Lipik AI
Research

The GLP-1 re-rating lands beyond pharma

Cross-sector re-rating thesis · Investment and strategy committee · June 2026

Overweight the filed adapters, underweight the silent absorbers, wire quarterly triggers

The GLP-1 re-rating lands hardest outside pharma; overweight the adapters re-betting in their filings, underweight the silent, and wire persistence triggers.

1. The wave is durable: US GLP-1 spending reached $71.7 billion in 2023, five times its 2018 level, one in eight US adults now use the drugs, and a Lilly and Novo duopoly past a $1 trillion valuation supplies almost the whole market.

2. The platform keeps widening: oral pills and a rising efficacy frontier broaden reach, four new medical indications unlock insured coverage, and a 2025 pricing reset cut the monthly cash price toward $245 to $350.

3. Every food major now names weight-loss drugs in its 10-K risk factors and repositions, with KPMG sizing the food and beverage hit at $48 billion a year, while UnitedHealth absorbed a 450-basis-point operating-margin collapse without naming the drug class once.

4. Durable value pools with filed adapters and the drug duopoly; persistence near half at twelve months but improving, plus Medicare negotiation in 2027, set the monitored bear case, while QSR, fitness, and devices stay unquantified watch items.

SECTION 1 OF 4

A measured mass-market wave, not a pharma story

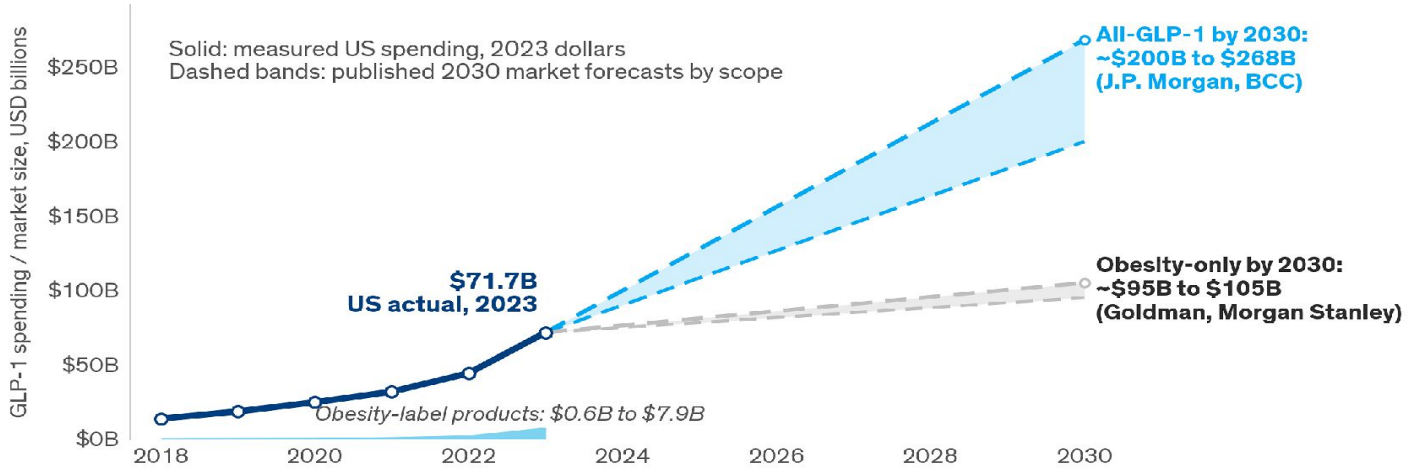
Situation. GLP-1 drugs moved from diabetes clinics into mass consumer use, with US spending reaching $71.7 billion in 2023.

Complication. The prescription mix shifted far beyond diabetes and forecasts tripled the market, yet most portfolios still price the wave as a pharma trade.

Question. How large and how durable is the adoption wave that every downstream sector effect depends on?

GLP-1 spending hit $71.7 billion by 2023; forecasts reach $105 billion obesity-only, $268 billion across all uses

