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GLP-1 Coverage and Its Impact on Employment-Based Health Plan Premiums: A Simulation-Based Analysis

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AT A GLANCE

The rapid growth in usage of glucagon-like peptide (GLP-1) drugs — initially developed for diabetes but now widely used for weight management — is reshaping employment-based health benefits. As these medications are increasingly prescribed to individuals with obesity, and even to those who are overweight without comorbidities, employers are grappling with how to manage access and costs. While the clinical promise of GLP-1s is expanding, their high price point and growing demand have raised concerns about their impact on premiums.

This *Issue Brief* uses a simulation model to assess how GLP-1 coverage may affect employment-based health insurance premiums under varying assumptions related to drug costs, adherence rates, cost-sharing structures, and eligibility criteria. Drawing on data from MarketScan and current literature examining GLP-1 usage trends, the model estimates how different combinations of these variables influence total spending and insurance premiums for large and small firms.

- Currently, GLP-1 drugs are very expensive. According to a recent estimate, the net price for a 30-day supply of GLP-1 drugs ranges from $617 to $766.
- Additionally, GLP-1 usage is relatively low: Only 3 percent of non-elderly adults covered by employment-based health insurance had a GLP-1 claim in 2022, and a 2024 survey found that one in eight respondents had ever taken a GLP-1. However, there is a massive pool of potentially eligible enrollees. Over 40 percent of privately insured adults — more than 57 million people — are clinically eligible for GLP-1 drugs resulting from diagnoses of diabetes, obesity, or being overweight with additional risk factors.
- Employer coverage is expanding: 55 percent of employers cover GLP-1s for diabetes, and 36 percent cover them for both diabetes and weight loss.
- Perfect adherence leads to higher premiums: More consistent drug use may improve individual well-being and health outcomes but drives up overall plan spending in the short term. Simulations assuming perfect adherence result in premium increases that are several percentage points higher than simulations assuming adherence patterns observed in recent studies.
- The impact of expanding GLP-1 coverage on employment-based health insurance premiums is sensitive to assumptions surrounding uptake and drug prices:
    - Using real-world drug cost scenarios, premium increases ranged from 5.3 percent to 13.8 percent, depending on adherence, cost-sharing, and eligibility assumptions.
    - Using a hypothetical lower-priced GLP-1 with a $200/month cost, increases ranged from 1 percent to 3.9 percent, reflecting the potential for future price reductions to mitigate cost pressures.

- Cost sharing helps but does not fully offset cost growth: Introducing a $90 copay reduced premium increases across all scenarios by 1–2 percentage points but could not fully neutralize the effect of expanded eligibility or perfect adherence.
- Broad eligibility significantly increases cost impact: Expanding coverage to include individuals who are overweight — along with those who are obese or have diabetes — resulted in notably higher premiums due to the increased size of the eligible population.
- While GLP-1s may eventually generate some medical cost reductions, these benefits would not be manifested immediately, and there is no evidence to suggest that the savings would fully offset GLP-1 prices. Long-term GLP-1 usage is necessary to achieve weight loss. Furthermore, studies of GLP-1 discontinuation indicate that patients regain weight they lost while taking GLP-1s, and improvement of cardiovascular risk factors regress towards the patient's baseline, suggesting that GLP-1s may need to be taken indefinitely, which could further increase cost pressures on insurance premiums.

As GLP-1 drugs gain FDA approval for a broader range of conditions such as cardiovascular disease, employers may need to revisit coverage policies. Without strategies such as targeted eligibility, prior authorization, or alternative payment models, rising GLP-1 utilization could drive sustained increases in health insurance premiums, affecting both employers and employees in the long term.

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Table of Contents

Figures

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Introduction

Glucagon-like peptide (GLP-1) receptor agonists are a type of medication originally developed to help manage Type 2 diabetes. They mimic the effects of a natural hormone that is released after eating. This hormone helps the body lower blood sugar by increasing insulin, reducing another hormone called glucagon (which raises blood sugar) and slowing how quickly food leaves the stomach. Together, these effects help people better manage their blood sugar levels — and, in many cases, also lead to significant weight loss.

Initially, GLP-1 drugs were approved for daily injection to manage Type 2 diabetes. But between 2014 and 2016, longer-acting, once-weekly versions became available — including dulaglutide (Trulicity), albiglutide (Tanzeum), and semaglutide (Ozempic) (Reisdorf, 2024). These more convenient formulations contributed to the growing popularity of GLP-1 medications among individuals managing Type 2 diabetes (Hegland et al., 2024).

As GLP-1 drugs became more widely used and studied, researchers found that they could promote significant weight loss — even in individuals without diabetes. This led to a surge in off-label use of GLP-1 drugs for weight management, particularly among obese and overweight adults. In 2021, semaglutide was officially approved for chronic weight management under the brand name Wegovy. Similarly, tirzepatide, first approved for diabetes as Mounjaro, later received approval for weight loss under the brand name Zepbound (Reisdorf, 2024).

