as well as cardiovascular risk reduction in some cases.
 - By law, Medicare cannot cover these medications for obesity or weight loss alone. However, a 2026 demonstration program administered by the Centers for Medicare and Medicaid Services (CMS), called the “Medicare GLP-1 Bridge,” covers GLP-1 medications. This demonstration program provides eligible Medicare beneficiaries who are enrolled in Medicare Part D with access to certain GLP-1 medications through the end of 2027. Medicare beneficiaries should check with their treating or primary care physician to find out whether they may be **eligible for this demonstration** due to their clinical condition(s).
 - Patients who are not eligible for coverage through Medicare Part D or who are deemed ineligible for the CMS Bridge program should work with their HCP to identify other options for financial assistance, such as discount programs offered by pharmaceutical companies.



A 101 on the Medicare GLP-1 Bridge

In April 2026, CMS announced a new initiative to cover most of the costs of GLP-1 medications for people who are enrolled in Medicare Part D and meet the eligibility requirements for GLP-1s. This program, known as the **Medicare GLP-1 Bridge**, began in July 2026 and will run until the end of 2027. **Medicare beneficiaries who wish to participate will need an HCP to write a prescription** and submit a **prior authorization** request to determine eligibility. Those determined to be eligible will be able to access GLP-1 medications with a monthly \$50 copay. It is important to note that this copay will not count toward a participant's Medicare Part D deductible or out-of-pocket costs, as the program operates outside of Medicare Part D. CMS has not yet announced whether or how the program will provide coverage after 2027.

Learn more about the Medicare GLP-1 Bridge.

- **Surgery:** Medicare Part B covers some surgical procedures if a person is deemed eligible.
 - Medicare covers some **bariatric surgical procedures** if a person has a qualifying BMI of 35 or more and meets certain conditions. Individuals must have at least one related **comorbidity** (e.g., diabetes, heart disease) and show that they have previously tried and failed to lose weight through medically supervised, non-invasive methods. A psychological evaluation may also be required to ensure that the individual is prepared for a life-altering procedure. Bariatric surgeries covered by Medicare as of June 2026 include:
 - **Adjustable gastric banding**
 - **Biliopancreatic diversion with duodenal switch**
 - **Gastric bypass surgery (Roux-en-Y)**
 - **Laparoscopic sleeve gastrectomy**
 - **Vertical banded gastroplasty**

Your physician may also recommend endobariatric procedures, which are covered by Medicare on a case-by-case basis. Medical evidence and coverage for these procedures

may evolve over time, so it's important to check with your plan to determine if your physician-recommended option is covered before scheduling the surgery.

It is difficult to predict the out-of-pocket costs of surgeries and procedures in advance. Factors that may affect how much you'll pay include where the procedure takes place, whether the procedure will be **outpatient** or **inpatient**, and whether you have supplemental insurance through Medigap, Medicaid, your employer, or your spouse's employer. **Learn more about bariatric surgery.**

- Medicare Part B may cover **panniculectomies** (removal of excess skin and tissue from the lower abdomen) if they are deemed medically necessary by an HCP. Medicare will not cover the surgery as a cosmetic procedure. If the procedure requires prior authorization and Medicare approves it, the individual should only be responsible for the deductible and coinsurance from the procedure. **Learn more about cosmetic surgery.**

A Note on Medicare Coverage

Original Medicare and Medicare Advantage plans may have different **cost-sharing** amounts (the out-of-pocket expenses like deductibles, coinsurance, and copayments that beneficiaries pay for Medicare services), so it's important to check your plan's coverage details. Additionally, many people with Original Medicare purchase Medigap — a supplemental insurance — that helps pay for these cost-shares. For those who qualify for retiree benefits through their former employer, their retiree plan may cover these costs. And for those who are dually eligible for Medicaid, states pay for Part B cost-sharing.

Consider reaching out to Medicare at **1-800-MEDICARE (1-800-633-4227)** or your State Health Insurance Assistance Program to answer questions and provide additional clarification.

Obesity Management Questions to Ask During Medicare Wellness Visits

These questions can be tailored to personal circumstances and medical history.

- What is my current BMI?
- How is having overweight or obesity affecting my overall health risk right now?
- Could my stress or sleep be affecting my weight?
- What can I do if pain or mobility issues make exercise hard?
- What kinds of physical activity would be best for me to meet my weight goals?
- Is there a specific obesity management program you would recommend for me?
- Am I currently taking any medications that might contribute to overweight/obesity?
- What are the pros and cons of medications like semaglutide, tirzepatide, or orforglipron for me?
 - If I were to go on one of these medications, would it be covered under Medicare?
 - How long would I need to take these medications for?
- What strategies could help me work through the challenges I'm facing with my weight?

