MBGH
Midwest Business Group on Health

GLP-1s & Beyond:

Navigating Cost, Coverage & Clinical Value

Understanding the GLP-1 Landscape

GLP-1 therapies are rapidly reshaping the landscape of metabolic care, offering new hope for individuals with diabetes, obesity, and other related conditions. Because obesity and type 2 diabetes are among the most prevalent and costly chronic conditions affecting the American workforce, these therapies carry significant implications for employer health plan design and total cost of care.

While GLP-1s represent a transformative treatment option, they also present employers with complex decisions related to coverage, utilization management, vendor alignment, and long-term return on investment. The rapid growth in demand is raising critical questions about affordability, equitable access, and the sustainability of benefit offerings.

To navigate this evolving environment, employers need practical, actionable insights to balancing clinical innovation with fiduciary responsibility and long-term financial viability.

The Obesity & Diabetes Epidemic

With obesity and type 2 diabetes reaching epidemic proportions in the U.S., there are significant workforce implications:

- **Prevalence:** Approximately 42% of American adults have obesity, and over 37 million Americans have diabetes[1]
- **Workforce Impact:** These conditions drive increased absenteeism, presenteeism, disability claims, and lost productivity[3]
- **Cost Burden:** Obesity and related comorbidities cost employers hundreds of billions annually in direct medical expenses and indirect costs[4]

The intersection of these two conditions – "diabesity" – affects millions and requires comprehensive clinical management strategies.

Recognizing Obesity as a Disease

Critical Paradigm Shift: Employers must understand that obesity is a chronic medical disease and not a personal failing or lifestyle choice. This recognition is essential for developing equitable coverage policies[5].

- The American Medical Association, American Heart Association, and other leading organizations recognize obesity as a disease requiring medical treatment[6]
- Like diabetes, hypertension, and heart disease, obesity warrants pharmaceutical interventions when indicated
- Stigma remains a significant barrier to care and must be actively addressed in plan design and communication strategies[7]

This Employer Action Brief provides evidence-based guidance to help organizations develop GLP-1 coverage strategies aligned with fiduciary responsibility, health equity principles, business objectives, and leadership education.

Throughout the brief, look for the **lightbulb icon**, which highlights employer perspectives, practical insights, and real-world experiences from health benefits leaders.

Access the latest findings from the MBGH 2026 **Employer Survey** on GLP-1s below, highlighting employer strategies, benefit design priorities, and emerging market direction.

Quick Links

Employer Action Steps
Employer Insights
2026 Employer Survey Results

What Are GLP-1s?

GLP-1s belong to a broader class of medications called incretins. These are natural hormones that regulate blood glucose and appetite. GLP-1s enhance the body's natural incretin response through:

- Improved glucose control
- Reduced appetite and food intake
- Increased satiety and body weight reduction
- Potential cardiovascular and renal benefits

Available Formulations:

- Injectable GLP-1 agonists: Diabetes – Ozempic®; Obesity – Wegovy®, and others
- Dual GLP-1/GIP receptor agonists: Diabetes – Mounjaro®; Obesity – Zepbound, and others
- Oral GLP-1s: On the market with other newer options emerging
- Branded vs. Compounded: FDA-approved branded medications offer proven efficacy and safety; compounded formulations may carry significant risks and should be approached with caution

Clinical Effectiveness:

- For Weight loss: 10-22% reduction in body weight in clinical trials[9]
- Glycemic control: Significant HbA1c reductions for diabetes management[10]
- Cardiovascular benefits: Reduced cardiovascular events in patients with established ASCVD[11]

Today's Landscape & Coverage Patterns

Coverage and use of GLP-1s has been rising[13].

- **For Diabetes:** 55% of employers cover for diabetes
- **For Obesity:** 36% cover them for both diabetes and weight loss

GLP-1 Emerging Market Opportunities

Beyond diabetes and obesity, GLP-1s show promise for multiple chronic conditions under active research[14]:

- Chronic kidney disease
- COPD and other metabolic disorders
- Emerging neurological applications (Alzheimer's, Parkinson's)
- Major adverse cardiovascular events (MACE)
- Metabolic dysfunction-associated steatohepatitis (MASH)
- Sleep apnea

Employers should anticipate coverage expansion requests as clinical evidence evolves and will need to consider long-term budget planning accordingly.

The Business Case

Significant Opportunity for Employers

GLP-1s can support employers in addressing two of the most costly and prevalent chronic conditions affecting their workforce – diabetes and obesity. However, successful implementation requires:

1. **Clinical Understanding:** Recognizing obesity as a disease and understanding GLP-1 mechanisms and effectiveness[5][8]
2. **Data-Driven Approach:** Using evidence to guide decisions and measure results[25]
3. **Strategic Thinking:** Viewing GLP-1 coverage as a health investment, not a drug cost line item[12]
4. **Thoughtful Plan Design:** Balancing access with appropriate utilization management[17]
5. **Vendor Partnership:** Selecting partners aligned with employer values and member outcomes
6. **Equity Focus:** Ensuring coverage decisions don't perpetuate disparities[22]
7. **Transparent Communication:** Being honest with employees about coverage and alternatives

Employers that take a comprehensive approach are seeing substantial improvements in member health, reduced comorbidity costs, improved workforce engagement, and positive ROI within 2-3 years[12].

