PEOPLE NAVIGATING OBESITY CARE INSIGHT REPORT

Obesity Treatment Costs: How GLP-1 Coverage Shapes Access to Care

A patient perspective on obesity treatment costs, GLP-1 and anti-obesity medication coverage, insurance denials, prior authorization, household budgets, treatment interruptions, lower-cost alternatives, and what makes care financially sustainable over time.

Context → Signal → Judgement → Action

87	complete responses
126	total survey records
5	countries represented
69%	completion rate

WHY THIS REPORT

A treatment plan is only a real plan if the patient can keep accessing it.

Obesity is increasingly treated as a chronic condition, and newer pharmacological options have expanded what medical weight management can offer. But long-term care also exposes a practical question: who can access treatment, how much do they pay, and what happens when coverage changes?

This report follows that experience across insurance coverage, out-of-pocket spending, treatment interruptions, approval hurdles, lower-cost alternatives, household impact, and the policy changes patients believe would improve access.

Global guidance increasingly treats obesity care as long-term chronic-disease management, which makes continuity especially important. For patients, however, the treatment pathway may depend as much on coverage rules, prior authorization, recurring medication cost, and access to nutrition or behavioral support as on the clinical recommendation itself.

> **Survey lens:** 126 survey records, including 87 complete responses. The export contains respondents from five countries, with the USA representing most records. Core question bases range from n=94 to n=87. Findings describe respondent experience and are not clinical or financial advice.

EXECUTIVE SUMMARY

The pattern in six findings

FINDING 01

Coverage is often uncertain or excluded

FINDING 02

Cost can interrupt treatment continuity

30.1% are unsure whether anti-obesity medicines are covered and **28.0%** report explicit exclusion.

17.0% have delayed, skipped, or stopped treatment multiple times because of cost.

FINDING 03

Prior approval leads the hurdle list

29.5% name insurance denial or complex prior authorization as their biggest barrier.

FINDING 04

Blocked coverage changes the route

39.8% would look for lower-cost alternative, compounded, or imported options if prescribed treatment were not reimbursed.

FINDING 05

Household strain is concentrated but real

11.4% say obesity-care costs force cuts to essential spending.

FINDING 06

Patients want several access levers changed

Price, medicine coverage, and multidisciplinary-care coverage each attract about one quarter of policy preferences.

01

SECTION 01 · CARE PATHWAY

Most respondents are trying to manage weight outside formal medical care

CONTEXT

The access story begins before insurance decisions. People may be managing weight on their own, actively seeking medical care, or returning after earlier treatment attempts. Many people begin with diet, exercise, or other self-directed strategies before entering formal medical weight management. That may reflect preference, access, cost, uncertainty about where to seek care, or the belief that medical treatment is not yet available to them.

WHAT THE DATA SHOWS

57.4% (54) are trying to manage weight on their own through diet, exercise, or lifestyle change; **27.7%** (26) are currently receiving or seeking medical weight-management care; **14.9%** (14) previously received or attempted care in the past three years.

THE INSIGHT

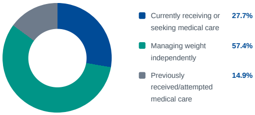
Formal obesity care is only one part of the respondent experience. Many people are still navigating weight management largely on their own. The high share managing weight outside formal care is important because financial barriers can operate before a prescription is ever written. A person may never reach a clinician if they already expect medication, specialist visits, or multidisciplinary support to be unaffordable.

WHY IT MATTERS

Cost and coverage barriers may influence not only whether treatment continues, but whether a person enters medical care in the first place. Access strategies need to consider the front door to care, not only reimbursement after treatment begins.

Current experience with weight management

Respondent weight-management pathway. Base n=94.