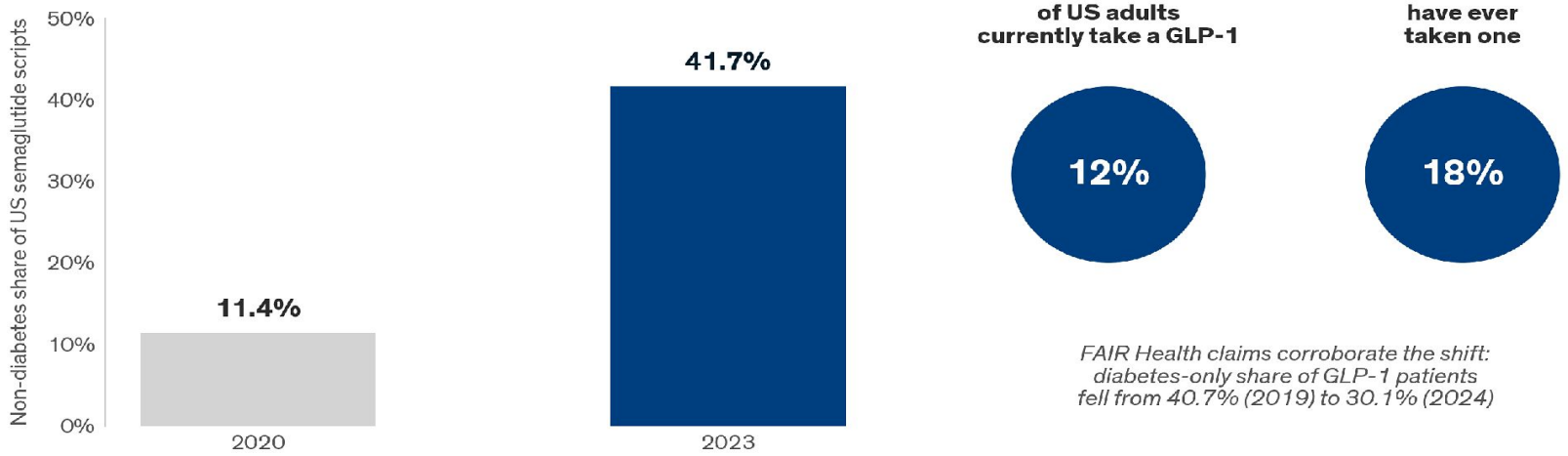
Exhibit 1



Source: JAMA Network Open via PMC, GLP-1 RA spending 2018–2023; J.P. Morgan, obesity drugs; BCC Research, January 2026; Goldman $95B via BioSpace · [1] JAMA Network Open reports growth of more than 500 percent in 2023 dollars; forecasts label scope explicitly, obesity-only (Goldman, Morgan Stanley) versus all-GLP-1 including diabetes (J.P. Morgan, BCC Research).

One in eight US adults take a GLP-1; non-diabetes scripts reached 41.7 percent

Exhibit 2



Source: KFF Health Tracking Poll; Teneo, March 2024; FAIR Health white paper

SECTION 2 OF 4

The engine: a duopoly, a widening pipeline, and a pricing reset

Situation. Two firms, Novo Nordisk and Eli Lilly, supply almost the whole market, and the wave's durability rests on what they ship next.

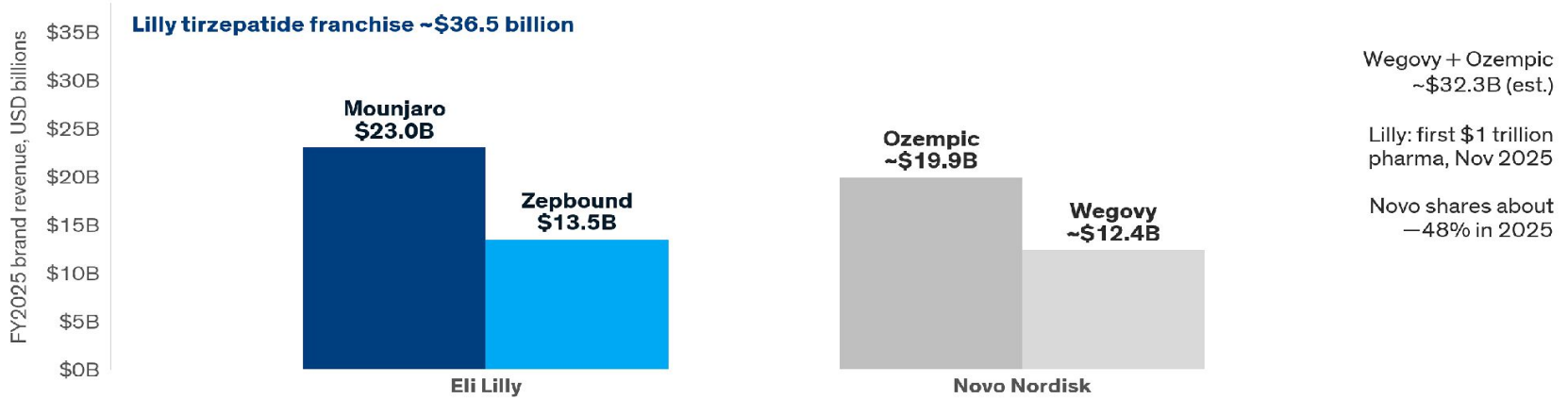
Complication. The efficacy frontier keeps rising and the first oral pills have arrived, even as a 2025 pricing reset cut the cash price by roughly three-quarters.

Question. Is this a transient spike or a durable, widening platform that every downstream sector must plan around?

Two firms own the market, and Lilly's tirzepatide passed Novo to lead the first $1 trillion drugmaker

Exhibit 3

So what. The supply side is a well-capitalized duopoly, not a fragile startup market, so the committee should treat the wave as durable and structural, not a spike to wait out.[1]

