GLP-1s:
Good Drugs, High Prices

November 2026



CVS Health

Executive Summary

GLP-1 drugs work. The challenge is paying for what they deliver.

THE CLINICAL PROMISE

Glucagon-like peptide-1 receptor agonists, known as GLP-1s, have shown substantial clinical benefit across a growing range of conditions. Developed for type 2 diabetes mellitus, they are now indicated for obesity and for cardiovascular, liver, and kidney disease, with more indications on the horizon. But clinical effectiveness alone will not deliver their full potential. As approved indications widen, demand for off-label cosmetic weight loss grows, and health care affordability remains a significant barrier for the everyday consumer, a clear real-world accounting of costs and benefits can help employers and payers build strategies that fit the populations they cover.

THE AFFORDABILITY CHALLENGE

Pressure from payers, consumers, and government has pushed list, net, and cash-pay prices down, but GLP-1s still add meaningfully to unsustainable health care cost trend increases. GLP-1s account for roughly half of prescription drug spending growth. Realizing their clinical potential at scale will require a more sustainable approach to access and affordability.

~8 in 10

employers identify GLP 1s as a key driver of rising health care costs

The challenge, then, is not whether GLP-1s deliver value, but how to translate that value into broader, affordable access.

GETTING THE GLP-1 VALUE EQUATION RIGHT REQUIRES 3 THINGS:

1

RIGHT PATIENT

Focus on the people most likely to benefit, based on clinical evidence and individual needs

2

STAY ON THERAPY

Support people in starting and staying on treatment to achieve better health outcomes

3

SUSTAINABLE PRICE

Increase broader access through more affordable pricing so more people can benefit

In this study, we look at real-world outcomes among commercial fully insured GLP-1 users with index years 2023-2025 and up to three years of follow-up. The findings tell a straightforward story:

> **GLP-1 use was associated with better clinical outcomes, lower hospital use, and lower medical spending;** however, total cost of care is higher for GLP-1 users than for matched non-users, because pharmacy spending rises more than medical spending falls.

Financial break-even is not the only measure of a drug's value, but it is an important benchmark for employers and payers setting coverage policies. For medicines as effective as GLP-1s, the goal is to expand access while preserving value at scale. Lower prices would make a real difference. But even at today's prices, ensuring that high-risk patients have access, and that people who benefit from GLP-1s can stay on them, can deliver real health care value.

GLP-1s are among the most promising therapies of our time. They are effective drugs, and millions of people could benefit from them. But for health care to be affordable, the price has to be right. Get it right, and broadly accessible GLP-1s can be both clinically transformative and economically sustainable.

