The Dartmouth Institute for Health Policy & Clinical Practice

Health Economics and Policy Lab

Brief: 2025-01, November 7, 2025

Health Economics and Policy Lab at Dartmouth

GLP-1s for Weight Management

Costs and Coverage Considerations

GLP-1s: Effective but Difficult to Access

Glucagon-like peptide-1 receptor agonists (GLP-1s) are a relatively new and highly promising weight loss treatment option, with numerous scientific studies demonstrating their effectiveness in reducing body weight and improving metabolic health.[1,2]

Mechanistically, GLP-1s mimic the incretin hormone secreted after meals, thereby stabilizing postprandial glucose levels and diminishing hunger signals. Multiple clinical trials have demonstrated substantial weight reductions with GLP-1 use, averaging 12% to 18% of baseline body weight. These results generally surpass those of other medications' weight-loss effects and those of lifestyle interventions alone.[2,3]

Many patients face barriers to accessing and paying for these medications. This policy brief reviews the current cost and coverage landscape of GLP-1s for weight loss, noting several proposed policy options to address the accessibility and affordability challenges associated with these effective yet high-cost medications.

Key Takeaways

1	**Clinical benefits** GLP-1s used to treat obesity and overweight have demonstrated substantial weight reductions in clinical trials.
2	**High prices** GLP-1s for weight loss carry a high net price in the commercial market, ranging from $7,000 to $10,000 per patient per year, creating significant access and affordability challenges.
3	**Fragmented coverage** Many payers have dropped or restricted coverage due to rising costs. Medicare has historically prohibited coverage of GLP-1s for weight loss.
4	**Policy responses** Payers have used or proposed several options to mitigate GLP-1s' fiscal burden while maintaining coverage, including: 1) Eligibility criteria and use controls; 2) Targeted time or weight caps; 3) Formulary limits and step therapy; and 4) Price negotiation and rebate strategies

History and Clinical Importance

GLP-1s have dramatically altered the clinical outlook for treating type 2 diabetes, obesity, and other chronic health conditions. After two decades of use in diabetes treatment, three GLP-1 receptor agonists received FDA approval for weight management in adults with obesity (a body mass index (BMI) of 30 kg/m2 or higher) or those who are overweight (BMI of 27 kg/m2 or higher) and have a weight-related comorbidity, such as high blood pressure or high cholesterol.[4,5]

Liraglutide (brand name Saxenda) was first approved in 2014, semaglutide (brand name Wegovy) in 2021, and tirzepatide (brand name Zepbound) in 2023, as noted in Table 1.[6] Liraglutide and semaglutide are also approved to treat obesity in adolescents age 12 and older.[7] The approval of GLP-1s specifically for weight loss affirms the medical community's position that obesity is a complex, chronic disease requiring its own unique management and treatment options.[8]

Table 1. GLP-1 Names, Maker, and Year of FDA Approval for Weight Management

Drug	Brand Name		Drug Maker	FDA Approval for Weight Loss
	Weight Loss	Type 2 Diabetes		
Liraglutide	Saxenda	Victoza*	Novo Nordisk	2014
Semaglutide	Wegovy*	Ozempic,* Rybelsus	Novo Nordisk	2021
Tirzepatide	Zepbound	Mounjaro	Eli Lilly	2023

Note. *Indicates this medication reduces the risk of adverse cardiovascular health events.
Source. Modified for formatting. U.S. DHHS. *Medicare Coverage of Anti-Obesity Medications*. U.S. DHHS; 2024:1-17. https://aspe.hhs.gov/sites/default/files/documents/127bd5b3347b34be31ac5c6b5ed30e6a/medicare-coverage-anti-obesity-meds.pdf

FDA Criteria: GLP-1 Use for Weight Loss

The FDA approved use of GLP-1s for adults with:

- **Obesity**: a BMI of 30 kg/m^2 or higher
- **Overweight with a weight-related comorbidity**: BMI of 27 or higher and a comorbidity such as high blood pressure or high cholesterol[4,5]

According to October 2025 Gallup data, the percentage of Americans who have taken a GLP-1 for weight loss more than doubled in less than two years, with 12.4% of U.S. adults reporting GLP-1 usage in Fall 2025, compared with 5.8% in the first quarter of 2024.[9] Total market prescriptions for GLP-1s hit 17 million in 2024, up from 2 million at the end of 2020.[10] This marked increase in GLP-1 utilization for weight loss coincides with the current decline in the U.S. obesity rate, which now stands at 37% after reaching a record high of 40% in 2022.[9]

