Truven

EMPLOYER AND HEALTH PLAN ANALYTICS

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Contents

Rx corner: Weight loss drug pipeline and industry updates

By: Katherine Shanahan

Across the industry, payers are grappling with the rising utilization and spend on weight loss medications – especially GLP-1 weight loss products such as Wegovy, Saxenda, and Zepbound. And this treatment area is only expected to grow in the coming years.

Looking ahead, weight loss treatments are projected to expand beyond the GLP-1 drug class to include other classes such as amylin analogs, MGAT2s, and activin receptor targets. Products in these drug classes will compete with weight loss GLP-1 products in the effort to demonstrate better efficacy, easier administration, improved side effects, and hopefully, lower costs.

In the table, there are some examples of medications in the drug development pipeline for weight loss and obesity-related conditions. On the right, are those products already available on the market, like Trulicity and Zepbound. On the left, are medications that are still in clinical trials.

Six products are in phase 3 clinical trials and nearing approval by the FDA (middle column) including two oral weight loss medications and four new dual agonist products that promise increased efficacy and reduced side-effects compared to the medications currently on the market. Another eight products are in phase 2 clinical trials and more than 18 are in phase 1 trials. This totals more than 30 products in the drug pipeline for weight loss and obesity-related conditions.

Weight loss/Obesity treatment drug pipeline as of June 2024

Phase 1-2 Clinical Trials	Phase 3 Clinical Trials	On Market
Danuglipron (GLP-1, Oral, Obesity)	Semaglutide (GLP-1, Oral, Obesity)	Trulicity (GLP-1, SC, T2D)
Cagrilintide (Amylin, SC, Obesity / MASH)	Orforglipron (GLP-1, Oral, T2D / CV)	Victoza (GLP-1, SC, T2D)
Petrelintide (Amylin, SC, Obesity)	CagriSema (GLP-1/Amylin, SC, T2D / CV)	Bydureon BCise (GLP-1, SC, T2D)
Efinopegdutide (GLP-1/GCG, SC, T2D / MASH)	Survodutide (GLP-1/GCG, SC, T2D / MASH)	Ozempic (GLP-1, SC, T2D)
Pemvidutide (GLP-1/GCG, SC, T2D / MASH)	Mazdutide (GLP-1/GCG, SC, T2D / CKD)	Rybelsus (GLP-1, Oral, T2D)
Dapiglutide (GLP-1/GLP-2, SC, Obesity)	Retatrutide (GLP-1/GIP/GCG, SC, T2D / Obesity / CKD)	Mounjaro (GLP-1/GIP, SC, T2D)
Maridebart cafraglutide (GLP-1/GIP, SC, T2D/ Obesity)	Tirzepatide (GLP-1/GIP, SC, HF/ OSA / CV/ MASH / CKD)	Saxenda (GLP-1, SC, Obesity)
Bimagrumab/Semaglutide (Activin Receptor II Inhib/GLP-1, IV/SC, Obesity)		Wegovy (GLP-1, SC, Obesity / CV)
S-309309 (MGAT2, Oral, Obesity)		Zepbound (GLP-1/GIP, SC, Obesity)
18+ in Phase 1 Trials		

GLP-1: glucagon-like peptide 1, GIP: glucose-dependent insulinotropic polypeptide, T2D: type-2 diabetes, CV: cardiovascular, HF: heart failure, OSA: obstructive sleep apnea, MASH: metabolic dysfunction-associated steatohepatitis, CKD: chronic kidney disease, SC: subcutaneous injection

But it is the horizontal growth of weight loss products that are really projected to disrupt the industry. Originally, GLP-1 products were indicated for type-2 diabetes followed by the treatment of obesity with appropriate utilization determined by a patient's BMI. But in early 2024, we saw the start of what will be an ongoing trend for weight loss products: expanding FDA approval out from just weight loss treatment to include preventative treatment for a series of obesity-related conditions. The first example of this was Wegovy, which expanded approval to include the prevention of cardiovascular risk, but in the pipeline (Table 1) we see many of the upcoming weight loss products are being tested for their impact on a myriad of obesity-related conditions such as cardiovascular disease, sleep apnea, T2 diabetes, chronic kidney disease, obesity-related hepatitis (steatohepatitis), and heart failure.

As this treatment area grows, payers will need to consider how they will adjust coverage and benefits. Some payers are considering leaving obesity and weight loss medications off formulary, however expanded approval (to include cardiovascular disease, diabetes, heart failure, etc), will challenge this strategy and may increase pressure to add them back. There may also be regulatory pressure in the future to cover at least one product or drug class for these expanded treatment options.

