WHITE PAPER

3 health plan strategies for balancing cost and access with GLP-1s

By Adam Siskind, Aleya Dutta Choudhury, Ayushi Khetan, Vinod Swarna, Vimbai Mudimu, Vikas Garg

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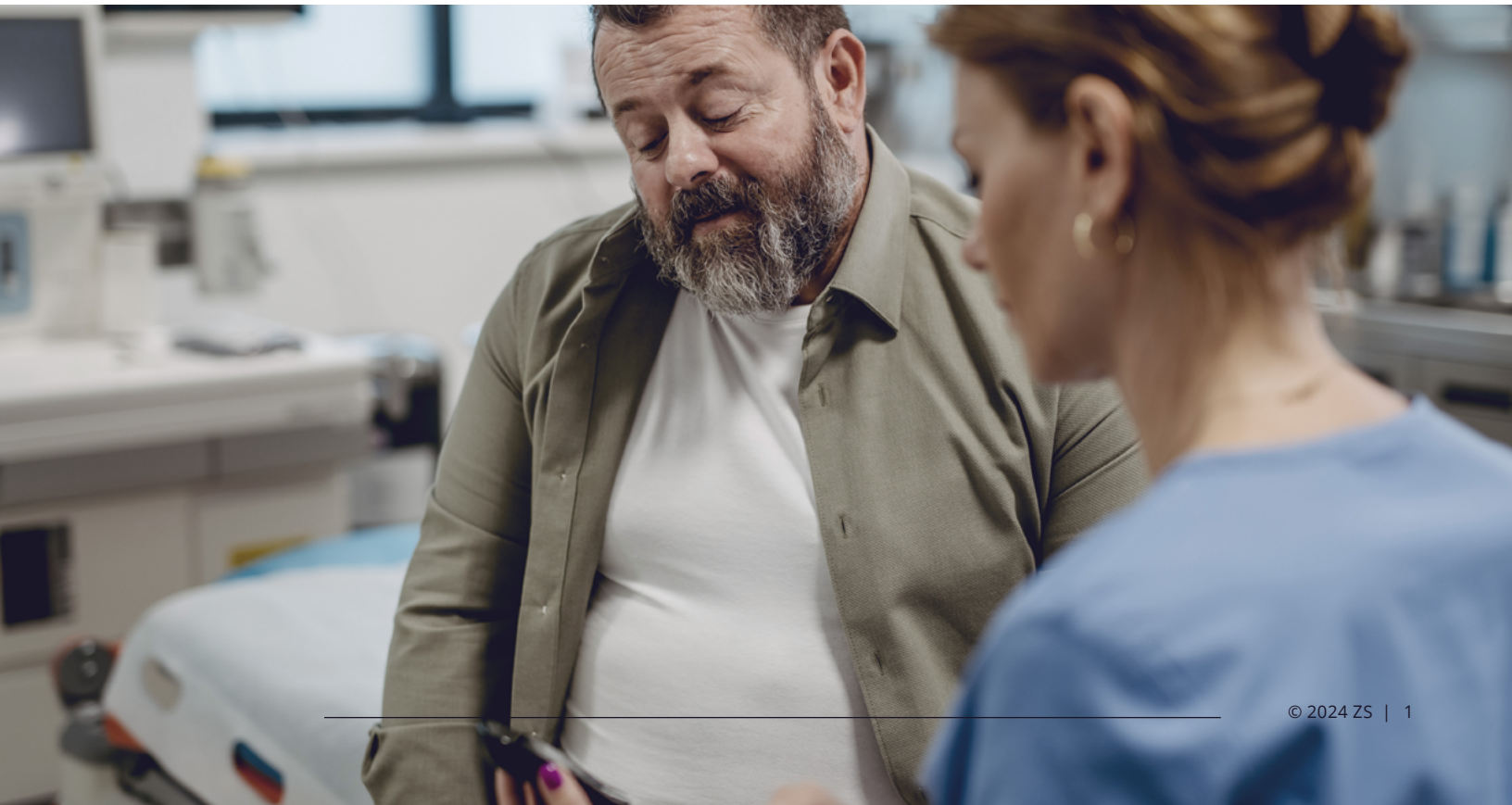
More than 70% of adults in the U.S. today are either overweight or obese, evidence the country is already in the midst of a significant public health crisis. Individuals with obesity are at increased risk of serious comorbidities, including type 2 diabetes, cardiovascular disease, acute and chronic pain, several types of cancers, mental illness, sleep apnea and osteoarthritis. Various treatment approaches have emerged over time, including lifestyle therapy, pharmacotherapy and surgery. Each treatment, however, comes with its own complexities, considerations and downsides. Enter GLP-1s.

