

The \$100 Billion Paradox: Strategic Imperatives for the GLP-1 Obesity Market

Executive Summary

The GLP-1 obesity market represents one of the most promising yet structurally fragile opportunities in modern pharmaceuticals. While 2024 revenues reached approximately \$52–63 billion, discussions around a potential \$300 billion market by 2030 overlook fundamental constraints that limit the sector’s true expansion potential. A realistic projection, accounting for price erosion, payer restrictions, and real-world adherence, places the 2030 market in the **\$110–125 billion range**.

The central determinant shaping the industry’s trajectory is **patient retention**. Clinical trials report persistence above 85 percent, yet real-world data shows that **68 percent of patients discontinue therapy within the first year**. This retention cliff erodes lifetime value (LTV), disincentivizes payer coverage, and compresses margins for manufacturers. Discontinuation also triggers rapid weight loss (50 percent of lost weight returning within six months) making the commercial model inherently cyclical rather than chronically sustainable.

At the same time, **oral GLP-1 formulations** are emerging as the most significant catalyst for future growth. Although less potent than injectable tirzepatide, oral molecules remove the psychological and practical barriers associated with weekly injections, opening access to a much broader population—particularly individuals motivated by lifestyle or cosmetic goals rather than strict medical necessity. As a result, convenience, rather than incremental efficacy, is likely to drive the next wave of market expansion.

Competitive dynamics are tightening. Eli Lilly holds a meaningful long-term advantage due to superior efficacy, a deeper next-generation pipeline, and longer patent protection. Novo Nordisk retains strong brand recognition and first-mover advantage, but the market is shifting rapidly toward multi-agonist and oral modalities where Lilly’s portfolio is better positioned.

Ultimately, the GLP-1 category can no longer rely on a traditional **product-centric model**. Success will depend on moving toward a **fully integrated, outcomes-based ecosystem** that addresses the entire patient journey—from initiation and titration to long-term weight maintenance. Companies able to align therapeutic efficacy with

behavioral support, payer incentives, and structured adherence programs will be the ones that unlock the market's full potential.



1. Market Landscape: Anatomy of the Gold Rush

1.1 Market Sizing: The Great Divergence

The GLP-1 market exhibits unusual forecast variance, with 2030 projections ranging from \$95 billion (Goldman Sachs) to \$300 billion (DataM Intelligence) - a 3x spread driven by conflicting assumptions on three critical variables:

Current Market (2024)

- **Total Addressable Market (TAM):** \$52-63 billion across all GLP-1 indications
- **Serviceable Addressable Market (SAM):** Diabetes Type 2 at \$30.7B (58%), Obesity at \$22.2B (42%)
- **Serviceable Obtainable Market (SOM):** Novo Nordisk (\$29.3B) + Eli Lilly (\$16.5B) = \$45.8B, representing 88% market concentration

Forecast Scenarios (2030)