On the other side of the pipeline, older GLP-1 products are nearing the end of their patent life and will have generic versions on the market soon. Victoza and Saxenda are expected to be the first, with generic versions expected by 2026.

As payers look ahead to managing treatment for weight loss and obesity-related conditions, we recommend considering the following:

- How will expanded approvals impact your current management strategy?
- What are other payers in your industry or geographic area doing to manage weight loss medications?
- Will you designate certain products as preferred or non-preferred based on contracted rates and rebates? Will some products be designated as preventive? How will efficacy and side-effects factor into these decisions?
- Will you implement step therapy requiring trial of older options before moving a patient to newer options if clinically necessary?
- Will certain products be left off formulary?

Payers will face these decisions and more in the coming months and years as weight loss and obesity-related treatments continue to grow in market share and clinical application.

Read whitepaper on weight management medications

SURVEY FOR EMPLOYERS

Weight loss medication coverage

Complete our quick survey now! Six simple questions about your coverage of obesity and obesity-related medications.

Results will be confidential, de-identified, and aggregated in our next Spotlight.

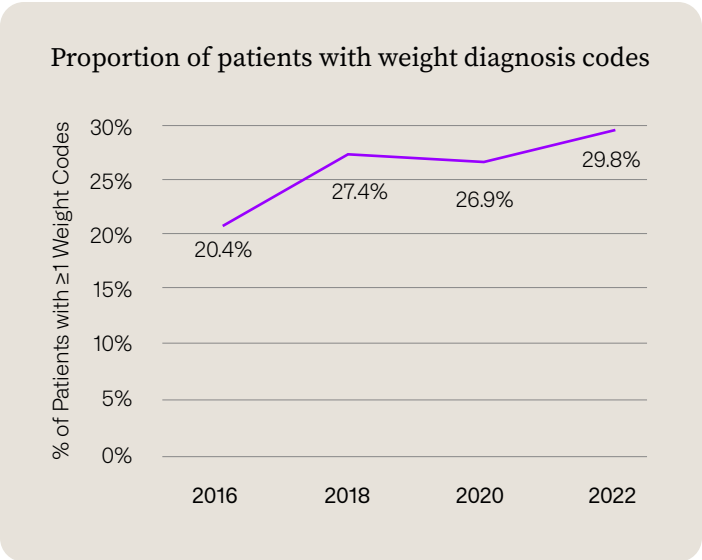
If you have multiple plans, please complete for each, or for your largest plan population – adding the plan information next to your organization's name at the top of the survey.

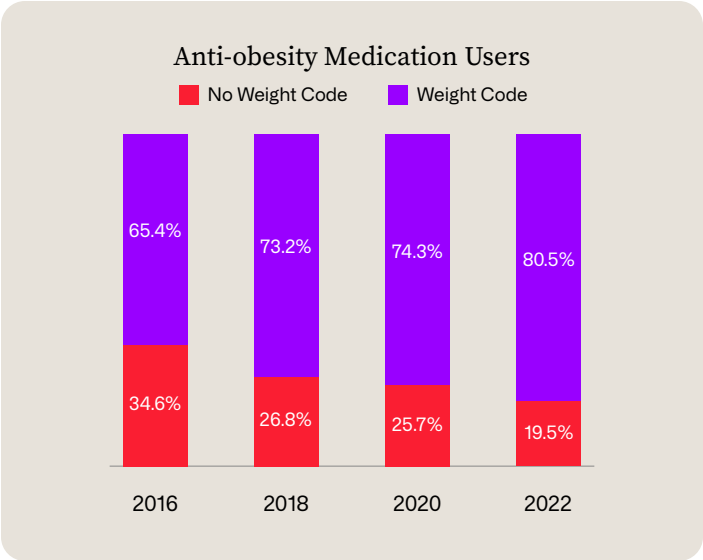
Start survey →

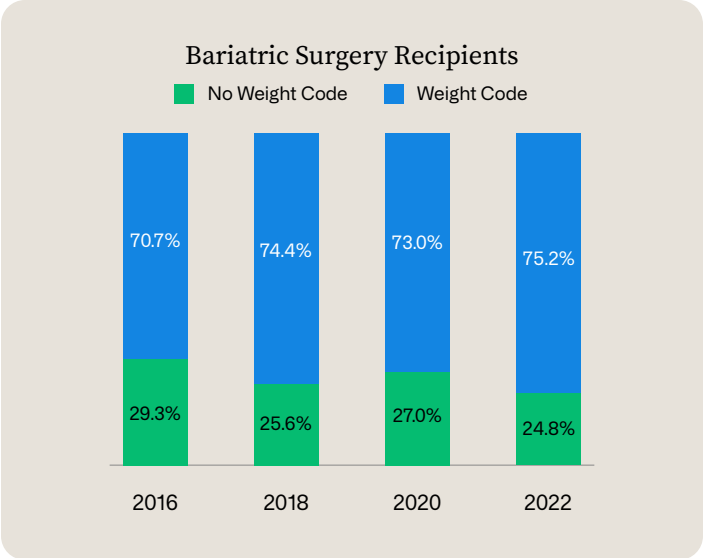
Trends and limitations of overweight and obesity codes in administrative claims data