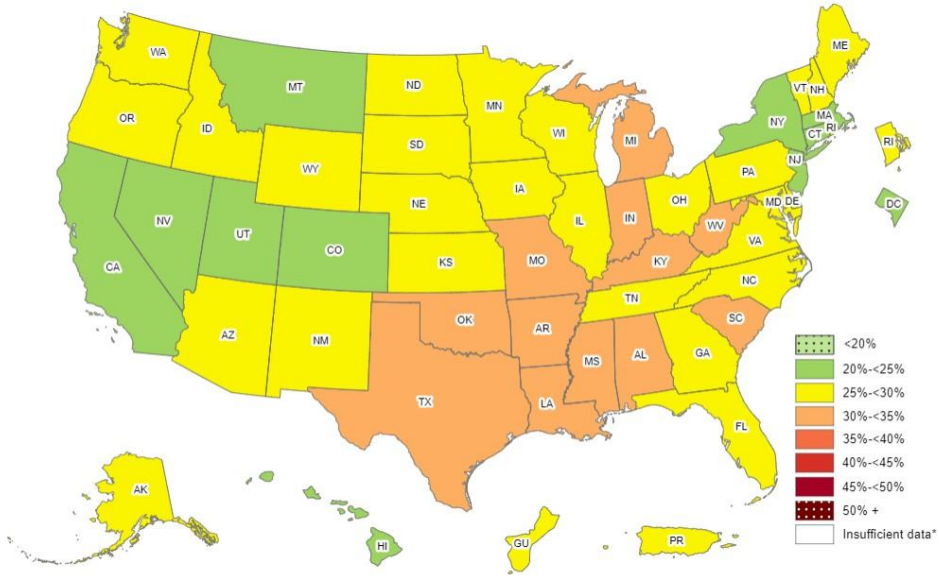
Although GLP-1 drugs have been available for several years, recent approvals for obesity treatment have triggered a surge in demand. This demand is expected to continue growing as newer demographics, including youth, gain access (Evernorth Health Services, 2025). The percentage of adults considered obese has increased dramatically since 2011; with obesity affecting at least 20 percent of adults in every U.S. state — and exceeding one-third of the adult population in 23 states (Centers for Disease Control, 2024) — the potential market for GLP-1 drugs in weight management now surpasses that for diabetes treatment.

Figure 1

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

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

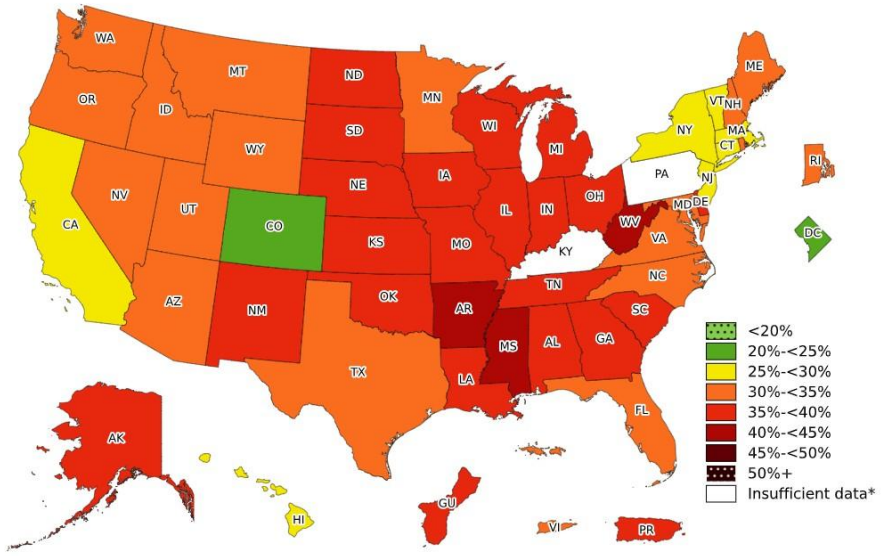
¶ Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



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

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

¶ Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



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

Coverage and use of GLP-1 drugs has been rising steadily, including within employment-based health plans. According to a 2025 survey by the International Foundation of Employee Benefit Plans (IFEBP), 55 percent of employers cover GLP-1 drugs for diabetes, while 36 percent cover them for both diabetes and weight loss (International Foundation of Employee Benefit Plans, 2025). Most insured adults who have taken GLP-1 medications had at least a portion of the costs covered by their insurers. Survey data also show that one in eight adults have ever used a GLP-1 drug, with usage rising to four in 10 among those with diabetes and one in four among those who have been overweight or obese in the past five years (Montero et al., 2024). Another survey by the IFEBP found that GLP-1 drugs prescribed for weight loss accounted for 10.5 percent of total claims in 2025, up from 6.9 percent in 2023, underscoring the rapid growth in demand (International Foundation of Employee Benefit Plans, 2025).

Employers and health plans are increasingly concerned about the costs associated with GLP-1 drugs for weight management, especially as their popularity continues to rise. One survey found that 27 percent of employers reported GLP-1 drug costs accounting for more than 15 percent of their annual claims (International Foundation of Employee Benefit Plans, 2025). Additionally, insurers have identified the growing use of GLP-1 medications as a contributing factor to rising health insurance premiums.

This *Issue Brief* explores the potential impact of GLP-1 utilization on premiums for employment-based health insurance under various scenarios and adds to the emerging body of literature focused on the financial implications of GLP-1 use.

Landscape of GLP-1 Usage and Coverage

According to a KFF survey analysis, 42 percent of non-elderly adults with private insurance — an estimated 57.4 million individuals — are clinically eligible for GLP-1 drugs.[1] Among those with employment-based health benefits, this translates to approximately 49.3 million eligible individuals, with 36.2 million eligible based on an obesity diagnosis alone. Since GLP-1s are relatively new, the landscape of GLP-1 usage has shifted significantly. Between 2012 and 2022, the share of Americans under age 65 covered by private insurance who filled at least one GLP-1 prescription rose by 717 percent. Despite the fast pace of utilization growth, however, relatively few adults take GLP-1s, as only 3 percent submitted a claim for a GLP-1 medication in 2022. Further, discontinuation rates are high, which further reduces utilization. For instance, research indicates that 26 percent of users discontinue within three months and 36 percent do so within a year (Do et al., 2024). These high discontinuation rates raise concerns, as patients may not experience the full clinical benefits of the medication without sustained adherence.

