

Staggering Cost of Obesity Care –

What's Next for Self-Insured Employers?

Written By Laura Carabello

Obesity care is exacting a heavy toll on self-insured employers. Soaring costs and increased demand for new weight-loss drugs -- better known as GLP1s -- are an outsized addition to most health plan budgets. Mounting pressures to offer programs that address workplace weight bias are also burdensome. The vast number of studies and surveys being conducted on this topic are indicative of the difficulties facing self-insured companies of every size and scope.

These all add up to exorbitant annual costs of obesity-related illnesses in the US, including direct medical costs for treating chronic diseases which are substantial and rising. Medical experts advise that obesity is linked to a variety of health problems like hypertension, hyperlipidemia, heart attack, strokes, various cancers, early-onset arthritis – even mental health risks for depression, anxiety, suicidal ideation and substance abuse.

Clearly, individuals with obesity are an expensive population. The Centers for Disease Control and Prevention (CDC) tell us that these individuals incur approximately \$1,861 more in medical expenses compared to those with a healthy weight. The National Institute of Health indicates that the spend on weight loss dietary supplements is approximately \$2.1 billion/year.



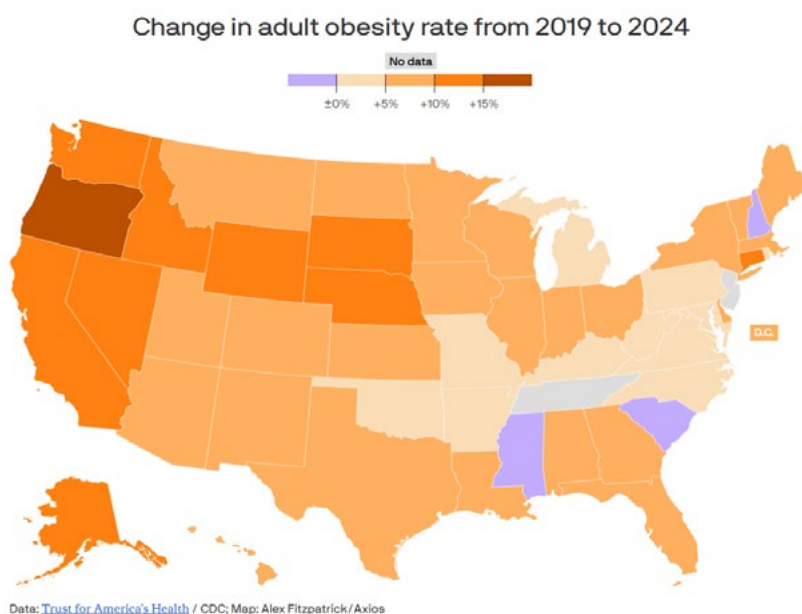
OBESITY BY THE NUMBERS

From the perspective of employers and employees, total economic costs and implications of obesity and being overweight are even higher. The most recent report from Global Data, a leading data and analytics company, shows that of the 158 million civilian employees on non-farm payrolls, 30% (46.9 million) are classified as having obesity and 34% (53.8 million) have overweight, causing a staggering \$425.5 billion in annual economic costs to US businesses:

- ✓ \$146.5 billion in higher medical costs for employees and their dependents
- ✓ \$82.3 billion in higher absenteeism (missed workdays)
- ✓ \$160.3 billion in higher presenteeism (reduced productivity due to illness)
- ✓ \$31.1 billion in higher disability costs
- ✓ \$5.2 billion in higher Workers' Compensation Program costs.

Regrettably, CDC further reports that only 2 in 5 young adults are weight-eligible and physically prepared for basic training in the U.S. military. What's more, the Wisconsin Collaborative for Healthcare Quality reports the direct and additional hidden costs of obesity are stifling businesses and organizations that stimulate jobs and growth in U.S. cities. They cite demographics which play an important role regarding prevalence and cost:

- ✓ In the 10 cities with the highest obesity rates, the direct costs connected with obesity and obesity-related diseases are roughly \$50 million per 100,000 residents. Amid estimates that the nation will incur higher costs for disability and unemployment benefits, businesses are suffering due to obesity-related job absenteeism to the tune of \$4.3 billion annually – with these costs expected to rise.
- ✓ In the “good news, bad news” report, the number of U.S. states with adult obesity rates at or above 35% dropped slightly in 2024 compared to a year prior -- BUT – the number remains far higher than just a decade ago.
- ✓ What's driving the news is that the latest “State of Obesity” report from the nonprofit, nonpartisan Trust for America's Health (TFAH) shows that nineteen states have adult obesity rates at or above 35% vs. only 3 states that had that rate 10 years ago.





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¹ Based on medical record review of 573 patients, from multiple employers, referred into the Mayo Clinic Complex Care Program in 2024.

² American Health Policy Institute (AHPI); High Cost Claimants: Private vs. Public Sector Approaches

- ✓ What states are on the rise? Oregon (+16%), Nevada (+12%) and South Dakota (+12%), while the highest states are West Virginia (41.4%), Mississippi (40.4%) and Louisiana (39.2%). It is stunning that the NO state had an obesity rate under 25% for the first time since 2011, when the data begins.



Glenn Fisher

Glenn Fisher, CEO, NavMD, offers this perspective, “Obesity remains one of the most pressing health and financial challenges of our time. The costs—measured in rising claims, comorbidities, lost productivity, and human suffering—continue to escalate. GLP-1 medications have disrupted budgets, delivering real outcomes but at a premium price.”

Many employers and payers are implementing criteria for prescribing and reimbursing weight loss drugs, balancing access with sustainability.

