

An Efficient Approach to Expand Equitable Access to Antiobesity Medications: Deprescribing After Weight Loss Plateau

David D. Kim, PhD; and A. Mark Fendrick, MD

Obesity is a significant population health crisis impacting more than 120 million individuals in the US. In this issue of *The American Journal of Managed Care*, the thoughtful review by Miller and colleagues describes the genesis of the obesity epidemic and its clinical, psychological, and equity consequences.¹ The authors call for a multifaceted approach to tackle the epidemic that includes enhanced public awareness campaigns to reduce the stigma of obesity and expanded coverage of effective behavioral, surgical, and pharmacologic treatments.

The new generation of antiobesity medications (AOMs), such as long-acting glucagon-like peptide 1 (GLP-1) receptor agonists, can result in substantial weight loss and clinically meaningful secondary benefits for several obesity-related conditions, such as cardiovascular disease, sleep apnea, liver disease, and obesity-related cancers.² However, the combination of adverse effects (eg, nausea, vomiting, and diarrhea) and coverage issues (eg, high out-of-pocket costs and coverage restrictions/limits) often lead to AOM discontinuation.³ Moreover, as we await more data establishing AOMs' long-term safety and effectiveness, adverse events associated with continued use, such as loss of skeletal muscle mass among older adults and incidence of pancreatitis, pose additional concerns regarding their continuous use.⁴ Thus, choosing an optimal treatment duration requires individuals, clinicians, and payers to address a trade-off between (1) weight regain after discontinuation and the potential loss of secondary health benefits and (2) the removal of drug-associated short- and long-term adverse effects and access-related hurdles.

In face of the extraordinary demand for these breakthrough drugs that have captured the imagination of the lay press and social media influencers, the high prevalence of the population indicated for AOMs, coupled with their current high acquisition cost and manufacturing shortages, present significant challenges to ensuring equitable access. Consequently, how best to efficiently allocate AOMs has become a top priority among public and private payers and is being deliberated at the individual employer, health plan, state, and federal levels.

Coverage policies for AOMs are largely unpredictable and highly variable. Advocating for generous access, Walters and Hughes

ALTHOUGH ATTENTION HAS BEEN PRIMARILY FOCUSED ON THE BUDGET IMPACT, THE UNMET NEED AND IMPLICATIONS OF INEQUITABLE ANTI-OBESITY MEDICATION ACCESS WARRANT A PATIENT-CENTERED AND AFFORDABLE SOLUTION THAT COULD MORE FAIRLY ALLOCATE OBESITY MANAGEMENT RESOURCES.

contend that AOMs should be classified as a preventive benefit and be covered without consumer cost sharing.⁵ At the other extreme of the coverage spectrum are the many payers—including Medicare—that have yet to approve AOM coverage. In between are payers that do cover AOMs but typically impose a mounting list of prerequisites to initiate or continue therapy and often require high levels of consumer cost sharing and/or have imposed coverage limits based on total spending or duration of use. For example, one large commercial insurer put strict requirements for initial coverage (eg, 12-week trial/failure of oral medication options, enrollment in the weight management program, prescription only after an in-person visit with an established provider) and renewals (eg, medication adherence rate > 80%, maintenance of a 5% weight loss, documented participation in coaching efforts). Citing raising premiums, an increasing number of employers and health plans have eliminated coverage of AOMs. The same commercial insurer whose strict initial and renewal requirements are described above will eliminate coverage for GLP-1s on January 1, 2025, with no exceptions.⁶

Currently, Medicare prohibits coverage of weight loss medications except for specific clinical indications for diabetes or heart disease. Using an estimated obesity prevalence of 41.5% among Medicare Part D enrollees, one of us previously estimated that if

10% of eligible beneficiaries used a GLP-1 at the annual net price of \$13,600, Medicare would spend \$26.8 billion annually (approximately 18% of total annual Part D spending).⁷

Despite these budget-busting estimates, the Medicare coverage exclusion of AOMs may change. The Treat and Reduce Obesity Act (TROA), which passed the US House of Representatives Ways and Means Committee with strong bipartisan support in July 2024, would require Medicare to cover AOMs.⁸ It is worth noting that, in response to the unsustainable Medicare spending estimates attributable to widespread AOM use, the latest version of TROA included a chairman's amendment limiting coverage to those diagnosed with obesity and who have been taking the drugs at least 1 year before enrolling in Medicare.⁹ The much narrower eligibility criteria will substantially reduce the Congressional Budget Office spending estimate and potentially ease concern about AOMs' untenable financial strain on the program.

Access barriers to AOMs (eg, prior authorization, step therapy, spending/duration limits, and prior use criteria [as in the current version of TROA]) could further exacerbate health disparities because obesity and related clinical sequelae disproportionately affect people from racial and ethnic minority populations and those of low socioeconomic status.¹⁰ Although attention has been primarily focused on the budget impact, the unmet need and implications of inequitable AOM access warrant a patient-centered and affordable solution that could more fairly allocate obesity management resources. We propose an AOM coverage strategy to optimize population health by maximizing the amount of weight loss—and associated clinical benefits—per dollar spent.

