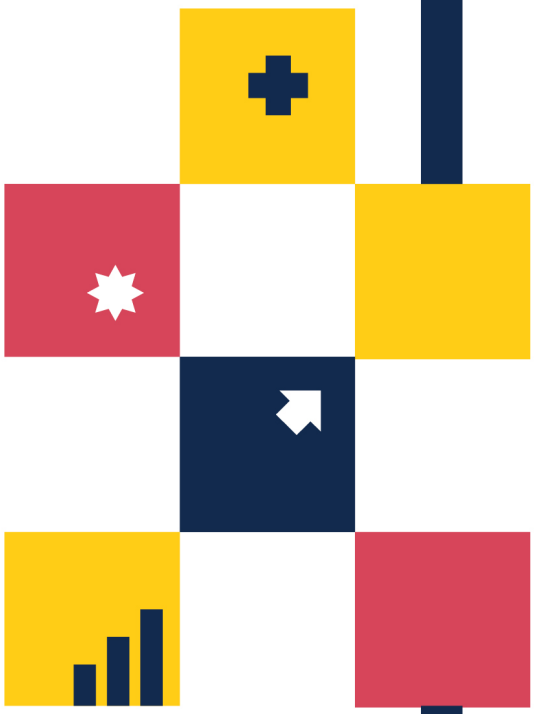
Maryland Privately Insured Weight Loss Medications Cost and Utilization 2021-2023

Maryland Health Care Commission
CENTER FOR ANALYSIS AND INFORMATION SYSTEMS



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Introduction:

Obesity is a significant health issue in the United States. About 40% of U.S. adults have obesity. A recent report from the National Center for Health Statistics derived from the National Health and Nutrition Examination Survey conducted from August 2021-August 2023 showed the age-adjusted prevalence of obesity in adults did not change significantly stable from the previous survey (2017-18), but the prevalence of severe obesity (BMI > 40) increased from 7.7% to 9.7%. A previous National Health and Nutrition Examination Survey administered from 2017-2020 found over 70% of adults are classified as overweight or obese. The prevalence of obesity in adults remains above the Healthy People 2030 goal of 36.0%. Monitoring obesity prevalence is important for understanding trends over time. In Maryland, 34.2% of adults had a BMI of 30 or higher, with percentages ranging from 25% to 47% across different Maryland counties.[1] Compared to Maryland, the prevalence of obesity was lower in the District of Columbia (23.4%), about the same in Virginia (34.3%), and higher in Delaware (35.7%) and West Virginia (41.2%)[2]

Weight control has been a hot topic in the past decades. The glucagon-like peptide-1 (GLP-1) drugs are a new class of therapies that is breaking the mold, and there's a groundswell of hope that they may dent obesity rates and interlinked chronic diseases.[3] GLP-1 drugs show promise against obesity-associated diseases.[4]

In the U.S., adult obesity raised annual medical care costs by $3,508 per obese individual (year 2010 values). However, the relationship between medical care costs and BMI is J-shaped; costs rise exponentially in the range of class 2 and 3 obesities (BMI ≥35). The heavier the obese individual, the more significant the reduction in medical care costs associated with a given percent reduction in BMI. The demand for ongoing treatment is not surprisingly high. However, the drugs are costly, with a sticker price of more than $1000 a month, and they may require lifelong use. [3]

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[1] https://www.countyhealthrankings.org/health-data/maryland?year=2024&measure=Adult+Obesity

[2] Obesity Prevalence Maps, https://www.cdc.gov/obesity/php/data-research/adult-obesity-prevalence-maps.html#cdc_data_surveillance_section_4-across-states-and-territories, accessed on October 9, 2024

[3] Science, Jennifer Couzin-Frankel. Accessed February 29, 2024. https://www.science.org/doi/epdf/10.1126/science.adn4691

[4] AAAS, Walter Beckwith. Accessed February 29, 2024. https://www.aaas.org/news/sciences-2023-breakthrough-glp-1-agonists-show-promise-against-obesity-associated-disease#:~:text=Right%20now%2C%20GLP%2D1%20drugs,including%20pancreatitis%20and%20intestinal%20obstruction.