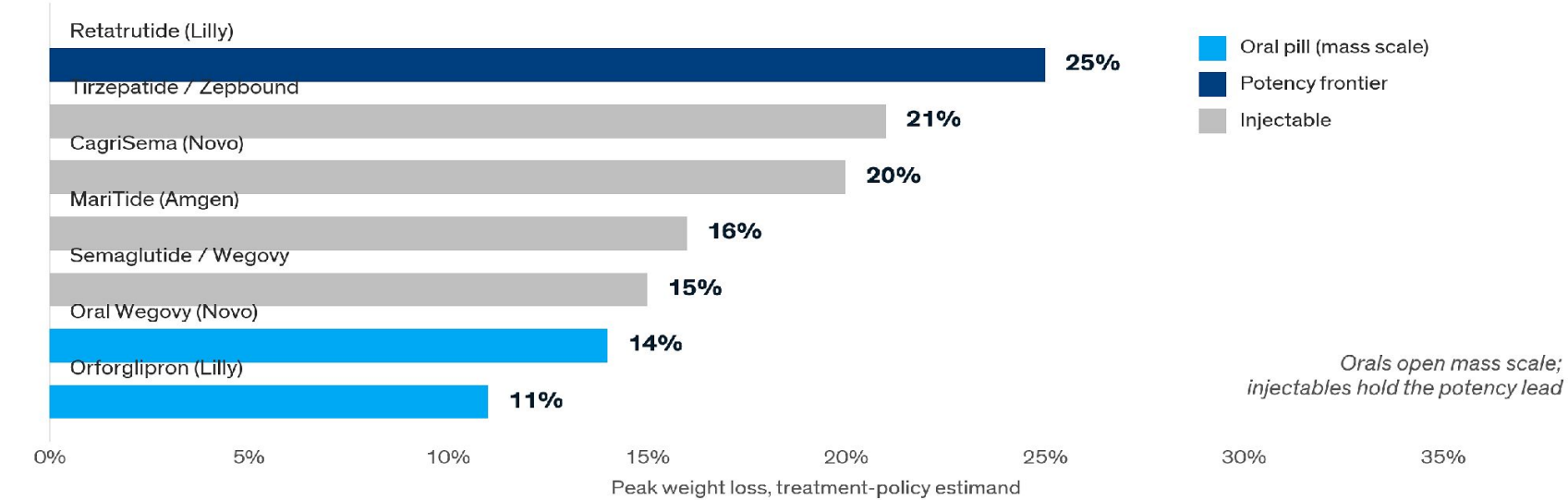


Source: Eli Lilly Q4 and FY2025 results; Novo Nordisk FY2025 6-K; BioPharma Dive, $1 trillion milestone

[1] Novo figures are reported in Danish kroner and converted to USD at about 6.4 kroner per dollar; the dollar values are estimates, not company-reported figures.

The efficacy frontier keeps climbing while the first oral pills trade potency for mass scale

Exhibit 4



Source: SURMOUNT-5 head-to-head, PubMed; Lilly TRIUMPH-1 retatrutide topline; Lilly Foundayo (orforglipron) approval; Novo oral Wegovy approval · [1] Retatrutide is phase-3 topline and not yet peer-reviewed; approved drugs and pipeline candidates are distinguished on the chart. Weight-loss figures use the treatment-policy estimand.

Four approvals turned GLP-1 from a weight-loss drug into a reimbursable cardiometabolic platform

Exhibit 5

So what. Every new medical indication enlarges the insured population the managed-care book must fund, which deepens the silent-absorber problem rather than relieving it.[1]

Each approval clears the statutory Medicare weight-loss exclusion, turning a cash-pay script into a reimbursable therapy
About 19.9 million US adults have established cardiovascular disease

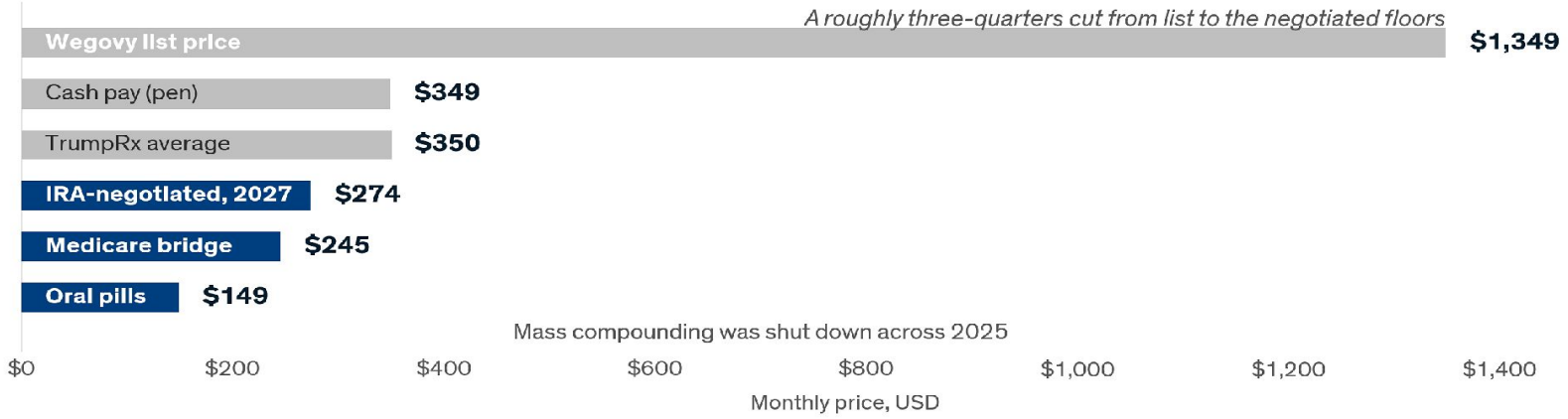
Source: SELECT cardiovascular outcomes, PubMed; SURMOUNT-OSA, PubMed; Wegovy MASH approval, BioSpace; KFF Medicare eligibility

[1] Cardiovascular, sleep apnea, kidney, and MASH indications are FDA-approved; the Alzheimer's program was terminated in November 2025 after the EVOKE trials missed their primary endpoint.

