AMERICA'S PHYSICIAN GROUPS

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 breakthrough anti-obesity drugs (AOM), 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.

Goal: Achieve the most weight loss and associated clinical benefits (e.g., reductions in diabetes, cardiovascular disease, sleep apnea, cancer etc.) within populations indicated for their use - given a certain level of spending.

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Expanding Equitable and Efficient Access to Anti-obesity Medications

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.
- Beneficiary demand / satisfaction

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
- Cost

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Thus, choosing the Who? When? For how long? for AOM use requires individuals, clinicians, and payers to address tradeoffs among:

- Beneficiary satisfaction (or not)
    - Access related barriers.
- Clinical and equity benefits achieved (or not)
    - Potential weight regain after discontinuation and the possible loss of secondary health benefits, and
    - Drug-associated short and long-term adverse effects
- Financial implications

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Expanding Equitable and Efficient Access to Anti-obesity Medications
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 spectrum are 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
  - require high levels of consumer cost-sharing and/or impose coverage limits based on total spending or duration of use (very few are clinically driven)
  - change policies frequently

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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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- 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 is primarily focused on 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.*
- We propose an AOM coverage strategy that aims to optimize population health and reduce disparities by **maximizing the amount of weight loss – and associated clinical benefits - per dollar spent.**

An Efficient Approach to Expand Equitable Access to Antiobesity Medications: Deprescribing After Weight Loss Plateau

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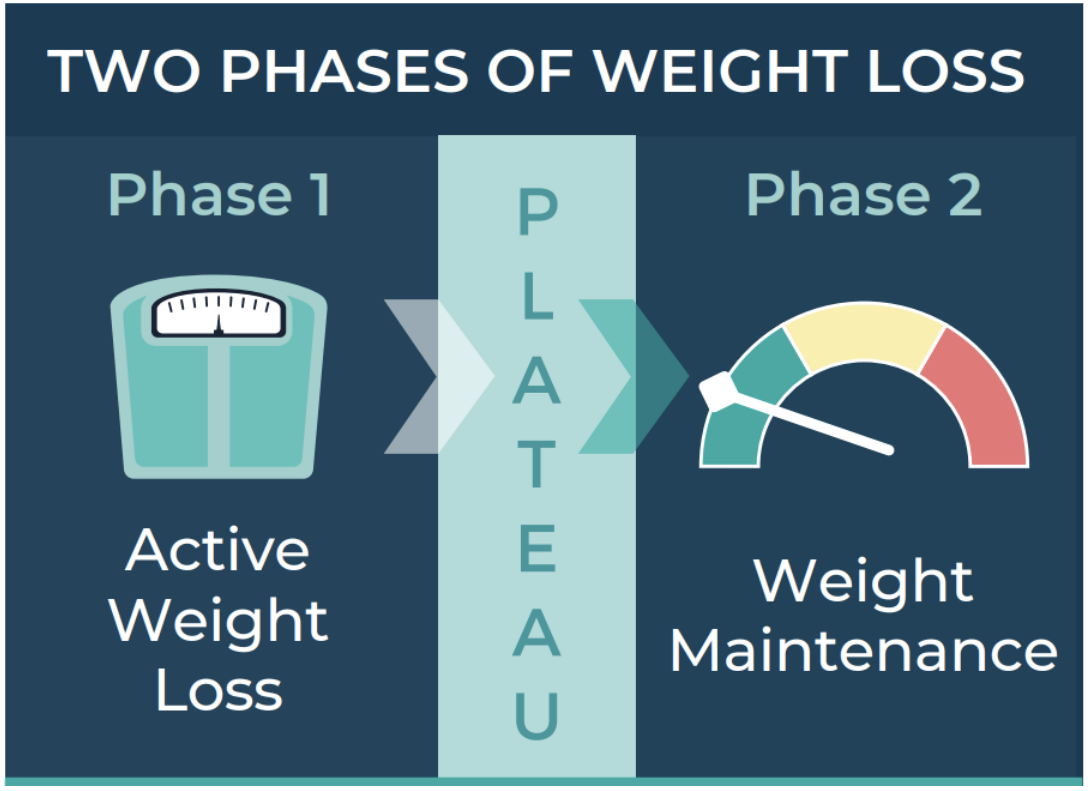
David D. Kim, PhD; and A. Mark Fendrick, MD

- To date, most of the clinical research and media attention on AOMs has focused on the amount of weight loss (i.e., active weight loss phase)
- Less consideration has been paid to the role of interventions to sustain the weight loss (i.e., weight maintenance phase)
- This distinction between these 2 phases of obesity treatment is essential, as **the differences in effectiveness and incremental expense attributable for the active weight loss phase and the maintenance phase can be substantially different**



Expanding Equitable and Efficient Access to Anti-obesity Medications

- 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 effectiveness 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 with that of a lower-cost alternative approach to maintain weight loss beginning **once a weight loss plateau has been achieved**.

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Can an alternative weight maintenance program reallocate obesity management resources to produce better clinical, equity and economic outcomes?

- 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 – where superiority has been established - to active weight loss instead of maintenance of weight loss,** 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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Balancing innovation and affordability in anti-obesity medications: the role of an alternative weight-maintenance program

David D. Kim[1,*], Jennifer H. Hwang[2], A. Mark Fendrick[3]

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY

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 (range 5- 100%) following a weight loss plateau. Given uncertain effectiveness in maintaining weight compared to full dose IM, we examined a wide range of relative effectiveness (5- 100%)

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The model's estimated that *compared with continuous full-dose AOM, an 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.***

Price Index	Incremental Lifetime Costs ($ in thousands)										
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
	0.05	0.10	0.20	0.30	0.40	0.50	0.60	0.70	0.80	0.90	1.00

Effectiveness Index (relative to best available Incretin Mimetic Treatment)

Balancing innovation and affordability in anti-obesity medications: the role of an alternative weight-maintenance program

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

Incremental Lifetime Costs ($ in thousands)

Price Index \ Effectiveness 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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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 to a personalize alternative program 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 (i.e., 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.

Thank you

Questions?

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