Key Employer Considerations for GLP-1 Coverage

Health Outcomes:

Opportunities to ensure effective disease management for two of the costliest chronic conditions include:

- Potential prevention or delay of diabetes and obesity-related complications[15]
- Cardiovascular benefits that reduce downstream costs
- Reduced progression to advanced metabolic disease
- Employee retention improvements through comprehensive benefit offerings

Cost Analysis:

While GLP-1 medications can be costly for branded products – the total cost of care (TCC) analysis is favorable:

- Reduced obesity-related comorbidities and slower progression to advanced metabolic disease and other high-cost diseases (e.g., renal disease, heart failure)
- Reduced ED visits related to these complications and hospitalizations from preventable complications
- Improved disability and workers' compensation outcomes
- Reduced absenteeism and short-term disability

Investment Perspective & Research Insights

Research shows the ROI for GLP-1 coverage becomes apparent within 24 months when employers view the decision as a health investment rather than a drug cost line item[12]. Leaders must view GLP-1s as preventive medicine with long-term savings.

Employers that take a comprehensive, thoughtful approach see substantial improvements in member health, reduced comorbidity costs, improved workforce engagement, and positive ROI within 2-3 years[12].

Employers need to ask themselves if they are viewing GLP-1s as an investment to improve employee health and need to understand that further down the road there may be a ROI. Right now, most employers are just considering what the cost is up front and not looking at the long-term health impacts down the road.

- 2025 AON Study Insight: Research shows return on investment within 2 years when GLP-1 coverage includes appropriate utilization management[12].
- Milliman published research on the prevalence of obesity and associated comorbidities to quantify the clinical burden and comorbidity patterns to support decision making[12].

Competing Barriers to Coverage

Many employers cite legitimate concerns when declining GLP-1 coverage[16]. The following are valid planning considerations and should inform decision-making alongside clinical and equity analysis.

BARRIER	CONTEXT
Budget Impact	Significant upfront investment; budgets remain constrained
Uncertain ROI	Market data still emerging; long-term outcomes under study
Clinical Uncertainty	Unclear standards of care for obesity management vs. diabetes
Long-Term Use Questions	Limited long-term data on duration of therapy and deprescribing
Equity Issues	Differential access raises fairness concerns between diabetes and obesity
Vendor Guidance Variability	Inconsistent recommendations from PBMs, carriers, and consultants/brokers
Market Volatility	Rapidly changing treatment options and new entrants
Rebate Concerns	Uncertainty about losing rebates if customizing formulary

Plan Design, Programs & Vendor Partnerships

Best Practice Plan Design Framework

High performing employers are implementing structured clinical criteria and moving away from "open access" to "managed access" for GLP-1s.. Coverage should incorporate the following key elements[17].

1. Tiered Coverage Based on Clinical Indication

Diabetes (Most Inclusive):

- Cover as standard pharmacy benefit
- Minimal utilization restrictions to encourage access
- Considered preventive for many new indications
- Work with PBMs and clinical programs to ensure appropriate use

Obesity (More Selective):

- Require documented diagnosis per clinical standards (BMI ≥27 with comorbidity or BMI ≥30) [19]
- Link to integrated weight management programs
- Consider step therapy with lifestyle interventions or lower-cost alternatives first
- Consider time-limited coverage with renewal based on clinical outcomes (e.g., 5% weight loss within 3-6 months)

2. Utilization Management Strategies

Prior Authorization (PA):

- Can improve clinical appropriateness when criteria are clear
- Some employers report 63-68% PA approval rates
- Risk: Can delay necessary care if criteria are overly restrictive

Step Therapy:

- Require documented trial of lifestyle management programs first
- Ensure integration with carrier or point solution provider programs
- Use to demonstrate medical necessity

Integration with Care Programs:

- Embed GLP-1 access within comprehensive weight management or cardiometabolic programs[18]
- Link to point solution providers offering coaching and monitoring
- Require clinical oversight and outcome tracking

BMI-Based Thresholds:

- Options range from BMI ≥27 with comorbidity to BMI ≥35[19]
- Consider equity implications: higher thresholds may disproportionately restrict access
- Avoid rigid criteria that prevent clinical judgment

3. Outcome-Based and Time-Limited Coverage

Instead of lifetime coverage, structure as:

- Time-limited initial authorization (e.g., 6-12 months)
- Renewal contingent on achieving clinical milestones
- Documented patient engagement with integrated programs
- Annual re-evaluation based on clinical outcomes and cost impact

4. Rebate Management and Formulary Customization

Critical Issue: Many employers fear losing rebates if they customize formularies or carve out GLP-1 benefits. Look for these key risk areas to avoid in rebate contracts:

1. Market-share or exclusivity guarantees that lock the employer into a single product
2. Rebate forfeiture triggers tied to utilization management changes
3. Indication-blind requirements that force obesity coverage to maintain diabetes rebates
4. Retroactive clawbacks if utilization thresholds are not met
5. Bundled rebate arrangements that tie GLP-1 performance to unrelated drug classes.

