Semaglutide and Tirzepatide for Obesity: Final Policy Recommendations

DECEMBER 16, 2025

Policy Recommendations

Introduction

The following policy recommendations reflect the main themes and points made during the Policy Roundtable discussion at the November 13, 2025 NE CEPAC public meeting on the use of semaglutide (injectable and oral) and tirzepatide for the treatment of obesity. At the meeting, ICER presented the findings of its revised report on these treatments and the NE CEPAC voting council deliberated on key questions related to their comparative clinical effectiveness, special ethical priorities and benefits beyond health, and long-term value for money at current prices. Following the votes, ICER convened a Policy Roundtable of two patients, two clinical experts, two individuals from the payer perspective, and two representatives from pharmaceutical manufacturers to discuss how best to apply the evidence and votes to real-world practice and policy. The discussion reflected multiple perspectives and opinions, and therefore, none of the statements below should be taken as a consensus view held by all participants.

A recording of the conversation can be accessed here, and a recording of the voting portion of the meeting can be accessed here. More information on Policy Roundtable participants, including conflict of interest disclosures, can be found in the appendix of this document. ICER's report on these treatments, which includes the same policy recommendations, can be found here.

The roundtable discussion was facilitated by Sarah Emond, President and Chief Executive Officer at ICER. The main themes and recommendations from the discussion are organized by audience and summarized below.

Health Equity

Recommendation 1

All stakeholders have a responsibility and an important role to play in improving access to semaglutide (injectable and oral) and tirzepatide in a way that will help reduce health inequities.

Obesity is a common condition, with more than 40% of Americans living with obesity. The cause of obesity is complex; there are multiple factors that affect a person's risk of developing obesity, including genetic influences on body composition, disruptions in appetite regulation, as well as environmental factors such as geography, food and physical activity environment, and socioeconomic status.[1,2] There are also racial and ethnic disparities in the prevalence of obesity, with Black and Hispanic people having higher rates of obesity than White people. These disparities extend to medical treatment for obesity. For example, Black women are less likely to be counseled about weight reduction;[3] individuals living with obesity also reported difficulty finding culturally

appropriate care, particularly in the area of nutrition, where often patient education does not take into account cultural differences in diet. Finally, we heard that insurance coverage issues had the potential to widen inequities; due to a lack of widespread insurance coverage of drugs for obesity, and a lack of patient assistance programs, many individuals living with obesity are not able to afford treatment.

Individuals living with obesity, patient advocacy groups, and clinical experts all emphasized that the main limitation of access to semaglutide and tirzepatide is economic – namely, insurance coverage is variable and out-of-pocket costs are high for individuals without insurance coverage. Furthermore, there appears to be a difference in who is prescribed GLP-1 RA therapy based on race/ethnicity, with Black men and American Indian/Alaska Native people less likely to receive GLP-1 RA therapy.[4]

To address these concerns:

<u>All stakeholders should take the following actions:</u>

- Take steps to promote culturally sensitive, comprehensive obesity care to all patients without stigma or bias, including promoting greater awareness throughout the healthcare system of obesity as a chronic disease requiring lifelong treatment, advocating for an adequate workforce to deliver obesity care, and provision of culturally appropriate nutrition and psychological support.

- Ensure that direct-to-consumer platforms do not worsen health inequities or threaten patient safety by increasing access to obesity medications without an adequate workforce to oversee prescriptions and adequate ancillary support (e.g., nutrition therapy, psychological support) to ensure that patients use medications and lose weight in a safe manner.

<u>Manufacturers should take the following actions:</u>

- Take steps necessary to include a more diverse patient population in clinical trials, including trying to mirror the prevalence of disease in US population and including participants with lower BMI but evidence of metabolic disease as is more often seen in Asian patients.

<u>Payers should take the following actions:</u>

- Ensure cost-sharing and coverage policies do not further exacerbate treatment disparities through high out-of-pocket cost burdens or onerous clinical eligibility criteria.

Clinical specialty societies should take the following actions:

- Educate clinicians on the effects of weight stigma and bias in treating people living with obesity.

- Advocate for improved support and education of primary care clinicians in obesity management and care. For example, using a hub-and-spoke model where primary care clinicians could consult with experts trained in obesity medicine.

Patients and Patient Advocacy Groups should take the following actions:

- Advocate for the implementation of comprehensive obesity care programs that could be modeled after the Diabetes Prevention Program and/or smoking cessation programs.

