



# HOW CAN EMPLOYERS BUILD AN EFFECTIVE GLP-1 EMPLOYEE BENEFITS STRATEGY?

INSIGHTS FROM MAXIS DATA



● **MetLife** and **AXA** in partnership

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EXECUTIVE SUMMARY

How can employers build an effective GLP-1 strategy – and sustain it?

by **Mattieu Rouot**,  
Chief Executive Officer at MAXIS GBN

For patients, GLP-1s have the potential to be life-changing – even life-saving – therapies.

Initially developed to improve glycaemic control in people with type 2 diabetes, GLP-1s are now also being used to manage obesity and, for certain patient populations, to reduce cardiovascular risks, protect kidney health and treat other obesity-associated conditions like obstructive sleep apnoea.

For employers and insurers, this widening clinical potential creates both an opportunity and a challenge.

In the long-term, GLP-1s could lead to a healthier and more productive workforce, as well as resulting in savings on medical spend as more employees live life at a healthy weight, improve diabetes control and reduce their risk of other costly chronic diseases.

The hope is that these improvements could ultimately moderate medical and disability expenditure, along with productivity losses.

However, these potential benefits must be weighed against substantial upfront costs, as our data shows that GLP-1s are now the second-fastest-growing category of pharmaceutical spend within multinational employee benefits (EB) programmes, second only to oncology drugs.



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Adding to that challenge, employers are confronted with uncertain and potentially delayed returns on investment in GLP-1 therapies, as well as variations in clinical response and high rates of treatment discontinuation. Consequently, the cost-benefit calculation for EB remains difficult to make with precision.

But for employers, taking no action risks overlooking an opportunity to address one of the most significant health challenges affecting today's workforce. More than one billion people globally are living with obesity and 43% of adults are overweight, with higher-than-optimal Body Mass Index (BMI) associated with approximately 3.7 million deaths a year.<sup>1</sup> At the same time, approximately 589 million adults are living with diabetes – a condition responsible for an estimated 3.4 million deaths annually and more than US \$1 trillion in direct global health expenditure in 2024.<sup>2</sup>

The economic implications extend further. Without interventions, the global cost of overweight and obesity is projected to reach US \$3 trillion annually by 2030 and more than US \$18 trillion by 2060.<sup>3</sup> These figures include not only healthcare expenditure, but also the consequences of premature mortality, disability and lost productivity. The question for employers is therefore not only whether to cover a new generation of weight-loss medicines – it is how GLP-1 therapies can be incorporated responsibly into a broader, evidence-based cardiometabolic health strategy.

The GLP-1 conversation continues to dominate headlines at least in part because it requires a radical rethink in how healthcare decision-makers view weight loss.

While behavioural and nutritional interventions remain essential to preventing obesity and related metabolic diseases, traditional advice to eat less and exercise more has not, on its own, reversed the prevalence of either problem.

The emergence of effective pharmacological treatment for obesity as a disease therefore places employers and insurers in an extraordinary – and potentially consequential – position.

In this whitepaper, Dr Leena Johns and her team have analysed the fascinating claims data we collect at MAXIS and have spotted a significant gap between the number of multinational employees whose health profiles suggest that they may meet recognised clinical criteria for GLP-1 based treatment and those who are currently receiving these therapies.

This raises a critical question for employers and insurers: not only whether GLP-1 medicines should be covered, but which employees should have access, for which clinical uses and under what eligibility criteria.

There are no easy or universally applicable answers. Our aim for this whitepaper is to provide a balanced and evidence-led examination of this all-important question, framed by our claims data and analysis.

But this whitepaper doesn't only raise questions – it also explores solutions. Dr Leena and her team make a compelling case for the importance of wraparound care in employer-funded GLP-1 programmes.

There are plenty of fascinating insights into the ever-evolving GLP-1 story and I hope the findings help you understand what this changing therapeutic landscape could mean for your organisation, your EB programme and, most importantly, the people those benefits are intended to support. My thanks go to Dr Leena and all involved in producing this whitepaper.

*Leena Johns*



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ABOUT THE AUTHOR



Dr Leena Johns is Chief Health & Wellness Officer at MAXIS GBN, where she leads the Health & Wellness function and serves on the Executive Committee. Based in the United States, she leads a global team responsible for healthcare data analytics, population health insights and health and wellbeing strategy, working with MAXIS member insurers and multinational employers across global markets.

Drawing on her clinical background and extensive experience in global health strategy, Dr Leena combines medical expertise with claims analytics to identify emerging risks, evaluate disease trends and develop evidence-based approaches to workforce health. Her areas of expertise include preventive health, screening, cardiometabolic disease, women’s health and reducing health inequities across diverse populations.

**Dr Leena Johns**  
Chief Health & Wellness Officer at MAXIS GBN

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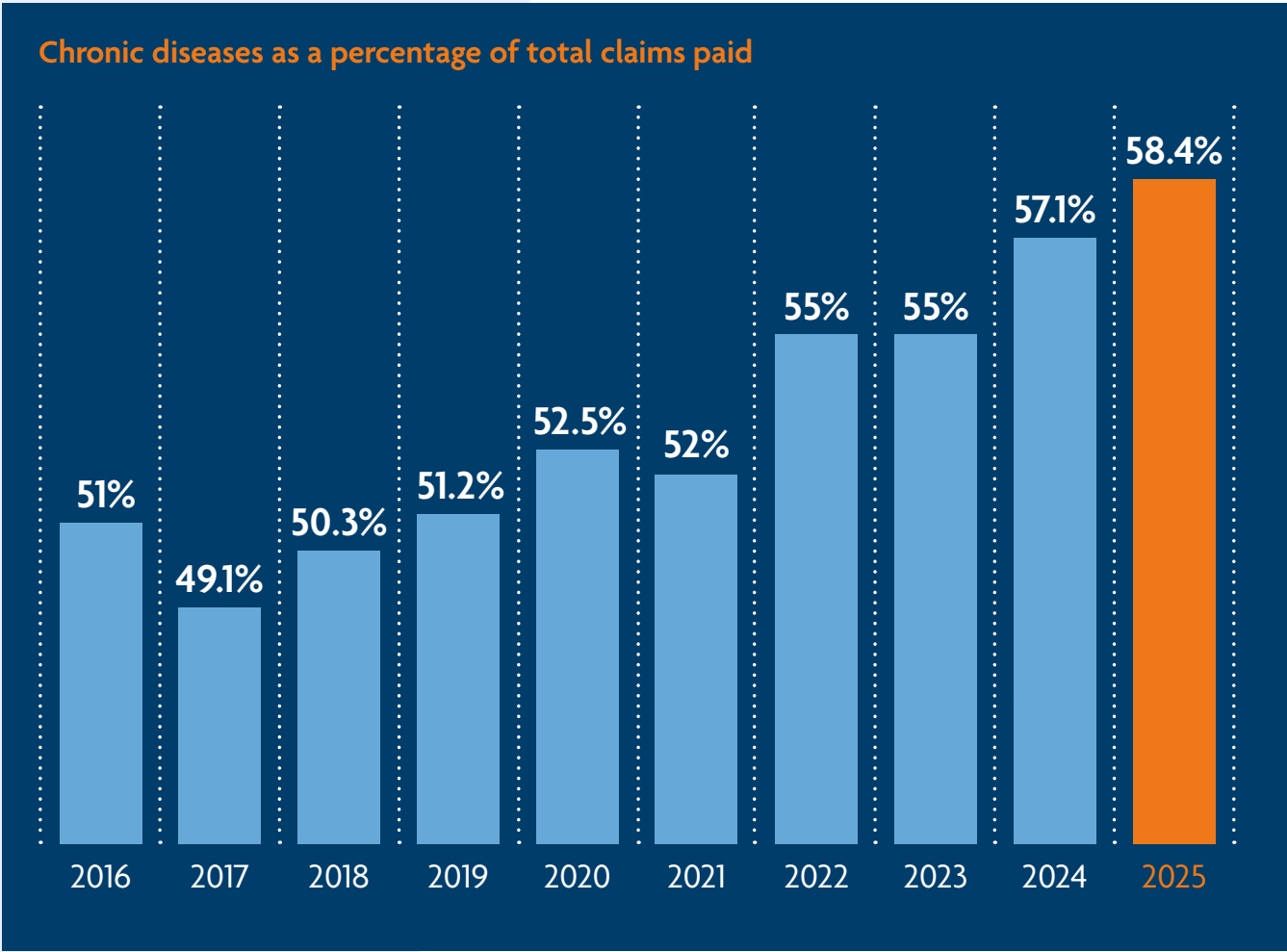
# ABOUT THIS PAPER

The key finding emerging from our MAXIS data is that 38% of claimants across our global portfolio are living with at least one chronic condition. Together, these conditions accounted for 58.4% of total claims paid across the network in the past year, illustrating the disproportionate health and financial burden that long-term disease places on employees, employers and healthcare systems.

As chronic disease affects a significant share of the working-age population, decisions about whether – and how – to provide access to GLP-1 therapies will become increasingly important to multinational employers and insurers. These medicines create a new opportunity to influence diabetes control, obesity and broader cardiometabolic risk, but they also introduce immediate and potentially sustained costs.

This paper uses MAXIS claims insights to examine three questions: how large the potentially eligible workforce may be, how spending patterns change among GLP-1 users compared with eligible non-users and how multinational employers can design access that is clinically appropriate, financially sustainable and supported over the long term.

Our claims insights illustrate why GLP-1 strategy should not be reduced to a binary decision between full coverage and exclusion. Employers have a wider range of options: targeted eligibility, phased market implementation, structured clinical pathways, active purchasing and continuous outcomes monitoring. The greatest opportunity lies not in funding a prescription in isolation, but in designing a programme that balances access, clinical value and affordability.



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# ABOUT OUR DATA

**MAXIS medical claims data comprises private medical claims paid by our network of insurers for multinational clients. The dataset covers 52 insurance partners in 36 countries, more than 7.9 million insured lives, over 1.5 million unique claimants and approximately 50 million claims records.**

Our network of insurers is made up of AXA and MetLife local entities and leading third parties. They operate within diverse healthcare ecosystems, encompassing both public and private healthcare and represent a wide range of healthcare practices, patient experiences and treatment outcomes.

The huge volume of anonymised medical claims data we receive from our network covers our multinational clients’ employees and their dependants. It is standardised by our Health & Wellness team to allow for comparison and in-depth analysis. The results of this analysis form the heart of this whitepaper and have helped to shape the insights you will see throughout.

All data included in this whitepaper is derived from MAXIS medical claims data unless referenced otherwise.

## Key data points

1.

The countries included in our claims data analysis are: Antigua and Barbuda, Bahrain, Belgium, Canada, Chile, Colombia, Costa Rica, Cyprus, Ecuador, Egypt, El Salvador, Greece, Guatemala, Honduras, Peru, Hong Kong, Indonesia, Jordan, Kuwait, Lebanon, Malaysia, Mexico, Nicaragua, Oman, Pakistan, Panama, Philippines, Qatar, Singapore, Spain, Taiwan, Thailand, Trinidad and Tobago, the United Arab Emirates (UAE), United Kingdom (UK) and Vietnam.
2.

Our dataset does not include public health claims data or mortality records – it comprises only the medical claims paid by our partner insurers. These claims are processed according to local insurer policies, which vary significantly from market to market, influenced by factors such as insurers’ risk appetite, regulatory frameworks and market-specific healthcare dynamics. These variations substantially shape the scope of the data we receive and should be considered carefully when interpreting our findings.
3.

MAXIS data does not cover the United States and is derived from healthcare claims data from our insurance partners in markets outside of the US.
4.