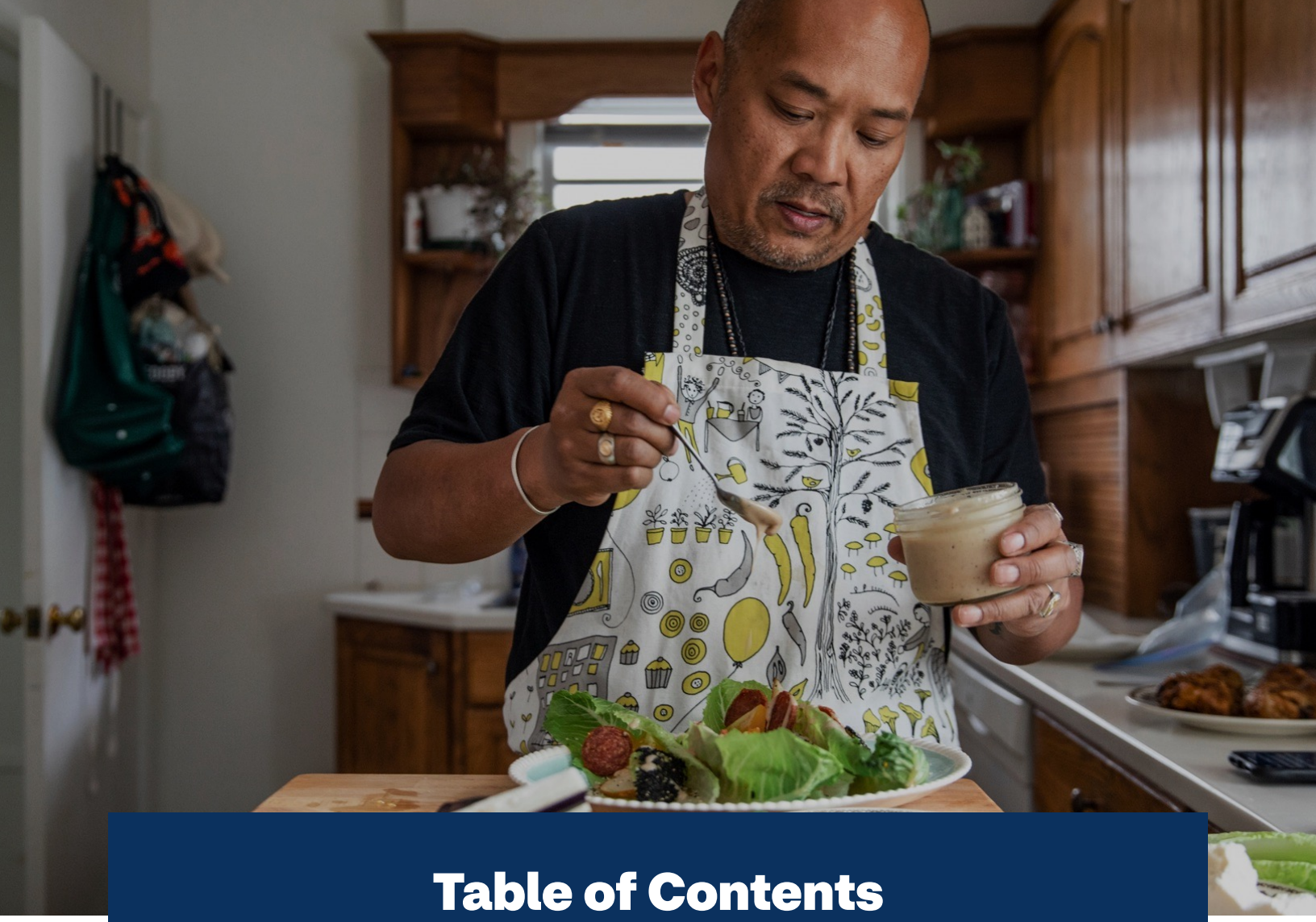


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The Transformative Potential

GLP-1s are powerful, multi-indication therapies with the potential to transform cardiometabolic health.

~ 3×

rise in obesity since the early 1960s

39.9%

peak obesity rate, 2022

37.0%

obesity rate declining since the 2022 peak

Paradigm-shifting drugs are rare, but when they emerge, they transform medicine. Antiretroviral therapy turned human immunodeficiency virus from a fatal diagnosis into a manageable chronic condition. The advent of immunotherapy has given hope to many fighting cancer. GLP-1s seem poised to be the next such advance. They have already begun to change how society sees obesity: not as a moral failing, but as a chronic disease with effective treatment. That promise makes sustainable access an urgent question.

Obesity (body mass index, BMI ≥30 kg/m^2) in the United States (US) has roughly tripled in prevalence since the early 1960s[1]. Along with genetic and biological predisposition, ultra-processed, calorie-dense foods, sedentary lifestyles, and inadequate sleep can contribute to developing obesity. But after decades of increasing prevalence, the trend may be starting to turn. The US adult obesity rate declined from a peak of 39.9% in 2022 to 37.0% in 2025[2], a drop that coincided with a sharp rise in GLP-1 use (Figure 1).

Figure 1. After Decades of Growth, Obesity Rates in the United States May Be Turning a Corner

