Pharmacy vs. Medical Benefit Explained: GLP-1 Coverage

By Adrien Laurent, CEO at IntuitionLabs • 11/7/2025 • 45 min read

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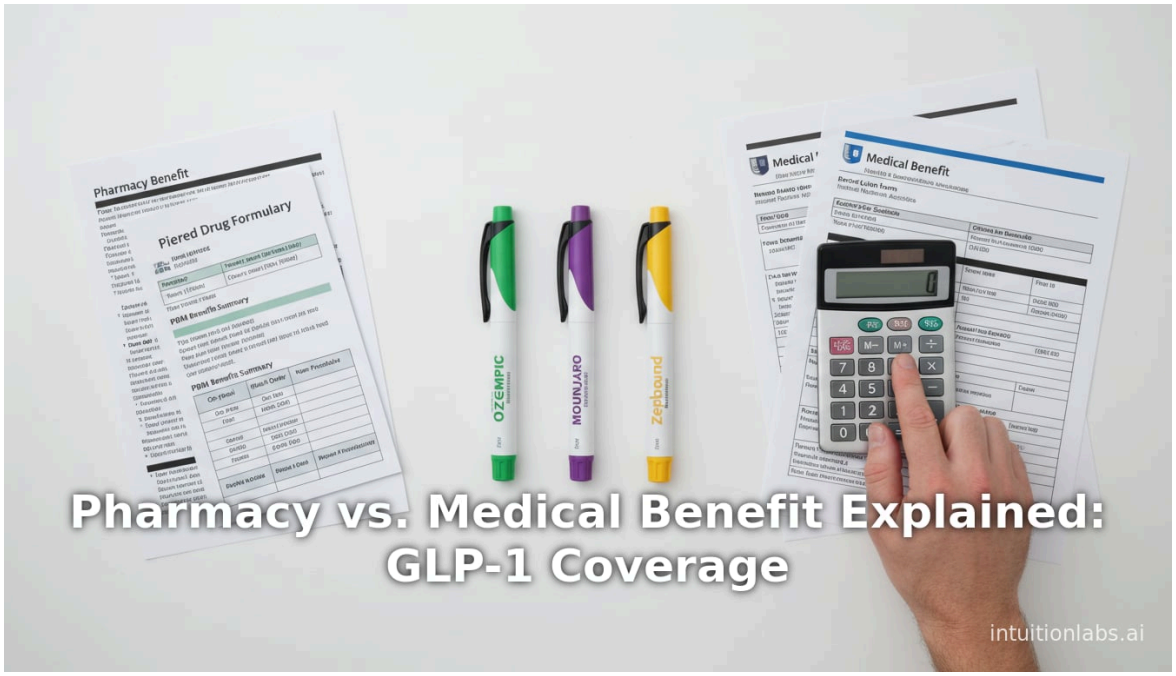

Executive Summary

This report provides an in-depth analysis of the distinctions between pharmacy and medical insurance benefits and applies these concepts to the coverage of GLP-1 (glucagon-like peptide-1) medications. It explains how health plans categorize and reimburse drugs and services under *pharmacy benefits* versus *medical benefits*, tracing the historical rationale and modern developments in benefit design. The analysis then focuses on GLP-1 receptor agonists – a class of drugs used for type 2 diabetes and obesity – examining their mechanisms, clinical impact, and especially how they are covered (or not) by insurers. We review public and private payer policies, including Medicare Part D and Medicaid rules, and highlight recent policy proposals and industry trends affecting GLP-1 access. Through extensive data and case examples (e.g. employer survey findings, patient cost strategies, state Medicaid decisions), we illustrate the real-world implications of benefit design on patient access, costs, and outcomes. The report also discusses cost-effectiveness and spending data, regulatory and legislative developments (e.g. Medicare proposals), and future directions in this evolving landscape.

Key findings include: pharmacy benefits generally cover self-administered outpatient drugs (dispensed by pharmacies) while medical benefits cover provider-administered treatments (infusions, injections in-clinic, physician services) ([1] www.xevant.com) ([2] www.thinkbrg.com). GLP-1 drugs like semaglutide and tirzepatide are typically self-injected and fall under pharmacy benefits, but many payers only cover them for diabetes, not obesity ([3] www.kff.org) ([4] www.investing.com). Medicare Part D (pharmacy) currently excludes GLP-1s for weight loss despite their use for diabetes ([5] www.techtarget.com), and state Medicaid programs can opt out of covering the obesity indications ([3] www.kff.org). Coverage policies vary widely: a Mercer survey found ~44% of large US employers covered weight-loss drugs (up from 41% prior year) ([6] www.investing.com), yet many patient advocacy reports and journalists note patients cutting doses or resorting to unapproved sources due to cost ([4] www.investing.com) ([7] www.investing.com).

The report concludes that as GLP-1 use explodes, payers face a dilemma balancing high drug costs against potential long-term health benefit. Strategies such as prior authorizations, formularies, pilot programs, and legislative action (e.g. proposed Medicare coverage expansions or trials ([8] www.washingtonpost.com)) will shape future access. All findings are supported with extensive citations from academic studies, industry reports, and recent news.

Introduction and Background

Pharmacy and medical benefits are two fundamental categories of health insurance coverage in the United States. In general, *pharmacy benefits* cover prescription medications obtained at a pharmacy (retail or mail-order) and taken by the patient at home, while *medical benefits* cover healthcare services (such as office visits, hospital stays, procedures) and drugs administered in a clinical setting ([1] www.xevant.com) ([9] www.thinkbrg.com). Over the past fifty years, health insurers have developed separate systems (often managed by pharmacy benefit managers, or PBMs) to handle the high volume of prescription drug claims. This split was originally intended to manage costs and logistics: in the 1960s and 1970s, pharmacy claims grew so rapidly that insurers began outsourcing them to specialized units ([9] www.thinkbrg.com) ([10] insuredandmore.com). Today, most patients have both benefits: for example, Medicare beneficiaries have Part D (pharmacy) and Part B (medical), and private plans have dedicated pharmacy coverage and an overarching medical plan.

GLP-1 receptor agonists (GLP-1s) have recently become high-profile drugs for **type 2 diabetes (T2D)** and especially for **obesity/weight loss**. Semaglutide (brand names *Ozempic* for diabetes, *Wegovy* for obesity) and tirzepatide (Mounjaro for diabetes, Zepbound for obesity) can produce dramatic weight loss (averaging ~15–20% in clinical trials ([11] kwsn.com)) and lower cardiovascular risk. Their monthly cost without insurance can

exceed $1,000 ([12] www.investing.com). Demand has surged, creating headlines about coverage: for instance, U.S. news outlets have documented millions of weight-loss drug prescriptions and the strain on insurers and patients. Thus, understanding how pharmacy and medical benefit design affects GLP-1 coverage is critical. In what follows, we first explain the pharmacy vs medical benefit framework, then review GLP-1 drugs and their coverage in Medicaid, Medicare, and commercial plans, interweaving data, policy developments, and real-world examples throughout.

