WHITE PAPER

Global payer attitudes influencing the future of obesity and GLP-1 drugs

Why the time is now to get creative and start expanding access

By Bill Coyle, Howard Deutsch and Paul Bergen

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It's no secret that obesity is a public health crisis. Roughly 2.5 billion adults worldwide are overweight, and almost 900 million live with obesity. The condition is responsible for hundreds of complications and comorbidities, fueling significant cost. But a new era is upon us with the dawn of glucagon-like peptide-1s (GLP-1s). Drugs such as semaglutide (Ozempic, Wegovy and Rybelsus) and tirzepatide (Mounjaro and Zepbound) are helping millions achieve an average weight loss of 15% to 20% in clinical trials. Pipeline molecules, meanwhile, are poised to offer weight loss of 25% or more, along with new modalities and improved tolerability.

While these drugs can help achieve and maintain a healthy weight, access to them remains restricted across the world. In Germany, for instance, it's against the law for national insurance to cover weight loss products, restricting Wegovy to those who can pay the full price out of pocket. In the U.K., the National Health Service (NHS) covers Wegovy and Zepbound for some patients, but a competitive cash-pay market exists alongside more traditional channels.

In the United States, meanwhile, only about 40% of employers cover these drugs, and the backlash against coverage appears to be growing. U.S. federal law currently bars Medicare from covering all weight loss drugs. However, the FDA's March 2024 decision to grant Wegovy a new indication for the prevention of major cardiovascular events in patients who are overweight or obese with established cardiovascular disease opened the door for Medicare to cover the treatment for an additional 5 million U.S. patients. The change offers drugmakers a blueprint for gaining broader coverage for these drugs in the absence of updates to federal law.

Given evolving market dynamics for obesity and analysts projecting the market for anti-obesity medications as high as $150 billion per year, we wanted to speak to global payers about obesity, GLP-1s and a range of related topics. Specifically, we wanted to find out:

- What payers believe about the underlying causes of obesity and how these beliefs inform their coverage decisions
- What challenges payers face with today's obesity interventions and what future challenges they anticipate
- If payers plan to cover these drugs and how they plan to do so
- How much payers are willing to spend to offer broad access to these new medications across different patient populations

To explore these topics, we conducted 60-minute interviews with between three and five payers from each of the U.S., U.K., France, Germany, Turkey, Brazil and China. We also conducted an online quantitative survey of 28 U.S. payers.

Global payers shared a general sense of frustration with past efforts to tackle obesity, which they deemed largely ineffective at achieving their chief aim: lowering rates of obesity at the population level. While they also shared a collective concern over the financial impact of today's obesity medications, they differed in their opinions of obesity's causes and the degree of urgency required to address it.

Question No. 1: What do payers currently understand about obesity?

It should surprise no one that payers consider poor diet and lack of physical activity the leading causes of obesity. Payers say biological factors and genetics also play a role, but they consider these drivers to be only about half as important as individual lifestyle choices.

Even though more than half the payers in our global survey recognize obesity as being responsible for a range of comorbidities—including Type 2 diabetes, coronary heart disease, osteoarthritis and mental illness—they expressed a general lack of urgency to address obesity itself.

"Obesity can be life-threatening, benign or anything in between. In most cases, it is benign in the sense that it's not as lethal as a lot of other habits, like smoking." – A U.S. payer

"We obviously recognize the connection between obesity and its consequences. The problem is that the National Health Service (NHS) is set up to treat ill people. Theoretically, an obese person isn't ill. What the NHS treats are stroke or heart attacks or diabetes. They don't treat just obesity." – A British payer

"Obesity impacts families and caregivers, work and access to clothes. There's isolation [too], so it's a vicious cycle. [People] give up on things, and it becomes difficult to reintegrate into social life and roles in society." – A Brazilian payer

Question No. 2: What challenges do payers face when deciding which obesity interventions to cover (and for whom)?

The payers in our survey outlined three major challenges that cloud the coverage picture for obesity interventions:

Cost and budget risks. Because many countries, especially high- and middle-income ones, have a high prevalence of obesity, covering GLP-1s at current prices for even a minority of eligible patients would severely strain payer finances in the short term. Helping large numbers of people to maintain a healthy weight could save more than it costs over the long term, but the full economic benefit of these medications is not yet proven.

"We try to serve patients but also seek a balance in public-service finances. Obesity ends up not being a priority, especially [compared] with CAR-T cell and gene therapies." – A Brazilian payer

Regulatory constraints. Most payers in our survey report some form of regulatory limits on what obesity medications they can cover and for whom. This is true for Medicare in the U.S., national insurance in Germany and payers in other markets where regulations may preclude coverage of weight loss medication.