Health insurance payors could play a vital role in relieving the cost burden for patients. Obesity was recognized as a complex, chronic disease that requires medical attention by the American Medical Association (AMA) in 2013.[5] Older weight loss medications have shown limited effectiveness or significant side effects, which led many public and some commercial payers to exclude them from coverage.[6] Employer coverage of weight-loss drugs varies; recent data from several Pharmacy Benefit Management (PBMs) shows that coverage in employer plans ranges from 33% to 63%. Further, the use of prior authorization requirements among employers that cover weight-loss medications ranges from 50% to 80% across the PBMs.[7] Obesity and weight loss medications are excluded from coverage in Medicare Part B and Part D by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. However, the versions of these medications that are indicated for diabetes (e.g., Ozempic, Victoza, and Mounjaro) are required to be covered at a class level for the treatment of diabetes under Medicare Part D.[5] Medicaid coverage for GLP-1 products usually needs prior authorization, and it must be with the diabetes indications.

Purpose:

Weight control is a vital aspect of preventive care, often managed within primary care settings. Given the high cost and long-term use associated with GLP-1 weight loss drugs, it's imperative to navigate the challenges and opportunities they present, considering both payer and patient perspectives. The Maryland Health Care Commission (MHCC) gathers data from various commercial health care entities doing business in the state on a quarterly basis, consolidating it into the Medical Care Data Base (MCDB), which serves as Maryland's All Payer Claims Database (APCD). This data includes claims and membership information from private insurers, HMOs, TPAs, and PBMs, offering insight into healthcare utilization and spending patterns. Analyzing this data provides a comprehensive overview of spending and utilization trends among Maryland residents. Considering extensive marketing efforts promoting the benefits of Saxenda, Wegovy, Mounjaro, and Zepbound in managing obesity

[5] Kyle TK, Dhurandhar EJ, Allison DB. Regarding Obesity as a Disease: Evolving Policies and Their Implications. Endocrinol Metab Clin North Am. 2016 Sep;45(3):511-20. doi: 10.1016/j.ecl.2016.04.004. PMID: 27519127; PMCID: PMC4988332. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4988332/

[6] AJ Ally, RPh, Milliman, Payer strategies for GLP-1medications for weight loss. Accessed Feb 29, 2024 from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-28-23_glp-1s-for-weight-loss_20230824.ashx

[7] Welliver, S., Susie, C., & Binkely, D. (March 16, 2023). #Ozempic: TikTok Fad or Weight Management Disruptor? Mercer. Accessed Feb 29, 2024 from https://www.mercer.com/en-us/insights/us-health-news/ozempic-tiktock-fad-or-weight-management-disruptor/.

and its related health issues since 2021, the purpose of this study is to describe the distribution of weight management drugs in the APCD and show the changes of cost (Total cost per patient, per member per month (PMPM), per patient per month (PPPM) and Out-of-pocket) and utilization of these drugs from 2021 to 2023.

Methodology:

The analysis is based on data from Maryland's Medical Care Data Base (MCDB) from 2021 through 2023. It encompasses fully insured and self-insured populations across various markets, including large employers (businesses with more than 50 full-time employees), small employers (businesses with two to 50 full-time employees), and individual members who directly purchased health benefit plans from insurers.

For this analysis, we included the following weight loss medications: Saxenda (liraglutide) is a medication that was initially approved for the treatment of type 2 diabetes in 2010 under the brand name Victoza. However, it is now available in higher doses than Victoza and is also used for managing weight loss. Similarly, Wegovy (semaglutide) was approved in 2017 as Ozempic for type 2 diabetes and is now prescribed for weight management as well. Recently, Mounjaro (tirzepatide) was introduced to the market as another option for managing type 2 diabetes. This medication has been shown to reduce body weight by an average of 15.7% to 22.5%. Zepbound (tirzepatide) is a prescription medication approved by the FDA in 2023 for adults with obesity or overweight who also have weight-related medical problems. These medications are crucial for people who struggle with weight management, particularly those with type 2 diabetes. National drug codes (NDC) were obtained from the FDA website. Refer to the appendix for a list of NDC codes for these medications.