Pharmacy vs. Medical Benefit: Definitions and Distinctions

Pharmacy benefit covers outpatient prescription drugs that are self-administered. These are typically dispensed by a retail or specialty pharmacy under a scheduled plan formulary. Patients may fill monthly or quarterly supplies of pills, inhalers, auto-injectors, or infusion home-care kits. The claim is processed via a PBM, and the patient pays a fixed co-pay or coinsurance. Examples of pharmacy benefits are daily pills (e.g. blood pressure meds) and injectables taken at home (e.g. insulin pens). By contrast, **medical benefit** covers services and treatments delivered by healthcare providers or facilities. This includes doctor office visits, hospital stays, laboratory tests, imaging, surgeries, and drugs that a provider administers (often by infusion or injection) during those encounters ([1] www.xevant.com) ([9] www.thinkbrg.com). For example, an intravenous biologic administered at a hospital infusion center is billed under the medical benefit (often coded with HCPCS *J*-codes).

The key difference is delivery channel and billing. Pharmacy claims are submitted by pharmacies to the insurer (or PBM) as prescription claims. Medical claims are submitted by providers or facilities for clinical services. Insurance plans (and Medicare) generally differentiate these in policy. For Medicare, self-injectable drugs are usually in Part D (pharmacy), whereas provider-administered drugs are in Part B (medical) ([3] www.kff.org). Similarly, private insurers have separate drug formularies: drugs on the pharmacy formulary may have tiered copays, whereas drugs under the medical benefit follow the provider and facility's cost-sharing rules.

Over time, however, the line has blurred. Many *specialty drugs* that are self-injected (e.g.biologic treatments for rheumatoid arthritis, Crohn's disease) can be handled either way. Some insurers now carve such drugs into their pharmacy benefit, running them through specialty pharmacy programs even if a doctor administers them in-office ([13] pmc.ncbi.nlm.nih.gov). Conversely, some self-injected drugs might have a medical benefit component (e.g. if the pharmacy dispenses and then arranges administration). In practice, the same drug can sometimes be covered under both benefits, depending on the plan's design ([2] www.thinkbrg.com) ([10] insuredandmore.com). Importantly, coverage rules (step therapy, prior authorization, patient eligibility) can differ between benefit pathways, leading to **concordant** or **discordant** policies for the same medication under medical vs pharmacy coverage ([14] pmc.ncbi.nlm.nih.gov).

Historical Evolution of the Benefit Split

The pharmacy vs medical benefit distinction has existed for decades. In the 1960s-70s, growth in prescription drug use led insurers to create a separate pharmacy benefits division. As one analysis notes, *"medical vs. pharmacy benefits split occurred when claims processing for pharmaceuticals grew to a volume requiring a unique solution for insurers"* ([1] www.xevant.com) ([10] insuredandmore.com). Pharmacy benefits were managed by PBMs (sometimes subsidiaries of insurers) and developed distinct formularies and networks of pharmacies. Meanwhile, medical benefits continued to cover services delivered by providers.

This legacy structure persists. For example, Medicare Part D was created in 2003 specifically for outpatient drugs, while Part B continues for physician-administered therapies. Private plans adopted similar carve-outs, often contracting with PBMs to manage medications. As a result, specialty medications (including GLP-1s) may be designated as either "medical benefit drugs" or "pharmacy benefit drugs" based on their mode of delivery

and approved uses ([10] insuredandmore.com). Over time, many specialty injectable and infusion drugs have been shifted into pharmacy benefits to tap efficiency gains and cost controls ([13] pmc.ncbi.nlm.nih.gov).

A recent study of 17 large U.S. commercial plans (as of 2020) found that plans frequently issued separate coverage policies under both benefits for the same specialty drug. In fact, *29% of cancer drugs* in the analysis had both medical and pharmacy policies under the same plan ([15] pmc.ncbi.nlm.nih.gov). In cases where plans had both, 86% of policy pairs were concordant (same criteria) but 14% differed, often because step-therapy rules or prescriber requirements did not align ([16] pmc.ncbi.nlm.nih.gov). This underscores that the pharmacy/medical benefit split can lead to inconsistencies in access.

The Role of PBMs and Insurers

Pharmacy benefit managers (PBMs) play a crucial role in shaping which drugs are covered and how much patients pay. PBMs design formularies (tier lists of drugs), negotiate rebates with manufacturers, and handle prior authorizations for pharmacy benefits. In contrast, medical benefit drugs are typically subject to utilization management at the plan or provider level, often requiring prior authorization through medical policy review. For example, a plan may place a drug on a pharmacy formulary with a tier-2 copay, whereas the same drug administered by infusion might require step therapy to a lower-cost alternative under medical policies (with even 20% coinsurance after deductible for the patient).

This division can confuse patients and prescribers. For instance, an injectable biologic may be prescribed, but the claimant might not know whether the patient should get the vial at a specialty pharmacy or receive an in-office infusion (making a difference in coverage and cost). Understanding which benefit applies often requires a detailed *benefits investigation* ([17] www.namapa.org). Advocacy groups note that such investigations are crucial for patient access: they reveal the net cost obligations and eligibility limits under both benefits ([17] www.namapa.org).

The interplay also affects how drugs are priced and reimbursed. Pharmacy benefit drugs are paid via negotiated rates with pharmacies (and often manufacturer rebates), while medical benefit drugs use reimbursement codes (e.g. Average Sales Price + 6% in Medicare Part B for infused drugs). Thus, manufacturers may prefer one route over another. Health plans may steer a drug into the pharmacy benefit to leverage rebates, or into the medical benefit to take advantage of site-of-care differences. This dynamic market context sets the stage for GLP-1 coverage issues.

GLP-1 Medications: Overview and Evolution

GLP-1 receptor agonists are a class of medications that mimic the gut hormone GLP-1, which increases insulin secretion, slows gastric emptying, and reduces appetite. They have been used in medicine since the mid-2000s primarily for type 2 diabetes. The first GLP-1 agonist, *exenatide* (Byetta), was approved in 2005. Over time, new formulations emerged: *liraglutide* (Victoza) in 2010 for diabetes, *dulaglutide* (Trulicity) and *semaglutide* (Ozempic) around 2017-2018. These were once-weekly injectables (Trulicity) or daily injectables (Victoza).

In parallel, researchers recognized that GLP-1's appetite-suppressing effects could be leveraged to treat obesity. *Liraglutide* was approved for weight management in 2014 (*Saxenda*), and *semaglutide* in a higher dose as *Wegovy* in 2021. Just recently, *tirzepatide* (brand Mounjaro), a dual GIP/GLP-1 agonist, was approved for diabetes (2022) and for weight loss as *Zepbound* (2023). Numerous other agents (oral semaglutide *Rybelsus*, injectable dulaglutide *Trulicity* for diabetes only, etc.) fall under this family. Table 2 below summarizes key GLP-1 drugs with their indications and typical insurance coverage context.