“Looking ahead, demand is unlikely to fade, and long-term affordability will require strategies to taper or “wean” members off medication, paired with holistic lifestyle and behavioral programs,” he continues. “Beyond drugs, weight management, nutrition, digital coaching and value-based care models are being explored to curb costs and improve health.”

Reiterating the message that GLP-1 medications are effective but costly and straining self-insured employers’ budgets, Jessica Lea, CEO, Tria Health, says, “With 40% of employees affected by obesity, demand for support is strong, but long-term, sustainable solutions are essential. This is why Tria Health developed Choose to Lose, requiring active participation in behavior management before members can access anti-obesity medications.”

Lea maintains that this helps members build lasting habits and in addition, they receive pharmacist oversight to ensure these high-cost medications are working as intended, reducing waste.

“By aligning medication coverage with behavior management, employers gain a framework that promotes accountability, improves health outcomes and delivers measurable impact,” she concludes.

Keith W. Kennerly, founder & CEO, PayRx, Inc., agrees that GLP-1s are transforming obesity care, adding this caveat, “But their recurring costs can destabilize even the most well-managed self-insured employer plans. At PayRx, we work with brokers and sponsors to help convert these high-cost exposures into predictable, budgetable spend — blending patient-level analytics (diagnosis, procedure, adherence) with structured financial reinsurance tools.”

He reaffirms the goal to give CFOs and advisors a better way to avoid sudden premium hikes, lasers, or access delays, noting, “GLP-1s may reshape metabolic health for the better, but without financial innovation, their cost trajectory could overwhelm traditional benefit design. We believe plans deserve both: better care and better financial control over trend-driving therapies.”



Keith W. Kennerly

The marketplace is responding as Tim Church, MD, MPH, PhD, chief medical officer, Wondr Health emphasizes, “Obesity care affects both the health of our people and our healthcare costs. Like many



Tim Church

employers, we've seen growing demand for GLP1s and take a careful, clinically guided approach to coverage. For us, that includes prior authorization, medical criteria and participation in a lifestyle program."

Dr. Church explains that the Company supports employees through its own comprehensive programs, plus additional support for fitness, mental health, family well-being and more.

"It's the same approach we offer our clients – evidence-based, sustainable and built for real-life results," he says. "The costs go well beyond claims—they also show up in absenteeism, lower productivity and disability. To manage both cost and outcomes, we've implemented criteria such as prior authorization with BMI requirements, and participation in our behavior-

change program as part of GLP-1 coverage."

He projects that while costs may eventually decline as more medications enter the market, demand for GLP-1s is expected to remain strong due to their significant results and expanding use in treating chronic conditions beyond obesity.

"As these medications become a long-term component of care, pairing them with proven, behavior-change programs is essential to drive sustainable outcomes, improve adherence and maintain cost control over time," he continues. "But looking ahead, the real cost of obesity care will depend on how proactive we are. Investing in prevention with proven weight management solutions—before conditions progress—can significantly bend the cost curve and protect both employee health and the bottom line."

OVERWEIGHT OR OBESE?

Body mass index (BMI) is the traditional way of defining or measuring overweight and obesity. CDC characterizes BMI as a quick, safe, and reliable screening measure that is inexpensive, noninvasive and easily collected during routine health care visits to assess a person's weight relative to their height.

BMI ranges of adults ages 20 and older

BMI	Category
18.5 to 24.9	Healthy weight
25 to 29.9	Overweight
30+	Obesity (including severe obesity)
40+	Severe obesity

Source: National Institutes of Health



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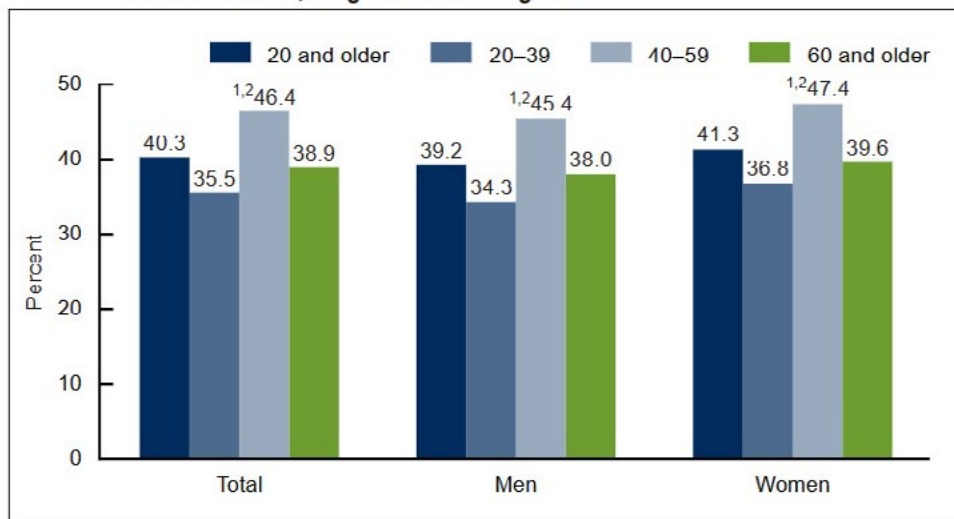
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Prevalence of obesity in adults age 20 and older, by sex and age: United States, August 2021–August 2023



¹Significantly different from ages 20–39 ($p < 0.05$).

²Significantly different from age 60 and older ($p < 0.05$).

NOTE: Age-adjusted estimates for adults age 20 and older are 40.3% for the total population, 39.3% for men, and 41.4% for women and were age adjusted by the direct method to the U.S. Census 2000 population using age groups 20–39, 40–59, and 60 and older.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey, August 2021–August 2023.

