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The $245 Question: How New GLP-1 Pricing Could Transform Medicare Part D

An Early Analysis of Proposed GLP-1 Changes

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On November 6, 2025, the Trump Administration announced[1] an intent to significantly reduce prices and expand coverage of GLP-1 medications used for diabetes, obesity, and cardiovascular conditions. This announcement came in the form of an agreement with pharmaceutical manufacturers Eli Lilly and Novo Nordisk. If implemented, this change would materially alter both the cost structure and expected utilization of GLP-1 therapies in Medicare Part D starting in 2026.

Key components of the proposal for Medicare Part D include:

- **Price Caps:** Medicare prices for key GLP-1s would be set at **$245 per month**.
    - Would initially apply to use of Ozempic, Wegovy, Mounjaro, and Zepbound[2]
- **Cost Sharing Limits:** Member cost sharing would be reduced to a **$50 monthly copay**.
- **Expanded Clinical Eligibility:** Coverage could extend beyond diabetes to **obesity and related comorbidities**.
    - This coverage expansion was initially proposed by the Biden Administration in 2024; however, this proposal was removed in 2025 and was therefore not included in 2026 Part D bids.

This paper provides a high-level overview of the proposed changes. It also examines the potential impact of these changes on Medicare Part D, including an analysis of the potential number of Part D members affected by expanded coverage and lower cost sharing, along with a high-level analysis of the potential change in net plan liability for Part D plans. Wakely, an HMA (Health Management Associates) Company, also highlights several outstanding questions regarding these potential changes.

The proposed GLP-1 price reductions are significant. Impacts on Part D plans are nuanced and expected to vary widely across organizations and plans. Not all members are expected to see lower cost sharing; in fact, some members may experience higher cost sharing.

[1] The White House. Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients. November 6, 2025. Available at: https://www.whitehouse.gov/fact-sheets/2025/11/fact-sheet-president-donald-j-trump-announces-major-developments-in-bringing-most-favored-nation-pricing-to-american-patients/

[2] These four drugs represent approximately 64 percent of all GLP-1 allowed costs, based on a Wakely analysis of 2024 Prescription Drug Event (PDE) data across 36 organizations.

The announcement also included details regarding changes to GLP-1 costs and access under Medicaid and a new direct-to-consumer website planned for launch in 2026, TrumpRx. This paper, however, focuses on the impacts to Medicare Part D.

Our analysis includes the following key findings:

- Approximately 72 percent of Part D members are enrolled in plans with a copay for relevant GLP-1 medications. These members will likely see either no change or higher annual cost sharing under the proposed policy because of the "greater of" maximum out of pocket accumulation logic.
- Approximately 28 percent of Part D members are classified as non-low-income (NLI) and are enrolled in Part D plans with a coinsurance for relevant GLP-1 medications. These members are likely to see lower annual cost sharing under the proposed policy.
- The net plan paid impact of changes in both GLP-1 list prices and expanded access varies widely and depends upon plan rebate levels, benefit design, GLP-1 utilization rates, and other cost drivers (see Table 1).
- Several questions remain regarding implementation of the proposed changes. Plans should evaluate these revisions, monitor additional details from the Centers for Medicare & Medicaid Services (CMS), and begin building strategies and contingencies for the potential impacts.

To illustrate the variation in paid impacts, Table 1 contains a summary of several scenarios that Wakely modeled to calculate the potential effect of the proposed changes on net plan liability. Specifically, this table shows that the impact of the reduced GLP-1 prices on net plan liability (plan paid amount net of rebates) ranges from a decrease of approximately $3 per member per month (PMPM) to an increase of approximately $4 PMPM depending on the rebate assumption and utilization adjustment used.