Drug (Generic)	Brand (Diabetes)	Brand (Obesity/Weight)	Administration	FDA Approval (Diabetes / Obesity)	Insurance Coverage (Benefit)
Liraglutide	Victoza	Saxenda	Daily injectable	2010 (DM), 2014 (Obesity)	Pharmacy benefit. Widely covered for diabetes; Saxenda often limited as weight-loss indication ([3] www.kff.org).
Semaglutide	Ozempic (weekly); Rybelsus (oral)	Wegovy	Weekly injectable (tablet for Rybelsus)	2017 (Ozempic DM), 2021 (Wegovy Obesity)	Pharmacy benefit. Ozempic covered for diabetes; Wegovy (same molecule) often *not* covered for weight in Medicare/Medicaid ([5] www.techtarget.com) ([3] www.kff.org).
Dulaglutide	Trulicity	–	Weekly injectable	2014 (DM only)	Pharmacy benefit. Trulicity is covered for T2D; not approved for obesity.
Exenatide	Byetta (daily); Bydureon (weekly)	–	Daily/weekly injectable	2005/2012 (DM only)	Pharmacy benefit. Covered for diabetes; older agent with limited current use.
Tirzepatide	Mounjaro	Zepbound	Weekly injectable	2022 (DM), 2023 (Obesity)	Pharmacy benefit. Covered for diabetes as Mounjaro; Zepbound for obesity is new and subject to plan limits.
Others	Lixisenatide (Adlyxin); Albiglutide (Tanzeum, now discontinued)	–	Injectable	2016/2014 (DM, older formulations)	Pharmacy benefit; rarely used.

Table 2. GLP-1 receptor agonist medications, common brands, administration routes, and insurance coverage notes. All are covered as pharmacy benefits (filled at pharmacies) under standard plans. State Medicaid programs must cover the formulations for diabetes (e.g. Ozempic, Victoza, etc.) but may exclude the obesity indications (e.g. Wegovy, Zepbound) ([3] www.kff.org). Medicare Part D covers these self-injectables (Ozempic/Rybelsus, etc) for diabetes, but CMS has declined to extend Part D coverage to the obesity label as of 2025 ([5] www.techtarget.com) ([3] www.kff.org).

GLP-1 drugs have become medical breakthroughs. In trials, they typically achieve significant weight reduction (15–20% body weight) and improved glucose control. They also confer cardiovascular benefits: for example, semaglutide and tirzepatide have been shown to reduce heart attack and stroke risk relative to placebos in obese or diabetic populations ([12] www.investing.com). This potency has fueled rapid demand. A 2025 Institute for Clinical and Economic Review (ICER) report notes that weekly GLP-1s like semaglutide (Ozempic/Wegovy) and tirzepatide (Mounjaro/Zepbound) have become more cost-effective over time due to price reductions and proven long-term benefits ([11] kwsn.com). At the same time, U.S. spending on GLP-1s soared: one study found total annual spending reached nearly **$72 billion in 2023** ([18] kwsn.com).

In sum, GLP-1s represent a transformative but expensive treatment category. Their route is nearly always patient self-injection, meaning coverage is primarily via pharmacy benefits. However, because these drugs now straddle diabetes and obesity treatment, coverage rules become complex (for example, a plan may cover them for diabetes but not for weight loss). The next sections examine exactly how pharmacy and medical benefits handle GLP-1s and the insurance landscape around them.

Pharmaceutical vs. Medical Benefits: Structural Differences

What Pharmacy Benefits Cover

Pharmacy benefits cover any prescription medication picked up at a pharmacy. These include:

- **Self-administered drugs:** Tablets, capsules, inhalers, eye drops, transdermal patches, nasal sprays, and injectables that patients give themselves (insulin pens, epinephrine pens, GLP-1 injections, etc.) ([1] www.xevant.com). When a prescription is dispensed, the claim goes to the insurer's pharmacy plan (often via a PBM) with an NDC (National Drug Code) identifier.
- **Specialty medications fill by a specialty pharmacy:** Many high-cost or complex drugs (like biologics for rheumatoid arthritis, multiple sclerosis pills, etc.) are still dispensed via specialty pharmacies. They count under the pharmacy benefit, albeit often managed with stricter utilization controls.
- **Formulary coverage tiers:** Pharmacy plans classify drugs into tiers (generic, preferred, non-preferred, specialty) with different copays or coinsurance. GLP-1s (being brand-name specialty injectables) typically sit in the highest tier, with coinsurance or high copays.

Patients using the pharmacy benefit will usually have a predictable copay per filling (e.g., $50 for a 30-day supply of a Tier-2 drug). Some plans use coinsurance percentages (e.g. 20% of drug price). PBMs negotiate rebates and discounts behind the scenes, but patients face the sticker price for cost-sharing purposes.

Pharmacy benefits do **not** cover drugs the patient does not take home. For example, an IV chemotherapy given in a doctor's office is not a pharmacy claim.

What Medical Benefits Cover

Medical benefits cover services and drugs administered by healthcare providers:

- **Physician Office Visits:** Charges for doctor consultations (coded by procedures, e.g. CPT codes) are in the medical benefit.
- **Observation/Hospital Services:** Emergency room visits, hospital admissions, imaging, lab tests, surgeries, and other procedures (e.g. MRI scans) are billed under medical benefit.
- **Provider-Administered Medications:** Crucially, many drugs given by infusion, injection, or on-site administration are paid as part of the medical benefit. For example:
- **Infused biologics:** Monoclonal antibodies (e.g. infliximab, rituximab) given at infusion centers.
- **In-office injections:** Vaccines or injectables the doctor administers (e.g. an onabotulinumtoxinA injection for migraine, or Eylea for macular degeneration eye injection).
- **Chemotherapy infusions:** Most chemotherapy drugs given to cancer patients.
- **Facility Fees:** Often bundled with medicine administration.

In this scenario, the medical claim includes both the drug (often a *J*-code at Medicare) and the administration service. Patients usually pay part of the provider charge (e.g. a visit copay or 20% coinsurance of the total).

One consequence is that medical benefit drugs are subject to different rules. Insurers may require prior authorization or specific criteria (e.g. specialist prescribing) as part of the medical policy. The patient's out-of-

pocket can vary depending on plan design (e.g. deductible plus coinsurance for an infusion day).

In Medicare, Part B covers most provider-administered drugs (paid at ASP+6%). Part D, conversely, is for drugs the patient administers(filled at pharmacy). For instance, diabetes insulin vials needed for infusion would be Part B, whereas insulin pens that a patient self-injects are Part D.

Historical Context and Rationale

The bifurcation of benefits has practical roots. By the 1970s, rapid growth in drug spending led health plans to spin off pharmacy benefits into the PBM industry. This allowed pharmacy claims to be processed differently than medical claims. According to a review article, *"services covered under the medical benefit include physician office visits, hospital stays … the pharmacy benefit covers outpatient prescription drugs dispensed through retail and specialty pharmacies"* ([9] www.thinkbrg.com). A patient with typical insurance might see a doctor (medical benefit with perhaps a $20 copay) and then fill a prescription (say, $10 copay at pharmacy).