Importance of Reviewing Coverage Annually

Choosing the Right Medicare Coverage as Your Needs Change

Your access to certain services and benefits can vary depending on whether you have Original Medicare or a Medicare Advantage plan. Similarly, coverage rules, provider networks, prior authorization requirements, and out-of-pocket costs can be different between plans. This includes differences in coverage for treatment of obesity. Even if your current plan covers the benefits you need today, it's important to review your coverage regularly as your health needs change.

It's also important to consider whether switching from Original Medicare to a Medicare Advantage plan (or vice versa) will cause any disruptions to your health and financial needs. For example, you may not be able to enroll in a Medigap plan if you switch to a Medicare Advantage plan and then try to come back to Original Medicare.

Obesity and related chronic conditions can require different types and levels of care over time, so reassessing and consulting with your plan each year on your specific testing and treatment needs can help ensure that you continue to have access to the services and supports that are right for you.





Featured Find!

Navigating Obesity Care Coverage Denials

EveryBODY Covered

If you have been denied coverage for obesity treatment, it can be challenging to understand the reasons why and what to do next. This resource includes helpful tips for navigating common coverage challenges, whether you get your insurance from your employer, the government, or the marketplace. Before getting started, know that gaining coverage may require persistence, and your HCP may have helpful advice about and offer assistance with navigating insurance denials.

Drug Plan Rules

Medicare Part D helps cover the cost of prescription medications, including brand-name and generic drugs. People who choose Original Medicare must be enrolled in either Medicare Part A and/or Medicare Part B to enroll in a Medicare Part D plan. Most Medicare Advantage plans include Part D coverage. Beneficiaries do not need to enroll in a separate Part D plan if their Medicare Advantage plan includes Part D coverage. Under most Medicare Advantage plans, people cannot join a separate Medicare drug plan.

Like private insurance companies, Medicare drug plans have rules about whether they cover certain drugs and how they cover them. Drugs may be evaluated for medical necessity, appropriateness, and efficiency of use.

These rules include:

- **Prior Authorization:** A process requiring the review and approval of a specific drug before it is prescribed based on specific criteria
- **Step Therapy:** A policy that requires a patient to try and “fail” a lower-cost treatment before the treatment originally prescribed or recommended by an HCP can be prescribed
- **Quantity Limits:** Restrictions about the amount of drugs that can be covered over a certain period for cost and safety reasons

You should check with your specific plan to learn your coverage rules and to determine whether your pharmacy is considered in-network or out-of-network. [Learn more about Medicare drug coverage.](#)

Note: When Medicare drug coverage begins, or when switching to a new Part D plan, **beneficiaries** may receive a one-time, 30-day supply of the medication they’ve been taking — even if the drug isn’t covered by their new plan or requires prior authorization or step therapy — to aid in the transition to their new plan.

Obesity and Medicare: What If ...?

MEDICATION COVERAGE

Q: What if Medicare won’t cover my obesity medication?

A: Prior to July 2026, Medicare only covered GLP-1 medications prescribed for people with certain conditions like diabetes, sleep apnea, or heart disease. Now, Medicare covers certain GLP-1s under the **Medicare GLP-1 Bridge** program. You should ask your provider if you **qualify for the Bridge program**. If you have questions about the Bridge program, visit the **OCAN website**. Continue to check with **Medicare** for the most up-to-date coverage information.

If you don’t qualify, ask your HCP about non-drug options that Medicare does cover, such as obesity behavioral therapy or nutrition counseling.

Q: What if my medication requires prior authorization or gets denied?

A: Your HCP can submit paperwork showing the medication is medically necessary. If it’s denied, you can file an appeal. It is also important to note that there are a number of non-FDA approved medications or compounded versions of medications on the market. These medications may not be approved based on safety and efficacy standards, which means that they may come with unknown risk and may not have the evidence to show that they are the right fit for you. Any medication should only be used after consultation with your HCP.