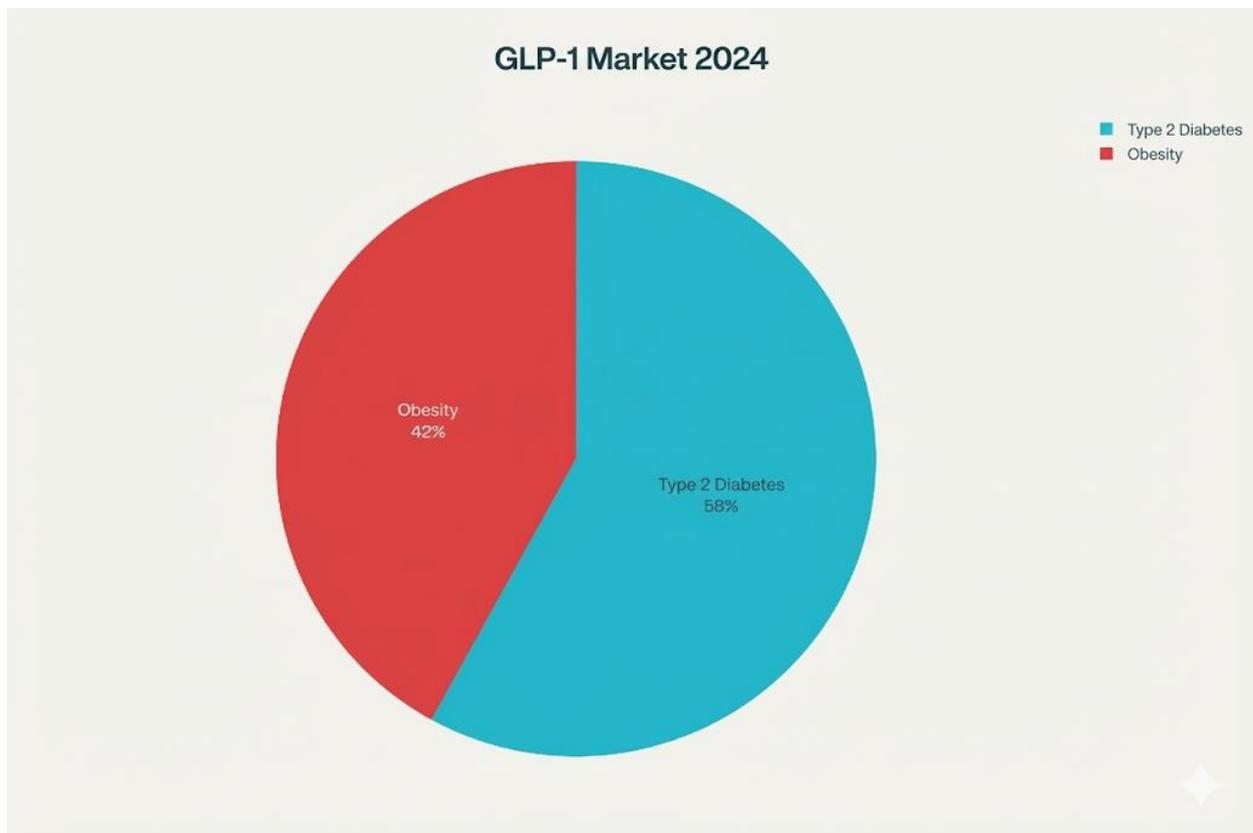
Source	CAGR	Market Forecast
Grand View Research	17,46%	\$156,71 billion by 2030
Fortune Business Insights	16,8%	\$186,64 billion by 2032
Market.us	17,5%	\$268,4 billion by 2034
MarketsandMarkets	13,0%	\$170,75 billion by 2033
DataM Intelligence	17,6%	\$299,08 billion by 2033

The Divergence Explained: Three variables account for 80% of forecast variance:

- Price Erosion Trajectory:** Goldman Sachs models 7% annual erosion through 2030, driven by direct-to-consumer channels (Eli Lilly's \$299 vials), biosimilar threat post-2031, and payer negotiation leverage. Each 1% variance in erosion rate impacts 2030 revenues by \$6-8 billion. Conservative forecasts assume cumulative price decline of 35-40% vs. current list prices.
- Insurance Coverage Expansion:** Medicare currently excludes obesity indication (statutory prohibition), removing \$60B+ in potential TAM. Employer-sponsored coverage for obesity reached 43% among large employers (5,000+ employees) in 2025, up from 28% in 2024—a 54% YoY increase. However, medium-sized employers (200-999 employees) lag at 19% coverage. A Medicare extension scenario would add \$65.9 billion over 10 years but generates only \$18.2 billion in healthcare savings, creating a \$47.7 billion net cost burden.
- Real-World Persistence:** Clinical trials demonstrate 85%+ adherence, but real-world data shows 32% persistence at one year. Optimistic forecasts assume improved formulations (oral GLP-1s, monthly injectables) will bridge this gap to 50-60% persistence. Conservative models factor current discontinuation rates as structural.

1.2 Market Composition Shift: Diabetes Erosion, Obesity Ascendancy

The market is undergoing a fundamental recomposition:



2024 Breakdown:

- Type 2 Diabetes: 58% (\$30.7B) | Growth: +26% YoY (Ozempic)
- Obesity/Weight Management: 42% (\$22.2B) | Growth: +86% YoY (Wegovy)

Projected 2030 Split (TD Securities):

- Type 2 Diabetes: 59% (\$82B) | Mature, decelerating growth
- Obesity: 41% (\$58B) | Accelerating, becoming co-dominant

Strategic Implication: The obesity segment exhibits 3x faster growth velocity but faces structural headwinds absent in diabetes (no Medicare coverage, higher discontinuation, weaker medical necessity narrative). DataM Intelligence projects obesity will reach 50% of total revenues by 2030, but this assumes resolution of access barriers that remain politically intractable.