For this analysis, ‘chronic disease’ includes a broad range of long-term conditions, including endocrine, cardiovascular, respiratory, gastrointestinal, musculoskeletal, and malignant neoplasm (cancer) conditions. This paper focuses particularly on cardiometabolic diseases relevant to GLP-1 treatment and risk reduction.

Throughout this paper, the term ‘GLP-1s’ is used as accessible shorthand for the wider category of GLP-1 receptor agonists and related dual-agonist therapies commonly discussed under the same public label. Product uses, regulatory approvals and clinical outcomes differ by medicine and market.

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CHAPTER 1:

THE CHRONIC DISEASE BURDEN IS RESHAPING THE POTENTIAL ROLE OF GLP-1s

Obesity is increasingly recognised as a chronic, relapsing disease shaped by biological, genetic, psychological, social, environmental and behavioural factors.<sup>4</sup> Yet this understanding is not consistently reflected in public policy, clinical pathways, insurance coverage or EB design.

In many markets, obesity treatment remains excluded from standard coverage or available only under limited circumstances, while individuals are still expected to manage the condition primarily through behavioural change.

This gap between clinical understanding and benefits design is becoming more consequential as effective pharmacological options expand. MAXIS data indicates that **more than one in four** chronic disease claimants may be eligible for GLP-1 therapy based on claims-recorded underlying conditions, yet only 5% of that population is currently receiving the medication.

That gap creates difficult strategic questions: how can access be expanded for those most likely to benefit while managing the substantial and potentially long-term cost of treatment? And can appropriately targeted coverage improve metabolic health sufficiently to reduce downstream disease burden and claims?

The answer begins with a clear understanding of the chronic disease environment into which these medicines are being introduced.



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### Who is potentially eligible for GLP-1 therapies?

In the MAXIS claims data, the potentially eligible population is comprised primarily of insured employees with recorded metabolic and cardiovascular-related conditions. The largest identifiable groups include people with diabetes, obesity, cardiovascular disease and related metabolic disorders. Many also have multiple chronic conditions, reflecting the interconnected nature of cardiometabolic disease.

Obesity is likely to be materially under-represented. This reflects the broader healthcare, reimbursement and public-policy frameworks operating in many of the markets covered – not the practices of individual MAXIS network partners alone. Obesity treatment may be excluded from standard coverage or reimbursed only in limited circumstances. As a result, obesity may not be visible in paid claims unless it is recorded as severe obesity or documented alongside another covered condition.

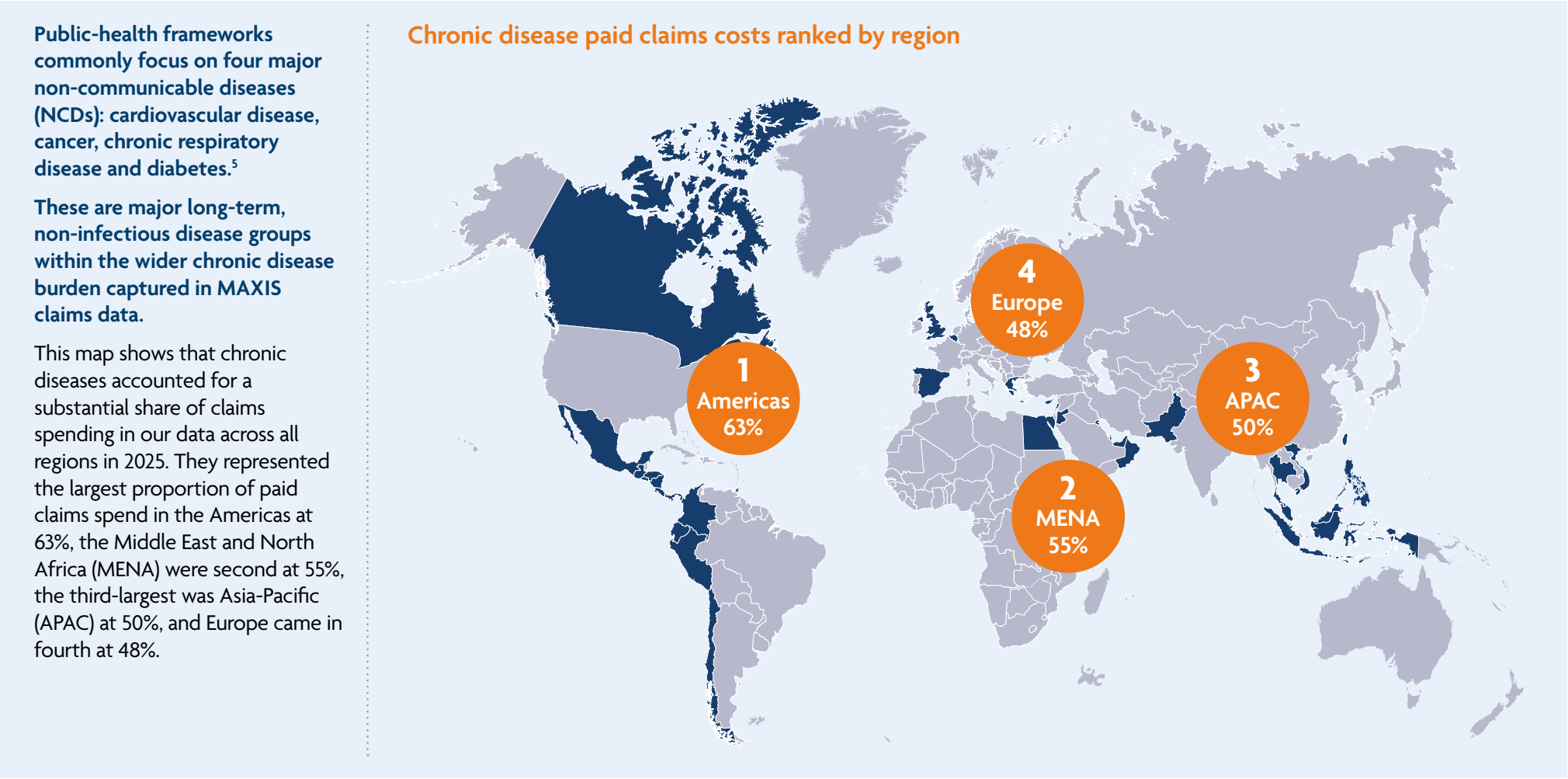
The obesity burden captured in the data therefore represents only the diagnosed, coded and reimbursed fraction. Employees with clinically meaningful obesity-related risk may appear only through associated or downstream conditions such as diabetes, hypertension, cardiovascular disease, fatty liver disease or sleep apnoea.

The eligibility estimate should consequently be described as a claims-based proxy for potential eligibility – not confirmation that every identified claimant satisfies all regulatory, clinical and prescribing criteria for GLP-1 therapies. Individuals’ Body Mass Index (BMI), waist circumference, laboratory values, restrictions for use alongside other medicines and treatment preferences are not fully available in claims data. Prescribing decisions would, of course, ultimately be made using clinical judgment.



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# 1. CHRONIC DISEASE IS A WORKFORCE ISSUE — NOT ONLY AN AGEING ISSUE



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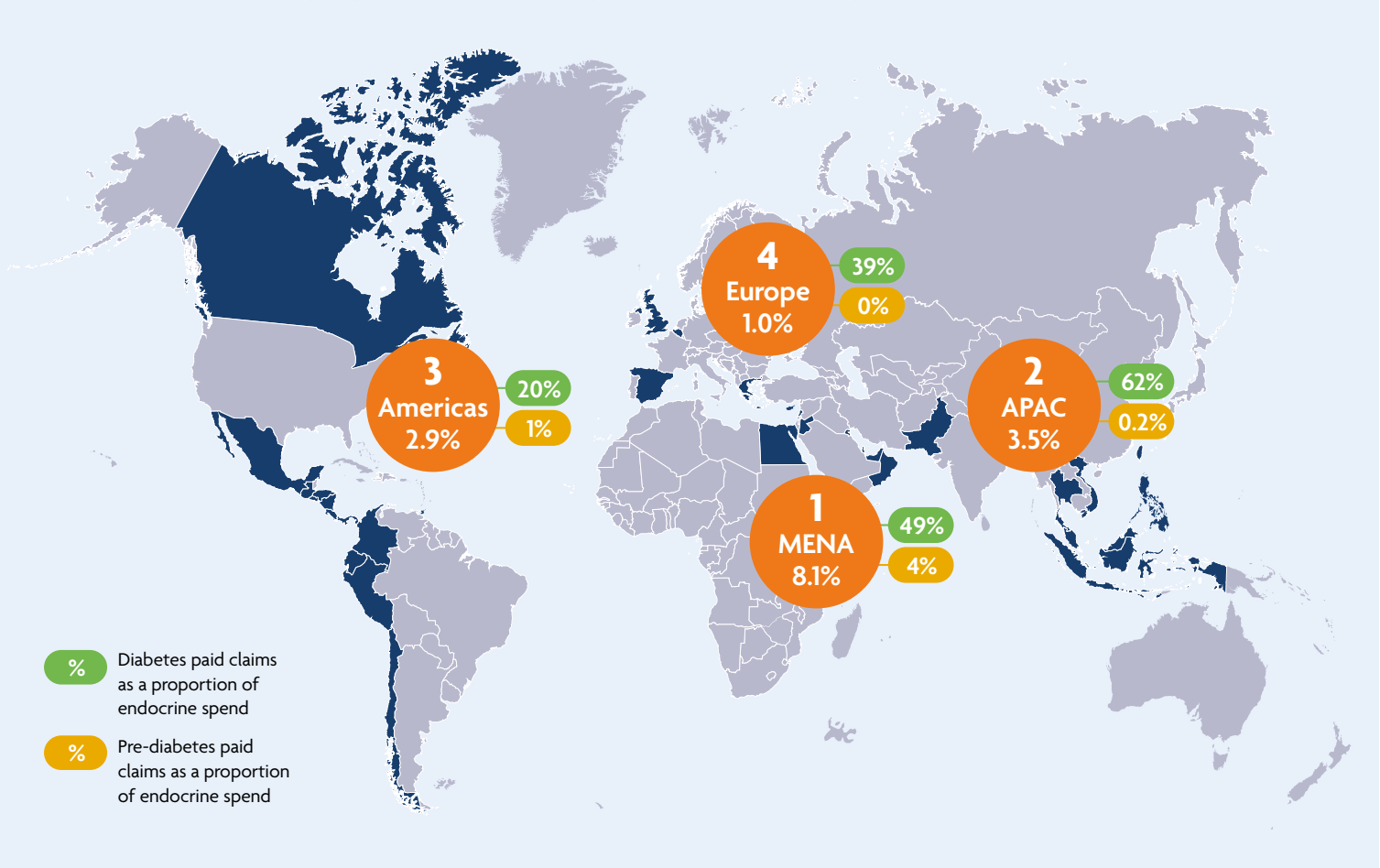
1. CHRONIC DISEASE IS A WORKFORCE ISSUE — NOT ONLY AN AGEING ISSUE CONTINUED

The impact of chronic disease extends beyond the initial diagnosis. These diseases can devastate people's lives.

For the person affected, chronic disease can bring physical limitations, disability, psychological distress and additional comorbidities. From a healthcare perspective, these diseases generate demand across specialist, pharmaceutical, inpatient and outpatient care and place pressure on workplace benefits.

