

NOTES

HEALTH CARE ON THE SCALE: A COMPARATIVE ANALYSIS OF OZEMPIC AND GLP-1 WEIGHT LOSS DRUG COST AND ACCESS IN UNITED STATES AND CANADIAN HEALTH CARE SYSTEMS

GRACE CURRY*

INTRODUCTION

By 2030, it is estimated that one in two adults will be obese.¹ This rising prevalence of obesity throughout the world has catalyzed a scientific revolution for weight management solutions. Among these, Glucagon-like Peptide-1 (“GLP-1”) agonists, such as Ozempic, have emerged in the pharmaceutical market, offering effective weight-loss solutions for patients struggling with obesity and the health risks associated with the disease. However, the overwhelming demand and excitement for these drugs are tempered by various challenges, particularly high prices and limited access to the medication.

In North America, these challenges are specifically pronounced due to the vast differences between the United States and Canadian healthcare systems. The United States, with its privatized, insurance-driven system, faces major criticism of high out-of-pocket costs and inequitable access to GLP-1 medications. In contrast, Canada’s single-payer healthcare system aims to provide more equitable access, but grapples with its own limitations. The disparities between these two countries’ healthcare systems raise important questions about how healthcare structure influences the affordability and availability of cutting-edge drugs, such as GLP-1 receptor agonist medications.

This Note examines cost and access issues surrounding GLP-1 weight loss

* Grace Curry, J.D. Candidate with Health Law Graduate Certificate, Class of 2026, Indiana University Robert H. McKinney School of Law; B.S. in Biological Sciences, 2023, Purdue University; B.A. in Political Science, 2023, Purdue University. The author would like to give special thanks to her faculty note advisor, Professor Jami Sayeed, for her invaluable guidance and expertise in Medicaid law throughout the development of this Note. Curry also thanks the *Indiana International & Comparative Law Review*, Volumes XXXV and XXXVI, for their work editing and providing feedback for this note. Finally, the author is deeply grateful to her friends and family for their unwavering support and encouragement. This Note is dedicated to the author’s family, whose careers in healthcare inspired her interest in health law and whose commitment to helping others shaped her understanding of the importance of equitable access to medical care.

1. Asuka Koda, *As Ozempic usage expands, accessibility dwindles*, YALE NEWS (Oct. 31, 2024), <https://yaledailynews.com/articles/as-ozempic-usage-expands-accessibility-dwindles> [https://perma.cc/37Z2-ERRM].

drugs, focusing on Ozempic and Wegovy, two brand-name GLP-1 medications, and provides a comparative analysis of the United States and Canadian healthcare systems and their methods for providing weight loss drugs to their citizens. It explores the implications of the differing insurance frameworks, pricing structures, supply chain issues, and policy proposals on cost and access to these drugs. Ultimately, the discussion aims to shed light on systemic inequities and propose strategies for the United States to bolster access and lower cost to these life-changing drugs.

As the demand for GLP-1 prescription drugs grows, so does the urgency to address these disparities. How can healthcare systems balance the promise of pharmaceutical innovation with the principles of affordability and equity? And what lessons can policymakers draw from these contrasting models in the United States and Canada? This Note seeks to answer these pressing questions while contributing to the broader conversation about the future of healthcare access in the era of costly innovation.

I. BACKGROUND

A. *The Global Obesity Epidemic*

According to the Center for Disease Control and Prevention (“CDC”), 42% of Americans are currently obese.² Since 1990, the rate of adult obesity has doubled, and adolescent obesity has nearly quadrupled, underscoring the urgency of this public health crisis.³ Obesity is associated with numerous serious and potentially life-threatening health conditions, such as high blood pressure, high cholesterol, heart disease, type 2 diabetes, sleep apnea, and gallbladder disease.⁴

The World Health Organization (“WHO”) has announced that approximately 1 billion people globally, or one in eight persons, were living with obesity in 2022.⁵ However in Canada, the prevalence of obesity among adults is lower than in the United States.⁶ Recent data from 2022 suggests that 30% of adult Canadians are obese, rising 9% since 2003.⁷ This is almost 12%

2. *Ozempic for weight loss: Does it work, and what do experts recommend?*, UC DAVIS HEALTH (June 3, 2025), <https://health.ucdavis.edu/blog/cultivating-health/ozempic-for-weight-loss-does-it-work-and-what-do-experts-recommend/2023/07> [<https://perma.cc/6BCB-R7LB>].

