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The Health Wonk Shop: New Weight Loss Drugs Raise Issues of Coverage, Cost, Access and Equity

Larry Levitt: Hello, I'm **Larry Levitt** from KFF. Welcome to the latest episode of the Health Wonk Shop. Roughly once a month we dive into timely and complex health policy topics with experts from a variety of perspectives.

Today we're discussing drugs that have shown promise in helping people to lose weight. The need here is great. About one third of adults are obese, including 5% who have severe obesity. This has implications for people's health and for health spending.

While take up of these medications is relatively modest for now, the potential demand is large. A new poll out today from KFF finds that almost half of the public would be interested in taking a prescription weight loss drug. But interest waned significantly If people hear they might gain weight back if they stopped taking the drug, and also if their insurance didn't cover it. Insurance coverage is the fundamental point of contention right now.

These drugs are expensive at over $1000 per month, so out of reach for most people to pay out of their own pockets. At the same time, that price tag and the number of potential patients is what worries insurers, employers, and state and federal health programs.

We're joined today by three experts who come at this issue from different angles. Juliette Cubanski is Deputy Director of KFF's Medicare Policy Program and an expert on Medicare drug coverage. **Shauna Levy** is an Assistant Professor of Surgery at Tulane's Medical School and Director of Bariatric Surgery and Medical Weight Loss. And Michael Manolakis is Doctor of Pharmacy and Senior Vice President at the consulting firm Aon.

If you have questions, submit them at any time through the Q and A button in Zoom, and we'll get to as many of them as we can. Also note that this session is being recorded and an archive version should be available later today.

Shauna Levy, let me start with you. What are these new or newest drugs? And how effective are they at treating obesity? From a clinical perspective, to what

extent do they replace or compliment the current standard of care today for treating obesity?

Shauna Levy: Right. Yeah, good morning, afternoon, I guess depending on where you are, to everyone. Thank you so much for having me here. I'm excited to have this conversation.

You say new medicine, but one thing that we need to remember is this GLP-1 receptor agonist class of medicine has been around since the early 2000s. The current iteration, that's the once weekly, the best version, has of course been around only for the last few years. But again, this category of medication's been around for at least 20 years.

And I say that because a lot of people think that there's not a lot of data, but we do have a lot of data when it comes to this medicine. The most recent iteration when it comes to weight loss is known as Wegovy. And this medication is incredibly successful at leading to weight loss, with nearly 90% of patients losing at least 5% of their total body weight over the course of just over a year.

It's really a game changer in terms of obesity medicine because prior to this medicine being available for the indication of obesity only, there was really only stimulants to go. The main medication that were in use were stimulants and led to a lot of side effects and a lot lower of weight loss.

These category of medication, it basically tricks your body into feeling fullness when you're naturally feeling hungry, which allows you to eat in calorie deficit, which ultimately leads to weight loss. They're very safe and like I said, have over 20 years of data in this category of medication, which allows them to be used by almost everyone. The main side effect is nausea and vomiting. But in the studies, a very small percentage of patients actually had to stop taking these medicines because of side effects, which allows them to be even more successful.

When it comes to standard of care that you mentioned, I think it depends on what degree of disease somebody has, as to what their actual standard of care of treatment is, whether that be medicine or surgery. I mean, certainly it's disrupted the whole game when it comes to obesity medicine.

And then the medications that are coming in the future are coming up against surgery. So I think it's going to be changing that game as well. So a lot to look forward to. It's a very exciting time to be in obesity and the game is certainly being changed.

Larry Levitt: That's great. And when you say coming up surgery, you mean as surgery at reducing?

Shauna Levy: Yeah.

Larry Levitt: Yeah. Reducing.

Shauna Levy: So the best medications that are coming in the near future, they're reporting like 25, 26% total body weight loss. And that's very competitive with what a sleeve gastrectomy might lead to, even gastro bypass in certain patients for terms of weight loss. So it's interesting.