Employer coverage of and spending on GLP-1s has changed significantly as well. A 2024 IFEBP survey found that 34 percent of employers surveyed covered GLP-1s for both diabetes and weight loss, an 8 percentage point increase from the year before (Goforth, 2025). A survey of employers conducted by KFF found that one in four employers that do not currently cover GLP-1s for weight loss are considering doing so (Claxton et al., 2024). The stark disparity between the number of individuals eligible and this relatively low number of claims suggests that GLP-1 utilization within employment-based health plans is likely to continue rising.

Methods

Study Design

We simulated hypothetical increases in health insurance premium rates using a modeling approach designed to estimate changes in total health care spending and corresponding premium adjustments under various eligibility, cost-sharing, and adherence scenarios. Key model inputs included health care data from the MarketScan database, eligibility criteria, adherence levels, hypothetical cost-sharing structures, and observed as well as hypothetical drug prices.

We generated synthetic firms of varying sizes, each populated with randomly assigned employees.[2] For each simulated firm, health care spending values were randomly allocated. Ten percent of employees were assigned zero health care spending, while the remaining employees received spending values drawn from an empirical distribution of nonzero

spenders. Total health care spending was then calculated for each firm, and premiums were estimated using an assumed 85 percent medical cost ratio.

Each employee was also assigned a body mass index (BMI) drawn from a log-normal distribution (as discussed in the data section), allowing classification into overweight and obese categories. A diabetes diagnosis was assigned probabilistically with a 10 percent likelihood. Based on these factors, individuals were determined to be eligible for GLP-1 treatment using one of several clinical criteria: diabetes with overweight, diabetes with obesity, or diabetes alone. Eligible individuals were randomly selected for treatment within each scenario.

Not all individuals eligible to take a particular drug actually do so. To model potential take-up rates, we assumed the proportion of the hypothetically eligible obese and overweight populations taking up GLP-1s would be similar to the population of patients with type 2 diabetes currently doing so.[3] Similarly, not all individuals taking prescription drugs adhere to clinical guidance. Accordingly, we modeled adherence to GLP-1s under two scenarios:

- Perfect adherence: All treatment individuals remained on the medication for 12 or more weeks.
- Real-world adherence: Adherence followed patterns observed in a Blue Health Intelligence (BHI) study examining GLP-1 treatment persistence, with 42 percent of individuals continuing treatment for 12+ weeks, 15 percent for 8–12 weeks, and 42 percent for 4–8 weeks.

Treated individuals were randomly assigned one of three GLP-1 medications: Saxenda, Wegovy, or Zepbound. List prices for GLP-1 drugs are very high; for instance, Wegovy currently has a list price of $1,349.02 for a 30-day supply.[4] However, manufacturers sometimes offer discounts and rebates, lowering the effective price. Thus, drug costs were sourced from a recent study of the price of GLP-1 drugs net of rebates and discounts (Figure 2).[5] Treatment duration scaled drug costs as follows: two units for 4–8 weeks, three units for 8–12 weeks, and four units for 12+ weeks. To reflect potential future pricing dynamics, we also modeled an alternative scenario where GLP-1 drugs cost $200 per month, allowing us to evaluate how lower prices might influence premium impact and patient cost burden.[6]

To estimate total health care costs post-treatment, the cost of GLP-1 drugs was added to the firm's baseline spending. New premiums were then calculated using the same 85 percent medical loss ratio. The percentage change in premiums was computed by comparing the new premium with the original baseline. To account for stochastic variability in costs, eligibility, and treatment duration, this simulation was repeated 10,000 times per scenario.

Figure 2
GLP-1 Drug Costs

Drug	Net Cost for a 30-day supply
Saxenda	$766
Wegovy	$617
Zepbound	$725

We modeled two cost-sharing scenarios to reflect common benefit designs in employment-based health plans:

- $0 copay: Represents full coverage of GLP-1s by the insurer or employer, with no out-of-pocket cost to the employee.
- $90 copay: Represents a typical tiered formulary design, where the employee pays $90 per 30-day supply, reducing the insurer's share of drug costs.

To evaluate the effects of different eligibility criteria, we compared narrow and broad inclusion thresholds; one scenario limited eligibility to individuals with both diabetes and obesity, while broader scenarios included those with obesity alone or those who were overweight. These scenarios reflect real-world policy decisions and evolving clinical guidelines.

The final output of the model is the percentage change in premiums under each scenario. Results are summarized using the 5th, 50th (median), and 95th percentiles of the simulated premium changes, providing a distributional view of possible outcomes.

Data

Our simulation model drew upon a range of empirical data sources to inform key parameters and assumptions. To assign eligibility criteria for GLP-1 drugs, we used probability distributions based on data from the Behavioral Risk Factor Surveillance System (BRFSS). Body mass index (BMI) values were assigned using a log-normal distribution, enabling classification of individuals as overweight or obese — an essential determinant of eligibility for GLP-1 treatment.

Adherence to GLP-1 medications was modeled using real-world findings from a BHI study based on Blue Cross Blue Shield claims data, which provided empirical estimates of treatment duration among patients. These adherence patterns were used to define both the "real-world" and "perfect-adherence" scenarios described in the study design.

- Current health care spending data were sourced from the MarketScan database, which contains comprehensive claims data from employment-based health plans. We used this database to obtain the synthetic firm's baseline health care spending.

Cost-sharing assumptions were drawn from the KFF Employer Health Benefits Survey, focusing on typical structures for specialty drugs, such as a $90 copayment per 30-day supply.