Table 1. Summary of Net Plan Liability Scenario Modeling[3]

Scenario	GLP-1 Rebate / Allowed Assumption	GLP-1 Utilization Adjustment	GLP-1 PMPM Net Plan Liability Increase / (Decrease)
Scenario 1	40%	0%	-$3.34
Scenario 2	40%	17%	-$2.59
Scenario 3	40%	77%	$0.02
Scenario 4	50%	0%	-$1.35
Scenario 5	50%	17%	-$0.60
Scenario 6	50%	77%	$2.01
Scenario 7	60%	0%	$0.64
Scenario 8	60%	17%	$1.39
Scenario 9	60%	77%	$4.00

[3] Omits the impact of reduced cost sharing on members ($50 copay max). The 17 percent utilization adjustment assumes a 10 percent GLP-1 prevalence rate for currently eligible members (pre-expanded access) and a 2.2 percent take-up rate for newly eligible members. The 77 percent utilization adjustment reflects a 10 percent prevalence rate for both eligible populations. Net plan liability change assumes rebates go to $0 with updated list prices.

CHANGES ANNOUNCED

Table 2 contains a summary of what is known so far regarding proposed changes to GLP-1 costs and coverage in Part D.

Table 2. Proposed GLP-1 Changes

Area	Current State	Proposed Change	Potential Implications
Drug Prices	List prices are **~$1,000 to $1,350/ month**[4] for applicable GLP-1s (Ozempic, Wegovy, Mounjaro, and Zepbound)	Capped at **$245/month** for Medicare	Reduction in ingredient cost Impact on dispensing fee (and total allowed cost) is unknown
Member Cost Sharing	**Low-Income (LI) Members:** Brand copays range from $0 to $12.65 per script **NLI Members:** Depends on plan design (copays from $0–$47, coinsurance up to 33%)	$50/month maximum for all members	**No change or higher cost sharing for LI members and some NLI members** on plans with a copay **Lower cost sharing for some NLI members** on plans with a coinsurance Potential **increase in net plan liability** (or CMS subsidy amounts[5]) due to lower cost sharing

[4] Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients.

[5] At present, CMS has not announced whether Part D plans will be liable for the increased costs from lower member cost sharing or if CMS will subsidize this amount in some way.

Area	Current State	Proposed Change	Potential Implications
Covered Indications/ Member Access	Limited to members with type 2 diabetes or cardiovascular conditions Not covered for weight loss only	Potential expansion for people who are obese, are overweight, and have related comorbidities	Increase in member access and associated utilization
Timeline	Coverage changes previously proposed in 2024 for 2026 plan year **but revoked in 2025** **Price reductions expected for Ozempic and Wegovy in 2027** through Medicare Drug Price Negotiation Program	Uncertain, but potentially April 2026 or mid-year 2026[6]	Acceleration of price reductions from 2027 to 2026 for Ozempic and Wegovy

As summarized above, the GLP-1 announcement is expected to significantly reduce ingredient costs for the announced GLP-1 drugs; however, Medicare Part D allowed costs include both ingredient costs and a per script dispensing fee. As expected with Medicare negotiated drugs in 2026, some partial offset increase in dispensing fees may be put in place for certain pharmacy distribution channels such as long-term care. This change is expected for negotiated drugs as some pharmacies may increase dispensing fees to avoid losing money on these drugs; however, potential increases to dispensing fees are unlikely to exceed the reductions in ingredient cost.

It is also worth noting that Ozempic and Wegovy will already see reduced list prices through the Medicare Drug Price Negotiation Program (MDPNP) starting in 2027[7] (along with Rybelsus). These drugs have a 30-day negotiated price of $274, which is higher than the $245 price announced through the previous Trump Administration Most Favored Nation announcement. Therefore, it is unclear how the two prices will interact with one another starting in 2026. It is

[6] Constantino AK. Trump Announces Deals with Eli Lilly, Novo Nordisk to Slash Weight Loss Drug Prices, Offer Some Medicare Coverage. CNBC. November 6, 2025. Available at: https://www.cnbc.com/2025/11/06/trump-eli-lilly-novo-nordisk-deal-obesity-drug-prices.html.