Larry Levitt: And, Michael Manolakis, let me turn to you. So as Shauna said, these drugs are effective, they are also pricey, and there's a large potential market for them given the prevalence of obesity. That is certainly worrying employers from a cost perspective. To what extent are employers covering, Wegovy in particular, for weight loss? And what kind of restrictions are employers putting on this in terms of BMI levels or prior condition, or other related health conditions?

Michael Manolakis: Sure. Thank you, Larry. And again, thank you for having me. It's a pleasure to be here today. Yeah, I think it's important to understand that at Aon, first things first, we do look at this as a disease. And so that recognition is first and foremost. When we're having our conversations with our clients, we begin with that discussion.

There was a time many, many years ago, and to some extent to the not too recent past, where this was considered to be lifestyle. And we are well past that and that's how we frame our conversations with our clients. When we do go into those conversations, it's roughly a 50/50. Split and those numbers are going to vary a little bit. And if you read in the literature, you might see it move a little bit to who actually is covering the weight loss drugs now and who's not? For many of those clients who are, they've been covering them for decades.

Dr. Levy mentioned the stimulant category or the stimulant drugs. These drugs have been around for a very long time. They were around when I was in pharmacy school, but they just didn't have that effectiveness profile and safety profile that we see today. But they were covered and they cost maybe a penny per member per month. They really didn't raise up to anybody's level on their own radar screens. But now that's changed. So they're asking the question, "What do we do?"

The other group is saying they're feeling pressure, they're reading the literature. They see social media, they understand it's a disease state, and they're saying the same question, "What do we do?" So folks on both sides of the ledger where they cover or don't cover, are asking a similar set of questions about, "How do I manage?"

And then to your second question about what's kind of happening right now? These drugs are on formulary, and so it's a prior authorization approach when we're looking at weight loss. The major PBMs and the carriers at this point are using the FDA labeled indication. So they're not diverging from that, which allows them then to get rebates on the backside. That additional discount that can happen for pricing purposes for those employers or health plans that work with that PBM or carrier.

But to date, they're following the FDA guideline. Now the thing that they're thinking about is what is it that I do with that piece of the FDA label that says an adjunct? It says the drug should be used as an adjunct too. And then it talks about, essentially my own words here, lifestyle modification, behavioral modification, sort of read as diet and exercise. What is that adjunct piece?

And that's what the market is really focusing on right now. The employer market is saying, "How do I do that? What do I do?" And we see point solutions popping up. We see solutions being built out at the PBMs right now to try to get at that element that allows the person who takes the drug to achieve a sustained weight loss through time. Perhaps if they can, get off the drug if that's possible. But that we don't get that rebound of when they stop, they add the weight back immediately, which we know will happen, and that's documented.

So it's really that third element, or excuse me, that adjunct element that is being looked at right now.

Larry Levitt: And, Michael, when you said employers, when they do cover it, are following the FDA label, what is that label for Wegovy? What are the indications?

Michael Manolakis: Sure. So you've got an age requirement, but then most importantly it's BMI measure. And so if you're 27, so 29.9, it's that BMI in a comorbid condition. In other words, you're at that BMI and maybe have hypertension, or maybe have high cholesterol, or maybe you have diabetes.

And then above 30, the BMI of 30, then you're just considered in that obese category and there doesn't need to be another comorbid condition. Those are essentially the criteria. And then it gets a little bit more granular with what

happens after the trial and those sorts of things, but that's basically our access point.

Larry Levitt: Got it. And, Juliette, let me bring you in. Some of these same cost issues that employers are grappling with are playing out in Medicare as well, but there's a wrinkle there. Medicare is prohibited by law from covering weight loss drugs. Describe where does that prohibition come from? And what are some of the current proposals in Congress to change it?