2. Competitive Dynamics: The War for Efficacy vs. Convenience

2.1 Current Duopoly: Novo Nordisk vs. Eli Lilly

The GLP-1 market is dominated by a tight duopoly, with Novo Nordisk and Eli Lilly jointly controlling approximately 88% of global revenues in 2024. Novo Nordisk's dominance is built on the semaglutide platform, which includes Ozempic for Type 2 diabetes, Wegovy for obesity, and Rybelsus as the oral formulation for diabetes. Ozempic alone generated \$17.47 billion in 2024, growing 26 percent year-over-year, while Wegovy nearly doubled its revenues to \$8.45 billion. Rybelsus added an additional \$3.38 billion, solidifying Novo's position across both injectable and oral markets. Clinically, semaglutide delivers 15–17 percent weight loss at 68 weeks, and Novo retains the advantage of having been the first company to commercialize an obesity-specific GLP-1 therapy.

Eli Lilly's portfolio, however, is rapidly reshaping competitive dynamics. Tirzepatide (marketed as Mounjaro for diabetes and Zepbound for obesity) generated a combined \$16.47 billion in 2024, with Mounjaro growing an astonishing 124 percent year-over-year. Clinically, tirzepatide offers a substantial efficacy advantage: 21–26 % weight loss across 72–88 weeks in the SURMOUNT trials, driven by dual GLP-1/GIP agonism. Beyond efficacy, Lilly benefits from stronger long-term patent protection, with exclusivity extending through 2036–2037, compared to Novo's 2031–2032 expiry for semaglutide. This gives Lilly a longer runway to maintain premium pricing and scale before facing biosimilar competition.

Overall, while Novo Nordisk maintains a lead in installed base and brand recognition, Eli Lilly holds the superior clinical profile and the more protective intellectual property position—factors that increasingly shift long-term advantage in its favor.

Novo Nordisk (Semaglutide Platform) - \$29.3B

- **Ozempic** (Type 2 Diabetes): \$17.47B | +26% YoY | Subcutaneous, 2.4mg weekly
- **Wegovy** (Obesity): \$8.45B | +86% YoY | Same molecule, rebranded indication
- **Rybelsus** (Oral Diabetes): \$3.38B | +26% YoY | Daily oral, lower bioavailability

Efficacy Profile: 15-17% weight loss at 68 weeks (STEP trials). First-mover advantage in both diabetes and obesity indications.

Eli Lilly (Tirzepatide Platform) - \$16.47B

- **Mounjaro** (Type 2 Diabetes): \$11.54B | +124% YoY | Subcutaneous, 15mg weekly
- **Zepbound** (Obesity): \$4.93B | First full year | Same dual-agonist mechanism

Efficacy Profile: 21-26% weight loss at 72-88 weeks (SURMOUNT trials). Superior efficacy driven by dual GLP-1/GIP agonism vs. Novo's GLP-1-only mechanism.

Competitive Assessment:

- **Clinical Superiority:** Eli Lilly holds a 6-9 percentage point efficacy advantage—clinically meaningful and commercially valuable in head-to-head positioning.
- **Market Entry Timing:** Novo's 24-month first-mover advantage in obesity (Wegovy approved June 2021 vs. Zepbound November 2023) created installed base and brand recognition.
- **Patent Cliff:** Semaglutide patents expire 2031-2032; tirzepatide protected through 2036-2037, giving Lilly extended exclusivity runway.

2.2 The Oral Disruption: Convenience as Competitive Moat

Modality convenience emerges as the critical differentiator for driving population-level adoption beyond the early-adopter segment.

Injectable Barrier: Survey data indicates 15-25% of potential patients reject therapy solely due to needle aversion, creating artificial demand constraint.