To reflect common eligibility approaches used by employers in determining GLP-1 drug coverage, we modeled scenarios based on multiple criteria:

- Individuals with both diabetes and obesity.
- Individuals with obesity alone.
- Broader eligibility that includes overweight individuals with at least one weight-related condition.

We characterized the distribution of BMI and diabetes prevalence in the simulated employee population using BRFSS data and supporting literature specific to adults with employment-based health plans. This allowed us to assign realistic health risk profiles to the synthetic work force and understand how eligibility expansion could impact overall utilization and costs.

Adherence to specialty drugs like GLP-1s varies widely in practice. Low adherence rates may result from high out-of-pocket costs, side effects, low engagement with prescribing providers, discouragement from a lack of results, or lack of sustained access. However, clinical research indicates that prolonged use is critical to realizing long-term health benefits, as discontinuation often results in weight regain (Wilding et al., 2022). Given the importance of adherence to both health outcomes and financial impact, we modelled multiple adherence levels in the simulation to assess their influence on employer premiums.

A detailed summary of all data sources and model input parameters is provided in Figure 3.

Figure 3
Model Inputs

Category	Value / Source
Population	5,000 employees
Number of simulations	10,000 per scenario
BMI distribution	Log-normal (meanlog = 3.33, sdlog = 0.210251); based on survey data
Health Characteristics	10%; assigned probabilistically
Eligibility Criteria-1	Diabetes or Obesity
Eligibility Criteria-2	Diabetes, Obesity, or Overweight
Perfect Adherence	100% on drug for 12+ weeks
Real-world (BHI) Adherence	42% (12+ weeks), 15% (8-12 weeks), 42% (4-8 weeks)
GLP-1 medications	9 drugs (e.g., Ozempic, Wegovy, Mounjaro) assigned randomly
Drug Costs	Net prices sourced from ICER report, normalized to a 30-day supply
Cost scaling	1x (4-8 weeks), 2x (8-12 weeks), 3x (12+ weeks)
Cost Sharing	$0 copay
Cost Sharing	$90 copay per 30-day supply
Cost Sharing	$200 per month (reflecting oral GLP-1 pricing)
Health Care Spending	MarketScan claims data
Zero-spend probability	10% of individuals
Medical Cost Ratio (MLR)	85%

Results

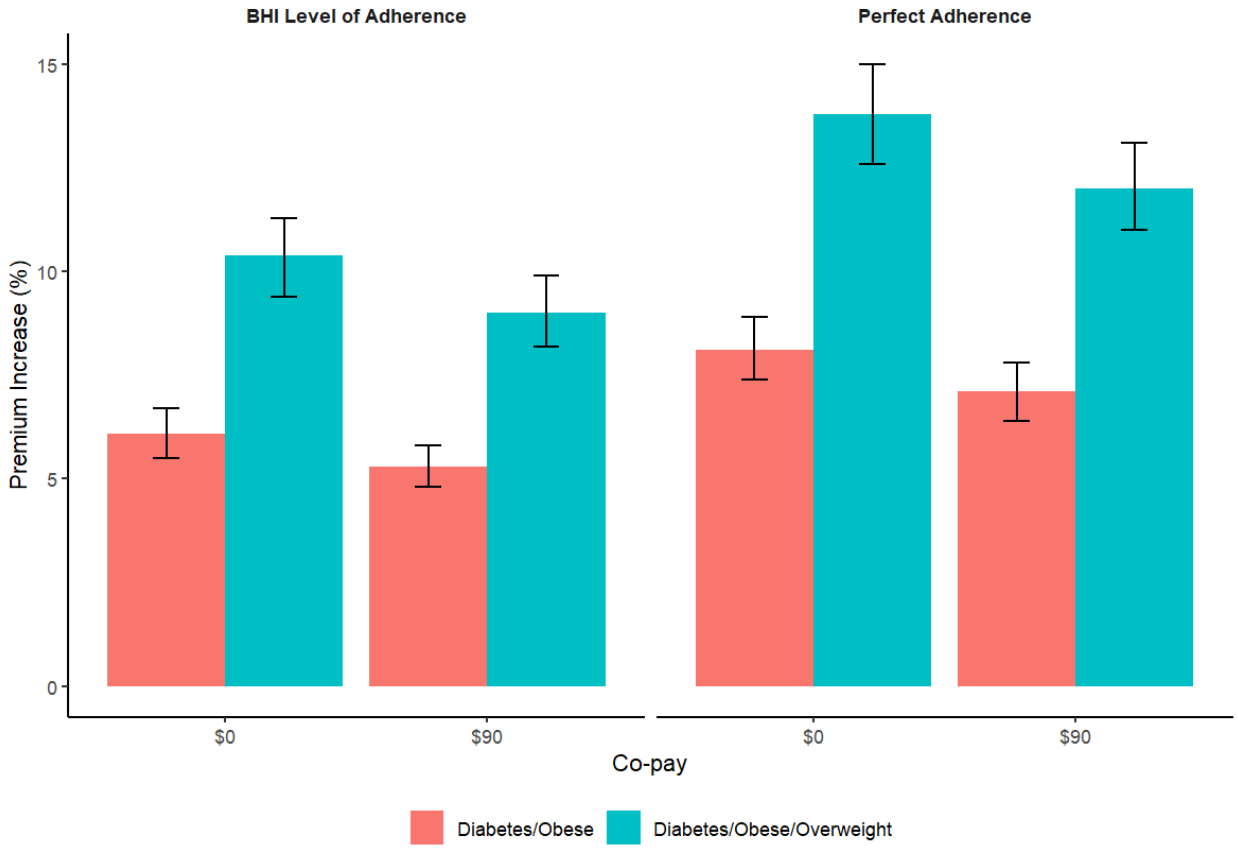
We simulated premium increases for a hypothetical larger firm with 5,000 workers, as well as under various scenarios defined by drug cost, copay level, eligibility criteria, and adherence assumptions. Drug cost scenarios included current net pricing and a lower, hypothetical $200 monthly cost to reflect future pricing possibilities. For each scenario, we modeled both perfect adherence and real-world adherence levels based on data from BHI. Here, we present the results for the 5,000-worker firm. Median premium increases are shown in Figures 2 and 3, with the 5th and 95th percentiles represented by error bars.