Juliette Cubanski: Yeah, so the prohibition against Medicare covering drugs used for weight loss dates back to 2003 when Congress created the Part D program, which is Medicare's outpatient prescription drug benefit. Congress specifically prohibited coverage of drugs used for weight loss, weight gain, and other so-called lifestyle medications, like drugs to grow hair or for erectile dysfunction.

The prohibition, I think, was meant to preclude coverage of these so-called lifestyle medications. And I think the perception at the time was that weight loss merely conferred cosmetic benefits and obesity wasn't recognized as a disease, but more sort of a behavioral condition.

And at the time, there were also, I think, legitimate concerns about the safety and effectiveness of the existing generation of weight loss products that had been approved by the FDA, but then ended up producing some serious side effects in people who use those medications. So 20 years later, that's where we stand with Medicare coverage with the statutory prohibition.

Sorry. And then to your question about proposals to expand coverage, there has been legislation introduced in the current session of Congress. And that legislation would authorize Part D to cover weight loss drugs for people with obesity, as well as for people who are overweight who also have one or more comorbidities. That legislation has languished in Congress for perhaps a number of reasons, but I think one of which is this issue of the potential cost impact of expanding Medicare coverage.

Larry Levitt: And give us a sense of what that cost impact could be kind of range? What are the ranges of potential costs here?

Juliette Cubanski: Yeah, so let's take a relatively conservative estimate of the prevalence rate of obesity in the Medicare population, which is 20%. And that's based on actual diagnosis of obesity in Medicare claims. If you assume 20%, or sorry, 10% of people use semaglutide, which is the drug in Wegovy, that could translate to annual Medicare spending of about $13 billion a year.

If you take a higher prevalence rate based on CDC's numbers of around 40% of people, older adults with obesity, that's $27 billion in Medicare spending annually. So multiply that times 10 for a 10-year estimate, we're talking about well over 100, maybe over $200 billion in added costs over a 10-year period.

Just to put that in context, right now, annual part D spending is running around $100 billion a year. So coverage of this medication based on even a small share of those who might potentially be eligible to take these drugs, would translate into substantially higher Medicare spending.

Larry Levitt: So we've been talking a lot about the cost, it's natural when we talk about healthcare, but people's health is important as well. Shauna, I mean, what are some of the downstream health benefits from reducing obesity? And how did this play out over the course of a patient's life?

Shauna Levy: Yeah, it's all I could think about actually when Juliette was talking because that math confuses me. So obviously we know, and I think I should have said this before, and I don't think I was clear about it, that this category of medicine, GLP-1 receptor agonists, were first developed and designed for people with diabetes. So it's also a treatment for diabetes.

And then it was found sort of by accident that it also led to weight loss, which is ultimately why this category of medication is now approved for weight loss. So we know not only does it treat obesity, but also treats diabetes. And it is extremely effective in terms of diabetes. So people who are taking multiple medications for diabetes are able to take this single class of medicine like either Wegovy, which is again FDA approved for weight loss. Or Mounjaro, which right now is only approved for diabetes, but we know is imminent, Tirzepatide also known as, for obesity.

But also it's the improvement in blood pressure, heart disease, fatty liver disease. I mean, honestly, it seems like, and we'll ultimately find out that sleep apnea, all the categories of comorbidities that are weight related, will ultimately be improved by this medicine.

So when I hear the math of what Medicare considers the expenditures, I don't understand why they don't subtract any of the cost savings that occur with this category of medication. And then when you think about people with diabetes who have Medicare, which is a substantial portion of the people with obesity, they may already be taking GLP-1.

So it doesn't seem fair to only consider people with obesity without subtracting people who already have diabetes. And also the health benefits and the cost savings that occur with these medicines.

I think it takes about two years, which I guess for employers or Medicare might seem like a long time, but only two years before you start seeing cost savings in terms of prescriptions cost savings and health benefits associated with this medicine. So there's a lot to consider for sure.