[7] Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2027. November 2025. Available at: https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf

possible that the $245 price will be the prevailing price as the minimum value of the two negotiated prices for these two drugs.

Importantly, not all members will be favorably impacted by the $50/month cost sharing cap. Low-income (LI) members already are subject to a cap on their copay, which is $12.65 for branded drugs in 2026. Therefore, LI beneficiaries will see no lower cost sharing as a result of the $50 copay cap. Furthermore, some NLI members already see reduced cost sharing through their enhanced Part D plan design because many plans offer GLP-1 drugs on Tier 3 with a copayment of $47 or less. For these beneficiaries, their cost sharing will likely increase as less cost sharing is accumulated to the True Out of Pocket (TrOOP) through the "greater of" logic. Therefore, the only members who are likely to experience lower cost sharing through the $50 copay cap are NLI members who pay coinsurance on GLP-1s. We examine the expected distribution and size of this population below.

Finally, the announcement shows an expansion of eligibility for GLP-1s in Medicare. While exact eligibility rules are still in question, early indications of expanded eligibility include:[8]

- Beneficiaries who are overweight, with a body mass index (BMI) greater than 27 or with prediabetes or established cardiovascular disease
- People with obesity (BMI >30) and uncontrolled hypertension, kidney disease, or heart failure
- Patients with severe obesity, or anyone with a BMI greater than 35

ANALYSIS OF ACCESS EXPANSION AND COST SHARING

To analyze the impact of the proposed GLP-1 changes on member access/utilization and cost sharing, we summarized data from 2025 publicly available CMS formulary files by plan for the relevant GLP-1 drugs (Ozempic, Wegovy, Mounjaro, and Zepbound), along with plan-level enrollment (as of September 2025),[9] plan-level, low-income percentages,[10] and other studies that show projected GLP-1 eligibility and take-up rates across the population.

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[8] Ibid.

[9] Centers for Medicare & Medicaid Services. Monthly Enrollment by Plan – September 2025. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-plan/monthly-enrollment-plan-2025-09.

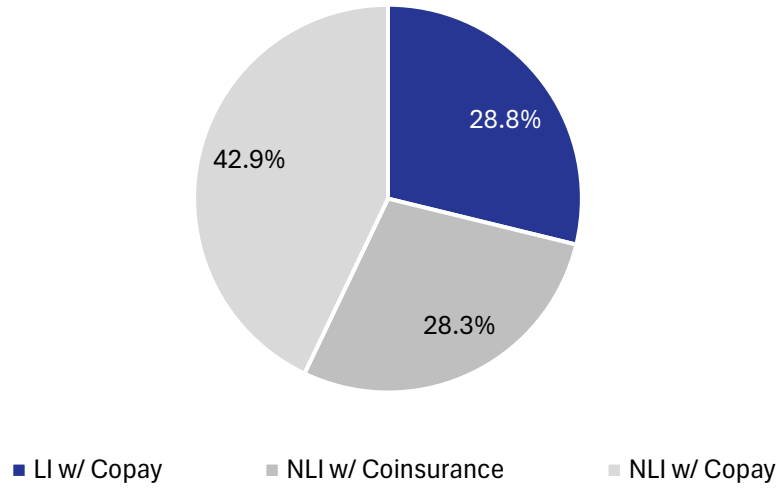
[10] Centers for Medicare & Medicaid Services. 2025 Low Income Subsidy Enrollment by Plan. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/lis-enrollment-plan/2025-low-income-subsidy-enrollment-plan.

The analysis includes the following assumptions:

- 50 percent of the total Medicare Part D population would be eligible for GLP-1s under the expanded eligibility rules.[11]
    - 28 percent currently eligible (not obese/overweight)
    - 22 percent newly eligible (obese or overweight)
- 10 percent of currently eligible members will use GLP-1s in 2026.[12]
- 2.2 percent of newly eligible members will use GLP-1s in 2026.[13]

The results of this analysis are shown in Figure 1.