However, public health experts acknowledge the limitations of BMI, leading to calls for more comprehensive diagnostic criteria with criticism that BMI does not differentiate between fat and muscle mass. As a result, a bodybuilder with a high amount of muscle might be classified as obese even if their body fat percentage is healthy.

BMI is far from perfect as the Obesity Association™, a division of the American Diabetes Association®, advocates that instead,

a diagnosis should be based upon an overall assessment of the individual – including their metabolic, physical and psychological wellbeing.

The outlook for rising obesity paints a dismal forecast. Researchers publishing in the Journal of the American College of Cardiology came to this conclusion: “By 2030, 50% of American adults will be obese, and there will be significant disparities in the prevalence of obesity among demographic subgroups. Obesity disproportionately affects individuals from low socioeconomic backgrounds as well as racial and ethnic minority populations, and the prevalence of obesity rises as the burden of adverse social determinants of health (SDOH) increases.”

This report also confirms that obesity is not an equal opportunity disease. In late 2024 the National Center for Health Statistics issued a data brief demonstrating significant reductions in obesity and severe obesity prevalence in adults were only seen in specific groups: White individuals, males, college graduates, those with private insurance and higher-income households—while divorced, separated, or widowed individuals saw a notable increase.



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With 5% weight loss, which is achievable through lifestyle counseling that helps people improve their diet and physical activity levels, 22% of workers with obesity would no longer meet the criteria for obesity.

With 25% weight loss, which often requires medical intervention, 78% of people with obesity could move out of obesity.

Sustained weight loss of 25% for people with obesity could reduce average healthcare expenditures by \$4,830 cumulative over 5 years—with estimated savings of \$7,950 among workers with Class III obesity (BMI of 40.0 or greater or BMI of 35.0 or greater with at least one serious obesity-related condition.)

Source: Global Data

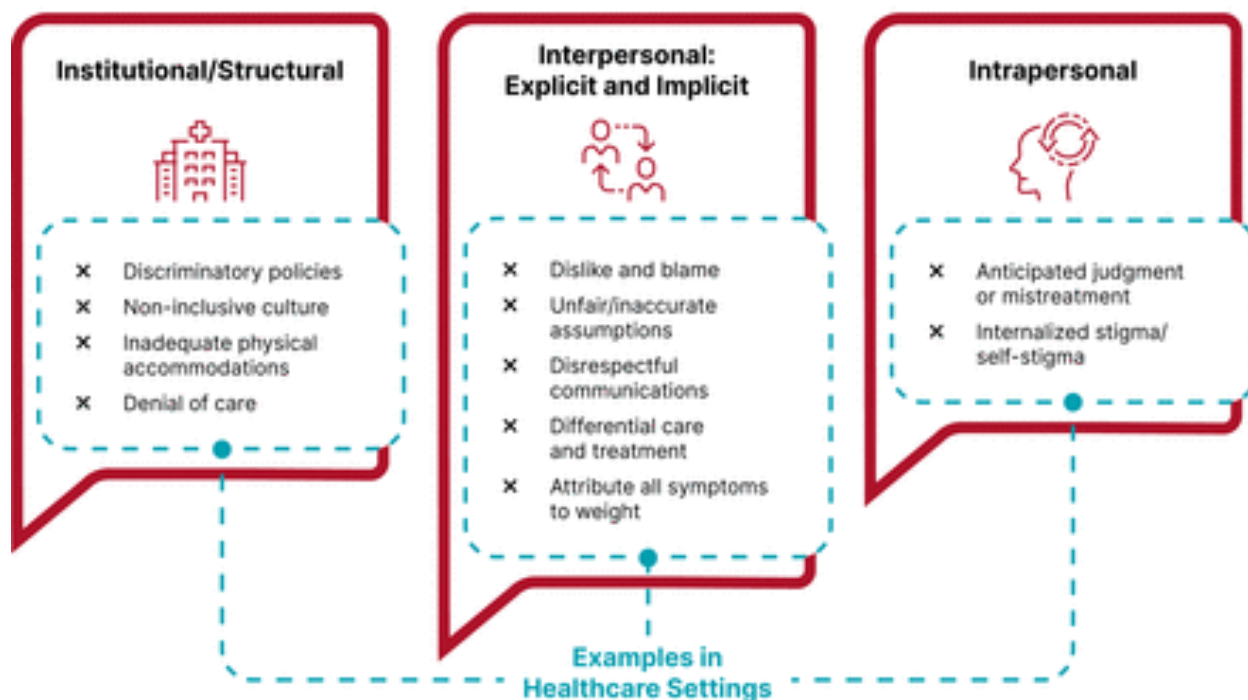
STIGMA OF WEIGHT IN THE WORKPLACE

Experts now understand that obesity is a disease, influenced by genetics, hormones, the environment and lifestyle behaviors. Back in 2013, the American Medical Association (AMA) announced this designation, largely dispelling the idea that obesity is caused by insufficient willpower, lack of discipline and bad choices. Conversely, many authorities lay blame on the changing food industry: portion sizes are bigger, and foods contain more fats, more sugar and more calories, making it easier than ever before to overeat.

Putting culpability aside, weight stigma is affecting workers. Key takeaways from the Weight at Work Report 2025, in which Levity surveyed 1,000 full-time American employees about weight stigma, company culture and the impact of weight-loss medications in the workplace, show that while many employees feel accepted, weight stigma still affects a meaningful share of the workforce, especially younger employees and women. These experiences can shape how people feel at work, whether they are productive, pursue promotions or even stay in their jobs.