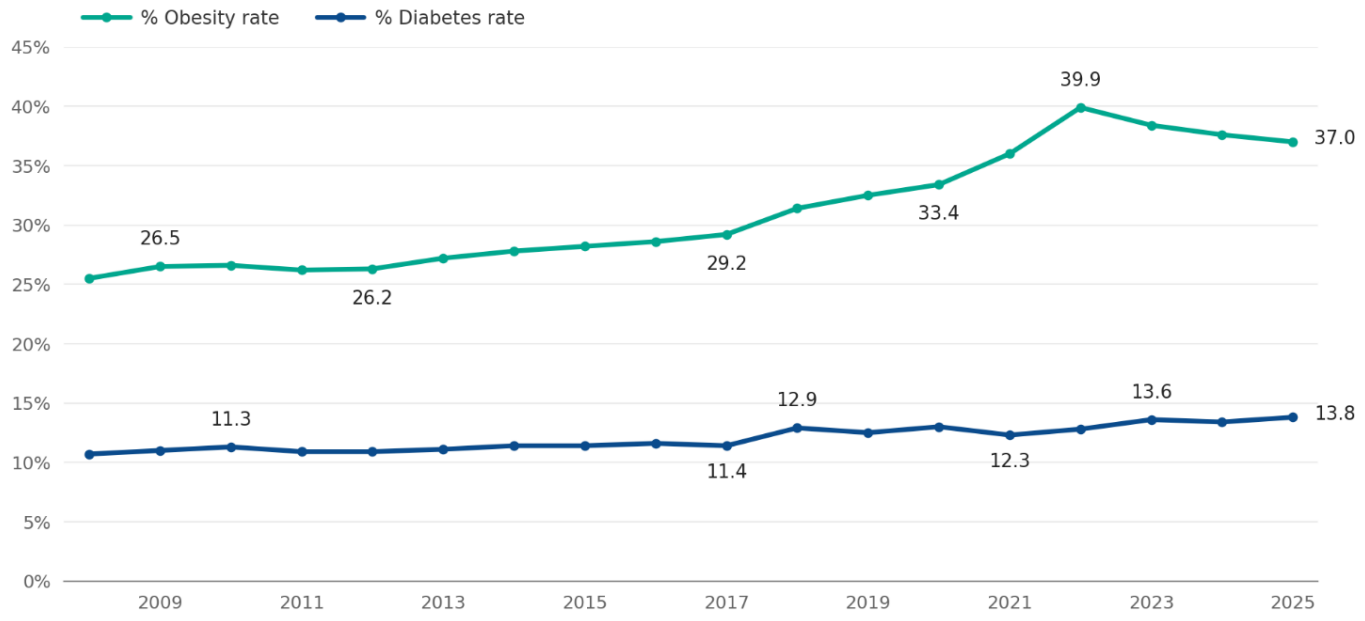


Figure 1 Legend. Adapted from Gallup National Health and Well-Being Index, 2025[2]. United States prevalence (%) of self-reported diagnoses of obesity (green) and diabetes (blue) from years 2008-2025.



GLP-1s: ORIGINS AND MECHANISM

GLP-1 therapies grew out of research into incretin hormones; GLP-1 itself was identified in the early 1980s. Engineered to last far longer than the body's natural hormone, these drugs stimulate insulin release when blood sugar is high, slow gastric emptying, and reduce appetite through the brain, supporting glucose regulation and weight loss with a lower risk of hypoglycemia. Earlier drugs such as exenatide and liraglutide paved the way for newer agents: semaglutide and tirzepatide, the latter of which also activates the receptor for glucose-dependent insulinotropic polypeptide.

USE BEYOND OBESITY AND DIABETES

GLP-1-based therapies are no longer just for obesity and diabetes. FDA-approved uses now include reducing major cardiovascular events, slowing kidney disease progression in adults with type 2 diabetes and chronic kidney disease, treating metabolic dysfunction-associated steatohepatitis, and treating obstructive sleep apnea in adults with obesity. Researchers continue to explore what else this class of medicines can do, including how patients can best navigate side effects and effectively support treatment with nutritional and lifestyle adjustments.

THE ACCESS GAP

Despite the breadth and strength of the evidence, access has not kept pace with clinical need. More than 137 million US adults are medically eligible for semaglutide, with many qualifying under more than one indication: 35 million for diabetes, 129 million for obesity, and 9 million for secondary cardiovascular prevention. Use for approved conditions is likely to keep growing[3]; however, high prices, variable insurance coverage, and out-of-pocket costs limit real-world access for many. The clinical promise is enormous. The challenge is designing access and coverage approaches that turn that promise into durable clinical benefit at a sustainable cost.

137M
US adults medically eligible for semaglutide

BY INDICATION (MANY QUALIFY UNDER MORE THAN ONE)

35M
diabetes

129M
obesity

9M
secondary cardiovascular prevention

What the Real-World Evidence Shows

The clinical story is compelling, with generally more favorable outcomes among people who stay on treatment.

MATCHED COMPARISON

To understand how GLP-1s perform in the real world, we compared commercial fully insured GLP-1 users with similar people who did not use GLP-1s. We matched the groups of Aetna® members based on factors that could affect their outcomes, including age, existing health conditions, prior health care use, and medical and pharmacy spending. Using anonymized Aetna claims data, we then looked at what happened to their health, health care utilization, and costs over a follow-up period extending to three years (Figures 2 and 3).