Emerging Solutions:

- Some employers successfully negotiate customized rebate arrangements that maintain rebate value when limiting coverage to specific GLP-1s
- See the box on page 12 for **Sample Contract Language** to structure formularies that avoid rebate loss while retaining formulary control
- Requires sophisticated negotiation with PBMs and manufacturers

Employers need examples around PBM contracts with different options to modify benefit plan design without losing rebates. We are trying to be more flexible, so when you make one change you do not lose all the rebates.

Transparency Strategy:

- Request clear documentation of rebate structures from vendors
- Understand what percentage of rebates flow to vendors vs. plan
- Ensure rebate language preserves employer flexibility for plan customization

5. Member Cost Design

Consideration: Low member cost-shares may mask the true cost of therapy and can inflate utilization.

- Coinsurance tied to clinical value (not highest rebate) encourages appropriate use
- Copay ranges: Leading employers target $0-$100 monthly with manufacturer assistance factored in (for those that qualify) and $100-$300 without this assistance
- Transparency: Provide members with cost visibility through receipts and communications
- Member education on costs helps manage demand and expectations

Coverage Models: Approaches Across Employers

Employers are implementing diverse models based on their workforce, budget, and values.

Employer A: Comprehensive Integrated Model

- Covers GLP-1s for both diabetes and obesity
- Integrates with specialized point solution provider
- Program includes provider guidance, member coaching, outcomes monitoring and includes lifestyle, behavioral, and clinical management components
- Results: High engagement, strong outcomes and significant cost offset within 2 years
- Lessons Learned: Requires higher upfront investment but offers better outcomes, including vendor selection expertise

Employer B: Selective Coverage with Outcomes Accountability

- Covers GLP-1s for diabetes automatically
- Covers GLP-1s for obesity with BMI requirement of ≥35 with comorbidity, and 5% weight loss outcome within 6 months
- Requires participation in lifestyle program
- Results: Controlled costs, targeted access and strong completion rates
- Lessons Learned: Clear eligibility criteria and strong accountability improved program integrity, balanced budget constraints, and supported progress toward comprehensive care, with plans to expand the type of obesity coverage in 2027–2028.

Employer C: Selective Coverage with Outcomes-based Management

- Covers select GLP-1s based on clinical criteria
- Outcomes-based renewal with 5% weight loss required
- Participation in programs required concurrently or before authorization of therapy
- Lessons Learned: Maintains cost control while improving access

Employer D: Vendor Diversification

- Covers diabetes GLP-1s through medical plan
- Obesity program offered through point solution provider – separate from medical plan
- Telehealth and coaching through separate virtual care platform
- Pharmacy managed through alternative/transparent PBM to align incentives with plan sponsor instead of drug list price
- Results: Specialized expertise for each pathway, but complex coordination
- Lessons Learned: Requires sophisticated internal management, and can be fragmented for members

Integrating Behavioral Health

Effective weight loss goes beyond diet, exercise, or medication—it requires a holistic care approach that integrates behavioral, physical, and mental health. While GLP-1 medications can accelerate results, lasting success depends on addressing behavioral health, lifestyle habits, and ongoing care support.

Key Considerations:

- Mental Health Support - Depression, anxiety, and stress can significantly impact eating behaviors, adherence to treatment, and motivation for lifestyle changes.
- Therapeutic Interventions - Cognitive-behavioral therapy (CBT) or motivational interviewing can help individuals manage emotional eating and develop sustainable habits.
- Stress Management - Mindfulness, meditation, and coping strategies can reduce triggers for unhealthy eating and support long-term behavior change.

Employers should take a structured, multi-pronged approach to support the use of GLP-1s for obesity and behavioral health, focusing on coverage, access, education, and outcomes tracking.

Employer E: Cautious Approach with Deferred Expansion

- Not currently covering GLP-1s for obesity; covering for diabetes only
- Actively monitoring market, outcomes, and emerging evidence
- Plans to expand coverage in 2027-2028 for obesity when long-term data is available
- Results: Budget preservation, reduced risk, opportunity to learn from early adopters
- Lessons Learned: Valid strategy for employers with budget constraints; requires ongoing monitoring of market

Employer F: No Coverage Approach with Potential of Deferred Expansion

- Not currently covering GLP-1s for either indication
- Considering future coverage as clinical evidence and market stabilization occurs
- Considering Alternative: Direct-to-consumer communication from pharmaceutical manufacturers so employees know options
- Risks: Leaves workforce without access to emerging standard of care in patients with established ASCVD[11]

Addressing Deprescribing & Discontinuation

An Important Reality – A significant percentage of members prescribed GLP-1s for obesity discontinue therapy within 6 months with reports ranging from 40-60%. This can be due to many factors, including high out-of-pocket costs, barriers from PA denials, step therapy requirements and coverage gaps, patient side effects, weight loss plateaus, and/or lack of wrap-around support.

