EMPLOYER SNAPSHOT

MBGH
Midwest Business Group on Health

Including Anti-Obesity Non-GLP1 Medications in the Workplace

Obesity Challenge for Employers – Soaring Demand and High Cost

Obesity management presents a complex challenge for employers, who must balance population health goals with rising costs and uncertain outcomes. Some employers chose not to cover anti-obesity medications while others cover non-GLP1s, GLP1s or both. Some organizations have adopted a range of cost-containment strategies to mitigate the high cost of these medications, including strict prior authorization protocols, mandatory weight management program participation and the exploration of alternative drugs therapies and payment models to control costs.

More employers are considering broad coverage approaches that include alternatives to GLP1 weight loss medications for the treatment of obesity. Lower cost alternatives are available and have proven to be successful in supporting diverse patient needs.

Why Employers Should Act

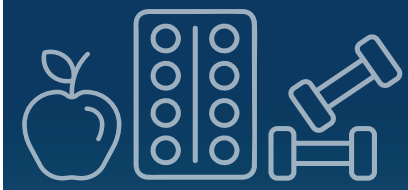
Obesity is classified as a chronic disease and is a risk factor for many other diseases including diabetes, heart disease, stroke and certain cancers. It directly impacts health care costs, absenteeism, presenteeism, and overall workplace wellbeing costing employers $6,472 annually per employee with obesity compared to $1,244 for an employee with overweight. These costs highlight the importance of a robust strategy to help manage costs and mitigate lost worktime.

What Employers Need to Consider

To curb the rising overweight/obesity epidemic, which is projected to impact 78% of the U.S. adult population by 2030, employers should consider a strategy which includes a holistic focus on both prevention and individualized treatment through comprehensive, effective weight management programs and ongoing support.

These efforts include lifestyle interventions like dietitian consultations, gym membership reimbursements, and on-site fitness facilities, as well as medical options such as behavioral therapy, FDA-approved medications, and bariatric surgery. While lifestyle changes typically yield modest results (5–10% weight loss), more intensive treatments offer greater outcomes (10-30%) but at a higher cost—ranging from under $98 to $625 monthly for oral medications and between $349 to $1,350 (before rebates) for injectables, with surgery costing between $17,000 and $30,000.

For individuals with employer-sponsored insurance, a 5% weight loss reduced health care spending by $670 or 8% per person annually.



Treatment guidelines recommend considering anti-obesity medications (AOMs) in combination with lifestyle modification as part of a comprehensive weight management strategy for adults with BMI ≥27 kg/m2 with comorbidities or BMI ≥30 kg/m2 with or without comorbidities.

The Right Medication for the Right Patient at the Right Time

To minimize side effects and increase the likelihood of success, a phenotypes-guided approach can identify the right treatment and medication for the right patient, at the right time. Phenotyping has been associated with 1.75-fold greater weight loss after one year – the proportion of patients who lost more than 10% at one year was 79%, compared with 34% whose treatment was not phenotype guided.

Those not using a phenotype-guided approach may experience negative side effects, abandon treatment, and ultimately, not achieve desired results.

Obesity phenotypes include:

- **Hungry brain** — mainly controlled by the brain-gut axis; abnormal calories needed to reach fullness
  - Oral medications like Qsymia
- **Hungry gut** — abnormally short duration of fullness
  - GLP1s like Saxenda, plus the newer GLP1s like Wegovy, and Zepbound
- **Emotional hunger** — desire to eat to cope with positive or negative emotions
  - Non-GLP1 medication like Contrave
- **Slow burn** — decreased metabolic rate
  - Oral medications, Lomaira and Adipex-P, and resistance training

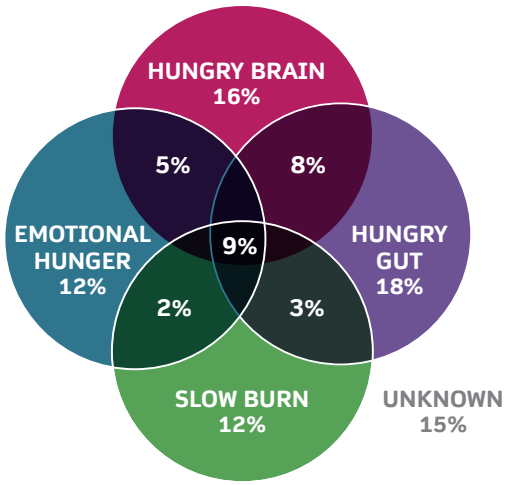
In a Recent Individualized-Approach Study, Patients with Obesity were Split into 4 Distinct Phenotypes

HUNGRY BRAIN	HUNGRY GUT	EMOTIONAL HUNGER	SLOW BURN
Satiation	**Satiety**	**Emotional/reward**	**Energy expenditure**
More calories consumed per meal	Appetite returns more quickly after a meal	Eating to cope with positive or negative emotions	Decreased metabolic rate
40% of Patients	**18%** of Patients	**30%** of Patients	**12%** of Patients
Tx: Qsymia phentermine/topiramate	**Tx:** Saxenda, Wegovy, Zepbound liraglutide	**Tx:** CONTRAVE (naltrexone/bupropion ER)	**Tx:** Lomaira & Adipex-P phentermine and increased resistance training