The analysis includes several key measures related to GLP-1 weight loss drugs. These measures encompass the count of patients using GLP-1 weight loss drugs (unique enrollees with Saxenda, Wegovy, Mounjaro, or Zepbound prescriptions) and the count of GLP-1 weight loss prescriptions. Additionally, the study examines associated expenditures, considering the total number of prescriptions filled in each calendar year and normalizing them based on a 30-day supply of medication. The details of each measure, as well as the definition and calculation, are included in the appendix.

A note about the Missing Data in the Commercial Component of the APCD

The Maryland APCD, like all state APCDs, cannot require private employer health plans established under the Employee Retirement and Insurance Security Act (ERISA) to submit claims due to the U.S. Supreme Court ruling in key holding for Liberty Mutual in Gobeille v

Liberty Mutual due to the administrative burden of complying with differing state APCD requirements. The U.S. Office of Personnel Management (OPM) subsequently concluded that they would not permit health plans to submit claims for federal employees, dependents, and federal retirees to state APCDs under similar reasoning. These populations represent approximately 44 % of the commercial market in Maryland. Given the missing claim data, readers should assume that the number of patients and prescriptions using weight loss drugs is significantly undercounted. The MHCC continues to work with private employers and OPM to obtain voluntary compliance with MHCC's APCD data submission requirements.

Results:

Data from Table 1 revealed a substantial increase in patients and prescriptions using weight loss medications from 2021 to 2023. The medications Saxenda, Wegovy, Mounjaro, and Zepbound showed varying patient utilization patterns, prescription numbers, total paid amounts, and out-of-pocket expenses over the years.

Saxenda's patient count increased by about 18% from 2021 to 2022 but decreased by 18% in 2023. The number of prescriptions, total paid amount, and out-of-pocket amount decreased from 2021 to 2023, indicating potential competition from other medications.

On the other hand, Wegovy exhibited a significant surge in patient count (194% from 2021 to 2022 and 351% from 2022 to 2023) and prescription numbers (400% from 2021 to 2022 and 300% from 2022 to 2023) from 2021 to 2023. The total paid amount for Wegovy also saw a substantial increase over the years, with a corresponding rise in out-of-pocket expenses.

Mounjaro, introduced in 2022, showed a remarkable surge in patient count (600% from 2022 to 2023) and prescription numbers (948% from 2022 to 2023) from 2022 to 2023, with a substantial increase in total paid amount and out-of-pocket expenses.

Since Zepbound was introduced only in May 2023, it's not feasible to compare its patient count and prescription numbers with those of other medications within its introductory year.

These findings indicated an overall significant upward trend in the usage of weight loss medications, with variable patterns of patient usage and associated costs for each medication over the years.

Table 1: Weight Loss Medications Distribution (2021 -2023)

Medication	Year	Patients	Prescriptions	Total Paid Amount	Out-of-Pocket Amount
Saxenda	2021	284	1,539	$1,709,530	$107,497
	2022	336	1,515	$1,667,276	$104,440
	2023	276	997	$1,291,072	$94,880
Wegovy	2021	260	413	$545,623	$100,559
	2022	765	2,067	$2,718,284	$205,961
	2023	3,451	8,272	$11,868,725	$1,070,283
Mounjaro	2022	2,102	4,842	$4,734,603	$244,309
	2023	14,729	50,734	$57,516,282	$2,218,974
Zepbound	2023	98	130	$144,374	$40,162

As shown in Table 2, Saxenda showed a fluctuating unit cost, starting at $1,111 in 2021, decreasing slightly to $1,101 in 2022, and then increasing to $1,295 in 2023. The Per Member Per Month (PMPM) remained relatively stable, slightly decreasing from $0.10 in 2021 to $0.09 in 2023. Utilization, measured in scripts per 1000 members per year, declined from 1.1 in 2021 to 0.8 in 2023. Correspondingly, the per patient per month (PPPM) decreased from $560 to $455, and the patients' utilization rate also dropped from 6,053 scripts/1,000 to 4,966 scripts/1,000.