Oral GLP-1 Pipeline (2025-2027 Market Entry):

Drugs	Weight Loss	Trial duration	Reference Trial
Wegovy (Semaglutide 2,4mg)	15-17%	68 weeks	STEP 1-5
Zepbound (Tirzepatide 15mg)	21-26%	72-88 weeks	SURMOUNT 1-4
Retatrutide 12mg	24,2%	48 weeks	Phase 2 (Jastreboff et al.)
Orforglipron 36mg	12-15%	36-40 weeks	Phase 3 complete

Strategic Trade-Off Analysis: Orforglipron delivers 70-80% of Zepbound's efficacy but eliminates the injection barrier. Behavioral economics suggests convenience wins for

the "weight management" patient segment (cosmetic motivation), while efficacy dominates for the "medical obesity" segment (BMI >35, comorbidities).

Key Insight: Efficacy exhibits diminishing returns beyond 20% weight loss for most patients. The marginal utility of 26% vs. 20% loss is lower than the utility gain from daily pill vs. weekly injection. **Orforglipron's commercial potential may exceed its clinical profile** due to superior patient experience.

2.3 Next-Generation Pipeline: Triple Agonists and Extended-Duration

Retatrutide (Eli Lilly) - Phase 3, results expected late 2025/early 2026

- **Mechanism:** Triple agonist (GLP-1/GIP/Glucagon) - "Triple G"
- **Efficacy:** 24.2% weight loss at 48 weeks (Phase 2)
- **Hypothesis:** Glucagon activation increases fatty acid oxidation and energy expenditure beyond dual agonism
- **Commercial Impact:** If Phase 3 confirms >24% efficacy with acceptable tolerability, Retatrutide becomes best-in-class and extends Lilly's market dominance through 2035+

MariTide (Amgen) - Phase 3, readout 2027

- **Mechanism:** GLP-1 agonist + GIP antagonist (inverse of Lilly's approach)
- **Efficacy:** 16-20% weight loss at 52 weeks
- **Administration:** Monthly injection (vs. weekly competitors)
- **Challenge:** Phase 2 data showed 92% vomiting rate without dose titration, requiring protocol modification for Phase 3

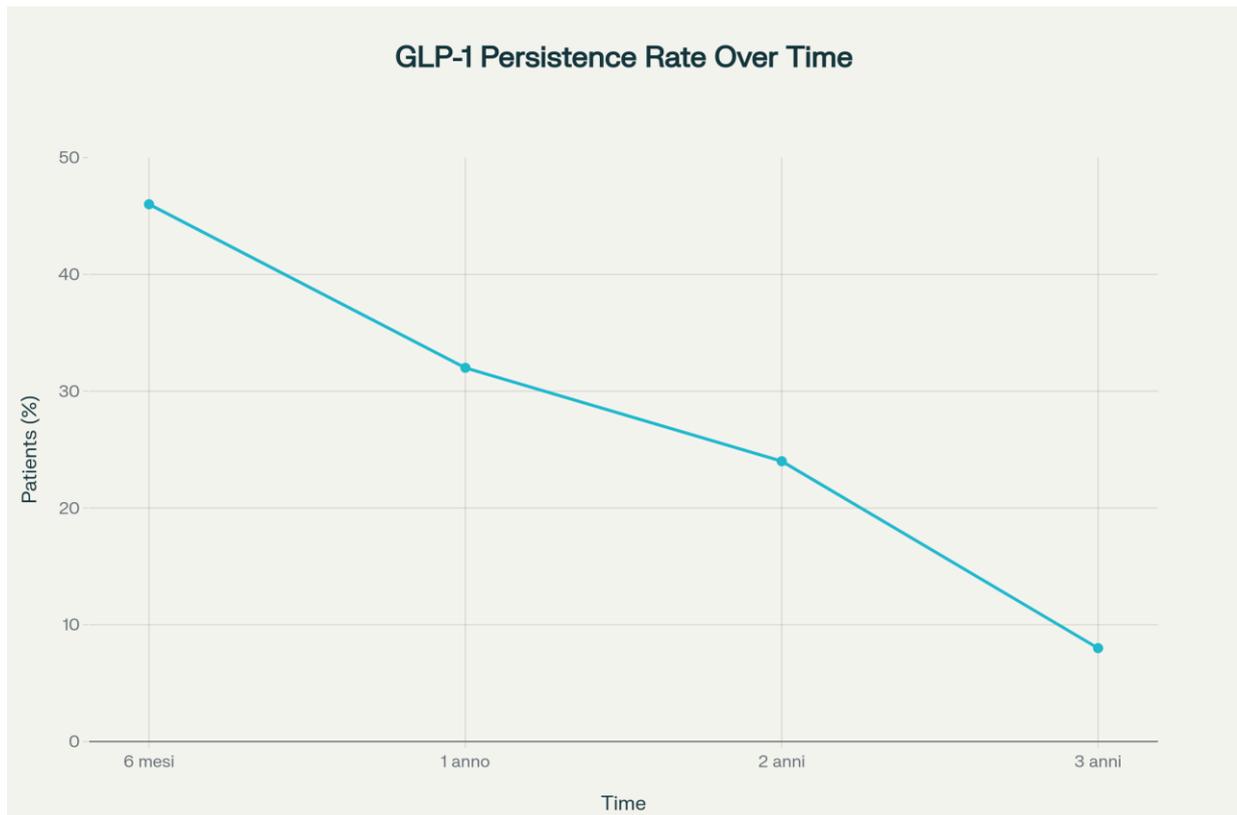
CagriSema (Novo Nordisk) - Phase 3 complete

