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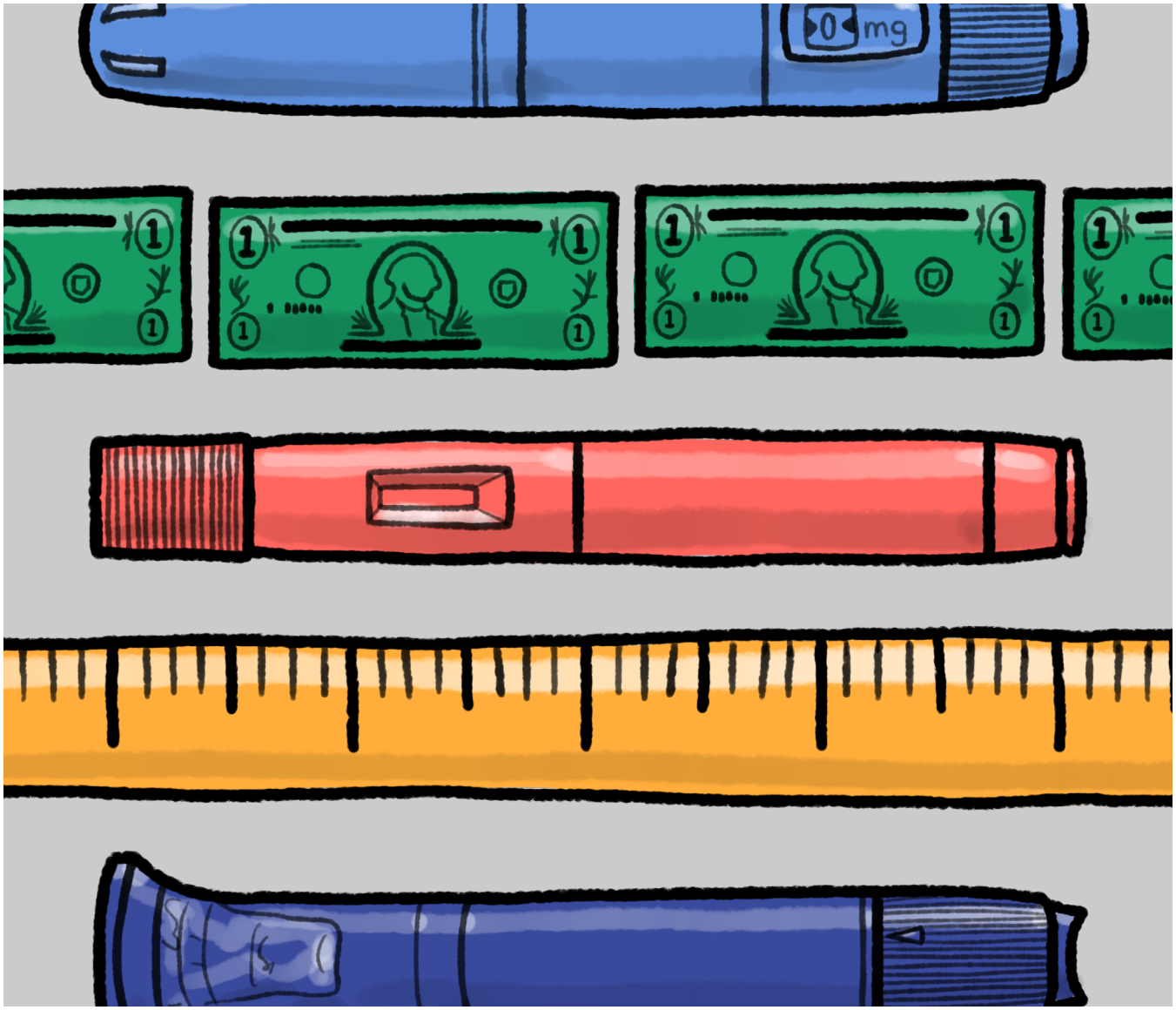

ENSURING AFFORDABILITY & ADVANCING PUBLIC HEALTH WITH GLP-1s

POLICY GUIDE FOR STATE LEADERS

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THE NEW SCHOOL
Institute on Race, Power and Political Economy

HEALTH+ POLITICAL ECONOMY PROJECT

THE CHALLENGE

GLP-1 medications, including well-known names like Ozempic, Wegovy, Mounjaro, and Zepbound, are clinically proven to treat metabolic diseases (including diabetes and obesity) and prevent costly complications of these diseases.[1,2] While these medications have strong promise for improving individual health and well-being and achieving broader public health impacts, their high upfront costs due to patent protection, monopoly pricing, and insurer cost-shifting create major access barriers.