Premium Increases Using Current Net Drug Costs

In the current net-drug-cost scenario, premium increases varied notably based on eligibility criteria, adherence level, and cost-sharing structure.

Assuming take-up rates that mirror GLP-1 take-up among adults with Type 2 diabetes, and with the adherence rates observed in the BHI paper and a $0 copay, premiums increased 6.1 percent when only those with diabetes and obese were eligible. They increased 10.4 percent when overweight individuals were also eligible (Figure 4). With a $90 copay, premium increases were slightly reduced to 5.3 percent and 9 percent, respectively. These results show that expanding eligibility to include overweight individuals significantly increases premium impacts, and copays blunt premium increases, but it does not do so by much.

Figure 4
Premium Increase Using Current Net Drug Cost

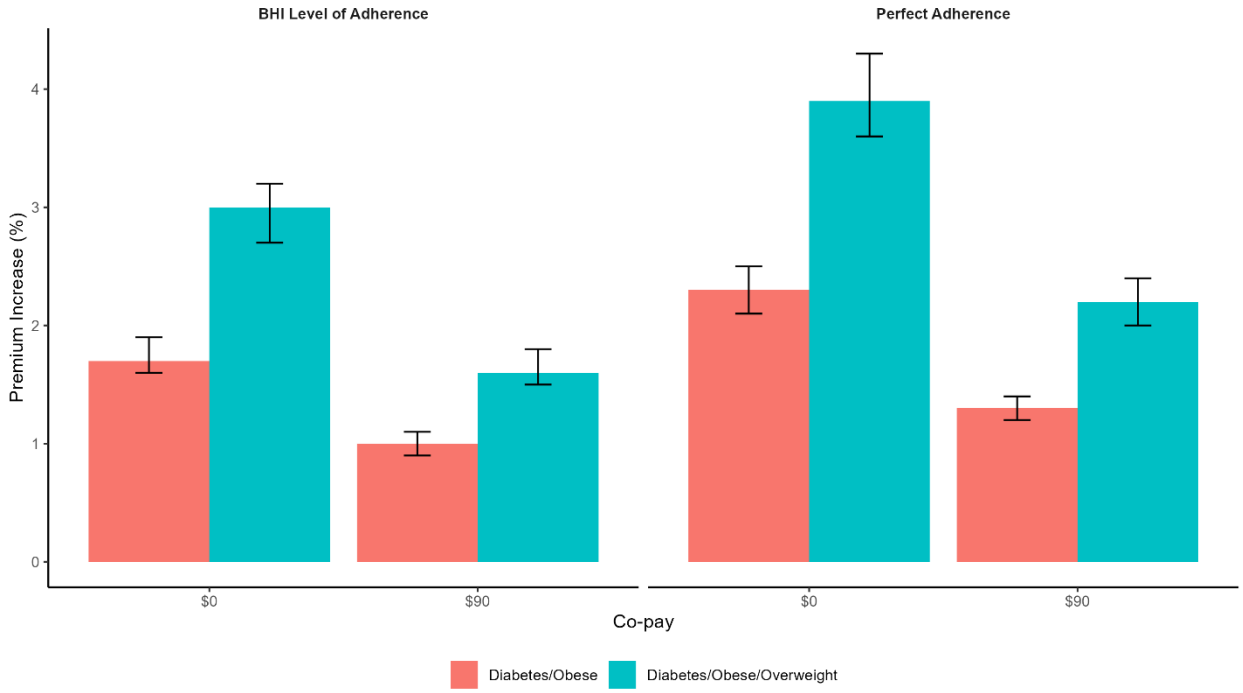


With perfect adherence and a $0 copay, premiums increased 8.1 percent when only those with diabetes and obesity were eligible and 13.8 percent when overweight individuals were also eligible. With perfect adherence and a $90 copay, premium increases were somewhat mitigated, dropping to 7.1 percent and 12 percent, respectively. These findings indicate that higher adherence levels — even with cost sharing — still lead to larger increases in premiums, driven by sustained medication usage.

Premium Increases Using Lower Drug Cost ($200/month)

The $200 monthly drug-cost scenario, representing potential pricing for future oral GLP-1 formulations, resulted in substantially lower premium increases across all groups. With BHI adherence and a $0 copay, premiums increased 1.7 percent when only those with diabetes and obesity were eligible and 3 percent when overweight individuals were also eligible (Figure 5). With BHI adherence and a $90 copay, premium increases dropped to 1 percent and 1.6 percent, respectively.

Figure 5
Premium Increase Using $200 Drug Cost



With perfect adherence and a $0 copay, premium increases were 2.3 percent when only those with diabetes and obesity were eligible and 3.9 percent when overweight individuals were also eligible. With perfect adherence and a $90 copay, premium increases declined to 1.3 percent and 2.2 percent, respectively.

Even under reduced drug prices, adherence remained a key driver of premium increases. Perfect adherence produced greater cost impact than BHI adherence, likely due to sustained drug utilization.