Larry Levitt: So, Michael, in your conversations with employers, how do these potential downstream savings figure into the calculation? There's turnover in workforces. So an employer may not have the same worker five years from now or even two years from now that they have to today. Employers tend to have a shorter term outlook on their costs. How do these conversations go?

Michael Manolakis: They're important, and they're something that we bring into to discussion with them. The challenge is the timing. We're looking at, if you look at one of the cost models for our ROI models that Novo Nordisk produce, that is looking at five and 10 year increments for those long-term medical outcomes.

And when you start to talk to an employer who's working on an annual budget about an outcome that they might not see for five years, that's just doesn't mix at that particular point in time. So it's a struggle point, it's a point of tension. And it really becomes a question about how much am I investing? And am I taking this very long-term look at outcomes? But it is part of the discussion.

And just to pick up on some of the things that have been talked about so far and insert another little fact element in here. Because first, one of the first interesting studies that came out of Prime Therapeutics recently released talked about adherence and persistence with therapy at a year. And it's 68% of folks had dropped off their treatment.

So we don't know if that was related to cost or side effects or just doing an injection or what. That's not in the data. But it's just interesting that it's like, "Well, are people even going to stay on this drug?" So it just raises a piece of worry for a payer. It's like, "Am I paying for something that people are really going to use and get that benefit over the long haul?"

So lots of different parts and pieces floating around with this conversation. But medical benefits are thought about. There's just not nothing at this point in time in a real world space to give evidence for that.

Larry Levitt: Shauna, let me, I mean in your practice and in your work with patients, have you seen this adherence issue? And any sense of when patients do stop taking the drug, why that is? Is it cost? Is it ineffectiveness? Is it the fact that it is an injection?

Shauna Levy: Cost is definitely the number one issue. There was that Mounjaro savings card that a lot of people got on, and lost tremendous amount of weight, but it only lasted one year. And so that coupon card, saving card is expiring in the last few months. And nearly every single person that got access through that card that no longer has access, had to stop because of cost.

I mean, they were very pleased with their outcomes. They were very pleased with their weight loss. A very small fraction of our patients have to stop because of side effects. I've definitely seen patients in my clinic that have seen other providers that were started on the wrong dosing, or taking compounded products, which I recognize is outside of what we're talking about, and had more severe side effects and had to stop because of that.

But when patients are up dosed appropriately, their side effect profile seems to be very low and does not lead to having to stop. But cost, an employer stopping coverage or losing access because of job change or something, seems to be a major issue.

Larry Levitt: Juliette, let me bring you in. And I want to bring some audience questions in because we have an enormous number of them. So one was about this question of Medicare coverage and the pricing. So last year the Inflation Reduction Act passed, which gave Medicare authority to negotiate prices for some drugs. If Medicare were to start covering Wegovy, would the Federal Government be able to negotiate the price?

Juliette Cubanski: Yes. The original FDA approval for semaglutide was in 2017. Medicare's new drug price negotiation authority allows the Federal Government to negotiate drug prices after drugs have been on the market for seven years, these small molecule drugs. So if Medicare coverage of anti-obesity medications were to be allowed, the negotiation program could apply to semaglutide as early as 2027.

Analysis that we conducted recently showed that Ozempic, the drug semaglutide that's been approved for diabetes, was actually the number 10 drug of Medicare's top 10 highest spending drugs in 2021. So that was before the latest discussions and sort of frenzy about these drugs for weight loss purposes. So I would expect if Medicare's coverage expanded, that ozempic would be subject to negotiation in the very near future.

Larry Levitt: And those prescriptions you're saying in Medicare are presumably for diabetes? Because there is the-

Juliette Cubanski: Right, exactly. That's exactly right. So it's not even in the context of using that medication off-label for weight loss purposes.

Larry Levitt: And we had another question about the Congressional proposals to allow for Medicare coverage and what types of indication or restrictions they have. Do these proposals set an eligibility, a BMI level, under which people would be able to get Wegovy or other drugs?