- 1 in 6 employees say they feel judged at work because of their weight.
- Over 1 in 10 employees say they've been passed over for a promotion because of their weight.
- 1 in 7 employees on weight-loss medication say how they feel or are treated at work because of their weight influenced their decision to take it.
- Over 1 in 4 employees say they would consider using weight-loss medication if their employer covered it, and 3% already do.
- 11% of employees who recently quit say weight or body image played a role in their decision. Top 5 industries where workers report judgment based upon weight: real estate, retail, hospitality, public service and technology.
- Many employees (78%) say their company culture isn't appearance-focused; however, over 1 in 5 employees (22%) say it is somewhat or very.

Examples of Weight Bias and Stigma at Multiple Levels



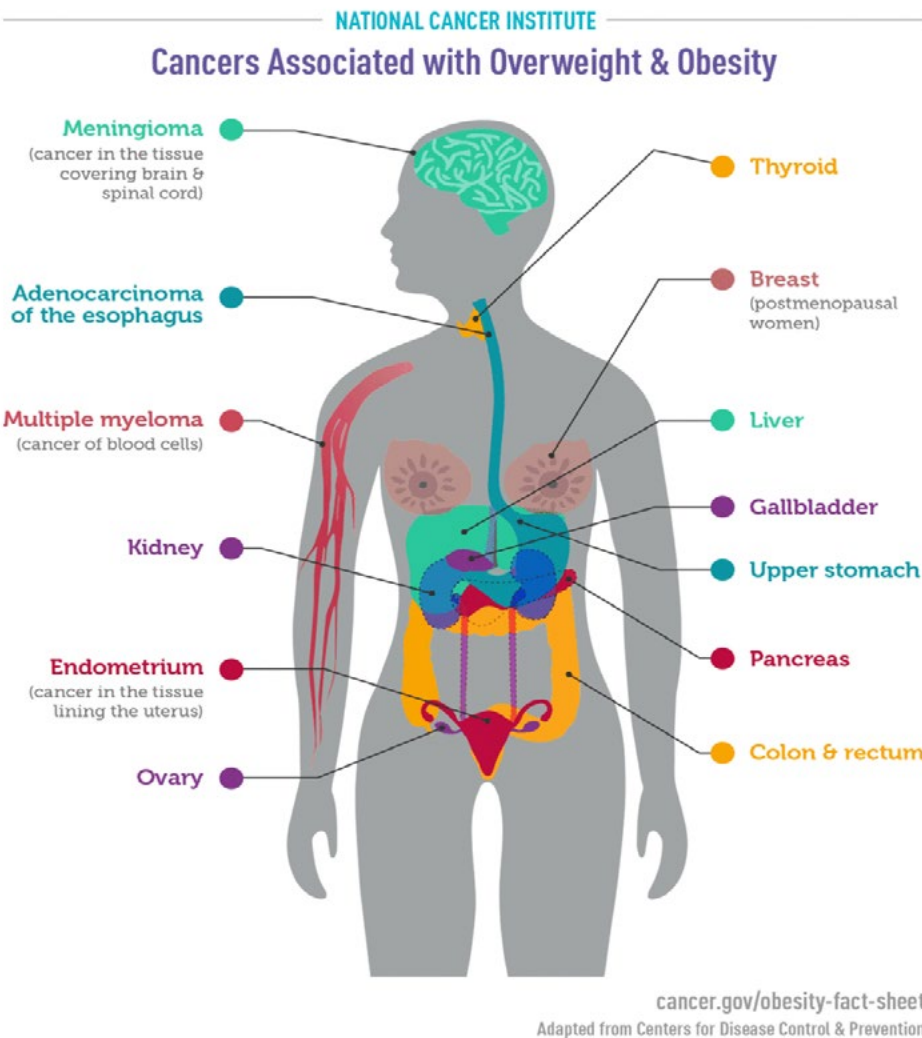
Source: American Diabetes Association

Until now, behavioral health has been left out of the conversation, although many recognize it is a known risk factor for and comorbidity of obesity. Dr. Robert Mines, founder and chief psychology officer, Mines & Associates, an organization that since 1988 has provided obesity care weight management programs and has been recognized as a pioneer in applications of cognitive behavioral interventions, adherence and compliance with weight management strategies, stresses, “Obesity is a complex psychological, and medical condition which requires a wholistic team approach for the obese individual and their families. Programs advocate for comprehensive wellness programs, biometric screenings and personalized coaching to reduce obesity-related costs. This includes chronic condition care management and at-risk disease management programs, which include targeted interventions for obesity and related conditions.”

He also reports that most plans require prior authorization, BMI thresholds and documented failure of lifestyle interventions before approving GLP-1 coverage. Some insurers mandate a six-month behavioral modification program before access

“MINES provides behavioral health coaching and therapy (as needed) as critical for discontinuation and long-term success,” he explains. “Persistence rates drop to 8–15% after three years, often due to cost and side effects, making structured off-ramp programs essential. Programs under development include lifestyle coaching, nutrition counseling and digital health tools to maintain weight loss post-GLP-1 therapy.”





Unfortunately, it's also now come to light that people with severe obesity are likely to face discrimination when seeking health care, with many clinics outright refusing to see them. Researchers used a "secret-shopper" method to attempt to schedule an appointment for a patient weighing 465 pounds at practices across five specialties (dermatology, endocrinology, ob/gyn, orthopedic surgery, and ear, nose and throat --ENT) in four metropolitan areas -- Boston, Cleveland, Houston and Portland, Oregon. Results of this new study were published recently in the *Annals of Internal Medicine*:

Interestingly, ENT doctors were the least likely to schedule a visit with the patient, with only 48% agreeing to see the person versus the overall rate of 59%. On the other hand, endocrinologists were most willing to schedule an appointment, and most likely to have offices designed to

accommodate severely obese people.

