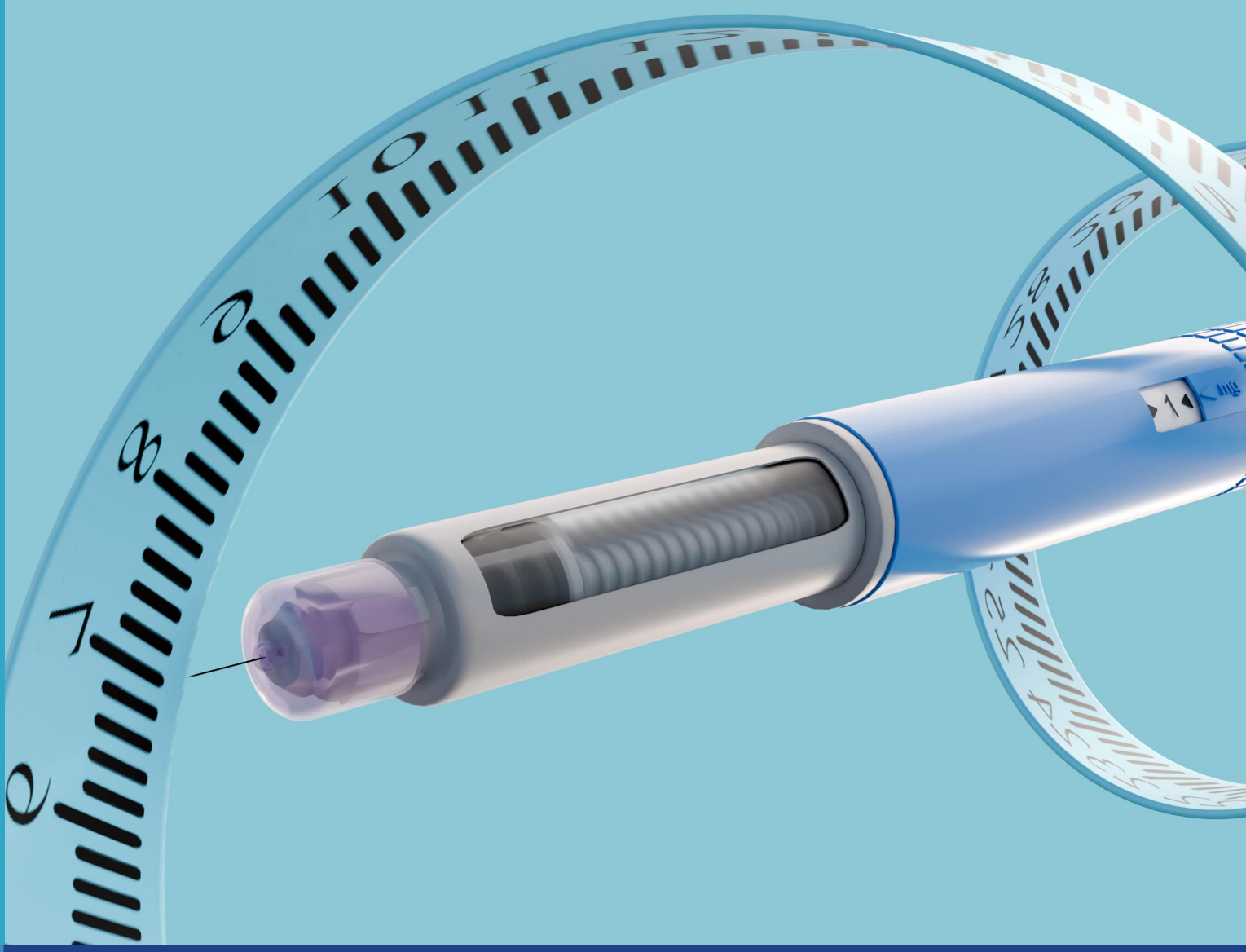

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GLP-1 Medications: Cost and Coverage Considerations

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Health Care Delivery Committee