A 2025 policy reset cut the monthly cash price by roughly three-quarters

Exhibit 6

So what. The price barrier that capped adoption is falling, so the consumer spillover accelerates while the insurer cost story worsens, and unit economics compress toward the negotiated floors.[1]



Source: Wegovy list and cash price; White House most-favored-nation fact sheet; KFF Medicare bridge; BioPharma Dive, IRA-negotiated price

[1] Figures are list and cash prices; net realized price is estimated near $600 to $750 a month by analysts and is not company-disclosed.

SECTION 3 OF 4

Five sectors absorb the shock at two speeds

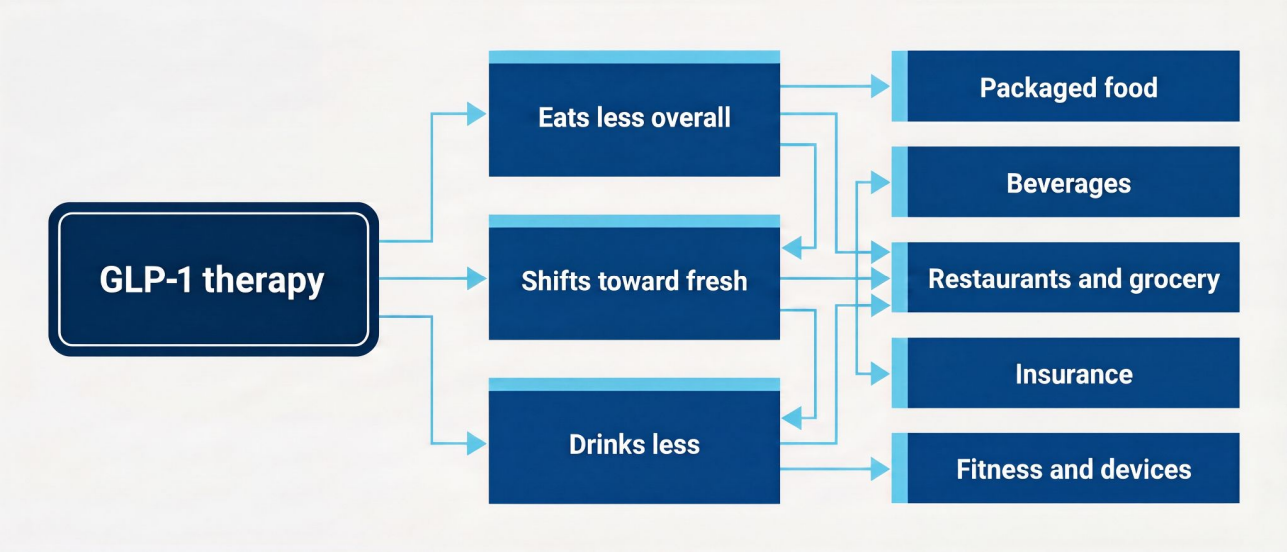
Situation. Users change what they eat, drink, and buy within months of starting therapy, and retailers already see it in the basket.

Complication. The disclosure record has split: every food major now names weight-loss drugs in its 10-K while the largest insurer absorbs the cost wave in silence.

Question. Which sectors and names are adapting, which are exposed, and how can primary records tell them apart?

One molecule reaches five consumer P&Ls through the same behavior change

Exhibit 7

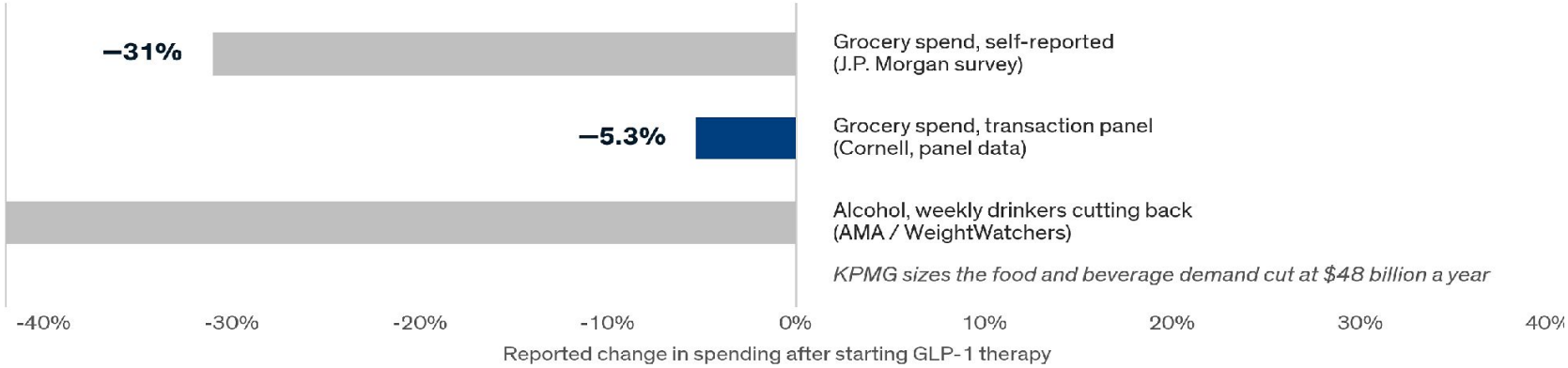


Source: Teneo, The Multi-Sector Impacts of GLP-1RA Drugs, March 2024; UC Davis FoodTech 11

