


# The Impact of GLP-1 Coverage on Health Insurance Premiums

*by* **Keshob Sharma, PhD** | *Employee Benefit Research Institute,* **Jake Spiegel** | *Employee Benefit Research Institute* and **Paul Fronstin, PhD** | *Employee Benefit Research Institute*

Glucagon-like peptide-1 (GLP-1) receptor agonists are a class of medications that mimic a naturally occurring hormone released after eating. They lower blood glucose by increasing insulin, reducing glucagon and slowing gastric emptying. These mechanisms support glycemic control for individuals with type 2 diabetes and can also reduce appetite, which is one reason these drugs have been associated with significant weight loss.

Over time, GLP-1 drugs have evolved from daily injection therapies to longer acting formulations administered weekly, increasing convenience and potentially affecting adherence. The clinical evidence base expanded as well. Research demonstrating meaningful weight loss contributed to increased off-label prescribing among individuals without diabetes, followed by regulatory approvals for chronic weight management for specific products.

The growth in the prevalence of obesity provides the context for why GLP-1s have become so prominent in employee benefit discussions. The percentage of adults considered obese has increased dramatically since 2011; with obesity affecting at least 20% of adults in every U.S. state—and exceeding one-third of the adult population in 23 states—the potential market for GLP-1 drugs in weight management now surpasses that for diabetes treatment (Figures 1 and 2).[1] Because obesity and overweight status are far more prevalent than diabetes, the number of individuals who may meet clinical eligibility criteria for GLP-1 therapy is large. That fact alone makes GLP-1 coverage different from most other high-cost drug categories.

For employers, the central issue is not whether GLP-1s are clinically effective for particular populations—many studies indicate that they are—but rather how a coverage decision scales across a workforce. When a drug category is expensive and the eligible population is potentially in the tens of millions, benefit design choices can translate quickly into higher plan spending and higher premiums.

This article summarizes findings from Employee Benefit Research Institute (EBRI) research on how GLP-1 coverage

## AT A GLANCE

- Glucagon-like peptide-1 (GLP-1) receptor agonists represent an important clinical development and a significant cost-management challenge for employment-based health plans. The Employee Benefit Research Institute (EBRI) conducted research to determine how GLP-1 coverage might affect employment-based health insurance under varying assumptions.
- EBRI research showed that GLP-1 prices are the dominant driver of premium effects, and the more employers expand eligibility to large segments of the workforce, the more premiums are affected.
- Sustained adherence to GLP-1s raises premiums in the short run even if it may improve health outcomes. Cost sharing can reduce premium increases, but the effect is modest relative to pricing and eligibility.

may affect employment-based health insurance premiums under varying assumptions about drug costs, eligibility criteria, adherence patterns and cost-sharing structures (Sharma, Spiegel and Fronstin, 2025). The research used a simulation-based analysis and was designed to help benefit professionals evaluate the magnitude of premium pressure that can arise under different coverage approaches and to identify the design levers that matter most.

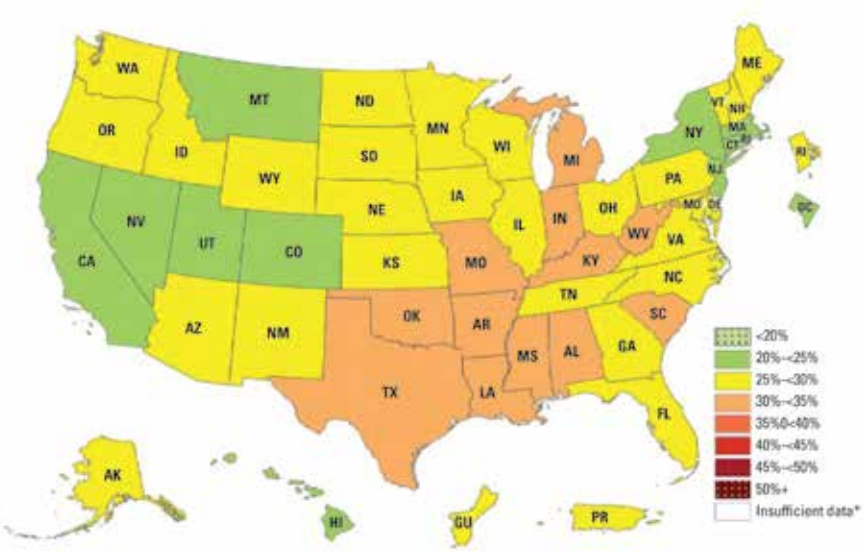
## Current Coverage and Use: High Eligibility, Lower Use...For Now

Employer coverage of GLP-1s has expanded, but coverage differs by indication. Survey evidence suggests that a majority of employers cover GLP-1s for diabetes, while a smaller share cover them for both diabetes and weight loss. Utilization remains limited relative to the size of the eligible population. Claims data indicate that only a small share of privately insured, nonelderly adults have a GLP-1 claim in recent years.