Summary Key Findings on Premium Increases

- **Drug Costs Drive Premium Impact**: Premium increases were significantly higher when using current net drug prices compared with the $200/month scenario.
- **Eligibility Expansion Matters**: Including overweight individuals (beyond those with obesity and diabetes) led to larger premium increases across all scenarios.
- **Adherence Amplifies Costs**: Perfect adherence led to greater premium increases than real-world adherence, even with cost sharing in place.
- **Cost Sharing Helps**: Introducing a $90 copay reduced premium increases by 1–2 percentage points across most scenarios.
- **Range of Premium Impacts**:
    - Current Net Drug Cost + Perfect Adherence + Broad Eligibility: Up to a 13.8 percent increase.
    - $200 Drug Cost + BHI Adherence + Narrow Eligibility + $90 Copay: As low as a 1 percent increase.

Discussion

This study assessed the impact of GLP-1 drug coverage on health insurance premiums in employment-based health plans. Through a series of simulations incorporating different drug costs, adherence level, cost-sharing designs, and eligibility criteria, we estimated how various scenarios affect overall health care spending and resulting premium changes. Across all scenarios, the findings revealed consistent increases in premiums — though the magnitude varied depending on the underlying assumptions.

Under the lower-drug-cost scenario ($200/month), premium increases were relatively modest but remained sensitive to both adherence and copay levels. Individuals with perfect adherence consistently exhibited higher premium increases than those with real-world adherence (based on BHI data), even when cost sharing was introduced. This pattern may reflect the fact that more adherent patients are also more engaged with the health care system, filling prescriptions regularly and thus driving up overall drug utilization. The presence of a $90 copay reduced premium increases in all scenarios, suggesting that even modest cost sharing can shift financial responsibility from the plan sponsor to the employee and dampen the impact on premiums. However, even with copays, perfect adherence still resulted in higher premium burdens than more typical adherence patterns.

Under the current net price scenario, premium increases were more pronounced across all groups. The most significant increases occurred among individuals with perfect adherence and those eligible under expanded criteria that included overweight status. Expanded eligibility to include overweight individuals — many of whom may have comorbid conditions such as hypertension or cardiovascular disease — compounded the premium impact. These findings suggest that as the number of eligible individuals grows, so too will the financial burden on employment-based health plans.

Importantly, these results highlight a potential tradeoff in the broader adoption of GLP-1 therapies. While clinical research increasingly points to the efficacy of GLP-1s for a range of conditions beyond diabetes and obesity (e.g., cardiovascular disease, sleep apnea, PCOS), expanding eligibility could drive significant increases in premiums. In our simulations, inclusion of overweight individuals alone led to substantial upward pressure on premiums. And, while insurers may eventually realize savings in the form of medical cost offsets, these benefits may not necessarily be manifested immediately. While some benefits are realized in the short term, long-term use is necessary to mitigate ailments concomitant with obesity and overweight, such as obstructive sleep apnea. Those potential savings will not be reflected in the short term, as insurance contracts are negotiated on a yearly basis and medical-cost offsets arising from fewer ailments concomitant with obesity and overweight may not be realized for many years. Further, the potential medical-cost offsets may be smaller than the cost of the drugs.[7] Additionally, there is increasing evidence that

GLP-1s must be taken indefinitely to realize and maintain long-term health benefits. Studies of GLP-1 discontinuation indicate that patients regain the weight they lost, and improvement of cardiovascular risk factors regress towards the patient's baseline.[8] And, longer-term spending on GLP-1s may not decrease appreciably, as maintenance doses — the lowest effective dosage to achieve and maintain weight loss — are priced similarly to initial and escalation doses.[9]

Taken together, the results underscore that premium impacts are not only a function of drug pricing but also of behavioral, clinical, and policy decisions — such as adherence, cost-sharing design, and eligibility expansion. As GLP-1s are considered for a broader set of indications, policymakers and employers must weigh the financial implications against the potential long-term health benefits for a growing population of eligible patients.

Limitations

This study has several important limitations that should be considered when interpreting the results.

First, the assignment of GLP-1 drugs in real-world clinical settings reflects individualized decision making based on factors such as injection frequency, side-effect profiles, comorbidities, and insurance coverage (Defnet, 2025). Our simulation randomly assumes different GLP-1 drugs among eligible individuals, which does not fully capture the nuanced clinical decision making guided by protocols such as those outlined by the American Diabetes Association (American Diabetes Association Practice Committee, 2025).

Second, although GLP-1 drugs have been shown to be effective in promoting weight loss, this benefit is often contingent on continuous use. Studies indicate that discontinuation frequently leads to rapid weight regain (Khan et al., 2025; Wilding et al., 2022). However, there is limited empirical data on long-term adherence and the share of individuals who remain on GLP-1 therapy over extended periods to sustain health outcomes.

Our analysis relies on general cost-sharing assumptions for specialty drugs due to limited availability of detailed, drug-specific cost-sharing data for GLP-1 medications. We use a $90 copay as a proxy, which might not accurately reflect the actual variability in out-of-pocket costs across different employer plans and formularies.

Fourth, while GLP-1 drugs have demonstrated clinical benefits beyond weight loss and diabetes — such as improvements in cardiovascular risk factors and other comorbid conditions (Anderer, 2025) — our model focuses on short-term impacts to employment-based health insurance premiums and does not incorporate potential medical-cost offsets resulting from improved health outcomes. Future research should assess the long-term impact of GLP-1 use on overall health care expenditures, particularly as weight loss may reduce the incidence and cost burden of chronic diseases, as well as potential improvements in health and quality of life outside the context of cost savings.

Finally, the pricing of GLP-1 drugs is expected to decline over time, particularly as generic formulations become available following patent expirations (BioPharmaAPAC, 2025). Widespread adoption of lower cost GLP-1 medications may drive higher utilization in the future. Our results reflect current or hypothetical pricing scenarios but do not capture the dynamic effects of future pricing shifts, eligibility expansion, or broader market access. Future studies should explore these factors, including the impact of price reductions, expanded clinical indications, and long-term cost offsets, to more comprehensively assess the implications of widespread GLP-1 adoption on insurance premiums.