Figure 1. Percent of Total Part D Population by LI Status and GLP-1 Cost Sharing Design



[11] Based on Congressional Budget Office (CBO) analysis of initially-proposed GLP-1 coverage expansion (https://www.cbo.gov/publication/60816) in 2026 and CBO's projection of Medicare Part D membership in 2026 (https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf). Note that the eligibility expansion in the CBO study may not directly align with eligibility rules proposed under the recent Trump Administration announcement.

[12] Hwang JH, Laiteerapong N, Huang ES, Mozaffarian D, Fendrick AM, Kim DD. Fiscal Impact of Expanded Medicare Coverage for GLP-1 Receptor Agonists to Treat Obesity. *JAMA Health Forum*. 2025;;6(4):e250905. doi: 10.1001/jamahealthforum.2025.0905

[13] Congressional Budget Office. How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect the Federal Budget? October 2024. Available at: https://www.cbo.gov/publication/60816.

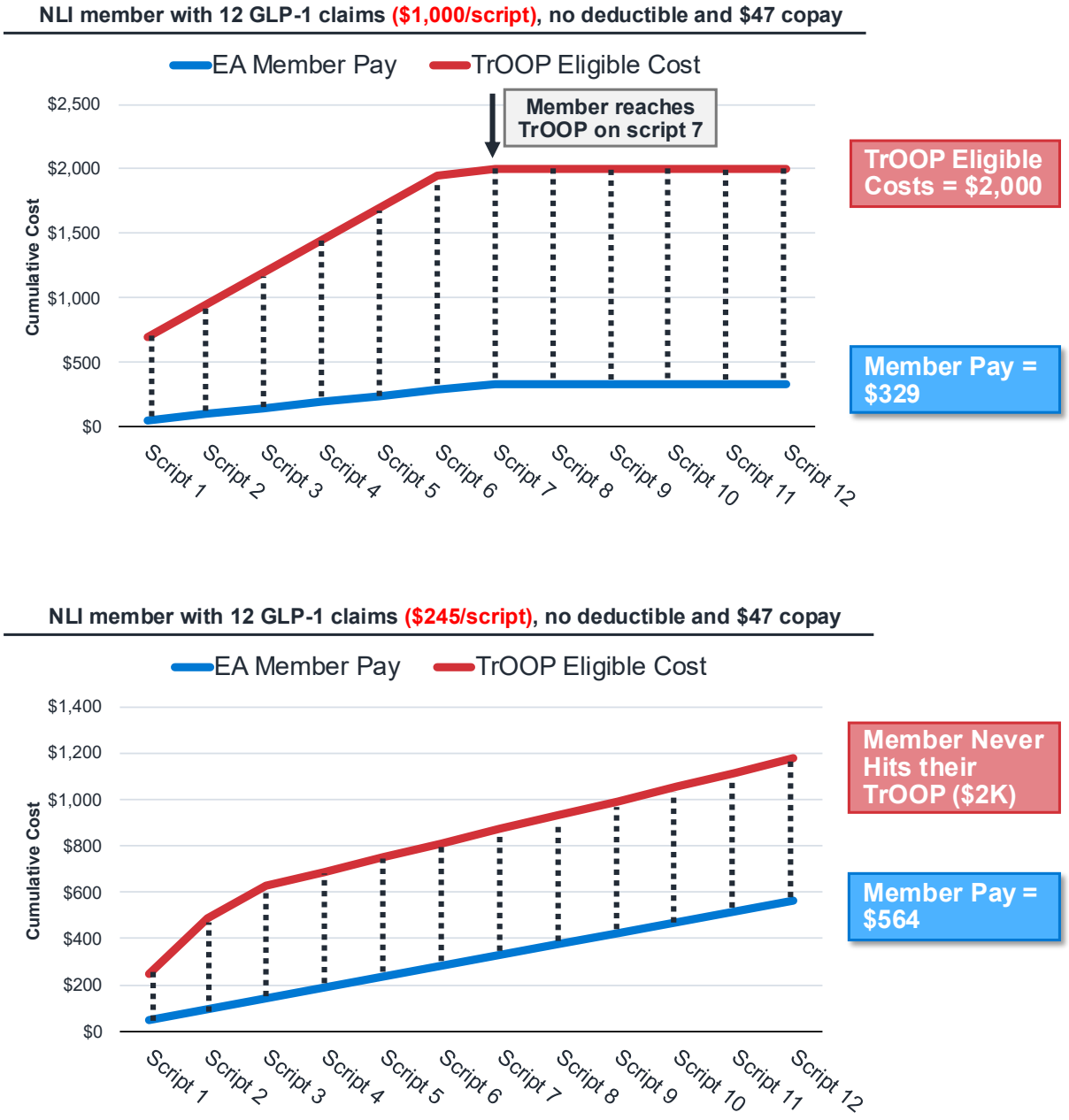
This analysis indicates:

- Approximately 72 percent of members (29% LI and 43% NLI) are enrolled in Part D plans with a copay for relevant GLP-1 medications.
    - LI member copays are typically $12.65 per script for a 30-day supply.
    - NLI member copays are $47 or less for a 30-day supply.
    - While these members will not be impacted on a per script basis (their copays are less than the $50 cap), **some members may see higher annual cost sharing**. (See Figure 2 and the corresponding explanation below.)
- Approximately 28 percent of beneficiaries are NLI and enrolled in Part D plans with coinsurance for relevant GLP-1 medications.
    - These individuals are **likely to pay lower cost-sharing** amounts (both per script and annually).
- Approximately 26 percent of Part D plans have a coinsurance amount for relevant GLP-1 drugs.

Figure 2 models how a member could pay higher annual cost sharing under a $245 GLP-1 drug versus a $1,000 GLP-1 drug because of Part D adjudication rules under the Inflation Reduction Act (IRA). In the initial coverage phase, members pay cost sharing until they hit the $2,000 TrOOP threshold for the year. The TrOOP accumulator, however, is based on the "greater of" cost sharing under a defined standard and alternative plan design rather than actual cost sharing. As a result, some members accumulate TrOOP-eligible costs (based on 25% defined standard coinsurance) more slowly under a reduced list price than they would with a higher list price. This situation leads to more months in which a member makes a copayment.

In the example below, the member pays only $329 for the year (under 2026 benefits) when the drug costs $1,000/month overall because they meet the TrOOP on the seventh script of the year. However, the same individual would pay $564 total when the drug costs $245/month because the member never accumulates sufficient TrOOP-eligible costs to satisfy the $2,000 maximum out of pocket. Therefore, the member pays a copay for all 12 fills of the drug. Note that this dynamic is not unique to GLP-1s and is also present for Part D negotiated drugs in 2026 and 2027.

Figure 2. Cost Sharing Illustration of $1,000 vs. $245 GLP-1



ANALYSIS OF NET PLAN LIABILITY IMPACT

When valuing the net plan liability impact of the proposed changes for Part D plans, it is important to consider the following factors:

1. Effect on allowed cost per script (reduced ingredient costs via the $245 price cap).
2. Impact on utilization (through expanded access and other potential sources of utilization change).
3. Part D plan benefit richness (paid-to-allowed ratio):
    a. Affects how much of the allowed cost change is retained by the plan sponsor and how much is shared with other entities (including CMS, beneficiaries, and manufacturers)
    b. Further impact of the $50 cost-sharing cap in place under the proposed changes
4. Effect on rebates:
    a. As plans have seen with negotiated drugs in 2026, it may be reasonable to assume that rebates are eliminated for the applicable GLP-1 drugs because manufacturers have already agreed to significant list price reductions and are unlikely to reduce net prices further through rebates.
5. Allocation of total rebates between the plan sponsor and CMS (through federal reinsurance).
6. Any potential offsetting savings from reduced medical costs. These impacts were not modeled in this analysis.[14]
7. The Part D risk corridor program may mitigate potential plan savings or losses above bid levels.