By: Rebecca Niehus

At the recent ISPOR conference in Atlanta, Merative's MarketScan® research team presented findings on trends in weight-related codes in administrative claims data. They found that although it is known that obesity is underreported in claims data, the proportion of patients with a weight-related diagnosis code increased from 20.4% in 2016 to 29.9% in 2022.







Overweight and obesity ICD-10 diagnosis codes include both billable codes, such as E66.*, as well as observational codes, such as Z68.*. Patients being treated for obesity-related comorbid conditions or especially anti-obesity interventions (e.g. medications or bariatric surgery) are expected to have at least one annual claim with a diagnosis of obesity recorded.

This study found that one of the possible drivers of this increase in weight-related coding is an increase in obesity interventions, leading to better recording of obesity diagnosis codes. Increases in both anti-obesity medication (from 0.5% in 2016 to 1.0% in 2022) and bariatric surgery (from 0.6% to 0.8%) were observed in the MarketScan claims data[1], and there was an increase in the percent of patients with these interventions who had overweight/obesity diagnosis codes.

- Among anti-obesity medication users, the presence of a weight-related code increased from 65.4% in 2016 to 80.5% of in 2022.
- Among bariatric surgery patients, the presence of a weight-related code increased from 70.7% in 2016 to 75.2% of in 2022.

While it is likely that overweight/obesity remains under-coded in administrative claims, the increase in coding means that the overall prevalence of the condition is better represented in claims, and subsequent analysis of those claims, than it used to be. However, as more members opt for anti-obesity medications, there may be a continued increase in obesity prevalence as reported through claims that is not necessarily indicative of an underlying change in the population. Payers may want to supplement claims data with biometric data to more accurately capture condition prevalence in the population. Regular collection of biometric data also allows for early observation of the impact of obesity interventions on patients and provides more specific information than what is captured in administrative data.

1. Merative MarketScan Commercial Claims and Encounters Database

   The MarketScan administrative claims databases contain data on the full healthcare experience (inpatient, outpatient, and outpatient pharmacy) for individuals with employer sponsored commercial or Medicaid insurance in the United States. Data from 1/1/2016 through 12/31/2022 were used for analyses.