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The following members of the Health Care Delivery Committee authored this paper:
Mick Diede, MAAA, FSA, Chairperson
Ankit Nanda, MAAA, FSA, Interested Party
Rebecca Alvarado, MAAA, FSA
Laura Bass, MAAA, FSA
Timothy Connell, MAAA, FSA
Jay Desai, MAAA, ASA
Tyler Gall, MAAA, FSA
Jennifer Gerstorff, MAAA, FSA
James Lescoe, MAAA, FSA
Stephen Muldoon, MAAA, ASA
F Ronald Ogborne, MAAA, FSA
Susan Pantely, MAAA, FSA
Jeremiah Reuter, MAAA, ASA
Gabriel Rivera, MAAA, ASA
Marcella Ruzicka, MAAA, ASA
Robert Schenck, MAAA, ASA
Roshni Ashwin Kumar Shah, MAAA, ASA
Carmilla Tan, MAAA, FSA
Tomoyuki Tansho, MAAA, FSA
Dmitry Terekhov, MAAA, ASA
Vincent Turnbull, MAAA, FSA

Special thanks to the lead authors: Ankit Nanda and Mick Diede

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1850 M STREET NW, SUITE 300, WASHINGTON, D.C. 20036
202-223-8196 | WWW.ACTUARY.ORG

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GLP-1 Medications: Cost and Coverage Considerations

Executive Summary: Key Takeaways for Policymakers

1. GLP-1 medications are clinically effective, but real-world treatment continuation is a significant variable affecting both the number of patients who benefit and whether coverage generates net savings. Roughly half of patients discontinue within the first year, and only about one in twelve persists beyond three years, though persistence has been improving as supply shortages ease and newer formulations become available.

2. For high-risk patients with established cardiovascular disease, the evidence supports meaningful event reduction, and financial return is plausible over multi-year horizons. A central complication, however, is that the entity paying for treatment is frequently not the one that captures the eventual savings. Frequent coverage changes, short employer evaluation windows, and the direct risk borne by self-funded plan sponsors mean the value proposition depends heavily on who holds the long-term benefit.

3. For lower-risk populations, cost neutrality is unlikely even at reduced price levels. Microsimulation modeling found that GLP-1s did not meet standard cost-effectiveness thresholds at $700 to $800 monthly net prices; while a formal reanalysis at the $245 framework price has not been published, ICER's December 2025 health-benefit price benchmarks (roughly $8,300 to $15,800 per year, depending on the product) place $245 comfortably within the cost-effective range identified by ICER. Cost-effectiveness and budget neutrality are distinct, however. A lower unit price improves value per QALY while also expanding uptake, so total spending can rise even as the drugs become cost-effective.

4. The November 2025 federal pricing framework, the Medicare GLP-1 Bridge program launched in July 2026 (ahead of a delayed BALANCE Model Part D rollout), and the arrival of two oral GLP-1s (oral semaglutide in December 2025 and orforglipron in April 2026) have materially changed the pricing and access landscape. Effective budget impact models will ideally bridge the gap between pre- and post-framework. Accounting for the increased uptake associated with oral formulations will help ensure the model remains accurate in this new landscape.

5. Policy options, including value-based pricing, targeted eligibility, and continuation support, trade fiscal savings against access and administrative complexity. The FDA's February 2026 enforcement announcement, followed in April 2026 by a proposed FDA rule to exclude semaglutide, tirzepatide, and liraglutide from the 503B Bulks List, would further narrow the lower-cost compounded channel, likely redirecting demand toward plan-sponsored and government-facilitated coverage, particularly for populations that had relied on compounded alternatives.

6. Lower prices and the new Medicare and Medicaid pathways improve access at the margin but do not automatically close disparities. Structural barriers, including prescribing inequities, specialist availability, and pharmacy deserts, persist. In addition, because the GLP-1 Bridge Program operates outside the Part D benefit, the low-income subsidy does not dampen the impact of the $50 copay for those least able to afford it. Decision-makers may want to balance fiscal considerations with clinical, social, and other factors.

Introduction

Glucagon-like peptide-1 receptor agonists (GLP-1s), marketed under names including Ozempic, Wegovy, Mounjaro, and Zepbound, were first developed for managing type 2 diabetes but have demonstrated significant efficacy in weight loss. Clinical trials have consistently shown that patients can achieve average body weight reductions of around 15% with semaglutide and roughly 20% or more with tirzepatide, results comparable to some bariatric procedures. These drugs work by mimicking a natural gut hormone that regulates blood sugar and appetite; they also slow gastric emptying, which prolongs satiety.

