News and Perspectives

Affordable GLP-1? When Digital Platforms Meet Policy Reform

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Abstract

Recent shifts in US policy and digital platforms are making obesity medications more affordable. In this *News and Perspectives* article, JMIR Correspondent Xiangming Jenny Zhan reports on this emerging access model and its potential implications.

Key Takeaways:

- Shifts in pricing, use of direct-to-consumer platforms, and digital prescriptions have made GLP-1 medications more affordable without insurance in the United States, opening a new access pathway.
- Early real-world data show rapid uptake but also high discontinuation rates within the first year, suggesting that affordability alone may not be sufficient to sustain long-term treatment outcomes.
- This model is already extending to other chronic disease medications, but its long-term viability remains to be seen.

Glucagon-like peptide-1 (GLP-1) receptor agonist drugs such as semaglutide and tirzepatide have shown 15%-20% weight loss in clinical trials, but, up until recently, at $1000-$1349 per month, they remained out of reach for patients without generous insurance coverage in the United States. Most commercial plans did not cover obesity indications, meaning that even insured patients often had to pay the full cost out of pocket. In early 2026, however, a convergence of factors brought monthly prices below $350 without insurance, opening a new access pathway that operates largely outside the traditional insurance-based model. This shift did not come from a single policy or platform, but from three distinct forces arriving at the same moment.

A New Pathway to the Patient

The first force was a shift in federal pricing policy. The Trump administration negotiated Most-Favored-Nation (MFN) pricing deals with Novo Nordisk, Eli Lilly, and other manufacturers, tying tariff exemptions to price concessions. Monthly costs for GLP-1s dropped to approximately $350, and oral formulations to $149 at starting doses. At these price points, out-of-pocket payment became a realistic option for patients who previously could not afford treatment.

The second force was initiation of manufacturer-led digital distribution. Novo Nordisk and Eli Lilly launched direct-to-consumer platforms that bypass insurers and pharmacy benefit managers, handling prescriptions, payment, and delivery digitally. As of early 2026, Novo Nordisk was routing much of its oral Wegovy demand through self-pay rather than insurance, led by its direct-to-patient pharmacy NovoCare and telehealth partners. Eli Lilly's LillyDirect reached over 1 million patients in 2025, with self-pay Zepbound vials as its most used product.

The third force was integration into telehealth prescribing. Platforms like Ro, Hims & Hers, and LifeMD integrated GLP-1 prescribing into their workflows, enabling patients to consult a provider and receive medication without visiting a clinic. Hims & Hers alone reached over 2.5 million subscribers in 2025. Costco, through its partnership with Sesame, and Amazon One Medical have also entered the space, extending digital GLP-1 access beyond telehealth startups into mainstream retail.

These three moves came together in a single federal entry point when the Trump administration launched TrumpRx.gov on February 5, 2026. The platform aggregates manufacturer discount programs, connecting cash-paying patients directly to reduced prices without requiring insurance. For medications not widely covered by insurance, such as obesity and fertility treatments, TrumpRx offers a lower-cost alternative to traditional pharmacy channels, though for many other drugs, insurance co-pays may still be cheaper than cash-pay prices.

Access Without Continuity

Lower prices have expanded who can start GLP-1 therapy, but starting treatment is not the same as sustaining it. A 2025 population-based study of over 77,000 first-time semaglutide users in Denmark found that more than half stopped treatment within 12 months, with cost, gastrointestinal side effects, and lack of ongoing clinical support cited as key drivers. Patients who discontinue use return to their baseline weight within approximately 1.7 years. These findings suggest that the central challenge has shifted: the barrier is no longer getting patients onto GLP-1 therapy, but keeping them on it.

Part of the problem is structural. The cash-pay channels that have made GLP-1s more accessible operate outside

the insurance system entirely. Purchases through TrumpRx and manufacturer platforms do not count toward insurance deductibles or out-of-pocket maximums, offering no cumulative financial protection for patients who need treatment indefinitely. Meanwhile, insurance coverage for obesity also remains limited: only 34% of employers surveyed covered GLP-1s for both diabetes and weight loss in 2024, up just 8 percentage points from the year before. Patients are left choosing between an affordable but isolated cash-pay channel and an insurance system that largely does not cover the treatment at all.

Even the direct-to-consumer platforms themselves face an uncertain foundation. Hims & Hers, which reached $2.35 billion in revenue in 2025, built much of its growth on compounded GLP-1 products, lower-cost alternatives produced during branded drug shortages that have not received Food and Drug Administration (FDA) approval. In early 2026, Novo Nordisk sued Hims & Hers for patent infringement, and the FDA moved to restrict compounded semaglutide shipping, creating a $65 million revenue headwind for Q1 2026. If the largest telehealth GLP-1 provider is forced to exit compounded products, the access gains it delivered may prove fragile.

Beyond GLP-1s

Despite these vulnerabilities, the momentum behind this model is accelerating. Novo Nordisk announced a further 35% to 50% list price reduction for its semaglutide products in February 2026, effective January 2027. And the policy framework is expanding beyond GLP-1s: insulin is available at $25 per month, AstraZeneca's chronic obstructive pulmonary disease inhaler dropped from $458 to $51, and 16 pharmaceutical companies have now signed MFN agreements.

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Whether this model can be replicated for other chronic conditions is less certain. GLP-1s benefited from a specific combination of factors: insurance coverage for obesity was already so limited that bypassing it carried little downside, patient motivation to seek and pay for weight-loss treatment was unusually high, and intense branded competition gave manufacturers a reason to build direct-to-consumer channels and cut prices. These dynamics may persist in the obesity space, where an estimated 16 new medications are expected to gain approval between 2026 and 2029, but for chronic disease managed by inexpensive generics with adequate insurance coverage, neither patients nor manufacturers have comparable incentive to move outside the existing system.

GLP-1s are, in effect, a test case for whether a viable access pathway for chronic disease medications can be sustained outside the insurance system. How far that pathway extends will depend on whether the infrastructure built for GLP-1s can support not just affordable first prescriptions, but the continuous care that chronic disease treatment requires.

Keywords: glucagon-like peptide-1 receptor agonists; telemedicine; drug costs; medication adherence; insurance, health; chronic disease; health services accessibility

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