Questions to Ask if You're Considering Obesity Medications

- Have you checked the latest guidance from CMS?
- Have you talked to your HCP to see if you meet the clinical requirements for obesity medications?
- Have you talked to your HCP to determine how obesity medication may impact any other co-existing conditions?
- If your treatment requires prior authorization from Medicare, will your HCP submit it?
- What will the total cost for medication be (including copays, deductibles, and any monthly costs)?
- Will the costs change over time? If so, can you afford to continue medication or will you need to stop?
- Are there any Medicare-covered alternatives?

Q: What if I'm not sure whether my condition qualifies for coverage?

A: Ask your HCP or call your Part D plan. Coverage for obesity medications often depends on specific diagnoses and FDA-approved uses.

Q: What if I start a treatment but can't continue it because the long-term cost is too much?

- A: If your medication is covered by your Medicare Part D plan:
- You may qualify for the Extra Help program, which helps cover the cost of deductibles and copays. Additionally, whether you receive your medications through a Part D plan or Medicare Advantage plan, you are able to participate in the Medicare Prescription Payment Plan and spread the costs of your medication throughout the year rather than paying all costs at once. **Learn more about the Extra Help program** and the **Medicare Prescription Payment Plan**.
 - Some states also administer State Pharmaceutical Assistance Programs (SPAPs) that provide financial assistance with Medicare drug plan premiums and/or cost-sharing. **Learn more about SPAPs in your area.**

- Some pharmaceutical companies help pay for prescriptions for people who have Medicare Part D through **pharmaceutical assistance programs**. Applying for a pharmaceutical assistance program, when available, or switching to a generic version of your medication, may also help reduce out-of-pocket costs. **Learn about pharmaceutical assistance programs.**

It's important to plan ahead. Ask your HCP about long-term affordability, lower-cost options, or strategies for transitioning to a different treatment option early.

SURGICAL PROCEDURES COVERAGE

Q: What if Medicare won't cover my surgical procedures?

A: Medicare generally covers bariatric surgical procedures if they are deemed medically necessary by an HCP, if a person has a qualifying BMI of 35 or more, and if they have an obesity-related condition, such as diabetes or heart disease. The surgery also must take place at a Medicare-approved facility. If you learn that your coverage has been denied, first check that these criteria have been met and that all of the correct paperwork has been submitted. Also, you can discuss with your HCP whether any additional information is needed in order to appeal.

ONGOING CARE AND PLAN SPECIFICS

Q: What if my plan changes what it covers?

A: Review your plan's benefits during Medicare Open Enrollment (October 15–December 7) each year to make sure that your current plan still meets your needs. If it doesn't, you might consider switching to a different plan.

Q: What if my specialist isn't in my Medicare Advantage plan's network?

A: You may need to get a referral, or you could face higher costs for seeing an out-of-network provider. During Medicare Open Enrollment (October 15–December 7), you can explore switching to a plan that includes your current specialists.

Q: Are the same services that I would get under Original Medicare covered under Medicare Advantage as well?

A: Medicare Advantage plans must cover all medically necessary services that are covered under Original Medicare. However, plans will use their own coverage criteria to determine medical necessity for certain services and may offer other benefits that are not covered under Original Medicare.

 Featured Find!

Understanding Obesity in Caregiving

Caregiver Action Network

This interactive learning experience from Caregiver Action Network and Paradigm Medical Communications is designed to help caregivers and care partners better support loved ones living with obesity. The tool combines expert guidance, real-world stories, and quizzes to give caregivers and care partners ways to offer meaningful support without bias or shame.

Obesity Medications: What to Consider When Buying Direct

If you purchase a GLP-1 outside of your Medicare Part D plan, such as paying cash through a discount website or telehealth service, those costs generally do not count toward your Part D coverage. This means the amount you pay won't apply to your plan's deductible or its out-of-pocket spending cap. If you decide to use these options, know that, while they may offer lower upfront prices, they do operate separately from Medicare. This means they won't count toward your out-of-pocket maximum. In Medicare D, once you hit your out-of-pocket spending limit, you won't pay for prescriptions for the rest of the year. If you buy direct, the cost of these prescriptions will not count toward your out-of-pocket limit, so you may end up paying more overall for your medications through the year.

 Featured Find!

How to Support a Loved One Living with Obesity

HealthyWomen

This article discusses how people can best support people in their lives who are living with obesity. Tips include recognizing obesity as a chronic disease, learning about the disease, asking questions, and testing your own bias.

Institutional and Long-Term Care for Obesity: Covered or Not?