Here's the reality: about 1 in 6 clinics (16%) that were willing to schedule the patient asked them to endure potentially humiliating workarounds, such as needing to stand during the exam because there would be nowhere to sit or to drape themselves with a sheet because no gowns would fit them.

- About 2 in 5 (41%) of clinics refused to schedule an appointment for a hypothetical patient weighing 465 pounds, according to findings.
- "We've reached our limit for bariatric patients at this site," one receptionist with an orthopedic surgeon's office said without providing a reason.
- More than half (52%) of respondents lacked the facilities or equipment that could meet the basic standards of care for patients with a body mass index (BMI) of 60 or greater -- no exam tables or chairs with a high enough weight limit, sufficiently wide hallways and doorways or large enough gowns.

THE OBESITY-CANCER CONNECTION

Alarming, the National Institute of Health data suggests that 30% of cancer cases are associated with unhealthy dietary practices. Scientists are calling for increased awareness and understanding of the influence of excess weight on cancer risk which could empower earlier interventions, new frontiers for tailored treatment and opportunities to support long-term health.

Research presented at ENDO 2025 revealed that obesity-related cancer deaths in the U.S. have tripled over the past two decades. Thirteen types of obesity-related cancers now account for 40% of all cancer diagnoses.

GLP1S ARE CHANGING WORKPLACE DYNAMICS

What began as a medication for treating diabetes, researchers soon discovered that GLP-1s (glucagon-like peptide-1) have an interesting side effect – reducing hunger. This makes them highly effective for weight loss, and they quickly gained immense popularity due to their highly effective weight-loss results. Amplified by celebrity endorsements, widespread discussion on social media and high visibility advertising, these medications transformed from a diabetes treatment into a cultural phenomenon -- despite ongoing discussions about cost, safety and supply.

Utilization continues to escalate, as researchers at Rand report that about 12% of all U.S. adults ages 18 and older have already tried using these drugs to control their weight. Earlier this year, McKinsey reported there were 11 GLP-1s on the market with indications for diabetes and weight loss, with many approved throughout the year and more than 40 others in the pipeline.

According to the American Journal of Managed Care (AJMC), GLP-1s accounted for just 1% of total prescription costs in 2020, but by early 2025, they represented 21%- a reflection of their rapid adoption and growing impact on healthcare budgets.

MedWatch, a leader in health plan management, has observed similar patterns across the plans it oversees. “We saw a 20% increase in pharmacy spend just from covering our Type II diabetic population,” says Sally-Ann Polson, president and CEO of MedWatch.

To address this financial challenge, MedWatch implemented targeted criteria for GLP-1 coverage. “Access is limited to members diagnosed with Type II diabetes and/or a BMI of 30 or higher with a weight-

related comorbid condition,” Polson explains. “Additionally, members must participate in a behavior modification and GLP-1 support program. The drugs and program are carved out of our medical plan and only offered where we have found the ability to reduce the drug cost by 2/3rds the cost.”



Despite these restrictions, she affirms adoption remains high with 16% of the eligible population enrolled. “We’re now paying only one-third of what we were previously paying to our PBM,” Polson notes. “Our goal is to improve compliance and maximize the effectiveness of these medications. Most participants are expected to experience significant weight loss and transition off the program within 12 to 14 months. This isn’t meant to be a lifelong treatment, but rather a catalyst for sustainable lifestyle change.”



Amy Tennis

MedWatch's program boasts an 80% three-year sustainable weight loss rate, thanks to its holistic approach. "It's not just a drug program- it's a lifestyle transformation," Polson emphasized. "By providing branded GLP-1 medications- not compounded or imported- we're able to offer this opportunity to more individuals at a significantly reduced cost, contributing to a healthier workforce."

Looking ahead, MedWatch anticipates continued demand for GLP-1s, driven by the rising prevalence of obesity and its link to a range of chronic conditions.

Recognizing that GLP-1s are not a permanent solution, MedWatch's comprehensive weight management program remains affordable for its clients. "We believe GLP-1s should be used as a tool, not a lifelong treatment," says Amy Tennis, BSN, MBA, MedWatch's senior vice president of Clinical Care. "Our program combines low-dose GLP-1s, lifestyle coaching, and behavioral support to help members adopt sustainable habits. Ongoing coaching is essential to ensure lasting results and reduce the risk of relapse."

ADDRESSING COST & COVERAGE

Some public health experts and market observers have identified the drugs as a weight loss 'staple' in American homes, with predictions that GLP-1s will soon be part of the U.S. health care infrastructure. According to data from KFF, over 12% of Americans have tried these medications and nearly 40% using them solely for weight loss.

But GLP-1 drugs have become troublesome for employers primarily due to their skyrocketing cost: A single GLP-1 prescription can cost over \$1,000 or as high as \$1,500, a month. Consider the expense for a company when just a small percentage of the workforce wants the drug and the impact of pharmacy expenditures that can quickly climb into the millions.

Another key concern is what happens once a person stops taking the medication, since there is a potential to regain the lost weight? Already, studies reported in JAMA document that many GLP-1 users quit within a year — often due to side effects, high costs or insurance issues.