For state policymakers overseeing both public health insurance programs and employee health plans, this leads to a difficult choice:

- Broadly cover GLP-1s when clinically-indicated, accepting near-term budget strain due to high costs but likely achieving meaningful long-term public health returns, or
- Restrict access to GLP-1s, avoiding near-term budget strain but incurring increased future costs through spending on Type 2 diabetes, cardiovascular disease, kidney disease, and other obesity-related conditions.

As evidence of this pressing choice, multiple states have recently ended coverage of GLP-1s to treat obesity in their Medicaid programs, citing budget constraints.[3,4,5]

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1 Lincoff, A. M. et al. (2023). Semaglutide and cardiovascular outcomes in obesity without Diabetes. *New England Journal of Medicine, 389*(24), 2221–2232. https://doi.org/10.1056/nejmoa2307563

2 Drucker, D. J. (2025). GLP-1-based therapies for diabetes, obesity and beyond. *Nature Reviews Drug Discovery, 24*(8), 631–650. https://doi.org/10.1038/s41573-025-01183-8

3 Berger, E. (2026, April 14). US states drop Medicaid coverage of GLP-1 weight-loss drugs as demand rises. *The Guardian.*

4 Williams, E. (2026, January 16). *Medicaid coverage of and spending on GLP-1s*. KFF.

5 While Medicaid typically must cover all FDA-approved drugs of manufacturers that participate in the Medicaid Drug Rebate Program, states are allowed to restrict coverage of weight loss medications under program rules.

THE STATE POLICY OPTIONS

Breaking through this dichotomy requires pursuing affordability via lower list prices. However, states cannot rely on voluntary price reductions from pharmaceutical corporations, and therefore must consider their counterbalancing authority and purchasing power. In response to the pressing combination of patient access, public health, and public finance goals at stake, this guide recommends multiple approaches states can use to lower GLP-1 costs while preserving access for residents.

In outlining recommended solutions, we prioritize:

- **Simple, affordable, and equitable access for patients:** Promoting equitable access to GLP-1s requires accountable, authentic patient engagement and allows people to maintain agency over their health and their lives regardless of income, insurance status, or neighborhood. Diabetes and obesity disproportionately affect Black, Latine, Native American, and low-income populations, driven by structural and social determinants of health including access to housing, healthy food, environmental quality, transportation, and economic security.[6,7,8] These same communities also face inequitable access to healthcare and quality health insurance coverage. Thus, both high prices broadly and restricted access, especially for Medicaid patients, create inequitable barriers to care for already vulnerable populations.[9]

- **Cost-effectiveness for states:** If states can afford to maintain or increase coverage of GLP-1s at lower prices, they may see improved health and stronger cost-effectiveness over time.[10] For example, investments in obesity treatments yield measurable returns, with one study showing a 5% weight reduction cuts annual healthcare costs by $670 per patient.[11] Diabetes prevention and treatment programs have also shown documented cost-savings.[12,13]

- **Renewed public power and capacity for a stronger healthcare system:** As health insurance costs and pharmaceutical prices increase, the public sector must build and leverage public power to contest concentrated corporate interests and ensure our healthcare system is oriented toward high-quality patient care. Bold state action on GLP-1s can ensure patients have access to needed medicines without navigating the complex barriers of limited insurance coverage, restricted formularies, and opaque discounts and rebates.