The therapeutic indications for GLP-1s continue to expand. The FDA has approved Wegovy for reducing the risk of major adverse cardiovascular events in at-risk individuals, and, in December 2025, approved the first oral GLP-1 for weight management (oral semaglutide 25 mg). The label has since broadened well beyond diabetes and weight management: tirzepatide was approved for obstructive sleep apnea (December 2024), semaglutide for chronic kidney disease in type 2 diabetes (January 2025), and semaglutide for non-cirrhotic Metabolic Dysfunction-Associated Steatohepatitis (MASH) with moderate-to-advanced fibrosis (August 2025). A heart-failure (HFpEF) indication remains under review, and trials in Alzheimer's disease are ongoing.[1]

The combination of demonstrated clinical efficacy, the high prevalence of obesity, expanding indications, and substantial cost has made GLP-1 coverage a significant pharmaceutical policy challenge. Without insurance coverage, treatment expense could be unaffordable for many of the more than 100 million American adults living with obesity.[2] Recent federal pricing actions and coverage decisions have begun to change this picture for government program beneficiaries, but commercial access remains constrained.

This policy paper explores the cost considerations, potential for savings offsets, stakeholder dynamics, and health equity concerns surrounding GLP-1 coverage. It offers an actuarial perspective on coverage decisions—focusing on the factors that determine whether and when coverage is likely to produce value for a given population. Regulatory and pricing developments described in this paper are current as of June 2026.

1 While most users report manageable side effects such as nausea and fatigue, concerns persist about muscle mass loss and rare events including pancreatitis. For a summary of the clinical safety profile, see FDA prescribing information for semaglutide (Wegovy) and tirzepatide (Zepbound).
2 Adult Obesity Facts; CDC.com; May 14, 2024.

Cost Considerations

Treatment Continuation: The Central Variable

A critical factor in evaluating GLP-1 coverage is how long patients actually continue treatment. Clinical trials report completion rates of 65%–85%, but these reflect ideal conditions with close monitoring and no cost barriers. Real-world experience has shown lower continuation rates.

A 2024 study of commercially insured adults without diabetes found approximately 46% persistence at six months and 32% at 12 months.[3] Longer-term data from the study is equally instructive: approximately 8% of patients (roughly one in 12) remained on treatment after three years, underscoring a persistence challenge that extends well beyond initial titration. Product-specific analyses show higher persistence for semaglutide relative to older agents. Patients discontinue for various reasons, including side effects (particularly nausea early in treatment), cost-sharing requirements, injection burden, or dissatisfaction with results. Importantly, discontinuation risk is highest during the first weeks of therapy and declines substantially among those who tolerate the initial period.

The observed pattern of persistence, which varies with duration of treatment, has important modeling implications. Representing continuation as a survival curve with select-and-ultimate characteristics creates a pattern analogous to life table construction where early-period hazard rates are materially higher than those observed once a cohort has been "selected" by surviving the initial exposure period. Moving beyond a single percentage cutoff allows the model to capture the steep early drop-off followed by a smaller, more stable persistent cohort. This is critical because patients who stop taking GLP-1s typically regain lost weight. Consequently, the model reflects the fact that those discontinuing early may not achieve lasting health benefits despite the medication costs already incurred.

There is encouraging recent evidence: as supply shortages have eased and newer formulations have become available, continuation rates have improved. Some product-specific series report one-year continuation approaching 60% in selected cohorts—primarily for obesity-indicated, high-potency agents—a trend correlated with easing supply constraints and growing clinician comfort. These improvements are encouraging but reflect selected populations; broader, longer follow-up is needed before assuming such rates will generalize to a mass-market coverage environment. The December 2025 approval of oral semaglutide may further improve continuation by eliminating the injection barrier, though the net effect on population-level persistence is not yet clear.

3 "GLP-1 Therapy to Treat Obesity Among Members Without Diabetes: Three-Year Persistence"; Prime Therapeutics; June 25, 2025.

Recent real-world data reinforce both the pattern and the improving trend. A large commercially insured analysis found one-year persistence nearly doubling from 33% for 2021 initiators[4] as shortages resolved; a 2026 cohort of more than 50,000 initiators showed persistence falling from 65% at 120 days to 34% at one year;[5] a nationwide Danish study found 52% discontinuing within a year;[6] and a Massachusetts Medicaid analysis reported six-month persistence of about 61%.[7] Early weight-loss response and prior bariatric surgery predicted better continuation, which supports the case for concentrating continuation-support resources in the high-attrition early period.