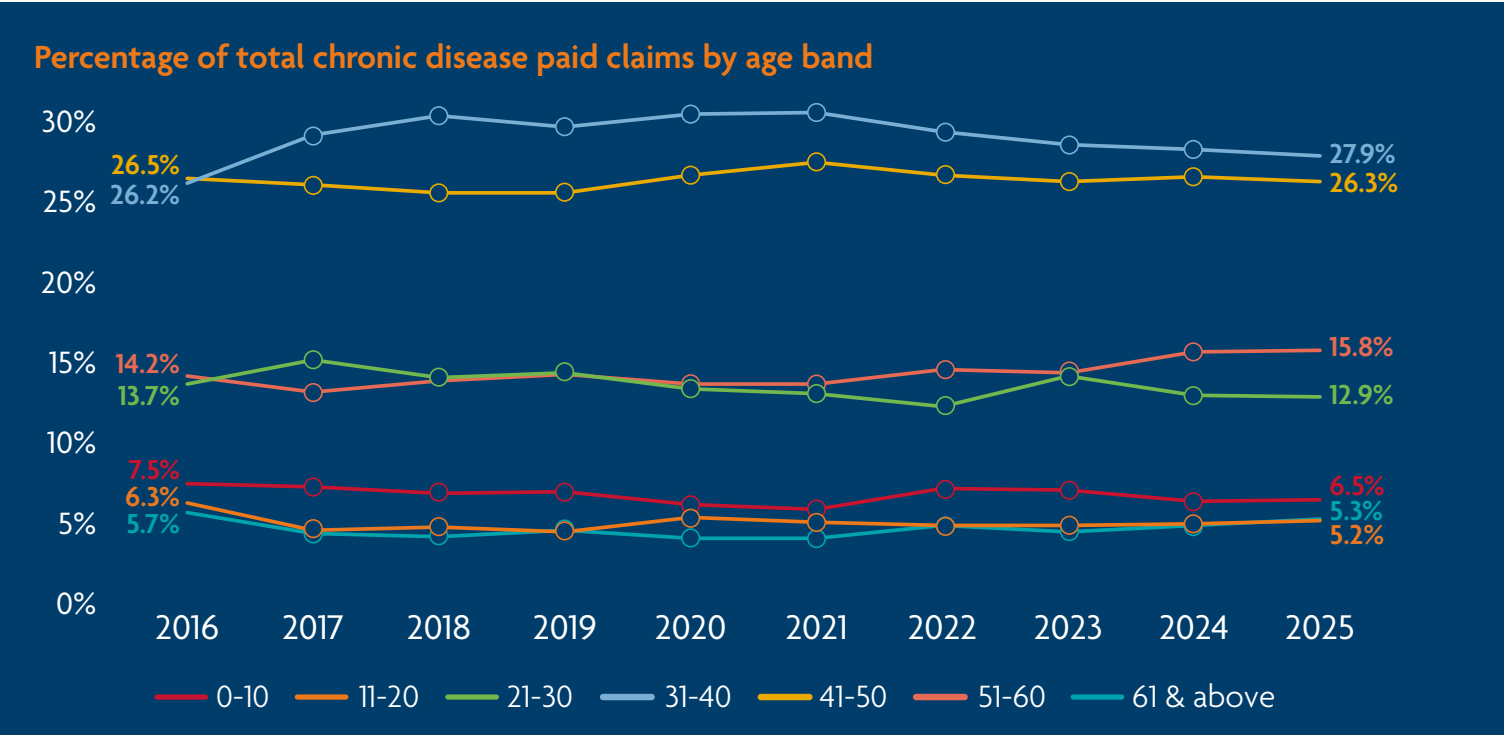
The relationship between chronic disease and mental health is a two-way one. Living with chronic illness can increase psychological distress, while poor mental health can make physical conditions harder to prevent, manage and treat.<sup>6</sup>

Endocrine diseases as a proportion of overall paid claims ranked by region



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1. CHRONIC DISEASE IS A WORKFORCE ISSUE — NOT ONLY AN AGEING ISSUE CONTINUED



MAXIS data shows that suffering from a chronic disease is most likely to occur in people’s prime working years. The largest share of chronic-disease claims spending is for employees aged 31–40, followed by those aged 41–50. The average age of chronic disease diagnosis is 42, and the most frequently observed age at diagnosis is also 42. For diabetes, the average age at diagnosis is 43.

The rise of chronic disease is not simply an ageing population story. Earlier diagnosis means employees may live and work for more years with chronic disease, extending the duration of treatment, the opportunity for complications and the cumulative financial impact on employer-funded healthcare.

Multimorbidity – living with multiple chronic diseases – intensifies that burden. In 2025, 38% of MAXIS claimants had at least one chronic condition and 36% of these chronic disease claimants were living with two or more. When a person is affected by metabolic, cardiovascular, musculoskeletal and mental health conditions all at once, clinical complexity and spending can cascade across multiple benefits categories.

Key takeaway

GLP-1 therapies are entering a claims environment already dominated by chronic disease – and increasingly by chronic disease diagnosed during employees’ prime working years.

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## 2. WHAT ARE GLP-1 THERAPIES AND WHY IS THEIR ROLE EXPANDING?

GLP-1 is a naturally occurring gut hormone involved in glucose regulation, appetite and digestion. GLP-1 receptor agonist medications mimic aspects of this signalling. They can increase glucose-dependent insulin secretion, reduce inappropriate glucagon secretion, influence appetite-regulating pathways and slow gastric emptying.<sup>7</sup> Related dual GLP receptor agonist medicines act on two hormonal pathways.<sup>8</sup>

These therapies were first used primarily in type 2 diabetes. Their role changed markedly after large clinical trials demonstrated substantial weight loss in people with obesity, including those without diabetes. Certain products have subsequently demonstrated cardiovascular, renal or other benefits in defined patient groups.<sup>9</sup>

The evidence supports meaningful clinical potential, but outcomes differ by medicine, use, dosage, patient population, treatment duration and adherence.<sup>10, 11</sup> Employers should therefore avoid treating ‘GLP-1s’ as a product with a single evidence base.



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2. WHAT ARE GLP-1 THERAPIES AND WHY IS THEIR ROLE EXPANDING? CONTINUED

Why multinational employers should be thinking about GLP-1s today

As the role of GLP-1s in healthcare expands, employers must prepare for the next wave of healthcare transformation – not react after costs arrive.

1. Current clinical impact

GLP-1 therapies are already transforming care across multiple disease areas.

Approved uses

✓

- Type 2 diabetes
- Obesity / weight management
- Cardiovascular risk reduction in eligible patient populations
- Chronic kidney disease (for patients with type 2 diabetes)<sup>12</sup>

Emerging clinical uses and current off-label prescribing

+

- Polyendocrine metabolic ovarian syndrome (PMOS), formerly known as polycystic ovary syndrome (PCOS)
- Positive reproductive health and fertility outcomes in people with PMOS
- Addiction and alcohol use disorders (early evidence)
- Metabolic dysfunction-associated steatotic liver disease (MASLD/MASH)
- Prediabetes and insulin resistance
- Obstructive sleep apnoea<sup>13</sup>

GLP-1 therapies are rapidly becoming foundational metabolic medicines, not simply weight-loss drugs.

2. The next wave

Clinical development is expanding potential GLP-1 use cases.

🧬

MASH / MASLD

– Potential to reverse fatty liver disease progression: research suggests promise in reducing liver inflammation and improving liver fibrosis in people with MASH/MASLD.

Heart failure with preserved ejection fraction (HFpEF)

– Potential to improve symptoms and physical functioning: studies show GLP-1s may improve exercise capacity and quality of life in people with obesity-related HFpEF.

Osteoarthritis

– Potential to reduce pain and improve mobility: researchers are investigating whether GLP-1s can improve physical function and reduce symptoms in obesity-related osteoarthritis.

Alzheimer's disease

– Potential to slow cognitive decline: researchers are exploring whether GLP-1s can protect brain cells and reduce neuroinflammation associated with Alzheimer's disease.

Parkinson's disease

– Potential neuroprotective effects: early research is investigating whether GLP-1s can help preserve neuronal function and slow disease progression.

Chronic liver disease

– Potential to reduce liver damage: GLP-1s are being evaluated across a broader range of liver diseases characterised by inflammation and fibrosis.

Sleep disorders

– Potential to reduce obstructive sleep apnoea severity: GLP-1s are being investigated for their ability to improve obstructive sleep apnoea alongside the benefits of weight reduction.

Broader cardiometabolic disease

– Potential to address multiple cardiovascular risk factors: research is expanding into hypertension, dyslipidaemia and metabolic syndrome, reflecting the drug's broad metabolic effects.<sup>13</sup>

GLP-1 therapies are moving beyond diabetes and obesity into cardiovascular, liver, neurological and inflammatory diseases, potentially expanding their impact across a much broader patient population.

3. Emerging cancer potential

Emerging real-world evidence suggests GLP-1s may influence cancer outcomes as well as metabolic health.

38-50%

Lower risk of metastatic progression

In observational studies, GLP-1 use has been associated with a 38-50% lower risk of progression to metastatic disease in selected obesity-related cancers, compared with other diabetes therapies.<sup>13</sup>

Cancer types highlighted include:

🪡

- Lung cancer
- Breast cancer
- Colorectal cancer
- Liver cancer<sup>14</sup>

Researchers are investigating whether weight loss, reduced inflammation and other biological effects of GLP-1 therapies may contribute to improved cancer outcomes.

Analysis

For multinational employers, the strategic implication is that the potentially eligible employee population may expand as product-specific evidence and approvals move beyond diabetes and chronic weight management.

Changing benefits categories

GLP-1-based therapies may increasingly intersect with cardiovascular, renal, sleep, liver and behavioural-health benefits rather than sitting within a single obesity or pharmacy decision.

Early adoption is key

This makes adopting a strategy early very important. Introducing broad access and then sharply restricting it when costs escalate may disrupt treatment continuity and erode some of the clinical gains already achieved.

At the same time, expanding access without a defined care pathway may increase pharmaceutical expenditure without delivering the expected long-term outcomes.

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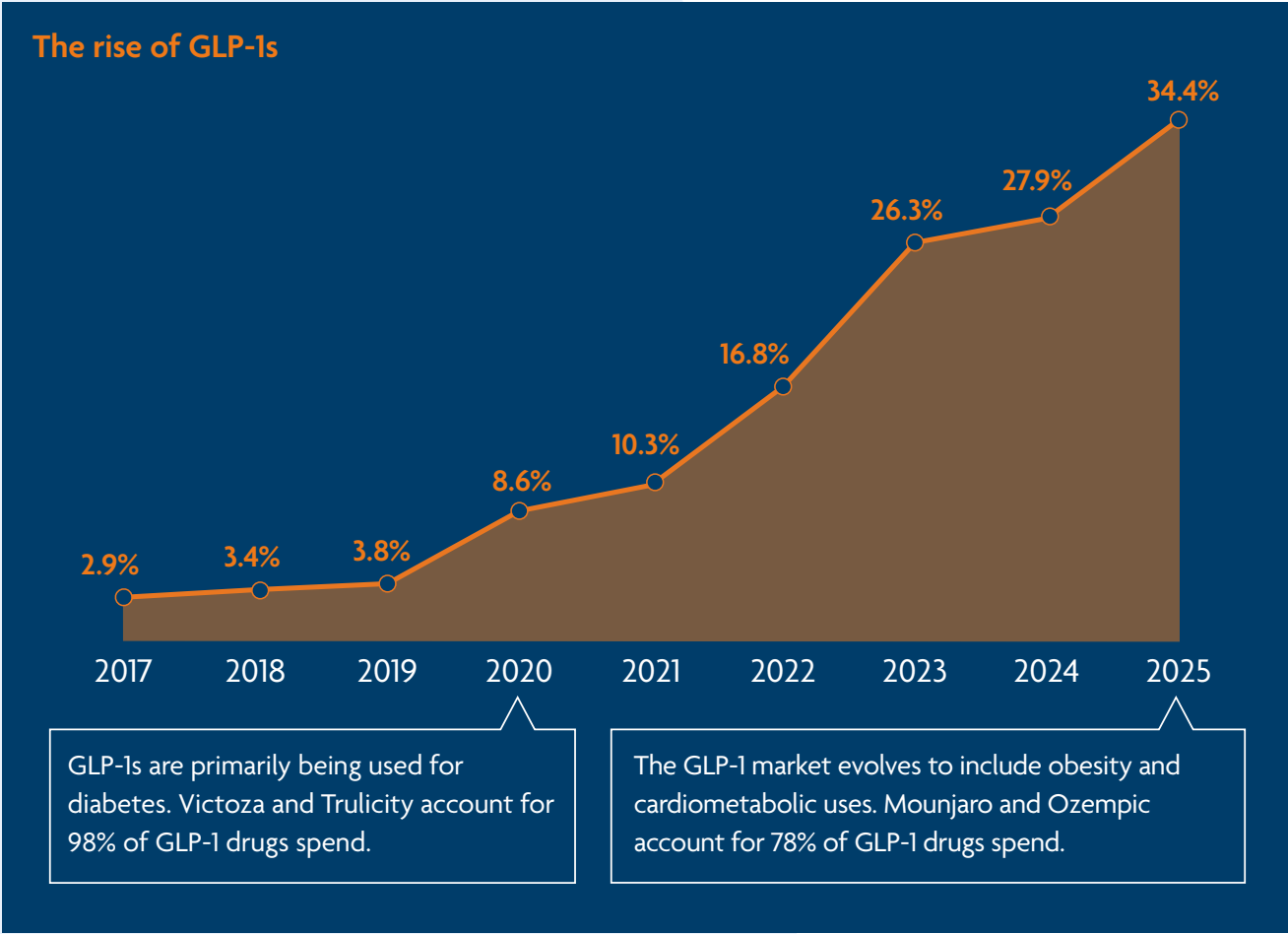
### 3. THE RAPID EVOLUTION OF GLP-1 USE