DOES STAYING ON TREATMENT MATTER?

We also looked at whether staying on treatment made a difference. We compared everyone who started a GLP-1 ("initiators") with members whose prescriptions covered at least 80% of the days during follow-up ("adherent"), measured using proportion of days covered (PDC ≥ 80%), a standard measure of medication adherence.

Figure 2. Clinical and Utilization Outcomes Among GLP-1 Users by Treatment Adherence

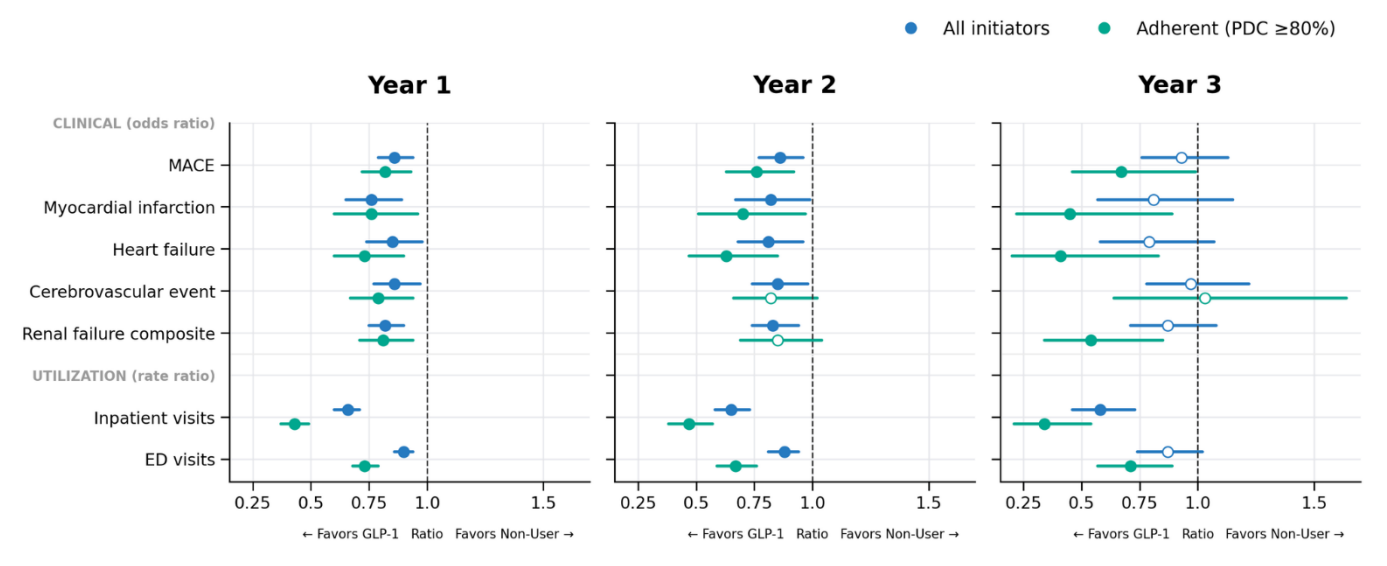


Figure 2 Legend. Observational, propensity-matched analysis of commercial fully insured Aetna® members comparing GLP-1 users (All Initiators, Blue; Adherent, Green) with matched non-users. Clinical outcomes are reported as odds ratios (ORs) and utilization outcomes as incidence rate ratios (IRRs), with 95% confidence intervals. Values below 1.0 favor GLP-1 users. Filled markers indicate statistically significant differences ($P<0.05$); open markers indicate differences that were not statistically significant ($P\geq0.05$). Adherence was defined as cumulative proportion of days covered (PDC) ≥ 0.8. Year 1, year 2, and year 3 populations were matched and analyzed separately and should not be interpreted as a single cohort's longitudinal trajectory. Associations do not establish causality and may reflect selection and healthy-adherer bias. The smaller year 3 sample warrants cautious interpretation.
Abbreviations: ED, emergency department; MACE, major adverse cardiovascular events.

What the Real-World Evidence Shows

Continued

The results were encouraging. Among all initiators, GLP-1 use was associated with fewer hospitalizations and emergency department visits, along with generally more favorable cardiovascular and kidney outcomes than among matched non-users (Figure 2). Hospitalization rates were 34–42% lower across the three years in the follow-up period. Emergency department (ED) visit rates were 10–12% lower in years 1 and 2.