Wegovy exhibited an increasing trend in unit costs, rising from $1,321 in 2021 to $1,435 in 2023. The PMPM significantly increased from $0.03 in 2021 to $0.80 in 2023, indicating a higher financial burden on insurance plans. Utilization rates surged dramatically from 0.3 scripts/1,000 in 2021 to 6.7 scripts/1,000 in 2023. The PPPM increased from $311 in 2021 to $662 in 2023, while the patients' utilization rate also showed a notable increase from 2,822 to 5,533 scripts/1,000.

Mounjaro, introduced in 2022, started with a unit cost of $978, which increased to $1,134 in 2023. The PMPM rose sharply from $0.30 to $3.89, reflecting a significant increase in utilization from 3.7 scripts/1,000 to 41.1 scripts/1,000. The PPPM increased from $328 to $662, and the patients' utilization rate grew from 4,031 to 7,008 scripts/1,000.

Zepbound, with data available only for 2023, had a unit cost of $1,111 and a minimal PMPM cost of $0.01. Its utilization rate was low at 0.11 scripts/1,000. The PPPM was $142, and the patients' utilization rate was 1,529 scripts/1,000.

The comparison between PMPM and PPPM for the medications Saxenda, Wegovy, Mounjaro, and Zepbound revealed distinct trends. PMPM cost represented the average cost spread across all members of an insurance plan, regardless of whether they used the medication, while PPPM cost reflected the average cost incurred by those who used the medication. For Saxenda, the PMPM cost remained relatively low and stable, decreasing slightly from $0.10 in 2021 to $0.09 in 2023, while the PPPM cost shows a more significant decrease from $560 to $447, indicating a reduction in the financial burden on individual patients. Wegovy's PMPM cost increased dramatically from $0.03 in 2021 to $0.80 in 2023, reflecting higher insurance coverage and broader acceptance. The PPPM cost also increased from $311 to $662. Mounjaro showed a sharp rise in PMPM cost from $0.30 in 2022 to $3.89 in 2023, alongside an increase in PPPM cost from $328 to $662, indicating rapid uptake and higher individual costs. Zepbound, with data only for 2023, has a minimal PMPM cost of $0.01 and a PPPM cost of $142, reflecting its initial low utilization and cost impact. This comparison highlights the varying financial implications for insurance plans and individual patients across different weight loss medications.

Table 2: Weight Loss Medications Cost and Utilization (2021-2023)

			Member Population		Patient Population	
Medication	Year	UnitCost	PMPM	Utilization (Scripts/1000)	PPPM	Utilization (Scripts/1000)
Saxenda	2021	$1,111	$0.10	1.1	$560	6,053
	2022	$1,101	$0.11	1.2	$455	4,966
	2023	$1,295	$0.09	0.8	$447	4,146
Wegovy	2021	$1,321	$0.03	0.3	$311	2,822
	2022	$1,315	$0.17	1.6	$611	5,573
	2023	$1,435	$0.80	6.7	$662	5,533
Mounjaro	2022	$978	$0.30	3.7	$328	4,031
	2023	$1,134	$3.89	41.1	$662	7,008
Zepbound	2023	$1,111	$0.01	0.1	$142	1,529

Table 3 compares the out-of-pocket (OOP) cost of the overall population and patients who used weight loss medications. From 2021 to 2022, Saxenda's OOP cost for the overall population remained constant at $0.01, while the cost for patients decreased from $35 to $29. Then, from 2022 to 2023, the cost for patients increased from $29 to $33.

For Wegovy, the OOP patient costs decreased from $57 to $46 from 2021 to 2022 and then rose to $60 the following year. In comparison, the OOP cost for the overall population also increased from $0.01 to $0.07.

Mounjaro's OOP for the overall population rose from $0.02 to $0.15. However, the OOP patient costs increased from $17 to $26.