MAXIS data captures a period in which GLP-1 use moved from a category dominated by diabetes treatment towards one increasingly shaped by obesity and broader cardiometabolic use.

In 2017, just 2.9% of pharmacy benefit claims were for GLP-1 medications, all of which were approved for claimants with diabetes.

Paid GLP-1 claims among employees without a diabetes diagnosis then doubled between 2021 and 2023.

By 2025, newer medicines used for obesity and other cardiometabolic purposes accounted for the majority of GLP-1 spend, and claims for the therapies accounted for more than one third (34.4%) of pharmacy benefit claims.



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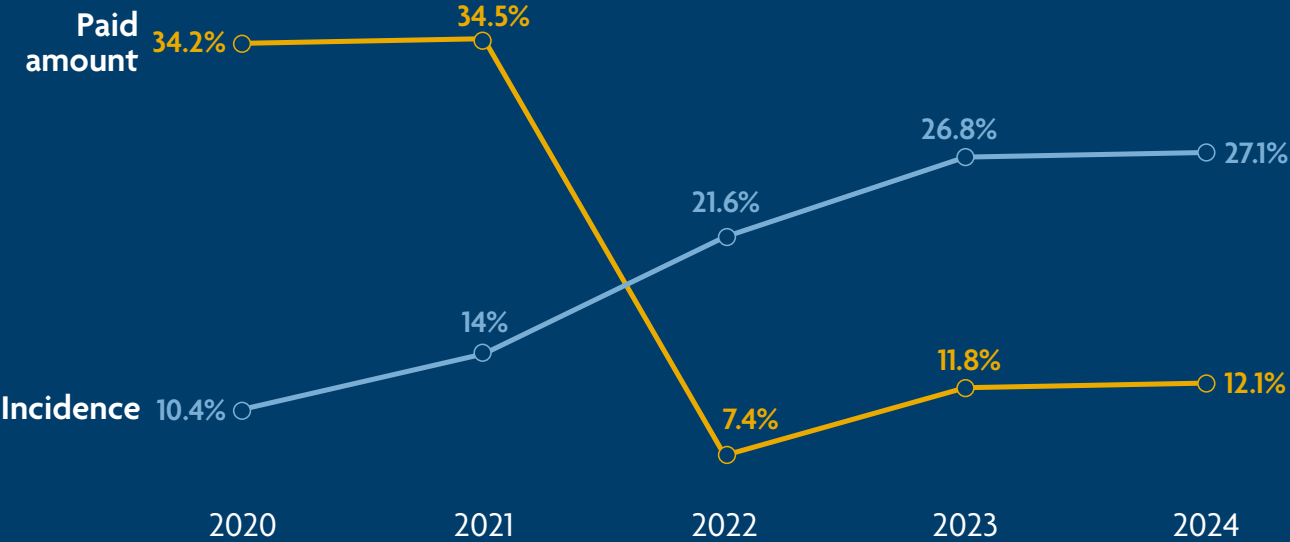
3. THE RAPID EVOLUTION OF GLP-1 USE CONTINUED

The market has also evolved in form and delivery. GLP-1 delivery has now expanded from injectable to oral treatment options in some markets. Meanwhile, additional oral obesity and metabolic therapies continue to progress through development. The greater convenience offered by oral GLP-1 medication options may improve acceptance but could also accelerate demand and increase employers' and insurers' need for clear eligibility and coverage rules.<sup>15</sup>

The MAXIS data in the chart shows all GLP-1 claims between 2020 and 2024. In our data we see that nearly 70% of total GLP-1 claims spend in this time period occurred in 2020 and 2021, despite the incidence totalling less than 25% during that period.

As the chart indicates, in 2022 there was a significant shift. Despite increases in the number of GLP-1 claims, the paid amount dropped significantly. There isn't a single causal explanation, but certain factors are likely influencing this, such as utilisation management, benefits design, negotiated pricing in some markets and treatment discontinuation.

GLP-1 incidence vs paid claims



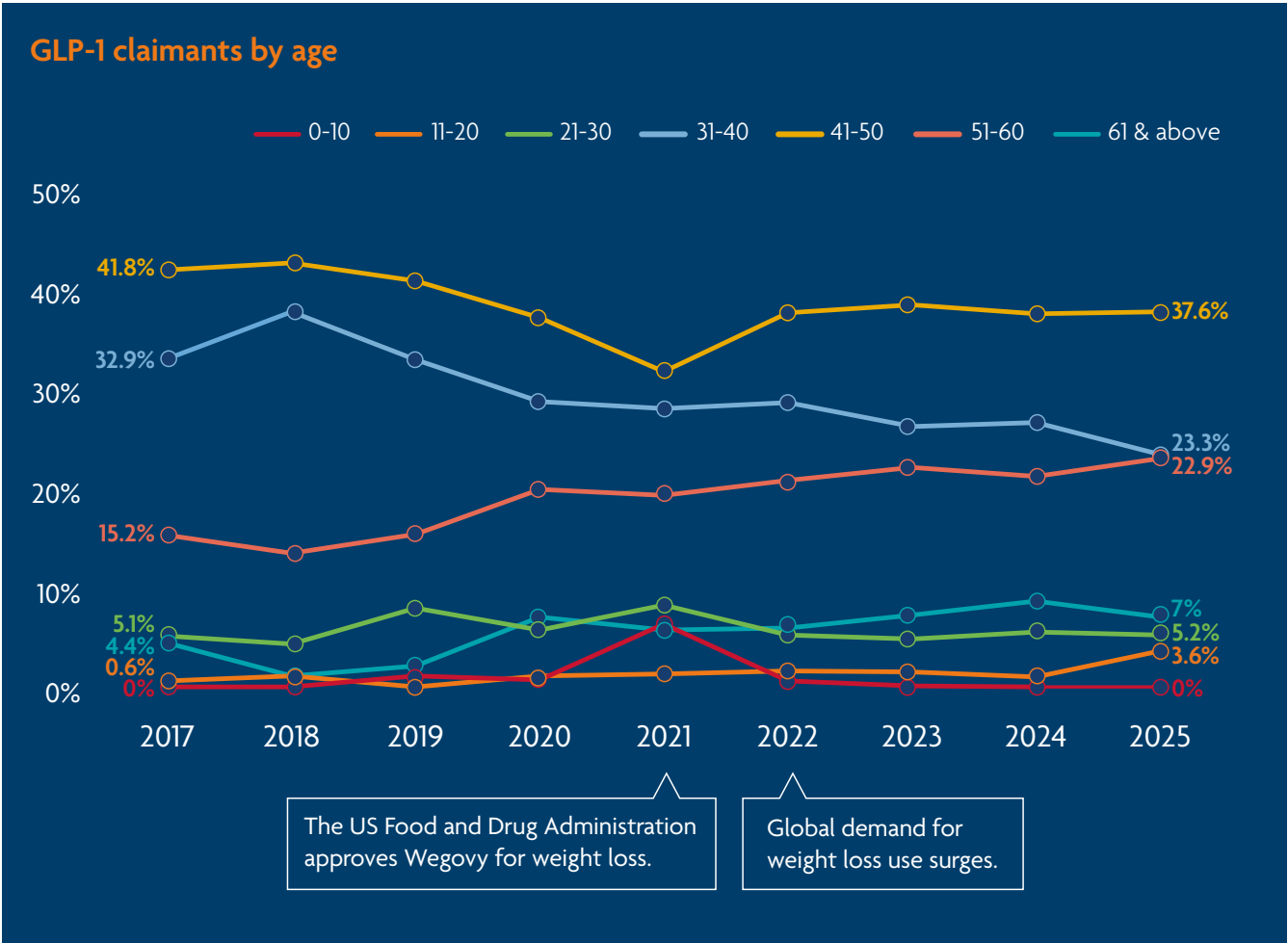
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3. THE RAPID EVOLUTION OF GLP-1 USE CONTINUED

Who is using GLP-1 therapies?

The chart opposite divides the share of GLP-1 claims in MAXIS data by age band. The average age of a GLP-1 claimant in the MAXIS data is 44. The most notable age trend is the growing share of claimants aged 51–60, which rose from just over 15% of all paid GLP-1 claims in 2017 to nearly 23% in 2025. This suggests that GLP-1 therapies are becoming increasingly relevant to older employees and to long-term workforce health strategy.

The gender distribution has also changed. Men previously represented a larger share of GLP-1 claimants, consistent with the earlier diabetes-dominated profile of the category. As weight-management use expanded, the proportion of women increased, producing a near-even split by 2025.