Conclusion

The rapid rise in the popularity of GLP-1 drugs mirrors the trajectory of other high-cost specialty medications that have historically influenced insurance premiums. For example, the introduction of hepatitis C treatments such as Sovaldi and Harvoni contributed significantly to national drug spending (Davy, 2015). Similarly, an Evernorth report from 2022 found that although less than 2 percent of the U.S. population uses specialty drugs, these prescriptions account for one-half of total pharmacy spending (Evernorth Health Services, 2022).

Our simulation results demonstrate that the impact of GLP-1 drug coverage on health insurance premiums is highly sensitive to a combination of factors, including drug prices, adherence levels, cost-sharing design, and eligibility criteria. Our results highlight the critical role of adherence on premium increases. While better adherence is associated with improved health outcomes, it also leads to higher drug utilization and places upward pressure on premiums. Additionally, scenarios involving higher drug costs had a substantially greater impact on premiums, regardless of adherence.

Cost-sharing mechanisms such as copayments can help reduce the financial burden on insurers and employers, but they do not fully offset the effects of broader eligibility and high adherence rates. Our findings underscore that expanding eligibility — especially to include overweight individuals or those with newer indications — can significantly amplify premium increases, raising important questions about long-term affordability and benefit design.

Looking ahead, the influence of GLP-1s on employment-based health plans is likely to continue to expand as these drugs gain FDA approval for additional indications, such as cardiovascular disease and other metabolic conditions. As the eligible population grows, employers may need to reconsider coverage strategies, potentially introducing stricter eligibility criteria, prior authorization requirements, or innovative payment models to manage costs. Without proactive planning, the widespread adoption of GLP-1s could drive substantial increases in premiums, affecting both employers and employees.

References

American Diabetes Association Practice Committee. "Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes—2025," *Diabetes Care*, vol. 48(1) (American Diabetes Association Practice Committee, January 2025). Available at https://doi.org/10.2337/dc25-S009.

Anderer, Samantha. "Study Identifies Benefits and Risks of GLP-1 Drugs Across 175 Health Outcomes." *JAMA*, vol. *333* no. 12, 1023 (JAMA Network, February 21, 2025). https://doi.org/10.1001/JAMA.2025.0542.

BioPharmaAPAC. "25 High-Value Drugs Losing Patent Protection in 2025: What It Means for Healthcare" (BioPharmaAPAC, December 27, 2024). Available at https://biopharmaapac.com/analysis/60/5727/25-high-value-drugs-losing-patent-protection-in-2025-what-it-means-for-healthcare.html.

Blue Health Intelligence. "Real-World Trends in GLP-1 Treatment Persistence and Prescribing for Weight Management," *Blue Health Intelligence Issue Brief* (May 2024). Available at https://www.bcbs.com/media/pdf/BHI_Issue_Brief_GLP1_Trends.pdf

Centers for Disease Control. "New CDC Data Show Adult Obesity Prevalence Remains High," *Centers for Disease Control Press Release* (September 12, 2024). Available at https://www.cdc.gov/media/releases/2024/p0912-adult-obesity.html.Claxton, Gary, Matthew Rae, Aubrey Winger, and Emma Wager. "Employer Health Benefits 2024 Annual Survey" (KFF, October 2024). Available at https://www.kff.org/health-costs/2024-employer-health-benefits-survey/.

Defnet, Ann Marie. "What's The Best GLP-1 For Weight Loss?," *The Well* (Northwell Health, May 12, 2025). Available at https://thewell.northwell.edu/obesity/glp1-treatment-options.

Do, Duy, Tiffany Lee, Samuel K. Peasah, Chester B. Good, Angela Inneh, and Urvashi Patel. "GLP-1 Receptor Agonist Discontinuation Among Patients With Obesity and/or Type 2 Diabetes," *JAMA Network Open*, vol. *7 no.* 5, e2413172 (JAMA Network, May 24, 2024). Available at https://doi.org/10.1001/JAMANETWORKOPEN.2024.13172.

Evernorth Health Services. "Navigating GLP-1 demand, cost, and sustainability." *Pharmacy in Focus* (Evernorth, March 25, 2025). Available at https://www.evernorth.com/articles/navigating-glp-1-demand-cost-and-sustainability

Evernorth Health Services. "What Is Drug Trend and How to Manage it" (Evernorth Health Services, April 20, 2022). Available at https://www.evernorth.com/articles/specialty-drug-trends-and-utilization.

Goforth, Alan. "Survey: 36% of employers now cover GLP-1s for weight loss & diabetes," *BenefitsPRO* (May 27, 2025). Available at https://www.benefitspro.com/2025/05/27/survey-36-of-employers-now-cover-glp-1s-for-weight-loss--diabetes/.

Hegland, Thomas A., Zhengyi Fang, and Karen Bucher. "GLP-1 Medication Use for Type 2 Diabetes Has Soared." *JAMA*, vol. 332 no. 12, 952–953 (JAMA Network, August 30, 2024). Available at https://doi.org/10.1001/JAMA.2024.18219.

International Foundation of Employee Benefit Plans" GLP-1 Drugs: 2025 Pulse Survey (U.S.)" (International Foundation of Employee Benefit Plans, 2025). Available at https://www.ifebp.org/resources---news/survey-reports/glp-1-drugs-us--2025-pulse-survey.

