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Obesity Drugs Will Make Billions. But They Could Break the Healthcare System in the Process.

Story by Josh Nathan-Kazis – September 21, 2023

Novo Nordisk and Eli Lilly are about to start raking in tens of billions of dollars a year on their new obesity drugs, say Wall Street analysts. That's great news for the drugmakers, certainly, but it could be a disaster for the companies and government agencies set to pick up the bill.

The new medicines, known as GLP-1 receptor agonists, promise body weight reductions of as much as 20%, and may cut patients' risk of heart attack or stroke. By all appearances, they're the most effective safe weight-loss drugs in history.

No surprise, then, that the demand for these medicines is huge and projected to get even larger as more supply comes on-line and more GLP-1s win Food and Drug Administration approval for weight loss.

But what has gotten less attention is the healthcare crisis that could come as spending on the drugs threatens to overwhelm the insurers, employers, and government programs that buy the country's medicines. The financial crunch would probably peak from 2025, when Medicare coverage of the medicines might begin, to 2027, when the cost of some of the drugs could start to drop.

The strain of paying for these drugs on a massive scale could set off a cascade of secondary effects: reduced benefits for Medicare prescription drug plans, pressure on state Medicaid budgets, a growing burden for taxpayers, and higher premiums for employers and workers who pay for commercial plans.

At its heart, the challenge posed by the drugs comes down to a combination of two factors. One, the sheer number of people who might benefit from them; more than 40% of U.S. adults are obese, up from 30% two decades ago. Two, these are expensive medicines: Novo's (ticker: NVO) Wegovy has a list price of more than $16,000 a year.

That means a potentially monumental tab for insurers: By 2030, J.P. Morgan analysts expect the amount spent on GLP-1 obesity treatments in the U.S. to be about $50 billion, or a tenth of the $421 billion spent on outpatient drugs in the U.S. in 2021.

Of course, curbing obesity would have the potential to save the healthcare system a lot of money. A recent USC Schaeffer paper argued that Medicare coverage of obesity medicines would save the program more than $700 billion over 30 years. But those savings, if they do materialize, won't do much to mitigate the shorter-term crisis.

"Health plans will be under extraordinary pressure from patients to cover these drugs," says Robin Feldman, a professor at University of California Law San Francisco, who has written extensively on drug pricing. "It will be hard to say no. But nobody can afford these prices long term across this large population."

Already, the new crop of GLP-1 drugs is increasingly available to treat Type 2 diabetes, which is having its own financial impact on payors. But access to the medicines for patients who don't have the disease remains limited. So far, only one, Wegovy, is approved by the FDA as an obesity treatment. (Novo's older GLP-1, Saxenda, is also approved, but less effective.) As more of the drugs come on-line—Lilly's (LLY) version, which has produced even more significant weight loss in clinical trials, is expected to receive FDA approval this year—the combined cost of paying for both diabetes and weight-loss treatment will certainly strain, and could even break, pieces of America's already groaning healthcare system.

Here's how the crisis could come for the three major categories of prescription drug payers—and for the patients whose taxes and salaries fund the system, and who rely on it for their care.

Medicare's prescription drug benefit, Medicare Part D, covers roughly 50 million older Americans. It is currently legally barred from paying for weight-loss drugs, under the theory that obesity is the result of lifestyle choices, rather than a medical condition. Whether that will change is perhaps the biggest question hanging over the future of the new obesity drugs.

The ban has existed since the creation of Medicare Part D in the early 2000s. Novo's announcement in August that Wegovy had not just helped patients lose weight, but also reduced their risk of heart attack or stroke, raised hopes that the larger health benefits might motivate Congress to expand coverage.

If that happens, the cost burden will be enormous. A paper in the New England Journal of Medicine estimated that if just 10% of Medicare participants with obesity took the medicine, it would cost $26.8 billion a year—roughly equivalent to 20% of all of Part D's spending in 2021.

Medicare has weathered similar shocks before. In 2013, Gilead Sciences (GILD) launched a hepatitis C antiviral that cost $84,000 per treatment course. The drug drove Part D's average spending per beneficiary up 8.6% in 2014, after it climbed just 1.9% in 2013. The next year, it rose another 8.3%. And

even so, patients paid a big chunk of the bill: According to one academic study, a full course of one of the new hepatitis C antivirals cost Medicare patients as much as $10,800 out of pocket in 2015.

The hepatitis C crisis resolved over time, as competition eventually reduced the cost of the drug. Ultimately, the same should happen with weight-loss drugs, though that will do little to curb the immediate funding challenges. The first real opportunity to bring down expenses will come in 2027, when the new law allowing Medicare to negotiate drug prices would apply to Wegovy (assuming the pharma industry fails in its legal efforts to derail the negotiation program).

But there are fresh wrinkles this time around. Legislation passed last year caps patients' out-of-pocket spending on Part D drugs at $2,000 a year beginning in 2025 and limits annual premium increases to 6%. That leaves the commercial plans that offer the Part D benefit with limited tools to mitigate costs.