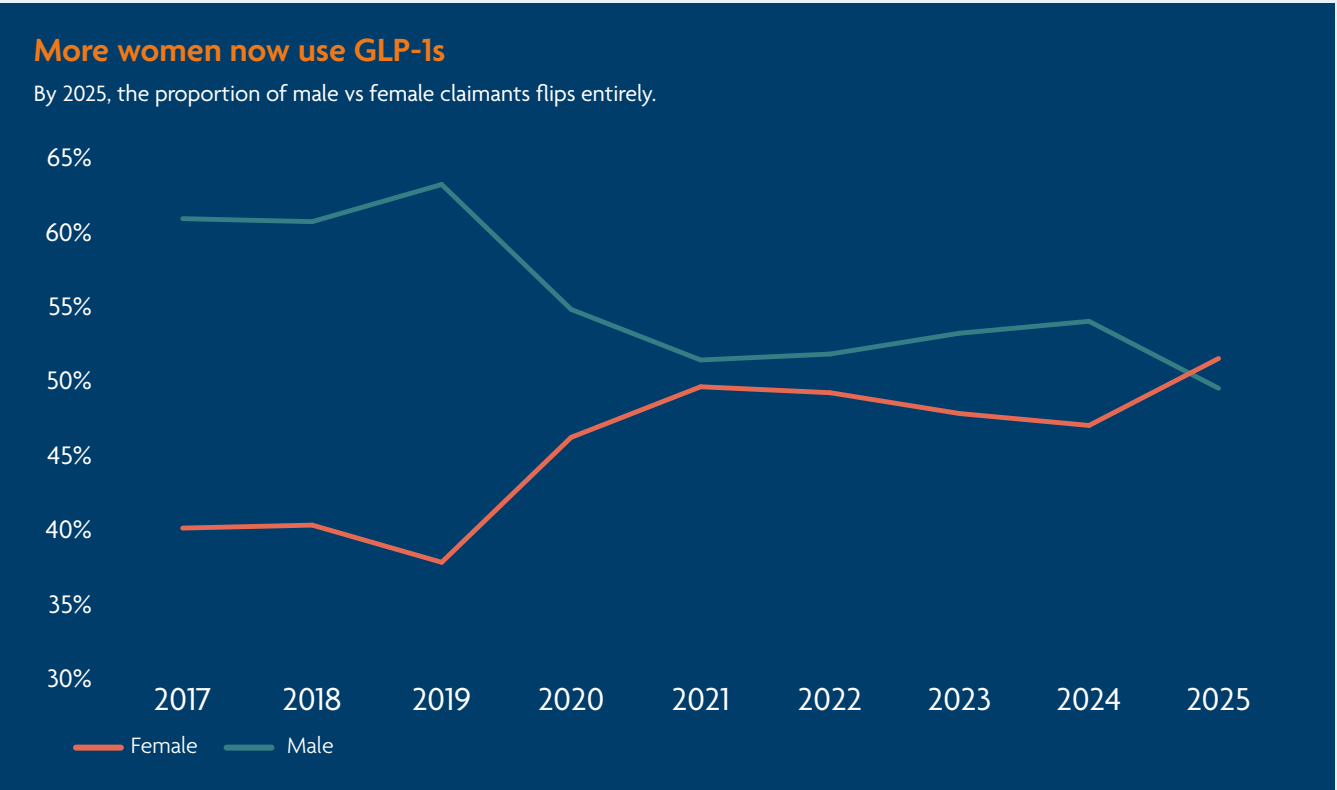
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3. THE RAPID EVOLUTION OF GLP-1 USE CONTINUED

External evidence suggests that women are more likely than men to engage with formal weight-management treatment. There are multiple likely reasons influencing this phenomenon. Women are more likely to have obesity formally diagnosed and to engage with structured weight-management care, including behavioural programmes, pharmacological treatment, and bariatric surgery. Men, by contrast, are generally less likely to seek formal weight-management support and may enter

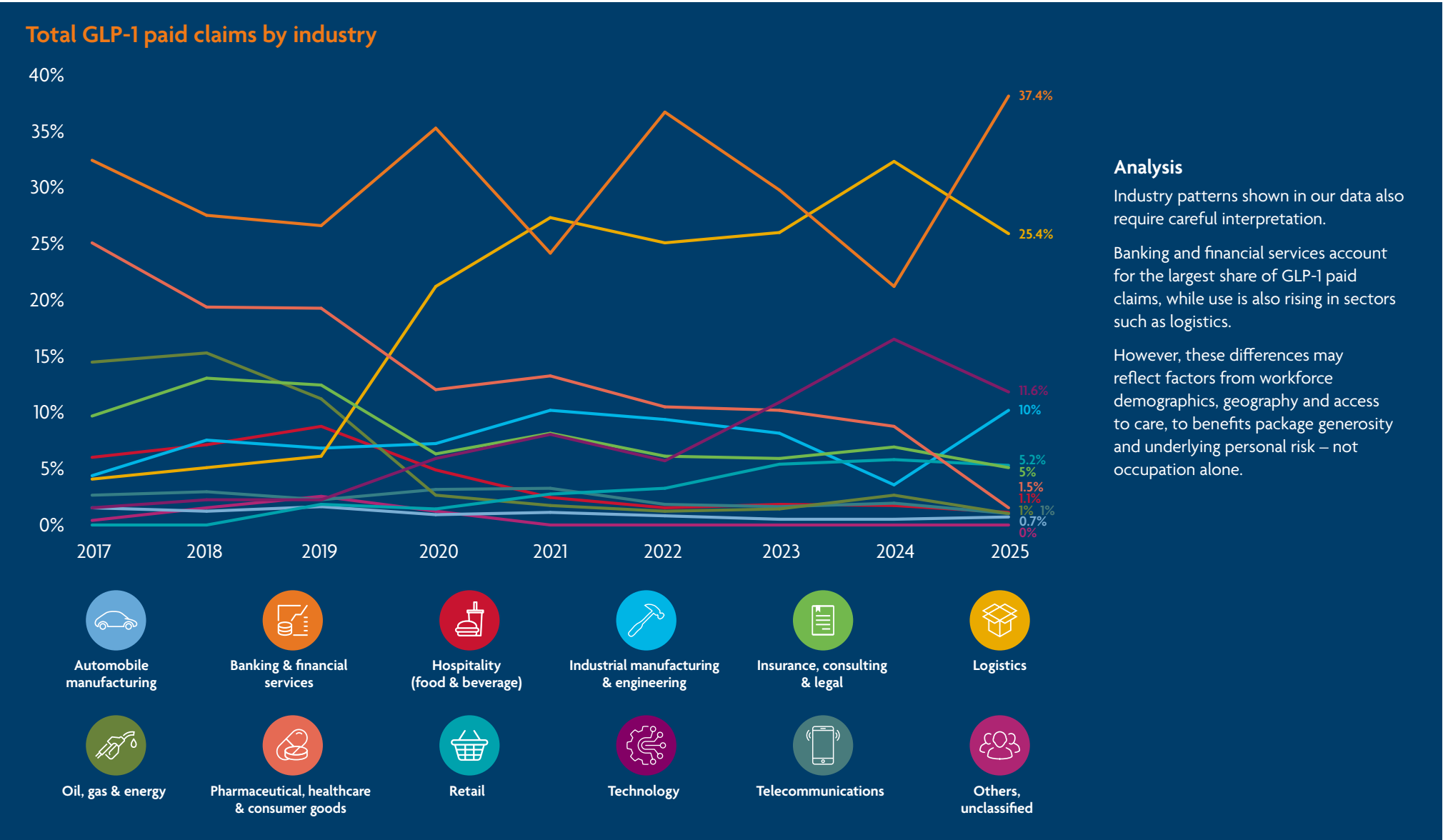
treatment later. Sociocultural factors may also play a role, as women experience greater societal pressure, weight-related stigma and scrutiny around body size.<sup>16,17</sup>

In addition, a 2026 meta-analysis of 64 clinical trials found that women achieved significantly greater average weight loss on GLP-1 therapy than men (around 10.9% of starting body weight vs. 6.8%).<sup>17</sup> However, the mechanisms behind this difference, and how much it drives treatment uptake itself, remain uncertain.



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3. THE RAPID EVOLUTION OF GLP-1 USE CONTINUED



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## 4. ARE GLP-1s REDUCING COSTS OR SHIFTING THEM?

### The GLP-1 cost landscape

Employer coverage and cost pressures



43%

of large US employers (with 5,000+ employees) in a 2025 survey reported covering GLP-1s for weight management



66%

of the employers surveyed who offered GLP-1 coverage reported increased pharmacy spending



34%

required participation in a lifestyle, weight-management or clinical support programme as a condition of coverage<sup>18</sup>

#### How much do GLP-1s cost?

While GLP-1 prices vary across global markets, approximate monthly US list prices for three brand-name GLP-1 medications offer a snapshot of 2025 spending expectations.\* Actual employer costs are often lower due to manufacturer rebates and Pharmacy Benefit Manager negotiations.

| Brand    | Main use        | Approximate monthly US list price* | Typical employer approach                                                                                               |
|----------|-----------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| Wegovy   | Obesity         | Around \$1,350 <sup>19</sup>       |  Prior authorisation                 |
| Zepbound | Obesity         | Around \$1,080 <sup>20</sup>       |  Prior authorisation               |
| Mounjaro | Type 2 diabetes | Around \$1,080 <sup>21</sup>       |  Coverage for approved indications |

\*US prices vary over time and do not reflect confidential rebates, discounts or net employer costs.

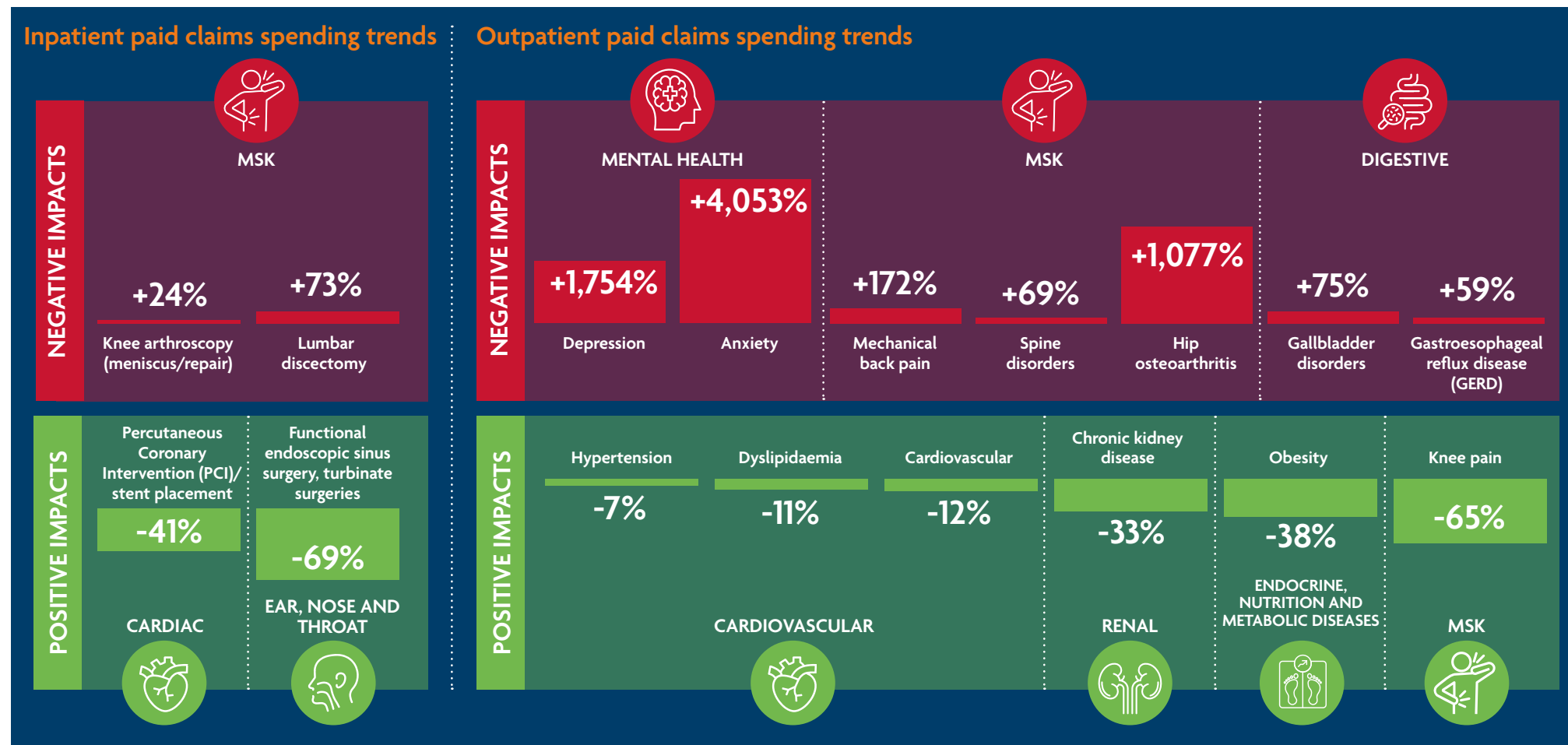
#### Key takeaway

While some employers are viewing GLP-1s as a strategic workforce health issue rather than a niche pharmacy benefit, growing demand, expanding clinical uses and high drug costs are driving tighter utilisation management in many markets.<sup>22</sup>

Prior authorisation, clinical eligibility criteria and support programmes are becoming common features of coverage.<sup>23</sup>

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#### 4. ARE GLP-1s REDUCING COSTS OR SHIFTING THEM? CONTINUED



## Understanding these claims trends

### How we made these comparisons

Our analysis compared two cohorts within our MAXIS data: claimants receiving GLP-1 therapy and claimants who appeared potentially eligible based on claims-recorded underlying conditions but did not receive treatment.

