

Understanding Insurance Coverage Policies for Incretin Mimetics for Weight Management

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Among individuals with obesity, as little as 5% weight loss can improve measures of cardiometabolic health¹ and prevent type 2 diabetes (T2D).² Greater weight loss ($\geq 10\%$) may be needed to manage or reverse weight-related conditions including sleep apnea, metabolic dysfunction–associated steatotic liver disease, and T2D.³ Multiple evidence-based weight loss treatments, including lifestyle-change programs, antiobesity medications (AOMs), and bariatric surgery, can support clinically relevant weight loss. Yet most treatments are underused, and most patients with obesity (75%) do not achieve 5% or greater weight loss.⁴

Newer AOMs, including semaglutide (Wegovy) and tirzepatide (Zepbound), can support initial and sustained weight loss of 15% to 20%.⁵⁻⁸ For clarity, these medications are referred to hereafter as *incretin mimetics for weight management (IMWM)* to distinguish them from the same agents used for T2D.^{9,10} The weight loss effectiveness of new IMWM, coupled with direct-to-consumer marketing approaches,¹¹ has accelerated unprecedented AOM prescribing practices.¹²⁻¹⁴ Yet there is wide variation in insurance coverage for IMWM due, in part, to high treatment costs (~\$1000/month^{15,16} with recommendation for lifelong use to prevent weight regain) and the vast number of individuals potentially eligible for treatment (at least 50% of the US adult population).^{17,18} As of May 2024, only approximately one-third of employer-sponsored health plans covered IMWM.^{19,20} Few state Medicaid plans (~30%) and almost no Affordable Care Act Marketplace plans (< 1%) cover IMWM.^{21,22} And Medicare prohibits coverage of all AOMs as of January 2025,²³ although Medicare Part D now covers semaglutide for certain individuals with cardiovascular disease.²⁴

Health plans that cover IMWM are struggling to manage their high utilization and untenable costs.²² Of these, some have announced or initiated policy changes to end or limit coverage of IMWM.²⁵⁻²⁷ Most have implemented utilization management strategies, including prior authorization criteria and step therapy (ie, initial trial of lifestyle change and/or an older AOM).^{20,22,28,29} A recent survey of health plan leaders reported use of additional strategies, including targeted provider and member communication about alternative weight management treatments and use of Food Is Medicine programs.²⁸

ABSTRACT

OBJECTIVES: Given the wide variation in insurance coverage for incretin mimetics for weight management (IMWM) in the US, we aimed to understand (1) coverage policies for IMWM and influencing factors, (2) coverage policies for other weight management treatments, and (3) opportunities to support weight management while constraining health care costs.

STUDY DESIGN: Qualitative study.

METHODS: Participants were leaders and high-level employees from large health insurance organizations in the US. Our aim was to survey 20 participants, 10 from organizations that covered IMWM and 10 that excluded coverage for IMWM. Participants completed a 30-minute interview. Interviews were audio recorded, transcribed verbatim, and analyzed using directed content analysis.

RESULTS: Twenty individuals completed an interview; 9 interviewees were from organizations that covered IMWM at the time of the study, and 11 were from organizations that excluded coverage for IMWM. We identified 5 key themes: (1) high cost as the primary barrier to coverage of IMWM, (2) perception of obesity as a lifestyle choice, (3) current or planned use of varied utilization management strategies to limit initial and ongoing prescribing of IMWM, (4) coverage for lifestyle-change programs to support weight management, and (5) perceived responsibility of pharmaceutical companies to lower list prices for IMWM to enable broad coverage and advance health equity.

CONCLUSIONS: High cost of IMWM is the primary limiting factor in coverage policies. There is variability in plan design, with utilization management strategies that aim to reduce near-term spending. Health plan leaders call on pharmaceutical companies to reduce list prices to increase equitable access to IMWM.

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To date, little is known about factors that influence variation in coverage policies for IMWM and potential opportunities to support weight management among eligible plan members while constraining costs. Prior survey work, lay press reporting, and economic analyses suggest high treatment cost as the primary barrier to coverage of IMWM.^{19,30-32} Yet, for decades, other factors have hindered health plans' coverage of more affordable AOMs, including perceptions of obesity as a lifestyle choice rather than a chronic condition.^{20,32,33} To advance understanding about the full range of factors guiding insurance coverage policies for IMWM, we conducted qualitative interviews with leaders of large health plans in the US. The objectives of this study were to obtain an in-depth understanding of (1) coverage policies for IMWM and influencing factors, (2) coverage policies for other weight management treatments, and (3) opportunities to improve delivery of effective obesity treatment while controlling health care spending.

METHODS

Study Design

This was a qualitative study. The study was reviewed by the University of Michigan's Institutional Review Board (IRB) and deemed exempt from IRB oversight (HUM00245319). We report our procedures and findings using the Consolidated Criteria for Reporting Qualitative Research.³⁴

Research Team

Our team includes members with expertise in clinical obesity medicine (D.H.G., L.O., A.K.), pharmacy benefit management (S.L.), health services and qualitative research (D.H.G., L.O.), and health policy (A.M.F., L.O., S.L.).

Participants and Recruitment

Participants were leaders and high-level employees from 167 of the largest US health insurance organizations. We aimed to recruit 10 leaders from health plans that cover IMWM and 10 from health plans that exclude coverage for IMWM. We worked with a custom market research firm, which specializes in surveying and interviewing senior executives, to identify, recruit, and interview participants.³⁵ Potentially eligible individuals were contacted by email, direct messaging on networking platforms, or telephone from February 12, 2024, to April 24, 2024; respondents were asked to complete a brief screening questionnaire by telephone. The screening survey was adapted from prior work²⁸ and is shown in **eAppendix 1** (eAppendices available at ajmc.com). Exclusion criteria were (1) uncertainty about health plans' IMWM coverage policies, (2) lack of involvement in discussions about IMWM coverage policies, (3) employment by a health plan with fewer than 50,000 covered

TAKEAWAY POINTS

- ▶ Leaders of large US health plans identified high cost as the primary barrier to coverage of incretin mimetics for weight management (IMWM).
- ▶ Health plans use varied utilization management strategies to limit initial and ongoing prescribing of IMWM. Such strategies aim to reduce near-term spending but may not support a comprehensive, equitable, or patient-centered approach to effective, longitudinal weight management treatment.
- ▶ Best-practice guidelines are needed to standardize insurance coverage policies and optimize treatment and outcomes for individuals with obesity.
- ▶ Health plan leaders call on pharmaceutical companies to reduce list prices to increase equitable access to IMWM.

lives, or (4) exclusive responsibility for a Medicare Advantage plan. Eligible individuals were invited to participate in a 30-minute interview; interviews were conducted between February 23, 2024, and April 26, 2024.