3. *Obesity and overweight*, WORLD HEALTH ORG. (Dec. 8, 2025), <https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight> [<https://perma.cc/EH8X-A6WK>].

4. *Consequences of Obesity*, U.S. CTR. FOR DISEASE CONTROL & PREVENTION (July 15, 2022), <https://www.cdc.gov/obesity/basics/consequences.html> [<https://perma.cc/3LMW-CLQ4>].

5. *Obesity and overweight*, *supra* note 3.

6. MARGOT SHIELDS, MARGARET D. CARROLL & CYNTHIA L. OGDEN, ADULT OBESITY PREVALENCE IN CANADA AND THE UNITED STATES (CTR. FOR DISEASE CONTROL & PREVENTION, 2011), <https://www.cdc.gov/nchs/products/databriefs/db56.htm> [<https://perma.cc/7TBV-548Q>].

7. *An overview of weight and height measurements on World Obesity Day*, STATS. CAN. (Mar. 4, 2024), <https://www.statcan.gc.ca/o1/en/plus/5742-overview-weight-and-height-measurements-world-obesity-day> [<https://perma.cc/6F3T-NLUN>].

lower than the United States obesity rate. As a result, obesity has become a significant public health challenge, contributing substantially to increased mortality rates and increased healthcare expenditures.⁸

B. GLP-1 and Its Role in Weight Management

GLP-1 is a naturally occurring hormone that is “released when food is eaten to slow down gastric emptying, the process by which food leaves the stomach, so that the body can absorb nutrients from the food.”⁹ GLP-1 also increases the release of insulin, a hormone that regulates the amount of glucose in the blood, from the pancreas.¹⁰ When food is eaten, blood sugar increases, signaling the body to release insulin.¹¹ In certain diseases, such as type 2 diabetes and obesity, the body does not respond properly to nutrients, leading to elevated blood sugar levels.¹²

GLP-1 receptor agonists mimic the GLP-1 hormone by binding to and activating GLP-1 receptors in the hypothalamus, the part of the brain which regulates food intake.¹³ This activation reduces hunger and increases satiety in patients.¹⁴ Additionally, GLP-1 has been shown to delay gastric emptying, resulting in feeling fuller faster when eating.¹⁵

There are four major kinds of GLP-1 receptor agonists approved and on the market, including: Semaglutide (commonly known as Ozempic®, Wegovy®, Rybelsus®); Liraglutide (Victoza®, Saxenda®); Dulaglutide (Trulicity®); and Tirzepatide (Mounjaro®, Zepbound®).¹⁶

8. See *Obesity and overweight*, *supra* note 3 (3.7 million deaths in 2021 from obesity related diseases).

9. Catherine Rivera, *How Do GLP-1 Receptor Agonists, Like Ozempic or Mounjaro, Work?*, ENDOCRINOLOGY ADVISOR (June 14, 2024), <https://www.endocrinologyadvisor.com/features/mechanism-of-action-glp-1-agonist/> [<https://perma.cc/G4BH-2PN2>].

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. Lauren Garfield, *Wegovy, Trulicity, Ozempic... Oh My!*, RGA (Sep. 2023), <https://www.rgare.com/knowledge-center/article/wegovy-trulicity-ozempic-oh-my> [<https://perma.cc/M6YJ-B83H>].