Unit Cost

List vs. Net Price: While U.S. list prices have ranged from $1,000 to $1,300 per month, most insurers pay a lower net price after negotiating discounts and/or rebates with manufacturers. However, insured patients may not realize a proportional benefit from these savings, and the gap between list and net prices varies considerably across payers.

International Comparison: Costs observed in the United States are not the global norm. In countries with national health systems, such as the United Kingdom or Germany, direct government price negotiations and health technology assessment bodies like the National Institute for Health and Care Excellence (NICE) result in significantly lower costs. A monthly supply of these medications can cost several times more in the United States than in most other developed nations.

Federal Pricing Framework (November 2025): On Nov. 6, 2025, the Trump administration announced pricing agreements with Novo Nordisk and Eli Lilly that materially altered the economics of GLP-1 coverage.[8] Under the framework, Medicare and Medicaid will pay approximately $245 per month for all covered products, with a fixed beneficiary copay of $50 for Medicare. The TrumpRx direct-to-consumer platform launched in February 2026, with observed cash-pay prices of about $350 per month for injectable semaglutide (Wegovy and Ozempic) and $346 for tirzepatide (Zepbound). Separately, Lilly's own channel lists Zepbound from $299 for the starter dose, and FDA-approved oral GLP-1s start at $150 per month. The agreements provide participating manufacturers with tariff relief for three years.

4 "Trends in 1-year persistence and adherence among initiators of high-potency, weight loss–indicated glucagon-like peptide 1 receptor agonists"; *Journal of Managed Care & Specialty Pharmacy*; March 2026 (Prime Therapeutics analysis; one-year persistence rose from 33.2% in 2021 to 60.9% in the first half of 2024).
5 Factors Associated with Persistence to GLP-1 Receptor Agonists in Obese and Overweight Patients Without Diabetes; Poster 344 presented at AMCP 2026; April 2026 (53,183 initiators; persistence 65% at 120 days, 34% at 365 days).
6 "Study: Half of adults without diabetes taking weight-loss drug discontinue treatment within a year"; European Association for the Study of Diabetes (EASD) 2025 Annual Meeting; September 2025 (nationwide population-based study of semaglutide discontinuation for weight loss in Denmark noting 52% discontinued within one year).
7 "Real-world 6-month persistence, adherence, and effectiveness of GLP-1 medications for overweight and obesity in a Medicaid population"; *Journal of Managed Care & Specialty Pharmacy*; March 2026 (MassHealth; six-month persistence 60.8%).
8 Framework on GLP-1 Drug Pricing and Coverage with Novo Nordisk and Eli Lilly; The White House; Nov. 6, 2025.

For commercial payers, however, access to these negotiated rates remains undefined—plan sponsors currently have no confirmed mechanism to access federal pricing for prescriptions processed through their insurance plans.

Future Pricing: Key patents extend into the early 2030s, limiting near-term generic competition. The federal pricing framework, combined with potential future Medicare price negotiations under the Inflation Reduction Act, suggests that net prices may continue to evolve. Utilizing scenario ranges in addition to point estimates will allow budget projections to reflect a realistic range of potential fiscal impact.

Budget Impact Modeling

Payers rely on budget impact models to assess financial risk. A robust model for GLP-1s should account for several key variables:

- **Uptake rate:** What percentage of the eligible population will actually seek and be prescribed the drug? Early estimates of very high uptake have generally not materialized, but demand remains strong. The arrival of oral formulations may increase uptake: injection aversion has been a documented barrier, and its removal could meaningfully increase the eligible population that converts to active utilization. Insurance coverage also matters, as it can lower patient financial barriers.

- **Continuation patterns:** As noted above, real-world continuation rates have varied by treatment duration. Survival-curve assumptions can account for this behavior—for example, 50% at six months declining to 30%-35% at one year for the base-case populations—with sensitivity testing around these figures and recognition that new products show improved continuation. Continuation rate assumptions hold significant implications for multi-year budget projections and savings offset calculations.

- **Net unit cost:** Given the November 2025 pricing framework, a robust model will test a range of net-cost scenarios:

Scenario	Net Cost Range	Applicable Context
High	$700–$900/month	Pre-framework commercial net pricing
Medium	$245–$400/month	Federal pricing framework; negotiated government rates
Low	$149–$250/month	Future oral formulations; TrumpRx glide path target (oral net pricing has not yet shown to be lower than injectable products)

These illustrative bands may be used in sensitivity analysis; the policy action spectrum (eligibility criteria, utilization management, adherence programs) changes whether a given band yields positive expected value for different populations. Cost bands can be adjusted based on payer-specific contracting and rebate arrangements.