Juliette Cubanski: The legislation refers to allowing coverage of these drugs for people with obesity, which is statutorily defined as BMI of 30 or greater. In addition to weight loss management for overweight people who have one or more comorbidities, and overweight is defined statutorily as BMI of 25 to 30. So there is some criteria that would limit use to those specific populations.

Larry Levitt: We also had several questions about how we think about effectiveness here. And we talked about 5% weight loss, potentially much higher weight loss under newer medications coming to market. And a question about, is 5% a lot? Is it not a lot? How do we think about that? Shauna, from a clinical perspective, is 5% weight loss significant from a medical standpoint?

Shauna Levy: 5% is significant in terms of leading to health benefits. We know that you can have reduction in blood pressure, improvement in your heart disease. Most people that I see are seeking more than 5%. And the figure that's impressive about these medications is not necessarily that it's only 5%, but the percentage of patients that were able to achieve 5%, like nearly 90%.

And even the Lilly data, I think that just came out for their impending, the triple agonist medication, which is another iteration of weight loss medication that is probably to release in the next five years of the Retatrutide. 100% of their participants were able to lose 5%. So it's just the thing about the 5% is how impressive it is that so many. With diet exercise, a very small fraction of patients are able to lose and maintain 5% total body weight loss. So that's what impressive about that.

But of course the average total body weight loss for Wegovy is 15%, which is much more desirable and much more impressive. It's way better than phentermine, which is adipex of the yesteryear. I mean, which still exists of course, but not used as frequently, was more like 7%. So 15% is really doubling what we've seen in the past.

Even Saxenda is somewhere between seven and 9% on average. So 15% is much better. But like I said, the Tirzepatide and the Retatrutide is looking at the 20 plus percentage of people with obesity without diabetes. So there's a lot, and a lot more to come, I think even still.

Larry Levitt: And you had talked about these drugs as a game changer, and potentially in the future comparable to bariatric surgery. We had a question about what effect these drugs are now having on demand for bariatric surgery? I mean, are more of your patients on a drug only or drug plus behavior change regimen, versus bariatric surgery compared to several years ago?

Shauna Levy: Yeah, well, certainly I'm seeing a lot more patients on obesity medicine because of Wegovy, no question. I do live in Louisiana, which is a very poor access to care state. So not a lot of people have access to Wegovy. So I don't think it's impacted our surgical volume in that sense.

But broadly speaking, we're hearing from my colleagues across the country, and certainly there's been a dip I think in access or in surgical volume. I ultimately think this is going to lead to an increase in surgical volume. It may be my lens, it may be my bias, but I think that using obesity medicine is a gateway to treatment for obesity that's more than diet and exercise.

And I think people are becoming interested in losing weight and seeing what it can do for them and having this realization that it's not a willpower issue or it's so much more than that. With these medications it's an introduction and then it may ultimately lead to surgery.

From a cost-effectiveness standpoint, we know that surgery is much more cost-effective than a lifetime of medication. So it'll be interesting to see how this plays out. I mean, when we think about cost-effectiveness, crazy idea, but then why isn't surgery required as a first step?

I don't think that's what people are playing around with. I don't think that's what people are saying, but from a purely cost-effectiveness standpoint, it makes much more sense.

Michael Manolakis: Larry, if I may.

Shauna Levy: Yeah, please.

Michael Manolakis: Pick up on that idea of the will surgery increase? It's interesting because employers, one of the things that we're talking about in our conversations is

what's the end point? Should I cover this for one year, two years, three years? When does this stop?

And the question, and we don't really have a clear answer on that yet, is well, what does stop look like? Is there going to be a subset, a cohort of the folks using these drugs that it should be bariatric surgery? Or perhaps there's a group that can just get off the drugs and because they've done lifestyle modifications, they can end the drug therapy and live without the drug. And just now they think about food and they think about exercise differently. And then is there a group that's going to just have to persist on the drugs through time?