To analyze these factors, we aggregated Part D Prescription Drug Event (PDE) and Monthly Membership Report data from 2024 across 36 organizations and approximately 21.9 million member months[15] to create high-level scenarios of how the changes could affect Part D organizations.

[14] Although some evidence points to reduced medical costs for people who use GLP-1 drugs, savings can often be multiyear. Because of Medicare Advantage member churn, a plan may not realize savings by initiating GLP-1 utilization. Risk-sharing arrangements with providers further complicate the allocation of any potential medical cost savings.

[15] This dataset is not a statistically representative sample of nationwide Part D experience.

Table 3 shows that without an adjustment for utilization (via expanded access), the approximate impact on net plan liability is a **decrease of approximately $1.35 PMPM**. This scenario assumes that rebates for GLP-1 drugs are 50 percent of allowed costs.[16] Even though allowed costs decrease for applicable GLP-1 drugs by approximately 72 percent, we also assume that rebates are eliminated under the new proposal. In addition, plans share a larger percentage of the allowed cost reduction with other entities (CMS, members, manufacturers) than they share in the rebate reduction (CMS only). Note that allowed costs are based on 2024 levels and that no adjustment is made for reduced member cost sharing.[17]

Table 3. Net Plan Liability Impact Without Utilization Adjustment, 50 Percent Rebate/Allowed

	GLP-1 Allowed PMPM[18]	GLP-1 Rebates PMPM	Plan Paid Portion[19]	Plan Rebate Portion[20]	GLP-1 Net Plan Liability
Pre-GLP-1 Announcement	$23.22	$11.61	67.4%	85.7%	$5.69
Post-GLP-1 Announcement	$6.44	$0.00	67.4%	N/A	$4.34
Difference	**-$16.78**	**-$11.61**			**-$1.35**
% Difference	**-72.3%**	**-100.0%**			**-23.8%**

Table 4 depicts an alternative scenario in which utilization increases by 17.4 percent for relevant GLP-1 drugs. This adjustment is based on the eligibility and take-up rate assumptions outlined in the "Analysis of Access Expansion and Cost Sharing" section. In this scenario, net plan liability shows a decrease of approximately $0.60 PMPM.

[16] Based on observed rates among Wakely clients.

[17] No adjustment has been made given the uncertainty regarding how CMS will (or will not) make plans whole for any potential increased costs associated with reduced cost sharing and increased utilization for GLP-1s.

[18] Values are shown for applicable GLP-1 drugs only (Ozempic, Wegovy, Mounjaro, and Zepbound). These 4 drugs represent approximately 64 percent of all GLP-1 allowed costs for 2024 dates of service.

[19] Weighted average net plan liability (gross of rebates) to allowed cost ratio across 2026 bids for Wakely clients.

[20] Weighted average plan rebate as a percent of total rebates across 2026 bids for Wakely clients.

Table 4. Net Plan Liability Impact With 17.4 Percent Utilization Adjustment, 50% Rebate/Allowed

	GLP-1 Allowed PMPM	GLP-1 Rebates PMPM	Plan Paid Portion	Plan Rebate Portion	GLP-1 Net Plan Liability
Pre-GLP-1 Announcement	$23.22	$11.61	67.4%	85.7%	$5.69
Post-GLP-1 Announcement	$7.56	$0.00	67.4%	N/A	$5.09
Difference	**-$15.66**	**-$11.61**			**-$0.60**
% Difference	**-67.4%**	**-100.0%**			**-10.5%**

The scenarios above show a slight decrease in net plan liability, but this impact is highly sensitive to plan rebate levels and to the GLP-1 take-up rate (percentage of eligible members taking a GLP-1). Table 5 shows the impact, assuming a 60 percent rebate/allowed ratio and a 10 percent take-up rate for the newly eligible population (same rate assumed for the current population), with an increase in net plan liability of $4.00 PMPM, or a 108 percent increase for the relevant GLP-1s.