- Continue to use their voices to advocate for more affordable prices and greater access for semaglutide, tirzepatide, and future obesity medications.

Policymakers should take the following actions:

- Take steps to address structural causes of obesity, such as by increasing access to healthy food sources in food deserts and increasing the number of safe places for physical activity, and support or implement policies that aim to increase the primary care workforce so as to increase capacity in the healthcare system to treat obesity.

- Increase access and affordable coverage for obesity medications by addressing policy barriers (e.g., removing or revising federal laws prohibiting Medicare Part D coverage for weight loss drugs) and updating health insurance coverage in public programs.

Researchers should take the following actions:

- Focus on developing measures of obesity other than BMI that may more clearly define risk groups for obesity-related comorbidities.

Payers

Recommendation 1

Payers should work with other stakeholders (e.g., manufacturers, plan sponsors, clinicians, patient groups) to find innovative ways to increase access to comprehensive obesity care.

Fewer than one-quarter of people in the U.S. who may qualify for treatment with GLP-1 RAs report currently using the drugs in a recent survey, with the number dropping to less than 10% of people age 65 and older.[5] Furthermore, persistence with therapy appears low, with fewer than two-thirds prescribed GLP-1 RA therapy still on it one year later.[6] The gaps in utilization and persistence are likely due to the large budget impact of offering access to the drugs, coupled with a lack of insurance coverage, as plan sponsors are left choosing between covering obesity drugs more widely and increasing premiums or limiting use by keeping coverage narrow.

To fully realize the benefits of obesity treatment, patients need access to comprehensive obesity care, including nutrition counseling, health coaching, monitoring by clinicians, options for treatment with obesity medications or, if indicated, surgery. Plan sponsors can look to the example of AT&T or the State of Connecticut – both entities offer their employees engagement with a comprehensive obesity management carve-out company. Such companies offer access to clinicians with expertise treating obesity, lifestyle management programs, and appropriate access to obesity medications such as GLP-1 RAs (and in the case of AT&T, access to surgical weight loss programs). Enrollment in such programs can increase the probability of adherence and persistence with GLP-1 RA and GLP-1/GIP RA drugs; early evaluation of Connecticut state employees enrolled in their contracted weight management program suggested an adherence rate to medication of almost 90% at one year.[7] The Peterson Health Technology Institute (PHTI) recently issued a purchaser guide, Employer Approaches to GLP-1 Coverage, which employers may find helpful as they manage the coverage of obesity medicines. In addition to carve-out programs, ICER's recent White Paper "Examining Strategies to Ensure Affordable Access for Obesity Medications" detailed several other innovative solutions such as subscription models, and aggressive price negotiations by the federal government (more on that below).

Coverage Criteria

Although both semaglutide and tirzepatide are cost-effective at current prices – and tirzepatide may even be cost-saving at the proposed Medicare prices announced in November 2025 – given the large eligible population and the likely need for long-term treatment, it is unlikely that all eligible patients will be able to be treated without substantial premium increases. Thus, in accordance with criteria from ICER's Cornerstones of "Fair" Drug Coverage: Appropriate Cost-Sharing and Utilization Management Policies for Pharmaceuticals, it is reasonable for payers to use prior authorization as a component of coverage. Prior authorization criteria for all drugs should be

based on clinical evidence and input from clinical experts and patient groups. The process for authorization should also be clear, accessible, efficient, and timely for providers. Perspectives on specific elements of cost sharing and coverage criteria within insurance coverage policy are discussed below. Relevant Fair Access Design Criteria set out in ICER's previous work are included.

Cost Sharing

• Patient cost sharing should be based on the net price to the plan sponsor, not the unnegotiated list price.

• If all drugs in a drug class are priced so that they represent a fair value, it remains reasonable for payers to use preferential formulary placement with tiered cost sharing to help achieve lower overall costs.

Drug-Specific Coverage Criteria: Semaglutide and Tirzepatide

The large number of patients with obesity or overweight with at least one comorbidity, combined with the annual net prices for injectable semaglutide and tirzepatide, has caused payers to develop prior authorization criteria and to consider other limits on utilization, in order to manage the budget impact.

None of these limits, however, should undermine the tenets of fair access to which all patients have a fundamental right.[8] To explore the appropriate application of evidence to coverage policy, and to reflect the views of patient experts and clinicians on specific ways that payers might appropriately use coverage policy to manage resources prudently, we present the following perspectives on specific elements of cost sharing and coverage criteria for semaglutide (injectable and oral) and tirzepatide.