Changes in paid claims spending before and after treatment began in the GLP-1 cohort were compared with changes over corresponding periods among eligible non-users.

This chart identifies differences in spending trajectories. The findings are intended to provide a foundation for further analysis and EB programme design.

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4. ARE GLP-1s REDUCING COSTS OR SHIFTING THEM? CONTINUED

The promise of GLP-1 therapies lies in their potential to improve metabolic health and reduce complications associated with obesity and related chronic diseases. The MAXIS claims analysis, however, identifies a more complex pattern: selected areas of spending improved among GLP-1 users, while other categories increased more sharply than among potentially eligible non-users.

These findings raise an important question: could some of the anticipated medical savings be offset by additional spending elsewhere, particularly when treatment is not embedded in a broader pathway of nutritional, behavioural, musculoskeletal and clinical support?

Mental health

Changing appetite and reward pathways may have consequences beyond weight loss



Mental health was one of the most striking areas of increased outpatient spending identified in the MAXIS analysis. Compared with potentially eligible non-users, GLP-1 users showed a **1,754% greater increase in paid claims spending for depression and a 4,053% greater increase for anxiety** in the before-and-after comparison.

The magnitude of these percentages is striking. Mental health is complex and has a two-way relationship with obesity. Psychological distress can contribute to weight gain, while obesity, stigma and associated health complications can adversely affect emotional wellbeing.<sup>24</sup>

There may also be another dimension to consider. For many people, food provides more than nutrition. It can also function as comfort, stress relief, celebration or social connection. GLP-1 medicines don't merely reduce hunger signals. They act on

areas of the brain involved in appetite, cravings, motivation and reward.<sup>25</sup> Interestingly, researchers are exploring GLP-1s' effects on cravings for alcohol and nicotine, too.<sup>26</sup>

When treatment substantially reduces hunger, cravings and 'food noise', the sense of an emotional reward triggered by eating may fade. There is no clear evidence to suggest GLP-1s are causing anxiety or depression. But it's worth asking the question: when a medication transforms a person's appetite, how might it change their emotional relationship with food, too?

For someone who has relied on food as a coping mechanism throughout their life, diminishing the power of food as a source of comfort doesn't resolve the issues driving their mental state. Weight loss can improve physical health without resolving underlying psychological distress and body-image concerns.<sup>27</sup>

The practical implication is clear – employers designing a comprehensive GLP-1 strategy within their EB programme should include behavioural and mental health assessment and support as an integral part of the care pathway.

Musculoskeletal health

Lean-mass loss, altered spinal mechanics and established disease may drive rising MSK burden



Compared with potentially eligible non-users, GLP-1 users recorded a **172% greater increase in outpatient spending for mechanical back pain, a 69% greater increase for spine disorders and a 1,077% greater increase for hip osteoarthritis. Inpatient spending increased 24% more for knee arthroscopy and meniscal repair and 73% more for lumbar discectomy.**

These relative changes should not be interpreted as proof that treatment caused new musculoskeletal disease, but the pattern is clinically meaningful and is unlikely to have a single explanation.

Carrying excess body weight is strongly linked to spinal diseases, and researchers are also finding associations between high BMI and lumbar disc degeneration, as well as a heightened risk of hip and knee osteoarthritis.<sup>28,29</sup> Weight loss reduces this external mechanical load, but it does not immediately reverse structural diseases that may have developed over many years. Substantial weight loss can also involve a reduction in lean tissue, including skeletal muscle.<sup>30</sup> Body-composition sub-studies of GLP-1 medications, tirzepatide and semaglutide, have reported that lean tissue represented approximately 26% and 40% of total weight loss, respectively.<sup>31</sup> Lean tissue is not synonymous with skeletal muscle, and whole-body scans cannot determine precisely how much loss occurs within the abdominal, core or paraspinal muscles.<sup>13</sup> Nevertheless, the findings are important because these muscles help stabilise the trunk, protect the spine and control movement.

Major changes in abdominal mass and body composition can also alter the body's centre of mass, habitual posture and balance.<sup>32</sup> These changes may ultimately be beneficial, but the musculoskeletal and neuromotor systems must adapt to a substantially different body shape and loading pattern. Where weight loss occurs swiftly, or without progressive strength and conditioning, it can affect muscle strength and cause rapid tissue loss.<sup>33</sup> Studies following major weight loss have identified measurable changes in postural control and spinal alignment.<sup>34</sup>

Improved mobility may create a further effect. As people lose weight and become more physically capable, they may walk further, exercise more or resume activities that had previously been restricted. This is positive, but greater movement can expose established degenerative disease or load joints and spinal structures that remain deconditioned. Increased MSK claims may therefore reflect not only deterioration, but also the re-emergence or recognition of symptoms as activity levels change.

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4. ARE GLP-1s REDUCING COSTS OR SHIFTING THEM? CONTINUED

Bone health is another potential contributor. Weight reduction decreases the mechanical stimulus placed on bone, and some loss of bone mineral density can accompany substantial weight loss.<sup>33</sup> In one randomised trial, semaglutide was associated with lower lumbar-spine and total-hip bone mineral density after 52 weeks in adults with increased fracture risk. A separate trial found that combining exercise with liraglutide preserved bone more effectively than liraglutide treatment alone.<sup>35</sup> These findings do not establish a uniform adverse effect across every GLP-1 medicine or population, but they reinforce the importance of muscle-strengthening exercise, good nutrition and bone health assessment in those at greater risk.

Another compelling potential factor driving the increased MSK spending is the possibility that some people whose orthopaedic or spinal procedures were previously deferred because of surgical risk or institutional BMI thresholds became eligible after losing weight. Higher procedure spending may therefore reflect access to previously indicated care that was off-limits, rather than treatment-related deterioration.

Taken together, the increased MSK spending observed in our analysis may reflect a combination of:

- established structural disease that weight loss cannot reverse immediately
- loss of lean tissue and potentially reduced core or paraspinal support
- changes in spinal mechanics, posture and body-mass distribution
- increased activity before strength and tissue resilience have been rebuilt
- changes in bone density
- greater access to previously deferred orthopaedic and spinal procedures.

The implication is that weight reduction alone should not be treated as musculoskeletal protection. GLP-1 pathways should incorporate adequate protein and nutrition, progressive resistance and core-strengthening exercise, assessment of existing joint and spinal disease and appropriate monitoring of muscle function and bone health.

Gastrointestinal health

Delayed gastric emptying and rapid weight loss may increase gastrointestinal and gallbladder burden



GLP-1 users showed a **75% greater increase in outpatient spending for gallbladder disorders and a 59% greater increase for gastro-oesophageal reflux disease.** These trends are consistent with recognised gastrointestinal effects of GLP-1 therapy and with the physiological consequences of substantial or rapid weight loss.<sup>36</sup> Delayed gastric emptying can contribute to nausea, bloating, reflux and other gastrointestinal symptoms. Changes associated with rapid weight loss can also increase the risk of gallstone formation.<sup>37</sup> These findings support proactive monitoring, patient education and clear escalation pathways.

Cardiovascular and renal health

Substantial reductions in high-cost inpatient and procedural spending



The analysis also identified encouraging spending reductions. In inpatient cardiovascular claims, GLP-1 users **showed a 41% greater reduction in spending for percutaneous coronary intervention (treatment to open a blocked artery) and stent placement.** The ear, nose and throat (ENT) claims data also revealed a 69% greater reduction in spending for selected functional sinus and turbinate categories (procedures to relieve chronic nasal congestion and breathing blockages). **Across outpatient claims, spending also declined sharply for hypertension, dyslipidaemia, ischaemic heart disease, chronic kidney disease and recorded obesity.**

The cardiovascular and renal trends are directionally consistent with the wider clinical evidence.<sup>38</sup> The ENT claims finding is harder to interpret because these procedures can be carried out for several different reasons. As a result, the trend cannot be linked solely to improvements in obstructive sleep apnoea.

**Key takeaway**

MAXIS data suggests that GLP-1 therapy can deliver meaningful cardiometabolic improvements but may also shift healthcare needs and costs into less anticipated areas, including mental health and musculoskeletal care. Employers should recognise these broader downstream effects and provide appropriate wraparound support. When we medically change hunger, we must support the whole person. This means funding the full care pathway – not simply access to the prescription – so that gains in one area are not offset by rising needs in another.

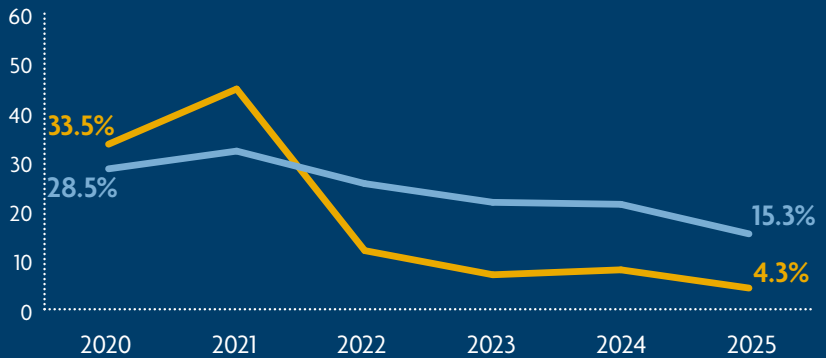
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## 5. HOW REGIONAL DISEASE BURDEN, WORKFORCE COMPOSITION AND HEALTHCARE ACCESS SHOULD SHAPE STRATEGY

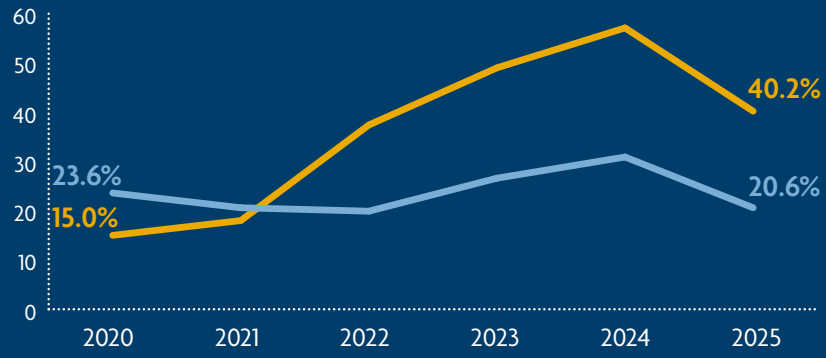
### GLP-1 incidence vs paid claims in pharmacy benefit

These charts explore trends in GLP-1s as a share of total pharmacy paid claims and incidence in each country.