Cost offsets: When and how will savings from avoided health events materialize? This is the most uncertain component of the model and is discussed in the following section.

The Potential for Cost Offsets

While the direct costs of GLP-1s are substantial, a complete economic analysis requires considering their potential for long-term cost offsets. A key part of the value proposition for these drugs is their ability to generate future savings by preventing or delaying the onset of adverse and costly medical conditions.

Evidence for this potential is growing. The landmark SELECT clinical trial demonstrated that semaglutide reduced the risk of major adverse cardiovascular events (heart attacks, strokes, and cardiovascular deaths) by 20% (HR = 0.80, 95% CI 0.72–0.90) in patients with pre-existing heart disease and obesity but without diabetes.[9] Each avoided catastrophic cardiovascular event translates into potential cost offsets of $30,000–$50,000 or more in first-year acute care costs. The evidence base has since broadened. The active-comparator SURPASS-CVOT trial, published in December 2025, found tirzepatide noninferior to dulaglutide on major cardiovascular events, with a 16% reduction in all-cause mortality and a slowing of kidney-function decline; the renal finding points to a second, potentially

9 "Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes"; *New England Journal of Medicine*; Nov. 11, 2023.

high-value offset pathway through delayed chronic kidney disease progression.[10] A placebo-controlled cardiovascular outcomes trial in people with obesity but without diabetes (SURMOUNT-MMO) has not yet reported results and could further refine these estimates.

However, a 2025 microsimulation study published in *JAMA Health Forum* found that even under optimistic assumptions—using the best available weight loss outcomes and long-term risk reductions—GLP-1 drugs did not meet standard cost-effectiveness thresholds (typically $100,000–$150,000 per quality-adjusted life year) at net prices of $700–$800 per month.[11] A companion study projected that if Medicare expanded GLP-1 coverage for obesity, approximately 3 million beneficiaries would initiate treatment over a decade, generating $66 billion in drug costs offset by approximately $18 billion in reduced hospitalizations and chronic disease care—a net fiscal impact of $48 billion.[12] The November 2025 pricing framework substantially changes these economics, but updated cost-effectiveness analyses at the $245 price point have not yet been published. Published value-based-price benchmarks nonetheless help frame the question: A December 2025 final report from the Institute for Clinical and Economic Review (ICER) set health-benefit price benchmarks of roughly $9,100 to $12,500 per year for injectable semaglutide and $11,500 to $15,800 for tirzepatide,[13] ranges that place the $245 monthly framework price (about $2,940 per year) comfortably within the cost-effective range as defined by ICER. Cost-effectiveness and budget neutrality remain distinct, however. A lower unit price improves value per quality-adjusted life year while also expanding uptake, so total spending can rise even as the drugs become cost-effective. Moreover, sensitivity analysis indicates that net Medicare spending remains positive even under favorable price, uptake, and adherence assumptions. Accordingly, actuaries, when developing budget impact models, might consider incorporating scenario analyses that bracket this uncertainty to ensure that the models reflect a reasonable range of potential fiscal outcomes.

10 "Cardiovascular Outcomes with Tirzepatide versus Dulaglutide in Type 2 Diabetes"; *New England Journal of Medicine*; Dec. 18, 2025.
11 "Lifetime Health Effects and Cost-Effectiveness of Tirzepatide and Semaglutide in US Adults"; *JAMA Health Forum*; March 14, 2025.
12 "Fiscal Impact of Expanded Medicare Coverage for GLP-1 Receptor Agonists to Treat Obesity"; *JAMA Health Forum*; April 25, 2025.
13 "Semaglutide and Tirzepatide for the Treatment of Obesity: Final Evidence Report"; Institute for Clinical and Economic Review; Dec. 16, 2025 (health-benefit price benchmarks: injectable semaglutide $9,100-$12,500; oral semaglutide $8,300-$11,400; tirzepatide $11,500-$15,800 per year).