34 – 42%

lower hospitalization rates over 3 years

10 – 12%

lower ED visit rates, years 1 2

14%

lower odds of major adverse cardiovascular events

We also saw favorable outcomes in the earlier year analyses. All initiators had 14% lower odds of major adverse cardiovascular events, 18–24% lower odds of heart attack, 15–19% lower odds of heart failure, and 17–18% lower odds of a composite renal failure outcome compared with matched non-users.

By year 3, however, fewer members had sufficient continuous enrollment and follow-up to be included in the analysis, resulting in a smaller sample and making some differences harder to distinguish from chance.



ADHERENT MEMBERS: GREATER DROPS IN HOSPITALIZATIONS AND ED VISITS

Findings were generally more favorable among adherent members. Across the sequential follow-up periods, hospitalization rates were 53–66% lower, ED visit rates were 27–33% lower, and odds of major adverse cardiovascular events were 18–33% lower in adherent GLP-1 users compared with matched non-users. In year 3, adherent members also had 55% lower odds of heart attack and 59% lower odds of heart failure than matched non-users, although that analysis had fewer matched pairs than those analyzed in years 1 and 2.

Together, these real-world findings reinforce the clinical promise of GLP-1 treatment, especially for people who are able to stay on it.

The Economics of GLP-1 Value

The clinical value is clear. Now we need to make the economics work.

Across the separately matched follow-up analyses, GLP-1 use was associated with lower medical spending, but pharmacy spending was higher (Figure 3). Medical spending was $1,300 lower per member in the year 1 analysis and $9,400 lower in the year 3 analysis, consistent with the lower hospital and ED use described in the previous section.

$13,300 higher net pharmacy spending per member

–

$9,400 lower medical spending per member (year 3)

=

$3,900 net increase in total cost of care per member

In the year 3 analysis, medical spending was $9,400 lower per member among all GLP-1 initiators, while incremental net pharmacy spending was $13,300 higher, a net increase in total cost of care of about $3,900 per member. Among adherent members, medical spending was $13,000 lower and incremental net pharmacy spending was $20,300 higher, a net increase of about $7,300. The larger medical savings among adherent members did not offset their higher medication costs at 2023–2026 prices; more consistent use of the drug means more pharmacy spending. Figure 3 shows the detailed net cost comparison.

Figure 3. GLP-1 Value Equation: Medical Cost Savings Grow, but Pharmacy Costs Grow Too