- **Mechanism:** Semaglutide + Cagrilintide (amylin analog)
- **Efficacy:** 22.7% weight loss at 68 weeks (REDEFINE-1)
- **Strategic Positioning:** Novo's response to Lilly's superior tirzepatide efficacy; 50.7% of patients achieved BMI <30

3. The Retention Cliff: The Existential Threat to Market Economics

3.1 The Real-World Persistence Gap

The GLP-1 market faces a crisis of retention that fundamentally challenges the economic model:



Context: These real-world persistence rates stand in stark contrast to clinical trial adherence (85%+), revealing a 2.5-3x gap between controlled research settings and commercial deployment.

Indication-Specific Divergence:

- **Diabetes + Obesity:** 46.5% discontinue at 1 year | 47.3% reinitiate within 1 year
- **Obesity Only:** 64.8% discontinue at 1 year | 36.3% reinitiate within 1 year

Root Cause Analysis: Patients using GLP-1s solely for obesity exhibit 40% higher discontinuation than those with diabetes comorbidity, driven by:

1. Weaker insurance coverage (43% vs. 55% employer coverage)
2. Perception of temporary intervention vs. chronic disease management

3. Lower medical urgency once cosmetic weight goals achieved

3.2 Drivers of Discontinuation: A Multi-Factor Breakdown

Primary Discontinuation Factors (ISPOR 2025 study, 125,474 patients):

1. **Gastrointestinal Adverse Events (28.2%)**
 - a. Nausea: 44% of patients (vs. 16% placebo)
 - b. Diarrhea: 30% (vs. 16% placebo)
 - c. Vomiting: 24% (vs. 6% placebo)
 - d. Constipation: 24% (vs. 11% placebo)
 - e. **Clinical Note:** GI events are dose-dependent, most severe during titration phase, and typically transient (resolve within 4-8 weeks). However, 4-11% of patients experience persistent severe GI symptoms requiring discontinuation.
2. **Cost and Access Barriers (12-17%)**
 - a. List prices: Wegovy \$16,200/year, Zepbound \$12,700/year
 - b. Out-of-pocket costs for uninsured/underinsured: \$1,000-1,350/month
 - c. **Danish national study:** 18% of patients abandon therapy within 3 months, correlating with insurance authorization delays and cost-sharing tiers.
3. **Perceived Treatment Completion (Variable)**
 - a. Patients using GLP-1s for "weight management" (vs. "medical obesity") treat therapy as time-limited intervention
 - b. Discontinuation accelerates after achieving target weight (BMI <30 or specific pound goal)
 - c. Lack of education on chronic disease model and weight regain risk
4. **Supply Chain Disruptions (2023-2024, now resolved)**
 - a. Acute shortages through October 2024 (tirzepatide) and February 2025 (semaglutide)
 - b. Forced treatment interruptions created permanent discontinuation for ~15-20% of affected patients

3.3 The Rebound Effect: Weight Regain Economics

Perhaps the most damaging finding: **GLP-1 discontinuation leads to rapid, substantial weight regain**, undermining the value proposition of the initial therapy investment.