Over time, however, specialty drugs blurred roles. Insurers discovered that many clinic-administered drugs (e.g. biologics, oncology infusions) were extremely expensive, sometimes far more than standard outpatient drugs. To control costs and simplify management, the trend has been to **shift specialty injectables to pharmacy benefits** whenever feasible ([13] pmc.ncbi.nlm.nih.gov). This allows use of specialty pharmacy networks, negotiated rates, and streamlined distribution. Indeed, a 2023 study by Levine et al. found *"health plans are increasingly shifting specialty drugs from their medical benefit to the pharmacy benefit"* ([13] pmc.ncbi.nlm.nih.gov).

Conversely, some advocates push to include more obesity/weight-loss drugs under medical benefits by treating obesity as a chronic disease warranting physician-guided therapy. Historically, however, certain weight-loss agents were excluded. For example, under Medicare Part D there was a 20-year rule prohibiting coverage of weight loss drugs – a policy only recently reconsidered ([19] www.medicaleconomics.com). Background: Starting in the DSM, obesity was long considered a lifestyle choice, not a disease, and many insurers did not cover treatment beyond diet and exercise programs. The new GLP-1s challenge that notion, and plans are responding variably.

Key Differences and Examples

Table 1 compares features of pharmacy-format vs medical-format coverage:

Feature	Pharmacy Benefit	Medical Benefit
Covered Services	Outpatient prescription drugs (dispensed at pharmacies) ([1] www.xevant.com) ([2] www.thinkbrg.com)	Healthcare services (office visits, ER, surgeries) and provider-administered drugs ([9] www.thinkbrg.com)
Drug Administration	Patient self-administers (pills, injectables at home) ([1] www.xevant.com)	Administered by clinician (infusion, in-office injection, surgery)
Claims Processed Via	Pharmacy/PBM claims (using NDC and Pharmacy IDs)	Medical claims (using CPT/HCPCS and physician/facility IDs)
Examples	Insulin pens, GLP-1 injection pens (Wegovy, Ozempic), asthma inhalers, antibiotics picked up at Rx	Chemotherapy infusions, physician-administered biologics, vaccines given in office
Cost-sharing typically	Copay or coinsurance per prescription (tiered formulary; e.g. $50 copay for a 30-day supply)	Copay/coinsurance per visit or service (e.g., $30 office copay, or 20% coinsurance of service)

Feature	Pharmacy Benefit	Medical Benefit
Medicare Context	Part D (outpatient drugs) – e.g., self-injectable GLP-1s covered here for DM	Part B (provider-administered) – e.g., infusible diabetes or obesity drugs in clinic
Formulary Management	PBM-managed drug formulary; prior auth for certain drugs (step therapy lists)	Medical policies or guidelines determine coverage criteria for treatments (often by specialty)

Table 1. Key contrasts between pharmacy and medical benefit coverage. Pharmacy benefits apply to medications dispensed to patients for home use ([1] www.xevant.com) ([2] www.thinkbrg.com); medical benefits apply to provider services and drugs given in healthcare settings ([9] www.thinkbrg.com). Medicare analogues: self-administered drugs are in Part D, provider-administered in Part B.

Because of these divisions, a drug's "benefit channel" can determine patient cost and access. For example, if a costly biologic is under medical benefit, the patient might pay 20% coinsurance on a $10,000 infusion (i.e. $2,000) plus site fees. If that same drug were placed under the pharmacy benefit (with the patient picking up syringes), the patient might instead pay a single $100 copay with a specialty tier. Insurers must decide how to categorize each drug.

In practice, **consistency issues** arise when both benefits cover a drug. Some insurers issue *medical-pharmacy policy pairs* for the same specialty drug. The study mentioned earlier found 1,619 such pairs among large plans ([20] pmc.ncbi.nlm.nih.gov). Of these, 86% were concordant (the policy allowed or denied similarly under both benefits) but 14% had discordant rules ([16] pmc.ncbi.nlm.nih.gov). Discordance usually came from differing step therapy protocols (e.g. requiring 2 alternate drugs under medical benefit but only 1 under pharmacy) or different prescribing restrictions ([16] pmc.ncbi.nlm.nih.gov). This can confuse patients and providers who may only request prior authorization through one benefit, inadvertently triggering inconsistent criteria.

Finally, **carve-outs** can complicate matters. Sometimes employers purchase pharmacy benefits separately from medical benefits (using different vendors). Specialty infusion services might be managed by a third-party infusion provider under medical benefits. These arrangements can affect GLP-1 drugs if, for example, an employer chooses to make weight-loss drugs available only through a certain program.

In summary, pharmacy benefits focus on medications dispensed to patients, while medical benefits focus on providers' services and in-office drugs ([1] www.xevant.com) ([9] www.thinkbrg.com). This dichotomy influences how GLP-1 therapies are covered, as described below.

GLP-1 Insurance Coverage Landscape

GLP-1 drugs' coverage depends on **payer type** (commercial/employer plans, Medicare, Medicaid) and on the **indication** (diabetes vs obesity). We address each in turn, noting how pharmacy vs medical design affects access.

Commercial Insurance (Employer and Individual Plans)

In employer-sponsored and private health plans, GLP-1 drugs are almost always covered under the *pharmacy benefit* (since they are dispensed from pharmacies). However, whether the plan *chooses* to cover them at all – particularly for weight loss – varies widely.

Coverage Trends

Recent surveys indicate rising coverage among employers. A Mercer study (2024) reported that **44% of U.S. employers (500+ employees)** covered "weight-loss medications" (including GLP-1s like Wegovy and Zepbound) in 2024, up from 41% in 2023 ([6] www.investing.com). Among mega-employers (20,000+ workers) 64% provided such coverage (up from 56%) ([21] www.investing.com). These figures primarily reflect pharmacy benefit coverage for GLP-1s under employee health plans. It suggests corporate benefit managers are increasingly adding GLP-1s to formularies, likely due to employee demand and pressure to offer competitive benefits.

However, surveys also show that nearly half of large employers still *do not* cover these medications for weight loss ([6] www.investing.com), often citing cost concerns. Private payers have implemented utilization management: many require prior authorization, limit treatment durations, or mandate documentation of medical necessity (e.g. BMI thresholds, failed diet/behavioral programs) before allowing GLP-1 drugs ([4] www.investing.com). On the pharmacy side, GLP-1s are placed in specialty tiers requiring high co-insurance or coinsurance. For example, a common policy might be a 30% coinsurance on a Wegovy pen (meaning $300 per weekly dose for the patient).

Physicians report encountering **coverage restrictions**. A Reuters report (Aug 2025) interviewed multiple US doctors on GLP-1s: *"insurance coverage has tightened in 2025 as many employers drop it for the expensive GLP-1 drugs,"* said one physician ([22] www.investing.com). Patients have responded by rationing doses (taking only part of each pen to make it last longer) or completely forgoing other expenses (like vacations) to afford these drugs out-of-pocket ([4] www.investing.com). This illustrates the burden when high-cost drugs move from pharmacy to self-pay because plans restrict them.