Qualitative Data Collection

The research team developed 2 interview guides, with one tailored to health plan leaders from organizations that cover IMWM and the other tailored to health plan leaders from organizations that exclude coverage for IMWM (**eAppendices 2 and 3**). Both interview guides explored (1) coverage policies for IMWM, (2) coverage policies for other weight management treatments, and (3) opportunities to improve delivery of effective obesity treatment while controlling health care spending. Interview guides were iteratively refined by research team members through team meetings and mock interviews.

Semistructured interviews with participants were conducted by videoconference. Participants provided verbal informed consent prior to interview participation. Interviews were approximately 30 minutes long; participants were compensated with a \$200 gift card.

Qualitative Data Analysis

All interviews were audio recorded and transcribed verbatim. Two authors (D.H.G. and E.W.C.) reviewed transcripts and drafted the initial codebook using directed content analysis, which is to say that initial codes were developed to reflect prior literature and main interview topics and were used to categorize the data; codes and their definitions were refined during data analysis, and new codes were added if text could not be categorized with existing codes.³⁶ These authors independently reviewed all transcripts, applied preliminary codes, and developed new codes and subcodes inductively. They met regularly to compare results until they established the reliability of the coding process (> 80% agreement). Thematic saturation (ie, the point at which no new information emerged from the data)^{37,38} was reached after 16 interviews. Coding discrepancies were resolved by consensus. Qualitative data analysis was performed using MAXQDA 24 (VERBI Software). The study team met regularly to discuss code summaries and used a consensus approach to refine the codebook and to synthesize final themes.³⁹

TABLE 1. Characteristics of Interviewees,^a Stratified by Those From Health Plans That Cover or Exclude Coverage for IMWM

Characteristics	All (N = 20)	IMWM-covered (n = 9)	IMWM-excluded (n = 11)
Title, n (%)			
Clinical executives ^b	16 (80%)	9 (100%)	7 (64%)
Senior actuaries ^c	2 (10%)	0 (0%)	2 (18%)
Nonclinical executives ^d	2 (10%)	0 (0%)	2 (18%)
Number of covered lives, n (%)			
100,000-499,000	7 (35%)	2 (22%)	5 (45%)
> 500,000	13 (65%)	7 (78%)	6 (55%)

IMWM, incretin mimetics for weight management; IMWM-covered, health plans that cover IMWM; IMWM-excluded, health plans that exclude coverage for IMWM.

^aA total of 21 interviews were completed, but 1 interview was excluded from analyses because the interviewee revealed the identity of their employer.

^bTitles for clinical executives included medical director, chief medical officer, director of pharmacy, pharmacy director (exchange products), and chief pharmacy officer.

^cTitles for senior actuaries included senior director of actuary and chief actuary.

^dTitles for nonclinical executives included director of medical management (nonclinical) and vice president of product.

RESULTS

Twenty-nine individuals completed the screening survey, and 21 (72%) completed an interview. Ten interviews were completed with individuals from organizations that cover IMWM (referred to hereafter as *IMWM-covered*), but 1 interview was excluded because the interviewee revealed the identity of their employer. Eleven interviews were completed with individuals from organizations that exclude coverage for IMWM (referred to hereafter as *IMWM-excluded*). Eight individuals screened ineligible or did not respond to interview scheduling requests. Characteristics of interviewees are shown in **Table 1**. We identified 5 key themes: (1) high cost as the primary barrier to coverage of IMWM, (2) perception of obesity as a lifestyle choice, (3) current or planned use of varied utilization management strategies to limit initial and ongoing prescribing of IMWM, (4) coverage for lifestyle-change programs to support weight management, and (5) perceived responsibility of pharmaceutical companies to lower list prices for IMWM to enable broad coverage and advance health equity. These themes are detailed below. When findings were similar between IMWM-covered and IMWM-excluded groups, the results are presented in aggregate. When findings differed, we specify the reference group. Representative quotes are shown in **Table 2**.

Theme 1: High Cost as the Primary Barrier to Coverage of IMWM

Most interviewees (n = 18; 7 [78%] IMWM-covered and 11 [100%] IMWM-excluded) perceived high cost as the primary barrier to coverage of IMWM, with one noting, “I don’t know how either as a plan, an industry, or a nation, we’re going to pay for trillions of dollars of [incretin mimetics]” (interviewee 1, IMWM-covered). Seven interviewees (4 [44%] IMWM-covered and 3 [27%] IMWM-excluded)

remarked on increased insurance premiums to offset the cost of IMWM, with one noting, “[B]road coverage of [IMWM] is going to bring everybody’s insurance premiums [up by] several hundred dollars a month.... [Patients] don’t really understand that when they say, ‘I want my insurance to cover it....’” (interviewee 4, IMWM-covered).

Four IMWM-excluded interviewees (36%) commented that coverage for IMWM is not financially viable for their health plan: “I was looking at some of our data last year and if we had approved everyone [who] got denied, it would have been a \$40 million hit per year to the organization” (interviewee 11, IMWM-excluded). In addition to cost concerns, some IMWM-excluded interviewees (3 of 11 [27%]) cited concerns about the lack of long-term safety and effectiveness data, with one noting, “[These medications are] FDA approved, but we don’t have evidence, experimentally, with longitudinal studies to prove that this is a value-based effective treatment” (interviewee 10, IMWM-excluded).

IMWM-covered interviewees discussed 3 reasons their health plan opted to cover IMWM despite the high cost. First, some (3 of 9 [33%]) perceived an opportunity to reduce spending on weight-related conditions: “You’re saving in hospital stays, etc, that come with obesity.... You may increase your pharmacy spend, but the patients are going to be healthier” (interviewee 7, IMWM-covered). Second, some (3 of 9 [33%]) noted the decision was driven by market pressure, with one stating, “Just to be honest, [we looked at] what competitors were doing and once they started covering, we started covering” (interviewee 7, IMWM-covered). Third, some (3 of 9 [33%]) noted that rebates on IMWM from pharmaceutical companies guided coverage and formulary decisions; interviewees did not discuss the details of rebate contracts or how cost savings offset drug prices.