Healthcare analytics blog: Solving common payer dilemmas

By: Kristen Hutchins

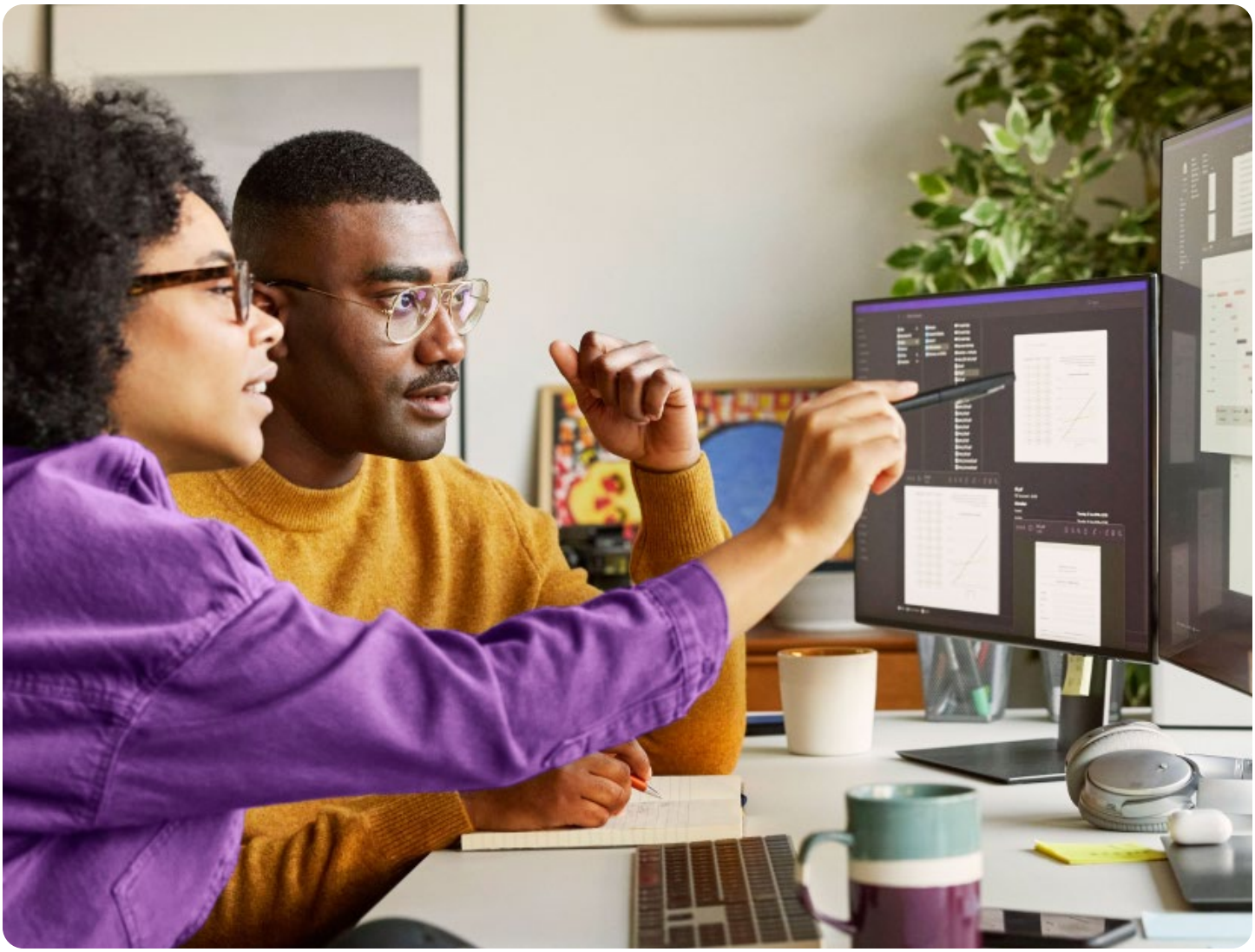
Our subject matter experts and seasoned analysts regularly post blogs on common business problems facing payers today. The most recent post, Maximize your insights: What happens when analytics algorithms are interconnected?, features the importance of consistent business definitions across organizations and the benefits of foundational methodologies that can build on one another. Upcoming topics will include the need for population classification; particularly for organizations looking to prioritize outreach in the face of limited resources, and the ongoing need for analytics on demand to drive more real-time insights. New posts will be featured quarterly. Consider sharing your own suggestions on topics you would like to learn more about with your account team.

Did you hear the news? **Truven is back!**

Truven

On July 18, we re-introduced Truven by Merative, our portfolio of trusted healthcare data and analytics solutions. In the announcement, you can read about the new enhancements we've made to our flagship offering, Health Insights, and try them yourself in the demo.

We also invite you to watch a 30-minute conversation focused on the critical question facing health plans and employers: "Am I basing my health program decisions on the best data?" Our CEO, Gerry McCarthy, and IDC Analyst, Jeff Rivkin, delve into the challenges and opportunities facing payers in 2025.



Site of care optimization

By: Mahil Senathirajah

Site of care optimization programs identify the most cost-effective and clinically suitable location for delivering health care services to patients. During the pandemic, a wide range of hospital-based diagnostic and therapeutic procedures moved from hospitals to ambulatory surgery centers and physician offices and, in some cases, to homes. Infusion therapy, advanced imaging, and ambulatory surgery are commonly addressed services.

The differences in price can be striking. Merative analysis showed that, in 2022, in the Los Angeles market, the median price for a colonoscopy was $731 in an Ambulatory Surgery Center compared to $2,591 in a Hospital Outpatient setting.

Merative can help you identify price differences between sites of care and model savings that may be achieved by moving volume from one setting to another, incorporating our MarketScan reimbursement benchmarks.

Machine-readable files and the value of real-world data

By: Bryan Briegel

The current state of Machine-Readable Files (MRFs) underscores the present and future need for MarketScan Reimbursement Benchmarks in performing rate analysis, evaluating network performance, and identifying competitive negotiated rate opportunities.

The present need:

The promise of machine-readable files: The legislatively required, readily accessible public data sets, by way of uniform files consisting of transparent rates negotiated between payers and providers, is off to a slow start. The Departments (Labor, HHS, Treasury) require this data to be made freely available, for regulators, legislators, third party application developers, employer group plans and others, to understand contract practices, price variation, and with an end goal of driving down costs in healthcare.