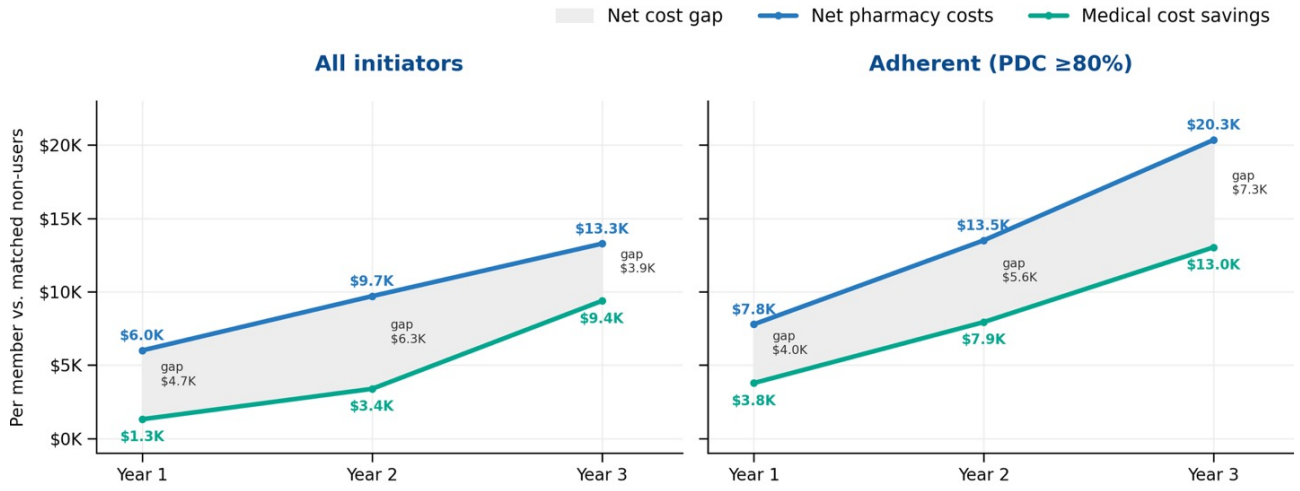


Figure 3 Legend. Observational, propensity-matched analysis of commercially fully insured Aetna® members comparing GLP-1 users with matched non-users. Values represent per-member differences in costs (net pharmacy costs, blue; medical cost savings, green) between GLP-1 users and matched non-users for each follow-up period. Net pharmacy costs include GLP-1 spending and reflect rebates and discounts; medical cost savings represent lower medical spending among GLP-1 users relative to matched non-users. The shaded area (gray) represents the remaining net cost gap, calculated as incremental net pharmacy costs minus lower medical costs. Adherence was defined as cumulative proportion of days covered (PDC) ≥ 80%. Year 1, year 2, and year 3 populations were matched and analyzed separately and should not be interpreted as a single cohort's longitudinal trajectory. Associations do not establish causality and may reflect residual confounding, including selection and healthy-adherer bias. The smaller year 3 sample warrants cautious interpretation.

The Economics of GLP-1 Value

Continued

GLP-1 use was associated with meaningful reductions in medical costs, but higher pharmacy costs more than offset those savings, increasing the total cost of care.



That raises the question:

At what net price would the medical savings observed offset the added pharmacy spending for a defined population and time horizon?

A treatment need not pay for itself to provide value. But in a world where health care is unaffordable for many, financial break-even remains a useful pricing benchmark. For the overall population in our analysis, internal modeling suggests that a net price of approximately $350 per month over three years would bring pharmacy spending and observed medical savings into balance. That is an average across the study population, not a single break-even price that applies to every patient or indication. The economics will vary based on factors like underlying clinical risk of people treated, how long they stay on treatment, and how adherent they are to therapy. A higher-risk patient with diabetes, for example, may have a different opportunity for near-term medical savings than a younger patient with obesity and lower short-term risk.

The aim is not to insist that GLP-1 treatments for every patient should pay for themselves, or to make savings the sole test of coverage. It is to align what we pay with what patients gain clinically, what the health system saves, and what broad access will cost. In our analysis, lower net prices are what close the gap.

The Importance of Staying on Treatment

Getting people on treatment is only part of the equation. Helping them stay on it matters too.



Taken together, the clinical and economic findings show why staying on treatment matters—and why access alone cannot solve the value equation. Obesity, like diabetes or hypertension, is a chronic condition, and for many people who benefit from GLP-1 therapy, treatment is not short-term. Success therefore means more than starting therapy: it means helping people stay on it while it works.

ALL INITIATORS

$9,400
lower medical spending (year 3)

$3,900
net cost increase (year 3)

vs

ADHERENT MEMBERS

$13,000
lower medical spending (year 3)

$7,300
net cost increase (year 3)

Figures 2 and 3 show why staying on treatment matters. Compared with matched non-users, adherent members had better clinical outcomes, lower hospital and ED visit rates, and larger medical spending reductions than all initiators did. By year 3, medical spending was $13,000 lower among adherent members compared with $9,400 lower among all initiators. At the same time, adherent members used more of the drug, so higher pharmacy spending left a larger net cost gap. That is why helping patients stay on beneficial treatment also requires a price that makes long-term use affordable, as well as additional research into how to effectively help patients manage side effects.

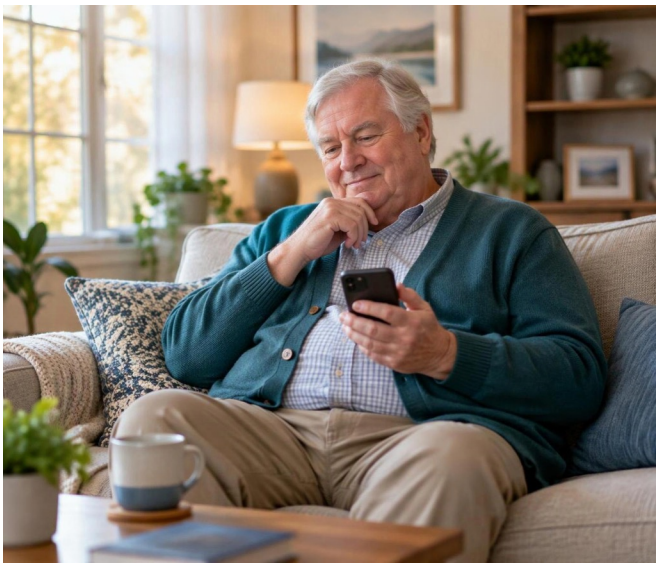
Shifts in the Cash-Pay Market

Lower cash prices expand access. How we expand it matters.