Emerging Understanding:

- Current evidence: No peer-reviewed studies definitively prove that weight loss achieved through GLP-1 therapy can be maintained after discontinuation[20]
- Clinical research is ongoing but not yet conclusive
- Many patients experience weight regain after stopping therapy

Employer Approach:

- Acknowledge this in member communications without creating unnecessary concern
- Emphasize that discontinuation should only occur under physician guidance
- Focus plan design on sustained engagement rather than short-term therapy
- Monitor adherence and re-engagement as potential opportunities

Why this matters for employers: High early discontinuation undermines both clinical outcomes and ROI, highlighting the importance of benefit designs that pair coverage with simplified access, predictable cost-sharing, and structured behavioral support – not just drug coverage alone.

Discontinuing GLP-1s should be done under the guidance of a provider. It is an important doctor/patient discussion that needs to occur to be able to determine if deprescribing works. In addition, if a member is doing all the right things, they should not lose access to the therapy.

Vendor Partnership Models

Employers have multiple pathways to implement GLP-1 coverage[21]:

Traditional Carrier/Health Plan & PBM Partnerships

- Maintains control of GLP-1 benefit design
- Point solution (if any) integrated through carrier
- **Pros:** Streamlined, existing relationships
- **Cons:** Limited customization; may prioritize carrier objectives over employer goals

Point Solution Primary Model

- Partner with specialized obesity management company
- Point solution designs program, manages access, tracks outcomes
- **Pros:** Specialized expertise, integrated coaching, better adherence tracking
- **Cons:** Additional program costs; potential narrow network, limiting access to clinicians

Hybrid/Multi-Vendor Model

- Diabetes through medical plan and PBM
- Obesity through point solution provider
- Multiple vendor partnerships (navigation, telehealth, condition management)
- **Pros:** Specialized solutions for each pathway; maximum flexibility
- **Cons:** Complex contracting; coordination challenges

Carved-Out/Unbundled Model

- Separate GLP-1 benefits from standard PBM
- Direct relationships with specialty pharmacy, PBM alternatives, or manufacturers
- **Pros:** Full control; potential rebate preservation
- **Cons:** Complex; requires sophisticated procurement, management, and employee navigation support

What to Ask Your Vendors: Critical Evaluation Questions

Before selecting or renewing vendor partnerships, employers should demand clear answers:

For Carriers and PBMs:

1. What revenue does your organization receive from GLP-1 coverage beyond rebates?
2. If we customize our GLP-1 formulary, how will rebate structures change?
3. What are the specific utilization management criteria, and what is your PA approval rate?
4. Can you provide de-identified claims data on GLP-1 utilization, outcomes, and costs?
5. What is your clinical expertise in obesity treatment?
6. How do you monitor and manage outcomes for GLP-1 members?
7. Are there incentive alignment mechanisms (e.g., performance guarantees)?
8. What happens if a member is successful with therapy – do you restrict access?

For Point Solution Providers:

1. What are total program costs, and can/how do you scale up?
2. What is your member engagement rate and outcomes by metric?
3. Do you require sole-prescriber arrangements, or can members use any provider?
4. What clinical oversight and physician guidance are included?
5. How do you manage members who discontinue therapy?
6. What outcomes guarantees are you willing to provide?

For Benefits Consultants/Brokers:

1. What conflicts of interest do you have in recommending specific vendors?
2. Can you provide objective comparative analysis of vendors?
3. What benchmarking data can you share on employer prevalence and strategies?
4. Do you have expertise in GLP-1 benefit design?

Key Principle: Know what incentives are driving vendor recommendations. Does the consultant benefit more if you choose a vendor with higher fees? Is the PBM incentivized to restrict access to protect its drug costs? Transparency on financial relationships is essential.

Equity & Anti-Bias Considerations

Critical Equity Principle: Employers must ensure GLP-1 coverage does not perpetuate disparities in access to treatment[22]. This matters because how employers design GLP-1 coverage can either narrow – or quietly widen – existing health inequities.

- GLP-1 access is often already unequal (e.g., covering for diabetes and not obesity) further perpetuating stigma about those living with obesity
- Obesity and diabetes disproportionately affect marginalized populations
- Benefit design choices shape real-world outcomes
- Disparities undermine employer goals
- Employers are increasingly accountable

Bottom line: If employers don't intentionally design GLP-1 coverage with equity in mind, they may risk spending more while helping fewer—and reinforcing the very disparities they're trying to solve.