Coverage Criteria

- **Age:** Age criteria are likely to follow the FDA label for each drug.
- **Clinical eligibility**:
    - According to ICER's Fair Access criteria, narrowing coverage for a fairly-priced drug is reasonable if the population size is large, broad coverage would create substantial increases in short-term insurance premiums, and waiting for treatment will not cause significant irremediable harm. The GLP-1 RA and GLP-1/GIP RA classes of drugs fit these criteria - there is a large eligible population for these treatments, and currently less than one-quarter of overweight adults or those living with obesity are taking semaglutide or tirzepatide[5] ICER estimates that less than 1% of the eligible population can be treated without exceeding ICER's budget threshold, even though

these drugs are fairly-priced. Thus, payers may temporarily seek to narrow coverage, with expansion of coverage as prices are lowered or through implementation of innovative payment schemes (e.g., performance agreements, subscription models, volume-based rebate agreements, etc.).[9]

    - Payers could follow the example of the proposed criteria for Medicare coverage: 1) BMI ≥27 with prediabetes or established CV disease, 2) BMI ≥30 with uncontrolled hypertension, kidney disease, or heart failure, 3) BMI ≥35.

    - As the evidence evolves, payers should have a mechanism in place to rapidly update clinical eligibility criteria to expand coverage to new populations.

- **Exclusion criteria**: The exclusion criteria are likely to follow the FDA label for each drug.

- **Dosing:** All three drugs require dose titration to maximize weight loss and minimize side effects. Payers should consider having prior authorization approval apply to all doses, rather than require prior authorization for each dose separately, to minimize burden on prescribers and patients.

- **Duration of coverage and renewal criteria**: Initial coverage will likely be for a period of 12 months, which is long enough for dose titration, assessment of side effects, and assessment of efficacy.

    - Renewal of therapy: Payers should use a patient's starting weight, not current weight, as the basis for judging whether further treatment is necessary. Clinical trial data demonstrate a high likelihood of weight re-gain after discontinuation in most patients.

- **Provider restrictions**: No provider restrictions.

Step Therapy

Payers considering step therapy should recognize that the extensive benefits seen with GLP-1 RAs and GLP-1/GIP RAs are unlikely to be seen with other classes of medications to treat obesity. The improvements in aspects of the metabolic syndrome and reductions in CV risk appear substantially larger with these medications than would be anticipated based on the degree of weight loss alone. Additionally, some older medications have only been approved for shorter-term use, and for many of the older medications it is unclear that they are safe when used for years. However, all medications appear to require ongoing treatment to sustain weight loss. In contrast, there is extensive experience with long-term use of GLP-1 RAs in patients with diabetes that provides reassurance about ongoing treatment.

Because of the budget impact of injectable semaglutide and tirzepatide, payers may still wish to employ step therapy, requiring enrollment in structured obesity management programs and/or trying less expensive medications. If payers choose to employ step therapy, they should do so in a patient-centered manner. For instance, most people living with obesity have tried multiple weight loss programs and obesity medications prior to being prescribed semaglutide or tirzepatide. There is no justification for payers to make patients re-try weight loss programs or medications that they have previously tried and that have failed them. Rather than using older medications from other classes for step therapy, it would be preferable for the reasons above to use other GLP-1 RAs, such as generic liraglutide.

Payers may opt to have one drug from the newer GLP-1 RA class as the preferred formulary option. We heard from clinical experts and patient experts that individualized therapy is needed since there is variation in individual efficacy and side effects with semaglutide and tirzepatide. Therefore, switching from one drug to another without clinical justification may not be appropriate, and if there is a preferred formulary option, payers should have a rapid exceptions process for patients to switch to or continue the non-preferred option.

Purchasers

Recommendation 1

For large employers and other entities tasked with providing health benefits to patients, consider some of the innovative direct-to-business options being tried to expand access to comprehensive obesity care.

In addition to the carve-out programs described above like those being offered by AT&T and the state of Connecticut, there is an emerging trend towards disintermediated delivery of medicines for obesity direct from the manufacturer to the purchaser. Recently, several efforts, such as those through Waltz Health, give employers the opportunity to offer access to tirzepatide and semaglutide directly, with transparent pricing, outside the traditional PBM arrangement.[10] Coupled with the recent direct-to consumer efforts, these direct-to-business sales may offer another innovative solution to providing more affordable access to the medicines. Transparent, upfront pricing is a hallmark of both approaches which could represent a shift in how the ecosystem understands and operationalizes rebates and discounts, in service to broader access for patients.