"Currently, provisional measures do not include weight loss drugs in the medical insurance catalog. If we want to include obesity in medical insurance, we need to [change] provisional measures." – A Chinese payer

Payer perceptions of patient commitment to lifestyle changes. More than any other factor making payers reluctant to cover weight loss drugs, payers cited patients' unwillingness to do the "hard part" by committing to making long-term healthy lifestyle changes.

"Patients bounce back if they come off these products, so they have to use these products chronically—which is not well received." – A German payer

"The [public payer system] supports patients until a certain point, but patients are [audited] monthly to determine if they really follow diet and physical activity recommendations. If they don't, doctors won't prescribe medication to be reimbursed again, and the [public payer system] won't want to be involved in that process again." – A Turkish payer

Payers expressed the commonly held belief that "individual responsibility" drives a patient's ability to maintain a healthy weight, dividing obesity interventions into artificial categories of "right" (losing weight through diet and exercise) and "wrong" (losing weight using medication). The social stigmatization of those suffering from obesity appears to influence payer decision-making for covering today's weight loss drugs.

Question No. 3: How are payers planning for a future with a larger, more competitive obesity market?

Morgan Stanley estimates that, by 2035, 24 million people in the U.S. will be taking a GLP-1 to manage their weight. Payers in our survey said they need to do a better job planning for how they will pay for modern anti-obesity medications, especially as new entrants are brought to market. The sudden rise of demand for GLP-1s began in earnest in 2023, when consumers seeking weight loss fueled both demand and a media narrative around these drugs. With demand unlikely to slow, payers are pursuing a range of options—from active to passive and points in between—to manage the significant near-term budget impact associated with covering GLP-1s and their eventual successors (Figure 1).

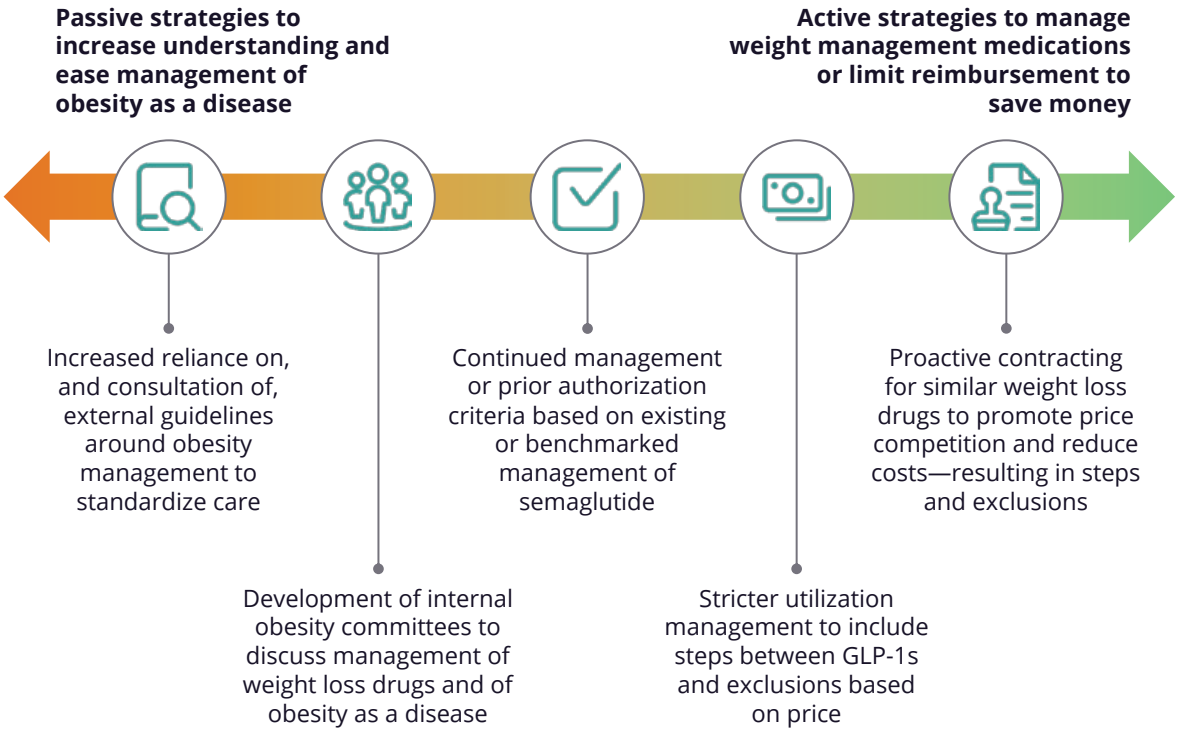
To manage the financial challenge of covering obesity medications, U.S. payers say they would prefer innovative coverage models over other long-term management options. When pressed on potential coverage models, however, payers acknowledged they do not yet know what these might look like for this class of drugs. As part of its effort to expand coverage, Cigna recently struck an agreement with both Eli Lilly and Novo Nordisk (makers of Zepbound and Wegovy, respectively) to cap at 15% the growth of its annual spend on weight loss drugs. This coverage model incentivizes drug manufacturers to become more actively engaged in ensuring their weight management drugs are prescribed for only the most appropriate patients—a difficult proposition when the indicated population is so vast.