Medicare beneficiaries who are living with obesity are more likely to have Type 2 diabetes, cardiovascular disease, sleep apnea, or mobility limitations, which may mean they require institutional care as part of their treatment plan. While determining coverage for certain facilities can be challenging, Medicare beneficiaries who are living with obesity may also have trouble accessing appropriately equipped facilities and safe transitions between settings.

Type: Outpatient Hospital Services

Description: Procedures and treatments that may be performed at a hospital but don't require an overnight stay (e.g., laboratory tests billed by the hospital, preventive and screening services, X-rays, and other radiology services billed by the hospital).

? Covered? Maybe. Medicare Part B covers several diagnostic and treatment services that are performed in hospitals that accept Medicare. Beneficiaries usually pay 20% of the Medicare-approved amount for the services and a copayment for each service received in a hospital outpatient setting, unless it's a preventive service that doesn't have a copayment. **Learn more about outpatient hospital services.**

Type: Inpatient (Acute-Care) Hospital Services

Description: Medical care provided in a hospital or facility that involves the patient staying overnight or longer.

✓ **Covered?** Yes. Medicare Part A typically covers inpatient hospital care if: 1) the person is admitted after an HCP's order and 2) the hospital accepts Medicare. (Most hospitals accept Original Medicare; some hospitals do not accept Medicare Advantage plans.) People pay \$0 for days 1–60 (after the Part A deductible has been met). The cost for days 61–90 changes each year. For hospital stays longer than 90 days, the patient may opt to use **lifetime reserve days**. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medicare Part B typically pays 80% of the Medicare-approved amount for the HCP's services at the hospital. **Learn more about inpatient hospital care.**

Type: Inpatient Rehabilitation Facilities

Description: Rehabilitation programs in rehab hospitals or rehab units in acute care hospitals.

✓ **Covered?** Yes. Medicare Part A covers medically necessary care received in an inpatient rehab facility if an HCP certifies the care. People pay \$0 for days 1–60 (after the Part A deductible has been met). The cost for days 61–90 changes each year. For hospital stays longer than 90 days, the patient may opt to use lifetime reserve days. With lifetime reserve days, Medicare pays all covered costs except a daily copay. Information about costs for coverage can be found on **Medicare.gov**. Medicare Part B covers the HCP's services while in the facility. Medicare Advantage plans may have different rehabilitation benefits and approvals, so you should review this information when selecting a Medicare plan. **Learn more about inpatient rehabilitation care.**

Lifetime Reserve Days

In Original Medicare, lifetime reserve days are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days you can use during your lifetime. These days cover any type of inpatient stay, including:

- Inpatient acute-care hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities

These days cannot be used for skilled nursing facilities.

Note that, while there are no limits on the number of hospital admissions that Medicare will cover, lifetime reserve days are not renewable year to year. You have 60 days to use over your lifetime. For example, if you use 35 days for one hospital stay, you will have 25 days left to use at any other time in life. If you have a Medigap policy, it will provide coverage of hospital coinsurance costs and extra days of inpatient coverage after your Medicare lifetime reserve days are used up.

While Medicare Advantage plans must cover the same inpatient hospital benefits as Original Medicare, including the 60 reserve days, Medicare Advantage plans may differ in terms of costs, such as copayments. Check your specific Medicare Advantage plan to determine coverage specifics.

Type: Long-Term Care Hospital Services

Description: Provide care to patients who need hospital care for more than 25 days on average and often have more than one serious medical condition. Many of these patients are transferred from an intensive or critical care unit.

✓ **Covered?** Yes, Medicare Part A covers long-term care hospital stays under certain circumstances, such as when patients need services such as respiratory therapy, head trauma treatment, therapy for a spinal cord injury, or pain management. **Learn more about long-term care hospital services.**



Featured Find!

Institutional and Long-Term Care Medicare.gov Resources

- **Outpatient Hospital Services**
- **Inpatient Hospital Care Services**
- **Inpatient Rehabilitation Facilities**
- **Home Health Services**
- **Medicare & Home Health Care**
- **Long-Term Care**
- **Nursing Homes**
- **Resources & Information for Patients and Caregivers**

Type: Long-Term Care Services

Description: Non-medical support services that help people live independently and safely, whether provided in a facility such as a nursing home or in a community setting. This may include assistance with transportation; help with daily activities, such as dressing and bathing; and meal delivery.