Beyond weight loss, GLP-1s have FDA-approved indications for cardiovascular disease, obstructive sleep apnea, chronic kidney disease, and metabolic dysfunction-associated steatohepatitis (i.e., fatty liver disease).[11–15] Early-phase clinical trials also suggest potential benefits for other conditions, such as Alzheimer's disease, Parkinson's disease, and substance use disorders, highlighting this drug class's broad therapeutic promise.[5,15]

Coverage Landscape

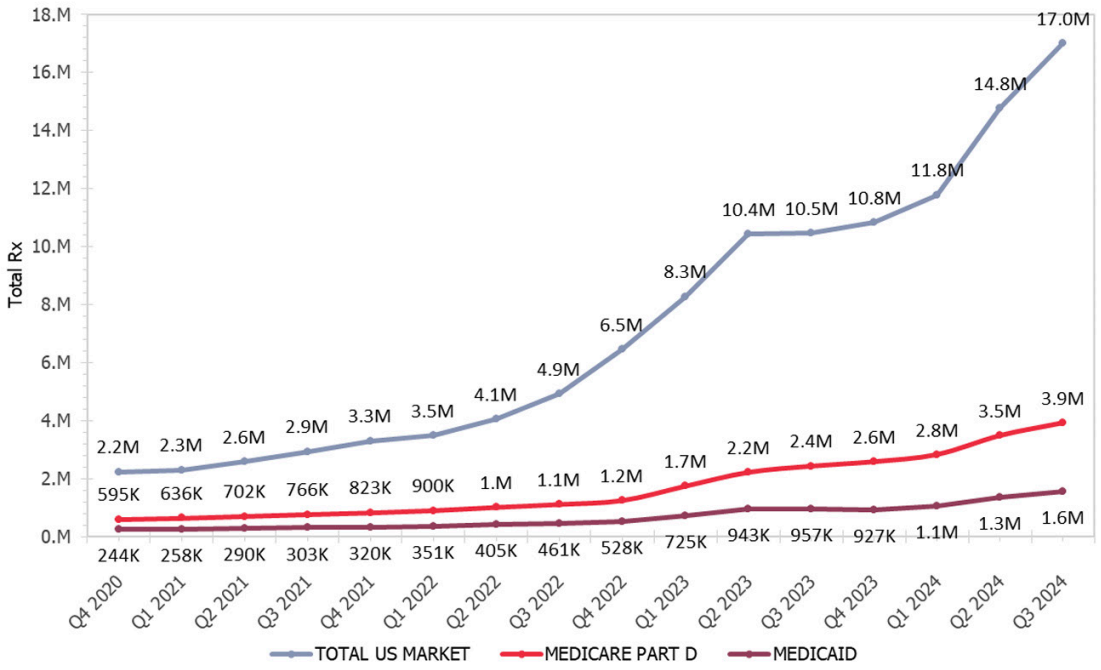
The coverage landscape for GLP-1 receptor agonists is rapidly evolving as payers attempt to balance patient demand with fiscal constraints. In the Medicaid arena, only 13 state programs covered GLP-1s for weight loss as of October 2025.[16] All Medicaid programs choosing to cover GLP-1s for weight loss applied utilization controls to help manage costs by preventing overutilization or misuse; these included prior authorization requirements and BMI thresholds.[5,17,18]

In 2025, some Medicaid programs that previously covered GLP-1s for weight-specific indications began to roll back coverage. North Carolina, which initiated Medicaid coverage of GLP-1s for weight loss in August 2024, terminated that coverage in October 2025 due to funding shortfalls.[19,20] New Hampshire Medicaid announced that it will no longer cover GLP-1s for weight loss as of January 1, 2026,[21] and Pennsylvania is moving toward limiting coverage to enrollees at the highest risk for obesity-related complications.[22]

Medicare fee-for-service and Medicare Advantage plans have historically been barred from covering GLP-1s solely for weight loss due to language in the 2003 legislation establishing Medicare Part D that prohibits coverage of medications to treat weight gain, anorexia, and weight loss.[11]

Medicare Part D does cover GLP-1s for type 2 diabetes, cardiovascular disease, sleep apnea, and heart failure prevention.[11] There have been multiple attempts to broaden coverage – such as the Treat and Reduce

