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# Market Perspectives

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GLP-1 receptor agonists (GLP-1s) are not newcomers to the pharmaceutical landscape – the first FDA approval dates back to 2005<sup>1</sup> – and many employers have been covering these drugs (most commonly for diabetes) for years. But improvements in efficacy, recent FDA approvals of drugs in this class for weight loss, and skyrocketing consumer demand raise new questions for employers.

On the one hand, GLP-1s herald breakthrough advancements in the management of diabetes and obesity; on the other, their high cost and demand suggest a new state of play, in which consumers' interests are sometimes at odds with their employers'. The rapidly evolving GLP-1 landscape underscores the complex relationship between scientific innovation and employer benefit management.

This paper aims to help employers understand the GLP-1 landscape, considerations for obesity care coverage, and approaches to cost management. In examining the landscape of GLP-1s and their impact on employer-led health care strategies for obesity, **three key takeaways emerge:**

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Demand is expected to remain high, driven by increased employer coverage, media-driven awareness, and expanding positive outcomes for various health conditions.

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Advanced primary care, augmented with additional supports, ancillary services, and technology, can be effectively equipped to provide obesity care.

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Going forward, strategies to address demand and maintain high quality of care for patients will be critical.



## 02 Obesity Coverage for GLP-1s

To help employers understand the current landscape, we break down how GLP-1s work along with the latest policies and practices.

GLP-1s mimic the effects of glucagon-like peptide-1, a hormone that enhances insulin secretion, suppresses glucagon release, and exerts satiety-inducing actions. As a result, these medications facilitate glycemic control, reduce post-meal blood sugar spikes, and promote weight loss by curbing appetite. In people with diabetes, GLP-1s help improve glycemic control, reduce HbA1c levels, and mitigate the risk of cardiovascular events. The medications also have proven effective in aiding individuals with obesity to achieve significant weight loss, including cases where lifestyle modifications alone have not yielded adequate results.

Figure 1 highlights FDA-approved pharmacotherapies for treating obesity, all of which have been approved for long-term use as of December 2023. The medications are recommended as an adjunct therapy to be used alongside a reduced-calorie diet and increased physical activity, and are indicated for individuals with obesity, or who are overweight with one weight-related comorbidity (e.g. hypertension, type 2 diabetes).

### FDA- Approved Pharmacotherapies for the Treatment of Obesity as of December 2023

(For the latest information on FDA approvals and guidelines visit the FDA website)

GLP-1 Receptor Agonist	Brand Name *	Manufacturer	Year Approved for Obesity
liraglutide	<a href="#">Saxenda</a> <sup>2</sup>	Novo Nordisk	2014
semaglutide	<a href="#">Wegovy</a> <sup>3</sup>	Novo Nordisk	2021
tirzepatide	<a href="#">Zepbound</a> <sup>4,5</sup>	Eli Lilly	2023

Figure 1.

\* All are considered maintenance medications which require lifestyle modification related to diet and exercise per FDA indications.

The large and growing demand for GLP-1s, and their ever-presence in the news cycle, can make it challenging to develop evidence-based policies about GLP-1 access and coverage. This section puts demand for GLP-1s in context of recent trends in prescribing patterns, coverage policies, utilization, and adherence.

### **Prescribing for obesity as a chronic condition:**

GLP-1s used for the indication of obesity with no other diagnoses points to a shift in how obesity is viewed by the medical community, not as the result of poor habits, but as its own medical condition, to be diagnosed and treated, with all available treatment options. This shift may be a leading indicator of changes to expect in coverage policies, but there's still a ways to go: [a majority of employers cover GLP-1s for type 2 diabetes, but only about 42% cover them for obesity.](#)<sup>6</sup>

### **Employer coverage decisions:**

Employers face difficult choices on GLP-1 coverage. In addition to whether to cover the drug for obesity, employer's must decide whether to authorize continuous coverage or reimburse for a finite period, after which plan members must either taper off the medications or pay for them out of pocket (GLP-1s' effects wane when a patient stops taking the drug, and weight loss results can decrease or reverse <sup>7</sup>.) On the one hand, covering GLP-1s indefinitely can add significant costs to an employers' health plan budget, given high demand; on the other hand, offering long-term coverage may help certain patients maintain a

healthy weight, send their diabetes into remission, and avoid other costly chronic conditions. The diversity of strategies employers are embracing may reflect different abilities to absorb new costs or different assessments of short-term versus long-term expense associated with obesity and weight management.

### **Payor coverage decisions (for additional indications):**

Payors are examining the emerging clinical evidence of positive [cardiovascular](#)<sup>8</sup> and [kidney](#)<sup>9</sup> outcomes associated with interventions like GLP-1s on their coverage determinations. This reflects an early but growing recognition of the clinical benefits and cost-effectiveness of managing obesity.

### **Uptake and adherence:**

[Utilization of GLP-1s will continue to grow](#)<sup>10</sup> with increasing evidence, persistent media presence, and [expanding employer coverage](#).<sup>11</sup> Still, non-adherence rates can be as high as [68% after 12 months of pharmacotherapy](#)<sup>12</sup> likely due to poorly managed side effects, titration inadequacy, or access related challenges.

## 04 Challenges and Uncertainties Surrounding Coverage

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Despite high demand and positive clinical outcomes, GLP-1s are still early in their life cycle as a treatment for obesity. They come with significant unknowns that may affect coverage decisions, including implications for their cost burden, their long-term efficacy, the time horizon for seeing benefits, and the influence of Medicare's coverage stance.

