




Confronting the Cost of Obesity Drugs

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Effective weight-loss medicines—referred to as GLP-1s—represent a huge clinical advance, but health plan sponsors find them hard to afford. Learn what strategies health plans are using to meet the demand for these drugs while mitigating the high price tag.

The rising rate of obesity in the United States and throughout the developed world has led to an increased occurrence of diabetes, heart disease, kidney failure, musculoskeletal disease and certain types of cancer. Health plan sponsors, employers, public health leaders and people with obesity have long sought an effective approach to weight loss, but the only long-term effective treatment has been bariatric surgery.

Glucagon-like peptides—medications referred to as GLP-1s—have changed this dynamic. These drugs are highly effective at driving weight loss, but they are extremely expensive. This class of drugs has been used to treat diabetes since 2005, but the first weekly injection labeled specifically for obesity was not approved until 2021. Plan sponsors may want to provide coverage for these medications but are struggling to address how to afford them. This article will highlight why some employers and plan sponsors are offering coverage and the tactics they are using to address the growing demand for these medications.

The Challenges of Treating Obesity

Our understanding of the causes of obesity has changed dramatically over the last few decades. Both genetic and environmental factors drive the rise in obesity, including the ready availability and low purchase price of calorie-dense, highly processed foods that don't lead to a sense of fullness.

People with established obesity who try to reduce calorie intake face “food noise”—an intense preoccupation with hunger that makes it hard to stay on a diet. Those who succeed in markedly reducing their calories often are thwarted in their effort to lose weight by a slowing metabolism. For instance, most of the winners of the 2009 season’s “Biggest Loser” contest on television regained substantial weight despite maintaining a strict calorie-limited diet and exercising many hours a day. Metabolic testing showed that they each burned hundreds fewer calories than would be expected based on their size.¹

Historically, medications to drive weight loss have been only modestly effective and sometimes have led to serious side effects. Phentermine, for example, can lead to a modest amount of weight loss through appetite suppression. The drug was more effective when paired with fenfluramine in the 1990s, but fenfluramine was withdrawn from the market when it was found to sometimes cause fatal pulmonary hypertension and severe heart valve problems. Other drugs, including Contrave® (naltrexone and bupropion), Qsymia® (phentermine and topiramate), and Alli® or Xenical® (orlistat), can lead to weight loss of up to 5% but often have troublesome side effects.

Bariatric surgery leads to sustainable weight loss for many with obesity but requires specially trained surgeons, multidisciplinary teams and highly motivated patients. Current surgical techniques generally lead to 15% weight loss, which substantially decreases risk for obesity-related medical problems. But few people who qualify for bariatric surgery have had it. Only an estimated 1% of those with obesity have had bariatric surgery,² and the demands of this surgery make it unlikely to be an effective way to address obesity at scale across the population.

Enter GLP-1 Drugs

GLP-1 drugs were first used to treat diabetes almost two decades ago. While many drugs that effectively treat diabetes cause weight gain, GLP-1 drugs have the beneficial side effect of causing weight loss. Most GLP-1 drugs are self-administered by injection; the early drugs were used daily much like insulin, and the most effective current drugs, Wegovy® (semaglutide) and Zepbound™ (tirzepatide), are injected weekly. The same GLP-1 drugs are used—sometimes at different doses and generally with different names and prices—to treat both diabetes and obesity. The Food

takeaways

- GLP-1 drugs (glucagon-like peptides) are highly effective at driving weight loss but also are extremely expensive. Health plan sponsors that want to cover these medications are struggling with how to afford them.
- GLP-1 drugs were first used to treat diabetes but have the beneficial side effect of causing weight loss. People who take them are less hungry and eat less, but side effects often include nausea and constipation.
- List prices for brand-name GLP-1 drugs approach \$17,000 a year, and researchers estimate that treatment can cost \$274,400 over a patient's lifetime.
- Plan sponsors are using a range of strategies to mitigate the costs of GLP-1 drugs, including covering them for only a subset of plan members with obesity or requiring participation in lifestyle programs or a previous trial with other medications.
- Some plans are shifting more costs to plan members or implementing lifetime maximums or other coverage limitations.

and Drug Administration (FDA) has approved these drugs for those with a body mass index (BMI) of 30 or a BMI of 27 with a complication such as high blood pressure or high cholesterol. While this group of drugs gained widespread publicity fueled by cosmetic use by Hollywood celebrities, they are not clinically indicated for those who are overweight (BMI between 25 and 30) without other related health conditions.