Theme 2: Perception of Obesity as a Lifestyle Choice

In addition to citing high cost as the primary coverage barrier, 4 IMWM-excluded interviewees (36%) discussed their organization’s long-standing exclusion of AOMs due to the perception of obesity as a lifestyle choice rather than a treatable chronic condition. Two interviewees endorsed this belief, with one stating, “Diet and exercise should be the way you lose weight” (interviewee 11, IMWM-excluded) and another referring to AOMs as “lifestyle medication” (interviewee 19, IMWM-excluded). Two IMWM-covered interviewees (22%) discussed the perception of obesity as a lifestyle choice, with one acknowledging this as a pervasive belief and calling for “people [to] start thinking about this as a medical condition, not as a lifestyle thing” (interviewee 6, IMWM-covered).

TABLE 2. Representative Quotes for Key Interview Themes, Stratified by Interviewees From Health Plans That Cover IMWM and Interviewees From Health Plans That Exclude Coverage for IMWM

Representative quotes from leaders of health plans that cover IMWM	Representative quotes from leaders of health plans that exclude coverage for IMWM
Theme 1: High cost as the primary barrier to coverage of IMWM	
<p>“Personally, I would love to see all of these covered across the board for all patients. The problem as we see it is simply the economics....These are good drugs. They have low risk, low [adverse events]. They seem to really work. And yet, this is one of the top 3 things on my radar with the potential to bankrupt American health care.... To say it plainly, if these were priced in the United States market like they are in most of Europe and Japan, I would strongly advocate for coverage everywhere starting tomorrow.” (interviewee 4)</p>	<p>“You know, the drugs obviously are effective and meaningful and life-changing for a lot of people. But right now, the cost is high enough and our projections for increases to our rates are high enough, that we don’t feel like it’s worth covering.” (interviewee 15)</p>
Theme 2: Perception of obesity as a lifestyle choice	
<p>“[The] trend [in coverage] overall [is] to make [these medications] more favorable for patients [who] really need [them] and really trying to avoid simple cosmetic utilization [and] intermittent or unregulated use.” (interviewee 2)</p>	<p>“Folks are concerned with the unnecessary spend for cosmetic purposes.” (interviewee 16)</p>
Theme 3: Current or planned use of varied utilization management strategies to limit initial and ongoing prescribing of IMWM	
<i>Strategies to limit initial prescribing of IMWM</i>	
<p>“There is a lot of demand for wraparound services to really help manage the deployment of these drugs effectively.... [We]...want to introduce step therapy, so [we’re] going to be pushing people into bupropion or phentermine first and [incretin mimetics] only when and if clinically appropriate [after] those drugs have been tried....” (interviewee 5)</p>	<p>“You might utilize management policies that...have very strict criteria... to be eligible for an [IMWM]. They could...require consumers to go through a diet [or] exercise program before [use of these medications].” (interviewee 17)</p>
<i>Strategies to limit ongoing prescribing of IMWM</i>	
<p>“The American society wants something that...doesn’t require a lot of effort.... That’s why as part of the coverage of [IMWM], we felt it was important to tell people, ‘If we’re going to pay for your incredibly expensive shot, you’re going to be active in...[a] behavioral program, and if you stop, guess who’s not going to pay for your \$1300 shot?’... The shot works, but if you don’t have some underlying behavioral change, the month after you go off of it, you’re going to be right back where you were.” (interviewee 4)</p>	<p>“...You’re either on [the IMWM] for life, in which case, it’s \$10,000 or \$15,000 a year...or the hope would be that people would be able to get weaned from them and then adopt exercise, diet, other lifestyle changes that might enable them to keep from regaining all or some of that weight.... It probably would make sense to also cover some of the older, less expensive products, like phentermine, indefinitely, such that someone could transition from a GLP-1 [receptor agonist] to something like a phentermine to try to maintain the weight loss through appetite suppression.” (interviewee 16)</p>
Theme 4: Coverage for lifestyle-change programs to support weight management	
<p>“We do offer gym membership with LA Fitness and 24 Hour Fitness, depending on the region. We do offer...free basic gym membership for all members. We do have 3 complimentary nutritionist/dietitian appointments a year, can be virtual or in person, that [are] fully covered. On the Medicaid side...we have some healthy grocery programs....” (interviewee 7)</p>	<p>“If you go sign up, we’ll pay your gym membership.... We pay for things like visits to nutritionists. We do have a program...with a local grocery store. You go in, you meet with a nutritionist, [and] they take you around the store and help you understand purchasing healthier foods.” (interviewee 15)</p>
Theme 5: Perceived responsibility of pharmaceutical companies to lower list prices for IMWM to enable broad coverage and advance health equity	
<p>“If you’re pharma, you’re going to have make a decision [whether] you’re going to make your money on the individual or you’re going to make your money on taking care of the masses.” (interviewee 3)</p>	<p>“It’s up [to] the pharmaceutical industry to charge a price that society can bear.... There’s a piece of this that’s just discriminatory.... I think it’s incumbent upon the pharmaceutical industry to recognize that in contrast to hepatitis C, where it’s 6 weeks, one and done, this is lifelong therapy, so I think there’s a moral imperative to price this at a level that is sustainable for the country.” (interviewee 12)</p>

GLP-1, glucagon-like peptide-1; IMWM, incretin mimetics for weight management.

Theme 3: Current or Potential Use of Varied Utilization Management Strategies to Limit Initial and Ongoing Prescribing of IMWM

Strategies to limit initial prescribing of IMWM. Most interviewees (n = 18; 7 [78%] IMWM-covered and 11 [100%] IMWM-excluded) discussed concern about clinicians’ off-label prescribing of incretin

mimetics for T2D to patients without the condition: “[We’re] getting pummeled by...the off-label use of [incretin mimetics].... The cost is just crippling us” (interviewee 10, IMWM-excluded). Strategies to reduce off-label prescribing included look-back procedures to confirm members’ historic diagnosis of T2D. One interviewee estimated that “...upwards of 35% of all of the [incretin mimetics]

prior authorization requests...are denied because they're coming through on the diabetes indication, [but] they're [being used] for weight loss" (interviewee 4, IMWM-covered).