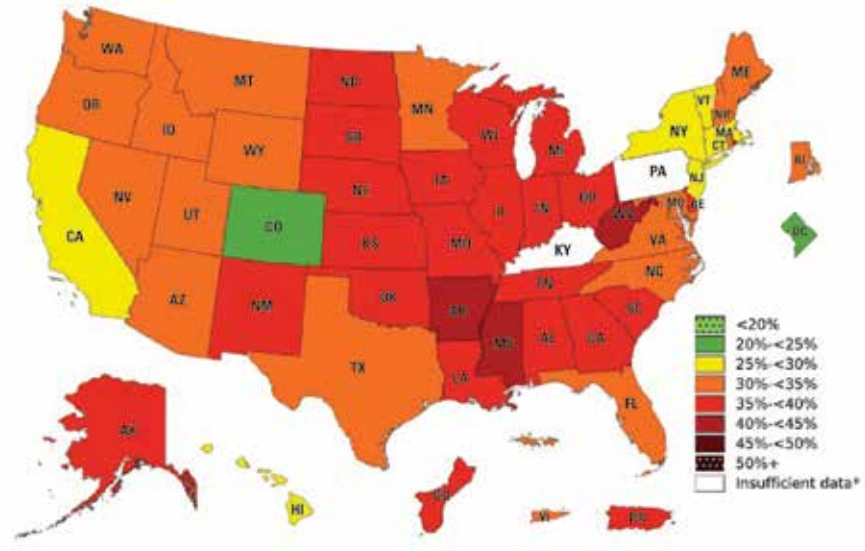
At the same time, multiple surveys suggest broader exposure: A notable share of adults report having used a GLP-1 drug, and usage rates are higher among people with diabetes or those who are overweight or obese. Employers are also reporting that GLP-1 spending is increasingly material within overall claims. These patterns are consistent with a market still in an early but rapidly evolving phase: a large eligible population, rising demand, but discontinuation and benefit design constraints limiting current utilization.

**FIGURES 1 AND 2**

### Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, 2011




### Prevalence of Obesity Based on Self-Reported Weight and Height Among U.S. Adults by State and Territory, 2023




*Sample size <50, the relative standard error (dividing the standard error by the prevalence) ≥30%, or no data in a specific year.

*Source:* Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System.

A key point for premium estimation is that utilization is not simply a function of clinical eligibility. It depends on coverage policy, patient take-up, provider prescribing, out-of-pocket costs and persistence on therapy. In practice, discontinuation is high. Studies find that a meaningful share of users discontinue taking GLP-1s within the first year, which reduces spending but also limits the likelihood of sustained benefits.

## Why Premium Effects Are Uncertain Without Modeling

Benefit professionals are being asked to forecast premium impact in an environment where multiple drivers are moving at once. Even within a single employer plan, premium effects depend on the following.

- Drug prices net of rebates and discounts
- Eligibility criteria (e.g., diabetes only, diabetes plus obesity, obesity alone, overweight plus risk factors)
- Take-up rates among eligible populations
- Adherence and persistence, including the share of users who remain on therapy for at least 12 weeks versus discontinuing earlier
- Cost sharing and its effect on both spending and patient behavior

In addition, premiums are typically set annually, while health improvements may accrue over longer horizons. Even if GLP-1 use reduces the risk of obesity-related complications, those reductions may not appear within the one-year premium-setting window. Employers therefore face a timing mismatch: Near-term drug spending is immediate, while any medical cost offsets, if realized, may be delayed and uncertain.

For these reasons, scenario-based modeling is useful. It does not eliminate uncertainty, but it can show how sensitive premium outcomes are to plausible assumptions.

## A Simulation-Based Approach Grounded in Real-World Inputs

EBRI's *Issue Brief* uses a simulation model to estimate the impact of GLP-1 coverage on employment-based premiums under alternative assumptions. The goal is not to produce a single forecast but to provide a range of outcomes and to clarify which assumptions drive results.