How They Work

GLP-1 drugs address the underlying causes of obesity. Those on GLP-1 drugs are less hungry due to hormonal changes that affect the satiety center of the brain, and they are able to eat less because the transit time through the stomach is longer. People on these medications who restrict their calories often lose the food noise that made them eat extra calories, and these medications reportedly also often decrease other compulsive behavior, including drug, alcohol and tobacco use.³ The drugs frequently cause gastrointestinal side effects, most prominently nausea and constipation, although these symptoms can diminish over time. They also cause loss of bone density and lean muscle as well as delayed stomach emptying, which can raise the risk of anesthesia complications.

Effectiveness

This class of drugs has been shown to have major clinical benefits in addition to weight loss. Their use is associated with a decreased progression to kidney failure in people with diabetes⁴ and a decrease in the incidence of major cardiovascular events (such as heart attacks and strokes) in both people with diabetes⁵ and obese people with a history of heart disease.⁶ In March 2024, the FDA approved the use of Wegovy to “help prevent life-threatening cardiovascular events in adults with cardiovascular disease and either obesity or overweight.” Both semaglutide and tirzepatide have been shown to reverse metabolic dysfunction steatohepatitis, otherwise known as fatty liver, so they might decrease risk of liver failure.⁷

Some reports⁸ show that as many as two-thirds of people who start GLP-1 medications for obesity are no longer taking them a year later, and some stop less than three months after starting. Some may have stopped due to insurance requirements or drug shortages. Others may have side effects or misaligned expectations. Most patients must continue to take

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the drugs continuously to maintain weight loss, though this increases the cost to the plan sponsor. These drugs should not be used intermittently for cosmetic weight loss.

Randomized clinical trials where a portion of those studied is switched from active medication to placebo generally show substantial weight regain after the drug is stopped. That said, average patients do not regain all the weight that they lost. One observational study⁹ of medical records suggested that two-thirds of those who discontinue these drugs continue to lose weight or maintain their GLP-1-associated weight loss, but some portion of the participants might have obtained these medications from other sources outside of their health plan. There are many studies in progress to determine whether discontinuation of the medication combined with an effective diet or lifestyle program can result in maintenance of weight loss after stopping the drug.

Costs

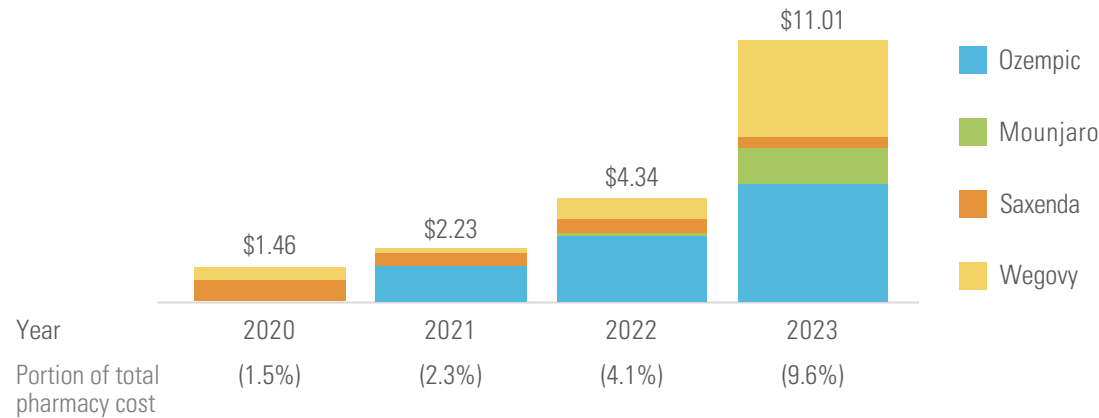
The GLP-1 drugs marketed for obesity are available only in a few countries—including the U.S.—that support relatively high pharmaceutical prices. The annual list price in the U.S. for Wegovy is more than \$17,000 and Zepbound is just under \$14,000. When the costs of GLP-1 medications are spread over the entire plan population, plans are paying about \$11 per member per month for these drugs (See figure). Discounts and rebates reduce the net price to a bit under \$10,000 for each of these medications. Zepbound is available to those without insurance coverage from the pharmaceutical company for \$6,600 a year. An earlier GLP-1 obesity medication, Saxenda, requires daily injections and has a current list price of over \$16,000.¹⁰ Saxenda loses its patent protection in 2024, but generic versions may not be available until 2026.