To date, most of the clinical research and media attention on AOMs has focused on the amount of the initial weight loss (ie, active weight loss phase), yet less consideration has been paid to the role of alternative weight maintenance programs to sustain the weight loss (ie, weight maintenance phase) and its duration, long-term effectiveness, and impacts on total expenditures. This distinction between these 2 phases of obesity treatment is essential, as the differences in effectiveness and incremental expense attributable to AOM use—compared with available alternatives—for the active weight loss phase can be substantially different for the maintenance phase.

Novel GLP-1s and other incretin mimetics (IMs) have been demonstrated to produce significantly more weight loss compared with available nonsurgical medical and behavioral interventions. Given this robust advantage, the greatest relative benefit and incremental cost-effectiveness is produced with active weight loss. Still, there is a dearth of evidence comparing the relative clinical and cost-effectiveness of continued full-dose AOM therapy vs that of a lower-cost alternative approach to maintain weight loss beginning once a weight loss plateau has been achieved. If a less-expensive maintenance program produces comparable results in sustaining weight loss, it would make sense from an efficiency standpoint to devote more AOMs (especially those in short supply) to active weight loss instead of maintenance, where clinical superiority of full-dose AOM compared with alternatives has yet to be established.

Accordingly, we examined whether an alternative weight maintenance program had the potential to more efficiently reallocate obesity management resources. Using the validated Diabetes, Obesity, and Cardiovascular Disease Microsimulation (DOC-M) model, we compared the estimated long-term health and economic outcomes of 2 weight maintenance programs: (1) continuous long-term full-dose IM use (\$530/month [50% discounted list price] and behavioral therapy for \$53/month) and (2) participation in a less-expensive alternative weight maintenance program following a weight loss plateau.¹¹ This alternative weight maintenance approach could incorporate personalized elements, such as behavioral interventions, food-is-medicine programs, and lower-cost medication(s) (eg, lower dose/frequency of GLP-1 and/or cheaper AOMs). It is worth noting that reducing drug dosages after achieving a specified clinical goal is a strategy used in other clinical scenarios, such as reducing the dose of a proton pump inhibitor or switching to a histamine 2 receptor antagonist after healing of erosive esophagitis.¹²

The DOC-M's estimates suggested that, compared with continuous full-dose AOM, the alternative weight maintenance program would result in a significant reduction in obesity-related treatment spending and produce minimal reductions in clinical benefits over a wide range of lower cost and effectiveness estimates. The resulting savings varied considerably over a wide range of the relative price and effectiveness of the alternative program. One example scenario where the alternative maintenance program was half the price of continuous full-dose AOM and 30% as effective (ie, patients regain 70% of their weight and lose 70% of the long-term clinical benefit) results in an estimated net lifetime savings of \$35,100 per patient enrolled. If these savings were redistributed, they could fund approximately 6 additional individuals to receive full-dose IM therapy for 1 year.

Clearly, challenges are likely to arise if individuals are offered to opt in to an alternative weight maintenance program once they experience an exceptional amount of weight loss produced by full-dose AOM and become aware of reported weight gain upon discontinuation (even though the available trial evidence supports that not all individuals who stop a GLP-1 regain weight¹³). However, the reluctance of some patients to switch may be overcome by highlighting the potential advantages of a switch that might include (1) reduction in AOM adverse effects and potential unknown long-term adverse effects; (2) lower out-of-pocket cost; (3) financial rewards for sustained weight loss; (4) inclusion of supplemental services, such as nutritional support and exercise programs; and (5) the option to restart the IM regimen when needed.

The advent of highly effective AOMs offers an unprecedented opportunity to address the global obesity epidemic. However, high levels of unmet need and unsustainable budget impact present a major challenge in how to balance equitable access and affordability. Although there is little doubt that substantial and exciting innovations are on the horizon for the unhealthy weight landscape, the consideration of 2 distinct phases of obesity management

(ie, active weight loss and maintenance of weight loss) allows a potential move away from the current less-efficient “full-dose AOM or nothing” approach to one that could improve efficiency of obesity-reducing expenditures. More importantly, this approach would enable substantially more people access to AOMs—particularly disadvantaged populations that are disproportionately affected by obesity and its sequelae¹⁴—who are most likely to benefit from their use. ■

Author Affiliations: Department of Medicine and Public Health Sciences, University of Chicago (DDK), Chicago, IL; Department of Internal Medicine, University of Michigan School of Medicine (AMF), Ann Arbor, MI; Division of Health Management & Policy, School of Public Health, University of Michigan (AMF), Ann Arbor, MI.

Source of Funding: None.