Manufacturers

Recommendation 1

For existing GLP-1 RA manufacturers, and those with products in the pipeline, consider steep discounts to prices in exchange for higher volume.

While the net prices of tirzepatide and semaglutide have decreased significantly, the budget impact for treating all patients with these drugs remains large. The manufacturers have demonstrated the ability to reduce prices even further with the recently announced negotiated price for Medicare for the lowest dose of semaglutide of $274/month, and the announcement from the Trump administration of $245/month pricing for both drugs for Medicare and Medicaid.[11] While details of that deal are still emerging, it does show that the manufacturers are willing to offer significant price concessions. Makers of the existing approved obesity medicines, as well as those with obesity products in the pipeline, should consider a pricing strategy that maximizes affordable access, such as lower prices that will lead to more prescriptions, ensuring significant revenue to fund future innovation.

Recommendation 2

For existing GLP-1 RA manufacturers, extend the same ability offered to CMS to narrow the eligible patient population to other payers and purchasers without reducing the rebate or discount available.

In the development of our White Paper, we learned that several payers and purchasers attempted to offer access to GLP-1 RAs to patients only with co-morbidities and obesity, or with more severe obesity. Those payers reported that discounts or rebates were not available if the patient population were narrowed. Now that both manufacturers have shown a willingness to offer steep discounts to Medicare and Medicaid, even with a narrowed patient population, similar arrangements should be made available to other payers. The narrower patient population for Medicare and Medicaid is reported to be: 1) BMI ≥27 with prediabetes or established CV disease, 2) BMI ≥30 with uncontrolled hypertension, kidney disease, or heart failure, or 3) BMI ≥35.[12]

Clinicians and Clinical Societies

Recommendation 1

Ensure timely updates to obesity treatment guidelines to reflect current treatment options in a form that is easy to interpret and use by clinicians, patients, and payers.

The most recent clinical practice guidelines for the treatment of obesity were published in 2022 by the American Gastroenterology Association, prior to the approval of tirzepatide for the treatment of obesity in 2023. Clinical societies should have processes in place to be able to update their practice guidelines quickly when new therapies that may change clinical practice are approved, since payers often base their coverage decisions and integration of utilization tools to a great extent on clinical guidelines. Clinical societies should follow the example of the National Comprehensive Cancer Network (NCCN), which updates their guidelines for cancer treatment at least annually and when needed with the approval of significant new treatments.

Recommendation 2

Obesity medicine clinical societies and obesity medicine certified clinicians should endeavor to facilitate the education of and support primary care physicians in providing comprehensive management of obesity.

Given the large size of the population affected by obesity, much of the treatment of obesity, including prescribing medications, will be done by primary care clinicians. However, we heard from patients and patient advocacy groups that finding clinicians who are well-versed in obesity management and can provide comprehensive, culturally sensitive care can be difficult, particularly in more rural areas. Given workforce limitations, it will be a challenge for persons living with obesity who may qualify for treatment with semaglutide or tirzepatide to be able to get treatment in a timely manner. Clinical specialty societies have a role in facilitating the education of non-obesity medicine specialists to facilitate timely access to treatment if indicated.

Patient Organizations

Recommendation 1

Patient organizations should continue to advocate for affordable access to comprehensive obesity care, including access to clinicians for evaluation and treatment, and insurance coverage of behavioral therapy, nutritional support, bariatric surgery, and obesity medications.

Individuals living with obesity shared that one of the biggest challenges to treatment is the lack of access to comprehensive obesity care. Present access to obesity care is often piecemeal – outside of obesity management programs, patients are often left to navigate finding care on their own. Additionally, there is a shortage of primary care physicians who are knowledgeable about treatment of obesity as well as an extreme shortage of obesity medicine specialists. Coupled with the uneven and restricted insurance coverage of obesity medications, very few individuals living with obesity could be considered as having access to comprehensive and affordable obesity care.