The model simulates firms with baseline health care spending and employee characteristics. Health care spending values are drawn from the national health claims database MarketScan, with a share of employees assigned zero spending and the remainder assigned nonzero spending drawn from an empirical distribution. A medical loss ratio assumption is used to translate spending into premiums.

Employees are assigned body mass index (BMI) values based on a log-normal distribution informed by survey data, allowing classification into overweight and obese categories. A diabetes diagnosis is assigned based on probability. Eligibility for GLP-1 therapy is then determined under alternative criteria—for example, scenarios that limit eligibility to individuals with both diabetes and obesity versus scenarios that also include overweight individuals.

The model also incorporates take-up and adherence assumptions. Take-up among eligible overweight and obese individuals is calibrated to be consistent with observed GLP-1 take-up among adults with type 2 diabetes, recognizing that take-up among newly eligible populations is uncertain and could change over time. Adherence is modeled in two ways: (1) a "perfect adherence" scenario in which individuals remain on therapy for an entire year and (2) a "real-world adherence" scenario based on empirical persistence patterns from Blue Health Intelligence, a health care data analytics company, which reports 42% discontinuation after eight weeks and an additional 15% after 12 weeks.

Finally, the model includes alternative cost-sharing structures, including a $0 copay and a $90 copay per 30-day supply, reflecting common plan designs for specialty medications.

## Drug Costs and Why Net Prices Matter

List prices for GLP-1 drugs are high. However, net costs to plans may be lower due to rebates and discounts. For modeling purposes, the simulation uses net price estimates for a 30-day supply for several GLP-1 medications. The net prices used in *Issue Brief* range from roughly $617 to $766 per month, depending on the product.

Because drug prices are central to the premium impact, the model also includes a hypothetical lower cost scenario of $200 per month. This scenario is based on off-label compounded

GLP-1s from online pharmacies and is intended to reflect the possibility of lower net costs in the future—for example, through oral formulations, greater competition or alternative contracting strategies—while allowing a clear comparison of how price changes alone could alter premium outcomes.

## Results: Premium Increases Under Current Net Drug Costs

Across modeled scenarios using current net drug costs, premiums rise. The magnitude depends on eligibility, adherence and cost sharing.

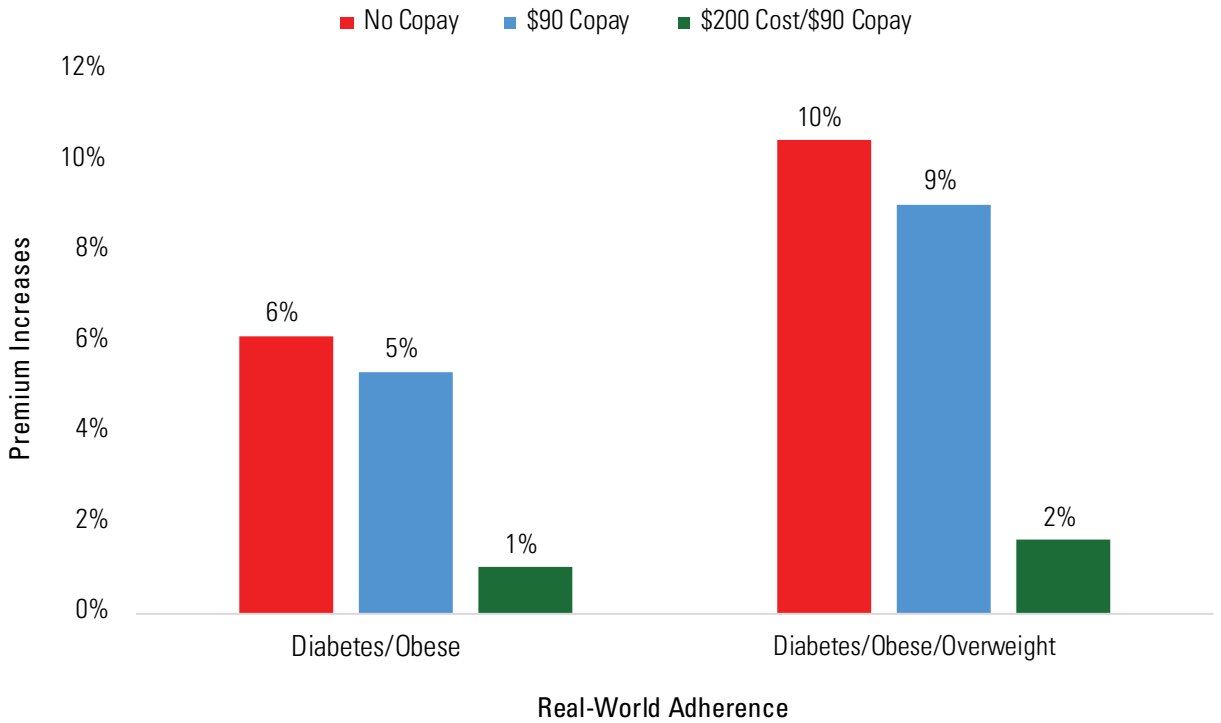
Under assumptions reflecting real-world adherence and a $0 copay, the model estimates that premiums increase 6% when eligibility is limited to individuals with both diabetes and obesity. When eligibility expands to include overweight individuals, the premium increase rises to 10% (Figure 3).