Employees simply cannot keep up with the high price tag of GLP-1s. Northwestern Medicine cardiologists attest that 50% to 75% of those who take GLP-1 drugs reportedly stop taking them within a year due to their price tag. They say the staggeringly



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high discontinuation rates of GLP-1s should raise alarms for clinicians, policy makers and public health experts.

Now a growing number of researchers, payers and providers are exploring deliberate “deprescription,” which aims to taper some patients off their medication after they have taken it for a certain amount of time or lost a certain amount of weight.

For benefits decisions makers, these issues have become one of their worst budgetary nightmares. While many employers cover GLP-1s for diabetes, also covering them for obesity adds significant and often unpredictable financial pressure. In some instances, as obesity-related GLP-1 costs have surpassed those for cancer and other high-cost specialty conditions, employers are forced to reassess their benefit strategies. It often comes down to balancing the aspiration to offer comprehensive coverage with the pressing need to manage budgets.

Fisher stresses that GLP-1s are already straining budgets as some employers on the NavMD platform report GLP-1 drug spending now represents 10.5 % of total annual claims, up from 6.9 % in 2022.

“There’s early evidence suggesting clinical benefit may offset downstream costs —patients on GLP-1s over a year showed reduced medical expenses in some analyses,” says Fisher. “But a recent two-year claims analysis showed overall annual costs rose 46 % (driven by drug spend) compared to 14 % in a matched control group.”



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EXPANDED INDICATIONS

It appears that GLP-1s are gaining approvals in the growing treatment market for diseases beyond diabetes and obesity into large and varied patient populations such as cardiovascular, kidney and liver health. Researchers are reportedly exploring them as potential treatments for cancer, neurodegenerative diseases, alcohol use disorder and metabolic dysfunction-associated steatohepatitis (MASH). One overlooked example is that the drugs improve patient eligibility for surgeries such as gastric bypass or transplants by helping people meet BMI requirements.

GLP1s have their cheerleaders. David Adamson, MD, FRCSC, FACOG, FACS, CEO of ARC Fertility believes the demand will continue because the GLP1s are effective for most people.

“While side effects exist, most people find the weight loss benefit to be much greater than the side effects,” he counsels. “Additionally, over time I think it is highly likely that the drugs will be shown to be safe, making them even more attractive. Financially, the cost will likely come down with competition and generics while the economic benefits with lower direct health care costs and less societal economic burden will make the drugs financially sustainable.”

Dr. Adamson also advocates for diet, exercise, weight management and wellness programs that promote changed habits and are very important adjuncts to GLP1s, adding, “Many people can wean themselves off the drugs and still maintain their weight loss.”



Tim Foster

Additional kudos from Tim Foster and Dr. Ajay Dalal, HonestRx Consulting, who extol the role of these drugs to transform care for diabetes, obesity and other conditions.

“Adoption is accelerating: 13% of U.S. adults have used them, with 35% expressing interest,” they report. “Yet costs remain high - \$12K-\$14K annually per patient, adding ~\$7,800 per user versus non-users.”

They observe that coverage for obesity is uneven, with large employers more likely to include these drugs, noting, “New approvals and oral formulations will expand demand further. Traditional management tools have proven insufficient. Employers must explore innovative models -- such as outcomes-based contracting, integrated care and compounding -- to balance affordability, access and long-term value. Compounding offers the most affordable access in the market today.”



RISKY COMPOUNDED DRUGS

Advisors at WTW report survey results showing that 70% of employers who do not currently offer weight loss drugs would do so if costs were lowered. High costs contribute to the migration to compounded drugs as a way to save money or obtain drugs when there is a shortage of branded product. These are medications customized by a compounding pharmacy and are prepared for individual patients based upon a doctor's prescription.

However, they are not FDA-approved and have not undergone the same rigorous testing for safety and effectiveness. This lack of FDA approval raises concerns about potential impurities, incorrect dosages and inconsistent active ingredients. During a drug shortage, the FDA can allow compounding pharmacies to create compounded versions of a drug but when the shortage is resolved, the FDA typically requires pharmacies to stop. The FDA has stated that the shortage of certain weight loss drugs has ended and has ordered compounding pharmacies to stop producing them.

But in their desperate attempt to get weight-loss drugs, consumers turn to the hundreds of telehealth companies, concierge medical practices, and medical spas that have over the last few years built huge businesses offering these compounded versions of popular GLP-1 obesity drugs.

While safety warnings persist, they can also create a different type of costly exposure for employers: When employees take these black market or compounded injectable drugs, they often panic with the onset of abdominal pain and head to the hospital emergency room – an expensive treatment setting.