Self-reports show grocery spend down 31 percent; transaction panels put the real cut near 5 percent

Exhibit 8

So what. The behavior change is real and directional but its size is genuinely uncertain, so the stance keys on the direction KPMG capitalizes into a $48 billion annual demand cut, not on a single survey number.[1]

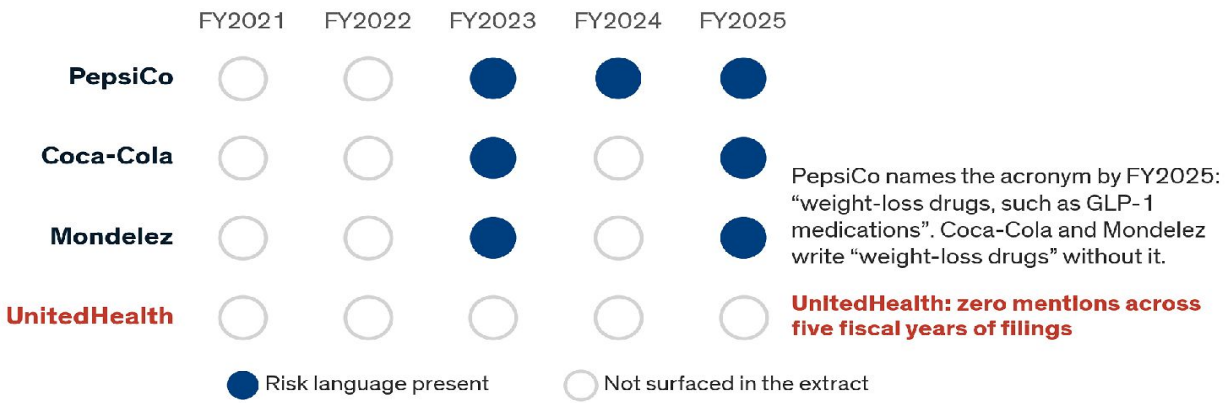


Source: J.P. Morgan, obesity drugs; Cornell transaction-panel study; KPMG, GLP-1 users and food and beverage; Teneo, March 2024

[1] The 31 percent grocery figure is a self-reported J.P. Morgan survey result; the 5.3 percent figure is a Cornell transaction-panel estimate. The two measure different things and bound the true effect.

Every food major now names weight-loss drugs in its 10-K; the insurer carrying the cost does not

Exhibit 9

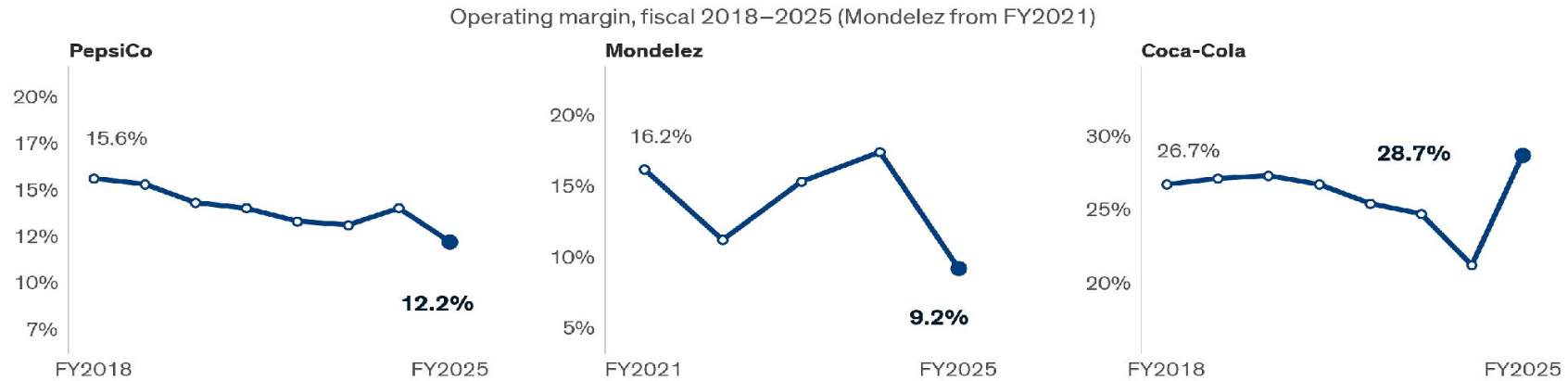


Source: PepsiCo 10-K FY2025; Coca-Cola 10-K FY2025; Mondelez 10-K FY2025; UnitedHealth 10-K FY2025; SEC EDGAR five-year walks

Pricing carries food revenue while PepsiCo and Mondelez margins compress beneath

Exhibit 10

So what. Topline resilience is pricing-led while volume and mix erode, so the basket shift lands exactly where the behavior data says it should.[1]