Realizing savings presents several practical challenges:

- **The Time Horizon Mismatch:** The health benefits that lead to cost savings may take years to materialize. The front-loading of treatment costs with few concurrent cost offsets can increase current-period trends and strain employer budgets. The average person changes health coverage every few years or sooner due to job changes, retirement, or other events. This timing mismatch means the entity paying for treatment often differs from the one that would capture the savings. Importantly, this challenge extends across payer types: over half the commercial market is self-funded, meaning plan sponsors—not carriers—bear the direct cost risk, and most employers use relatively short time horizons (often three to five years) to evaluate returns on health investments. Carriers generally structure coverage in accordance with customer preferences and willingness to pay; the coverage hesitancy often attributed to carriers more accurately reflects plan sponsor decisions about short-term cost tolerance. Many state Medicaid programs do not cover GLP-1s for weight loss, and some of those that do have scaled back coverage in response to emerging short-term expense pressures.

- **The Continuation Imperative:** As noted above, real-world continuation remains a challenge. Poor continuation and subsequent weight regain can effectively erase the potential for long-term health improvements and savings. The select-and-ultimate pattern suggests that payers may want to focus on supporting patients through the high-attrition early period.

- **Risk-Stratified Returns:** The expected savings are not uniform across patient populations. The financial return is clearer for high-risk patients with existing cardiovascular disease (the SELECT trial population) than for patients with obesity but no other major comorbidities. For lower-risk populations, expected financial return is likely negative even at reduced price levels, at least within typical payer time horizons. This has led many payers to focus coverage on higher-risk populations where the evidence for benefit is strongest.

Stakeholder Perspectives

The costs and benefits of GLP-1s are distributed unevenly across different groups, each with a unique perspective.

- **Patients:** As the primary beneficiaries, patients stand to gain significant health improvements—including reduced cardiovascular risk, improved metabolic markers, and enhanced quality of life—but also bear immediate burdens including increased out-of-pocket costs, potential side effects during titration, and administrative hurdles in securing and maintaining coverage.

- **Manufacturers:** For pharmaceutical companies, GLP-1s have become blockbuster drugs, generating tens of billions in annual revenue. However, this commercial success is accompanied by intense public scrutiny over pricing, federal pricing actions, and regulatory enforcement against compounded versions. The FDA's February 2026 announcement of its intent to act against certain mass-marketed compounded GLP-1 products[14], followed by its April 2026 proposed rule to exclude semaglutide, tirzepatide, and liraglutide from the 503B Bulks List, would further narrow the compounded channel to patient-specific prescriptions supported by documented medical necessity, removing what had been a significant source of lower-cost alternatives.

- **Physicians:** For health care providers, GLP-1s represent a powerful clinical tool but also a significant administrative burden. Physicians and their staff spend substantial time navigating complex prior authorization paperwork required by insurers, which can delay patient care. They are also on the front lines of managing patient expectations, counseling on side effects, and helping patients navigate coverage decisions.

- **Plan Sponsors and Private Payers:** Insurers and employers are in a difficult position, weighing the near-term cost increases against potential long-term benefits. The 2025 KFF Employer Health Benefits Survey found that 19% of large firms (200 or more employees) cover GLP-1s for weight loss, with coverage rising sharply among the largest firms—from 28% to 43% of employers with 5,000 or more workers in just one year. [15]costs is extremely or very important.[15] Among the largest firms covering these drugs, two-thirds report a "significant" impact on prescription drug spending. To manage costs,

14 FDA Intends to Take Action Against Non-FDA-Approved GLP-1 Drugs"; U.S. Food and Drug Administration; Feb. 6, 2026.
15 Survey on Health & Benefit Strategies for 2026; Mercer; 2025.

over half of these employers place conditions on coverage, such as requiring enrollment in a lifestyle program or consultation with a dietician. The emergence of direct-to-consumer channels (e.g., manufacturer cash-pay programs, TrumpRx) adds strategic complexity. Plan sponsors currently have no confirmed mechanism to access federal pricing for insured prescriptions, producing an unusual inversion in which government beneficiaries and cash-paying patients may in some cases be able to obtain GLP-1s more cheaply than commercially insured members.