Figure 1. Total U.S. Market Prescriptions for Anti-Obesity Medications, 2020-2024



Source. Modified for formatting. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. *Medicare Coverage of Anti-Obesity Medications*. U.S. Department of Health and Human Services; 2024:1-17. https://aspe.hhs.gov/sites/default/files/ documents/127bd5b3347b34be31ac5c6b5ed30e6a/medicare-coverage-anti-obesity-meds.pdf

Obesity Act of 2023 and a November 2024 Biden administration proposal[23,24] – though the 2026 Medicare Part D final rule released in April 2025 reaffirmed the exclusion of anti-obesity drugs, including GLP-1s.[11,25] A potential future Centers for Medicare & Medicaid Services (CMS) demonstration may expand coverage to Medicare beneficiaries with severe obesity (BMI>35) and those with lower BMIs and certain comorbid conditions.[26,27]

Among private and employer-sponsored plans, coverage for GLP-1s for weight loss remains limited and fragmented.[28,29] In 2025, 19% of employers with at least 200 employees covered GLP-1s for weight loss, with higher coverage rates among larger firms (43% among firms with 5,000-plus workers).[30] Major insurers have tightened access in the last few years: several Blue Cross affiliates (e.g., Michigan,[31] Massachusetts,[32] Independence Blue Cross[33]) have stopped covering GLP-1s for weight loss altogether, citing internal data that roughly 30% of patients discontinue therapy in the first month, before they were likely to achieve meaningful weight loss.[34] Kaiser Permanente also recently removed coverage for individuals with a BMI below 40.[35]

In addition to the cost and medication adherence issues noted above, insurers may be less inclined to cover GLP-1s for weight loss due to high beneficiary turnover rates: any potential downstream cost reductions associated with sustained weight loss would not accrue to them, but rather to a new payer. Estimates show that between 10% to 25% of enrollees switch insurers every year.[36–38] In a 12-year study of a major health insurer, about 80% of beneficiaries left the insurer at least once during the study period, with an average enrollment duration of 48 months.[38]

Cost and Budget Implications

The public health impetus for expanding access to GLP-1s for weight loss is compelling. The 37% of U.S. adults who are obese are at higher risk for mortality and weight-related morbidities.[4,5] Obesity also imposes a substantial economic burden: adults with obesity incur approximately $1,861 more in annual medical expenses than people of normal weight, while severe obesity adds roughly $3,097 per person per year.[34,39]

Obesity treatment with GLP-1s currently carries a high price tag, with net prices ranging from $7,000 to $10,000 per patient per year, even after a typical 40% insurance rebate (Table 2).[2,20] Annual net prices for obesity-indicated GLP-1s are notably higher than those indicated to treat type 2 diabetes, due in part to dosing differences. Manufacturers may also offer direct-to-consumer self-pay options, charging reduced rates of about $4,200 - $6,000 per year.[40] Some experts anticipate that the price of GLP-1s will decrease with the anticipated rollout of new market entrants and generics, much as Hepatitis C drug costs went down following enhanced competition.[41]

Insurers' spending on GLP-1s for conditions like type 2 diabetes demonstrate the potential financial impact of covering these medications for weight loss. For example, Medicare expenditures on GLP-1s for non-weight-loss indications increased a hundredfold in four years, surging from $57 million in 2018 to $5.7 billion in 2022.[42] An analysis of 2020 data found that 19% of Medicare beneficiaries already qualified for GLP-1s for type 2 diabetes and secondary prevention of cardiovascular disease.[43] If GLP-1s were prescribed to just 5% or 10% of Medicare enrollees who met the FDA's weight-loss treatment criteria, annual Part D costs would increase by $3.1 billion or $6.1 billion, respectively.[29]

The fiscal stakes for federal programs were highlighted in an October 2024 Congressional Budget Office (CBO) report estimating that extending Medicare coverage of GLP-1s for obesity would result in $35 billion in additional spending from 2026 to 2034, partially offset by a projected $3.4 billion in medical cost savings over the same period.[44] Meanwhile, a recent study from the Institute for Clinical and Economic Review (ICER) found that only 1% of eligible patients could be treated with GLP-1s at current net prices before exceeding the estimated