GLP-1s (glucagon-like peptide-1s) are a class of medications that play a critical role in regulating blood sugar by stimulating insulin production and suppressing glucagon secretion. While GLP-1s have been approved for diabetes since 2005, additions like Wegovy and Mounjaro (in 2021 and 2022, respectively) offer significant weight-loss advantages over previous drugs, accelerating demand for them and fueling significant class growth.

GLP-1s' results speak for themselves: 15%-20% weight loss, plus an emerging body of research showing that some of these drugs lower the risk of heart failure and stroke. These impressive results have made these drugs extremely popular, with studies reporting that one in eight people in the U.S. have used a GLP-1 and roughly 6% of the population are currently taking one. Prescriptions for some of these drugs are up by 2,000% since 2019, and manufacturers are struggling to keep pace with the surge in demand.

The explosion in popularity of GLP-1s is also causing an acute financial challenge for payers, who are being forced into difficult coverage choices for their members. However, there are a number of strategies they can use to thread the needle by offering coverage of these drugs to members who would benefit without exploding their budgets. In this white paper, we focus on strategies for commercial plans, for which coverage decisions are made by employers and payers.



Payer strategies for GLP-1 drug coverage

To understand the impact of GLP-1s on payers' bottom lines, take the example of Wegovy, which costs a little more than $16,000 per member per year before rebates. The financial impact of coverage decisions comes with extremely large multipliers, as seen in the figure. For a payer with a million members, covering just 5% of additional eligible members would cost around $420 million per year.

FIGURE :

Annual impact of incremental coverage expansion for a hypothetical payer

Number of members	1,000,000	
Eligible members: 51.9%*	519,000	
Annual cost to payer for Wegovy**	$16,188	
Coverage of 10% of eligible members	51,900	$840,157,200
Coverage of 15% of eligible members	77,850	$1,260,235,800
Annual cost to payer for Wegovy**		$420,078,600

* Defined as those with BMI>30 (41.9%) and BMI>27 with weight-related comorbidities (10%).

** List price for Wegovy 2.4mg as of 2024: $1,349 per month. Rebates and drug adherence are not factored in.

While the annual incremental cost to payers is extremely high, it fails to capture the true impact on payers' long-term bottom line. This is because GLP-1s are not intended for short-term use, since those taking GLP-1s report regaining most of their weight after discontinuing use. Multiplying the high annual cost of GLP-1 coverage by years and even decades has created a future payer cost burden well into the billions of dollars.

On the other hand, the lifetime cost of insuring a member who struggles to maintain a healthy weight is also extremely high. Those living with obesity are prone to multiple comorbidities, and their annual medical costs are approximately twice as high as those who maintain a healthy weight. According to one study, broad Medicare coverage of GLP-1s would save taxpayers $176 billion over the first 10 years and more than $700 billion over 30 years.

These savings would come from reduced healthcare spending on hospitalizations, surgeries, doctors' visits, other medications, nursing home stays and more.

All this begs the question: Should payers continue to cover the significant costs of GLP-1 drugs? And if so, then how? The answer to these questions will vary depending on a mixture of factors, from member populations and their risk factors to plan type, benefit design and other trade-offs a payer may choose to make when weighing the costs and benefits of covering GLP-1s.

