Medicare Access for Patients Rx™
Convened by **Lupus Foundation of America**

THE MEDICARE GLP-1 BRIDGE:

WHAT PATIENT ADVOCATES NEED TO KNOW ABOUT PART D'S TEMPORARY OBESITY COVERAGE AND STRUCTURAL BARRIERS TO PERMANENT ACCESS

July 2026

In December 2025, the Centers for Medicare & Medicaid Services (CMS) announced two major initiatives to expand access to obesity management medications (OMMs) for Medicare and Medicaid beneficiaries: the Medicare GLP-1 Bridge program and the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive Health) Model. Four months later, CMS announced an indefinite delay of the BALANCE Model's Medicare Part D component due to insufficient plan participation.

What remains is the Bridge, a temporary demonstration program, that will provide obesity medication coverage from July 1, 2026, through December 31, 2027. While this represents progress for Medicare beneficiaries who have been statutorily excluded from OMM coverage, the delay of BALANCE reveals fundamental structural barriers to integrating these medications into Part D.

BALANCE faced unresolved structural challenges. Patient advocates must understand both what the Bridge offers today and what structural barriers must be addressed to achieve permanent coverage.

WHAT IS THE MEDICARE GLP-1 BRIDGE PROGRAM?

The Medicare GLP-1 Bridge is a temporary demonstration program that provides coverage for specific weight-loss medications to eligible Medicare Part D beneficiaries. It operates completely outside the traditional Part D benefit structure, meaning Part D plans do not manage the coverage, bear the financial risk, or need to opt in for their members to participate.

Original plan: July 1–December 31, 2026 (6 months)
Extended timeline: July 1, 2026–December 31, 2027 (18 months)

The extension was announced following the BALANCE Model delay. CMS stated the extension would allow the agency to collect utilization data to share with Part D sponsors before any future implementation. The Bridge serves as a data collection period to generate evidence about utilization patterns, persistence rates, and health outcomes that can inform future coverage decisions.

The Bridge covers three medications approved for chronic weight management:

- **Wegovy (semaglutide)** – All injectable formulations and the 25mg daily tablet
- **Zepbound (tirzepatide)** – KwikPen formulation only
- **Foundayo (orforglipron)** – All oral formulations

Note on coverage scope: The Bridge covers these medications when prescribed for weight management. The same molecules branded for diabetes management (Ozempic, Rybelsus, Mounjaro) continue to be covered through regular Part D plans when prescribed for diabetes.

This reflects the statutory distinction between diabetes treatment (covered under Part D since 2006) and weight management (historically excluded).

ELIGIBILITY AND COST

Eligibility is based on body mass index (BMI) thresholds and health conditions at the time GLP-1 therapy was initiated:

Note: OMM coverage for obesity alone is restricted to beneficiaries with a BMI of 35 or higher; those with lower BMIs require specific documented co-morbidities

Beneficiaries pay a flat $50 monthly copayment.

BMI ≥ 27

Pre-diabeties, history of heart attack or stroke, or symptomatic peripheral artery disease.

BMI ≥ 30

Heart Failure with Preserved Ejection Fraction (HFpEF), uncontrolled hypertension, or chronic kidney disease stage 3a or higher

BMI ≥ 35

No additional conditions required.

CRITICAL: Bridge spending does NOT count toward Part D deductibles or the OOP cap

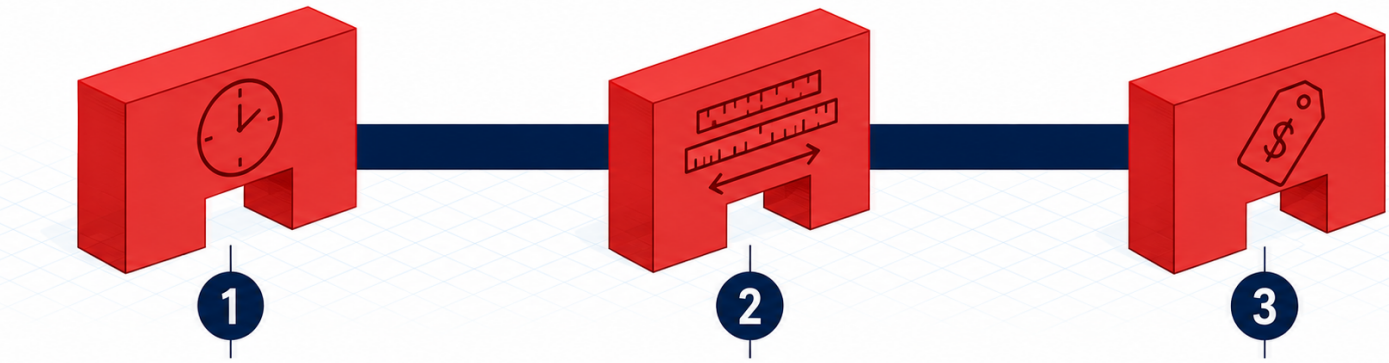
Because the Bridge operates outside Part D, the $50 copay does not count toward beneficiaries' deductible or annual out-of-pocket maximum ($2,100 in 2026; $2,400 in 2027). Low-income subsidies do not apply—even $0 copay beneficiaries pay the full $50.