Pharmacy Benefit Specifics

Since GLP-1 drugs are self-injectables, they are coded and paid at pharmacies. Most insurers list GLP-1 agents on their specialty drug formularies. Even if covered, they often require step therapy (the patient must try an older medication first) or have quantity limits (e.g. approvals limited to 3–6 months at a time) ([22] www.investing.com). Plans may differentiate by indication: a policy might cover semaglutide for T2D with minimal restrictions, but treat a Wegovy prescription with the same molecule as *off-label* (for weight) and therefore require stricter criteria.

The pharmacy benefit has advantages (faster dispensing, lower patient cost share) over medical benefit. For example, if a new GLP-1 were an infusion drug, the patient might pay the full coinsurance on thousands of dollars of service. Under pharmacy coverage, a patient might just pay a tier-3 copay of $50–100 per pen. This difference can make PBMs motivated to classify as much GLP-1 dispensing as possible under pharmacy. In fact, the trend toward *medical-to-pharmacy shifts* means that if any GLP-1 formulations were previously administered in clinics (e.g. older weight-loss injections like Saxenda, which is a patient-delivered pen, but some plans might have paid it under medical if given in a clinic setting), they are likely being carved into pharmacy now.

Employer Strategies

Employers seeking to manage GLP-1 costs have adopted strategies. Large payers like Cigna have advised employers to impose controls while offering coverage ([23] newsroom.cigna.com). Common tactics include requiring prior authorization records of BMI≥30 (with comorbidities), step edits to generic drugs first, and caps on treatment duration. Some employers consider sharing costs more with employees (shifting higher coinsurance) to mitigate spend. Others are adding wellness programs emphasizing nutrition and exercise, sometimes contingent on GLP-1 use.

Despite cost restraints, many employers recognize longer-term benefits. For instance, proponents argue GLP-1 coverage can reduce incidents of diabetes and cardiovascular events (as clinical trials suggest). Mercer's

survey indicated that some employers chose to "enhance key benefits" by adding GLP-1 coverage even as overall health costs rose modestly ([24] www.mercer.com). Hence, commercial coverage is a patchwork: substantial uptake with rigorous management, but also notable gaps where coverage is denied or limited.

Real-World Example: Employer Coverage

Mercer Survey (2024). A representative case: In Nov 2024, Reuters reported on the Mercer National Survey of Employer-Sponsored Health Plans. It found that 44% of mid-size and large employers offered coverage for weight-loss medications in 2024, up from 41% in 2023 ([6] www.investing.com). This jump included "newer GLP-1 drugs Wegovy and Zepbound" by name ([21] www.investing.com). The survey emphasizes the employer perspective in late 2024: coverage is increasing, likely driven by employee demand, and not limited to the largest firms alone (over 40% coverage among 500+ firms). However, it also implicitly reflects that over half still did *not* cover these drugs at that time.

This data illustrates the rapid change: just 1-2 years prior, virtually no large employers covered GLP-1 weight-loss treatments. The fact that nearly half do so now is unprecedented. Employers may vary coverage by benefit. Some might cover GLP-1s only for diabetes (with an expectation that weight loss is a secondary benefit), or cover weight loss meds only via the pharmacy benefit if a specific BMI is documented. For example, one large employer could allow Wegovy with a $150 monthly copay under pharmacy benefits if the employee has a documented BMI≥35, but disallow it if BMI<35 or treat it as lifestyle.

Such policies can generate confusion: patients might think "my doctor prescribed Wegovy, but my insurer says it's not covered." This underscores the need for clear benefits communication. Many benefits consultants now note that employers must outline explicitly under which conditions (e.g. obesity with comorbidity) these drugs are covered, and what cost share the employee faces. The intersection of pharmacy benefit design and employer health goals is crucial for understanding coverage realities.

Medicare Coverage of GLP-1s

Part D (Pharmacy Benefit)

For Medicare beneficiaries (typically 65+ or disabled), GLP-1s for diabetes have long been covered under Part D (the outpatient drug benefit) as prescription drugs. Drugs like Victoza, Ozempic, Rybelsus, and Trulicity are all included on formularies (though specific coverage tiers vary by plan).

Important highlight: **Weight-loss indication is *excluded* from Part D**. Historically, Medicare Part D included a statutory exclusion on weight loss drugs. A Kaiser Family Foundation (KFF) report explains that under the Medicaid Drug Rebate Program rules (which Part D essentially follows), "weight-loss drugs" may be excluded ([25] www.kff.org). Specifically, while LIS (low-income subsidy) rules must cover all drugs for medically accepted indications, GLP-1s for obesity fall into a narrow statutorily excludable category (often referred to as the "weight loss exclusion"). Thus, Medicare Part D plans typically do *not* cover GLP-1s when used strictly for obesity.

In April 2025, CMS formally announced it would **not finalize** a pending proposal to allow Medicare to cover GLP-1 weight-loss drugs ([5] www.techtarget.com). This Biden-era proposal (subject to finalization) would have reversed the long-standing exclusion and required Part D to cover approved obesity drugs (Wegovy, Zepbound) under certain criteria. However, in the finalized 2026 rules, CMS concluded that existing policy would stand: Medicare Part D plans remain allowed but not required to cover these drugs for weight. In plain language, for the current administration Medicare will continue to *not* pay for Wegovy, only for Ozempic (since Ozempic's approval is diabetes, which Part D does cover) ([5] www.techtarget.com) ([3] www.kff.org).

The effect is: A Medicare patient with diabetes can get Ozempic at the usual Part D cost share, but if the same patient switches classification to "weight loss" (say they lose weight and no longer meet diabetes ICD-10 criteria), Medicare will no longer pay and the patient would face full out-of-pocket costs. This particularly affects borderline patients whose labs might indicate remission of diabetes.

Part B (Medical Benefit)

Medicare Part B covers drugs that require physician administration or that are given in certain settings (e.g. outpatient hospital, infusion chair). GLP-1 peptides like semaglutide and tirzepatide are not standardly administered in clinic, so Part B is not typically involved. One hypothetical medical coverage path could involve a doctor injecting a patient at a clinic instead of the patient self-injecting at home, but this is uncommon and not established practice for GLP-1s.

Thus, as of now, **all known GLP-1 products for diabetes/obesity are covered under Part D** when covered at all. (An exception would be if a state's medical policy insisted on physician administration, but that is not the standard). In contrast, an obesity drug like *orlistat* or older weight drugs similarly fell outside Part B.

Recent Proposals and Pilot Programs

Policy has been in flux. Agenda on GLP-1 coverage shifted with political changes. In late 2024, the Biden administration proposed a 2026 Medicare rule expanding weight drug coverage (based on the Treat and Reduce Obesity Act provisions) ([26] www.investing.com) ([19] www.medicaleconomics.com). However, by April 2025 CMS opted not to proceed ([5] www.techtarget.com).