But we're actually having the conversation about is bariatric surgery sort of part of that endpoint? Which kind of picks up on Dr. Levy's comment that bariatric surgery could increase in the out years. And it's certainly going to be, it's part of the discussion that we're having as a result of this drug. Will that contribute to that increase? I don't know. But it's part of the conversation. And what weren't talking about that from the pharmacy benefit side six months ago, we're talking about that now.

Larry Levitt: And there are other medications that people effectively do take for life, of statins for cholesterol or HIV medications. The prices of those have come down quite a bit over time, particularly as they go generic.

On the pricing of Wegovy, let's say. I mean, are you seeing rebates from Novo Nordisk on this? I won't ask you to disclose proprietary information, but are these drugs getting discounts or rebates? And as the newer drugs come onto the market, how do you expect that to play out?

Michael Manolakis: There certainly are, well, in an insured world, a self-insured employer is going to receive discounts from their PBM off of an AWP discount as an example, and they're going to be a rebate discount that's also going to be applied. The question will be, when we get more competition in the market, what does that begin to look like?

And do we actually get more discounting through rebates in that scenario, when there's more competition on the market? Do they begin to feel some price pressure? Or because the new drugs that are coming out are different than the older drugs and they're more effective than the older drugs, does that get neutralized going forward?

We're not going to see generic entities for the injectable semaglutide out until in the 2030s, early 2030s. So cost relief is going to come through competition in the anticipated, in the near future, but we'll have to see what that looks like.

There's a many chapters to be told on the economics of these drugs going into 2024 and 2025 because the pipeline is very deep with new products. In both in phase three trials, which as you know, are close to market. Phase two trials, it's very deep. In phase one trials, which of course, not all those products ever make it out of phase one. They're just testing things.

But it's incredibly deep and they're starting with different, blending different products together, different chemical entities. So there's a lot to happen yet. And we're going to be talking, we'll have the repeat of this webinar in a year, and we'll probably talk about very different things in a year.

Juliette Cubanski: Larry, I'm sorry to interrupt. Can I pick up on this question in the context of Medicare coverage? Because I think, well, when I was talking earlier about a $13 billion additional spending or $27 billion additional spending, that's sort of just price times quantity. Which is far more simplistic than the approach that the Congressional Budget Office would need to take in estimating the cost of legislation to authorize Medicare coverage of obesity medications.

And for Medicare's purposes and the purposes of Congress that pushing this legislation forward, the Congressional Budget Office's estimation, I think is what matters the most. And how many beneficiaries would use these drugs? How much weight would they lose? How long would they be taking these medications? And then I think critically, how would that weight loss affect their future healthcare spending?

The CBO would need to make assessments on all of these questions in developing a cost estimate. And I think frankly faces challenges in doing so, since it seems that even if there is a body of evidence, it may be more limited in the context of how weight loss among older adults would affect their future healthcare spending, and therefore Medicare spending and the federal budget.

The gold standard, I think from CBO's perspective is evidence from randomized control trials. Despite what we've seen in terms of some of the micro simulation models that have come out showing really large cost offsets to Medicare. With all due respect to those micro simulation models, I think CBO's standard may be set a little bit higher in terms of the evidence that would be most helpful in evaluating the cost to Medicare of expanding coverage of these medications.

Larry Levitt: And I think one of the challenges here for advocates of Medicare coverage, is that CBO, the price versus quantity calculation you talked about. The cost side is somewhat easier to quantify than the downstream savings side. So CBO may put more weight on those costs than on the potential savings, at least based on current evidence.

Juliette Cubanski: Right. And in the short term, I think we know there would be added costs to Medicare. And the real question, the important question that I think everybody wants the answer to, is what are the long-term benefits and costs associated with these drugs in the Medicare population?

Larry Levitt: Juliette, let me stay with you. We also had a question about short of Congressional action to cover weight loss drugs, are there any administrative mechanisms available to CMS to provide this coverage? I mean, are there conceivable pilots or demonstrations that could be used?