Among IMWM-covered interviewees, most (8 of 9 [89%]) discussed their health plans' current use of prior authorization criteria (eg, body mass index, comorbidities) and approximately half (5 of 9 [56%]) discussed current step therapy requirements, including nonachievement of weight loss goals with participation in a lifestyle-change program (n = 4) and/or use of older AOMs (n = 1). One interviewee commented on the potential effectiveness of step therapy, which "can divert 40% [to] 45% of the patients to other older, cheaper therapies [that] will be effective, and [the patient] won't ever graduate to the incretin mimetics" (interviewee 5, IMWM-covered).

Among IMWM-covered interviewees, none restricted prescribing IMWM to specialist groups (eg, endocrinology, obesity medicine), although one acknowledged that "[not all] provider[s] [have] the right tool set in their bag to manage obesity as a disease" (interviewee 3, IMWM-covered).

Among IMWM-excluded interviewees, approximately two-thirds (7 of 11 [64%]) discussed strategies their health plan may use to limit IMWM prescribing if coverage were offered. Such strategies include required participation in a lifestyle-change program (5 of 11 [45%]) and use of step therapy (3 of 11 [27%]). Approximately one-third (3 of 11 [27%]) anticipated use of prescribing restrictions, with one voicing concern about telehealth platforms: "[There are] bad actors... that don't have any patient interactions or they're just script mills" (interviewee 14, IMWM-excluded). This same interviewee speculated on processes, including retrospective audits and in-person visit requirements, to ensure "members are being taken care of by providers that have proper training and education to manage the weight loss..."

Strategies to limit ongoing prescribing of IMWM. Among IMWM-covered interviewees (n = 9), 5 (56%) noted their organization's current requirement for documented achievement of a minimum weight loss threshold (eg, $\geq 5\%$), 1 (11%) noted their organization's requirement for continued participation in a lifestyle-change program, and 1 (11%) noted their organization's long-standing 12-month limit on all AOMs: "We don't cover [them] beyond a year under any circumstances" (interviewee 8, IMWM-covered).

Three interviewees (2 [22%] IMWM-covered and 1 [9%] IMWM-excluded) discussed the need for benefit design strategies to support adherence to IMWM when effective for weight loss. Referring to the high potential for weight regain with IMWM discontinuation, 1 interviewee described the need to avoid "a situation that we euphemistically call 'the high school reunion diet.' It's something people do, but it's one thing if it involves not going to McDonald's until your high school reunion. It's another thing to get involved with a \$1300-a-month drug" (interviewee 4, IMWM-covered).

Theme 4: Coverage for Lifestyle-Change Programs to Support Weight Management

Most interviewees (n = 18; 8 [89%] IMWM-covered and 10 [91%] IMWM-excluded) reported coverage for programs to support

healthy lifestyle habits. Programs aimed to increase members' access to healthy foods through Food Is Medicine initiatives such as coverage for "healthy food with a non-prescription drug card" (n = 6; 3 [33%] IMWM-covered and 3 [27%] IMWM-excluded), physical activity resources (n = 14; 7 [78%] IMWM-covered and 7 [64%] IMWM-excluded), and nutrition counseling (n = 8; 5 [56%] IMWM-covered and 3 [27%] IMWM-excluded). None of the interviewees discussed plan members' engagement in or outcomes with the offered programs, although one noted that "the people [who] use [wellness resources] are the people [who] generally are healthy now" (interviewee 15, IMWM-excluded). Another noted, "I think it's well-known...that dietary and behavioral modifications for the plurality of patients have little to no effect. [These programs] are more a marketing incentive" (interviewee 1, IMWM-covered).

Theme 5: Perceived Responsibility of Pharmaceutical Companies to Lower List Prices for IMWM to Enable Broad Coverage and Advance Health Equity

Ten interviewees (4 [44%] IMWM-covered and 6 [55%] IMWM-excluded) remarked that the high costs of IMWM may potentiate health disparities, with one stating, "If only people [who can] pay cash, or people [who can] work their way through shortages to get drugs, or only high-end commercial insurance covers [IMWM], it could significantly worsen health disparities" (interviewee 1, IMWM-covered). Five interviewees (2 [22%] IMWM-covered and 3 [27%] IMWM-excluded) discussed the responsibility of pharmaceutical companies to offer affordable pricing in the US, with several referencing lower price points in international markets. Two IMWM-excluded interviewees (18%) speculated that pharmaceutical companies could maintain profits, even with lower list prices, with one saying, "...[I]f the drug companies would consider decreasing their price, their market share would increase significantly..." (interviewee 18, IMWM-excluded).

Despite perceived feasibility of lower list prices for IMWM, 1 interviewee doubted this would occur, saying, "Rather than make their drugs economically make sense for a weight loss indication, we expect [pharmaceutical companies] to push [new] FDA indications for...adverse cardiovascular events and for fatty liver disease...kidney insufficiency...and in effect get us into a position where, essentially, we end up covering [IMWM] without it actually being a weight loss indication" (interviewee 4, IMWM-covered). Another voiced a more optimistic perspective, saying, "I think you can get to a level where it really could be very profitable for the pharmaceutical industry and cost saving or close [for health plans]. That's my hope. What a great story it would be..." (interviewee 12, IMWM-excluded).

DISCUSSION

In this qualitative study, we interviewed leaders of large US health plans to elucidate factors influencing insurance coverage policies for IMWM and opportunities for health plans to support delivery of effective obesity treatment while controlling health

care spending. Consistent with findings from recent surveys of health plan leaders,^{20,29,32} most interviewees expressed concern about the high cost of IMWM and off-label prescribing of incretin mimetics indicated for T2D. Our findings also suggest that health plans' coverage policies remain influenced by the perception of obesity as a lifestyle choice rather than a treatable chronic condition. This perception was directly discussed by some interviewees and suggested by all organizations' willingness to cover incretin mimetics without reservation when indicated for other chronic conditions (eg, T2D, cardiovascular disease). Recent survey data have similarly demonstrated variation in perceptions of obesity as a chronic condition among health plan leaders,^{20,32} and coverage policies that reflect such perceptions may potentiate existing weight bias among health care professionals.⁴⁰ To optimize care for patients with obesity, multilevel strategies are needed to mitigate weight bias and advance treatment of obesity as a medical condition.