Patient organizations should follow the example of the Obesity Action Coalition and the STOP Obesity Alliance, who have used their voices to advocate for state-level legislation to improve access to comprehensive obesity care and issued evidence-based treatment guidelines for a comprehensive obesity benefit (https://stop.publichealth.gwu.edu/sites/g/files/zaxdzs4356/files/2022-02/cob_checklist.pdf). Continuation of such efforts are essential for ensuring that all individuals living with obesity have access to appropriate and affordable care.

Researchers

Recommendation 1

Funding agencies and researchers should put a high priority on understudied aspects of obesity, including increasing the precision of the diagnosis of obesity, characterizing caregiver burden, the feasibility of treatment de-escalation or withdrawal, the effectiveness of drugs compared to each other, and the long-term efficacy and safety of GLP-1 RA and GLP-1/GIP RAs.

BMI alone is currently the standard to diagnose obesity. However, there are limitations to using BMI as the main diagnostic criteria, as it is an imperfect measure of the consequences of obesity, since some people with higher BMI may not show any metabolic consequences of obesity, and some subgroups may show impact at BMIs lower than 26. The most recent Lancet Diabetes & Endocrinology Commission report suggests combining BMI with a second assessment of anthropometric measures or biomarker testing.[13] However, which measures or biomarkers are both accurate and feasible to implement in clinical practice requires further study.

Additional research gaps include the long-term efficacy and safety of the drugs, including whether treatment de-escalation or withdrawal is possible without significant weight re-gain. Furthermore, in conducting our systematic review, we found a lack of comparative data in the population of interest for some critical patient-important outcomes, including cardiovascular outcomes. While real-world evidence studies have been published to estimate such effects, due to the risk of bias in observational studies, for critical outcomes such as CV disease, manufacturers, funders, and researchers should aim to do head-to-head clinical trials, such as was done in SURMOUNT-5 (tirzepatide vs injectable semaglutide).

Finally, there has been little research into the experience of caregivers, particularly family caregivers, of people living with obesity. This is an important dimension to capture, particularly when assessing the benefits of obesity treatment from a societal perspective.

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Appendix

Appendix Tables 1 through 3 contain conflict of interest (COI) disclosures for all participants at the November 13, 2025 Public meeting of Semaglutide and Tirzepatide for Obesity.

Appendix Table 1. ICER Staff and External Collaborators Conflict of Interest Disclosures

ICER Staff and External Collaborators	Conflict of Interest
Sarah K. Emond, MPP **President & CEO, Institute for Clinical and Economic Review**	No conflicts to disclose.
Shahariar Mohammed Fahim, PhD Research Lead, Institute for Clinical and Economic Review	No conflicts to disclose.
Chloe Fandetti, BA Operations & Program Coordinator, Institute for Clinical and Economic Review	No conflicts to disclose.
Anna Geiger, BS Communications Coordinator, Institute for Clinical and Economic Review	No conflicts to disclose.
Grace Ham, MSc Senior Strategic Partnerships & Events Coordinator, Institute for Clinical and Economic Review	No conflicts to disclose.
Woojung Lee, PharmD, PhD Associate Director of Health Economics and Decision Modeling	No conflicts to disclose.
Grace Lin, MD, MAS Medical Director for Health Technology Assessment	Financial support provided to Grace Lin from the Institute for Clinical and Economic Review (ICER). Dr. Lin also reports receiving research grant funding from the National Human Genome Research Institute, National Institute on Aging, Mt. Zion Health Fund, GRAIL, Inc., and the California Health Benefits Research Program.
Becca Piltch, MPP Program Manager, Institute for Clinical and Economic Review	No conflicts to disclose.
Finn Raymond, BS Research Assistant, Institute for Clinical and Economic Review	No conflicts to disclose.
David Rind, MD, MSc Chief Medical Officer, Institute for Clinical and Economic Review	No conflicts to disclose.

Appendix Table 2. New England CEPAC Panel Member Participants Conflict of Interest Disclosures