02

SECTION 02 · HOW CARE IS FUNDED

Private insurance is the main funding route, but that does not guarantee obesity treatment coverage

CONTEXT

Having health insurance and having obesity treatment covered are not the same thing. Benefit design can exclude or restrict specific medicines and services. Having private insurance does not automatically mean obesity treatment is covered. Plans can separate medical visits, medications, procedures, nutrition services, and behavioral support into different benefit rules and approval pathways.

WHAT THE DATA SHOWS

58.5% (55) primarily fund medical care through private insurance; **16.0%** (15) use a public or national system; **13.8%** (13) are entirely self-funded.

THE INSIGHT

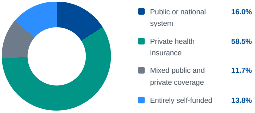
The dominant funding model is insured care, yet subsequent questions show that obesity treatment can still be excluded, partly covered, or unclear. The funding source therefore tells only part of the story. What matters to the patient is the benefit that applies to the specific treatment being recommended and the amount that remains out of pocket month after month.

WHY IT MATTERS

Patients may discover the real cost only after a treatment plan has been discussed, prescribed, or submitted for authorization. Coverage conversations should be specific to the treatment pathway so patients know which parts are covered, partially covered, excluded, or subject to approval.

How respondents primarily fund medical care

Main source of healthcare funding. Base n=94.



03

SECTION 03 · MEDICATION COVERAGE

Coverage for anti-obesity medicines is often partial, excluded, or simply unclear

CONTEXT

A prescription only becomes a practical treatment option when the patient knows whether it is covered and what they will still have to pay. Uncertainty about coverage can be a barrier in its own right. A patient who does not know whether an anti-obesity medication is covered may delay discussing it, postpone filling a prescription, or assume the cost will be unaffordable.

WHAT THE DATA SHOWS

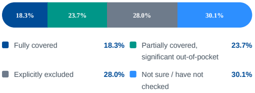
30.1% (28) are unsure whether prescription anti-obesity medicines are covered; **28.0%** (26) say the medicines are explicitly excluded; **23.7%** (22) report partial coverage with significant out-of-pocket cost; **18.3%** (17) report full coverage.

THE INSIGHT

Uncertainty is as common as explicit exclusion. That means the access burden includes information friction before the affordability calculation even begins. The survey shows that access friction is not limited to outright denial. Partial coverage and lack of clarity can create the same practical question: can I afford to start and continue this treatment?

Coverage of prescription anti-obesity medicines

Primary coverage or national-system reimbursement. Base n=93.



WHY IT MATTERS

Clear benefit information at the point of prescribing can prevent patients from building a treatment plan around coverage they do not actually have. Simple benefit checks, clear prior-authorization requirements, and transparent expected patient cost can reduce uncertainty before treatment is interrupted.

04

SECTION 04 · HOUSEHOLD BUDGET

For most, monthly spending is manageable, but a smaller group faces meaningful financial strain

CONTEXT

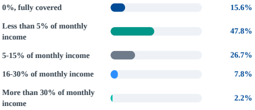
Obesity care can include medication, clinician visits, laboratory tests, nutrition support, behavioral care, and procedures. The total burden may be broader than a single prescription copay. A monthly cost that looks modest once can become significant when it continues for many months and sits alongside visits, tests, nutrition support, transportation, and other health expenses. Household burden is therefore cumulative rather than a one-time purchase decision.

WHAT THE DATA SHOWS

47.8% (43) spend less than 5% of monthly income out of pocket; **26.7%** (24) spend 5-15%; **7.8%** (7) spend 16-30%; **2.2%** (2) spend more than 30%.

Share of monthly household income spent on weight-management care

Out-of-pocket weight-management expenses. Base n=90.



THE INSIGHT

The typical burden is not catastrophic, but a meaningful minority is spending enough to force difficult monthly trade-offs. Most respondents report low or moderate spending, but the smaller group with significant or severe burden matters because they are the patients most likely to face trade-offs with savings or essential expenses.

WHY IT MATTERS

Affordability should be assessed as a recurring treatment burden, not just whether the patient can pay for the first month. Affordability discussions should use recurring cost over time and include the whole care pathway, not only the sticker price of one medication.

