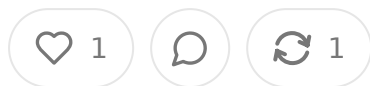


How Commercial Insurers, Self-Insured Employers, PBMs, and Manufacturers Are Turning GLP-1 Pharmacy Benefits Into Active Managed-Access Operating Systems and Where the Infrastructure Opportunity Sits

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Abstract

- Commercial payer tailwind: GLP-1 cost and utilization have broken the old formulary model, forcing employers, carriers, and PBMs to rebuild benefit design around eligibility, adherence, and outcomes logic rather than yes/no coverage.
- Cost anchor: KFF 2025 data shows 43% of firms with 5,000+ workers cover GLP-1 for weight loss (up from 28% in 2024), 59% report usage higher than expected, and 66% say the spend impact is significant. Mercer shows 77% of large employers say managing GLP-1 cost is extremely or very important for 2026.
- Employer-as-payer: 34% of firms covering GLP-1s now require dietitian, case management, therapy, or lifestyle participation (up from 10% the year prior). Business Group Health reports 79% of large employers have seen GLP-1 uptick with flat obesity-indication coverage and more utilization mgmt.
- Indication fragmentation: Wegovy added CV risk reduction (2024) and noncirrhotic MASH with F2-F3 fibrosis (2025); Zepbound got moderate-to-severe OSA in adults with obesity (Dec 2024). Each indication carries a different medical-necessity narrative and cost-offset story.

- Incumbent infrastructure already exists: Evernorth EncircleRx has 9M enrolled offers a 15% cost cap or 3:1 savings guarantee, has saved plans ~\$200M since 202 Evernorth also added a \$200 patient-copay cap on Wegovy and Zepbound in 202 Optum Rx's Weight Engage pairs GLP-1 access with obesity specialist navigation coaching, and lifestyle programs. UHC Total Weight Support requires coaching engagement (Real Appeal Rx or WeightWatchers for Business) as a coverage gate
- Manufacturer channel-war: Lilly Employer Connect (Mar 5, 2026) goes direct-t employer at \$449/dose Zepbound KwikPen with 15+ program administrators including GoodRx, Cost Plus Drugs, Teladoc, Calibrate, Form Health, 9amHealt Waltz. Novo Nordisk is running a parallel DTE play with Waltz Health and 9amHealth (launched Jan 1, 2026 model).
- Persistence problem: Meta-regression data shows ~50% GLP-1 discontinuation within 1yr and ~60% of lost weight regained within 12 mo of cessation. Prime Therapeutics' 3yr data cited by Mercer shows only 1-in-12 still on therapy after 1 years. That is the entire ROI problem in one stat.
- Build opportunity: utilization mgmt infra, outcomes-based contracting rails, indication-specific cardiometabolic programs (CV, OSA, MASH, perimenopause prediabetes), adherence/tapering/discontinuation systems, and employer-side financing or subsidy products.

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Why the old pharmacy benefit model cannot hold

The thing worth saying up front is that GLP-1 economics are not just “expensive same playbook.” They break the playbook. Pharmacy benefit managers were built to manage formularies of drugs where the eligible population is bounded, utilization fairly predictable, and the plan sponsor mostly just needs a tier, a prior auth, and a rebate story. GLP-1s blow up every assumption in that stack. The eligible population is enormous (KFF estimates 36.2 million commercially insured adults have a BM that would medically qualify them), the cost is recurring at roughly \$1,000 to \$1,200+ per month list, persistence is uncertain, and the indications keep expanding into territory that is harder to refuse (cardiovascular risk reduction, obstructive sleep apnea, noncirrhotic MASH). Put that all together and the plan sponsor cannot realistically answer a simple yes/no question about coverage anymore. What they have to answer is which population, under what diagnostic threshold, through which channel, with what behavioral gate, at what subsidy level, for how long, and with what stop rules. That is a different product than a formulary. It is an operating model.

The KFF 2025 Employer Health Benefits Survey made the shape of the problem more concrete. Among firms with 5,000 or more workers, 43% cover GLP-1 agonists primarily for weight loss, up from 28% the prior year. Among the firms that do cover, 59% say use has been higher than expected and 66% say the impact on prescription spending has been significant. One employer told KFF the class went from its 32

biggest drug spend line to its single biggest in one year. That is not a trend curve is a cliff. The behavioral reaction is exactly what anyone watching benefits design decade would predict: sponsors are not so much de-covering as re-covering with logic bolted on.

What the KFF and Business Group data actually shows



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