Adding a $90 copay modestly reduces premium impact. Under the same real-world adherence assumptions, premiums increase 5% under the narrower eligibility definition and 9% under the broader definition. The difference reflects that cost sharing shifts a portion of drug costs from the plan sponsor to the employee, but the overall premium effect remains driven by the high net cost of therapy and the size of the eligible population.

Adherence assumptions meaningfully change results. Under perfect adherence and a $0 copay, premium increases rise to 8% (narrow eligibility) and 14% (broad eligibility). With perfect adherence and a $90 copay, premium increases are 7% and 12%, respectively. These results, not shown in the figure, illustrate a straightforward mechanism: More sustained therapy increases drug spending in the premium-setting window.

**FIGURE 3**

### Premium Increases, Real-World Adherence, by Eligibility and Copay




*Source:* Employee Benefit Research Institute.

Two practical implications follow. First, premium impacts can increase as persistence improves—even though higher adherence may be desirable clinically. Second, eligibility expansion from obesity and diabetes to include overweight individuals can move premium effects by several percentage points because the eligible population expands materially.

## Results: Premium Increases Under a Lower $200 Monthly Drug Cost

When the model assumes a lower $200 monthly drug cost, premium increases are smaller across all scenarios, but the same pattern remains: Eligibility and adherence still matter.

Under real-world adherence and a $90 copay, premiums increase 1% under the narrower eligibility definition and 2% under broader eligibility. This set of results suggests that lower net prices could materially reduce premium pressure, but lower prices alone do not eliminate the need for employers to define eligibility and manage utilization. If eligibility remains broad and adherence increases, premium effects still rise—just from a lower base.

## Interpreting the Findings for Benefit Design

The *Issue Brief* results are sensitive to assumptions by design; the point is to show how premium outcomes shift under different policy choices. The patterns across scenarios suggest several considerations for employers.

### *Eligibility Is a Primary Lever*

Eligibility criteria are among the most consequential design choices. Limiting coverage to narrower populations (for example, individuals with both diabetes and obesity) produces substantially smaller premium increases than broader eligibility that includes overweight individuals.

This does not imply that broader eligibility is inappropriate; rather, it highlights the trade-off. The more coverage expands into large segments of the workforce, the more premiums are affected.

### *Drug Price Changes Can Shift the Whole Premium Picture*

The contrast between current net prices and the $200 scenario illustrates how strongly premium outcomes depend on net cost. In the model, reducing the monthly cost from current net levels to $200 reduces premium increases from mid-single digits to low single digits, depending on eligibility and adherence.

Employers and plans may therefore watch pricing developments closely, including competition, contracting strategies and the availability of lower cost alternatives. However, lower prices could also increase take-up, which may partially offset the savings from lower unit cost.

### *Cost Sharing Matters, but the Effect Is Modest*

Introducing a $90 copay reduces premiums by about one to two percentage points across many scenarios. That effect is meaningful but limited. In other words, cost sharing can dampen premium increases, but it does not fundamentally change the cost dynamics when prices are high and eligibility is broad.

Cost sharing also raises employee affordability and equity questions, particularly for lower income workers. Any cost-sharing approach needs to be considered in the broader context of employee contributions, access and workforce goals.

### *Adherence Creates a Near-Term Spending Trade-Off*

Better adherence and persistence are typically viewed as positive from a clinical standpoint. In the premium-setting window, however, higher adherence increases spending and therefore increases premiums.