X Covered? No. Original Medicare, Medicare Advantage, and Medigap plans generally do not cover long-term care. Medicare Advantage may cover some supplemental healthcare benefits, such as meal delivery. **Learn more about options for long-term care resources.** If you qualify for dual eligibility, you may be able to get long-term care coverage through Medicaid. **Learn more about Medicaid coverage for long-term care.** Other federal programs such as the Older Americans Act and the Department of Veterans Affairs pay for long-term care services, but only for specific populations and in certain circumstances.

Type: Skilled Nursing Facilities (SNFs)

Description: Live-in facilities that provide medical care on a full-time, short-term basis.

? Covered? Maybe. Original Medicare may cover skilled care at a nursing home or via home health care if the beneficiary meets certain conditions and requires short-term skilled care for an illness or injury. These conditions include:

- **Qualifying Hospital Stay:** The person must have been an inpatient in a hospital for at least three consecutive days. Certain skilled nursing

facilities may also be able to bypass the three-day requirement through the **skilled nursing facility three-day rule** waiver. Patients should ask their social worker or **patient navigator** whether the stay will be covered by their plan.

- **Admission Within a Certain Window After Leaving the Hospital:** The acceptable time frame is generally 30 days.
- **Medically Necessary Skilled Care:** Your HCP must certify that you need daily skilled care.
- **Medicare-Certified Facility:** The SNF must be Medicare-certified.

If all the above conditions are met, Medicare Part A will cover benefits that include a semi-private room, skilled nursing care, medications, medical supplies and equipment, and more. Learn more about skilled nursing facility care.

Note on Institutional Care: If you're living with obesity, it's important to know that Medicare may cover your stay but that not every facility is equipped to meet your needs. For example, not all facilities will have bariatric equipment, such as patient lifts, which could lead to delays in placement or being sent to a facility that's farther from your home. Planning ahead and asking the right questions can help you get safer, more appropriate care. Questions that can be helpful to ask the healthcare facility include the following (and can be tailored based on your personal circumstances and needs):

- Does this facility have bariatric equipment (beds, lifts, chairs)?
- Are staff trained to safely assist patients with my needs?
- Have you cared for patients with similar needs before?

Type: Home Health Care

Description: Services that can be provided within the home for an illness or injury.

? Covered? Maybe. **Medicare Part A and/or Part B** cover eligible home health services if certain conditions are met, such as when a person is home-bound and requires skilled services. People living with obesity may have home health care covered if it's deemed medically necessary and ordered by an HCP. Non-skilled services such as assisting with everyday care and needs are not covered. **Medicare Advantage plans** cover home health care, but the coverage may be different than under Original Medicare. **Learn more about home health services.**

Obesity Resources and Support

Alliance for Women's Health & Prevention: Through its **EveryBODY Covered** campaign, AWHP advocates for expanded access to comprehensive, evidence-based obesity care.

American Heart Association: Provides information for understanding weight and the intersection between metabolic, heart, and kidney health.

American Medical Women's Association: Provides education about obesity, its comorbidities, and management to public health HCPs.

American Society for Metabolic and Bariatric Surgery: Works to enhance the well-being of individuals affected by obesity and related conditions through advances in metabolic and bariatric surgical techniques and other medical interventions.

HealthyWomen: Offers education on obesity for women across their lifespan.

Medicaid.gov: Provides essential services to support obesity management, particularly for low-income individuals.

Medicare.gov: Offers details on coverage options for obesity screening and treatment.

National Council on Aging: Provides tools and resources, including on obesity care and treatment, so people can age with health and economic well-being.

Obesity Action Coalition: Works to help individuals along their journey toward better health through education, advocacy, awareness, and support.

Obesity Association: A division of the American Diabetes Association that works to reduce the prevalence of obesity and improve health in at-risk and affected communities, including by setting standards for obesity care in clinical practice.

Obesity Care Advocacy Network (OCAN): Aims to increase access to evidence-based obesity treatments by uniting key stakeholders and the broader obesity community around significant education, policy, and legislative efforts.

Prevent Blindness: Offers bilingual obesity-related diabetic eye disease education, support, and resources.

Society for Women's Health Research: Offers resources for patients, families, clinicians, and policymakers on diseases, conditions, and life stages, including obesity, that uniquely, differently, or disproportionately affect women.

State Health Insurance Assistance Programs: Provide free counseling to help navigate Medicare benefits.

Strategies to Overcome and Prevent (STOP) Obesity Alliance: Conducts research, makes policy recommendations, and develops hands-on tools for providers, advocates, consumers, and policymakers.