

Can Different Pricing Models Address the Obesity Problem in America?

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In the US, prescription weight loss medications have become much more popular in recent years. According to a CNBC article,¹ prescription usage of semaglutide (Wegovy) had increased by 300% from early 2020 to the end of 2022, with more than 9 million prescriptions written in the last 3 months of 2022.

“The field of obesity medicine is probably one of the fastest-expanding specialty fields,” Eden Miller, DO, who practices at Diabetes and Obesity Care, said in an interview with *The American Journal of Accountable Care (AJAC)*. “And it is one of the fastest-growing thing[s] in part due to the percentage of individuals [who] are considered overweight or have class 1, 2, or 3 obesity.”

According to the CDC, obesity prevalence increased to 41.9% by March 2020 from 30.5% in 1999.² Obesity is estimated to produce \$173 billion in excess medical costs annually for US adults, according to a 2019 CDC estimate.³ With numbers like these, it’s easy to see how obesity medication could be beneficial to a large population of patients. However, access to these drugs is limited and expensive for the average patient, especially those with state-sponsored Medicaid and Medicare insurance. The question remains: Are there any ways to get these treatments to the patients who need them without breaking the bank for all involved?

The Usage and Cost of Weight Loss Drugs

The common drugs used for weight loss include semaglutide, which is commonly referred to by its brand names of Ozempic and Wegovy; liraglutide (Victoza); and a new medication, tirzepatide (Zepbound). According to Miller, previous medications had been approved for weight loss but reduced body weight by only 5% to 8%. These new medications, she says, can eliminate between 10% and 20% of body weight when combined with diet and exercise.³

“These are amazing metabolic drugs that have impact far beyond weight loss. [Patients] have improvement in the

liver and in the kidneys, and prevention of heart disease and improvement of glycemia, and prevention of prediabetes to diabetes conversion,” Miller said.

Semaglutide works by signaling to the brain that the body is full to reduce hunger and increase the feeling of fullness, according to *USA Today*.⁴ This includes reducing what’s referred to as “food noise,” where patients think of and reach for food when they are stressed or bored. This medication could be helpful to the significant population classified as overweight or obese in the US.

However, cost is a big deterrent to more widespread use. Although obesity was responsible for approximately \$260 billion in aggregate medical costs in the US in 2016,⁵ only 25% of insurance companies cover treatments for obesity.⁶ This includes Medicare and Medicaid, whose bylaws forbid covering such medications.

“In the Medicare bylaws—think of it as the Medicare constitution—there is a line that says Medicare may not cover or promote or provide weight-related treatments,” Miller said. “And so the reason why Medicare doesn’t cover it is because it’d be going against the bylaws. The bylaws would have to be changed.”

Semaglutide costs approximately \$900 for a month’s supply in the US without insurance; the price is about \$300 in Canada.⁷ This has led to some Americans crossing the border to access the medication.

“That big price difference is because [other countries] do not have a middleman in their system that changes and up-charges the medication,” said Miller. “In the US, pharmaceutical companies are only allowed to make a 3% profit. Now, that’s a massive number. But that is in part what contributes to the cost of medications.”

The cost of obesity treatment is between \$10,000 and \$15,000 per year, she said, but the secondary savings would be immense. She said previous estimates have calculated \$1.7 billion in savings if Medicare covered weight-related treatments.

However, insurance companies remain hesitant about covering obesity drugs, largely due to cost. But are there

ways these costs can be mitigated and access be improved? A different type of payment model may be the solution.

The Netflix Model: Effective for Weight Loss Drugs?

In 2014, breakthrough medications for the treatment of the hepatitis C virus (HCV) became available for patients.⁸ These medications could be used in 3- to 6-month intervals and would cure up to 80% of patients of the virus completely. However, these medications were extremely expensive, ranging from approximately \$20,000 to \$80,000 for 1 course of the treatment. The incidence rate of HCV rose 71% from 2014 to 2018; cost was a major barrier to accessing treatment because a disproportionate amount of individuals diagnosed with HCV were on state-sponsored Medicaid.⁹

Louisiana, among other states including Washington and Michigan, opted to try a different payment model, dubbed the “Netflix model.” This model allows for a subscription-based payment plan, where the state negotiates a price with a single manufacturer to give patients on state-sponsored insurance access to a specific treatment. This move has allowed 11,000 patients to access the full course of HCV treatment with no out-of-pocket cost.⁹

David Matthews, PhD, chief business officer at Beacon Biosignals, told *AJAC* that a model like this mirrors the way software has been sold in the past 30 years.