This creates a common benefit design tension: Policies that support persistence (for example, reducing barriers to access) may improve outcomes but increase near-term premiums. Employers need to decide how to weigh near-term affordability against longer term health objectives, particularly given turnover and the annual nature of premium setting.

## Medical Cost Offsets: Why They Are Not a Short-Run Premium Solution

A frequent argument for GLP-1 coverage is that weight loss and improved cardiometabolic risk factors could reduce future medical spending. That may be true for some conditions, but there are reasons to be cautious about counting on offsets to balance costs in the near term.

First, premium rates are negotiated and set annually. Many potential benefits—reduced complications of obesity, improved cardiovascular outcomes and reduced incidence of certain chronic conditions—may take years to materialize. Second, evidence indicates that discontinuation often leads to weight regain and regression of risk factor improvements. If long-term use is needed to sustain benefits, then long-term drug spending may persist as well. Third, even if medical costs fall, the reduction may be smaller than the drug costs, particularly at current net prices.

For these reasons, the simulation focuses on near-term premium effects and does not assume medical cost offsets. Employers evaluating GLP-1 coverage may still consider longer term outcomes, but the results suggest that short-run premiums will be driven primarily by drug costs and utilization.

## Practical Coverage Approaches Employers Are Using

Employers are responding in different ways, often combining several strategies:

- Targeted eligibility that begins with diabetes and more severe obesity, with possible expansion over time
- Prior authorization and clinical criteria intended to align use with medical guidelines and reduce inappropriate prescribing
- Step therapy or program participation requirements in some settings, such as requiring engagement in lifestyle or coaching programs
- Benefit designs that limit exposure through cost sharing, formulary placement or vendor-based programs.

The model results suggest why these approaches are becoming common. With current net prices, broad eligibility and sustained use translate into premium increases that many employers will view as difficult to absorb. Employers may therefore adopt strategies that manage the size of the treated population and the pace of utilization growth.

## Conclusion

GLP-1s represent an important clinical development and a significant cost-management challenge for employment-based health plans. Simulation results show that expanding GLP-1


**AUTHORS**

**Keshob Sharma, PhD**, is a research associate with the Employee Benefit Research Institute (EBRI). Prior to joining EBRI, he was a Steven M. Teutsch Prevention Effectiveness Fellow at the Centers for Disease Control and Prevention (CDC). While at CDC, he conducted research on topics including long-acting reversible contraception and the impact of Medicaid reimbursement policies on contraception usage. Sharma received a PhD degree in economics from the University of Georgia in 2022. He can be reached at sharma@ebri.org.

**Jake Spiegel** is a a senior health and wealth associate at the Employee Benefit Research Institute. He completed his undergraduate work in economics at Carnegie Mellon University and earned a master's degree in applied economics from Johns Hopkins University. Previously, Spiegel worked for Morningstar on its public policy research team and for HelloWallet, where he conducted research on personal finance and financial wellness issues. He can be reached at spiegel@ebri.org.

**Paul Fronstin, PhD**, is director of health benefits research at the Employee Benefit Research Institute (EBRI). He also oversees the Center for Research on Health Benefits Innovation. He currently serves on the board of trustees for Emeriti Retirement Health Solutions. He also serves on the National Advisory Board for the University of Michigan Center for Value-Based Insurance Design and is a TIAA-CREF Institute Fellow. Fronstin earned his bachelor of science degree from SUNY Binghamton and a PhD degree in economics from the University of Miami. He can be reached at fronstin@ebri.org.

coverage increases premiums, with the magnitude of the increase depending primarily on net drug prices and the breadth of eligibility criteria. Adherence and cost sharing also matter: Improved persistence increases near-term premiums, while copays reduce premium increases modestly.

The main lesson for benefit professionals is that premium outcomes are not driven by a single factor. Coverage decisions involve trade-offs among access, affordability and the timing of benefits. As drug prices evolve and clinical indications expand, employers will likely need to revisit GLP-1 coverage policies regularly and evaluate them using clear assumptions about eligibility, utilization and cost. BQ

## References

Sharma, Keshob, Jake Spiegel and Paul Fronstin, "GLP-1 Coverage and Its Impact on Employment-Based Health Plan Premiums: A Simulation-Based Analysis," *EBRI Issue Brief*, no. 644, Employee Benefit Research Institute, October 2025.

**International Society of Certified Employee Benefit Specialists**

Reprinted from the Second Quarter 2026 issue of *BENEFITS QUARTERLY*, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.



pdf/626