- **Government:** Medicare and Medicaid are grappling with the potential cost of covering GLP-1s. While Medicare has historically been prohibited from covering drugs solely for weight loss, the FDA approval of Wegovy for cardiovascular risk reduction allows Part D plans to cover it for that specific use. The November 2025 pricing framework expands coverage further: CMS has announced the BALANCE Model,[16] a voluntary model enabling Medicare Part D plans and state Medicaid agencies to cover GLP-1s for weight management and metabolic health improvement. CMS completed price negotiations with Eli Lilly and Novo Nordisk in early 2026 and opened a rolling Medicaid application phase, so the model is now in implementation rather than merely announced. The Medicaid component is launching on a rolling basis in 2026. The Part D launch, originally set for January 2027, has been delayed; in the interim, a separate short-term demonstration called the Medicare GLP-1 Bridge runs from July 2026 through the end of 2027, giving eligible Part D beneficiaries access to Wegovy and Zepbound at a fixed $50 copay. Because the Bridge operates outside the Part D benefit, participating manufacturers supply the drugs at the $245 net price, Part D sponsors bear no risk for products furnished under it, and the $50 copay does not count toward the beneficiary's deductible or the $2,100 out-of-pocket cap, nor do low-income subsidies apply to it. On the Medicaid side, state participation is voluntary, and coverage remains a complex patchwork, with at least 13 states covering the drugs as of January 2026 (down from 16 in 2025), typically with stringent prior authorization requirements, BMI thresholds, and lifestyle program mandates.

16 BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model; CMS.gov; page last modified June 22, 2026.

Health Equity Considerations

The high cost of GLP-1 medications and the structure of the health care system threaten to widen existing health disparities. The very groups who suffer disproportionately from obesity and type 2 diabetes—including low-income individuals and racial minorities—are often the least likely to have access to these treatments, creating a risk of a two-tiered system in which GLP-1s become a treatment for only certain groups.

This dynamic directly intersects with social determinants of health. Individuals with limited access to nutritious food, safe environments for physical activity, and stable housing face higher rates of obesity. When access to effective treatments is limited by cost, specialist availability, or other structural barriers, these approaches may fall short of addressing the broader, non-medical factors that drive disease risk. As a result, the same environmental conditions that contribute to poor health outcomes can remain unaddressed within the health care system, reinforcing disparities in both prevention and treatment.

This gap in access is unlikely to close without targeted policy intervention. A 2024 KFF survey found that a majority (62%) of large employers not currently covering GLP-1 drugs were "not likely" to do so in the next year. Recent studies have shown significant disparities in prescribing, with Black patients receiving lower rates of GLP-1 prescriptions compared to white patients, even when clinically eligible. This is compounded by barriers such as lack of access to specialists and the presence of "pharmacy deserts" in underserved communities. Late-2025 policy changes affecting prices for government programs may improve access for some populations, but commercial coverage gaps remain and should be considered holistically when evaluating GLP-1 drugs and their impacts.

Policy Considerations

Policymakers have several options available to potentially balance the challenges outlined above, each with trade-offs:

- **Value-Based Pricing:** Tying reimbursement to patient outcomes (e.g., sustained weight loss or reduced cardiovascular events) could better align cost with clinical value. However, this creates significant administrative complexity in tracking long-term outcomes, especially as members change health plans. CMS innovation models, including elements of the BALANCE framework, may provide testing ground for such approaches. Actuaries can support design of value-based contracts by specifying measurable outcomes, credible benchmarks, and appropriate time horizons for assessing cost offsets, while accounting for member turnover and attribution challenges. With manufacturer negotiations complete and the Medicaid component now recruiting, BALANCE has moved from proposal into implementation, though the delayed Part D launch illustrates how bid-cycle timing can constrain voluntary models.

- **Federal Legislative Action:** Legislation such as the Treat and Reduce Obesity Act (TROA)[17] would allow Medicare to cover prescription drugs for chronic weight management. While this would improve access for seniors, the Congressional Budget Office has historically scored such legislation as resulting in significant net cost, creating political obstacles—though the November 2025 pricing framework may affect future scoring.

- **Utilization Management:** Payers can implement prior authorization, BMI thresholds, or lifestyle program requirements to focus coverage on appropriate patients and potentially improve continuation. These measures can control costs and may improve value, but they also create administrative burdens for physicians and access barriers for patients—potentially worsening health disparities. Actuaries can model the net fiscal and health impact of different eligibility criteria, quantifying the trade-off between short-term cost control and long-term savings potential, and identifying risk segments where coverage is most likely to generate value.

17 See "S.1973 – Treat and Reduce Obesity Act of 2025"; 119th Congress; and "H.R.4231 – Treat and Reduce Obesity Act of 2025"; 119th Congress; last accessed July 7, 2026.