Our findings underscore heterogeneity in utilization management strategies among health plans that cover IMWM. Key areas of variation include requirements for (1) step therapy, (2) initial and continued participation in a lifestyle-change program while prescribed an IMWM, and (3) documented achievement of at least 5% weight loss. Recent survey data similarly demonstrate limited use of step therapy (18%-41%).^{20,28,41} This may be a missed opportunity to effectively support weight management among health plan members while also limiting spending on IMWM, as older, less expensive options may be highly effective for individual patients.^{4,42,43} Moreover, many individuals do not desire to use an IMWM⁴⁴ and may prefer and benefit from other options, including lifestyle-change programs, first-generation AOMs, and bariatric surgery.^{4,45} Thus, strategies are needed to support treatment of obesity as a heterogeneous chronic condition, with benefit design decisions that enable individually tailored use of the full range of weight management treatment options.

Forty-four percent of IMWM-covered interviewees (n = 4) noted that participation in a lifestyle-change program is required prior to initial IMWM prescribing; only 1 interviewee noted lifestyle-change program participation as a requirement for continued prescribing. Approximately half of IMWM-covered interviewees (n = 5) noted their organization's requirement for documented weight loss (eg, $\geq 5\%$); this aligns with prior survey data demonstrating that 14% of health plans measure weight change and 42% planned to do so in the future.²⁰ At present, few strategies exist to objectively evaluate individuals' lifestyle program participation and/or weight change via the electronic health record and claims data; innovative tools are needed to support a population health-based approach to weight management.⁴⁶

Most interviewees noted health plans' coverage for lifestyle-change programs, including Food Is Medicine initiatives, physical activity programs, and nutrition counseling. Interviewees were unaware of specific data on members' engagement in or outcomes with the offered programs, although several suggested that, in general, lifestyle-change programs have low levels of utilization and

clinical effectiveness. These perceptions are consistent with prior literature demonstrating variable levels of uptake in and weight change with workplace and employer-sponsored lifestyle and wellness programs.⁴⁷⁻⁴⁹ Efforts are needed to rigorously evaluate plan members' uptake, engagement, and weight-change outcomes with covered lifestyle-change programs; coverage policies should be subsequently refined, as needed, to limit low-value spending.

An additional opportunity to optimize weight loss with IMWM may include prescribing requirements, including specific visit types (eg, face-to-face encounter) and/or clinicians' training in obesity medicine to overcome knowledge gaps.⁵⁰⁻⁵³ Although such requirements are not typically used among US health plans, there is international precedent for this approach,⁵⁴ and some interviewees anticipated their organizations' future use of provider restrictions. Interviewees voiced concern about the rise of telehealth companies that promise prescriptions for IMWM⁵⁵ and suggested the need for strategies to ensure the appropriateness and effectiveness of obesity treatment practices. To better inform policy decisions, additional work is needed to determine whether weight loss among plan members prescribed IMWM varies based on clinical context (eg, telehealth vs primary care) and/or clinicians' training in obesity medicine.

Limitations

This study has several key limitations. First, we interviewed 20 leaders from large health plans in the US, and the findings may not reflect the views of other health plan leaders, including those of smaller organizations. Second, given the voluntary nature of the interview, the results may be subject to respondent bias, as plan leaders with a specific interest in this topic may have been more likely to participate. Third, we evaluated health plan leaders' self-reported coverage policies; due to the blinded nature of the interviews, we were not able to confirm the accuracy of interviewees' responses by comparing with published policies. Fourth, few interviewees acknowledged the role of pharmacy benefit managers and rebate contracts in IMWM coverage policies. This suggests a potential information gap among health plan leaders because these may be key factors guiding coverage and formulary decisions. Fifth, our findings reflect a snapshot in time where the cost of IMWM exceeds the ability for open coverage without the need for utilization management; new clinical and cost-effectiveness data may emerge and lead to near-term changes in the views captured in this study.⁵⁶

CONCLUSIONS

New IMWM offer a promising tool to improve individual and population health by reducing weight-related conditions and their consequences. Yet, in the US, the high cost of these medications is financially untenable for patients and payers. Our qualitative interviews with health plan leaders reveal wide variation in coverage for IMWM, with policies that generally aim to reduce near-term health care spending but may not support a comprehensive, equitable, or patient-centered approach to effective, longitudinal

weight management treatment. Such an approach might include (1) enhanced use of step therapy, (2) robust coverage for effective lifestyle-change programs, (3) exclusion of coverage for programs without demonstrable clinical benefit, and (4) requirements for IMWM prescribing. Best-practice guidelines are needed to standardize insurance coverage policy, and advocacy efforts are needed to encourage pharmaceutical companies to fulfill what one interviewee described as a “moral imperative...[to] price [IMWM] at a level that is sustainable for the country.” ■

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eAppendix 1. Screening survey used to identify potentially eligible interview participants

Question	Response items and exclusion criteria
<p>FDA-approved incretin mimetics for <u>weight management</u> include semaglutide (Wegovy), liraglutide (Saxenda), and tirzepatide (Zepbound). Does your organization currently cover one or more of these medications for <u>weight management</u>?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 3. Unsure [Exclude]
<p>Have you been involved in discussions about coverage for incretin mimetics for weight management at your current organization?</p>	<ol style="list-style-type: none"> 1. Yes 2. No [Exclude]
<p>Approximately how many covered lives does your plan have across all lines of business (fully insured, Administrative Service Only (ASO), Medicare, Medicaid, Individual)?</p>	<ol style="list-style-type: none"> 1. Under 50,000 [Exclude] 2. 50,000 to 99,000 3. 100,000 to 249,000 4. 250,000 to 499,000 5. 500,000 to 1 million 6. Over 1 million
<p>Which of the following best describes your health plan?</p>	<ol style="list-style-type: none"> 1. Blues plan 2. National plan 3. Regional plan 4. Integrated payer provider organization 5. Other (please specify)
<p>What is your title?</p>	<ol style="list-style-type: none"> 1. Medical Director 2. Chief Medical Officer of COMPANY 3. Chief Medical Officer of REGION 4. Vice President of Clinical Programs 5. Chief Clinical Officer 6. VP of Actuarial Services 7. Chief Actuary 8. Vice President of Product 9. Chief Pharmacy Officer 10. Vice President of Pharmacy 11. President 12. Chief Financial Officer 13. Chief Commercial Officer 14. Chief Executive Officer 15. Other (please specify)
<p>Of the following, for which of these lines of business are you personally responsible? <i>Check all that apply.</i></p>	<ol style="list-style-type: none"> 1. Individual / Family Plans 2. Fully Insured 3. Self-funded employer groups 4. Administrative Services Only (ASO) 5. Medicaid 6. Medicare Advantage [Exclude if only selected response] 7. Other (please specify)

eAppendix 2. Interview guide for health plan leaders from organizations that cover incretin mimetics for weight management