Many Part D plans now offer enhanced coverage, which goes beyond the required minimums. If costs of the obesity drugs grow significantly, insurers may compensate by cutting the benefits of those plans. "That just means that costs are shifted more onto enrollees," says Juliette Cubanski, a Medicare expert at the health policy research group KFF.

Experts say it's far from certain that Congress will allow Medicare to pay for obesity medicines. Legislators would probably need to find enormous cost offsets to fund it. And a consensus on whether obesity should be viewed as a medical condition that taxpayers should pay to treat might also be hard to reach.

Still, problems in Congress might not forestall Medicare coverage of the drugs. Lilly is running a trial of its GLP-1 obesity drug as a treatment for sleep apnea, which affects roughly 20% of adults. That study is expected to produce data next year; if its results are positive, FDA approval in that indication could open a backdoor that would allow Medicare coverage for patients without diabetes, perhaps as soon as 2025. (Medicare spent $2.6 billion on Ozempic, a version of Wegovy used to treat Type 2 diabetes, in 2021.)

In a statement, Novo said that spending on obesity drugs saves money over the long term. "Clearly, inaction in addressing the serious chronic disease of obesity, including inaccessibility to available treatment options, is a major cost driver in our economy," the company said. "In contrast, the cost of treating obesity is significantly lower."

About 87 million Americans—roughly a quarter of the population—get their insurance coverage through Medicaid. In contrast to Medicare, state Medicaid programs, which use state and federal funds to pay for the care of low-income people, are allowed to cover obesity drugs.

Medicaid plans receive big rebates from drugmakers, and in return are generally required to cover all FDA-approved medicines. Weight-loss drugs are exempt from that requirement, however, and only a few states have chosen to pay for Wegovy. Still, spending on the new GLP-1 drugs is growing: According to a September KFF report, Medicaid spending on the four approved versions from Novo and Lilly—Wegovy for weight loss and the others for diabetes—surged from $547 million in 2021 to $1.1 billion in 2022. (Medicaid spent a total of about $80.6 billion on outpatient prescription drugs in 2021.)

As with Medicare, an approval of the Lilly drug for sleep apnea would force coverage. States might try to limit access by setting strict eligibility requirements, though that could open them to legal challenges. Here, too, the hepatitis C precedent is instructive: Many state Medicaid programs initially sought to limit use of the new hepatitis C medicines to patients who were extremely sick with the disease, but those limits were broadly rejected by the courts.

For the employer-based insurance market, the new obesity medicines are already exacerbating the perennial tension between offering competitive benefits and keeping premiums affordable for employers and individuals.

“You’ve got midsize employers, smaller employers, and even some of the larger ones looking to say, how are they going to afford these medications?” says Tracy Spencer, national pharmacy practice leader at Aon, which advises employers on benefits.

Some insurers have already sought to crack down on so-called off-label use of the new GLP-1 drugs, where the medicines are prescribed as weight-loss treatments for patients without diabetes, a practice that is legal but could violate plan policies.

Unlike the government programs, private insurers have vast leeway to decide which medicines they will and won’t pay for. The problem for insurers is that just saying no to paying for the obesity drugs might not be tenable. These drugs aren’t just any medicines; they’re cultural phenomena, already backed by omnipresent advertising campaigns.

“The drugs are new, they’re marketed heavily, they’re marketed in a way that is going to be difficult to tell people, ‘Look, it’s a safe and effective drug, it works really well, but we don’t want you to have it

because it's too expensive,'" says John Jones, a former managed-care executive now on the faculty of the University of California Irvine School of Pharmacy and Pharmaceutical Sciences.

The drugmakers, for their part, say coverage needs to expand. Lilly declined to comment on the cost of its obesity medicine, which does not yet have FDA approval. "Many barriers in the healthcare system affect people living with this disease and their ability to access evidence-based treatment plans," the company said.

A guide from Aon for insurers looking to manage GLP-1 obesity drugs provides a window into how the industry will seek to keep costs down. Aon suggests that insurers require patients who receive GLP-1 drugs for obesity to first spend three months complying with a diet and exercise program. It also recommends that only certain doctors be allowed to prescribe the drugs, and that insurers require documentation of an eligible body-mass index and previous weight reduction efforts as a condition of authorization.

A spokesperson for Cigna Group (CI), which owns a health insurer and a major pharmacy benefit manager, or PBM, said that plan sponsors are "rightfully cautious about covering new medications without robust clinical evidence," citing a "long, complicated history" with weight-loss drugs. In a separate statement, a spokesperson for CVS Caremark, CVS Health's (CVS) PBM, said it was working with its customers to help manage costs. "We offer a variety of options for our customers who choose to include these drugs in their benefit plan with the goal of ensuring that coverage of these products is clinically appropriate and cost-effective," Caremark said.

Insurers will do what they can to manage costs, but success is not guaranteed. "It's entirely possible the premiums will rise considerably for everyone, if no solution is found for a deal on pricing," says Feldman of UC Law SF.

For Medicare, Medicaid, commercial plans, and the patients they cover, the long-term benefits of the obesity drugs might eventually balance out the costs. But until that tipping point comes, there will be only so many sandbags that can be thrown in the way of the tidal wave of demand.

Write to Josh Nathan-Kazis at josh.nathan-kazis@barrons.com