This remains, to our knowledge, the only current example of an innovative coverage model designed specifically for GLP-1s, suggesting this as a key untapped opportunity for payers looking to develop nontraditional methods to pay for these drugs. The prevailing method today seems to be to limit access through increasingly strict utilization management in traditional pharmacy benefit coverage models—for example, by implementing prior authorizations or step edits.

Key takeaways: Payers already have begun to introduce stricter utilization management practices to limit how many patients are on GLP-1s. We can expect these efforts to continue and to be implemented for new market entrants.

FIGURE 1:

Payer strategies for managing the financial impact of obesity drugs



Question No. 4: How much are payers willing to spend on GLP-1 drugs?

A key question for patients and the healthcare community: At what price would payers consider broad coverage of GLP-1s? To understand payers' thinking, we asked how much they would be willing to spend annually on patients in each of four categories, ranging from all eligible patients ("Population A") to only those facing the gravest health-related consequences of living with obesity ("Population D"). We used body-mass index (BMI) to define stages of obesity, age to define how long a patient has been living with excess weight and complications to define how severely obesity has affected the patient's life.

Population A: Label-indicated population—those with a BMI higher than 30 or higher than 27 with a weight-related comorbidity.

Population B: Adults aged 40 and younger with a BMI higher than 30 and no weight-related comorbidities.

Population C: Adults aged 40 and older with a BMI higher than 30 and at least one weight-related comorbidity.

Population D: Adults aged 40 and older with a BMI higher than 40 and at least one severe weight-related comorbidity. Examples of "severe" comorbidities include heart failure, stage 3 (or later) chronic kidney disease and metabolic dysfunction-associated steatohepatitis with fibrosis.

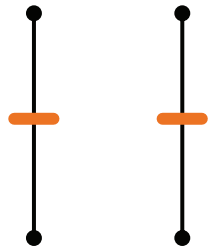
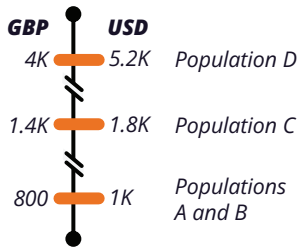
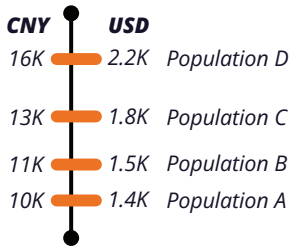
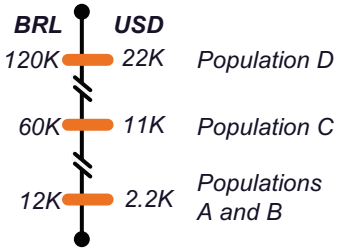
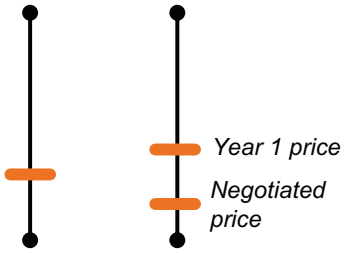
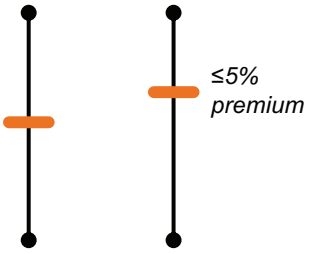
Responses generally fell into one of three categories:

1. **Population agnostics.** Survey respondents hailing from France, Germany and Turkey said they'd pay the same for drug coverage for patients in all four categories, regardless of age or comorbidities—if required by national policy. These payers all benchmarked future drug prices to semaglutide, the highest-priced GLP-1 available in these markets at the time of our survey.

2. **Patient-stratification advocates.** Payers in China and Brazil expressed greater appetite for stratifying patients (Figure 2), although they did not distinguish between populations A and B. These payers were likely to cite less expensive, nonpharmacological alternatives such as diet and exercise via gym memberships as price benchmarks for these patients. These payers expressed a willingness to spend more on weight loss drugs for populations C and D—though more from a desire to treat the weight-related comorbidity than to treat the underlying obesity.