“In the case of, say, Microsoft selling Microsoft Word, a company might buy it for all their employees. Each person will be using their Word license at a different rate, some more and some less,” he explained. “It’s the same with commercial payers and CMS—they want to look at their whole population, with some patients consuming more value from a therapy and some less. We wanted to create a license, a way to pay for this drug, that covers the aggregate health of their entire population.”

In a talk he gave at the TED Institute, Jean-Manuel Izaret, global leader of marketing, sales, and pricing practice at Boston Consulting Group, compared this pricing model to streaming services. “In this model, we can give the drug to everybody in the same way we give access to all movies to everybody, and we would pay for the drug over time,” he said. “If we do this, we can have the savings to pay for the drug.”¹⁰

Although HCV and obesity work differently, there are some similarities, Matthews said. Increased body mass index (BMI) leads to increased costs generated for the patient, and increased severity of HCV and BMI would produce a similar cost to the health care system.

In an interview with *AJAC*, Izaret explained that, for HCV, pricing for the population is better because of the disease’s infectious nature, even when the value is created differently

per patient. Time components, he said, also cause a major discrepancy in the pricing of the treatment.

“The value can come 10 years from now, 20 years from now, 30 years from now, when people get really sick on the [HCV] side, and the disease progresses. But [payers] want to get paid when you treat the person right away,” he said. “And that basically pulls up payments far from the value and that creates the unaffordability in the health care system.” Addressing the entire population with payments over time could mitigate these issues, he added.

When thinking of applying the Netflix model to obesity, Izaret said it’s a little different because there are usually immediate benefits to losing weight, whereas the Netflix model is banking on long-term outcomes. However, a time component comes into play as more health problems are created the longer someone remains obese, pushing the costs out to 10 to 30 years rather than avoiding the cost by treating a patient right away.

“In the case of [semaglutide] and the other drugs, you have slightly more marginal cost [compared with HCV treatment], but you can very easily imagine a pricing model where you have a fixed component per population over time and you have a component per patient,” said Izaret. “Then instead of being \$1000 per month, if the injection pens are \$4 to \$8, well, give them a 50% margin. Then you price them at \$8 to \$16 or \$20. [It] suddenly becomes very affordable.”

Izaret was concerned, based on how the drugs are being distributed now, that most of the patients who need the treatment will not be able to afford it or access it, much in the same way that HCV treatment was rolled out. In the case of semaglutide and similar drugs, a contract would be over a shorter period of time, such as 10 years, so that companies could see the benefits of long-term usage of the drug. This would include accrued payments to the pharmaceutical company as long as the benefits of the treatment remain. This might incentivize the companies to see that patients taking the medication continue to have a healthy weight.

A Path Forward

The Netflix model is an intriguing method of getting weight loss drugs to as many people who need it as possible at the lowest price point. Although there are notable differences between HCV and obesity, the rollout of HCV treatment could offer a glimpse of what is possible for weight loss drugs as well as other types of drugs.

Both Izaret and Matthews acknowledged that the multipayer system in the US would make the implementation of a Netflix model for weight loss drugs difficult but not impossible.

“The simplicity that comes from solving this in the rest of the world is actually quite compelling...and the cost-effectiveness

of establishing these sorts of payment models is quite clear when you run the math,” Matthews said.

Although Miller said the length of time that HCV treatment is taken vs obesity treatment is much different and could present challenges, she ultimately believes that obesity needs to be treated as a disease like any other, as these medications can be used to address obesity for life. “The challenge of obesity-related medicine is that food is life, and so you’re changing an essential part of life, a culture, an enjoyment, a heritage. It’s challenging, but it’s not insurmountable by any means,” she said.

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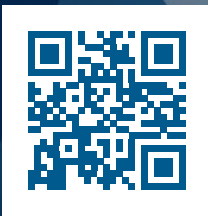
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