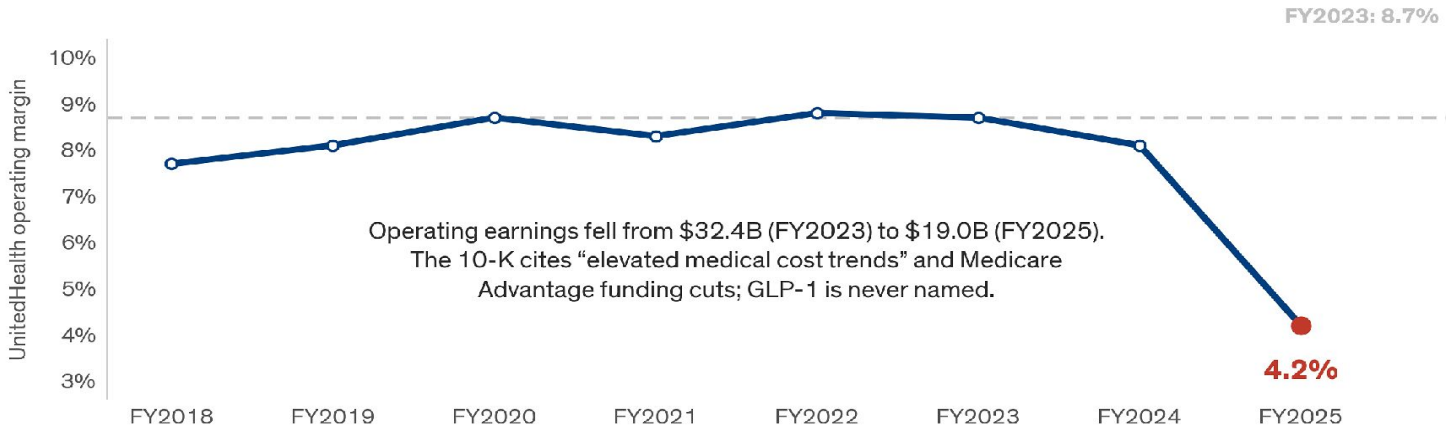
Source: PepsiCo 10-K FY2025; Mondelez 10-K FY2025; Coca-Cola 10-K FY2025; SEC XBRL company facts

[1] Attribution is confounded: Mondelez assigns fiscal 2025 margin compression primarily to record cocoa input costs; GLP-1 demand effects are not isolated as a line item in any of the three filings.

UnitedHealth operating margin halved in two years; the filings never name the drug class

Exhibit 11

So what. The largest managed-care P&L absorbed a 450-basis-point margin collapse while its public record stays silent on the drug class; silence is not a strategy the portfolio should fund.[1]



Source: UnitedHealth 10-K FY2025; Teneo, March 2024; KFF Health Tracking Poll

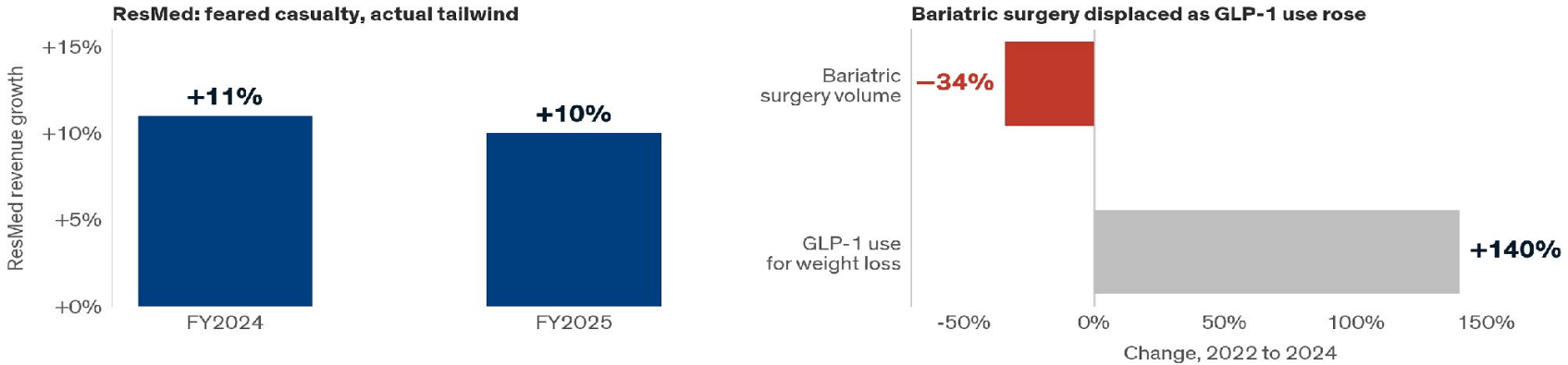
[1] The 10-K attributes the decline to Medicare Advantage funding cuts and elevated medical cost trends; GLP-1 spend is not separately disclosed, so direct attribution is not possible.

[2] FY2025 operating earnings of $19.0 billion include a $2.8 billion one-time charge; adjusted to about $21.7 billion, the margin-collapse trend still holds.

Not every exposed name loses: sleep-apnea devices grew while bariatric surgery fell by a third

Exhibit 12

So what. Exposure is not destiny, so the stance must score each name on its own adaptation rather than on the sector label, which is exactly what the disclosure and P&L tests do.



Source: MedTech Dive, GLP-1 and medtech; JAMA Surgery bariatric-volume analysis, EurekAlert

[1] ResMed revenue growth is company-reported for fiscal 2024 and 2025; bariatric-surgery and GLP-1-use changes span 2022 to 2024 from the JAMA Surgery analysis.