Adapted from: Reference: 1. Acosta A et al. obesity *(Silver Spring)* 2021:29(4):662-671. DOI:10.1002/OBV 23120

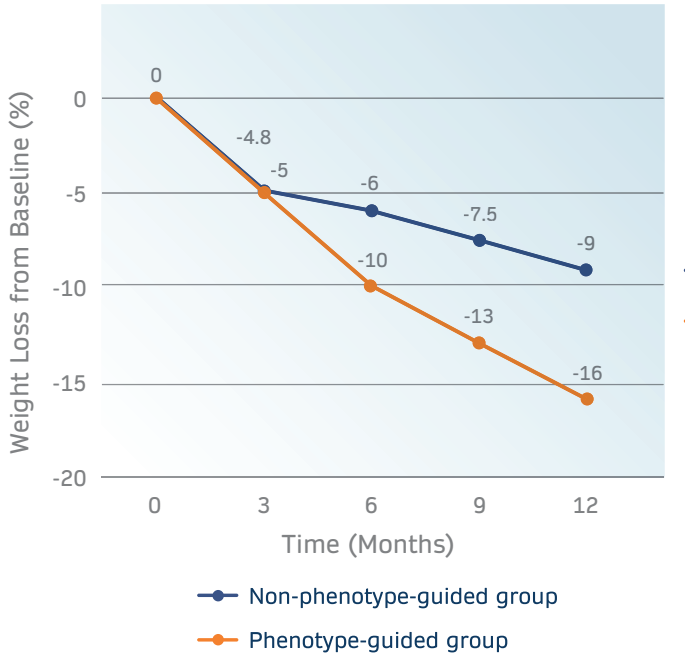
As part of a comprehensive weight management approach, employers can work in collaboration with vendor partners to provide education on obesity phenotypes to help guide conversations between members and health care providers to select the most effective treatment approach.

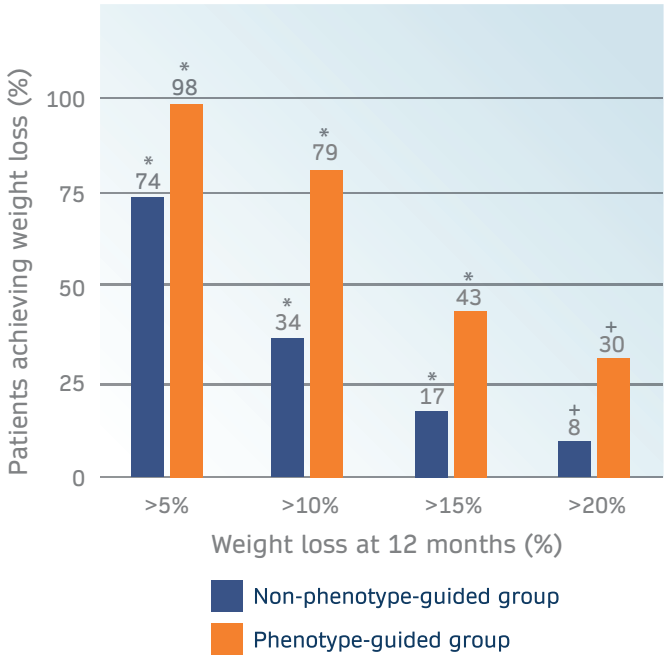
Distribution of Patients with Obestiy (N-450) Based on Pathophysiological Phenotypes



Reference: 1. Acosta A et al. Obesity (Silver Spring). 2021;29(4):662-671. doi:10.1002/oby.2310

The Individualized Treatment Approach Significantly Improved Weight-Loss Outcomes





*P<0.001. and + P<0.01.

Study limitations: Outcomes require replication and validation in larger, more racially and metabolically diverse cohorts, such as multicenter, randomized studies. This outcome with phenotype-guided pharmacotherapy has limitations that deserved further study, including appraising a "testing bias." Participants who underwent additional testing may be conditioned to greater responsiveness based on clinical education and consent, lack of blinded randomization, and potential group-difference confounders, such as age and comorbidities.

Reference: 1. Acosta A et al. Obesity *(Silver Spring)*. 2021;29(4):662-671. doi:10.1002/oby.23120

Non-GLP1s - Making Weight Loss Medications Affordable

While Wegovy and Zepbound are effective in treating certain pathways, these medications may not be the best approach for all patients and also come with a hefty price tag. Non-GLP1 AOMs such as phentermine, Contrave, and Qsymia are therapies designed to aid weight loss through various pathways including appetite suppression, fat absorption reduction, metabolic regulation, and/or brain neurotransmitter modulation. These medications have distinct indications and benefits depending on individual health factors, obesity phenotypes, and weight-loss goals.

Drug manufacturers offer **cash programs and savings coupons** to help patients access medications at reduced out-of-pocket costs, especially when insurance coverage is limited or unavailable.