Equity Analysis Framework:

- Do coverage criteria for obesity differ substantially from diabetes?
- Are BMI thresholds or eligibility criteria applied equitably across all populations?
- Do member cost-shares disproportionately burden lower-income employees?
- Does the plan include equal clinical support (coaching, monitoring) for both conditions?
- Have you analyzed utilization patterns by race, ethnicity, income, and gender?

Addressing Bias in Communications:

- Avoid language that stigmatizes obesity or implies moral failing
- Frame GLP-1s as clinical tools, not "quick fixes"
- Include diverse representation in member communications and educational materials
- Emphasize the disease model of obesity consistently[5]

We found that GLP-1 utilization was disproportionately high among lower-income and racial/ethnic minority populations. Upon investigation, this reflected actual prevalence of disparities in the workforce. However, the employer implemented intentional program enhancements to ensure equitable access and outcomes tracking.

Financial & Operational Impacts

Understanding the Cost Structure

Medication Costs:

- Branded GLP-1s: $1,000-$1,500+ per month before rebates/copay assistance
- Compounded GLP-1s: $250-$500+ per month (lower cost, lower quality, and safety concerns)
- Direct-to-consumer programs from pharmaceutical manufacturers: $149-$449 per month (emerging access model)[23]

Program Costs (if using point solutions):

- Point solutions: $100-$300+ per member per month depending on intensity
- Includes coaching, monitoring, telehealth, behavioral support
- Total program cost to employer: medication + program support

Budget Impact Analysis – Employer Cost Scenario

Employers with approximately 3% of their population eligible for weight-loss therapy (BMI ≥30) and fewer than 10% currently treated could experience:

- Rapid utilization growth: Uptake may increase 3–5x within 12–24 months following coverage expansion as awareness, demand, and prescribing accelerate
- Per-member cost concentration: Annual drug costs of $12,000–$16,000 per user can quickly shift GLP-1s into a top pharmacy cost driver
- Pharmacy trend acceleration: Overall pharmacy spend may increase 1–2+ percentage points in annual trend, depending on adoption and duration of therapy
- Long-term budget exposure: High persistence and chronic use assumptions significantly increase multi-year liability
- Use the matrix below to determine potential cost scenarios based on total covered population and uptake of GLP-1s for obesity

Measuring Success & ROI

Traditional Metrics (Insufficient Alone):

- Claims reduction
- Medication utilization rates
- Pharmacy trend management

Health Outcome Metrics:

- Weight loss achievement (target: ≥5% within 3-6 months)
- HbA1c reduction for members living with diabetes (or pre-diabetes, if known)
- Blood pressure and cardiovascular risk reductions
- Medication adherence rates

Business Metrics:

- Absenteeism and presenteeism improvement[24]
- Workers' compensation claim reduction
- Disability claims prevention or improvement
- Healthcare costs per member living with diabetes/obesity
- Healthcare costs per participant (total population)
- Talent retention and recruitment improvement

Member Experience Metrics:

- Satisfaction with program
- Engagement rates for program participation
- Member testimonials and success stories
- Quality of life improvements

Best Practice: Track outcomes across multiple dimensions. Stories and testimonials often prove more persuasive to leadership/members than claims data alone.

We were able to document 131,000 pounds lost by our employees on GLP-1 therapy; this is a powerful metric for us to use in communicating.

Budget Impact Analysis – Employer Cost Scenario

Variable	Description	Employer Input
Total covered lives	**All employees + dependents**	**X**
Percent eligible for therapy	**Typically, 3% of total covered lives** (BMI> 30% or 27% with comorbidities)	**X %**
Net annual drug cost	**Range: $6,000 to $10,000** (after rebates; varies by PBM, formulary and drug channel)	**$**

Data-Driven Decision Making

Use Your Data:

- Analyze prevalence of diabetes and obesity in your workforce
- Model cost-benefit scenarios with different coverage options
- Compare your trend rates to industry benchmarks[25]
- Identify high-cost subpopulations that could benefit most
- Include disability, workers' compensation, and absence data in analysis

Leverage Available External Data:

- MBGH Pulse of the Purchaser Survey and other employer coalitions who can provide benchmarking on employer prevalence, coverage patterns, and outcomes[25]
- Industry benchmarks showing what percentage of employers are covering vs. not covering, and how
- Case studies from peer employers demonstrating different approaches and outcomes

Financial Modeling:

- Budget for multi-year ROI rather than expecting immediate savings
- Model scenarios: no coverage, limited coverage, comprehensive coverage
- Include all program costs, not just drug costs
- Consider secondary benefits (workers' comp, productivity, talent)

Employer Insights

This employer-directed research project on GLP-1s brought up various reoccurring themes and important perspectives:

Recurring Themes

1. Transparency & Vendor Relationships

Large Multi-National Employer – *We realized we couldn't rely on consultants, brokers, or carriers to give us objective advice. We had to educate ourselves and negotiate from a position of knowledge. When we weren't happy with a vendor, we walked away.*

Insight: Employers with the best outcomes took active control of their strategy, asked tough questions, and were willing to switch vendors when needed.