05

SECTION 05 · TREATMENT CONTINUITY

Cost has already interrupted treatment for more than one in three respondents

CONTEXT

Long-term obesity treatment depends on continuity. When cost causes a delay, skipped dose, or stop, the clinical plan and the financial plan have become inseparable. When a person delays, skips, or stops treatment because of cost, the behavior can look like non-adherence while the underlying problem is affordability. The distinction matters because education alone cannot fix a plan the patient cannot pay for.

WHAT THE DATA SHOWS

17.0% (15) have delayed, skipped, or stopped treatment multiple times because of cost; **19.3%** (17) have done so once or twice; **20.5%** (18) have considered stopping because of cost; **43.2%** (38) say cost has never affected adherence.

THE INSIGHT

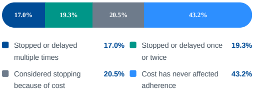
Affordability is not an abstract concern. It is already changing treatment behavior for a substantial share of respondents. The survey indicates that treatment interruption is already part of the lived experience for a substantial share of respondents. Even those who have not stopped may be considering it, which suggests financial pressure can exist before a visible break in care.

WHY IT MATTERS

Clinicians and care teams need cost conversations early enough to choose a plan the patient can sustain, not only one they can start. Clinicians and care teams can ask about cost proactively and discuss safe covered alternatives or support options before the patient reaches the point of stopping on their own.

Has cost delayed, skipped, or stopped recommended treatment?

Effect of affordability on treatment continuity. Base n=88.



06

SECTION 06 · BIGGEST HURDLE

Insurance denial and prior approval are the leading single hurdle

CONTEXT

Patients can face multiple barriers, but asking for the single biggest hurdle shows where the access pathway most often becomes difficult enough to define the experience. Prior authorization and insurance denial can turn a clinical recommendation into weeks of paperwork, repeated documentation, appeals, or a requirement to try another option first. For patients, that delay may feel like a rejection even when the clinician still supports the plan.

WHAT THE DATA SHOWS

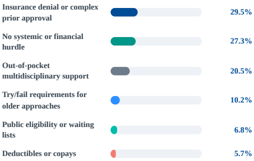
29.5% (26) name insurance denials or complex prior approval as the biggest hurdle; **27.3%** (24) report no major systemic or financial hurdle; **20.5%** (18) name out-of-pocket multidisciplinary support.

THE INSIGHT

Access friction is concentrated in the approval pathway more than the point-of-sale copay alone. The survey identifies administrative friction as the leading single hurdle, showing that access can fail even when the patient has insurance and a treatment recommendation.

Single biggest systemic or financial hurdle in obesity care

Primary access barrier. Base n=88.



WHY IT MATTERS

Reducing prior-authorization complexity and making coverage criteria transparent can remove delay before patients are forced into alternative routes. Clear criteria, predictable documentation requirements, and support for appeals can reduce the gap between the treatment selected in the clinic and the treatment the patient can actually obtain.

07

SECTION 07 · WHEN COVERAGE FAILS

When reimbursement disappears, many people start looking outside the standard route

CONTEXT

A treatment can remain clinically recommended while becoming financially inaccessible. The next choice may be to pay, seek assistance, stop, appeal, or look for lower-cost alternatives. When coverage disappears, people begin weighing full cash payment, assistance programs, appeals, or lower-cost alternatives. That is a high-risk decision point because financial pressure can push patients toward options whose quality, regulation, or clinical appropriateness they may not be able to assess.

WHAT THE DATA SHOWS

39.8% (35) would look for alternative, compounded, or imported lower-cost options; **19.3%** (17) would pay the full cost despite strain; **19.3%** (17) would seek assistance or discounts; **17.0%** (15) would opt not to take the medication.

