Expanding Equitable and Efficient Access to Anti-obesity Medications: Deprescribing After Weight Loss Plateau

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Expanding Equitable and Efficient Access to Anti-obesity Medications

- The extraordinary demand for these breakthrough anti-obesity drugs (AOM) by the high prevalence of the population indicated for AOMs, coupled with their current high acquisition cost and manufacturing shortages, present significant challenges to ensuring equitable access.
- Consequently, how best to efficiently allocate AOMs has become a top priority among public and private payers and is being deliberated at the individual employer, health plan, state, and federal levels.

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Incretin Memetics - Pros

- Substantial weight loss
- Clinically meaningful secondary benefits for several obesity-related conditions, such as cardiovascular disease, sleep apnea, liver disease, and obesity-related cancers.

Incretin Memetics – Cons

- Side effects, including nausea, vomiting, diarrhea,
- Adverse event associated with continued use, such as loss of skeletal muscle mass among older adults and incidence of pancreatitis
- Lack of long-term safety data pose additional concerns regarding their continuous use

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Thus, choosing an optimal treatment duration requires individuals, clinicians, and payers to address a tradeoff between

- Potential weight regain after discontinuation and the possible loss of secondary health benefits, and
- Removal of drug-associated short and long-term adverse effects as well as access-related hurdles.

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Coverage policies for AOMs are largely unpredictable and highly variable.

- Advocating for generous access, some contend that AOMs should be classified as a preventive benefit and be covered without consumer cost-sharing
- At the other extreme of the coverage spectrum are the many payers – including Medicare – that have yet to approve AOM coverage.
- In between are those payers that do cover AOMs, but typically impose a mounting list of prerequisites to initiate or continue therapy and often require high levels of consumer cost-sharing and/or have imposed coverage limits based on total spending or duration of use. (very few are clinically driven)

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- Access barriers to AOMs (e.g., prior authorization, step therapy, spending/duration limits, and prior use criteria [as in the current version of TROA]) could further exacerbate health disparities
- *While attention has been primarily focused on the budget impact, the unmet need and implications of inequitable AOM access warrant a patient-centered and affordable solution that could more fairly allocate obesity management resources.*

Clinically Driven Payment And Benefit Design To Improve Health Equity: The Case Of Obesity Prevention And Treatment