Introduction:

Thank you for participating in this research project. The objective of this research is to understand health plan leaders' perspectives on obesity treatment and coverage for weight management medications, specifically incretin mimetics. Incretin mimetics are often referred to as Glucagon-like Peptide 1 Receptor Agonists, or GLP-1 RAs. Incretin mimetics for weight management include semaglutide (brand name Wegovy), liraglutide (brand name Saxenda), and tirzepatide (brand name Zepbound). The same incretin mimetics are separately approved for the treatment of type 2 diabetes, and include the brand name drugs Ozempic, Rybelsus, Victoza, and Mounjaro. *For this conversation, we are specifically asking about use of incretin mimetics used exclusively for weight management and not for the management of type 2 diabetes.*

While we will be recording our conversation for transcription, your identity as well as all of your responses will remain anonymous. We understand that some of the questions we will ask you may concern decisions or policies that have not yet been finalized or formally announced to the public, but please be assured that your identity and the name of your organization will not be disclosed and none of the information you provide will be attributed to you or your organization. At the conclusion of our conversation, we will stop the recording to discuss the honorarium arrangements.

We're interested in learning about your organization's current coverage policies for incretin mimetics for weight management as well as any anticipated changes to those policies.

Section 1: General questions about coverage for incretin mimetics for weight management

1. Which of the following incretin mimetics for weight management does your organization currently cover?
 - a. Semaglutide (Wegovy)
 - b. Liraglutide (Saxenda)
 - c. Tirzepatide (Zepbound)

PROBE: what factors influenced the current coverage policies for this medication? For example, if certain drugs are covered vs. not covered, why is this?

2. How, if at all, do you anticipate your organization's coverage to change for any of these incretin mimetics for weight management?
 - a. **PROBE, if changes anticipated:** What factors have influenced these changes?
 - i. Are there any consequences of these changes? (e.g., loss of rebates if coverage is limited?)
 - ii. How, if at all, do you anticipate the FDA's recent approval of semaglutide for patients with overweight or obesity and cardiovascular disease to change your organization's coverage policies for this incretin mimetic?
 1. How, if at all, do you anticipate coverage to change if/when the FDA approves incretin mimetics for other indications such as chronic kidney disease, metabolic dysfunction-associated steatohepatitis (MASH))?
 - b. **PROBE, if changes anticipated:** When do you anticipate these changes will be implemented?
 - c. **PROBE, if no changes anticipated:** What factors influenced your organization's decision to maintain current coverage policies for incretin mimetics for weight management? (e.g., concern regarding loss of rebates for more restrictive policies)

- d. **PROBE, regardless of whether changes are anticipated:** How, if at all, do you anticipate your organization's coverage policies would change if Medicare were to provide coverage for anti-obesity medications?
3. To what extent, if at all, is your organization seeing off-label prescribing of incretin mimetics for diabetes to non-diabetic patients for weight management, and how is this being monitored and addressed?
- a. **Note to interviewer:** For example, this might include an automated lookback for diabetes-related diagnosis codes followed by a warning letter to off-label prescribers.
4. What strategies, if any, is your organization using to limit/prevent off-label prescribing of incretin mimetics for diabetes to non-diabetic patients for weight management?
- a. **Note to interviewer:** For example, this could include prior authorizations, step therapies, or diagnosis submissions.
5. *We would like to understand your organization's current coverage policy for each of the covered incretin mimetics for weight management noted in **Q1** and how, if at all, you anticipate these policies will change.*
- a. Is there currently a preferred formulary placement for one or more incretin mimetic(s) for weight management?
- i. How, if at all, do you anticipate these formulary placements to change?
1. **If changes anticipated:** When do you anticipate these changes will be implemented?
- b. What steps, if any, do patients currently have to take before your organization provides coverage for an incretin mimetic for weight management?
- i. **PROBE, if not addressed in above response:**
1. Do patients need documented participation in a lifestyle change program? For how long?
2. Do patients need to try other weight management treatments or medications? (i.e., step therapy requirements)
3. Do these covered drugs require prior authorization?
- a. **PROBE:** If yes, what are the criteria?
- ii. How, if at all, do you anticipate the requirements for your organization to provide coverage for incretin mimetics for weight management to change?
1. **If changes anticipated:** When do you anticipate these changes will be implemented?
- c. Once coverage is approved, what is the current patient cost-sharing for the covered incretin mimetic(s) for weight management mentioned in Q1.
- i. What changes, if any, do you anticipate to patient cost-sharing for the covered incretin mimetic(s) for weight management?
1. **If changes anticipated:** When do you anticipate these changes will be implemented?
- d. We would like to understand whether your organization is using any strategies or policies to support use of incretin mimetics for weight management among patients most likely to benefit from them. **Note to interviewer:** this could include higher BMI, certain co-morbidities, history of bariatric surgery, etc."
- i. **PROBE:**
1. What factors influenced these coverage criteria?
- ii. How, if at all, do you anticipate your organization's coverage criteria for incretin mimetics for weight management will change?
1. If changes are planned, what factors have influenced these anticipated changes?
2. If changes are planned, when do you anticipate they will be implemented?

- e. Tell me about any current prescriber restrictions for incretin mimetics for weight management.
 - i. **PROBE**, if not specifically addressed:
 - ii. Do covered prescriptions for incretin mimetics for weight management need to be prescribed by certain specialist types (e.g., endocrinologists / obesity medicine specialists)?
 - 1. Are there any provider groups that are restricted from prescribing incretin mimetics for weight management?
 - iii. How, if at all, do you anticipate prescriber restrictions for incretin mimetics for weight management to change?
 - 1. **If changes anticipated:** When do you anticipate these changes will be implemented?
- f. Do patients currently need to fill their prescriptions for incretin mimetics for weight management at a specific pharmacy?
 - i. Do you anticipate changes to this?
 - 1. If so, what factors have influenced this decision?
 - 2. If so, when do you anticipate these changes will be implemented?

Script: We are now going to shift to talk about current policies for ongoing coverage of incretin mimetics among patients taking them for weight management as well as any anticipated changes to those policies.