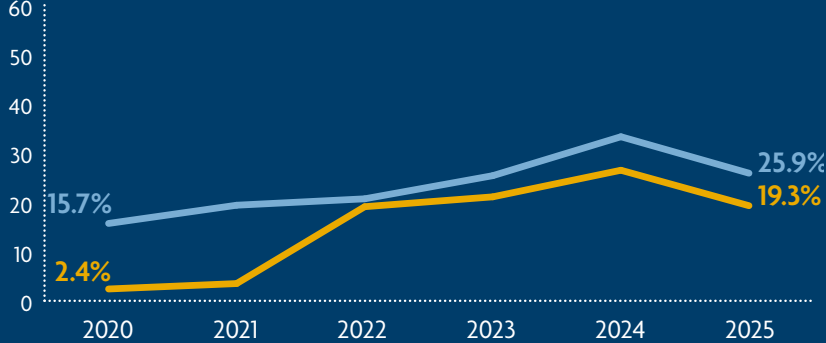
#### Egypt



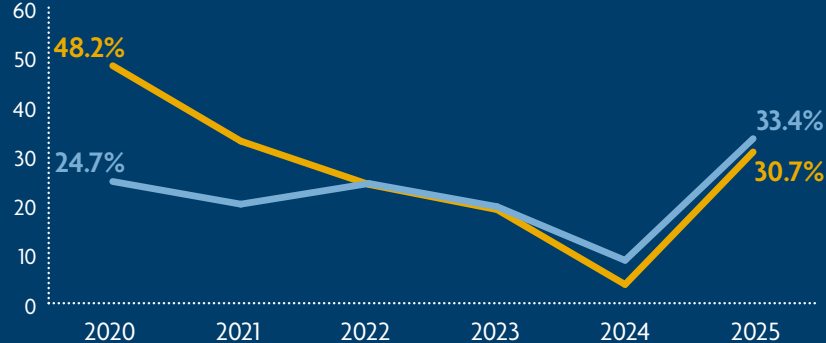
#### United Arab Emirates



#### Canada



#### Mexico



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5. HOW REGIONAL DISEASE BURDEN, WORKFORCE COMPOSITION AND HEALTHCARE ACCESS SHOULD SHAPE STRATEGY CONTINUED

GLP-1 access does not follow a single regional pattern. It is shaped by regulatory approval, public reimbursement, insurer policy, medicine availability, affordability, prescribing capacity and the way an employer's benefits are funded.

Across many Latin American and Asia-Pacific markets represented in the MAXIS data, use remains concentrated primarily in diabetes care, even as employer interest in obesity and broader cardiometabolic coverage grows. In parts of Europe, access is often more tightly governed through public reimbursement and national clinical pathways. Selected Middle Eastern employer arrangements have shown greater flexibility, particularly where multinational clients use captive, self-funded or bespoke structures. The US, which is not included in the MAXIS claims dataset, has more established employer-sponsored access but highly variable coverage and utilisation controls.

The regional story should therefore not be interpreted as a simple ranking of advanced and less advanced markets as they respond to the GLP-1 trend. Employers need to understand both the clinical need in the workforce and the ability of the local system to deliver supported treatment.

Workforce composition matters as much as market location

Multinational workforces may be far more ethnically diverse than the general population of the country in which they are based. National obesity and diabetes averages do not always mirror the risk profile of the multinational employees actually covered. This is especially important in high-migration markets such as the UAE, Singapore and Australia.

For instance, many Asian populations – and South Asians in particular – develop type 2 diabetes and cardiovascular risk at younger ages and lower BMI levels than white European populations.<sup>39</sup> This is sometimes described as the 'thin outside, fat inside' phenotype: an individual may appear lean and have

a BMI within the conventionally defined healthy range, while carrying a disproportionately high amount of metabolically harmful fat internally. At a comparable BMI, South Asians may have greater abdominal and ectopic fat accumulation (fat stored in and around organs such as the liver) and lower skeletal muscle mass than other ethnic groups. This combination can contribute to insulin resistance and metabolic disease even in the absence of visible obesity. A BMI of 23, for example, remains within the healthy range under conventional Western classifications, yet may already be associated with increased metabolic risk in some Asian populations.<sup>40, 41</sup> Conventional BMI thresholds can therefore underestimate risk in a workforce with a substantial Asian population, wherever that workforce is located.

Some clinical frameworks recognise these differences through lower screening or treatment-assessment thresholds, but such approaches are not consistently reflected in prescribing rules, reimbursement criteria or insurance policies across global markets. The science may identify elevated risk before the local coverage system recognises it.

Latin American populations provide a different example of why context matters. A genetic predisposition to type 2 diabetes is particularly common in people with Indigenous American ancestry, and evidence of this phenomenon is strongest in Mexico.<sup>42</sup> However, Latin American populations are highly diverse. The finding should support more locally informed risk assessment, not ancestry-based eligibility or the assumption that all Latin American populations share the same genetic risk profile.

The objective for multinational employers is not to create different standards of care based solely on ethnicity. It is to ensure that apparently uniform criteria do not systematically overlook employees whose metabolic risk develops earlier or at lower BMI levels. Population characteristics should guide screening, risk identification and programme design, while individual treatment decisions remain clinically determined.

“

**Richard Reyf explains what this means for stakeholders:**

“Our global claims data shows that countries are effectively running different approaches to GLP-1 implementation. Some have integrated multidisciplinary support around treatment, while others have focused primarily on medication access.

As these approaches mature, claims analytics provide a unique opportunity to understand which models produce the most sustainable clinical and financial outcomes. What makes the MAXIS dataset particularly compelling is that the story is still unfolding.

We are beginning to see patterns emerge across countries and industries, including both expected improvements and unexpected downstream effects. Continuing to track these populations longitudinally will be essential to understanding where lasting value is being created and where additional support may be needed.”

Richard Reyf

Director of Health & Wellness Data Analytics at MAXIS GBN



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5. HOW REGIONAL DISEASE BURDEN, WORKFORCE COMPOSITION AND HEALTHCARE ACCESS SHOULD SHAPE STRATEGY CONTINUED

A strategic GLP-1 roadmap for multinational employers

1. Anticipate the expanding use case

Treat GLP-1s as an evolving cardiometabolic category rather than a temporary weight-loss trend. Begin by analysing claims and population data to understand what is driving the organisation's current burden – such as diabetes complications, obesity-related cardiovascular and renal disease, high-cost admissions, medication utilisation and persistence, regional variation and emerging downstream mental health or musculoskeletal costs. Use these findings to identify the populations with the greatest unmet need and define measurable priorities, whether improving diabetes control, preventing disease progression, reducing cardiovascular and renal events or supporting sustainable obesity treatment. Eligibility criteria, clinical pathways, outcome measures and governance should then be designed around those priorities before demand accelerates.

The organisation's GLP-1 objectives should reflect where the greatest clinical and financial need exists within its own workforce – not how these medicines are promoted or perceived.

2. Map the actual workforce

Use employee demographics, migration patterns and workforce concentration not national averages alone to identify where cardiometabolic risk may be emerging earlier or at lower BMI thresholds. For example, an employer may classify its workforce as UK-based and apply national averages or standard BMI thresholds across the population. However, a UK business unit may include a large concentration of employees with South Asian, Black African or African-Caribbean backgrounds –

populations in whom cardiometabolic risk can develop at lower BMI levels. The UK's National Institute for Health and Care Excellence (NICE) therefore recommends lower BMI thresholds for identifying increased risk in these groups.<sup>43</sup>

The employer should use aggregated workforce demographics to identify these concentrations and overlay them with claims patterns, diabetes and cardiovascular diagnoses, screening uptake, BMI or waist-to-height measures and gaps in preventive care. This may support earlier risk assessment, more targeted screening and culturally appropriate engagement in selected locations or business units, rather than applying a single UK-wide approach that could overlook higher-risk employees.

This is not about determining treatment eligibility by ethnicity. It is about recognising that a workforce's health profile may differ substantially from the national average and designing screening and prevention accordingly.

3. Interrogate claims and screening data

Examine employees' age at first diabetes diagnosis, as well as prediabetes, hypertension, dyslipidaemia, fatty liver disease and sleep apnoea (where data is available). Also examine multimorbidity data and the gap between potential eligibility and current treatment.

4. Rank markets by need and readiness

Assess clinical burden, access gaps, local prescribing and reimbursement rules, care infrastructure and the flexibility of the funding arrangement. High-need markets may require screening and pathway development before broad pharmaceutical coverage.



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5. HOW REGIONAL DISEASE BURDEN, WORKFORCE COMPOSITION AND HEALTHCARE ACCESS SHOULD SHAPE STRATEGY CONTINUED

5. Model uptake and cost

Do not equate potential eligibility with expected utilisation. Model alternative scenarios for treatment uptake, persistence, dosage, net medication cost, wraparound support, discontinuation and possible changes in medical claims.

6. Fund a care pathway (wraparound care)

Build nutrition, adequate protein intake, resistance and weight-bearing exercise, mental health support, gastrointestinal management, clinical review and maintenance planning into the programme. Access to medication should be integrated with support, not treated as the whole intervention.

7. Negotiate and partner actively

Work with insurers, pharmacy partners, providers and manufacturers to improve price transparency, supply, authorisation, care coordination and outcomes measurement. Captive and self-funded structures may provide greater flexibility to pilot bespoke pathways, subject to local regulations.

8. Measure total value and refine

Track pharmacy spending alongside total medical spend, treatment persistence, metabolic outcomes, mental health, MSK and gastrointestinal claims, inpatient use, disability, absenteeism and equity of access. Scale only after reviewing both intended and unintended outcomes.

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Strategic roadmap



# CHAPTER 2: FROM ACCESS TO FINANCIAL SUSTAINABILITY

GLP-1 coverage can reasonably be viewed as an investment in preventive and chronic-disease care. It should not, however, be sold internally as a guaranteed short-term cost-saving measure. The first years of implementation may bring higher pharmacy expenditure and changes in medical utilisation before any longer-term reduction in disease burden becomes visible.

A sustainable strategy therefore requires more than eligibility rules. It requires continuity planning, structured support, active purchasing, clear governance and a willingness to refine the programme as evidence, pricing and workforce outcomes evolve.



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1. WHY WRAPAROUND CARE MATTERS

Employee GLP-1 use is fragmented

| What the MAXIS data shows*                                                                                                                   | Analysis                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div>1 in 3</div> <div>employees on GLP-1s</div> <div>discontinued treatment after one year</div>                                            | <div>1. Early drop-off = lost investment</div> <div>A significant portion discontinue within year one</div> <div>This outcome limits both clinical benefit and return on investment (ROI) for the employer</div> |
| <div>5%</div> <div>of employees on GLP-1s</div> <div>discontinued treatment for one year and later resumed it following weight rebound</div> | <div>2. Cycling behaviour = cost volatility</div> <div>Patients stop and restart after weight rebound</div> <div>This creates repeated spending without sustained health outcomes</div>                          |
| <div>6%</div> <div>of employees on GLP-1s</div> <div>remained on treatment for more than three years</div>                                   | <div>3. Sustained adherence = value</div> <div>A small cohort of employees remain on therapy long-term</div> <div>This is where meaningful clinical and financial ROI is realised</div>                          |

\*MAXIS data covering GLP-1 patient utilisation patterns between 2020–2025.

GLP-1 therapies can result in substantial weight loss and improvements in metabolic health, but medication alone does not address every factor that contributes to obesity or every consequence of weight loss. Nutrition, physical activity, mental health, treatment persistence and long-term maintenance all influence outcomes.

Discontinuation is common in real-world practice. People stop for many reasons, including and not limited to: cost, loss of coverage, adverse effects, supply constraints, limited response and personal preference. After treatment stops, substantial weight regain and reversal of some cardiometabolic improvements are common. Employers should therefore decide at the outset whether treatment is intended as a long-term therapy, how continuation will be reviewed and what support will be available if treatment is interrupted or stopped.

Rapid or substantial weight loss can include lean-tissue loss and may affect muscle strength and bone health. A supported programme should include nutritional assessment, a diet that includes sufficient protein, progressive resistance training and weight-bearing exercise, as well as clinical monitoring for people at higher risk.