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6 Bentley, R. A., Ormerod, P., & Ruck, D. J. (2018). Recent origin and evolution of obesity-income correlation across the United States. *Palgrave Communications,* 4(1). https://doi.org/10.1057/s41599-018-0201-x

7 Deng, Y., Moniruzzaman, M., Rogers, B., Hu, L., Jagannathan, R., & Tamura, K. (2024). Unveiling inequalities: Racial, ethnic, and socioeconomic disparities in diabetes: Findings from the 2007-2020 NHANES data among U.S. adults. *Preventive Medicine Reports*, 102957–102957. https://doi.org/10.1016/j.pmedr.2024.102957

8 Hill-Briggs, F., Adler, N. E., Berkowitz, S. A., Chin, M. H., Gary-Webb, T. L., Navas-Acien, A., Thornton, P. & Haire-Joshu, D. (2020). Social determinants of health and diabetes: a scientific review. Diabetes care, 44(1), 258. https://pmc.ncbi.nlm.nih.gov/articles/PMC7783927/

9 Chungsoo, K., Ross, J.S., Jastreboff, A.M, et al. (2025). Uptake of and Disparities in Semaglutide and Tirzepatide Prescribing for Obesity in the US. *JAMA. 333*(24), 2203–2206. https://doi.org/10.1001/jama.2025.4735

10 While we aim to support states in managing their health care costs, the potential for states to realize cost savings will depend on long-term utilization, insurance coverage, and other factors. Detailed economic modeling can help states assess concrete budget impacts of each solution.

11 Thorpe, K. E., & Joski, P. J. (2025). Estimated reduction in health care spending associated with weight loss in adults. *JAMA Network Open, 7*(12). https://doi.org/10.1001/jamanetworkopen.2024.49200

12 Kuo, S., Ye, W., Wang, D., McEwen, L. N., Santos, C. V., & Herman, W. H. (2024). Cost-effectiveness of the National Diabetes Prevention Program: A real-world, 2-year prospective study. *Diabetes Care, 48*(7). https://doi.org/10.2337/dc24-1110

13 Zhong, Y., Lin, P.-J., Cohen, J. T., Winn, A. N., & Neumann, P. J. (2015). Cost-utility analyses in Diabetes: A systematic review and implications from real-world evidence. *Value in Health, 18*(2), 308–314. https://doi.org/10.1016/j.jval.2014.12.004

RECOMMENDATION 1

ADVOCATE FOR THE FEDERAL GOVERNMENT TO PURSUE GENERIC GLP-1 LICENSING

States should formally request the federal government authorize use of the necessary patents to allow production of generic alternatives to GLP-1s through its authority under 28 U.S.C. § 1498 ("Section 1498"). Under Section 1498, the federal government would provide reasonable compensation to the patent holder and could then produce GLP-1s directly or contract with a generic producer.[14] A recent petition to the U.S. Department of Health and Human Services (HHS) filed by nonpwrofit consumer advocacy organization Public Citizen outlines how invoking Section 1498 for GLP-1s could contain costs within public programs including Medicaid and Medicare.[15, 16]

Unlike in the U.S., where patents prevent generic GLP-1 competition for many years, key patent and regulatory exclusivities on semaglutide have already expired in Canada and will expire in several other countries throughout 2026.[17] In Canada, generic producers have been preparing to launch more affordable versions of semaglutide with list prices as low as $73 per month.[18] Canada approved the first two generic semaglutide products in April and is currently reviewing seven other applications.[19,20]

While comparing these to U.S. prices can be challenging given spread pricing and variability by insurance coverage and medication, the U.S. list prices of GLP-1 drugs currently range from $200 to $1,350 per month.[21,22] Notably, some Medicare patients will be eligible to receive certain GLP-1 medications for $50 a month beginning in July 2026. However, patients must have Medicare Part D drug coverage, which is a supplemental benefit, must not currently use GLP-1s covered by that plan, and must meet certain medical criteria.[23] Conditioning participation on already having supplemental prescription drug coverage and not expanding the program to non-Medicare patients means even this federal attempt at ensuring affordability stands to worsen inequities in access.