- g. Once patients initiate treatment with a covered incretin mimetic for weight management, what, if anything, do they currently need to do to maintain coverage for the medication?
 - i. **PROBE, if needed:**
 - 1. Document a specific amount of weight loss?
 - a. How much weight loss?
 - 2. Document ongoing / continued weight loss?
 - 3. Document weight maintenance?
 - 4. Document adherence to a lifestyle program?
 - a. Is there a specific program required?
 - 5. Attend regular follow-up visits with their prescriber?
 - ii. How, if at all, do you anticipate the requirements for maintaining coverage for incretin mimetics for weight management will change?
 - 1. **If changes anticipated:** When do you anticipate these changes will be implemented?
- h. Tell me about any current policies in place at your organization that determine the duration of coverage for incretin mimetics for weight management.
 - i. **PROBES:**
 - 1. What limits, if any, are there on the **amount a plan can spend** on incretin mimetics for weight management?
 - 2. What limits, if any, are on the **duration** an individual can use incretin mimetic for weight management?
 - 3. What limits, if any, are on the **number of times an individual can refill a prescription** for incretin mimetics for weight management?
 - ii. What changes, if any, do you anticipate your organization making to the policies determining the duration of coverage for incretin mimetics for weight management?
 - 1. **If changes anticipated:** When do you anticipate these changes will be implemented?

- i. Tell me about any policies your organization currently has in place to transition patients from incretin mimetics for weight management to other weight-loss medications or treatments (**Note to interviewer:** this could be referred to as step down therapy or de-escalation therapy).
 - i. Tell me more. (We are interested in understanding the specific treatments/medications that are offered as substitutes for incretin mimetics for weight management once they are discontinued [for any reason].)
 1. **If no plan to transition patients off** incretin mimetics for weight management, **ASK:** how does your organization cover the cost of incretin mimetics for long term weight maintenance?
 - ii. Tell me about any policies your organization anticipates implementing to transition patients from incretin mimetics for weight management to other weight-loss medications or treatments.
 1. **If new policies anticipated:** When do you anticipate implementing these new policies?
 2. **If no plan to transition patients off** incretin mimetics for weight management, **ASK:** how will your organization cover the cost of incretin mimetics for long term weight maintenance?
6. If your organization could go back in time, what, if anything, would your organization change about its decision to cover incretin mimetics for weight management?

Thank you. We've finished our questions about incretin mimetics for weight management. We'd like to shift gears now and take a few minutes to discuss your organization's coverage policies for non-pharmacological weight management treatments.

Section 2: Coverage policies for non-pharmacological treatments for weight management

7. What programs to support healthy diet and increased physical activity, if any, does your organization cover?
 - a. [*Examples might include* Food Is Medicine initiatives, coverage for gym membership, coverage for lifestyle change programs (such as Weight Watchers), etc.]

NOTE: For each strategy mentioned above, we want to know the following:

- a. What patients or populations are eligible?
 - b. What is the cost of the program to your organization?
 - c. What is the duration of coverage for the program?
 - d. What about this program is working well?
 - e. What about this program is not working well?
8. How, if at all, do you anticipate your organization's coverage for lifestyle programs for weight management to change?
 - a. **If changes anticipated:** When do you anticipate these changes will be implemented?
 9. Is bariatric surgery part of your organization's covered weight management treatment options?
 - a. If no: Are you able to speak to the details of this?
 - i. If NO, skip to question 8.
 - ii. If Yes:
 1. **PROBE:** Tell me about why bariatric surgery isn't covered.

2. **PROBE:** Tell me about any anticipated changes in your organization's coverage policy for bariatric surgery.
- iii. **If changes anticipated:** When do you anticipate these changes will be implemented?
- b. If yes: Are you able to speak to the details of your organization's coverage for bariatric surgery?
 - i. IF NO, skip to question 8.
 - ii. **IF Yes, PROBE:**
 1. Please describe your organization's current coverage policy for bariatric surgery.
 2. What changes do you anticipate in your organization's bariatric surgery policy?
 3. **Example policy changes:**
 - a. Reduce / eliminate prior authorization criteria to make it easier for patients to undergo bariatric surgery.
 - b. **If changes anticipated:** When do you anticipate these changes will be implemented?

Let's wrap up with a few final questions:

10. What concerns, if any, do you have about direct-to-consumer telehealth platforms?
11. What benefits, if any, do you perceive / anticipate with direct-to-consumer telehealth platforms?
12. What strategies, if any, is your organization using to support providers' education about obesity and its treatment options?
13. Tell me about steps your organization is taking, if any, to prevent (rather than treat) overweight and obesity.
14. Tell me about how your organization's weight management coverage policies might mitigate or worsen health disparities? [**Note to interviewer:** disparities may include racial / ethnic disparities / SES disparities / physical disabilities, etc.]
15. If drug cost were not an issue, what might be your organization's ideal coverage policy to support weight management?
16. Is there anything else you'd like to share?

Conclude Interview: Thank you for your time. I will now turn off the recorder.

eAppendix 3. Interview guide for health plan leaders from organizations that exclude coverage for incretin mimetics for weight management

Introduction:

Thank you for participating in this research project. The objective of this research is to understand health plan leaders' perspectives on obesity treatment and coverage for weight management medications, specifically incretin mimetics. Incretin mimetics are often referred to as Glucagon-like 1 Peptide Receptor Agonists, or GLP-1 RAs. Incretin mimetics for weight management include semaglutide (brand name Wegovy), liraglutide (brand name Saxenda), and tirzepatide (brand name Zepbound). The same incretin mimetics are separately approved for the treatment of type 2 diabetes, and include the brand name drugs Ozempic, Rybelsus, Victoza, Mounjaro. *For this conversation, we are specifically asking about use of incretin mimetics used exclusively for weight management and not for the management of type 2 diabetes.*

While we will be recording our conversation for transcription, your identity as well as all of your responses will remain anonymous. We understand that some of the questions we will ask you may concern decisions or policies that have not yet been finalized or formally announced to the public, but please be assured that your identity and the name of your organization will not be disclosed and none of the information you provide will be attributed to you or your organization. At the conclusion of our conversation, we will stop the recording to discuss the honorarium arrangements.