FIGURE 2:

How much global payers say they're willing to pay for GLP-1s

FR	UK	CN
	Reasonable prices at which minimal restrictions are likely for indicated populations  *Must demonstrate cost effectiveness*	Reasonable prices at which minimal restrictions are likely for indicated populations 
Prices likely to be benchmarked to existing prices of GLP-1s, such as semaglutide. If clinically comparable, price will be discounted to existing GLP-1s; if clinically superior, price can be matched or set at a slight premium.	Prices expected to be benchmarked off semaglutide's current price in the U.K. All cost-effective treatments likely to be reimbursed to encourage price competition. A 10% premium will likely result in heavy restrictions. A 20% premium will likely result in noncoverage.	Prices expected to be benchmarked to existing prices of GLP-1s, like semaglutide for Type 2 diabetes. A 50% premium will likely result in heavy restrictions. A 100% premium will likely result in noncoverage.
BR	**DE**	**TK**
Reasonable prices at which minimal restrictions are likely for indicated populations: 	Price of SEMA Expected price of future treatment(s) 	Price of SEMA Expected price of future treatment(s) 
The ideal price for obesity drugs for the broad people with obesity is equally affordable for the private out-of-pocket market and Brazil's public system. A 50% premium will likely result in heavy restrictions. A 100% premium will likely result in noncoverage.	If obesity treatments are removed from the social codebook as lifestyle drugs, there will be unconditional reimbursement for the first year of availability. Thereafter, prices are expected to be negotiated based on existing prices of GLP-1s, like semaglutide for Type 2 diabetes.	New obesity treatments must be benchmarked from existing GLP-1s like semaglutide. The maximum price is 5% more than the existing licensed equivalent drug and will apply to all obesity subpopulations.

* Annual net prices in local currency converted to USD based on currency exchange rate as of July 15, 2024

3. **Those offering no discernible consensus.** U.S. payers we surveyed expressed tremendous variation, with the average range across national, regional and local commercial payers shown in Figure 3. Payers said they generally would be more willing to pay a premium to cover GLP-1s for Population D patients than those in Population A. The annual costs they cited represented between a 35% and 95% discount over the current U.S. cost of Wegovy.

FIGURE 3:

What U.S. commercial payers are willing to spend to cover GLP-1s

	Annual net prices by patient population			
Patient population	**A**	**B**	**C**	**D**
USD $*	$700-$3,000	$2,300-$4,400	$3,700-$6,200	$6,900-$10,000
Estimated size (rounded)	190 million	15 million	63 million	9 million
Potential market size	$130 billion-$570 billion	$35 billion-$65 billion	$230 billion-$390 billion	$60 billion-$87 billion

* Annual net prices U.S. commercial insurers said they would pay to cover GLP-1s for weight management

Key takeaways: The prices payers are generally willing to accept to cover weight loss drugs represent significant discounts over current list prices, highlighting their concerns over the size of the eligible patient population. Brazil stands out as a notable exception, with payers there showing a willingness to pay a premium to cover those suffering from the most severe obesity-related complications—especially if the drugs demonstrate benefits in addition to weight management.

Ultimately, it's not about how much payers are willing to spend on weight management drugs for each hypothetical individual patient. They understand that innovative, efficacious drugs are inherently valuable. But given the size of the indicated population, the expected short-term budget impacts are potentially staggering.

Payers faced a similar challenge in the 2010s, when the FDA approved the first direct-acting antiviral medications for hepatitis-C—another chronic disease that carries a high disease and economic burden. Although that curative treatment offered a strong long-term business case, payers still balked at the drugs' short-term budget impact, which drove them to aggressively manage all categories at launch. Given that the short-term budget impact of GLP-1s dwarfs that of hepatitis-C antivirals, while the long-term business case is currently murkier, this impasse is likely to persist.

How healthcare stakeholders can tackle obesity now

By one measure, the average person will attempt more than 125 fad diets, a reflection of the pervasive belief that individual choices drive obesity. A corollary to this belief is that there is a "right" way to lose weight—through exercise, dieting and other lifestyle changes—and that, only after these efforts have been exhausted, should an individual be given access to weight loss drugs. This attitude would appear to ignore the fact that underserved patients already struggling to cover expenses are also those most at risk of obesity-related health challenges.

Changing payer attitudes toward obesity depends on steering them to recognize it as they do other chronic illnesses, to treat it proactively and to stop pinning their hopes on individual responsibility alone to solve the problem. Type 2 diabetes is another chronic disease for which individual choices play a role, but payers don't refuse to cover treatments for the disease or its comorbidities on this basis.