Notably, multiple states have already taken public action related to generic licensing of GLP-1s. In 2024, the North Carolina State Treasurer also submitted a letter to HHS under the Biden administration advocating for the federal government to pursue generic licensing of branded GLP-1s to reduce costs for its health plan.[24] In 2025, the Connecticut State Legislature passed a law directing the State Department of Social Services to submit a similar petition to HHS.[25]

While states cannot invoke Section 1498 themselves, if the federal government were to do so, states could both achieve significant cost-savings and ensure broad access to treatment for people who receive health insurance coverage through public programs. A state-led movement for federal generic GLP-1 licensure offers a path towards mitigating the downstream effects of structural health-based inequities, which result

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14 For a detailed analysis of the federal government's authority under Section 1498 and its usefulness on this issue, see Brennan, H., Kapczynski, A., Monahan, C. H., & Rizvi, Z. (2016). A prescription for excessive drug pricing: Leveraging government patent use for health. *Yale Journal of Law and Technology,* 18(1), 7.

15 *New HHS petition Calls on the Trump Administration to Authorize Affordable Generic GLP-1 Drugs for Americans*. (2026, February 12). Public Citizen.

16 Public Citizen has led organizing and advocacy efforts around this proposed federal use of Section 1498 and provided significant contributions to the development of this recommendation.

17 In the U.S., generic semaglutide is prevented until at least 2032 and generic tirzepatide is prevented until at least 2036.

18 Zafar, A. (2026, January 6). Cheaper obesity medications could come to Canada this summer, as Health Canada reviews generics. CBC News.

19 Padmanabhan Ananthan. (2026, April 28). Canada approves first generic version of Ozempic amid rising GLP-1 competition. *Reuters.*

20 Health Canada. (2026, May 1). *Canada approves second generic semaglutide, the first G7 country to do so*. Government of Canada.

21 Ellsworth, K. T. (2026, March 30). *How much do GLP-1 medications cost?* USA Today.

22 The complexities and financialization of the U.S. healthcare system mean list prices often do not accurately capture the price patients pay for medications. For patients with commercial insurance, co-pays for GLP-1s can range from $25-$150 per month. Eligible patients who do not have insurance or cannot get coverage through their insurance can pursue manufacture rebates or direct-to-consumer programs ranging from $149-$499 per month.

23 *Medicare GLP-1 Bridge*. (2026, June 22). Centers for Medicare and Medicaid Services.

24 Folwell, D. (2024, July 29). *Letter to U.S. Dept. of Health and Human Services Secretary Xavier Becerra Re: Need for Federal Action Due to Unaffordability of GLP-1 Weight Loss Drugs* [Letter].

25 H.B. 7192, 2025 Gen. Assemb., Reg. Sess. (Conn. 2025)

in persistent disparities in metabolic disease rates across race and socioeconomic status, and expanding access to essential medicines, especially for Medicare and Medicaid recipients across the country. As GLP-1 prices increasingly strain state budgets, advocacy from state leaders can build public awareness of and support for federal action.

RECOMMENDATION 2

ENACT REFERENCE PRICING BASED ON MEDICARE MAXIMUM FAIR PRICES

States should enact legislation to cap what payers can pay for certain high-cost drugs. Specifically, states should establish the authority to set that cap at the prices Medicare has already negotiated by tying upper payment limits (UPLs) to Medicare's maximum fair price (MFP) for applicable drugs.

The Medicare Drug Price Negotiation Program, established as a provision of the Inflation Reduction Act of 2022 (IRA) under the Biden administration, allows the Centers for Medicare and Medicaid Services (CMS) to directly negotiate the price of certain high-cost drugs for the first time.[26] CMS negotiated maximum fair prices (MFPs) for 10 drugs in its first round of negotiations, for which the negotiated MFPs took effect January 1, 2026.[27] Already, these MFPs are projected to save both Medicare and patients money. CMS estimates Medicare would have saved $6 billion, or a net savings of 22%, if the negotiated MFPs had been in effect in 2023 and that Medicare beneficiaries will save $1.5 billion in 2026 with just round 1 price negotiations.[28]

To leverage these MFPs and extend these savings beyond Medicare and its beneficiaries, states should pursue legislation enabling them to set Medicare's maximum fair price as the upper payment limit on reimbursements for applicable drugs. As proposed in recently revised model legislation from the National Academy for State Health Policy (NASHP), states can use these UPLs for the entire state-regulated commercial market.[29,30] Importantly, NASHP's model explicitly allows self-insured plans, which are regulated under the federal Employee Retirement Income Security Act (ERISA), to opt-in, extending participation in these capped prices to plans that cover workers who receive health insurance coverage through self-insured employer plans.