THE INSIGHT

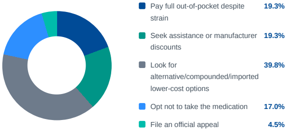
Blocked coverage changes the route, not necessarily the desire for treatment. The largest group begins searching for a cheaper substitute. The survey shows that the standard pathway can lose patients when affordability fails. The issue is not simply price sensitivity, but the search for continuity when the recommended option is financially out of reach.

WHY IT MATTERS

That search can create quality and safety risks. Patients need access to regulated, clinically appropriate alternatives and clear advice before cost pushes them outside standard care pathways. Affordability conversations should keep patients connected to clinicians and regulated supply channels so a lower-cost decision does not become a safety compromise.

What respondents would do if prescribed medication is not reimbursed

Likely next step when coverage is unavailable. Base n=88.



08

SECTION 08 · FINANCIAL WELLBEING

For one in three, obesity care requires budgeting or cuts into essentials

CONTEXT

A monthly percentage can feel abstract. Asking about household wellbeing shows whether care competes with groceries, utilities, savings, or other essential spending. Financial strain is not always visible in the clinic. A patient may continue treatment while cutting discretionary spending, delaying other care, drawing down savings, or reducing spending on essentials.

WHAT THE DATA SHOWS

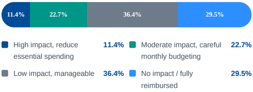
11.4% (10) say costs have high impact and require reducing essential spending; **22.7%** (20) report moderate impact requiring careful budgeting; **36.4%** (32) report low impact; **29.5%** (26) report no impact.

THE INSIGHT

Most respondents describe low or no impact, but the financially vulnerable subgroup is large enough to matter in any long-term care model. The survey shows a spectrum from little financial impact to meaningful household trade-offs. That makes a simple question such as can you afford this prescription too narrow for understanding the real burden.

WHY IT MATTERS

Affordability screening should identify not only whether a patient can pay today, but whether care is crowding out essentials or savings over time. Teams can ask whether the total care plan is sustainable over the next several months and whether cost is affecting other health or household priorities.



Impact of obesity-care costs on household financial wellbeing

Reported household impact. Base n=88.

09

SECTION 09 · POLICY PRIORITY

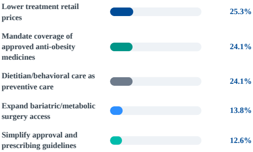
Patients do not agree on one policy fix because the access problem has several layers

CONTEXT

Coverage, retail price, surgery access, nutrition and behavioral support, and prescribing rules all sit in different parts of the obesity-care pathway. Patients do not choose one policy fix because the barriers occur at different points. Medication price, insurance coverage, multidisciplinary services, surgery access, and approval rules each solve a different part of the pathway.

WHAT THE DATA SHOWS

25.3% (22) prioritize lower retail prices; **24.1%** (21) prioritize mandated coverage of approved medicines; **24.1%** (21) prioritize standard coverage for dietitian and behavioral care.



Policy change most likely to improve access to obesity care

Single preferred policy change. Base n=87.

THE INSIGHT

The response distribution is unusually balanced. Patients are describing an access problem distributed across price, benefits, and the wider care team. The spread of preferences suggests that improving access will require several levers rather than a single reimbursement change. A patient may have medication coverage but no affordable nutrition support, or surgical access but long eligibility delays.

WHY IT MATTERS

A single reimbursement fix is unlikely to solve the full burden. Sustainable obesity care needs medication access, multidisciplinary care, and simpler administrative pathways together. Policy discussions should measure whether people can start, continue, and complete evidence-based care across the full pathway, not only whether one treatment category is technically covered.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about obesity treatment costs and GLP-1 coverage

Why are anti-obesity medicines not always covered by insurance?

Coverage varies by country, health plan, indication, eligibility criteria, prior-authorization rules, and the specific medicine. Some plans exclude obesity medicines, while others cover them only for certain clinical criteria or require substantial cost sharing.

What is prior authorization for obesity treatment?