1 in 8

US adults now take a GLP-1; the deepest P&L effects land outside pharma

SECTION 4 OF 4

Where durable value pools once the wave settles

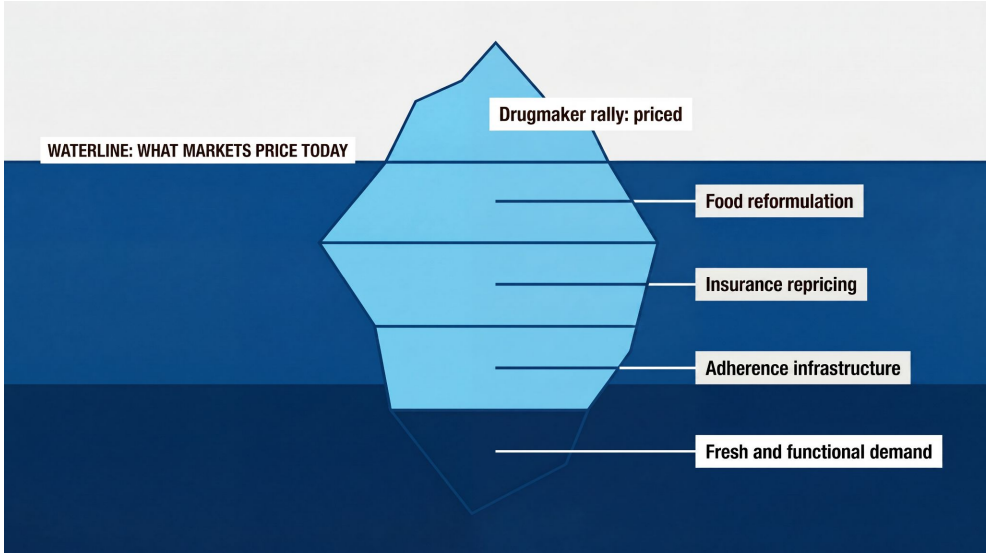
Situation. The drug duopoly's gains are already priced; the consumer-side re-rating is still forming.

Complication. Persistence near half at twelve months, Medicare negotiation in 2027, and three unquantified sectors leave any stance contingent on monitored triggers.

Question. Where should the portfolio overweight, underweight, and watch, and on what evidence does each call rest?

Markets price the drug trade above the waterline; the consumer repricing forms beneath

Exhibit 13



Source: Teneo, March 2024; Goldman Sachs Top of Mind via SpirePoint; KPMG

The five KPMG personas split the food wallet into defend, adapt, and grow plays

Exhibit 14

So what. The wallet redistributes rather than vanishing[1]; adapters capture Category Hoppers and Premium Purchasers while undifferentiated snacking defends the Calorie Cutter.[2]

1	2	3	4	5
The Calorie Cutter	**The Healthy Choicemaker**	**The Category Hopper**	**The Premium Purchaser**	**The Basics Buyer**
Same items, less of them; craves familiar flavors. Defend with portion and pack architecture.	Similar diet, healthier forms of the same categories: lean, skim, lower salt.	Hops to fresh, functional, science-based nutrition; does not mind paying more.	Less volume, traded up; keeps dining out. Upside for nutrition-led premium lines.	Eats for satiety and function; plain, price-led basics; banks part of the budget.

Source: KPMG, Getting to know GLP-1 users

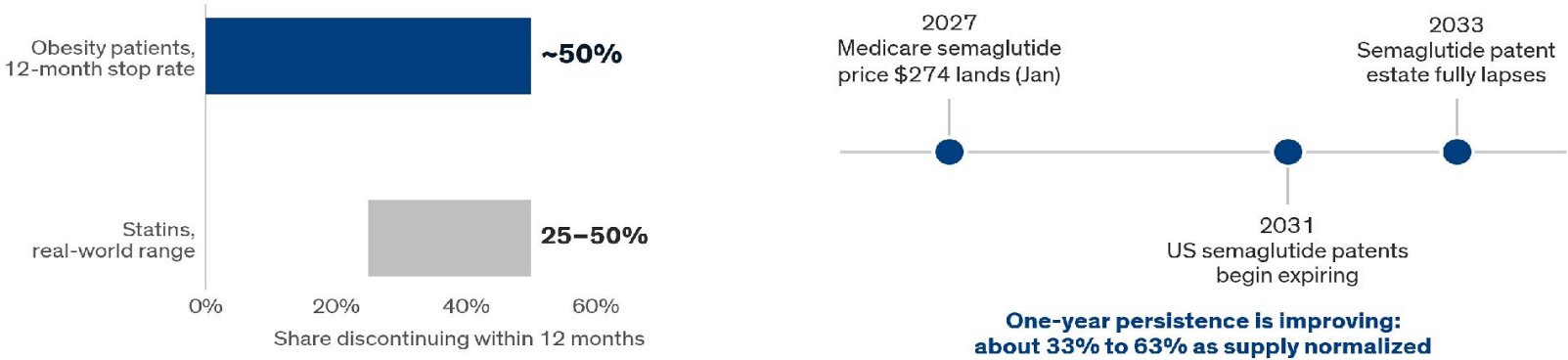
[1] KPMG sizes remaining GLP-1-user food and beverage demand near $190 billion a year post reduction.