2. Integration is Essential

Fortune 500 Employer – *GLP-1s alone are not a solution. Members need clinical guidance, behavioral support, program accountability, and ongoing monitoring. The medications work, but the program has to work too.*

Insight: Employers using point solutions with integrated programs reported better adherence and outcomes than those treating GLP-1s as a standalone pharmacy benefit.

3. Be Ready for Communication Challenges

Mid-Size Employer – *This is a confusing space. Members don't understand the differences between branded and compounded medications, between incretins and GLP-1s, or why coverage varies. We're still working on simple, engaging communications.*

Insight: Effective communication requires simplicity, repetition, and multi-channel approaches. Visual materials (infographics, videos) work better than text-heavy content.

4. Equity Matters

Multinational Employer – *We initially had different restrictions for obesity vs. diabetes coverage. When we stepped back and looked at it, we realized we were creating an inequitable situation. We're working toward more aligned coverage for both conditions.*

Insight: Intentional review of plan design reveals unintended disparities. Leading employers align coverage philosophies across conditions.

5. Performance Guarantees and Outcomes Focus

Large Employer – *We went from engagement metrics (did members show up?) to outcomes metrics (did members achieve 5% weight loss?). That shifted everything about how we structure contracts.*

Insight: Contractual arrangements that align vendor incentives with health outcomes produce better results than engagement-focused or volume-based arrangements.

Alternative Access to GLP-1s

As GLP-1 demand increases, alternative access models are emerging outside traditional options[23]:

Direct-to-Consumer (DTC) Programs – Members may bypass the employer plan and pay out-of-pocket or through alternative programs such as:

- **Pharmaceutical Manufacturers** – Programs sponsored by pharmaceutical manufacturers are accelerating patient awareness and demand for GLP-1 therapies by promoting eligibility screening, facilitating connections to prescribing providers, offering patient navigation and adherence support, and in some cases providing financial assistance or introductory pricing. While these initiatives can improve access and speed appropriate treatment initiation, they also increase demand pressure and shape employee expectations. For employers, the expanding DTC presence heightens the need for clearly defined coverage criteria, proactive and transparent employee communication, and disciplined utilization management strategies to ensure appropriate use while maintaining affordability and long-term benefit sustainability.
- **Telehealth/Compounded Pharmacies** – Programs often operate outside traditional health plans, reducing employer visibility and bypassing established utilization management, clinical oversight, and care coordination. They can include telehealth prescribing with home delivery for branded products or compounding pharmacies offering non-standard, non-FDA-approved formulations. While cash-pay compounded GLP-1 options may reduce short-term plan spend, they often introduce therapy without consistent physician oversight or integration into a patient's long-term care plan. This can create a pathway to long-term, high-cost chronic treatment, with employees later seeking coverage through the plan. Key risks include limited clinical supervision, variable compounding standards, care fragmentation across providers, and inequitable access driven by out-of-pocket requirements. As demand grows, employers will increasingly need to define clear coverage policies, actively monitor utilization trends, and ensure that access to GLP-1 therapies is clinically appropriate, coordinated, and financially sustainable over time.

Direct-to-Employer Models – Direct-to-employer programs involve pharmaceutical manufacturers partnering directly with employers to offer negotiated pricing, integrated patient support, and tailored program design. These arrangements can disrupt traditional health plan structures by providing more predictable pricing and programmatic control, helping employers better manage budgets and cost exposure. Despite these advantages, employers still need to maintain clear coverage policies, communicate proactively with employees, and enforce robust utilization management to ensure that GLP-1 therapies are accessed appropriately while maintaining affordability and long-term sustainability

Employer Perspective:

- Educate employees on all available access options
- Ensure awareness does not discourage uptake of covered programs
- Consider potential impact on claims experience if members self-fund alternatives
- Evaluate direct-to-employer opportunities if offered, but carefully assess conflicts

Buyer beware – Be careful of legal implications to recommending compounding to your employees. Maybe it's not our place to cover compounding if we are not recommending a program that includes it in the first place.

Employer Action Steps

GLP-1s have created a classic purchaser dilemma: a clinically transformative therapy with strong demand and long-term health potential, paired with immediate, material budget pressure. For employers, the issue is not simply whether to cover these medications—it is how to manage utilization, clinical value, and financial risk in a way that aligns with fiduciary responsibility.

When employers treat GLP-1s as a strategic clinical program, rather than a pharmacy benefit add-on, they have the potential of obtaining near-term cost growth while positioning for long-term health and productivity gains. Market dynamics are stabilizing, long-term outcomes data are emerging, and leading employers are demonstrating effective implementation models.