Table 1. Summary of GLP-1 receptor agonists available in the United States¹⁷

Generic Name	Brand Name(s)	Formulation	FDA Approval	Highlights
semaglutide	Wegovy	2.4 mg weekly injection	Approved 6/2021 for weight management in adults and children age 12+	Approved for weight loss. Approved for teens.
	Ozempic	0.5, 1.0, 2.0 weekly injection	Approved 12/2017 to improve blood glucose in adults with Type 2 diabetes and to reduce major CVD events in people with Type 2 and CVD	Approved for both Type 2 and to reduce major CVD events in Type 2.
	Rybelsus	7.0, 14.0 daily tablet	Approved 9/2019 for blood glucose control in adults with Type 2 diabetes	First oral GLP-1 drug available in the US.
tirzepatide	Mounjaro	2.5, 5, 7.5, 10, 12.5, 15 mg weekly injection	Approved 5/2022 to improve blood glucose control in adults with Type 2 diabetes	Approved 5/2022 to improve blood glucose control in adults with Type 2 diabetes.
liraglutide	Victoza	1.2, 1.8 daily injection	Approved 1/2010 (original approval) for Type 2 in adults. Additional approval 8/2017 to reduce CVD events in type 2; Approved 6/2019 to treat patients 10+ with Type 2 diabetes.	Approved to treat Type 2 in kids ages 10 and up. Also approved to reduce CVD events in adults with Type 2 diabetes.
	Saxenda	3 mg daily injection	Approved 12/2014 for chronic weight management in adults. Approved 12/2020 for kids age ≥ 12 .	Approved for weight loss in kids ages 12-17.
dulaglutide	Trulicity	.75, 1.5, 3.0, 4.5 mg weekly injection	Approved 9/2014 to improve glycemic control in adults with type 2 diabetes and to reduce risk of CVD events in adults with Type 2. The 11/2022 approval was extended to kids age 10+ for Type 2 diabetes.	Approved for both Type 2 diabetes and to reduce major CVD events in Type 2 diabetes. Approved for use in kids ages 10 and up for Type 2 diabetes.

¹⁷. *Id.*

Ozempic, a semaglutide GLP-1 receptor agonist, was originally approved in 2017 for diabetes management.¹⁸ Doctors often prescribe these medications to people with type 2 diabetes because they help control their blood sugar levels.¹⁹ However, more recently, in 2021, the Food and Drug Administration (“FDA”) approved these drugs for weight loss in people with obesity, even if they do not have diabetes.²⁰ Wegovy, a higher-dose brand-name version of Ozempic, is prescribed for chronic weight loss management in adults with a body mass index (“BMI”) of 27 or above, with weight-related health conditions.²¹

This drug causes patients to experience reduced appetite and hunger, lower preference for high-calorie foods, a decrease in food cravings, and better overall control of their eating habits.²² Additionally, patients can expect an average weight loss of 15-20% of their body weight.²³ This is significantly higher than previous non-surgical weight loss solutions on the market, which yielded 5-10% loss in body weight.²⁴ However, even with the significant benefits in weight loss, there are various side effects to this medication, including nausea and vomiting, diarrhea or constipation, headaches, and injection site reactions.²⁵

C. Popularity, Media Coverage, and Benefits of Ozempic

After FDA approval in 2017, Ozempic and similar GLP-1s have experienced a rapid rise in both use and visibility, accompanied by an unprecedented level of media attention that has transformed these drugs from a clinical treatment to a cultural movement.²⁶ While originally approved as a type 2 diabetes treatment, the drug quickly gained attention for its weight loss potential.²⁷

18. *Id.*

19. *Id.*

20. Press release, U.S. Food & Drug Admin., FDA Approves New Drug Treatment for Chronic Weight Management, First Since 2014 (June 4, 2021), <https://www.prnewswire.com/news-releases/fda-approves-new-drug-treatment-for-chronic-weight-management-first-since-2014-301306223.html> [<https://perma.cc/75B5-YS3T>].

21. Emma Bartlett, *Is Ozempic a weight-loss miracle drug or too good to be true?*, BRYANT U. (Mar. 18, 2024), <https://news.bryant.edu/ozempic-weight-loss-miracle-drug-or-too-good-be-true> [<https://perma.cc/76S9-HYKL>].