[2] KPMG cites Nestlé Vital Pursuit, the high-fiber frozen-meal line launched for GLP-1 users in May 2024.

Half of patients stop within a year, but persistence is improving and the bear case is dated

Exhibit 15

So what. The bear case is real but dated, improving, and monitorable, which is exactly what quarterly triggers are for; it tempers sizing, not direction.[1]

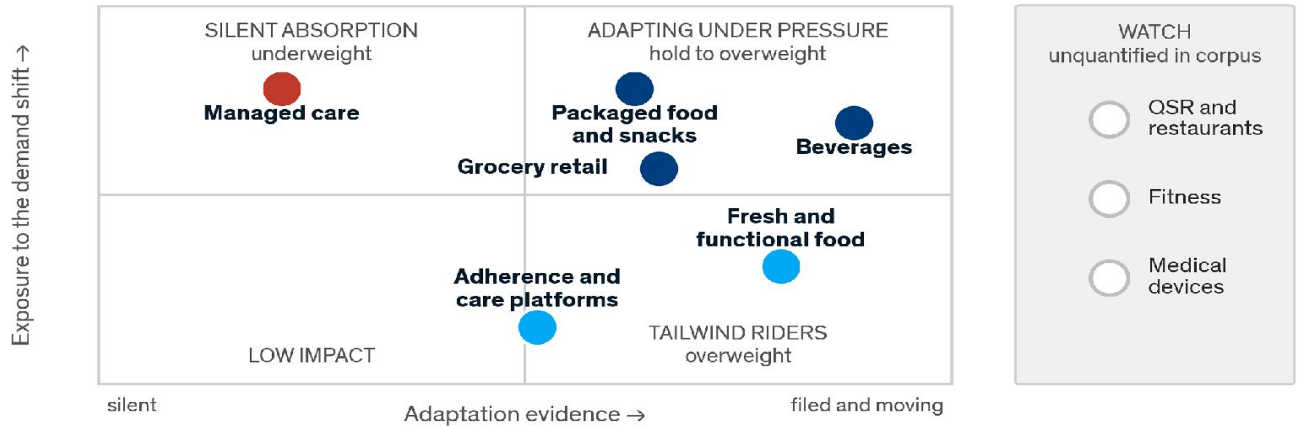


Source: JAMA Network Open 2024 via PMC; Prime Therapeutics persistence; BioPharma Dive, Medicare negotiation

[1] The 50 percent discontinuation figure is from a JAMA Network Open 2024 obesity cohort of about 196,000 patients; the 33 to 63 percent one-year persistence improvement is from Prime Therapeutics as supply normalized.

Exposure crossed with adaptation speed sorts the stance into overweight, underweight, and watch

Exhibit 16



Source: Teneo, March 2024; KPMG · ¹ Elasticity sources for QSR, fitness, and medical devices failed extraction in this corpus; per the evidence policy those sectors are flagged as unquantified rather than scored.

Reweight toward filed adapters now and wire the quarterly triggers that revise the stance

The GLP-1 re-rating lands hardest outside pharma; overweight the adapters re-betting in their filings, underweight the silent, and wire persistence triggers.

Move	Owner	When	Sizing
Shift the consumer-staples sleeve toward filed adapters with reformulation, portion, and fresh and functional lines in market	Consumer sector portfolio manager	Q3 2026	**Reallocation, no new capital**
Underweight managed-care names with undisclosed GLP-1 cost exposure; revisit after 2027 Medicare pricing lands	Healthcare sector portfolio manager	Q3 2026	**150 bps position move**
Commission the primary demand-elasticity study on QSR, fitness, and medical devices that the public record lacks	Head of research	Q4 2026	**$250K external budget**
Stand up the quarterly trigger scan covering persistence data, Medicare negotiation milestones, insurer coverage policy, and 10-K disclosure language	Strategy office	From Q3 2026, quarterly	**Internal analyst time**

The objections the committee will press, answered directly

Pre-empted before they come up.

Half of users stop within a year; are we underwriting a fad that unwinds?	About 50 percent discontinue at twelve months, comparable to statins, which still rebuilt cardiology economics; one-year persistence is improving from about 33 to 63 percent, oral pills are now approved, and the stance sizes to a quarterly persistence trigger.
If Medicare cuts semaglutide to $274 and cash drops to $245, does that kill the thesis?	No: the thesis is cross-sector and volume-led, so a lower price expands the user base and the spillover while compressing only the drugmakers' unit economics, and the stance already underweights the silent insurer.
The filings blame cocoa and Medicare funding, not GLP-1; why act before attribution is clean?	Correct, and the deck says so on each exhibit; the stance keys on disclosed behavior, filings language, and volume and mix direction, not headline margins. Waiting for clean attribution means entering after the re-rating.
Where is the QSR, fitness, and medical-device evidence?	Mostly unquantified here: elasticity sources failed extraction, so those sectors enter as watch items, though the device cross-currents show ResMed adapting; the action program funds the study that closes the gap.

Source: JAMA Network Open 2024; BioPharma Dive, Medicare negotiation; SEC EDGAR 10-K walks

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THE ASK

Approve the adapter reweight, the managed-care underweight, and the quarterly trigger scan