GLP-1 DRUGS

EMPLOYERS EXPERIMENT WITH DIRECT-TO-CONSUMER ACCESS

EMPLOYERS GRAPPLING with the cost and complexity of GLP-1 drugs are increasingly testing a workaround: steering certain employees to direct-to-consumer (DTC) arrangements that operate outside the company's health plan.

The shift reflects a growing tension for benefits executives: how to manage soaring GLP-1 demand while preserving affordability, plan sustainability and clinical oversight.

How direct-to-consumer works

Under a DTC model, employees purchase GLP-1 drugs outside the pharmacy benefit on a manufacturer or designated website. Deductibles, out-of-pocket maximums, prior authorization and PBM utilization management requirements do not apply.

While this removes plan-level clinical guardrails, it can materially lower employees' monthly costs. In many cases, cash-pay prices offered by manufacturers or online platforms are lower than what employees would pay through insurance even after discounts and coinsurance.

Instead of covering GLP-1s as a plan benefit, some employers provide fixed monthly stipends — often $100 to $200 — to offset the cost of direct purchases. This allows employers to cap financial exposure while still offering employees access to treatment.

Drug manufacturers are accelerating this shift. Eli Lilly and Novo Nordisk have expanded DTC programs that allow patients to purchase GLP-1 drugs without using insurance, with monthly cash prices below historical list prices.

Beyond consumer programs, both Lilly and Novo Nordisk are piloting direct-to-employer models that bypass traditional PBM structures. In these arrangements, self-insured employers negotiate pricing directly with manufacturers, while third-party administrators handle eligibility screening, prescribing coordination and fulfillment. The goal is to move pricing closer to net cost and reduce employee cost-sharing.

According to the Peterson Health Technology Institute, some employers are evaluating DTC and DTE arrangements because these may offer lower prices than those through traditional pharmacy benefits. They also provide employers with more predictable spending.

However, benefits leaders should view these arrangements as complementary tools rather than replacements for a structured GLP-1 strategy.

Pros and cons of DTC arrangements

Advantages

- Lower out-of-pocket costs for certain employees.
- Second-chance access for employees who do not qualify under plan rules.
- Predictable employer cost exposure when using fixed stipends or subsidies.
- DTC models typically bypass prior authorization and PBM requirements, reducing friction and administrative delays for employees.

Disadvantages

- Loss of clinical oversight and utilization controls. Off-benefit purchases bypass prior authorization, step therapy and ongoing clinical management built into the plan.
- Employers lose access to claims data needed to track adherence, safety, effectiveness and long-term cost trends.
- Employees may underestimate their total financial exposure, particularly if they later transition back to plan-based coverage.
- Cash-pay prices can make plan coverage appear inefficient or overpriced, even when the pricing structures are not directly comparable.
- Manufacturer DTC pricing reflects market strategy, not negotiated benefit contracts, and can change or be withdrawn with little notice.
- Once established for GLP-1s, employees may expect similar pathways for other high-cost medications.