Clinical Evidence:

- **Tirzepatide (SURMOUNT):** Patients regain ~50% of lost weight within 6 months post-treatment
- **Semaglutide/Liraglutide:** Patients regain 66% of lost weight within 12 months post-treatment
- **Mechanism:** Cessation of appetite suppression, reduction in resting energy expenditure, preferential regain of fat mass vs. lean mass
- **Timeframe:** Weight regain initiates within 2 months of discontinuation (BMC Medicine, July 2025)

Critical Finding: Weight regain occurs even in patients maintaining diet and exercise protocols, suggesting pharmacologic dependence for weight maintenance.

3.4 Business Implications: Broken Unit Economics

The retention cliff creates a fundamental financial problem:

Patient Lifetime Value (LTV) Calculation:

- Average treatment duration (real-world): 7-9 months before discontinuation
- Revenue per patient: \$9,500-12,000 (assuming 60% payer reimbursement on list price)
- Reinitiation rate: 36-47% within 12 months (suggesting "subscription cycling" behavior)

Customer Acquisition Cost (CAC):

- DTC marketing spend: Estimated \$1,500-2,500 per converting patient (Meta/Google ads, influencer partnerships)
- Provider detailing: \$500-800 per prescription (sales rep costs, samples, prior authorization support)
- Compounding: Average 2-3 prior authorization cycles before approval adds \$200-400 administrative burden

LTV/CAC Ratio: 3-5x in current model. Industry benchmark for sustainable SaaS/subscription models: 3x minimum, 5x+ optimal. **GLP-1s sit at the lower bound, suggesting margin pressure and vulnerability to competitive disruption.**

Goldman Sachs Insight: The combination of 7% annual price erosion and 50% discontinuation rates creates a "\$6 billion per percentage point" sensitivity. Each 1% improvement in retention or 1% slowdown in price decline adds \$6B to 2030 market size.

4. Strategic recommendations

To fully capture the long-term value of the GLP-1 category, pharmaceutical companies must adopt a fundamentally different approach, one that prioritizes **patient outcomes, adherence, and ecosystem design** rather than molecular innovation alone.

The first strategic imperative is a shift from selling a drug to delivering **a long-term metabolic health solution**. The **market's greatest weakness—poor persistence—**derives from predictable barriers: gastrointestinal side effects, limited insurance coverage, insufficient patient education, and unrealistic expectations around weight maintenance. An outcomes-centric model would integrate personalized titration, early-phase GI management, digital coaching, behavioral reinforcement, and ongoing weight maintenance protocols. Improving retention by even 10–15 percentage points would unlock tens of billions in cumulative market value by 2030.

A second priority is accelerating the development and market penetration of oral GLP-1 formulations. While injectable options remain the gold standard for clinical efficacy, oral molecules represent the most powerful lever for market expansion. They eliminate needle aversion, simplify onboarding, and significantly broaden the eligible patient population. In particular, they appeal to individuals who view weight loss pharmacotherapy as a wellness-driven or cosmetic intervention. By repositioning orals as the entry point to therapy—potentially preceding injectables—manufacturers can meaningfully increase both initiation and persistence rates.

Third, manufacturers must evolve pricing and reimbursement models in partnership with payers. Traditional fee-for-therapy structures are increasingly incompatible with high discontinuation rates and modest long-term cost savings. **Value-based contracts**, in which rebates or reimbursement tiers are tied to weight outcomes or treatment durability, can increase payer willingness to cover therapy while protecting manufacturer margins. Employer-based insurance plans, especially self-insured groups, offer an immediate opportunity to pilot these models.

Additionally, addressing the first 90 days of therapy should become a strategic priority. The majority of discontinuations occur during this early phase due to titration-related side effects or administrative friction. Providing structured onboarding pathways—such as dynamic titration algorithms, proactive medical check-ins, digital symptom tracking, and short-term coverage support—would significantly reduce early-stage churn.

Finally, companies must prepare for the post-2031 environment, when biosimilars and further competition will exert strong pricing pressure. To preserve differentiation, the competitive battleground will shift from the molecule itself to the **surrounding ecosystem**: proprietary coaching platforms, integrated wearables, metabolic monitoring, subscription-based follow-up programs, and AI-driven personalization. The winners will be companies

that treat their drug not as a standalone product, but as the core engine of a broader metabolic health platform.