New England CEPAC Member	Conflict of Interest
Rob Aseltine, PhD Professor and Chair, Division of Behavioral Sciences and Community Health Director, Center for Population Health, UCONN Health	No conflicts to disclose.
Austin Frakt, PhD Vice President and Chief Research Officer, Joint Commission	No conflicts to disclose.
Rebecca Kirch, JD EVP, Policy and Programs for the National Patient Advocate Foundation (NPAF)	No conflicts to disclose.
Stephen Kogut, PhD, MBA, RPh Professor of Pharmacy Practice, University of Rhode Island College of Pharmacy	No conflicts to disclose.
Donald Kreis, JD Consumer Advocate, New Hampshire Office of the Consumer Advocate	No conflicts to disclose.
Julie Kueppers, PhD, FNP Vice President of Clinical Analytics and Advocacy, Alera Group	No conflicts to disclose.
Tara Lavelle, PhD Assistant Professor, Center for the Evaluation of Value and Risk in Health at Tufts Medical Center	No conflicts to disclose.
Kimberly Lenz, PharmD, MBA, FAMCP Chief Pharmacy Officer, MassHealth Office of Clinical Affairs, UMass Chan Medical School	Dr. Kimberly Lenz's employer, MassHealth, currently covers products for Obesity.
Aaron Mitchell, MD, MPH Assistant Attending, Memorial Sloan Kettering Cancer Center	No conflicts to disclose.
Josephine Porter, MPH Chief Strategy Officer, NH Center for Justice and Equity Consultant, Institute for Health Policy and Practice Co-Chair, All-Payer Claims Database Council Board of Director Chair, NH Fiscal Policy Institute and Leadership Team for the NH Food Alliance	No conflicts to disclose.
Jim Rebitzer, PhD Emeritus Peter and Deborah Wexler Professor of Management, Boston University, Questrom School of Business	No conflicts to disclose.
Joseph Ross, MD, MHS Professor of Medicine (General Medicine) and Professor of Public Health (Health Policy and Management), Yale School of Medicine Associate Physician of the Center for Outcomes Research and Evaluation, Yale-New Haven Health System Co-Director, National Clinician Scholars Program, Yale University	No conflicts to disclose.

New England CEPAC Member	Conflict of Interest
Co-Director, Yale-Mayo Clinic Center for Excellence in Regulatory Science and Innovation (CERSI)	
Jason L. Schwartz, PhD Associate Professor, Department of Health Policy and Management, Yale School of Public Health Affiliated with Yale's Institution for Social and Policy Studies and the Section of the History of Medicine, Yale School of Medicine	No conflicts to disclose.
Jason H. Wasfy, MD, MPhil Associate Professor at Harvard Medical School, Director of Outcomes Research, Massachusetts, General Hospital Cardiology Division Mass General Brigham	No conflicts to disclose.
Stephanie Vail, PharmD, MPH, BCPP, BCPS, FCCP, Professor of Pharmacy Practice, University of New England College of Pharmacy	No conflicts to disclose.

Appendix Table 3. Policy Roundtable Participants and COI Disclosures

Policy Roundtable Participant	Conflict of Interest
Jason Brett, MD Principal Medical Head, Novo Nordisk Inc.	Dr. Jason Brett is a full-time employee at Novo Nordisk Inc.
Pat Gleason, PharmD, FCCP, FAMCP, BCPS	Dr. Pat Gleason is a full-time employee at Prime Therapeutics.

Assistant Vice President, Health Outcomes**,** Prime Therapeutics, LLC	
Alyssa Guest, PharmD Associate Director, Clinical Pharmacy at IPD Analytics	Dr. Alyssa Guest is a full-time employee at IPD Analytics.
Melanie Jay, MD, MS Professor, Departments of Medicine and Population Health, NYU Grossman School of Medicine	No conflicts to disclose.
Joe Nadglowski President/CEO**,** Obesity Action Coalition	Joe Nadglowski has no personal relationships with industry. The Obesity Action Coalition receives 25% of financial support from health care companies including, Boehringer Ingelheim, Eli Lilly, Novo Nordisk, Amgen, Pfizer, AstraZeneca, Boston Scientific, Currax, Genentech, Intuitive, Kailera Therapeutics, Madrigal Pharmaceuticals, Medtronic, Regeneron, Rhythm Pharmaceuticals, Structure Therapeutics, Wave Life Sciences and Zealand Pharma.
Tracy Sims, MA Executive Director, Corporate Affairs, Eli Lilly and Company	Tracy Sims is a full-time employee at Eli Lilly and Company.
Michele Tedder, MSN, RN, BCC Director of Chronic Disease, Black Women's Health Imperative	Michele Tedder is an Obesity Action Coalition board member.
Alexa Triot, MD Clinical Director, Weight Management Programs, and Primary Care Physician, Healthcare Associates at Beth Israel Deaconess Medical Center	Dr. Alexa Triot's spouse works for Verve Therapeutics, a wholly owned subsidiary of Eli Lilly and Company.