Juliette Cubanski: Yeah, so conceivably the administrative pathway of a demonstration program, or a model run through the Center for Medicare and Medicaid Innovation or the Innovation Center. A model could be designed that maybe limited coverage of obesity medications to older patients who had clinical evidence of obesity or serious obesity related conditions.

I think it would take some time to stand up a model through the Innovation Center. And I think there are also important questions related to the statutory goal of the Innovation Center is to either reduce program spending without affecting the quality of care. Or improve the quality of care without increasing spending. And so checking those boxes in terms of the spending impact could be a challenge in pursuing coverage through a demonstration, but it is a potential pathway.

Larry Levitt: And, Shauna, you mentioned earlier being in Louisiana, I think what you called a low access state. Also a state with a high prevalence of obesity. Obesity rates are higher for people of color, particularly Black and Hispanic adults. How do you think about equity with respect to treatment of obesity? And in particular these new drugs?

Shauna Levy: I don't know exactly what you're asking me. I mean, I think that obesity discrimination feels alive and well in terms of getting patients access to care. I mean, luckily Medicaid covers surgery, so there is some treatment available for patients, but it just feels like we have to wait for patient's disease to get more progressed before we can treat disease.

We can't practice preventative meds in our early intervention, particularly patients. But actually Medicaid offers more access than some people in our state who one of the most popular insurance companies is the Blue Cross Blue Shield Louisiana, which offers no treatment. So there's a lot. I'm not sure if I'm answering your question exactly.

Larry Levitt: That's helpful. I mean you talked about the cost challenges earlier. If someone changes jobs or their insurer stops covering it. In treating a new patient, how do those conversations go? I mean, do you talk about insurance coverage? Are you working with patients trying to help them?

Shauna Levy: Yeah, I mean, I've been asked before what the hardest aspects of treating obesity? And for me it's that I can't just be a doctor. I can't walk in, talk to a patient, see what the best treatment option is for them, and go for it. I have to first, before I even walk in the door, look what their access is.

We have to have a person that's specifically employed in our clinic to call the insurance company on every single patient to find out what is their medicine coverage? And what is their surgical coverage? Because it varies by employer and it varies by what type of insurance they have. And it's not like other things that are just covered and it's so variable. It's so hard for us to keep track of what are their requirements.

It's a real burden for our clinic, which is I think why a lot of people don't even practice obesity medicine because it's just too much work for a general primary care physician. They don't have that type of coverage. So when I walk in and a patient's like, "Oh, I'm here for the shots." And I'm like, "Sorry, you don't have coverage for that, but you have coverage for surgery." And they're like, "No, thank you."

I mean, some people are open to it, but I can't just either give them what they want or give them what they need. I have to give them what they have access to and that's tough.

Larry Levitt: And, Michael, I assume you have clients all over the country. I mean, there's certainly regional differences in the prevalence of obesity. Are there regional differences in how employers or insurers are approaching this?

Michael Manolakis: Not that I can nail down to a regional factor. They are, as we talked about earlier, all my clients and all our clients, are thinking about this issue. And again, whether you're on the we're currently covering it or we're thinking about covering it side of the ledger, they're thinking about it.

But when you get into that equity issue, we start to think about it as an issue of fairness. How are individuals going to be treated fairly? And it comes to a threshold question is we're going to consider this a disease, it's going to be covered under the benefit. That's a fair approach. We're not ruling you out because you have this disease, you're not included under the benefit.

And those are some of the tough decisions at just that initial threshold about how are we going to pay? It gets to how are we going to pay for it? It gets to the Medicare challenge, how is Medicare going to pay for it? But once we start to drill into the details, then it becomes very nuanced questions.