A DIVIDED PERSPECTIVE ON COVERAGE

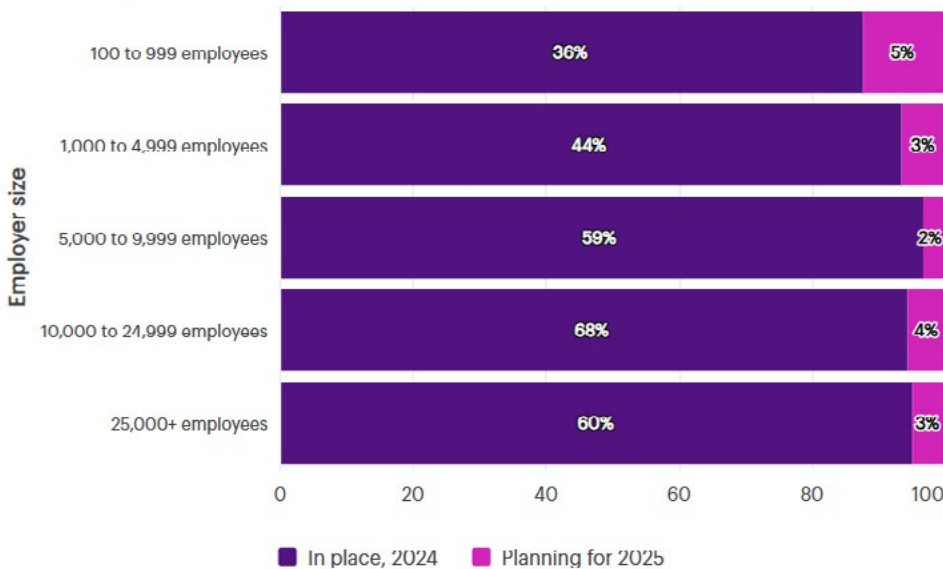
Payers remain conflicted about whether pharmaceutical treatment for obesity should be covered. Navigating this coverage terrain requires a delicate balance of fiscal responsibility and commitment to employee well-being. The Pharmaceutical Strategies Group conducted a comprehensive survey of over 200 healthcare payers, including health plans and employers, to better understand their perspectives on the use of GLP-1s for treatment of obesity.

Respondents were asked to rate their organization's viewpoint regarding coverage of obesity medications on a scale from 1 (lifestyle condition – should not cover) to 10 (chronic condition to treat – should cover). The average score was 5.4, with similar numbers of respondents on each side of the scale. It appears that payers are almost evenly split in their perspectives on treatment of obesity, with some regarding pharmaceutical coverage for obesity as a response to a chronic medical condition, while others see it more as addressing a lifestyle issue.

This split underscores the complex factors behind coverage decisions, as stakeholders assess the clinical realities of obesity against beliefs about personal responsibility and concerns about long-term benefit.

When it comes to coverage decisions on diabetes vs. obesity, nearly all survey respondents cover GLP-1s for type 2 diabetes (T2D), versus only 39% who provide coverage for obesity. About 17% of plans are actively considering coverage of GLP-1s for obesity, and another 5% previously covered these drugs but have since excluded them.

Coverage GLP-1 medications for obesity



While the NIH reports that 73 percent of Americans are categorized as overweight or obese, only 11.6 percent have been diagnosed with diabetes. This translates into millions of patients that will lose their insurance coverage for GLP-1s in 2026, sending shock waves throughout patient communities.

- Earlier this year, Tufts Health Plans told members that it would no longer be covering Zepbound for obesity after also ceasing coverage of Wegovy for obesity.

Source: [WTW 2024 Best Practices in Healthcare Survey](#)

- Blue Cross Blue Shield of Massachusetts has also announced a new policy that applies to self-insured and fully insured companies: it will stop covering GLP-1s for obesity in 2026 for employers with <100, although employers with >100 employees can choose to cover the drugs at an additional cost.

- CVS Caremark removed Zepbound from its formulary in 2025.
- Harvard Pilgrim Health Care is ending GLP1 coverage for weight loss for most commercial plans starting January 1; large fully insured employers with >100 employees can opt to pay for continued coverage. Members of these plans will be required to complete a 6-month behavioral modification program before accessing the medication unless they are already using it.

While high costs are a major factor for both employers and health plans choosing to withdraw coverage, other factors such as low patient adherence and early discontinuation also play a role. Plan sponsors are now forced to scrutinize utilization patterns, clinical outcomes and cost-effectiveness, as CMS has opted not to require coverage for obesity treatments in Medicare for 2026, leaving commercial payers to independently navigate the issue.

But the stakes go beyond health costs with a competitive labor market emphasizing that benefits send a clear message about an employer's values. 9amHealth surveyed over 1,300 Americans and discovered that workers are willing to leave their jobs (or stay at one they hate) and cut back on spending across the board to get their hands on these medications. In fact, 67% of respondents stated they would be "likely" or "very likely" to stay at a job they didn't like in order to sustain coverage for weight loss medication.

Healthline reports that an increasing number of employees say they would take a new job if it came with GLP-1 coverage. Beyond generational trends, access to GLP-1s is quickly becoming a premium benefit that top performers and high-value talent segments use to compare employers. If employees lose coverage, employers may also lose top performers to organizations willing to treat it as a premium benefit -- a turnover cost few companies can afford to ignore.

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EMPLOYERS VS. HEALTH PLAN COVERAGE FOR GLP1S

Employers tend to view obesity as a chronic condition, while health plans lean slightly toward viewing obesity as a lifestyle condition. Employers are more likely than health plans to offer obesity GLP-1 coverage (43% vs. 29%).

Over 75% of health plans and over 50% of employers are moderately or very concerned about off-label use of GLP-1s approved for type 2 diabetes, but awareness of how much current spend is off-label is notably lower: nearly half of employers and a quarter of health plans are unsure.

Employers may see coverage of these drugs as a way to support mental health, reduce absenteeism, and improve overall productivity while health plans are more likely to evaluate obesity treatment through the lens of clinical effectiveness balanced with cost-efficiency, considering the large percentage of members who would be eligible to take the drugs.

Additionally, health plans operate within broader regulatory and actuarial frameworks, which can slow the adoption of coverage for emerging treatments.

Source: 2025 Pharmaceutical Strategies Group

According to WTW's 2024 Best Practice Survey, employers that currently cover GLP-1 medications are also implementing restrictions, including lifestyle modification requirements (69%), trialing lower-cost medications first (63%) and limiting therapy duration (63%). One in seven (14%) employers covering GLP-1s for obesity are considering discontinuation due to cost, and 20% of employers report that they cover GLP-1s for obesity only at a BMI of 35 or more. Employers will have new opportunities to optimize their benefits as new GLP-1 formulations and competitors enter the market.