Working with MRFs for the past three years, our consensus, as well as that of the industry is to proceed with caution. The current guidance and lax enforcement landscape includes ambiguity in the schemas and content requirements in the files. Also, the variability in the interpretation of the representation and completeness of the products and networks represented within the negotiated rate files, is an issue.

See our insights on MRFs

Rates, items, and services for providers can exist in a contract and the MRFs, though those items and services are outside of the provider's scope of practice. Approaches to contracts, for example global contracting with multi-specialty provider groups, may result in MRFs bloated with countless items and services providers do not and will never render to a member/patient because they are outside a provider's scope of practice. While the Transparency in Coverage rule (TiC) calls for the disclosure of "applicable rates" in the files, interpretation when creating the MRFs often includes a dump of global contract rates, which confounds the value of the data. Not only does this create unnecessary and excess data in the MRFs, but also can create confusion about which of the negotiated rates listed for the provider is accurate.

The negotiated rates in the MRFs, extracted from rate and contract tables, do not always represent real-world billing and payment practices in the delivery of healthcare. This is another consideration when using MRFs to perform your analysis. Providers, items and services, and the negotiated rates within the files, need to be placed in context.

Reimbursement Benchmarks bring a critical third component to the analysis: Real world, fully adjudicated claims at the market and procedure level from the leading source of closed claims data, MarketScan.

When evaluating plan, product, network, or billing code performance, MRFs provide a raw framework for comparison, informing on other payer and provider contracted rates. Reimbursement benchmarks provide the needed context to understand how the commercial rates published in the MRF compare to actual market payment practices. This context can place your experience, as well as the rates in the MRFs into focus – are they at or below median rates? Are they outliers? Once identified, opportunities to further understand what may be driving outliers (i.e., practice differences, spurious rates in the MRFs) or engaging in contract discussions are more confidently pursued.

The future need:

On June 28th, the US Supreme Court overturned the Chevron Deference. This ends a forty-year practice of the courts deferring to the Departments for interpretation of congressional intent, in cases where Congress passed laws that were (intentionally at times) unclear or vague. The subject matter experts of the Executive Branch were given deference for interpretation. As of today, this balance has shifted to the Judicial branch, with Federal judges now charged to interpret statute, without the precedence of deferring to the Departments.

The Departments' basis for the MRFs required by the TiC and the hospital transparency were interpreting and enforcing Transparency disclosure provisions of the Affordable Care Act, specifically section 1311(e)(3) requiring disclosure of "Other information as determined appropriate by the Secretary."

Determining whether Congress intended public rate disclosures as part of transparency requirements, will now be in the hands of the Judicial branch when challenged in court. This does present risk that the courts will find including public rate disclosures as part of "Other information as determined appropriate by the Secretary." was not the intent of the law. Such a decision could potentially make the requirements for publishing MRFs come to a halt. With this, it is important to note, there are two Bills in Congress that would write Hospital Price Transparency and Transparency in Coverage, and their MRF requirements, into law. House Bill: The Lower Prices, More Transparency Act and Senate Bill: Health Care PRICE Transparency Act 2.0. Transparency in healthcare has broad public and bipartisan support, however if this risk were realized, there would almost certainly be a quiet period, between a judicial decision and law making, where MRFs may no longer be available.

This further drives the future use case of applying Reimbursement Benchmarks in your discount analysis.

Insights and events you don't want to miss:

- Explore our new webpages to see how Truven is improving health and financial outcomes with trusted data and proven expertise.
- Healthcare analytic models: Build, buy, or both?
  In a rapidly changing marketplace, payers are being driven to develop an information-centric strategy that brings more healthcare analytics in-house. Which approach is best, build or buy?
- 5 essential strategies for EDGE Server data management
  Read actionable advice from our experts on how to optimize your EDGE data submissions and accurately represent your commercial risk.
- Don't be passive when it comes to employee financial wellness
  See the top strategies to help employees understand the basics of health insurance terminology, the potential tax advantages of HSAs, and a clear view of costs.

About Truven

Truven by Merative is a portfolio of healthcare data and analytics solutions, backed by 40 years of deep healthcare expertise. We provide trusted insights and proven expertise to help employers, health plans, life sciences organizations, and government agencies drive better health and financial outcomes. With market-leading solutions like Health Insights and MarketScan, Truven serves 7 of the top U.S. health plans, over 40% of the Fortune 500, and the top 20 global pharmaceutical companies.

Learn more at merative.com/truven

About Merative

Merative provides data, analytics, and software for healthcare and government social services. With focused innovation and deep expertise, Merative works with providers, employers, health plans, governments, and life sciences companies to drive real progress. Merative helps clients orient information and insights around the people they serve to improve decision-making and performance.

Learn more at merative.com

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