David D. Kim, Dina H. Griauzde, Caroline R. Richardson, A. Mark Fendrick

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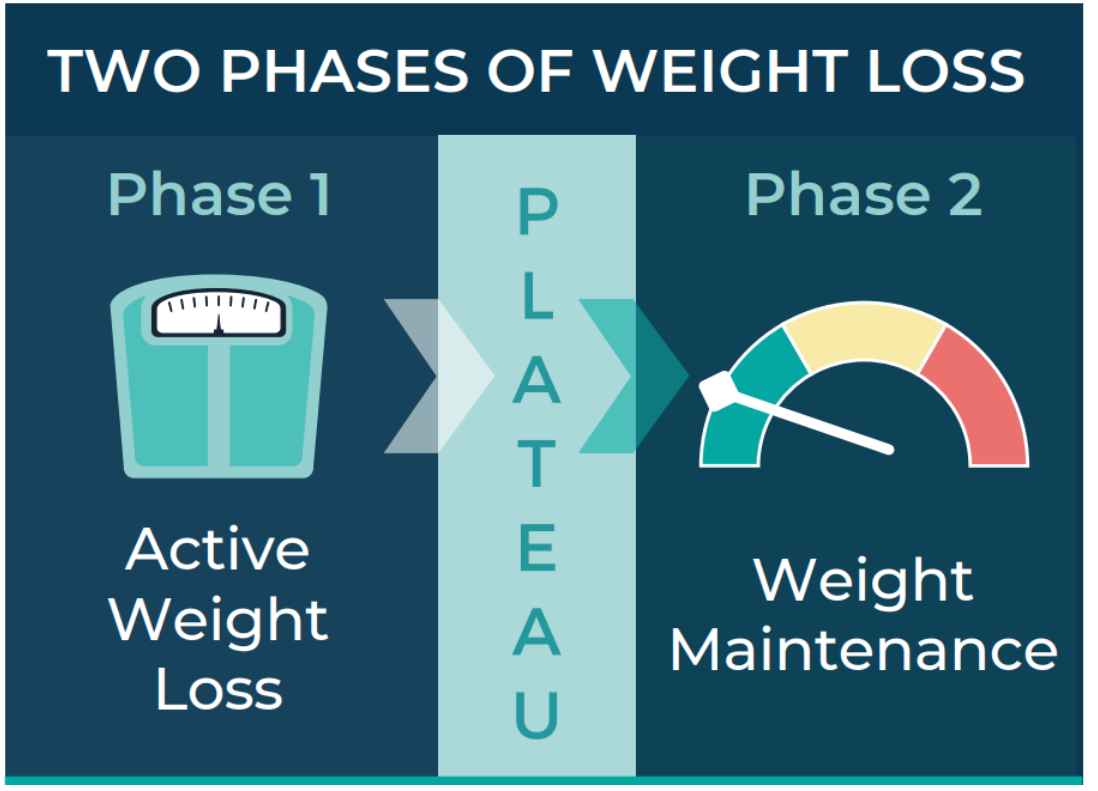
- We propose an AOM coverage strategy that aims to optimize population health by maximizing the amount of weight loss – and associated clinical benefits - per dollar spent.
- To date, most of the clinical research and media attention on AOMs has focused on the amount of the initial weight loss (ie, active weight loss phase).
- Less consideration has been paid to the role of interventions to sustain the weight loss
- This distinction between these 2 phases of obesity treatment is essential, as the differences in effectiveness and incremental expense attributable to AOM use—compared with available alternatives—for the active weight loss phase can be substantially different for the maintenance phase.



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- Novel GLP-1s and other incretin memetics (IMs) have been demonstrated to produce significantly more weight loss compared with available nonsurgical medical and behavioral interventions.
- Given this robust advantage, the greatest relative benefit and incremental cost-effectiveness is produced with active weight loss.
- Still, there is a dearth of evidence comparing the relative clinical and cost-effectiveness of continued full-dose AOM therapy vs that of a lower-cost alternative approach to maintain weight loss beginning once a weight loss plateau has been achieved.

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- If a less-expensive maintenance program produces comparable results in sustaining weight loss, **it would make sense from an efficiency standpoint to devote more AOMs (especially those in short supply) to active weight loss instead of maintenance,** where clinical superiority of full-dose AOM compared with alternatives has yet to be established.

ELEMENTS OF AN ALTERNATIVE WEIGHT MANTENANCE PROGRAM

- Decrease GLP-1 dose or different medication
- Behavioral therapy
- Nutrition support
- No / lower consumer cost-sharing

Unknown effectiveness in maintaining weight

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We examined whether an alternative weight maintenance program had the potential to more efficiently reallocate obesity management resources. Using the validated Diabetes, Obesity, and Cardiovascular Disease Microsimulation (DOC-M) model, we compared the estimated long-term health and economic outcomes of 2 weight maintenance programs:

(1) continuous long-term full-dose IM use ($530/month [50% discounted list price] and behavioral therapy for $53/month) and;

(2) participation in a less-expensive alternative weight maintenance program following a weight loss plateau

ELEMENTS OF AN ALTERNATIVE WEIGHT MANTENANCE PROGRAM

- Decrease GLP-1 dose or different medication
- Behavioral therapy
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The model's estimates suggested that, *compared with continuous full-dose AOM, the alternative weight maintenance program would result in a significant reduction in obesity-related treatment spending and produce minimal reductions in clinical benefits over a wide range of lower cost and effectiveness estimates.*