3 strategic considerations for health plans concerning GLP-1 medication coverage

The first strategic decision payers face with GLP-1s is whether to cover them and for whom. Assuming they plan to cover these drugs for at least some of their members, they must then devise ways to do so that ensure the best possible outcomes for members, considering both cost and the quality of care. Internal stakeholders must be prepared to answer three questions to equip decision-makers with the information they'll need to strike a balance between member benefit and fiscal responsibility.

Question No. 1: What lines of business are you concerned with?

Approximately 40% of employers today provide coverage for GLP-1s for weight loss. While coverage decisions for commercial plans lie solely with payers, coverage decisions for Medicare and Medicaid are slightly more complicated.

For Medicare Part D. The current statutory guidelines for Medicare Part D state that medications for anorexia, weight loss or weight gain will not be covered. There is increasing public and industry pressure on the Centers for Medicare & Medicaid Services (CMS) and lawmakers to reconsider these guidelines; this, in addition to the FDA's recent expanded approval of Wegovy for the treatment of heart disease, has prompted changes to coverage, with CMS stating that obesity drugs receiving FDA approval for an "additional medically accepted indication" may now be covered under Part D.

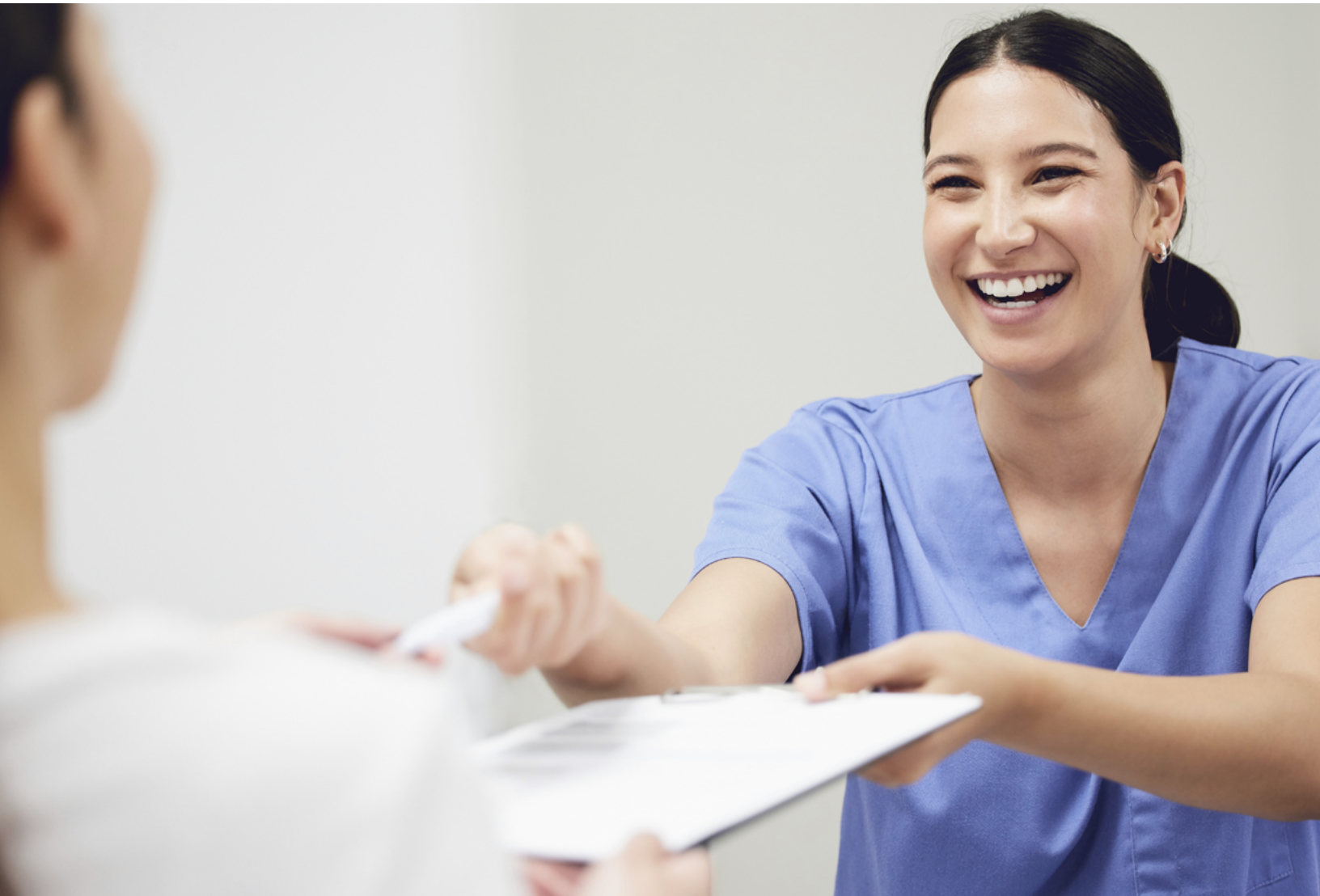
For Medicaid. Medicaid coverage varies depending on state policies, the financial implications of which have been significant. In 2022 alone, Medicaid spending on GLP-1s was nearly $7.9 billion, or 8.6% of all plan spending. This considerable outlay has raised concerns with policymakers, prompting some states to consider further coverage restrictions. Even so, as of early 2024, 16 states covered weight-loss medications through Medicaid, and this number is expected to increase.