Ultimately, the critical factor is not simply whether to cover GLP-1s, but to make a deliberate, evidence-informed decision that aligns with organizational values and is adaptable as clinical evidence and market conditions evolve.

Organizations achieving cost control and workforce value share three characteristics:

- Clinical discipline – defined eligibility, outcomes monitoring, reauthorization
- Program integration – medication embedded within chronic disease management
- Financial guardrails – caps, contracting leverage, and utilization controls

When implemented this way, GLP-1s shift from an uncontrolled pharmacy trend to a managed population health investment. The decision is less about "cover or exclude" and more about intentional coverage aligned to the business strategy.

Step 1: Presenting to Leadership

Frame It Right:

- Make the business case by leading with health outcomes and workforce impact, not pharmacy costs
- Position GLP-1 coverage as preventive medicine for two of the largest disease burdens
- Show benchmark data: "X% of employers are covering, and here's what they're achieving"[25]
- Present financial analysis as multi-year investment with demonstrated ROI[12]
- Connect to talent retention, recruitment and business competitiveness

Executive Priorities to Address:

- Financial Impact: What is the cost, what are the savings, what is the net impact to the benefits budget?
- Benchmarking: What are other companies doing? How do we compare?
- Timeline: When will we see ROI? What's the multi-year projection?
- Risk Management: What are the risks of covering vs. not covering?
- Equity: How does this align with our values around equitable healthcare?
- Clinical Evidence: Is this backed by science and clinical guidance?[26]

Step 2: Arm Yourself with Data

- If covering, understand current utilization and costs
- Obtain claims data on prevalence of diabetes and obesity in your workforce
- Calculate prevalence rates and cost burden of these conditions[27]
- Compare your health profile to industry benchmarks[25]

Step 3: Define Your Strategy and Values

- Clarify organization's commitment to obesity as a disease[5]
- Decide on coverage philosophy: diabetes only, both, outcomes-based, etc.
- Establish guiding principles: equity, transparency, member focus, etc.
- Set financial parameters: budget available, acceptable cost per member, ROI timeline

Step 4: Evaluate Your Vendor Options

- Request proposals from multiple vendors (carriers, PBMs, point solution vendors)
- Ask critical questions outlined in this brief
- Understand vendor incentive structures and conflicts of interest
- Assess finalists, their clinical expertise and program quality
- Ask your employer coalition colleagues who they are using and why
- Ask for employer references

We need the information, stats and resources for our leadership to help them effectively understand the marketplace and how these therapies can impact the health and wellbeing of our workforce – short- and long-term.

Step 5: Close the Direct-to-Consumer and Compounding Gap

To protect the safety of members and prevent unmanaged utilization, consider the following actions.

- Exclude non-FDA-approved compounded products
- Education employees on safety and quality risks
- Require prescriptions through credentialed network providers
- Monitor claims for off-benefit acquisition patterns where possible

Step 6: Negotiate Plan Design and Vendor Arrangements

- Specify GLP-1 coverage parameters (indications, criteria, utilization management)
- Negotiate rebate and pricing arrangements to ensure transparency
- Establish performance guarantees and outcome accountability
- Include flexibility for adjustments based on market changes and emerging evidence
- Ensure contract language supports your member continuity of care

Sample Contract Language

Rebate provisions for GLP-1s should avoid rigid utilization or formulary constraints and explicitly protect the employer's ability to manage coverage based on fiduciary priorities (cost control, clinical appropriateness, and workforce needs). Below is employer-focused language highlighting and the key elements to include.

- Employer Control: "Plan Sponsor retains sole discretion to design, modify, or administer coverage criteria for GLP-1 medications, including eligibility, prior authorization, step therapy, quantity limits, site-of-care requirements, and clinical management protocols, without forfeiture of rebate eligibility unless expressly agreed in writing."
- No Exclusivity Requirement: "Rebate eligibility shall not be contingent upon exclusive formulary placement, minimum market share guarantees, or restrictions that limit the Plan Sponsor's ability to cover alternative therapies or future competitive products."
- Indication Flexibility: "Plan Sponsor may independently determine coverage by indication (e.g., diabetes vs. obesity) and apply differential clinical or cost-sharing criteria without rebate penalty, unless explicitly specified and accepted."
- Mid-Year Changes: "Plan Sponsor may implement formulary or utilization management changes during the contract term in response to clinical evidence, safety concerns, utilization trends, or fiduciary considerations, with rebates maintained on eligible claims."
- Population Management: "Employer may apply targeted eligibility criteria (e.g., BMI thresholds, comorbidity requirements, lifestyle program participation, reauthorization standards, or outcomes-based continuation) without rebate forfeiture."
- Future Market Protection: "Plan Sponsor retains the right to add biosimilars, authorized generics, or new market entrants and adjust preferred status without rebate clawbacks or retroactive penalties."
- Financial Transparency: "All rebate terms, administrative fees, and performance guarantees related to GLP-1 products shall be fully disclosed, with no spread pricing or undisclosed offsetting arrangements."