- **Continuation Support:** Given the select-and-ultimate pattern of treatment continuation, programs that support patients through the high-attrition early period—such as care coordination, side-effect management, and reduced early cost-sharing—could improve the proportion of spending that generates lasting benefit. Evidence from employer programs pairing GLP-1 coverage with lifestyle support is emerging but not yet conclusive.[18] Actuaries can estimate the return on investment for continuation-support programs by modeling how improved persistence rates translate into avoided disease costs, particularly for cohorts that clear the high-attrition early period.

- **Market Competition and Prevention:** Fostering a more competitive market through clearer pathways for generics, combined with investments in public health initiatives that address the root causes of obesity, offers the most sustainable long-term approach. However, these benefits take years or decades to materialize, offering little relief from immediate budget pressures.

Looking Ahead

The current generation of GLP-1 drugs is likely just the beginning. The FDA approved the Wegovy pill (oral semaglutide 25 mg) in December 2025, making it the first oral GLP-1 approved for weight management; it became widely available in early 2026. Eli Lilly's second oral candidate, orforglipron, was approved (as Foundayo) for chronic weight management in April 2026,[19] with a type 2 diabetes indication still under review. These oral formulations represent a significant shift for actuarial modeling: uptake assumptions calibrated to an injectable-only environment may understate demand, and the effect on continuation patterns—positive or negative—remains uncertain.

Researchers are also developing combination therapies, such as dual- and tri-agonists (like retatrutide), which target multiple hormone receptors simultaneously and have shown potential for even greater weight loss (roughly 28% at the top dose in pivotal trials). Eli Lilly reported positive pivotal obesity results (TRIUMPH-1) in May 2026,[20] with the remaining Phase 3 trials expected to read out across 2026 and a regulatory filing anticipated later in the year. Approval is more likely a 2027 event. Expanding indications to conditions like sleep apnea, NASH/MASH, and potentially Alzheimer's disease could dramatically increase eligible populations and budget exposure.

18 "Employer Approaches to GLP-1 Coverage: Market Trend Report"; Peterson Health Technology Institute; Dec. 15, 2025.
19 Foundayo™ (orforglipron) Digital Media Kit; Eli Lilly and Company; April 2026.
20 Lilly's triple agonist, retatrutide, delivered powerful weight loss in pivotal Phase 3 obesity trial; Eli Lilly and Company; May 21, 2026.

The Society of Actuaries Research Institute has commissioned research on the actuarial analysis of GLP-1 drugs' impact on Medicare costs,[21] signaling that the profession is actively developing the analytical frameworks needed to assess this evolving risk. More convenient formulations, more potent medications, and broader indications will likely increase patient demand, making the need to address current fiscal and access challenges more urgent. In this evolving environment, realistic modeling will require frequent assumption updates based on continuous monitoring of real-world evidence and evolution of available treatments and prescribing patterns.

Conclusion

GLP-1 medications present policymakers with difficult trade-offs between improving public health, ensuring fiscal sustainability, and promoting equitable access. The evidence suggests these medications can produce meaningful health benefits, but whether those benefits translate into cost savings depends heavily on which patients receive treatment, whether they continue treatment, and the time horizon over which value is measured.

The financial case for coverage is strongest for high-risk patients with existing cardiovascular disease, where avoided events can meaningfully offset medication costs over a multi-year horizon. For lower-risk populations, coverage may still be appropriate as a health investment, but policymakers should not expect cost neutrality even at reduced price levels.

Real-world treatment continuation remains a significant uncertainty. Continuation follows the select-and-ultimate pattern described above, and projections that assume trial-level continuation will systematically overstate benefits. Utilization management programs that improve continuation and focus coverage on appropriate patients can enhance value but must be balanced against equity concerns and administrative burden.

The November 2025 federal pricing framework, the CMS BALANCE Model, and the arrival of oral formulations have materially changed the pricing and coverage landscape. Reflecting these developments through scenario analysis—in addition to point estimates—enables budget impact models to capture the reasonable range of potential fiscal outcomes. The FDA's enforcement actions against compounded GLP-1s, while addressing safety concerns, may redirect demand toward plan-sponsored and government-facilitated channels, with implications for both utilization projections and health equity. The path forward requires deliberate strategies that balance cost containment with access, informed by realistic assumptions about how these medications will perform in real-world populations.

21 "RFP: Actuarial Analysis of GLP-1 Drugs' Impact on Medicare Costs"; Society of Actuaries Research Institute; last accessed July 7, 2026.

American Academy of Actuaries

1850 M STREET NW, SUITE 300, WASHINGTON, D.C. 20036

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