Later, press reports in mid-2025 (Aug 2025) indicated the White House (in a confusing timeline credited to "Trump administration" but likely an Obama-era script revived) is planning a **5-year Medicare/Medicaid demonstration** allowing optional coverage of GLP-1s for obesity ([8] www.washingtonpost.com). Under this proposal, CMS would permit Medicare Part D plans and state Medicaid programs to optionally cover drugs like Ozempic, Wegovy, Mounjaro, Zepbound for weight management if they choose. This marks a potential policy shift from outright exclusion toward experimentation. While not a guarantee of permanent coverage, it signals federal willingness to explore GLP-1 access in public insurance. (The timeline suggested these pilots could start in 2027 under CMS discretion ([8] www.washingtonpost.com).)

Summary of Medicare Coverage

- **Diabetes Indication:** Medicare Part D covers GLP-1s for diabetes (subject to plan formularies and cost-sharing, just like any brand drug). Part B largely irrelevant except by now occasional Part D case by case.
- **Obesity Indication:** Part D currently does *not* cover GLP-1s for weight loss. CMS reaffirmed this position in 2025 ([5] www.techtarget.com). Proposed pilot programs aim to allow optional coverage, but as of late 2025 this has not been finalized. Medicare Advantage plans (which operate Part D) may have special benefits or wellness programs, but they too fall under these rules.
- **State Medicaid:** states have flexibility. We discuss below.

Overall, Medicare's refusal to broadly cover GLP-1 obesity dosing means older Americans generally must pay full price if they want this treatment. Many advocates have called this a gap in coverage, given that obesity and related costs (heart disease, diabetes) are high in Medicare populations.

Medicaid Coverage of GLP-1s

Medicaid offers further complexity because although it follows federal rules on drugs, **drug coverage (especially for optional purposes)** is decided by states.

By law, state Medicaid programs are required to cover almost all FDA-approved drugs under the Medicaid Drug Rebate Program for *medically accepted indications* ([27] www.kff.org). However, **weight loss drugs** are one of the limited *optional* categories that states may exclude by choice. The statute allows states to omit "agents used for weight loss" from coverage ([27] www.kff.org). In practice, this means Medicaid MUST cover GLP-1s when prescribed for diabetes but MAY (but does not have to) cover them when used for obesity.

KFF reports (Nov 2024) found that as of late 2024 only a handful of states covered the obesity-labeled GLP-1 drugs for Medicaid patients ([27] www.kff.org). The newest agents – Wegovy, Saxenda, Zepbound – are "optional" for state Medicaid. Initially, Novo Nordisk successfully lobbied many states: by 2023, **14 states had agreed to cover Wegovy under Medicaid** for eligible recipients, arguing that weight loss would save on long-term disease costs ([28] www.investing.com). For example, Mississippi pursued coverage as early as 2022 after public advocacy ([29] www.investing.com).

However, the tide shifted in 2024–25 as multi-billion-dollar spending projections mounted. A Reuters investigation (Oct 2025) reveals that some Medicaid programs (led by budget directors) began retracting or scaling back coverage of Wegovy, citing runaway costs ([30] www.investing.com). Specifically, states like California, North Carolina, Pennsylvania and Connecticut reportedly announced cuts or freezes in coverage ([31] www.investing.com). West Virginia even halted a pilot program for state workers after costs reached $1.4M per month ([32] woub.org), as a tangible case study. These moves reflect the challenging budgetary balance states face: GLP-1s are effective, but paying for them at scale is onerous for cash-strapped Medicaid budgets.

States that do cover GLP-1s typically require stringent criteria: BMI thresholds (e.g. >=35), documented lifestyle program participation, specialist prescribing, etc. The KFF brief points out that if all states covered obesity drugs, about **40% of Medicaid adults and 26% of Medicaid children with obesity** could gain access to these medications ([33] www.kff.org). That potential cross-state variability means coverage is very heterogeneous: a Medicaid patient in State A might get Wegovy after meeting criteria, while in State B it might be categorically denied or delayed.

Importantly, any GLP-1 injected by a Medicaid beneficiary at home will be billed via the pharmacy benefit of Medicaid. For those given in-office (unlikely for these drugs), it could theoretically be medical. But essentially, Medicaid's stance parallels Medicare: diabetic use is a mandatory coverage, but obesity use is optional.

Case Example: State Action on Medicaid

The saga in West Virginia illustrates the on-the-ground impact. In 2024, West Virginia launched a pilot providing Wegovy to 1,000 state employees and dependents. However, by late 2024 (pilot cost $1.4M/mo), the state abruptly paused the program ([32] woub.org). Online and local news coverage (AP News syndicated) quotes patients like Lory Osborn who achieved dramatic weight loss on Wegovy but feared being cut off. This shows the tension: recognition of clinical benefit versus fiscal reality.

Similarly, other states tell similar stories. The Reuters article notes that while industry predictions highlighted healthcare savings, several state budget offices saw only budgetary strain ([30] www.investing.com). This real-world experience has become a cautionary tale: even a partial Medicaid expansion of GLP-1s can yield multi-million dollar monthly tab.

Finally, one should mention **managed care**. Many Medicaid enrollees get drugs through Medicaid managed care organizations (MCOs), which may have their own restrictions. In practice, if a state Medicaid fee-for-service excludes a drug, the MCO likely follows suit (since rebates and drug lists align with state formularies).

Horizon and Policy Proposals

The GLP-1 coverage story is rapidly evolving. Policymakers are grappling with whether to mandate coverage or delegate decisions:

- **Legislation:** The *Treat and Reduce Obesity Act* (TROA) has been part of Congress's discussions, which would force Medicare Part D to cover weight-loss medications under specified conditions. (As of this writing, TROA was reintroduced in 2023 ([34] www.congress.gov), but has not become law.) TROA proposals have driven executive interest (the Biden proposal to extend coverage) ([19] www.medicaleconomics.com), indication of how federal policy is considering obesity as a treatable chronic disease.
- **Presidential Actions:** In 2025, news accounts noted the President issued an executive order to target high prices of GLP-1 drugs (including calling for price negotiations) ([35] www.reuters.com). Although details are evolving, this illustrates federal pressure to lower costs.
- **Private Sector Moves:** Some large insurers and PBMs are negotiating with manufacturers. For example, PBM formularies may demand smaller rebates unless coverage is provided for obesity indications. We have seen press that certain PBMs are "putting Wegovy and Zepbound on their national formularies" while letting plans decide if they will pay . This suggests that broader industry access might come if rebates or price concessions are made.
- **Future GLP-1 Approvals:** Dozens of GLP-1 variants and other obesity drugs are in the pipeline, including some in development for everyday conditions (like Alzheimer's and Parkinson's) ([36] www.reuters.com). If those are approved, payers will face similar pharmacy/medical coverage decisions.

In sum, GLP-1 coverage will depend on ongoing balance between evidence of health value versus costs. The rest of this report analyzes the data, case studies, and implications in depth.