Step 7: Develop Member Communication and Education Strategy

- Plan phased rollout to manage demand, expectations, clinical appropriateness, lifestyle support, and cost stewardship
- Create simple, engaging educational materials[28]
- Explain coverage criteria clearly (what qualifies, what doesn't)
- Address common concerns (safety, long-term effects, discontinuation)
- Provide resources for employees, family members, physicians
- Anticipate demand surge and manage expectations

Step 8: Implement Program and Monitor Outcomes

- Establish baseline metrics and targets
- Track health outcomes (weight loss, HbA1c, cardiovascular markers)
- Monitor program engagement and adherence
- Measure business impacts (absence, disability, productivity)
- Obtain regular data from vendors and conduct analysis
- Adjust program as needed based on performance

Step 9: Share Learnings and Benchmarking Insights

- Connect with peer employers through coalitions (e.g., MBGH)[25]
- Participate in industry discussions and surveys
- Share your learnings—successes and challenges
- Build relationships with others implementing similar programs
- Stay informed on market changes, new evidence, and emerging options

Timeline for Communications & Outreach

Phase 1: Foundation (Pre-Launch – 60–90 days before coverage change)

Objective: Set expectations and prevent uncontrolled demand

Key Messages:

- GLP-1s are part of a comprehensive weight and metabolic care program, not a standalone benefit
- Coverage is limited to specific clinical criteria
- Participation requires clinical oversight and lifestyle support

Tactics:

- Benefits leadership alignment (HR, call center, vendor partners)
- Train member services with:
  - Eligibility criteria
  - Prior authorization requirements
  - Expected timelines
  - Cost-sharing details
- Prepare:
  - FAQ document
  - Coverage policy summary
  - "Who is eligible / who is not" decision guide
  - Quiet website posting (no broad announcement yet)

Phase 2: Targeted Awareness (Launch – Weeks 0–4)

Objective: Reach clinically appropriate members without triggering broad interest

Audience:

- Members with:
  - BMI ≥30 (or ≥27 with comorbidities)
  - Diabetes, prediabetes, or cardiometabolic risk
  - Prior weight-management claims or conditions

Key Messages:

- This is a medical treatment for qualifying conditions
- Requires:
  - Prior authorization
  - Participation in a clinical/lifestyle program
  - Ongoing engagement to continue coverage

Channels:

- Targeted email or portal message (condition-based outreach via vendor/health plan)
- Care management outreach
- Primary care provider notification (critical demand control lever)
- Digital portal banner for logged-in members (not public homepage)

Phase 3: Broad Education (Stabilization – Months 2–6)

Objective: Normalize the program once utilization patterns and vendor capacity are stable

Content Focus:

- How the program works
- Expected results (realistic weight loss timelines)
- Side effects and adherence importance
- Program discontinuation rules if engagement drops
- Member cost responsibility

Channels:

- Benefits newsletter
- Open enrollment materials
- Wellness program integration
- Webinars or recorded education sessions

Tone:

- Clinical, evidence-based, and responsibility-oriented – "GLP-1 medications are powerful therapies intended for members who meet medical criteria and are committed to long-term health management."

Phase 4: Ongoing Stewardship (Continuous)

Objective: Maintain appropriate utilization and manage long-term cost risk

Communication Triggers:

- Renewal reminders tied to:
  - Weight loss thresholds
  - Program participation
  - Clinical follow-up
- Re-engagement outreach for non-adherent members
- Annual reminder of coverage criteria and program requirements

Transparency Elements:

- Coverage may change based on clinical evidence and plan affordability
- Emphasize long-term therapy expectations vs. short-term use

Phase 5: Core Messaging Guardrails (Across All Phases)

Positioning:

- Treatment for chronic disease, not a lifestyle perk
- Requires commitment and clinical partnership
- Part of a whole-person metabolic health strategy

Expectation Management:

- Weight regain risk if therapy stops
- Supply variability possible
- Prior authorization and step therapy may apply

Demand Management Language:

- Avoid – "New weight loss benefit"
- Instead use – "Coverage available for members who meet medical criteria and participate in a structured care program."

MBGH

Midwest Business Group on Health

About MBGH

Midwest Business Group on Health (MBGH) is a 501c3 non-profit supporting employers seeking solutions to better manage the high cost of health care and the health and productivity of their covered populations. Founded in 1980, MBGH offers members leading educational programs, employer-directed research projects, purchasing opportunities and community-based activities that increase the value of health care services and the health benefits they offer to members. MBGH serves over 170 companies who provide benefits to over 4 million lives, with employer members spending more than $15 billion on health care each year.

mbgh.org

Author

Cheryl Larson
President & CEO
MBGH

The information provided in this resource is based on the author's and contributors' experiences working in the health benefits and health care industry. For more information on any aspect of this report, please contact info@mbgh.org.

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