	GLP-1 Allowed PMPM	GLP-1 Rebates PMPM	Plan Paid Portion	Plan Rebate Portion	GLP-1 Net Plan Liability
Pre-GLP-1 Announcement	$23.22	$13.93	67.4%	85.7%	$3.70
Post-GLP-1 Announcement	$11.43	$0.00	67.4%	N/A	$7.70
Difference	**-$11.79**	**-$13.93**			**$4.00**
% Difference	**-50.8%**	**-100.0%**			**108.1%**

OUTSTANDING QUESTIONS

Questions regarding the proposed GLP-1 changes include:

- When will these proposed policies take effect? Several sources have noted April 2026 to mid-2026 start dates, but exact timing is unknown.
    - Are the changes expected to be one-time or permanent?
- Will plan participation be mandatory or optional? Previous examples of optional plan participation include the Part D Senior Savings Model for insulin cost sharing reductions.
- Will the changes be offered under a demonstration/pilot model or nationwide? Will CMS need rule changes to allow the coverage of anti-obesity GLP-1s in Part D?
- What specific eligibility criteria should be applied? For example, will weight-loss/obesity indications alone qualify under Part D or only when tied to a comorbidity (diabetes, cardiovascular disease, kidney disease)?
- What specific benefit adjudication rules apply?
    - Is the $50 copay included under a new defined standard benefit design for 2026?
    - How will the adjudication work across benefit phases (deductible, initial coverage, catastrophic) and TrOOP accumulation?
    - How will the reduced list prices affect the manufacturer discount program? Will they function similarly to negotiated drugs, where CMS covers this liability for manufacturers through the subsidy for selected drugs?
- What contracting changes may occur with rebates, dispensing fees, discount guarantees, etc., between plans, pharmacy benefit managers (PBMs), and manufacturers?
- Given that plans have already submitted their 2026 bids without these changes incorporated, how will CMS handle any variance between actual experience and bid-expected experience resulting from these changes?
- How are plan formularies for 2026 (which have already been filed) and utilization management/step therapy rules affected?
- Do the changes apply only to Medicare/Medicaid plans, or will they also affect private/commercial insurance?

Please note that as additional information is released to answer these questions, the resulting impacts shown in our analyses above are likely to change.

CONCLUSION AND RECOMMENDATIONS

The administration's proposed GLP-1 reforms could dramatically reshape drug benefit costs, coverage, and member access beginning in 2026. While lower negotiated prices may yield long-term population health gains and allowed cost savings, the immediate financial exposure for Part D plans—particularly those with high GLP-1 rebate revenue and coinsurance structures—could be substantial.

Ongoing regulatory clarification will be critical to inform market strategy, actuarial planning, and stakeholder alignment across Medicare Parts C and D.

For health plans, recommendations for a near-term action plan include:

1. **Model utilization impact** under multiple eligibility scenarios
2. **Reproject net plan liability**, including potential rebate erosion and reduced cost sharing
3. **Prepare bid contingencies** assuming mid-year regulatory changes
4. Coordinate **Part C + Part D** financial modeling for end-to-end impact analyses
5. **Monitor CMS guidance** and potential mandatory lists affecting utilization management (UM) tools

Although our high-level modeling above shows potential high-level industry impacts for members and Part D plans, significant variability exists across plans in relative rebate levels, utilization, benefit design, risk-sharing arrangements, and other relevant cost drivers. Therefore, it is critical that health insurers measure and anticipate potential changes to their specific plans.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.