EXPANDING ACCESS TO GLP-1s THROUGH A VOLUNTARY AGREEMENT

On November 6, 2025, Lilly and the U.S. Department of Health and Human Services announced a voluntary agreement for lower prices on select GLP-1s* (in Medicare and Medicaid) to expand access and improve transparency. On December 23, 2025, CMS announced the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) model, for which Lilly has applied to participate, to effectuate these lower GLP-1 prices.

Separately, the Center for Medicare and Medicaid Innovation (CMMI) announced the voluntary five-year GENEROUS (GENErating cost Reductions fOr U.S. Medicaid) Model, as a way to effectuate lower prices in Medicaid via CMS-facilitated supplemental rebates on certain products, excluding GLP-1s.** The BALANCE and GENEROUS model terms are both still being finalized.

Presently, Lilly can offer select GLP-1* products to state Medicaid programs at $245 per month through existing Supplemental Rebate Agreements and is ready to engage with states now to establish mutually agreed-upon terms.

BALANCE MODEL INFORMATION:

Participation:	Voluntary by State
Access begins :	5/1/2026: State Medicaid Programs 1/1/2027: Medicare Part D (as early as 7/1/2026 for Medicare bridge program)
Monthly Price:	$245
Proposed bundled portfolio:	Mounjaro (tirzepatide), Zepbound (tirzepatide) and orforglipron (subject to FDA approval).
Execution:	Supplemental rebate via a Guaranteed Net Unit (GNUP) Price with CMS-facilitated terms executed through Supplemental Rebate Agreements with state Medicaid Agencies
Model Eligibility Criteria:	Type 2 diabetes MASH with moderate to advanced liver fibrosis BMI ≥27 with pre-diabetes, previous MI, previous stroke, or symptomatic PAD BMI ≥30 with uncontrolled hypertension, CKD (Stage 3a+), HFpEF, or moderate/severe sleep apnea, MASH BMI ≥35 with obesity

Independent of BALANCE or other federal models, Lilly can offer select GLP-1* products to state Medicaid programs at $245 per month through existing Supplemental Rebate Agreements and is ready to engage with states now to establish mutually agreed-upon terms.

*This includes glucagon-like peptide-1 (GLP-1) receptor agonists and dual-activating GIP (glucose-dependent insulinotropic polypeptide) medications

** Trulicity (dulaglutide) would be eligible for inclusion in the GENEROUS model

DELIVERING BETTER OUTCOMES FOR STATES

OBESITY IS A TREATABLE DISEASE DRIVING STATE COSTS

Obesity is a chronic, multifactorial metabolic disease linked to more than **200 health conditions**, including Type 2 diabetes and cardiovascular disease.[1] Untreated, it drives avoidable costs through medical spending, disability, and lost productivity—burdens that fall heavily on Medicaid, state employee plans, and safety-net systems.

- Adults with obesity incur an average of **$2,505 more per year** in medical costs than those with normal weight, accounting for **$260.6 billion annually** in U.S. healthcare spending.[2]

GLP-1s HAVE THE POTENTIAL TO IMPROVE OUTCOMES AND SUPPORT BUDGET SUSTAINABILITY

BALANCE expands access to clinically appropriate obesity management medications through a comprehensive care model, with the potential to reduce downstream healthcare utilization. In fact, CMS projects that BALANCE will reach budget neutrality within two years through savings from reduced pricing and improved diabetes and cardiovascular disease management.

- In a workforce-focused analysis, GLP-1 users experienced a **7-percentage-point reduction in medical cost growth** by year two compared to a matched control group, driven largely by lower inpatient hospital spending.[3]

OBESITY TREATMENT COULD STRENGHTEN STATE ECONOMIES

Obesity reduces productivity by **20–30%,** resulting in **$6,000–$12,000 per worker per year** in indirect costs.[4] Expanded treatment access has the potential to help individuals remain employed, reduce disability, and re-enter the workforce—supporting economic growth while lowering public program reliance.

- In 2023, obesity and overweight were estimated to impose **$425.5 billion** in economic costs on U.S. businesses and employees, reflecting lost productivity, absenteeism, and disability.[5]

INCREASED ACCESS WILL ADDRESS DISPARITIES IN OBESITY BURDEN

Obesity disproportionately affects certain populations:

- Black/African Americans are **1.3× more likely** to have obesity than non-Hispanic White adults[6]
- Nearly **4 in 5 Black and Hispanic women** have overweight or obesity[6]
- Obesity rates remain significantly higher in **rural communities**[7]
- Women with obesity face **20% lower odds of employment** and lower earnings[5]

A Sustainable Path Forward for States

Obesity is one of the most pressing and expensive health challenges facing states—and it is treatable. **Through BALANCE or through direct negotiations with manufacturers, states have practical, evidence-based options to improve outcomes, strengthen workforce participation, and manage long-term costs with predictable pricing.**

[1] https://pubmed.ncbi.nlm.nih.gov/37197879/
[2] https://www.jmcp.org/doi/pdf/10.18553/jmcp.2021.20410
[3] https://assets.aon.com/-/media/files/aon/reports/2025/workforce-focused-analysis-on-glp-1s.pdf
[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC5770108/pdf/joem-60-06.pdf
[5] https://www.globaldata.com/media/healthcare/us-businesses-employees-face-staggering-425-5-billion-economic-costs-obesity-overweight-2023-reveals-globaldata/
[6] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25
[7] https://pmc.ncbi.nlm.nih.gov/articles/PMC3481194/