Author Disclosures: Dr Kim is a member of the Institute for Clinical and Economic Review Midwest Comparative Effectiveness Public Advisory Council and a statistical consultant for *Annals of Internal Medicine*; has grants pending from the National Institutes of Health's National Institute on Minority Health and Health Disparities and National Heart, Lung, and Blood Institute; and has received grants from the American Heart Association. Dr Fendrick reports serving as a consultant to AbbVie, CareFirst BlueCross BlueShield, Centivo, Community Oncology Alliance, EmblemHealth, Employee Benefit Research Institute, Exact Sciences, Grail, Health at Scale Technologies,* HealthCorum, Hopewell Fund, Hygieia, Johnson & Johnson, Medtronic, MedZed, Merck, Mother Goose Health,* Phathom Pharmaceuticals, Proton Intelligence, RA Capital Management, Sempre Health,* Silver Fern Healthcare,* Teladoc Health, US Department of Defense, Virginia Center for Health Innovation, Washington Health Benefit Exchange, Wellth,* Yale New Haven Health System, and Zansors* (asterisks indicate equity interest); research funding from Arnold Ventures, National Pharmaceutical Council, Patient-Centered Outcomes Research Institute, Pharmaceutical Research and Manufacturers of America, and Robert Wood Johnson Foundation; and outside positions as co-editor in chief of *The American Journal of Managed Care*, past member of the Medicare Evidence Development & Coverage Advisory Committee, and partner at VBD Health, LLC.

Authorship Information: Concept and design (DDK, AMF); analysis and interpretation of data (DDK); drafting of the manuscript (DDK, AMF); critical revision of the manuscript for important intellectual content (DDK, AMF).

Address Correspondence to: David D. Kim, PhD, Department of Medicine and Public Health Sciences, University of Chicago, 5841 S Maryland Ave, Chicago, IL 60637. Email: David.Kim@bsd.uchicago.edu.

REFERENCES

1. Miller E, Edelman S, Campos C, Anderson JE, Parkin CG, Polonsky WH. Inadequate insurance coverage for overweight/obesity management. *Am J Manag Care*. 2024;30(8):In Press.
2. Tak YJ, Lee SY. Anti-obesity drugs: long-term efficacy and safety: an updated review. *World J Mens Health*. 2021;39(2):208-221. doi:10.5534/wjmh.200010
3. Gleason PP, Urick BY, Marshall LZ, Friedlander N, Qiu Y, Leslie RS. Real-world persistence and adherence to glucagon-like peptide-1 receptor agonists among obese commercially insured adults without diabetes. *J Manag Care Spec Pharm*. Published online May 8, 2024. doi:10.18553/jmcp.2024.23332
4. Sodhi M, Rezaeianzadeh R, Kezouh A, Etminan M. Risk of gastrointestinal adverse events associated with glucagon-like peptide-1 receptor agonists for weight loss. *JAMA*. 2023;330(18):1795-1797. doi:10.1001/jama.2023.19574
5. Walters W, Hughes R. New anti-obesity medications should be considered preventive health care. *Health Affairs Forefront*. July 5, 2024. Accessed July 22, 2024. doi:10.1377/forefront.20240702.323360
6. Minemyer P. Blue Cross Blue Shield of Michigan pulling back on GLP-1 coverage. *Fierce Healthcare*. June 13, 2024. Accessed July 22, 2024. <https://www.fiercehealthcare.com/payers/blue-cross-blue-shield-michigan-pulling-back-glp-1-coverage>
7. Baig K, Dusetzina SB, Kim DD, Leech AA. Medicare Part D coverage of antiobesity medications - challenges and uncertainty ahead. *N Engl J Med*. 2023;368(11):961-963. doi:10.1056/NEJMp2300516
8. Treat and Reduce Obesity Act of 2023, HR 4818, 118th Cong (2023). Accessed July 22, 2024. <https://www.congress.gov/bills/118th-congress/house-bill/4818>
9. Explanation of changes reflected in the chairman's amendment in the nature of a substitute to H.R. 4818, Treat and Reduce Obesity Act. US House Committee on Ways & Means. June 27, 2024. Accessed July 22, 2024. <https://waysandmeans.house.gov/wp-content/uploads/2024/06/Ways-and-Means-Description-of-the-AINS-to-H.R.-4818-Green-Sheet.pdf>
10. Waldrop SW, Johnson VR, Stanford FC. Inequalities in the provision of GLP-1 receptor agonists for the treatment of obesity. *Nat Med*. 2024;30(1):22-25. doi:10.1038/s41591-023-02669-x
11. Kim DD, Hwang JH, Fendrick AM. Balancing innovation and affordability in anti-obesity medications: the role of an alternative weight-maintenance program. *Health Aff Sch*. 2024;2(6):qxae055. doi:10.1093/haschl/qxae055
12. Metz DC. Long-term use of proton-pump inhibitor therapy. *Gastroenterol Hepatol (N Y)*. 2008;4(5):322-325.
13. Bartelt K, Mast C, Deckert J, Gracianette M, Joyce B. Many patients maintain weight loss a year after stopping semaglutide and liraglutide. *Epic Research*. January 23, 2024. Accessed July 22, 2024. <https://www.epicresearch.org/articles/many-patients-maintain-weight-loss-a-year-after-stopping-semaglutide-and-liraglutide>
14. Ogden CL, Fryar CD, Martin CB, et al. Trends in obesity prevalence by race and Hispanic origin—1999-2000 to 2017-2018. *JAMA*. 2020;324(12):1208-1210. doi:10.1001/jama.2020.14590

Visit ajmc.com/link/89586 to download PDF