Regarding GLP-1s specifically, CMS included the GLP-1s Ozempic, Rybelsus, and Wegovy in their second round of price negotiations.[31] The negotiated MFPs for these drugs is $274 and will take effect January 1, 2027.[32] Notably, this price is $29 higher than the $245 price the Trump administration announced as part of a recent most-favored-nation pricing deal with Novo Nordisk. While it is unclear how these prices will interact, states should pay attention to how this price difference plays out once the Medicare MFP takes effect in January 2027 and adapt their GLP-1 reference price accordingly.

Ensuring Medicare MFPs benefit non-Medicare beneficiaries promotes pricing equity and expands affordability to broader populations. While the large rebates Medicaid programs already receive through the Medicaid Drug Rebate Program may mean state Medicaid programs would opt-out of using Medicare MFPs, we recommend states explicitly evaluate this for GLP-1s given the unique and dynamic market.

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26 Cubanski, J. C., & Neuman, T. (2026, March 11). *Key facts about Medicare drug price negotiation*. KFF.

27 CMS's first round of Medicare price negotiations included Januvia, Fiasp and variations (Fiasp FlexTouch, Fiasp PenFill, NovoLog, NovoLog FlexPen, and NovoLog PenFill), Farxiga, Enbrel, Jardiance, Stelara, Xarelto, Eliquis, Entresto, and Imbruvica.

28 Centers for Medicare and Medicaid Services. (2024). *Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2026*.

29 National Academy for State Health Policy. (2026, June 29). *Revised model legislation: An Act to reduce prescription drug costs using Medicare Maximum Fair Price (MFP) reference-based pricing*. NASHP.

30 States could also apply UPLs to a narrower group, such as people covered by state employee health plans.

31 Centers for Medicare and Medicaid Services. (2025). *Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2027*.

32 Cubanski, J. (2025, November 26). *Understanding the Trump administration's negotiated drug prices for Medicare*. KFF.

RECOMMENDATION 3

PURSUE STATE-RUN DRUG IMPORTATION FROM CANADA THROUGH THE SECTION 804 IMPORTATION PROGRAM (SIP) FOR MEDICAID

Given lower drug pricing in Canada, states could also seek federal approval to import applicable medicines, including certain GLP-1s, for their Medicaid programs under the Section 804 Importation Program (SIP). Two states have obtained U.S. Food and Drug Administration authorization under SIP to date: Florida in 2024 and Colorado in June 2026.[33, 34]Notably, Colorado's approved drug list includes Ozempic (semaglutide), establishing that brand-name injectable GLP-1s are viable SIP candidates.[35, 36]

While no state has yet imported drugs through this pathway, several additional states have enacted authorizing legislation and are pursuing FDA approval.[37] To successfully implement SIP, states will need to navigate administrative hurdles, including finding a willing Canadian supplier, which has proven difficult for Florida and Colorado. Yet the benefit could be substantial, especially for delivering on a commitment to equitable access to medicines for Medicaid populations that are facing increased restrictions to coverage through state programs.[38]

RECOMMENDATION 4

DEVELOP A SUBSCRIPTION PURCHASING MODEL FOR GLP-1S

In the absence of meaningful federal action, states can develop subscription purchasing models to leverage their bulk purchasing power (also known as a "Netflix model" or an advanced purchasing commitment).[39] In a subscription purchasing model, a state negotiates with a drug manufacturer to secure either a capped annual price for unlimited access to the drug or a fixed subscription fee per treatment course with a spending cap.[40]

Through this approach, states achieve:

- **Immediate discounts:** States maximize public resources by leveraging their purchasing power through Medicaid, employee plans, and other programs to secure a lower price;
- **Budget predictability:** States eliminate uncertainty in pharmaceutical spending by securing a known price for volume; and
- **Potential for increased patient access:** If patient use of GLP-1s increases, the manufacturer absorbs the increased cost in line with the negotiated model.Subscription models for state pharmaceutical purchasing have proven successful. In 2019, Louisiana negotiated a subscription model for hepatitis C treatment that transformed a projected $760 million cost into a fixed $35 million annual payment. This

33 U.S. Food and Drug Administration. (2024, January 5). *FDA authorizes Florida's drug importation program* [Press release].