Prior authorization is a process in which a health plan requires clinical information or approval before it will pay for a medicine, procedure, or service. The exact rules differ by payer and country.

What costs can be part of medical weight management besides medication?

Depending on the care plan, costs may include clinician visits, laboratory tests, dietitian or behavioral support, monitoring, devices, procedures, transportation, and time away from work.

What should I do if a prescribed obesity medicine is not covered?

Ask the prescribing clinician and insurer about the reason for non-coverage, appeal options, covered alternatives, legitimate patient-assistance programs, and whether another evidence-based treatment is appropriate. Do not switch to an unverified product without clinical advice.

Are compounded or imported weight-loss medicines the same as approved products?

Not necessarily. Product quality, regulatory oversight, formulation, sourcing, and evidence can differ. Patients should discuss any alternative product with a qualified clinician and use regulated supply channels.

Why is obesity care often described as long-term care?

Obesity is a chronic, multifactorial disease. Effective management may require sustained nutrition, activity, behavioral, medical, or surgical support, and treatment needs can change over time.

PATIENT ACCESS LENS

What affordability looks like before and after the prescription

The financial burden is not a single copay. It appears at multiple points in the care pathway, and each one can change the plan.

Coverage clarity

The information lens

Many people are unsure whether anti-obesity medicines are covered at all.

Focus: Make benefits and eligibility understandable before treatment begins.

Approval friction

The administration lens

Insurance denial and prior authorization are the leading single hurdle.

Focus: Reduce avoidable delay between recommendation and access.

Sustainable monthly cost

The continuity lens

Safe alternatives

The risk lens

Cost has already caused some respondents to delay, skip, or stop treatment.

Focus: Choose a plan that remains affordable over time.

When coverage fails, the largest group looks for lower-cost alternatives.

Focus: Keep cost-driven choices inside regulated, clinically supported pathways.

CLOSING PERSPECTIVE

Obesity care is not truly accessible if the patient cannot sustain it month after month.

The survey makes the access problem tangible. Coverage may be partial, excluded, or simply unclear; prior authorization can delay the start of treatment; recurring monthly costs can force budgeting decisions; and when reimbursement disappears, some people begin looking for lower-cost routes outside the standard pathway. None of these choices are separate from treatment continuity. They become part of the care plan whether the clinical team intends them to or not.

A more patient-centered approach starts by discussing affordability before the prescription becomes fixed. That includes medication, visits, laboratory monitoring, nutrition and behavioral support, procedures, and the possibility that coverage rules may change. The safest and most sustainable plan is the one a patient can continue through a legitimate clinical pathway without repeatedly choosing between treatment and other household needs.

1. **Check coverage before the plan hardens**
   Clarify reimbursement, eligibility, and expected out-of-pocket cost early in the treatment discussion.
2. **Talk about total care cost**
   Include visits, labs, behavioral support, nutrition care, and procedures, not only medicine price.
3. **Plan for continuity**
   Discuss what happens if coverage changes, a prior authorization expires, or cost becomes difficult to sustain.
4. **Keep alternatives safe**
   Route affordability conversations through clinicians, regulated pharmacies, and legitimate assistance programs.

What makes obesity care financially sustainable in real life?

Join MDForLives to share patient and caregiver perspectives that can help future healthcare insights reflect the reality of access and long-term care.

Discover · Share · Shape

Join the Panel

DATA SOURCE AND CONTEXT

1. MDForLives Obesity Insight Survey_July export, report SGID 8916068. Survey export: 126 total records, 87 complete, 39 partial, 69% completion rate. Question-level bases vary by completion depth.
2. World Health Organization. Obesity and overweight fact sheet, updated December 2025. https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight
3. World Health Organization. Global guideline on GLP-1 medicines for treating obesity, 1 December 2025. https://www.who.int/news/item/01-12-2025-who-issues-global-guideline-on-the-use-of-glp-1-medicines-in-treating-obesity

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