James, Davy. "Hepatitis C Drugs Drive Increase in Average Cost of Specialty Prescription," *Pharmacy Times* (April 2, 2015). Available at https://www.pharmacytimes.com/view/hepatitis-c-drugs-drive-increase-in-average-cost-of-specialty-prescription.

Khan, Sadiya S., Chiadi E. Ndumele, and Dhruv S. Kazi. "Discontinuation of Glucagon-Like Peptide-1 Receptor Agonists," *JAMA*, vol. 333 no. 2, 113–114. (JAMA, November 13, 20240. Available at https://doi.org/10.1001/JAMA.2024.22284.

Montero, Alex, Grace Sparks, Marley Presiado, and Liz Hamel. "KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs," KFF (May 10, 2024). Available at https://www.kff.org/health-costs/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/.

Reisdorf, Ana. "History of GLP-1 Medications" (GLP-1 Hub, December 19, 2024). Available at https://glp-1hub.com/history-of-glp-1-medications/.

Pearson, Steven D., Christopher M. Whaley, and Sarah K. Edmond. "Affordable Access to GLP-1 Obesity Medications: Strategies to Guide Market Action and Policy Solutions," *Institute for Clinical and Economic Review* (April 9, 2025). Available at https://icer.org/wp-content/uploads/2025/04/Affordable-Access-to-GLP-1-Obesity-Medications-_-ICER-White-Paper-_-04.09.2025.pdf.

Wilding, John P. H., Rachel L. Batterham, Melanie Davies, Luc F. Van Gaal, Kristian Kandler, Katerina Konakli, Ildiko Lingvay, Barbara M. McGowan, Tugce Kalayci Oral, Julio Rosenstock, Thomas A. Wadden, Sean Wharton, Koutaro Yokote, and Robert F. Kushner. "Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension." *Diabetes, Obesity and Metabolism*, vol. *24*, no. 8, 1553–1564 (April 19, 2022). Available at https://doi.org/10.1111/DOM.14725.

Yeo, Yee Hui, Ali Rezaie, Tina Yi-Jin Hsieh, Xiaoqin Hu, Srinivas Gaddam, and Kevin Sheng-Kai Ma. "Shifting Trends in the Indication of Glucagon-like Peptide-1 Receptor Agonist Prescriptions: A Nationwide Analysis." *Annals of Internal Medicine*, vol. *177* no. 9, 1289–1290. (July 23, 2024). Available at https://doi.org/10.7326/M24-0019.

Endnotes

[1] The KFF study defines eligibility as adults with obesity, diabetes, or overweight with other risk factors present, such as coronary heart disease, hypertension, hypercholesterolemia, previous strokes, previous heart attacks, or angina.

[2] We also modeled premium increases for a smaller firm employing 500 workers to account for differences in risk pooling; the median increases are the same for 500 and 5,000 worker firms, but the 95 percent confidence intervals are much wider for smaller firms because of their shallower risk pool.

[3] A recent CDC study leveraging the National Health Interview Survey found 26 percent of adults with diabetes take a GLP-1 (see https://www.cdc.gov/nchs/products/databriefs/db537.htm), and 55 percent of employers currently offer GLP-1 coverage for Type 2 diabetes, implying roughly 47 percent of patients with Type 2 diabetes have coverage through their employer. This is not a perfect estimate of potential take-up rates among a newly eligible overweight and obese population, as smaller firms may be less likely to cover GLP-1s and also, by their nature, employ fewer workers than larger firms. However, the popularity of GLP-1 drugs may encourage more overweight and obese workers to take them up.

[4] As of October 2025, the list price for Wegovy is $1,349.02: see https://www.novocare.com/obesity/products/wegovy/let-us-help/explaining-list-price.html.

[5] Net prices — inclusive of rebates and discounts — were obtained from an Institute for Clinical and Economic Review (ICER) report on affordable access to GLP-1s, which, in turn, were produced using data from SSR Health, Inc.

[6] We chose to model a scenario in which GLP-1s cost $200, as that is a price point targeted by firms such as Cigna (see https://www.evernorth.com/articles/evernorth-launches-new-benefit-option-drives-lower-net-cost-weight-loss-medicines), Hims (see https://investors.hims.com/news/news-details/2024/Hims--Hers-Announces-Access-to-GLP-1-Injections-Passing-Cost-Savings-Onto-Customers/default.aspx), and Noom (see https://www.noom.com/med/glp1-microdose/?srsltid=AfmBOopzqQcLWvGakWVjx8N9OLEjSqCjtiGNEGQBOdUs_dbi5z-jBsxp). Additionally, international pricing for several GLP-1s indicates that $200 may be a realistic price point for GLP-1s purchased in the United States (see https://www.healthsystemtracker.org/brief/prices-of-drugs-for-weight-loss-in-the-us-and-peer-nations/#List%20prices%20of%20drugs%20used%20for%20weight%20loss%20in%20the%20U.S.%20and%20peer%20nations).

[7] For instance, the Congressional Budget Office (CBO) estimated in 2024 that if Medicare covered anti-obesity medications such as GLP-1s, Medicare would spend $7.1 billion covering these drugs in 2034, but the cost savings realized from healthier Medicare beneficiaries would total only $1 billion.

[8] For instance, see Wilding et al. (2022) and Khan, Ndumele, and Kazi (2025).

[9] There was, for instance, a $57 difference between the retail prices for a 30-day supply of the 0.25mg dosage of Ozempic and the 2mg dosage in the Marketscan database, although this does not reflect potential manufacturer discounts or rebates. Similarly, retail pricing for Zepbound through Lilly Direct ranges from $349 for the 2.5mg dosage, while the 5mg, 7.5mg, 10mg, 12.5mg, and 15mg dosages are all priced at $499 as of August 20, 2025.