Zepbound, introduced in the last quarter of 2023, had out-of-pocket expenses (OOP) of $0.00 and an out-of-pocket maximum (OOP) of $39.

Table 3: Weight Loss Medications Out-of-Pocket Cost (Population vs Patients) (2021-2023)

Medication	Year	Member Population		Patient Population	
		PMPM(Total)	PMPM(OOP)	PPPM(Total)	PPPM(OOP)
Saxenda	2021	$0.10	$0.01	$560	$35
	2022	$0.11	$0.01	$455	$29
	2023	$0.09	$0.01	$447	$33
Wegovy	2021	$0.03	$0.01	$311	$57
	2022	$0.17	$0.01	$611	$46
	2023	$0.80	$0.07	$662	$60
Mounjaro	2022	$0.30	$0.02	$328	$17
	2023	$3.89	$0.15	$662	$26
Zepbound	2023	$0.01	$0.00	$142	$39

Discussion:

This study provides essential insights into the evolving landscape of obesity treatment and its economic implications in Maryland. The results from 2021 to 2023 underscore a significant shift in the utilization and cost dynamics of weight management medications, particularly those in the GLP-1 category, such as Saxenda, Wegovy, Mounjaro, and Zepbound.

A noticeable increase in the distribution and usage of these drugs parallels the broader recognition of obesity as a complex, chronic disease requiring sustained medical intervention. This trend reflects the growing acknowledgment of the effectiveness of GLP-1 medications in managing not just obesity but its associated comorbidities, aligning with the hopeful perspectives seen in the medical community. The data reveals that despite the high cost and the necessity for long-term use, there is a rising demand for these medications, indicative of their perceived value in the healthcare ecosystem.

However, the financial burden on patients remains a critical concern, compounded by the variable coverage policies of health insurance payors. Blue Cross Blue Shield (BCBS) of Michigan has announced that it will discontinue coverage for three major weight loss

drugs: semaglutide (Wegovy), tirzepatide (Zepbound), and liraglutide (Saxenda) starting in January 2025[8]. This might indicate what other payors might do with future weight loss medication coverage policies. The study's findings highlight a landscape marked by significant out-of-pocket costs for patients despite the intervention of insurance entities. This economic strain underscores the necessity for a more inclusive insurance coverage framework that could alleviate the financial pressure on individuals seeking these treatments.

Moreover, the missing data from the commercial component of the APCD, due to regulatory and administrative hurdles, suggests that the actual utilization and cost impact of GLP-1 drugs could be even more substantial than reported.

Patients, providers, and payers must choose between using costly but effective GLP-1 agonists for chronic conditions or cheaper but less effective older drugs with behavioral coaching. Combining GLP-1 agonists with lifestyle changes may provide greater benefits, but it doesn't solve the long-term challenges of cost or adherence nor the structural inequities of lifestyle counseling.[9] Rationing GLP-1 agonists reduces costs but sacrifices short-term weight loss benefits for many patients.

In conclusion, this study underscores the need for strategic interventions at the policy level to enhance access to effective obesity treatments, mitigate financial burdens on patients, and ultimately contribute to a healthier population. The path forward should involve concerted efforts from all stakeholders to reassess the framework of healthcare coverage and ensure that those in need can equitably access the benefits of innovative treatments.

[8] Update: Changes coming for select weight loss drugs for some commercial members (bcbsm.com)
[9] https://jamanetwork.com/journals/jama/article-abstract/2815919

Appendix

GLP-1 Weight Loss drugs NDC codes:

Proprietary Name	NDC Package Code	Labeler Name	Non Proprietary Name	Start Marketing Date
Saxenda	0169-2800-15	Novo Nordisk	liraglutide	01/19/2015
Saxenda	0169-2800-90	Novo Nordisk	liraglutide	01/19/2015
Saxenda	0169-2800-97	Novo Nordisk	liraglutide	01/19/2015
Saxenda	50090-4257-0	A-S Medication Solutions	liraglutide	04/09/2019
WEGOVY	0169-4501-14	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	0169-4505-14	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	0169-4517-14	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	0169-4524-14	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	0169-4525-14	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	0169-4525-94	Novo Nordisk	semaglutide	06/05/2021
WEGOVY	50090-5824-0	A-S Medication Solutions	semaglutide	10/25/2021
MOUNJARO	0002-1457-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1460-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1471-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1484-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1495-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1506-80	Eli Lilly and Company	tirzepatide	05/13/2022
MOUNJARO	0002-1506-61	Eli Lilly and Company	tirzepatide	06/08/2022
MOUNJARO	0002-1152-01	Eli Lilly and Company	tirzepatide	07/28/2023
MOUNJARO	0002-1243-01	Eli Lilly and Company	tirzepatide	07/28/2023
MOUNJARO	0002-2214-01	Eli Lilly and Company	tirzepatide	07/28/2023
MOUNJARO	0002-2340-01	Eli Lilly and Company	tirzepatide	07/28/2023
MOUNJARO	0002-2423-01	Eli Lilly and Company	tirzepatide	07/28/2023
MOUNJARO	0002-3002-01	Eli Lilly and Company	tirzepatide	07/28/2023
ZEPBOUND	0002-2457-80	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2460-80	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2471-80	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2484-80	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2495-80	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2506-61	Eli Lilly and Company	tirzepatide	11/08/2023
ZEPBOUND	0002-2506-80	Eli Lilly and Company	tirzepatide	11/08/2023
Zepbound	0002-0152-01	Eli Lilly and Company	tirzepatide	03/28/2024

Proprietary Name	NDC Package Code	Labeler Name	Non Proprietary Name	Start Marketing Date
Zepbound	0002-0243-01	Eli Lilly and Company	tirzepatide	03/28/2024
Zepbound	0002-1214-01	Eli Lilly and Company	tirzepatide	03/28/2024
Zepbound	0002-1340-01	Eli Lilly and Company	tirzepatide	03/28/2024
Zepbound	0002-1423-01	Eli Lilly and Company	tirzepatide	03/28/2024
Zepbound	0002-2002-01	Eli Lilly and Company	tirzepatide	03/28/2024
Zepbound	0002-0152-04	Eli Lilly and Company	tirzepatide	08/08/2024
Zepbound	0002-0243-04	Eli Lilly and Company	tirzepatide	08/08/2024

Source: National Drug Code Directory (https://dps.fda.gov/ndc) retrieved on 09/11/2024

Utilization Measures

Count of Patients: The unique enrollees who were privately insured in the calendar year 2021 and calendar year 2022 with Saxenda, Wegovy, and Mounjaro prescriptions.

Count of GLP-1 Weight Loss Prescriptions: This is the total number of Prescriptions filled in each calendar year. Prescriptions have been "normalized" or adjusted to be counted based on a 30-day supply of medication. Therefore, each 90-day prescription is counted as three 30-day prescriptions.

Expenditures Measures

Total Paid Amount: This amount was calculated as the total aggregate spending during the calendar year (with three months of claims run out). It includes the insurance paid amount, coinsurance paid amount, deductibles, and other member liabilities.

Out-of-Pocket Amount: This amount was calculated based on the member's cost-sharing responsibility (i.e., the sum of the member's copay, coinsurance, and deductible amounts).

Unit Cost: This measure was calculated using the following formula:

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(Total Paid Amount ÷ Prescriptions)
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Per Member Per Month: This measure was calculated using the following formula:

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(Total Paid Amount ÷ Pharmacy member months)
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Utilization Scripts per 1000 per year: This measure was calculated using the following formula:

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(Prescriptions ÷ Pharmacy member months) * 1000 * 12
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Per Patient Per Month: This measure was calculated using the following formula:

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(Total Paid Amount ÷ Patients Pharmacy member months)
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Patients Utilization Scripts per 1000 per year: This measure was calculated using the following formula:

```
(Prescriptions ÷ Patients Pharmacy member months) * 1000 * 12
```

Acknowledgments

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The Maryland Health Care Commission is an independent regulatory commission administratively located within the Maryland Department of Health.