The GLP-1 drugs can lead to substantially improved health for many and can prevent heart attacks, strokes, the need for kidney dialysis and other serious illnesses. However, studies have shown that these drugs are unlikely to

FIGURE

GLP-1 Costs, 2020-2023

Cost per Member per Month of Selected GLP-1 Medications After Discounts and Rebates



Note: Mounjaro and Zepbound are both the drug tirzepatide. Mounjaro was marketed in 2022 and Zepbound was marketed in late 2023.
Source: WTW Collaborative data on file. Analysis limited to plans that covered GLP-1 medications for obesity.

lower medical costs over any time horizon unless they are sold at dramatically lower prices. For instance, the Institute for Clinical and Economic Review (ICER)¹¹ found that the cost to a plan sponsor for semaglutide over a lifetime would be \$274,400, while the medical costs averted over a lifetime would be \$61,600. A very large study¹² showed that 100 people with obesity would need to be treated for three years to prevent one major cardiovascular event. An industry-funded simulation¹³ showed that 100,000 people treated for five years with the loss of 15% of their body weight would lead to \$85 million lower medical spending. But at current prices, the cost of the drugs would be over \$4.5 billion over five years, so the cost saving is less than two cents per dollar spent on the medications.

WTW research shows that more than one-third of employers (38%) currently cover GLP-1 medications for obesity, although almost all employers cover these drugs for diabetes. Some plan members likely obtain the GLP-1 medications labeled for diabetes to help them lose weight. The survey showed that 10% of employers said that they were covering these medications for only those with a BMI higher than recommended by the FDA, and 26% said they require a medically supervised diet or a trial of less-expensive

antiobesity drugs prior to offering coverage for GLP-1 medications.¹⁴ The total cost to commercial health plans of GLP-1 drugs that can be used for obesity has increased by more than 600% between 2000 and mid-2023, leading to steep increases in total pharmacy costs for many plans that cover these medications.

Employers and Plan Sponsors Respond

Employers and plan sponsors are taking a range of actions to address the costs of GLP-1 medications. These strategies are described below.

1. Implement documentation requirements to prevent use of these medications for cosmetic purposes

Prior authorization with required documentation can decrease the likelihood that drugs are approved for a cosmetic rather than a medically necessary purpose. This approach is being used by a wide range of plans that offer coverage for these drugs. Members who have successfully lost weight with these drugs might not qualify if asked to repeat prior authorization. Plans changing pharmacy benefit managers (PBMs) can seek to transfer previous prior authorization approvals to avoid interruption in treatment.

2. Cover antiobesity medications only for a subset of plan members with obesity

Those who have higher BMIs or a history of cardiovascular disease are more likely to have medical complications from obesity, so these drugs will provide more medical benefit for those with higher risk. Plans seeking to provide the highest value care can restrict coverage to those with a history of cardiovascular disease or set a threshold for coverage that is higher than the FDA-recommended BMI of 30 (or 27 with comorbidities). Such a restriction requires an effective prior authorization process. These drugs have high rebates, and agreements between pharmaceutical manufacturers and PBMs can limit rebates to plan sponsors that provide coverage at the BMI levels as approved by the FDA. Plans considering limiting coverage based on BMI or medical history should ask their PBM or pharmacy consultant to assess the financial impact of this approach.

3. Restrict providers who can prescribe this class of medications

Some plans seek to restrict prescribing based on medical specialty (for instance, endocrinology or primary care), which requires the PBM to restrict to a limited prescriber network. Some vendors offer virtual medical care and obesity-trained providers to use other less expensive alternatives before prescribing GLP-1 medications. Having virtual providers prescribe obesity treatments could lead to fragmentation and undermine efforts to get plan members at risk for chronic disease to develop primary care relationships. Limiting which providers can prescribe GLP-1s could reduce rebates in some instances.

4. Shift more costs to members for medications to treat obesity

Some employers and plan sponsors have considered putting drugs that treat obesity in a special tier with a larger member out-of-pocket responsibility. They should consult with counsel to be sure that such plans are consistent with the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA) and mental health parity requirements. While the Affordable Care Act (ACA) does not allow annual or lifetime maximums for essential health benefits, these medications are not considered essential health benefits by most state marketplace plans that serve as benchmarks for commercial health plans.

Therefore, plan sponsors could consider shifting costs to members by not applying these drug costs to the out-of-pocket maximum. This approach will likely be more attractive to employers that face less difficulty attracting talent.