Question No. 2: Which members will be eligible for coverage?

Payers can't afford to cover GLP-1s for all members indiscriminately. While the majority of a carrier's members may qualify for coverage because they are either obese or overweight with one or more comorbidities, expanding access to all members would mean providing coverage for both those who would benefit medically as well as those seeking GLP-1s for nonmedical reasons. The latter scenario is not tenable.

In reality, there are three clear sets of members who would benefit medically from taking a GLP-1: those with type 2 diabetes, those who are overweight or obese and those with cardiovascular risks. There are benefits of GLP-1s for each of these populations as well as mechanisms for managing utilization and costs (see "Question No. 3" below).

Along with the strategies laid out below, payers also can and should seek greater understanding of these three segments through analyzing claims, hospitalization data, medical records and social drivers of health data. Understanding cost exposure, treatment pathways, comorbidities, socioeconomic and cost histories can help health plans predict utilization and inform coverage decisions.



Question No. 3: What policies should I implement to manage cost?

Once payers have decided on which lines of business and member segments to focus, they must then implement three policies to preserve the proper balance between member outcomes and fiscal responsibility. They are:

Policy 1: Thoughtful benefit design

When designing benefits, employers must consider several factors. The first is the potential for benefit decisions to improve member health outcomes, increase productivity and improve employee retention. Research has found that obesity can raise absenteeism due to injury or illness by three days (or 128%) per employee per year. Managing a chronic condition such as obesity effectively can significantly depress absenteeism while also promoting employee well-being. Additionally, considering the rising demand for GLP-1s, it's possible that employers coverage decisions may have a significant effect on employee satisfaction and retention.

Given the price tag that comes with GLP-1s, however, employers owe it to themselves to thoroughly explore cost-containment strategies. Two stand out:

Flexible savings accounts and health savings accounts. For plan members who are either obese or overweight with a comorbidity, plans could consider offering Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). Since these plan features allow employees to set aside pretax dollars to cover out-of-pocket expenses to pay for GLP-1s, this strategy would help ensure that only those who want the drug pay for it and that other members avoid subsidizing the cost through higher premiums. Positives of this approach: Greater flexibility for employees to manage healthcare costs. Negatives: Contribution limits mean that employees would quickly max out an HSA or FSA.

Alternative contracting arrangements. Payers can and should explore alternative contracting arrangements, such as value- and outcomes-based contracts, directly with drug manufacturers. These arrangements can help mitigate costs by tying payments to agreed-upon outcomes related to the primary health condition, other comorbidities or the reduction in healthcare utilization. Positives of this approach: Significant cost containment potential. Negatives: The complexity of implementing these arrangements can be a deterrent.