Table 2. Annual and Monthly GLP-1 Supply Prices for Weight Management in 2024

Drug	Brand Name	One Year Supply Prices		One Month Supply Prices	
		List Price	Net Price	List Price	Net Price
Liraglutide	Saxenda	$16,188	$8,437	$1,349	$703
Semaglutide	Wegovy	$16,189	$7,793	$1,349	$649
Tirzepatide	Zepbound	$12,719	$9,716	$1,060	$810

Note. Rounded to the nearest dollar.
Source. Modified to include annual pricing. U.S. DHHS. *Medicare Coverage of Anti-Obesity Medications*. U.S. DHHS; 2024:1-17.https://aspe.hhs.gov/sites/default/files/documents/127bd5b3347b34be31ac5c6b5ed30e6a/medicare-coverage-anti-obesity-meds.pdf

annual affordability threshold of $880 million.[45]

More evidence is needed to determine whether and when long-term savings from GLP-1 treatments may accrue.[46] Estimating future expenditures hinges on a number of variables, including prescription volume, adherence patterns, the expanding list of approved indications, and the unknown impact of weight loss on other chronic conditions—each of which can dramatically shift the budget forecast of GLP-1 therapies.[2] To date, no data suggest that GLP-1 utilization for obesity reduces overall spending on other health services or leads to long-term health system cost savings.[44]

Scholarly articles have also found mixed results when examining GLP-1s' cost effectiveness,[47] though recent ICER reports suggest that GLP-1s for weight loss are cost effective, despite their high prices, due to their vast health benefits.[45,48] ICER determined that semaglutide and tirzepatide treatment resulted in an additional quality-adjusted life year (QALY) at a cost of between $58,000 and $76,000, making these drugs highly cost effective when measured against the common cost effectiveness benchmark of $100,000 or less per QALY gained.[45]

Addressing GLP-1 Coverage and Cost: Proposed Policy Approaches

Below are four proposed policy approaches that states, health plans, and other insurers could adopt to provide equitable and accessible GLP-1 coverage for weight loss, while also accounting for fiscal constraints.

1. Enhanced Clinical Criteria

This approach outlines specific medical criteria for GLP-1 coverage, typically based on a patient's BMI. While GLP-1s are FDA-approved for individuals with a BMI of 30 or above, some insurers are raising the BMI threshold to 32 or 35, or to align with existing bariatric surgery guidelines (i.e., BMI ≥35 with complications or ≥40 without).[49]

Additional coverage requirements could include the presence of co-occurring conditions, such as uncontrolled hypertension; participation in an additional weight loss or lifestyle management program (including evidence-based telehealth options); and specialist-led therapy initiation.[29,30,50] These enhanced clinical criteria may be enforced through a prior authorization requirement, in which a health care provider submits administrative and clinical information about the patient to the insurance company for review and approval.[18,51]

As of the third quarter of 2024, over 80% of GLP-1 claims required prior authorization, up from below 15% just a year earlier.[18] Use of prior authorization may help target patients who are most likely to benefit from GLP-1 treatment, yet this practice can also create administrative burdens that unduly affect under-resourced care providers treating more marginalized communities.[18]

Figure 2. Proposed Policy Approaches to Balance Accessibility and Affordability

Enhanced Clinical Criteria	Specifies clinical criteria for coverage, limits prescribing to specialists, or requires engagement in lifestyle management program
Time-limited or Weight Target-based Caps	Time or weight targets to transition from GLP-1 to less expensive medication and/or lifestyle management program
Formulary Management	Limit coverage to a single GLP-1 drug or require step therapy through earlier obesity medications
Price Negotiation & Rebates	Unique payment structures and/or support for uncovered patients through OOP navigation programs

2. Time-Limited or Weight Target-Based Caps

Policies under this option set explicit time or weight-based targets to transition patients from GLP-1 treatments to less expensive medications or lifestyle interventions.