Formulary Design

If weight loss medications are not included on formulary, employers could be missing an opportunity to provide access to comprehensive weight management solutions. Despite whether employers choose to cover GLP1s, non-GLP1s provide a lower cost alternative. These medications are FDA-approved and have been clinically proven to aid in weight loss. Without coverage, members may turn to compounded medications that are not FDA-approved, and their use falls outside regulatory safeguards—posing potential safety and compliance risks.

What works for one person may not work for another. Some individuals may be unable to tolerate side effects or may prefer an alternative delivery method such as a pill instead of a GLP1 injection. Like management of other chronic diseases, step-therapy and tiering help guide members toward the most effective and cost-efficient treatments.

Utilization Management for AOM Access:

Alternative Approach provided by Dr. Veronica Johnson - Obesity Medicine Specialist, Assistant Professor - Northwestern Medicine

- Member is living with obesity or is overweight with one weight-related condition. For example: Hypertension
  - Provide non-GLP1 AOM without prior authorization as a first-line alternative to GLP1. If unsuccessful,
    - Consider providing GLP1 without prior authorization.

    or
    - Require prior authorization documentation to support contraindications for oral medication or prior use with inadequate weight loss (i.e. < 5-10%) if GLP1 preferred by clinician.
- Member is living with obesity or overweight with a documented history of cardiovascular disease – GLP1 is first line therapy.
- Member is living with obesity with a documented history of moderate to severe Obstructive Sleep Apnea, GLP1 is first line therapy.
- Member is living with Metabolic Dysfunction-Associated Steatohepatitis (MASH) with moderate to advanced liver fibrosis, GLP1 is first line therapy.

Some employers choose not to cover specific non-GLP1s, but instead, cover the generic ingredients used in an FDA approved combination product. For example, employers may cover the generic versions of naltrexone and bupropion as well as phentermine and topiramate, but not the extended-release naltrexone/bupropion combination drug, Contrave or the extended-release phentermine/topiramate, Qsymia.

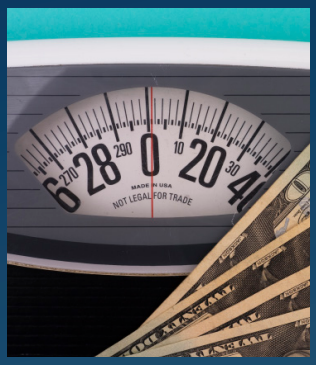
There are no generic or equivalent versions of these medications.

This is not recommended for many reasons, including:

- Individual generics haven't been studied and are not FDA approved for weight loss when used on their own.
- Dosing is not the same for individual generic components and they lack the benefits of the extended-release FDA approved AOMs.

Employer Action Steps

Consider these steps to evaluate your current benefits strategy.



1. Recognize obesity as a chronic disease.
   - Make a conscious effort to approach obesity as a disease and consider treatment options that don't include judgment and bias.
   - Educate leadership to speak of obesity as a chronic disease to foster informed, stigma-free conversations and health benefits and policy decisions.
2. Use data to evaluate the business impact of obesity.
   - Review medical and pharmacy claims to understand the cost of obesity, including co-morbidities associated with the disease.
   - Quantify the impact of disability claims and lost workdays/productivity attributed to the disease.
3. Design medical, pharmacy, and obesity management programs to support members living with obesity.
   - Take a deep dive into current coverage models to fully understand what programs and medications are covered – identify gaps in coverage and potential rebate impact.
   - Understand direct-from-manufacturer cash program offerings and their place in your overall benefits strategy.
   - Implement PAs and step therapy consistent with coverage of other diseases such as cardiovascular and diabetes.
   - Partner with point solution partners, health plans, and TPAs to communicate plan offerings, including educating members on obesity phenotypes and how they can be used to identify the best treatment option.
4. Analyze the outcomes of an obesity management strategy and make revisions.
   - Establish key performance indicators (KPIs) to set clear expectations, measure outcomes, and keep partners accountable.
   - Don't hesitate to make changes to your benefits strategy to best meet the ever-changing needs of your population; keep communications fresh and up-to-date.

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About MBGH

Midwest Business Group on Health (MBGH) is a 501c3 non-profit supporting employers seeking solutions to better manage the high cost of health care and the health and productivity of their covered populations. Founded in 1980, MBGH offers members leading educational programs, employer-directed research projects, purchasing opportunities and community-based activities that increase the value of health care services and the health benefits they offer to members. MBGH serves over 150 companies who provide benefits to over 4 million lives, with employer members spending more than $15 billion on health care each year.

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Conclusion

Employers play a critical role in supporting obesity treatment by recognizing this condition as a chronic disease rather than a lifestyle issue. Obesity care should be readily accessible without unnecessary barriers.

Individuals exhibit diverse genetic, physiological, and behavioral characteristics that influence disease progression and treatment response. To have a successful weight loss strategy, employers are encouraged to recognize these differences and implement a strategy that includes a variety of treatment choices for those with obesity and overweight. Coverage of low-cost, non-GLP1s, in addition to newer medications, is an important component of any weight management strategy that strives to provide a personalized approach with cost-effective outcomes.

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The information provided in this resource is based on the authors' and contributors' experiences working in the health benefits and health care industry. For more information on any aspect of this report, please contact info@mbgh.org.