34 Colorado Department of Health Care Policy & Financing. (2026, June). *Colorado's drug importation program: Frequently asked questions.*

35 Daley, J. (2026, June 15). *Colorado wins federal approval to import prescription drugs from Canada.* Colorado Public Radio.

36 SIP eligibility does not currently extend to generic GLP-1s, since the SIP pathway requires the imported drug to mirror an existing FDA-approved brand or generic already marketed in the U.S., and no FDA-approved generic semaglutide or tirzepatide exists yet.

37 Ravitz, J. R., Gadiock, P. S., Hill Daley, M., & Jackson, K. (2024, May 16). Imported drugs: (Possibly) coming soon to a state near you. National Law Review.

38 Tu, S. S., Kesselheim, A. S., Tadrous, M., & Beall, R. F. (2026). Early generic semaglutide in Canada—Implications for US patients and policy. JAMA Internal Medicine. https://doi.org/10.1001/jamainternmed.2026.2209

39 Pennsylvania state legislators introduced bipartisan GLP-1 subscription purchasing legislation in 2025.

40 In a fixed subscription fee model, if the state purchases a predetermined number of subscriptions, the manufacturer provides additional treatments at no additional cost to the state.

approach increased hepatitis C prescription fills by 534% in Louisiana, dramatically expanding access while controlling costs.41

A subscription model for GLP-1s will be most beneficial to states that are positioned to negotiate hard for ideal economic terms and incorporate the model into existing public health programs, given the dynamic pricing environment and GLP-1s' role as a non-curative treatment.[42] Importantly, for a subscription purchasing model to ensure equitable access, states must intentionally negotiate with this goal in mind. For example, states should condition the agreement on ensuring the negotiated prices allows the state to include it on its Medicaid formulary.

Manufacturers of some existing GLP-1s may be especially incentivized to negotiate with states as the recent introduction of oral versions of GLP-1s, like orforglipron, and impending introduction of newer agents in the class, like retatrutide, threaten to disrupt their market share. Novo Nordisk's market share appears particularly vulnerable to these trends.[43]

RECOMMENDATION 5

PURSUE INTERSTATE PURCHASING COALITIONS FOR GLP-1S

States should leverage existing networks, or build new ones if necessary, to form multi-state purchasing coalitions and pool demand across State-run public programs to negotiate deeper discounts than any single state could achieve alone.

This approach has precedent: ArrayRx, initially formed by Washington and Oregon, has enabled participating states to negotiate lower prices by combining purchasing volume.[44] Beyond immediate savings, interstate coalitions build shared administrative capacity that states can leverage when navigating other high-cost drugs. However, this requires an upfront investment in a shared governance framework to support coordination across different state procurement rules and Medicaid structures.

States could begin a GLP-1-focused coalition with a small group of willing states and expand membership as the model demonstrates results. This coalition should include stakeholders representing populations with the highest concentrations of diabetes, obesity, and other metabolic diseases across each state to strengthen community participation in the decision-making process.

ABOUT US

This Policy Guide is authored by the Health and Political Economy Project at the Institute on Race, Power and Political Economy (HPEP) and endorsed by T1International and health policy expert Stephanie Krieg. The Partnership for Public Pharma provided significant contributions to ideation and development.

To follow up on this brief or to get in touch with authors, endorsers, or the Partnership for Public Pharma, please contact HPEP Director Mara Heneghan at henegm@newschool.edu.

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41 McKoy, J. (2021, August 27). *Subscription-based payment models may improve access to Hepatitis C medications*. *Boston University School of Public Health.*

42 Subscription models provide significant benefits for manufacturers through multi-year contracts that enable certainty in exchange for lower pricing, essentially guaranteeing a market. This is especially true for non-curative treatments like GLP-1s.

43 Novo Nordisk currently manufactures semaglutide and liraglutide, while Eli Lilly manufactures tirzepatide, orforglipron, and retatrutide.

44 *ArrayRx*. (2026). ArrayRx Solutions; Moda Partners, Inc.