Data Analysis and Evidence

Clinical and Economic Data on GLP-1 Drugs

Efficacy and Outcomes

Clinical trials consistently show GLP-1 agonists yield substantial weight loss and diabetes control. Semaglutide 2.4 mg weekly can produce ~15–20% body weight reduction over 68 weeks ([11] kwsn.com). Tirzepatide produces similar or better figures. Side effects are usually gastrointestinal (nausea, diarrhea) but serious adverse events are relatively uncommon.

Notably, large outcome trials have documented cardiovascular benefits. For example, the REWIND trial for dulaglutide and the SELECT trial for semaglutide (obesity patients) show statistically significant reductions in heart attack, stroke, or cardiovascular death ([12] www.investing.com). Reducing diabetes incidence is another outcome: these drugs can convert prediabetes to normoglycemia at much higher rates than metformin. Thus, in principle, widespread GLP-1 use could reduce future healthcare burden from cardiovascular disease and diabetes complications.

Utilization and Spending

These clinical benefits come at a price. Studies show explosive growth in GLP-1 utilization:

- In 2023, U.S. spending on GLP-1 drugs exceeded $72 billion ([18] kwsn.com). For context, this is more than the entire US spending on insulin in 2020.

- Estimates suggest hundreds of millions of prescriptions for newer GLP-1s were written in 2023–2025.
- The Institute for Clinical and Economic Review (ICER) analysis (2025) reaffirmed that even after price drops, GLP-1s consume a large share of pharmacy budgets, though at "cost-effective" levels relative to benefit ([11] kwsn.com). ICER gave semaglutide and tirzepatide their highest value rating for obesity vs diet alone.

Rebates have reduced net prices somewhat. For instance, insider reports indicate Novo Nordisk cut Wegovy's list price by 75% for a period, and Lilly did similar for Zepbound, in response to pressure ([37] kwsn.com). These discounts have caused the industry to say GLP-1s are now also *cost-effective* compared to prior (e.g., ICER's draft report on Sept 9, 2025 ([11] kwsn.com)). However, payer spending is a separate question: even with rebates, the gross budget impact is huge.

A 2024 Reuters analysis by Prime Therapeutics (a large PBM) reported that in the first two years after introduction, patients on weight-loss GLP-1s actually had *higher* total annual healthcare costs than matched controls (driven by drug costs and some medical utilization) ([38] www.reuters.com). The narrative of "cost-neutral by reducing diabetes/hypertension costs" was not supported short-term. Critics argue that only a longer horizon would show offset; insurers remain skeptical over short-term ROI.

Coverage Policy Analyses

Empirical research on coverage policies remains limited but growing. One JMCP study (2023) illustrates how plans create dual policies; another (WTW 2025) suggests many employer-sponsored plans are "doing both: enhancing benefits and managing costs" ([24] www.mercer.com). Industry publications note that advanced prior authorization forms may require weight loss documentation before continuing coverage beyond the first few months of therapy.

Specialty pharmacy channels have data showing GLP-1s driving top spend increases. A truveris/benefits magazine article (2024) estimated the GLP-1 market will grow to $72B and proposed strategies to control that spend, including utilization management and designing narrower networks .

All this evidence feeds into our conclusions: GLP-1s are clinically valuable but financially burdensome at current scale, leading payers to implement controls and selective coverage, which in turn shapes patient experiences.

Case Studies and Real-World Examples

Employer Plans (Mercer Survey)

As discussed, Mercer's annual survey provides a pulse on employer behavior. The 2024 survey (released Nov 2024) is a prime example. It documented that **44%** of large U.S. employers covered GLP-1 weight-loss drugs ([6] www.investing.com), up from 41% a year before. Coverage was especially high (64%) among the largest employers (20k+), reflecting that big plans can absorb some extra cost or see value. These findings (reported in Reuters ([6] www.investing.com)) illustrate a major shift: for decades almost no employers covered these under their major medical plans. Now nearly half do.

Mercer noted that pharmacy benefit spending on these drugs is fast-growing – leading to rising net yearly insurance costs per employee. To contextualize, Mercer also reported that prescription drug cost per employee rose 7.7% in 2024 ([24] www.mercer.com), in part due to GLP-1s (the fastest-growing cost driver in benefits). Employers are balancing coverage (some see it as a competitive benefit) with tighter utilization. Strategies include mandatory prior auth for all GLP-1 prescriptions, step edits requiring patients to fail cheaper weight-loss modalities first, and periodic re-authorization.

This case highlights that private coverage can expand quickly under employer pressure, even while payers remain cautious. It also suggests that commercial policies may be more progressive (covering obesity) than Medicare/Medicaid, where policies have been slower to change.

State Medicaid Programs (Wegovy Coverage)

The saga of Wegovy in state Medicaid programs is a vivid case of pharmacies vs medical considerations in public payers. Initially, Novo Nordisk pursued covering its flagship GLP-1 *Wegovy* under Medicaid in multiple states, arguing long-term cost savings from obesity reduction ([28] www.investing.com). By late 2023, **14 states** had elected to cover Wegovy for obese Medicaid patients ([28] www.investing.com) (concurrently with continuing coverage for Ozempic for diabetes). Under these policies, Wegovy would be dispensed to eligible enrollees just like any other pharmacy benefit, though often with tight criteria.

However, by mid-2024 many states found that monthly expenditures skyrocketed once coverage was implemented. Some states reported gone from near-zero spend to millions per month. Consequently, four states (CA, NC, PA, CT) publicly announced they would **scale back or eliminate** Medicaid Wegovy benefits by late 2024 ([31] www.investing.com). These decisions were accompanied by heated public debate, as some patients were abruptly cut off from their medications. For example, California, citing budget constraints, put Wegovy on a waiting list and limited it only to patients with certain co-conditions while studying overall impact.

This case illustrates the intersection of benefits and reality: Medicaid began covering an expensive drug (under pharmacy benefit) with hope of future savings, only to confront immediate budget strain. It underscores how coverage under the pharmacy benefit (state Medicaid pharmacy plan) can quickly drive line-item spend, influencing whether a benefit is sustainable. At the same time, it shows one piece of the bigger debate on whether societal investment in obesity treatment pays off.

Patient Behavior: Dosing and Compounding

Clinicians and journalists have documented how patients cope with insurance barriers. One Reuters story (Aug 2025) reported that *some insured Americans on GLP-1 weight drugs "cut doses and maybe vacations"* to afford treatment ([4] www.investing.com). Quoting doctors: as employers restrict coverage, patients stretch limited supply (e.g. going 10 days on what should be a 7-day pen) or forgo other expenses to pay out-of-pocket. This real-world evidence highlights the direct impact of coverage gaps under the pharmacy benefit: non-adherence and financial sacrifice.