WHY BALANCE WAS DELAYED: PLAN NON-PARTICIPATION AND UNRESOLVED STRUCTURAL BARRIERS

The BALANCE Model was intended to provide temporary OMM coverage in Medicare Part D beginning January 1, 2027 as a way of testing how to offer OMM drugs in the benefit. The model required voluntary participation from Part D plans covering at least 80% of beneficiaries. Plans covering the required share of beneficiaries declined to participate, the threshold was not met, and CMS announced the delay in April 2026.

The delay reflects three challenges that contributed to non-participation from plans on the proposed timeline.

WHY BALANCE WAS DELAYED: THREE STRUCTURAL BARRIERS



1 TIMELINE CONSTRAINTS & DATA GAPS

Implementing a new therapeutic class within 13 months proved impossible. Plans lacked historical claims data to model utilization, project savings, and determine sustainable actuarial bids for the newly covered population.

2 EVOLVING INDICATIONS AND COVERAGE BOUNDARIES

Coverage status for identical molecules varies entirely by documented indication, creating administrative chaos as the FDA continually updates approvals.

3 OPERATIONAL FRICTION

Integrating demonstration-based pricing with the Inflation Reduction Act's (IRA) statutory Maximum Fair Prices (MFPs) created immense, unresolved operational complexities on a compressed timeline.

Challenge 1: Timeline Constraints and Data Gaps

BALANCE was announced in December 2025 with implementation planned for January 2027, less than 13 months later. Building sustainable Part D coverage for a new therapeutic class typically requires:

- Historical claims data to model utilization patterns and costs
- Evidence of long-term health outcomes and potential savings
- Actuarial analysis to determine sustainable bid amounts
- Time to integrate coverage into benefit design and systems

Because Medicare had never covered these medications for obesity, plans lacked direct utilization and cost data for the population the model would newly cover. While GLP-1 claims data from diabetes and cardiovascular indications offered some reference points, plans still faced the challenge of making binding financial commitments for 2027 without the indication-specific evidence base typically used to inform coverage decisions.

Challenge 2: Evolving Indications and Coverage Boundaries

Medicare coverage depends on both the product and the indication for which it is prescribed. Under current policy:

- GLP-1s prescribed for diabetes covered under regular Part D
- GLP-1s prescribed for cardiovascular risk reduction covered under regular Part D
- GLP-1s prescribed for sleep apnea covered under regular Part D
- GLP-1s prescribed for weight management excluded from Part D (requiring the Bridge or similar mechanism)

This means coverage status for the same molecule varies based on documented clinical indication. As Food and Drug Administration (FDA) continues to evaluate these medications for additional uses, the coverage landscape continues to evolve. Designing a multi-year demonstration model around a rapidly shifting regulatory environment presents significant challenges for all stakeholders.

Challenge 3: Operational Friction with Statutory Drug Pricing Frameworks

While CMS maintained the legal waiver authority to allow BALANCE demonstration pricing to supersede the Inflation Reduction Act's (IRA) Maximum Fair Prices (MFPs), integrating these two parallel pricing structures created immense operational complexity on a compressed timeline. Part D sponsors faced administrative hurdles in reconciling alternative manufacturer rebates with statutory price caps, leaving critical implementation questions unresolved as the 2027 plan year approached.

WHAT THIS MEANS FOR PART D BENEFICIARIES

The Bridge Preserves Access While Structural Issues Are Addressed

The Bridge operates as a parallel coverage pathway entirely separate from Part D. CMS funds it directly, and beneficiaries' spending does not integrate with their Part D benefit accounting.

The 18-month Bridge period provides time to gather utilization data, observe how expanding FDA indications affect prescribing patterns, and determine how demonstration-based coverage can work within existing statutory frameworks.

When the program ends at the end of 2027, continuity of access beyond that date will depend on either:

- Legislative or regulatory action to remove the statutory exclusion of weight-loss medications from Part D, or
- A revised BALANCE Model that addresses the structural challenges identified in 2026

Without action on at least one of these pathways (and likely a mandate of some kind), beneficiaries could face a gap in coverage beginning January 1, 2028.