The United Kingdom's National Institute for Health and Care Excellence (NICE), for example, released guidance endorsing a two-year limit on GLP-1 use,[52,53] a decision based on results from a two-year evaluation.[3] NICE recently updated its guidance to suggest that patients discontinuing GLP-1 treatment should be provided with at least a year of follow-up support to help them maintain weight loss.[54]

A similar strategy would be to discontinue GLP-1 coverage once a certain BMI threshold is met or a certain percentage of body weight is lost. Gradual tapering is recommended to avoid abrupt cessation harms.[55] The risk with both aforementioned approaches is the possibility of regaining weight once GLP-1 treatment ends; weight regain after discontinuing GLP-1s is common, and obesity treatment – much like that of other chronic conditions – should be considered a long-term undertaking. One study found that individuals who stopped taking GLP-1 medication regained two-thirds of their lost weight.[56] However, individuals who transitioned from a GLP-1 to a generic, older generation obesity medication successfully maintained their weight loss.[57]

3. Formulary Management

Formulary changes have become a key strategy for managing GLP-1 costs; they often involve limiting coverage to a single or a small number of GLP-1 drugs. Massachusetts Medicaid (MassHealth) removed

coverage for semaglutide and liraglutide in early 2025, opting to cover only tirzepatide.[58] In July of the same year, CVS Caremark reported that it would no longer cover Eli Lilly's tirzepatide, citing the need to encourage competition among drug makers to lower prices.[59] Formulary restrictions were difficult to impose when GLP-1s were on the FDA's drug shortage list; now that the shortage is resolved, more insurers and their pharmacy benefit managers may pursue formulary changes.[60]

Another formulary management strategy is step therapy, which requires patients to try non-GLP-1 weight loss medications before being approved for GLP-1 coverage.[51] MassHealth, for example, now requires people to try phentermine, an oral medication that acts as a nervous system stimulant and appetite suppressant, before receiving tirzepatide.[58,61] While step therapy can delay access to GLP-1s, it also provides a data point for payers to assess treatment failure before incurring higher drug costs.[48] Exceptions should be available for patients with contraindications or complications.

4. Price Negotiation and Rebates

This option explores the use of innovative payment models, such as volume-based rebates, subscription pricing, and manufacturer negotiations, to lower net costs.[48] It also includes support programs to assist patients with out-of-pocket expenses. Novo Nordisk and Eli Lilly have already lowered out-of-pocket costs for non-insured patients to about $500 per month, translating to an annual net cost of approximately $6,000—a figure that may become a benchmark under negotiated arrangements.[59] Market competition is expected to further reduce GLP-1 prices over the next five years, with 39 new GLP-1 drugs in development from 34 different companies,[6,48] and the imminent introduction of additional generic options. The first weight loss-specific generic of liraglutide was released in August 2025.[62,63]

Additionally, semaglutide was chosen as one of 15 Medicare Part D drugs to be included in a second round of price negotiations with manufacturers; CMS will announce maximum fair prices for these drugs by November 30, 2025, with the prices going into effect in 2027.[44] These negotiations could set a low-price reference point for future private-payer deals; the first round of Medicare Part D price negotiations resulted in discounts ranging from 38% to 79% of list price, though rebate eliminations offset some of the savings.[64]

Under a separate initiative detailed in a November 6, 2025, announcement, CMS reached a voluntary deal with drug manufacturers to lower GLP-1 prices for Medicare and Medicaid enrollees via a demonstration project. These negotiated rates would bring down Medicare prices of GLP-1s for weight loss to less than $3,000 annually (enrollees would be responsible for up to a $50 copay per month). State Medicaid programs would need to opt in to receive comparable prices.[26,27]

Finally, outcome-based pricing schemes, which link manufacturer payments to actual outcomes (e.g., sustained weight loss, reduced healthcare utilization), could also be explored.[65]

Conclusion

The future use of GLP-1s for weight loss presents both uncertainties and opportunities, with reason to be optimistic regarding the medication's positive health impacts and price trajectories. Insurers, policymakers, and researchers should closely monitor the continually growing repository of clinical data and the dynamic coverage and pricing landscape to determine how to best ensure equitable and affordable coverage for patients.

The Health Economics and Policy Lab is affiliated with the Dartmouth Institute for Health Policy and Clinical Practice and the Geisel School of Medicine at Dartmouth College, Hanover, NH.

This issue brief was written by Maia Crawford and Amy Barry with guidance from Emma Dean. Carrie H. Colla and Johnny Huynh offered comments.

Similar work was presented to the New Hampshire Department of Insurance on October 24, 2025, by Emma Dean and Sarah Finn of Dartmouth Health. See event information at https://www.insurance.nh.gov/event/ 2025-annual-hearing-healthcare-premium-and-claim-cost-drivers.

This document can be found at https://sites.dartmouth.edu/health-econlab/policy-briefs.

Please send comments to healtheconomicsandpolicylab@groups.dartmouth.edu.

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