Incremental Lifetime Costs ($ in thousands)

Price Index	0.05	0.10	0.20	0.30	0.40	0.50	0.60	0.70	0.80	0.90	1.00
1.00	28	27	24	21	18	15	12	9	6	3	Reference
0.90	17	15	12	9	7	4	1	-2	-5	-8	-11
0.80	6	4	1	-2	-5	-8	-10	-13	-16	-19	-22
0.70	-5	-7	-10	-13	-16	-19	-22	-25	-28	-30	-33
0.60	-17	-18	-21	-24	-27	-30	-33	-36	-39	-42	-45
0.50	-28	-29	-32	-35	-38	-41	-44	-47	-50	-53	-56
0.40	-39	-40	-43	-46	-49	-52	-55	-58	-61	-64	-67
0.30	-50	-51	-54	-57	-60	-63	-66	-69	-72	-75	-78
0.20	-61	-63	-66	-69	-71	-74	-77	-80	-83	-86	-89
0.10	-72	-74	-77	-80	-83	-86	-88	-91	-94	-97	-100
0.05	-78	-79	-82	-85	-88	-91	-94	-97	-100	-103	-106

Effectiveness Index (relative to best available Incretin Mimetic Treatment)

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When the alternative maintenance program was half the price of continuous full-dose AOM and 30% as effective (ie, patients regain 70% of their weight and lose 70% of the long-term clinical benefit) results **in an estimated net lifetime savings of $35,100 per patient enrolled.** If these savings were redistributed, they could fund approximately **6 additional individuals to receive full-dose IM therapy for 1 year.**

Incremental Lifetime Costs ($ in thousands)

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1.00	28	27	24	21	18	15	12	9	6	3	Reference
0.90	17	15	12	9	7	4	1	-2	-5	-8	-11
0.80	6	4	1	-2	-5	-8	-10	-13	-16	-19	-22
0.70	-5	-7	-10	-13	-16	-19	-22	-25	-28	-30	-33
0.60	-17	-18	-21	-24	-27	-30	-33	-36	-39	-42	-45
0.50	-28	-29	-32	-35	-38	-41	-44	-47	-50	-53	-56
0.40	-39	-40	-43	-46	-49	-52	-55	-58	-61	-64	-67
0.30	-50	-51	-54	-57	-60	-63	-66	-69	-72	-75	-78
0.20	-61	-63	-66	-69	-71	-74	-77	-80	-83	-86	-89
0.10	-72	-74	-77	-80	-83	-86	-88	-91	-94	-97	-100
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Effectiveness Index (relative to best available Incretin Mimetic Treatment)

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Clearly, challenges are likely to arise if individuals are offered to opt in to an alternative weight maintenance program, once they experience weight loss produced by full-dose AOM and become aware of reported weight gain upon discontinuation (even though the available trial evidence supports that not all individuals who stop a GLP-1 regain weight).

However, the reluctance of some patients to switch may be overcome by highlighting the potential advantages of a switch that might include

(1) reduction in AOM adverse effects and potential unknown long-term adverse effects;

(2) lower out-of-pocket cost;

(3) financial rewards for sustained weight loss;

(4) inclusion of supplemental services, such as nutritional support and exercise programs; and

(5) the option to restart the IM regimen when needed.

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- The advent of highly effective AOMs offers an unprecedented opportunity to address the global obesity epidemic.
- However, high levels of unmet need and unsustainable budget impact present a major challenge in how to balance equitable access and affordability.
- The consideration of 2 distinct phases of obesity management (ie, active weight loss and maintenance of weight loss) allows a potential move away from the current less-efficient "full-dose AOM or nothing" approach to one that could improve efficiency and enhance equity of obesity-reducing expenditures.
- This approach would enable substantially more people access to AOMs—particularly disadvantaged populations that are disproportionally affected by obesity and its sequelae—who are most likely to benefit from their use.

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Thank you

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