TAKING ACTION

Bracing themselves for the new wave of obesity medications that are expected to literally dwarf the diabetes spend, employers are recognizing that medication alone isn't enough to treat the disease. The critical question is this: are GLP1s a short-term fix or a sustained program to lose and sustain weight loss? Some benefit firms that acknowledge the benefits of GLP-1s are adopting a more nuanced approach to the drugs, prioritizing behavioral changes first.

What is becoming obvious is that without intensive lifestyle intervention and medication access management to drive outcomes and control cost, members will be left on next-generation obesity medications for the long term – and employers will bear the expense.

Moving from claims cost to performance indicators will require employers to reframe obesity -- not simply as an isolated diagnosis, but as a broader indicator of employee wellbeing that impacts population systemic health risk and organizational performance. While some employees are hesitant to enroll in weight-loss programs due to stigma, others may not realize the full potential of the program. Nutrition programs are not just for individuals with obesity as many join with goals tied to sports performance, chronic disease

management or simply building healthier long-term habits.

GlobalData recommends actionable steps for employers:

- Offer insurance coverage and wellness programs for obesity care at parity with other chronic diseases
- Implement wellness programs
- Foster a culture of support and inclusion that recognizes and accommodates the needs of employees with obesity
- Provide education and resources to employees to educate them about the health risks associated with obesity as well as strategies for obesity care and weight management.

Weight loss involves more than eating well and exercising regularly since every individual has unique, complex needs. A personalized, holistic approach that includes health coaching is often recommended along with reduced co-pay incentives for active participation in lifestyle programs to achieve sustainable results.

Dr. Mines observes that both internal and external sources agree demand for these drugs will remain high or increase due to expanded indications (sleep apnea, fatty liver disease) and strong consumer interest.

“However, insurers are tightening coverage or dropping weight-loss indications to control costs,” he says. “Without aggressive price negotiations or federal intervention, GLP-1 drugs will remain far above cost-effectiveness thresholds, requiring up to 80% price reductions to meet standard benchmarks.

Remarkably, there is still support for bariatric, weight-loss surgery vs. medication. Doctors at the Cleveland Clinic maintain that people with obesity and diabetes who undergo bariatric surgery face a significantly lower risk for several adverse health outcomes when compared to those treated with GLP-1s. They point to new data showing that surgery should not be reserved as a last resort but should be part of early, shared decision-making for patients with type 2 diabetes and obesity, providing benefits beyond medications alone.

HOT OFF THE PRESS

With increased demand for weight loss drugs, some high-profile stakeholders are rolling out new programs.

Vs. GLP-1s, bariatric surgery reduced the risk for:



- Death by 32%
- Nephropathy by 47%
- Retinopathy by 54%
- Major adverse cardiovascular events by 35%



In an effort to make it easier for its members to access weight management medications, WeightWatchers is setting up a way for employers to subsidize GLP1 prices and joining forces with Amazon Pharmacy. Members will be able to access information on real-time medication availability, automated coupon savings and home delivery for key medications. Amazon Pharmacy will automatically apply coupons for members at the point of checkout with same day delivery available as an option.

While it's not a "done deal," there's some suggestions from the White House to reduce the cost of popular weight-loss drugs like Ozempic to \$150 a month. CNN says this would be a game changer. TrumpRx launches in 2026. a government-backed initiative to lower prescription drug costs by creating a direct-to-consumer website.

Not to be outdone, drug manufacturers Eli Lilly and Novo Nordisk have started selling the products directly to patients at about \$500 a month. Employers are being incentivized by startups such as RxSaveCard and Andel to subsidize part of the cash price for their workers. They can pay less than they would if they covered the drugs through insurance and, with a subsidy, employees could get the treatments at a lower cost than if they paid the full cash price on their own.

->->Fast Forward

While only about 2% of adult patients are taking a GLP-1 drug to treat obesity or overweight as of June 2025 (FAIR HEALTH), pharmaceutical companies are competing to capture more market share. They are launching new drugs or introducing lower-cost oral versions positioned to drive down the cost of the injectables – although doctors at UT Health San Antonio say injectable delivery methods don't seem to deter many patients.

Looking ahead, employers will surely play an important role in obesity care management. Goodpath, a virtual provider of integrative care for chronic conditions, offers a practical playbook for 2026 that may include these activities:

1. Audit the at-risk population now. Run the numbers on who's currently using GLP-1s, why they were prescribed, and what's at stake if coverage changes. Look beyond claims data. High-risk, high-value employees may be the ones most affected. Understanding that profile now gives you room to make intentional choices instead of scrambling later.
2. Create a safe landing zone for those losing coverage. When employees lose access to FDA-approved GLP-1s, many will turn to compounded versions from online or local pharmacies. Some of these products are safe and legitimate; many are not. The risks include incorrect dosing, contamination, untested formulations, and in some cases, entirely different molecules.
3. Integrate alternatives, not just exclusions. If full coverage is off the table, give employees other routes to address weight and related conditions. That could include partial coverage with clear clinical criteria,



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wraparound programs for side-effect management and habit change, or access to nutrition, behavioral health, and metabolic care services.

Amid all the hype, new data from Truveta Research suggests that the anti-obesity drug boom may actually be cooling, as overall prescribing of GLP-1 medicines remained relatively flat for the three months ending in September. This may indicate a trend that even with more approved uses for the drugs, the high cost, variable insurance coverage policies and the fact that many patients can't stay on them are softening some expectations. ■

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