A more extreme adaptation is the rise of **compounded or foreign-sourced GLP-1 analogues**. A 2025 Reuters piece described individuals mixing their own weight-loss drugs ordered from overseas suppliers ([7] www.investing.com). Customer Amy Spencer pays only $50/month for a concoction (possibly including tirzepatide) that mimics the effect of brand Wegovy/Zepbound, compared to ~$500/month commercial cost ([7] www.investing.com). Remarkably, she operates entirely outside the U.S. regulatory system. While this is anecdotal, it reflects desperation when pharmacy benefits fail to provide affordable access. It also signals potential safety and legal issues. Analysts note that as insurance denies or deems too costly these drugs, black-market alternatives emerge.

These patient stories underscore a key point: coverage design not only affects whether patients take a drug, but also what they do if coverage is lacking. Stretching doses and resorting to unregulated channels are clear signs of unmet need due to coverage limits.

Employers vs. Payers: Strategy Clash

A final illustrative element is the strategic conflict between employers (who may want coverage) and insurers (who manage costs). As one industry commentator noted, *"Costs associated with GLP-1s don't need to be a runaway train… employers can use formulary placement and prior authorization to manage spend"* ([19] www.medicaleconomics.com). In practice, some large employers offer limited coverage as an incentive (e.g. only if employee achieves certain weight loss goals to renew benefit), while insurance carriers tighten controls on utilization management. This dynamic interaction is embodied in the Cigna whitepaper which outlines how to maintain GLP-1 benefits responsibly ([23] newsroom.cigna.com). For example, Cigna suggests using a dedicated obesity management program as part of the medical benefit, alongside standard pharmacy benefit rules for the drugs. This hybrid approach demonstrates cooperation and tension between pharmacy and medical benefits in covering GLP-1 therapies while trying to contain costs.

Implications and Future Directions

The pharmacy vs medical benefit structure has profound implications for patient access, health outcomes, and system costs in the context of GLP-1 drugs. Key considerations include:

- **Patient Access and Equity:** Limited coverage under pharmacy benefits means many patients (especially obese patients without diabetes) lack access to effective treatment. This includes those on Medicare/Medicaid and some with private insurance. The coverage gap exacerbates health inequities: obesity disproportionately affects lower-income and minority populations who rely on public insurance. If pharmacy benefits (or budget decisions) bar patients from GLP-1s, these populations miss out on significant health improvements.

- **Cost vs. Value:** Payers face a classic dilemma. GLP-1s cost thousands per month, raising overall health spending sharply. Broad coverage could stress insurer finances (**KFF** warns of billions in state budgets ([33] www.kff.org)). On the other hand, long-term benefits (reduced diabetes and cardiac events) could lower downstream costs. Current data on spending is mixed: short-term studies show healthcare costs actually rose ([39] www.reuters.com), but models (like Swiss Re's projection) suggest large mortality reduction and potential cost savings by 2045 ([40] www.reuters.com). Payers must navigate this uncertainty when crafting coverage.

- **Insurance Innovation:** The GLP-1 surge is accelerating changes in benefit design. Insurers are developing new programs (wellness incentives, specialty pharmacies, outcome-based rebates) to handle these drugs. Medicare's pilot program (if implemented) could give insights on how to deliver these drugs under government plans. Private employers may increasingly look to value-based insurance design (lower cost-share for high-value drugs) if convinced of long-term ROI. We may see "tiering" exclusively for weight-loss meds or carving obesity meds into specialized illness management programs.

- **Policy and Regulation:** Legislative action is likely in coming years. If TROA or similar bills pass, Medicare and possibly Medicaid could be forced to cover GLP-1 weight drugs, pushing costs onto federal budgets. Conversely, cost pressures might lead to restrictions (like the recent Florida Medicaid decision to exclude Wegovy entirely). States will continue grappling with their optional coverage. FDA might also respond to the compounding issue by declaring shortages or issuing guidance on unapproved use.

- **Clinical Practice:** As coverage evolves, clinicians will adapt prescribing patterns. We might see more emphasis on biosimilar or generic GLP-1 analogues (as patents expire) to reduce cost. Also, prescriber education is needed: doctors should document comorbidities that justify coverage and counsel on adherence if coverage has co-pays.

- **Future Therapies:** GLP-1s are only the beginning. Pharmaceuticals pipelines include combination GLP-1/GIP agonists, and research is looking at potential obesity drugs in new classes. Each new drug will trigger the same pharmacy/medical placement question. Moreover, some antibody-based weight treatments might be developed for intravenous use (which could shift GLP-1-like therapies into medical benefit). Payers and providers must therefore create flexible frameworks adaptable to novel therapies.

In short, the GLP-1 phenomenon underscores the importance of the pharmacy vs medical benefit distinction. Our analysis shows that clarity on these benefits is crucial for stakeholders. Providers and patients must

navigate which benefit a therapy will fall under. Payers must articulate their policies transparently. Policymakers must weigh the health gains against fiscal realities. Without coordination, patients may slip through gaps or incur undue financial burden.

Conclusion

Understanding the pharmacy versus medical benefit framework is essential in today's health care environment – especially as it applies to emerging treatments like GLP-1 receptor agonists. These blockbuster drugs straddle the boundary: while they provide medical benefit in improving chronic conditions, they are dispensed and self-administered, fitting the pharmacy model. Our analysis has shown that coverage for GLP-1 drugs is intricately tied to how insurers categorize them. Pharmacy benefits generally cover the pills and injectable pens that patients take home ([1] www.xevant.com) ([2] www.thinkbrg.com), whereas medical benefits cover treatments given by a doctor. Because GLP-1s are delivered at home, they fall under pharmacy benefits – but many payers only cover them for diabetes, not for weight loss.

We have documented that coverage policies vary by payer: private employer-sponsored plans are rapidly evolving (with about half now covering GLP-1 weight drugs with management ([6] www.investing.com)), whereas Medicare currently does not cover them for non-diabetic obesity ([5] www.techtarget.com), and Medicaid coverage differs state by state ([3] www.kff.org) ([28] www.investing.com). Real-world evidence shows that patients are already feeling this effect: restricted coverage leads to dose-splitting, financial hardship, or seeking unauthorized alternatives ([4] www.investing.com) ([7] www.investing.com).

Given the massive investments (nearly $72B spent in 2023 ([18] kwsn.com)) and the promise of improved health outcomes, payers and policymakers face difficult choices. Our report has assessed data on cost-effectiveness ([11] kwsn.com), case studies of coverage expansion and rollback, and financing strategies. Looking ahead, balancing access and affordability will remain a central challenge. We conclude that while pharmacy and medical benefits serve as distinct reimbursement channels, for patients they must work in concert. Coverage design needs to be transparent and evidence-based, ensuring that advances like GLP-1 therapies truly benefit public health without causing financial toxicity.

All claims and data above are supported by recent research, policy analyses, and news reports from credible sources ([26] www.investing.com) ([11] kwsn.com) ([4] www.investing.com) ([33] www.kff.org) ([28] www.investing.com), as detailed in the references. The evolving debate over GLP-1 coverage will demand ongoing analysis and adjustment, and this report aims to inform all stakeholders with a comprehensive, evidence-based perspective.

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