5. Implement a lifetime maximum or other coverage limitations for GLP-1 medications to encourage “deprescribing”

Some plan sponsors¹⁵ have announced that they will cap total lifetime coverage for GLP-1 medications for obesity (which would be permitted, as long as the drugs are not ACA essential health benefits). This would mean that plan members would lose insurance coverage for GLP-1s after 18-24

Employer Strategies for GLP-1 Drugs

A November 2023 survey report from the International Foundation (*GLP-1 Drugs: 2023 Pulse Survey*) showed that 27% of respondents provided coverage of glucagon-like peptides (GLP-1s) for weight loss, and 13% were considering covering the medications for weight loss. More than three-quarters (76%) covered the medications for diabetes.

Organizations that cover GLP-1 drugs for weight loss used the following cost-control mechanisms.

- Utilization management: 79%
- Step therapy: 32%
- Eligibility requirements: 16%
- Annual maximum: 5%
- Lifetime maximum: 4%

Fourteen percent of organizations indicated that they had no cost-control mechanisms for the medications.

Following are the four most common options besides GLP-1 medications that organizations said they offered for diabetes and weight loss.

- Disease management/case management programs: 76%
- Nutritional counseling: 63%
- Bariatric surgery: 59%
- Lifestyle modification programs: 51%

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months, at which point they would have to pay out of pocket or go off the medications. Limiting the duration of treatment could worsen health equity since lower wage workers would likely have difficulty affording continued treatment when they reached their coverage limit.

Current clinical evidence suggests that most individuals off GLP-1s would rapidly regain the weight they lost, and some employees might seek to change employers to avoid such a coverage “cliff.”¹⁶

6. Offer or require lifestyle modification programs for management of obesity before or during drug treatment

Many employers and plan sponsors offer comprehensive programs that can include nutritionists, coaches and apps to help people lose weight and maintain weight loss. The FDA recommends that these GLP-1 drugs be used “as an adjunct to a reduced calorie diet and increased physical activity,” and formal programs can support plan members to maintain calorie restriction and increased exercise. Still, some published data suggests that intensive behavioral intervention alone is far less effective than GLP-1 treatment.¹⁷ Some plans are considering requiring participation in a lifestyle program to maintain eligibility for GLP-1 drug coverage or as a step before drugs are prescribed. Plan sponsors should consider the cost of any new lifestyle program and potential loss of rebates when projecting financial implications of GLP-1 coverage. They may also want to consider potential discrimination issues under HIPAA based on what requirements are imposed for initial or continued coverage of these medications.

Many vendors sell programs they say will help individuals transition off GLP-1 medications, but it is too early to assess whether these programs will help most members maintain weight loss without medication. One vendor has shown maintenance of weight loss after GLP-1 discontinuation with a low carbohydrate diet and counseling,¹⁸ and one small research study showed those randomized to a structured and vigorous exercise program regain less weight after GLP-1s are discontinued.¹⁹

7. Do not provide coverage for these medications

The majority of employers (62%) currently do not provide coverage for obesity medications such as GLP-1 medications. Medicare Part D was prohibited from covering weight-loss medications by its initial enabling legislation in 2003. Some plans have reversed prior coverage policies and elected to stop

bios



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covering these drugs for obesity, including several health system plans and state-run employee benefit plans. Members of health plans that provide no coverage for this class of medications for obesity can pay for these medications out of pocket, although few will be able to afford this. One manufacturer offers a steep discount to self-paying customers, but the total cost would still exceed \$6,000 per year. Some plan members will qualify for the diabetes versions of these drugs.

Employers might find that noncoverage will hurt their efforts to recruit and retain talent. It will also decrease health equity since lower wage plan members likely won’t be able to afford the drugs without coverage. Employers that do not cover obesity medications can still cover bariatric surgery, which has a high up-front cost but is less costly for plan members who remain on the plan for over three years.

Conclusion

No other nonsurgical treatment today is as effective in decreasing obesity as the GLP-1 drugs. Long-term use of these drugs appears to be safe and is consistent with our clinical understanding of the metabolic disease of obesity. However, the expense of these medications will mean that a large portion of the population will have limited access for now.

With dozens of related drugs in the pipeline, the per person cost of treatment could decline substantially over the

coming years, which could mean that plan members will get the full medical and social benefits of this effective therapy. Until then, employers have multiple options to mitigate the cost impact of these medications to their bottom line. 📌

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Editor's note: *Benefits Magazine* goes to press several weeks before distribution. The status of research related to GLP-1 drugs was current at the time of writing but continues to evolve.

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