Section 1: General questions about coverage for anti-obesity medications

1. Can you describe your organization's current coverage policy for anti-obesity medications? These may include Orlistat, Qsymia, Contrave, and/or incretin mimetics for weight management including Wegovy, Saxenda, and Zepbound.
 - a. **PROBE:**
 - i. What anti-obesity medications, if any, are covered?

Note to interviewer: If the interviewee notes coverage for any of the following anti-obesity medications, they should be transitioned to the interview guide for health plan leaders from organizations that cover incretin mimetics for weight management:

- i. Semaglutide (Wegovy)
 - ii. Liraglutide (Saxenda)
 - iii. Tirzepatide (Zepbound)
2. What factors influenced your organization's decision not to cover incretin mimetics for weight management?
3. If your organization could go back in time, what, if anything, would your organization change about its decision not to cover incretin mimetics for weight management?
4. To what extent, if at all, is your organization seeing off-label prescribing of incretin mimetics for diabetes to non-diabetic patients for weight management, and how is this being monitored and addressed?
 - a. **Note to interviewer:** For example, this might include an automated lookback for diabetes-related diagnosis codes followed by a warning letter to off-label prescribers.

5. What strategies, if any, is your organization using to limit/prevent off-label prescribing of incretin mimetics for diabetes to non-diabetic patients for weight management?
 - a. **Note to interviewer:** For example, this could include prior authorizations, step therapies, or diagnosis submissions.

Section 2: Anticipated changes

Script: We would now like to discuss any anticipated changes to your organization's policies for incretin mimetics for weight management.

6. How, if at all, do you anticipate your organization's coverage for incretin mimetics for weight management will change?

If **no** anticipated changes:

- a. **PROBE:**
 - i. Why not?
 - ii. How, if at all, do you anticipate the FDA's recent approval of semaglutide for patients with overweight or obesity and cardiovascular disease to change your organization's coverage policies for this incretin mimetic?
 - a. How, if at all, do you anticipate coverage to change if/when the FDA approves incretin mimetics for other indications such as chronic kidney disease, metabolic dysfunction-associated steatohepatitis (MASH))?
 - iii. How, if at all, do you anticipate your organization's coverage policies would change if Medicare were to provide coverage for anti-obesity medications?
 - iv. **SKIP TO Section 3.**

If anticipated changes: **PROBE:**

- b. When do you anticipate these changes to be implemented?
- c. What factors influenced / are influencing these changes?
 - i. **PROBE:** How, if at all, do you anticipate the FDA's recent approval of semaglutide for patients with overweight or obesity and cardiovascular disease to change your coverage policies for this incretin mimetic?
 - a. How, if at all, do you anticipate coverage to change if/when the FDA approves incretin mimetics for other indications such as chronic kidney disease, metabolic dysfunction-associated steatohepatitis (MASH))?
 - ii. How, if at all, do you anticipate your organization's coverage policies would change if Medicare were to provide coverage for anti-obesity medications?
- d. What policies, if any, might your organization use to limit the use of incretin mimetics for weight management.
 - i. **PROBES:**
 1. Will there be any limits on **how much an individual can spend** on incretin mimetics for weight management?
 2. Will there be any limits on the **duration** an individual can use incretin mimetics for weight management?

3. Will there be any limits on the **number of times an individual can refill** a prescription for incretin mimetics for weight management?
- e. Tell me about any policies that your organization plans to implement to transition patients from incretin mimetics for weight management to other weight-loss medications or treatments (Note to interviewer: this could be referred to as step down therapy or de-escalation therapy).
 - i. Tell me more.
 1. If no plan to substitute, ASK: how does your organization plan to cover the cost of incretin mimetics for long term weight maintenance? (e.g., increase cost-sharing, increase premiums?)
- f. Are you considering any prescriber requirements?

PROBE:

- i. Training in obesity medicine or other sub-specialties (e.g., endocrinology)?
- ii. Participation in specific programs, e.g., telehealth obesity medicine platform(s)?

Thank you. We've finished our questions about incretin mimetics and other anti-obesity medications, but we know that a lot of health plans are also considering or already covering the use of non-pharmacological treatment for weight management. We'd like to shift gears now and take a few minutes to discuss your organization's coverage policies for these treatments.

Section 3: Coverage policies for non-pharmacological treatments for weight management

7. What programs to support healthy diet and increased physical activity, if any, does your organization cover?
 - a. [*Examples might include* Food Is Medicine initiatives, coverage for gym membership, coverage for lifestyle change programs (such as Weight Watchers), etc.]

NOTE: For each strategy mentioned above, we want to know the following:

- a. What patients or populations are eligible?
 - b. What is the cost of the program to your organization?
 - c. What is the duration of coverage for the program?
 - d. What about this program is working well?
 - e. What about this program is not working well?
8. How, if at all, do you anticipate your organization's coverage for lifestyle programs for weight management to change?
 - a. **If changes anticipated:** When do you anticipate these changes will be implemented?
 9. Is bariatric surgery part of your organization's covered weight management treatment options?
 - a. If no: Are you able to speak to the details of this?
 - i. If NO, skip to question 8.
 - ii. If YES:
 1. **PROBE:** Tell me about why bariatric surgery isn't covered.
 2. **PROBE:** Tell me about any anticipated changes in your organization's coverage policy for bariatric surgery.
 - b. If yes: Are you able to speak to the details of your organization's coverage for bariatric surgery?
 - i. If NO, skip to question 8.
 - ii. **If YES, PROBE:**
 1. Can you describe your organization's current coverage policy for bariatric surgery?

2. What changes, if any, do you anticipate in your organization's bariatric surgery policy?
3. **Example policy changes:**
 - a. Reduce / eliminate prior authorization criteria to make it easier for patients to undergo bariatric surgery.
4. **If changes anticipated:** When do you anticipate these changes will be implemented?

Let's wrap up with a few final questions:

10. What concerns, if any, do you have about direct-to-consumer telehealth platforms?
11. What benefits, if any, do you perceive / anticipate with direct-to-consumer telehealth platforms?
12. What strategies, if any, is your organization using to support providers' education about obesity and its treatment options?
13. Tell me about steps your organization is taking, if any, to prevent (rather than treat) overweight and obesity.
14. Tell me about how your organization's weight management coverage policies might mitigate or worsen health disparities? [**Note to interviewer:** disparities may include racial / ethnic disparities / SES disparities / physical disabilities, etc.]
15. Is there anything else you'd like to share?

Conclude Interview: Thank you for your time. I will now turn off the recorder.