WHAT PATIENT ADVOCATES SHOULD DO

1. Support Durable Coverage Solutions Through Legislation or Regulation

Starting July 1, 2026, track:

The Treat and Reduce Obesity Act (TROA) would remove the statutory exclusion of weight-loss medications from Part D, providing a durable legislative foundation for coverage. Congress has 18 months before the Bridge expires to act on permanent coverage solutions.

On the regulatory side, CMS could establish coverage through notice-and-comment rulemaking by reinterpreting the statutory exclusion of agents used for weight loss so that it does not apply to drugs used to treat obesity. CMS proposed exactly this reinterpretation in the CY2026 Medicare Advantage and Part D proposed rule and declined to finalize it in the April 2025 final rule but stated it may address the proposal in future rulemaking, so the regulatory path remains available.

2. Seek Clarity on Policy Interactions

Any future coverage model must clarify how demonstration-based pricing interacts with statutory Maximum Fair Prices, how coverage determinations will handle evolving FDA indications, and how beneficiary cost-sharing will integrate across coverage pathways.

3. Request Transparency on Implementation Progress

CMS should provide regular updates on Bridge utilization data, progress toward addressing BALANCE & structural challenges, and the timeline for any revised demonstration model.

4. Monitor Bridge Implementation

Starting July 1, 2026, track:

- Prior authorization approval rates and processing times
- Beneficiary understanding of coverage scope and limitations
- Access challenges or administrative barriers
- Coordination between Bridge coverage and regular Part D coverage for different indications

5. Prepare for 2027 Open Enrollment

Beneficiaries will need clear information during 2027 open enrollment about coverage options for 2028. Advocates should push for standardized disclosure requirements that help beneficiaries understand whether and how OMMs will be covered after the Bridge ends.

6. Press Part D Plans to Participate in Future Coverage Models

Because plan non-participation — not statutory impossibility — stalled BALANCE, any revised demonstration will succeed only if enough plans opt in. Advocates should engage Part D sponsors directly, and press CMS to strengthen participation incentives, so that the next coverage model clears the threshold the BALANCE Model could not.

7. Prioritize Beneficiary and Provider Education on Bridge Access Workflows

Because the Bridge program bypasses traditional Part D plan structures, standard pharmacy cards and automated insurance systems will not automatically process these prescriptions. Advocates must lead comprehensive communication campaigns to educate key stakeholders on how to navigate this unique program:

- For Beneficiaries: Emphasize that the Bridge program is not a normal Part D benefit and that their usual cost-sharing protections (like the Low-Income Subsidy or annual out-of-pocket caps) do not apply to the $50 copay. Ensure beneficiaries understand they must verify their clinical criteria and baseline BMI history with their provider to qualify.
- For Prescribing Physicians: Educate clinicians that prior authorization (PA) forms and prescriptions for obesity management medications (OMMs) cannot be sent to the patient's Part D plan. Providers must submit documentation directly to the CMS-designated central processor using the newly released June 2026 standardized fax forms and portals.
- For Pharmacies and Retail Stakeholders: Disseminate technical billing sheets reminding independent and retail pharmacists to route these specific obesity-indicated claims using the custom Bank Identification Number (BIN) and Processor Control Number (PCN) established exclusively for the Bridge program, rather than the patient's primary Part D insurer.

CONCLUSION: THE PATH TO SUSTAINABLE COVERAGE

The Medicare GLP-1 Bridge represents progress toward obesity medication access for Medicare beneficiaries. For the first time, eligible beneficiaries will have coverage for FDA-approved weight-management medications at affordable cost-sharing. The Bridge also provides a critical opportunity to gather the evidence needed to design sustainable long-term coverage.

However, the BALANCE delay demonstrates that demonstration programs alone cannot resolve fundamental structural challenges. Integrating a new therapeutic class into Medicare Part D requires addressing data gaps, navigating evolving clinical evidence, and reconciling demonstration authority with statutory frameworks.

For patient advocates, the priorities are clear:

- ✓ Support legislative or regulatory action to provide permanent coverage authority
- ✓ Encourage Part D plan participation in future iterations of the BALANCE model
- ✓ Advocate for policy clarity on how different coverage pathways interact
- ✓ Monitor Bridge implementation to ensure it achieves its access goals
- ✓ Plan for continuity of coverage beyond December 31, 2027

Obesity is a chronic disease affecting 40% of older Americans, with disproportionate impact on Black and underserved communities. Anti-obesity medications are evidence-based therapies that reduce cardiovascular events, prevent diabetes progression, and improve quality of life. Medicare beneficiaries deserve access to these medications through sustainable coverage that integrates with their Part D benefits.

The Bridge provides 18 months of temporary access. The question for policymakers is whether they will use that time to build a permanent solution.