### Cost:

List prices for GLP-1s, which often require weekly injections, typically hover around **\$1,000 per month**.<sup>13</sup> Due to the cost burden of GLP-1s, **some employers are reevaluating coverage policies for obesity**.<sup>14</sup>

### Long-term efficacy:

One primary concern is the lack of historical data regarding the long-term efficacy of GLP-1s. While they show promise in addressing obesity and related conditions, questions linger about their sustained effectiveness and potential side effects over extended periods.

### Clinical and cost benefit:

GLP-1s can drive weight loss within a short period, but their broader clinical benefit, in delaying or preventing onset of other conditions, accrues over a longer time horizon, as does any resulting cost savings. Employers will spend much more on covering GLP-1s than they will save, at least initially; their savings also rely on employees staying with their employers long enough for their avoided costs to accrue. Additional research/clinical data is needed to determine when the value of GLP-1 coverage for employees is realized by the employer.

### Medicare's coverage stance:

Commercial health plans and self-insured employers often take cues from Medicare regarding coverage decisions. As of now, Medicare does not provide coverage for GLP-1s for weight loss. \*

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The rapidly evolving GLP-1 landscape underscores the complex relationship between scientific innovation and employer benefit management.

\* GLP-1s approved for weight loss are not covered by Medicare. GLP-1s approved for diabetes are covered only for an indication of diabetes.

In this complex and rapidly evolving landscape, employers have worked hard to develop evidence-based coverage policies that balance consumer demand, clinical effectiveness, and cost. Below are some of the common approaches we are seeing proliferate in the marketplace.

### Coverage criteria:

Common criteria (aligned with FDA guidelines) for covering GLP-1s for weight loss are 1) the drug must be indicated/approved for this purpose and 2) must be paired with lifestyle modifications. Many employers also require that employees have both an obesity diagnosis and additional health complications.

### Managing cost increases:

While some employers and payers are holding off on expanding coverage for GLP-1s given their expense, others are taking the opposite track, placing [limits on coverage](#)<sup>15</sup> in terms of quantity and duration. Some employers see this as a short-term expense with long-term payoff; others may be using GLP-1 coverage as a way to attract or retain top talent.

### Shared accountability:

Some employers are structuring coverage rules to grant access to GLP-1s only once alternative treatment options (including other drugs classes) have been exhausted, or when plan members have demonstrated compliance with lower-cost fitness, nutrition, or behavioral programs. These requirements strike a balance between providing access to effective treatments and managing costs. Further, they introduce shared accountability between employers and their employees - both must play a role to see maximum results.

### Strengthened utilization management:

Traditionally, employers have relied on plan and PBM-based prior-authorization (PA) requirements as their main utilization management channel. Increasingly, we are seeing organizations implementing [more restrictive PA requirements](#)<sup>16</sup>, involving vendors to provide lifestyle modification support and tailored treatment recommendations for each patient. In some cases, employers are looking to avert pharmacotherapy altogether by deploying programs, which take into account individual patient risk factors, co-morbidities, and existing medication regimens, and customize recommendations for interventions most likely to improve the patient's outcomes without drugs.

### Formulary design:

Some employers are working with their PBMs, including some alternative, more transparent PBMs, to finetune formulary decisions, secure favorable pricing, and purchase only the most cost-effective GLP-1 medications. By strategically aligning formulary decisions with negotiated terms, some employers have improved the cost-effectiveness of these therapies.

### Holistic approaches:

Some employers are offering access to lifestyle weight-loss programs, virtual coaching, and other wrap-around services as part of their benefits packages, aiming to address obesity alongside employees' other health and wellness needs.

# Morgan Health offers three actionable suggestions for benefits leaders and others weighing complex decisions about GLP-1 coverage for obesity.

### **Reconsider the current obesity care paradigm:**

For GLP-1s to produce optimal results, patients need ongoing management and support from a provider who understands their clinical profile and their personal circumstances. Primary care is best positioned to serve this role, with its emphasis on chronic disease management and longitudinal care. However, most PCPs lack enough hours in the day<sup>17</sup> to provide all recommended chronic, preventative, and acute care to their patients. Further, medical schools on average spend only 10 hours<sup>18</sup> training physicians how to treat patients with obesity. Improving care for these patients – and the efficacy of GLP-1s – requires embracing an Advanced Primary Care (APC) model, in which providers have a care team working with them to manage their patients collaboratively. Some APC models also deploy technology through virtual care teams; leveraging apps for both providers and patients to track symptoms, report issues, and ensure adherence to care plans.

### **Increase appropriate use and access:**

Large employers are increasing coverage for obesity-indicated GLP-1s. According to Mercer's 2023 National Survey of Employer-Sponsored Health Plans,<sup>19</sup> currently 42% of large employers with 500 or more employees cover GLP-1 medications for obesity treatment, and 19% are considering it. Specifically, employers are exploring ways to enhance appropriate use determination: some companies are relying on third party point solutions from obesity management vendors to implement prior authorization/utilization

management, while others work through existing partners (PBMs, navigators, etc.) to do so.

### **Zero in on outcomes:**

Employer initiated outcomes-based contracting in the pharmaceutical market remains scarce. Among obesity management vendors however, we are seeing companies that incorporate pharmacotherapy into treatment protocols putting fees at risk, and in some cases, offering entirely value-based payment models (e.g. upside and downside risk) to clients. We continue to collect market intelligence on the broader adoption of these models alongside general employer appetite to incorporate quality metrics into vendor management contracting. A complicating factor for quality considerations are median employee tenures<sup>20</sup> in the US: 3.7 years in the private sector, and 6.8 years in the public sector. Many employers face pushback when seeking to utilize novel outcomes-based payment models that require longitudinal patient engagement, when turnover rates, especially in the private sector, remain high.

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The rising demand for GLP-1s is expected to remain high.

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