

Factors Associated With Semaglutide Initiation



A recent study by the Boston University School of Public Health (BUSPH) highlights significant barriers faced by individuals with obesity in accessing weight-loss medications like semaglutide, particularly within a healthcare system that has historically deprioritised obesity treatment.

Initially developed to manage diabetes, glucagon-like peptide-1 (GLP-1) receptor agonists, such as semaglutide (Ozempic/Wegovy), gained widespread attention after receiving FDA approval for weight loss in 2021. More recently, tirzepatide (Mounjaro/Zepbound) was approved in 2023 as an even more effective option.

Despite their popularity among the public and celebrities, access to these medications remains uneven. According to the study published in *JAMA Network Open*, access varies significantly based on factors such as insurance type, employment industry, sex, and concurrent medication use.

Among commercially insured, non-diabetic individuals with obesity, researchers found that individuals with point-of-service or preferred provider organisation (PPO) insurance were more likely to receive semaglutide compared to those with health management organisation (HMO) or exclusive provider organization (EPO) plans. Similarly, those in the financial and real estate sectors were more likely to be prescribed semaglutide than individuals in retail or similar industries. Females and individuals using antidepressants, thyroid medications, or hormone therapies were more likely to start semaglutide. The study also shows that access was higher among residents of the Northeast compared to other regions. Those with BMIs of 40 or above had the highest likelihood of receiving prescriptions, reflecting a trend where physicians prioritise these drugs for individuals with severe obesity.

The study underscores systemic obstacles in accessing obesity treatment. While the FDA approves GLP-1 medications for individuals with BMIs of 30 or higher (or 27 with comorbidities), physicians often limit prescriptions to those with higher BMIs, leaving others reliant on lifestyle changes alone.

The authors point out that the care paradigm has traditionally recommended lifestyle changes and only introduced pharmacological treatments after the onset of metabolic diseases like diabetes. But sustainable weight loss is biologically challenging, and earlier intervention with GLP-1 drugs could prevent disease progression.

Access is further restricted by insurance policies. Only 25% of employers offer insurance coverage for GLP-1 drugs for weight management, while most cover them for diabetes treatment. Additional barriers include step therapy, prior authorisation requirements, and limited coverage under Medicare and Medicaid.

These barriers reflect systemic inequities and misaligned incentives in the healthcare system. The researchers emphasise that expanding insurance coverage for GLP-1 medications and addressing cost-related challenges are critical for equitable access.

The study analysed insurance claims data from over 97,000 commercially insured U.S. adults with obesity (but not diabetes) from June 2021 to July 2022. Using machine learning, the team identified sociodemographic, clinical, and healthcare factors influencing semaglutide prescriptions.

Looking ahead, the team plans to investigate disparities in GLP-1 access across socioeconomic, racial, and ethnic groups, as well as differences in coverage under Medicare and Medicaid.

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The barriers to accessing GLP-1 drugs reflect broader inequities in healthcare, note the authors. Policymakers need to address systemic challenges like cost, insurance restrictions, and site-of-care limitations to ensure equitable access to these life-changing medications.

The findings underscore the importance of rethinking healthcare policies to prioritise obesity treatment as a disease in its own right, not just a risk factor for other conditions.

Source: [Boston University School of Public Health](#)

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