And I'll give you one example. If you're to bring a point solution in, let's say, and that point solution says, "We're going to manage member enrollment and we're going to manage member engagement. And we want them to be engaged in the program to assure that coverage under the plan continues." I think that's a fair trade. If the company's going to invest in you, and they're going to invest in a point solution to come in and help manage it, then I think it's fair to say that you're going to engage with this program.

Well, how do we measure engagement? Do we say you stand on the connected scale every day? You talk to your coach every week, every month? You do your food journal entry every day. What is fair as a responsibility and a requirement on the employee to continue to get coverage under the plan?

And so it immediately goes from, we want to treat you fairly, but how are we going to do that? And those are some of challenges that are raised by this class because we know safety and efficacy are there. Dr. Levy clearly articulated that point. We know cost and prevalence make it challenging. So how do we get to fairness in this discussion? And that's how we're thinking about it at Aon across those three areas.

Larry Levitt: Shauna, from a clinical perspective, this type of engagement that Michael's talking about or wellness programs, does that seem appropriate for you in this case?

Shauna Levy: Absolutely. The problem is nobody's paying for them, right? To pay for therapy for people, I mean with obesity. Comprehensive obesity care includes medication, surgery, and behavioral health. And medicine and behavioral health are the least covered. Surgery is more covered. And so it's hard to develop wellness programs when nutritional visits aren't covered and therapy visits aren't covered for the purposes of obesity. So it's really hard to have these programs and be sustainable.

Fairness just feels out of the question. We're not even close to being fair when it comes to treating the disease of obesity. From my lens, there's so much discrimination, and I just think we're not even scratching the surface of fairness.

The questions that I have when we talk about obesity medicine is why aren't Qsymia and Contrave covered? When people tend to have exclusions on their policy when it comes to obesity, it's not like, "Oh, we're just excluding Wegovy." They exclude everything, even the cheaper medicines. And so I don't understand how that's not obesity discrimination because it's not a cost issue.

I mean, they do cost something, but they're not like $1500 a month. And so that really, I guess, irks me when it thinks about patients and access to care. It's not like they don't have Wegovy, but they do have these lesser expensive medicines. They have nothing.

Larry Levitt: And we're unfortunately coming to the end of our time. But one final question. You talked about these drugs being a game changer. You were just talking about discrimination against people with obesity. Do you think these drugs will help with discrimination? Or are they going to potentially make it worse?

Shauna Levy: I hope, and I actually think they already have made a difference when it comes to discrimination. Because I think that we're seeing people who we've traditionally always thought as lacked willpower, and that's why they weren't able to lose weight. But suddenly they're able to lose weight when they're given appropriate medical therapy.

So I already think that it's changing people's perspective. Now I think that those gossip magazines and the things that are just really focusing on the celebrity aspect of it, and people who are doing it for vanity reasons, is really doing a disservice to the treatment of people with the disease of obesity. But I think for the most part, a lot of improvements are being made from understanding and treatment of this disease.

Michael Manolakis: I would agree with that. And from an employer perspective, no one's sitting out there saying, "It's just a choice. It's a lifestyle thing." That conversation is over. It's a disease and we treat it as a disease. So how it gets treated becomes a whole nother set of issues. But I think that I would agree with Dr. Levy on that point.

Shauna Levy: I wish we had a full nother hour to talk about this. Because there's so many things that are coming to my brain with this conversation.

Larry Levitt: No, it is been a great discussion and the number of questions has been enormous, and I apologize that we didn't get to all of them. We will certainly have to come back to this topic.

Michael, Shauna, Juliette, I just want to thank you for a great discussion. Thank the audience for participating as well. And watch out for a recording of this likely later today and join us for the next Wonk Shop.

Shauna Levy: Can I just say one last thing?

Larry Levitt: Oh, please.

Shauna Levy: People should go to the Obesity Action Coalition website and find their local representative and advocate for the pass of the Treat reduce Obesity Act so that Medicare can cover these medications. We need to band together to make this happen. So thank you for having me.

Larry Levitt: Thanks everyone.