Mental health support is equally important. Weight loss does not automatically resolve emotional eating, stigma, body image concerns, depression or anxiety.<sup>44</sup> Programmes should include a route to behavioural and psychological support without making mental health treatment a punitive condition of access.

Gastrointestinal symptoms and gallbladder complications also require patient education and clinical management. Employees should understand expected side effects, warning signs and when to seek medical review.

Key takeaway

A GLP-1 prescription is just one component of an intervention. The employer’s role is to fund and govern a clinically supported pathway.

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1. WHY WRAPAROUND CARE MATTERS CONTINUED



**Dr Neil Gordon**  
INTERVENT International CEO



**Dr Neil Gordon, CEO of INTERVENT International, and co-author of the American Journal of Lifestyle Medicine article ‘Health and well-being coaching adjutant to GLP-1 induced weight loss’ says:**<sup>45</sup>

“GLP-1 medications have transformed obesity treatment and can produce substantial weight loss together with improvements in cardiometabolic health. But medication alone should not be viewed as a complete obesity-management strategy. Obesity is a chronic, relapsing condition, and achieving durable benefits requires attention to multiple factors such as healthy nutrition, regular physical activity, preservation of muscle mass, medication adherence and sustainable long-term behaviour change.

“Evidence-based health coaching can play an important role throughout the GLP-1 journey. It can, for example, help individuals establish healthier eating and physical activity patterns, incorporate appropriate resistance training to help preserve lean muscle mass, manage common side-effects and remain adherent to treatment when continued pharmacotherapy is warranted.

“Just as importantly, coaching can help individuals develop the skills, confidence and habits needed to maintain both weight loss and healthier behaviours over the long term, including supporting the transition off medication, under appropriate clinical supervision, for individuals who choose or need to discontinue treatment.

“This is particularly important because discontinuing GLP-1 therapy commonly results in weight regain. For employers investing significantly in these medications, effective wraparound care should therefore not be regarded as an optional extra. Integrating GLP-1 therapy with evidence-based lifestyle intervention and behaviourally oriented health coaching provides a more comprehensive strategy for maximising clinical benefit and protecting the employer’s investment in employee health.”

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## 2. DESIGNING ELIGIBILITY AND CONTINUATION RULES

### Eligibility should be clinically grounded and sufficiently flexible to recognise cardiometabolic risk beyond BMI alone.

Multinational employers can take action by examining whether their screening programmes and benefits rules continue to rely on a single BMI threshold across every market. Generic cut-offs of a BMI of 25 for overweight and 30 for obesity – and diabetes-screening criteria triggered at a BMI of 25 – remain embedded in official guidance in several countries. Although some of these guidelines also acknowledge the limitations of BMI and recommend assessment of waist circumference and comorbidities, the standard thresholds can still operate as the principal gateway to screening, referral or treatment. This is particularly important because cardiometabolic risk does not emerge at the same BMI across all populations.

| How different countries approach BMI                                  |                                                                                                                                               |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Some countries have adopted lower BMI action thresholds, for example: |                                                                                                                                               |
| India                                                                 | Generally defines overweight from BMI 23 and obesity from BMI 25 <sup>41</sup>                                                                |
| Singapore                                                             | Generally identifies moderate risk from BMI 23 and high risk from BMI 27.5 <sup>46</sup>                                                      |
| UK                                                                    | In the context of weight-loss medications, NICE recommends reducing BMI thresholds by 2.5 for several higher-risk ethnic groups <sup>47</sup> |

For multinational employers, global consistency should not mean identical thresholds. Employers should audit the criteria used across health assessments, diabetes screening, obesity programmes, prior authorisation and reimbursement to identify where a uniform BMI gate may overlook employees with meaningful cardiometabolic risk.

Where legally and clinically appropriate, employers and captives can fund earlier risk assessments using BMI alongside waist circumference or waist-to-height ratio, glycaemic status, blood pressure, lipids, fatty liver disease, sleep apnoea, cardiovascular or renal disease, family history and previous gestational diabetes. They can also broaden access to screening and multidisciplinary support beyond the minimum available through the local healthcare system.

Claims-derived risk models can help identify populations and markets for programme planning, but individual eligibility must be confirmed by an appropriately qualified clinician. Ethnicity or ancestry-driven risk factors should inform earlier assessment, not operate as a standalone treatment criterion.

Continuation criteria should focus on safety, clinical benefit, treatment tolerance and engagement with appropriate follow-up – not weight loss alone. Rigid performance thresholds can disadvantage people with slower but clinically meaningful responses and may encourage unhealthy behaviour.

Employers should also define transition arrangements before launch. Abrupt withdrawal of coverage can disrupt treatment, contribute to weight regain and undermine employee trust. Any change in coverage should include advance communication, clinical transition support and consideration of those already established on therapy.

A captive cannot rewrite local prescribing law – but it can prevent a generic BMI threshold from becoming an unnecessary barrier to earlier identification and care.



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### 3. FUNDING, PARTNERSHIP AND GOVERNANCE OPTIONS

**Traditional pharmacy-management tools – including formularies, prior authorisation, clinical eligibility criteria and, where appropriate, step therapy (requiring a patient to try several alternative and usually lower cost medication options before GLP-1s) remain important. However, they are not sufficient on their own to optimise long-term outcomes.**

Employers are increasingly exploring direct-to-employer, direct-pharmacy and specialist-provider arrangements that may offer more predictable pricing, negotiated discounts and integrated clinical support.<sup>48</sup> These models can create value, but they may also fragment care, reduce claims visibility or weaken coordination with the existing insurer and primary-care system. They should be assessed against the same standards for clinical governance, data quality, safety and continuity as conventional coverage.

Higher employee cost-sharing models may reduce use but can also reduce treatment persistence and worsen inequity by creating a financial barrier to access medication.<sup>49</sup> Cost-sharing decisions should be modelled for their effect on both budget and adherence rather than treated as a neutral demand-control mechanism.



### 4. CAPTIVE MODELS

**Captives and other self-funded and bespoke arrangements are powerful as they can give multinationals greater flexibility to design targeted coverage and negotiate directly with insurers.**

Multinationals writing their EB programmes through a captive will also be in a strong position to take control of costs to balance high upfront GLP-1 spending. By using a captive, the multinational becomes the ultimate risk bearer and has the power to cover claims that may not be possible under the terms and conditions of a local insurer.

This gives employers control to choose whether they wish to offer GLP-1 coverage in the markets they work in, regardless of local insurers’ policies.

The captive can also choose to reinvest any underwriting profits into wellbeing initiatives, wraparound care or to fund the additional pharmacy costs associated with GLP-1 coverage.

When writing a comprehensive GLP-1 programme through an EB captive, that flexibility should be accompanied by stronger governance: clear clinical criteria, privacy safeguards, independent outcomes assessment and transparent reporting to the employer and insurer.

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# 5. PHASED IMPLEMENTATION BY MARKET

A phased approach allows multinational employers to test programme design before committing to global rollout.

Priority markets should be selected using the combination of clinical need, access gap, delivery readiness and benefits flexibility – not simply the highest recorded obesity prevalence or the greatest employee demand. The following table offers a guide for a phased approach in a priority market and how to undertake a review.

## Pilot

A pilot should specify:

- target population
- eligibility model
- care pathway
- funding mechanism
- data fields
- outcomes
- time horizon
- comparison strategy (where feasible) to provide context for outcome changes.

## Review

The review should consider:

- treatment initiation
- treatment persistence
- metabolic outcomes
- adverse effects
- mental health outcomes
- MSK claims
- gastrointestinal claims
- inpatient utilisation
- outpatient utilisation
- total paid claims
- pharmacy spend
- disability outcomes
- employee experience.

Findings should be used to refine:

- eligibility criteria
- support mechanisms
- contracting arrangements before expansion.



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## 6. COMMUNICATING ACCESS FAIRLY AND RESPONSIBLY

**GLP-1 therapies sit within a highly visible cultural conversation about weight, body image and fairness. Employees may experience stigma for living with obesity, for using medication or for being unable to access treatment. Communication should therefore be clinically grounded, confidential and free from moral judgement.**

Employers should explain what the benefit covers, why clinical criteria apply, how privacy is protected and where employees can obtain independent medical advice. They should avoid language that presents thinness as the objective or implies that treatment is a reward for programme compliance.

Where different markets or employee groups have different access, the rationale should be clear and accessible in terms of regulation, clinical criteria, benefits design and programme readiness. Transparent principles are essential even when identical coverage is not possible in every country.

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# CONCLUSION

## BUILD THE PATHWAY BEFORE SCALING THE PRESCRIPTION

**For decades, obesity was viewed largely through the lens of lifestyle, personal responsibility and behaviour rather than as a chronic disease requiring medical treatment. That legacy still shapes insurance design today.**

The American Medical Association only formally recognised obesity as a disease in 2013, and in 2025 Italy became the first country to recognise it as a progressive, relapsing disease through national legislation.<sup>50,51</sup> Clinical understanding has therefore moved faster than reimbursement architecture. Many health plans continue to restrict obesity treatment while routinely covering its downstream consequences, including diabetes, cardiovascular disease and musculoskeletal conditions.

Against this backdrop, GLP-1 therapies are not simply another pharmaceutical launch. They are changing how healthcare systems, insurers and employers think about obesity, diabetes and cardiometabolic risk – and they are likely to affect a growing range of benefits over time.

The clinical opportunity is meaningful, but the financial outcome is not predetermined. MAXIS data shows encouraging reductions in selected cardiometabolic and procedural categories alongside greater increases in mental health, musculoskeletal and gastrointestinal spending. These patterns do not prove causation or establish that total costs have shifted, but they do show why the success of a GLP-1 programme cannot be measured through pharmacy spend or weight loss alone.

For multinational employers, the strongest strategy is neither blanket coverage nor blanket exclusion. It is a globally governed, locally adapted pathway that identifies populations with the greatest unmet need, accounts for the realities of local healthcare access, supports treatment safely and measures outcomes across the whole benefits system.

What does that strategy look like in practice?

Multinationals must:

- establish governance as early as possible – before demand accelerates.
- use workforce and claims data to rank markets and define clinically appropriate access.
- evolve benefits infrastructure and design to include wraparound care-led lifestyle interventions and mental health therapies.
- negotiate actively with insurers and pharmacy partners.
- measure total value before scaling.

How do you begin this evolution? We are big advocates of data monitoring. Multinationals' own EB programmes provide incredibly rich data from which to create a GLP-1 strategy that can evolve responsively and effectively to their workforce's needs.

Multinationals writing their EB programmes through a captive will also be in a strong position to take control of costs to balance

high upfront GLP-1 spending. Data can offer oversight of claims trends and the power to evolve the terms and conditions needed to reflect those patterns, subsequently generating underwriting profits that can be reinvested back into the wellbeing initiatives that sustain healthy lifestyles.

Done well, GLP-1 access can become part of a broader strategy, designed to intervene earlier in chronic disease and improve workforce health. Done poorly, it risks becoming an expensive prescription benefit disconnected from the clinical and behavioural support required to sustain its effectiveness.

The strategic question is therefore no longer simply whether GLP-1s should be covered. It is whether employers are prepared to build a system around them.

**Thank you to Richard Reyf, Talia Shadwell, the MAXIS Health & Wellness and Marketing teams for all their work producing this whitepaper, and Mattieu Rouot for his support and contributions.**

GLP-1 coverage varies significantly by market and insurer. Multinationals should work with their local insurance partners to understand applicable coverage rules, clinical eligibility criteria, prior-authorisation requirements, exclusions and continuation protocols in each market.

MAXIS+ clients can contact a MAXIS representative for information about covering GLP-1s in their employee benefits programme.



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