Policy 2: Smart utilization management

Formulating strong utilization management practices, such as a well-defined prior authorization framework or structured step therapy, is crucial to controlling the high costs associated with GLP-1s.

Due to surging demand for GLP-1s, robust prior authorization frameworks are needed to ensure that coverage is only granted for medically appropriate uses of the drug. After identifying eligible members, drafting comprehensive coverage guidelines will ensure that

these drugs are covered for only those members who qualify. And finally, devising well-defined treatment pathways for members can help reduce costs and manage drug demand.

Treatment pathway examples:

For those with type 2 diabetes. There exist well-established treatment pathways for this patient cohort—typically starting with metformin in the first line before initiating pricier therapies such as GLP-1s or SGLT-2 inhibitors.

For those with a BMI over 40 (or over 35 with at least one comorbidity). Researchers project that expanding coverage for bariatric surgery can save between $1.50 and $4.80 per member per month over the long term, depending on plan design. While undeniably effective, this option is only recommended for a small cohort of members with the highest BMIs.

For all other eligible members. Lifestyle therapy remains the preferred first-line treatment for those living with obesity. Aetna's prior authorization policy for Wegovy, for example, requires eligible members to participate in a comprehensive weight-management program for at least six months before becoming eligible for a GLP-1.

Analyzing where a member is in his or her health journey and identifying which treatment options are appropriate using a stepped, pathway approach will help payers control costs while improving member outcomes and experience.

Policy 3: Innovative care management

Payers should look to innovative care management strategies to deliver on the approaches to utilization management outlined above. We suggest three pathways for managing care for members who struggle to maintain a healthy weight:

1. **Proactive interventions.** Predictive analytics can be used to identify members at risk of developing obesity-related health problems and to stratify them by risk level and projected patient journey. This allows care managers to tailor member-specific treatment paths. Members with cardiovascular issues, in particular, can benefit from proactive interventions that initiate care management before the member becomes eligible for GLP-1 coverage. These interventions can serve to divert patient volume from expensive drug therapies, safeguarding payer dollars while improving long-term member outcomes.
2. **Member education and shared decision-making.** Payers aren't the only ones fazed by the high cost and impact of GLP-1s; members are too. Education on treatment pathways and options can help members better understand their options and encourage shared decision-making. Guiding members through their options can empower them to make the best care decisions for their own health.

3. **Equity and access.** Roughly four out of five Black women in the U.S. live with obesity, underscoring the need for care management frameworks that personalize care, improve access and provide advocacy and support in ways that help address issues of drug access and health equity. Care management can help ensure members from demographic groups at greater risk for obesity-related health issues enjoy the same access to GLP-1s and other weight-management solutions as their more advantaged counterparts.

Looking ahead at the future of GLP-1s

GLP-1s can be genuinely life-changing for those living with obesity and obesity-related health conditions such as diabetes and heart disease. But these drugs' efficacy has now shown promise across a range of comorbidities and diseases unrelated to obesity—everything from reducing the risk of kidney disease-related events and alleviating obstructive sleep apnea to improving cognition and brain shrinkage in patients with Alzheimer's disease and lowering colorectal cancer risk.

Not only are clinical trials demonstrating the benefits of the GLP-1s independent from and in addition to weight loss but drug manufacturers are also creating clinical differentiation across indications—for instance, with semaglutide for cardiovascular benefits and tirzepatide for sleep apnea. If anything, the complexities of the landscape for these drugs are increasing, not decreasing.

Given the volume of new studies and data concerning GLP-1s, health plans must be nimble in crafting their policies for covering this drug class as a step therapy in diabetes, for weight management and as a treatment for obesity-related comorbidities. While some health plans already have adopted an agile approach to utilization and care management, many more will need to build a GLP-1 Center of Excellence to stay in front of evolving trends and continually adapt programs and policies to ensure they are optimally balancing cost with quality of member care and member outcomes.

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