This emphasis on individual responsibility can exacerbate health inequities, since obesity is strongly linked with social drivers of health (SDOH) such as race, ethnicity, sex, gender identity and income. A view of obesity's causes that focuses on individual choices will inevitably exclude many millions who are genuinely trying to maintain a healthy weight but are held back by social drivers outside their control. This failure to acknowledge the reality for many people living with obesity represents a misguided and paternalistic barrier to covering medication for many who would benefit.

Those prepared to begin tackling the obesity epidemic at a population level should consider the following three actions:

No. 1: Advocate for regulatory and policy changes. To improve the lives of as many people as possible suffering from weight-related health conditions, policies constraining payers from covering obesity interventions—pharmacological or otherwise—should be revisited. This includes policies, for instance, that prevent Medicare and some state Medicaid plans from covering any drug meant for weight loss or weight gain. Similar policy restrictions are common across other markets. While these policies probably reflect the longstanding stigma painting obesity as a product of poor lifestyle choices, they also reflect the fact that earlier weight loss medications simply didn't work that well.

No. 2: Develop holistic treatment plans that address the multifaceted causes of obesity and recognize its societal impact. We must start by recognizing obesity as a chronic illness requiring the same level of proactive, long-term care and prevention as other chronic diseases. This means better and more plentiful treatment options covered by insurance, with fewer patient hurdles to clear—treatment options such as food as medicine, intensive behavioral therapy, physical therapy and prescription, either on its own or in combination with other interventions. It also means that we do not attribute to individual responsibility what is a much larger social, environmental and biological problem.

Eli Lilly, Novo Nordisk and other drug manufacturers are studying molecules with the potential to prevent and treat not only obesity but also other obesity-related complications. Adding indications for these drugs will increase pressure on payers to cover them. Payers, drug companies and others could partner to help identify clinical, behavioral and SDOH characteristics to use to subsegment those who are overweight and obese to personalize these treatment plans, especially as we gain further evidence that GLP-1s can drive health outcomes beyond weight loss.

No. 3: Better align pricing agreements with payers' near-term budget fears. Dropping prices for GLP-1s won't magically expand access dramatically. There still won't be enough supply and, in any case, payers won't open up the coffers if the short-term budget impact becomes too extreme. Rather, drugmakers should seek to enable broader coverage without exploding budgets by getting creative. Contracting arrangements such as volume-based discounts, budget-capping mechanisms, givebacks based on predetermined population outcomes and refunds for patients who discontinue due to tolerability issues—and more—should be on the table.

Payers are right to be concerned about the short-term financial impact of covering these drugs for everyone who qualifies. But sooner rather than later, the combination of loosening supply and competition from new entrants will push prices down, meaning expanding coverage today to give patients the best possible lifelong outcomes doesn't commit payers to an irreversible future path of high drug spending. In fact, expanding coverage now will help offset or even reverse other categories of spend down the line.

Reversing the course of obesity will require a broad societal shift in mindset and priorities

Payer beliefs and actions will go a long way toward either solving the obesity crisis or perpetuating the status quo. This research suggests payers have a long way to go. To help patients lose weight in the short term and embrace healthy habits in the long term, we must first change both payer and public attitudes toward obesity and individual patients' health journeys. This means seeing obesity not as a condition driven primarily by individual failings but rather as one that sees personal choices as just one potential cause in a constellation of interconnected ones.

Our health systems aren't built to implement population-level preventive medicine because the upfront cost can be so high and the payoff for those who make the investment isn't guaranteed. Vaccine access represents a strong example of successful preventive medicine at scale, albeit at much lower per-capita costs than GLP-1s. But while the long-term economic and health benefits of GLP-1s have yet to be clearly demonstrated, the early signs are positive. In any case, we don't require decades of long-term benefit data on vaccines before prioritizing broad access to them.

The COVID-19 vaccines aren't the only prime examples of prioritizing population-level access to preventive health. The annual influenza or respiratory syncytial virus vaccines also illuminate the path. What we value in vaccines is that they prevent diseases with both near- and long-term benefits and consequences. GLP-1s have shown similarly consequential benefits for those living with obesity. As such, we can't afford to wait any longer to treat the obesity epidemic at scale.

About the authors

Bill Coyle is the global head of biopharma at ZS, where he helps shape the firm's perspective on the industry's future and leads ZS engagements with a variety of global clients. His expertise spans topics across the pharmaceutical and biotech sector, including asset development and early commercialization, value and access and key account development. Having split his time at ZS between the U.S. and Switzerland, his expertise spans the U.S. and key European and global markets.

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