Novo Nordisk® and Eli Lilly® have teamed with the US government to cut the out-of-pocket price of GLP-1 therapies sold directly to consumers—the "cash-pay market" for patients who buy without insurance. The TrumpRx platform now provides access to GLP-1 therapies at cash prices far below list[4]. For people without coverage, that can meaningfully lower the barrier to treatment.

For people with insurance, the question is whether lower prices come with strings attached. Making GLP-1s easier to access is important, but access and appropriate use must go hand in hand. **We should be able to do both: lower prices and make eligibility simple and fast to confirm, without extending coverage beyond medical need.**

Botox® offers a useful comparison. Insurance may cover it for chronic migraine, muscle spasms, and overactive bladder, but people generally pay out-of-pocket to smooth forehead wrinkles. GLP-1s should work the same way. Coverage criteria can help distinguish between use for a medical need and use outside those needs. Studies show GLP-1s are safe and effective for people with obesity, diabetes, and cardiovascular risk, while the evidence is much more limited for healthy-weight people seeking cosmetic weight loss. These coverage criteria are not intended to keep people from effective treatment. They are intended to align coverage with medical need, which matters deeply when millions of people may qualify and the cost ultimately affects premiums.



$28,303

average annual premium for employer-sponsored family coverage, 2026

Cost matters even when a treatment works. In 2026, the average annual premium for employer sponsored family coverage reached $28,303, up 5% from 2025, placing enormous pressure on employers and families[5]. Covering an expensive drug beyond medical need would add spending without clear clinical justification.

Getting the GLP-1 Value Equation Right

For GLP-1s to reach their full potential, the right patients need access to clinically effective treatment at a sustainable price.

For people with a clinical indication, manufacturers should offer health plans and employers net prices at least comparable to cash-pay prices for the same product and dose. Price concessions should not require abandoning evidence-based eligibility criteria, but those criteria should be applied through a quick and simple eligibility process that does not create unnecessary barriers to treatment. As new oral therapies and additional GLP-1–based medications enter the market, competition creates an opportunity to improve affordability without weakening appropriate coverage.

The economics* are moving in the right direction. Prices have fallen for some patients, particularly through cash-pay options, but lower cash prices alone are not the whole answer.

*Economic claims should remain grounded in the populations, prices, and time horizons studied.

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Supporting Information

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Methodology

This retrospective, new-user, matched-cohort study used anonymized Aetna® medical and pharmacy claims to evaluate clinical outcomes, health care utilization, and costs associated with GLP-1 treatment. The study included index years 2023-2025, with a 12-month baseline period and up to three primary 365-day follow-up years, subject to continuous eligibility and claims run-out. Adults initiating a study drug were evaluated against GLP-1–naïve comparison members. Year 1, year 2, and year 3 populations were matched and analyzed separately; therefore, results should not be interpreted as a single cohort followed longitudinally.

Treated and comparison members were matched 1:1 using propensity-score matching based on demographic, clinical, utilization, and cost characteristics. Clinical outcomes were evaluated using logistic regression, utilization using Poisson regression, and costs using adjusted ordinary least squares models. Analyses were adjusted for corresponding baseline measures as applicable.

Results are reported for all GLP-1 initiators and separately for adherent users with cumulative PDC $\geq$ 0.80 through the applicable follow-up period. The PDC threshold was applied before matching. Because adherence is measured after treatment initiation, adherent users may differ from other initiators in ways associated with outcomes. The adherent-user analysis should not be interpreted as demonstrating that adherence caused the observed differences.

This observational study identifies associations and does not establish causality. Propensity-score matching reduces measured baseline differences but cannot account for unmeasured confounding. Claims indicate medication availability but do not confirm actual use, and longer follow-up periods include progressively smaller eligible populations. Economic findings and modeled break-even estimates should be interpreted within the populations, products, prices, and follow-up periods studied and should not be considered universally applicable estimates or price recommendations.