22. *Weight Loss Medication*, UNIV. OF UTAH HEALTH, <https://healthcare.utah.edu/weight-management/weight-loss-medication> [<https://perma.cc/99U5-34L6>] (last visited Apr. 22, 2026).

23. *The Ozempic Effect: Everything You Need to Know About Medical Weight Loss*, COLUM.: SURGERY, <https://columbiasurgery.org/news/ozempic-effect-everything-you-need-know-about-medical-weight-loss> [<https://perma.cc/Z73B-62Q4>] (last visited Nov. 23, 2024).

24. *Id.*

25. *See id.*

26. Deidre McPhillips, *CNN Exclusive: Prescriptions for popular diabetes and weight-loss drugs soared, but access is limited for some patients*, CNN HEALTH (Sep. 27, 2023), <https://www.cnn.com/2023/09/27/health/semaglutide-equitable-access> [<https://perma.cc/5CN5-U74Z>].

27. Barlett, *supra* note 21.

This surge in attention is reflected among usage rates and public awareness.²⁸ Recent polling indicates that one in eight adults (12%) have taken some form of GLP-1 medication.²⁹ Furthermore, the number of semaglutide prescription refills has increased 442% from January 2021 to December 2023, highlighting the remarkable speed at which these drugs have entered mainstream use.³⁰ Public awareness of the drug has also increased, with about one-third (32%) of adults now reporting they have heard “a lot” about these drugs,³¹ and eight in ten (82%) adults reporting they have heard “a little” about these drugs.³² In addition, a Google trend analysis from 2018 to 2023 demonstrates exponentially growing public interest in weight-loss medications, particularly semaglutides such as Ozempic and Wegovy.³³ Together, this data illustrates not only the widespread adoption of the drug but also a significant shift in awareness, as GLP-1s have become widely discussed weight loss treatments.³⁴

Media coverage has played a significant role in shaping this narrative.³⁵ News outlets, television advertisements, and social media platforms have amplified the clinical promise of weight loss, contributing to the normalization of the drug.³⁶ Ozempic first made headlines as a “blockbuster” weight loss drug in 2021, when the drug was featured on a showing of the Dr. Oz Show.³⁷ By 2023, there were more than 4,000 ads on Instagram and Facebook alone mentioning semaglutide.³⁸ As a result, awareness of GLP-1 drugs has expanded rapidly in a relatively short time period following approval.³⁹

This growing visibility carries important public health implications. In 2021, obesity and related obesity conditions led to an estimated 3.7 trillion

28. Alex Montero et al., *KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs*, KFF (May 10, 2024), <https://www.kff.org/health-costs/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/> [https://perma.cc/XYK9-E2ZL].

29. *Id.*

30. Christopher Scannell et al., *Prescription Fills for Semaglutide Products by Payment Method*, 5 JAMA HEALTH F. 1, 1 (2024) <https://doi.org/10.1001/jamahealthforum.2024.2026> [https://perma.cc/ZPM7-E93B].

31. Montero et al., *supra* note 28 (up from 19% in July 2023).

32. *Id.*

33. Sabrina H. Han et al., *Public Interest in the Off-Label Use of Glucagon-like Peptide 1 Agonists (Ozempic) for Cosmetic Weight Loss: A Google Trends Analysis*, 44 AESTHETIC SURGERY J. 60, 61 (2024).

34. Montero et al., *supra* note 28; *id.*

35. See David Ingram, *More than 4,000 ads for Ozempic-style drugs found running on Instagram and Facebook*, NBC (June 15, 2023), <https://www.nbcnews.com/tech/internet/ozempic-weight-loss-drug-ads-instagram-wegovy-semaglutide-rcna88602> [https://perma.cc/H8Y8-AY54].

36. *Id.*

37. Arvind Sommi, *How Ozempic Became a Celebrity Weight Loss Sensation*, DIATRIBE (Nov. 7, 2022), <https://diatribe.org/diabetes-medications/how-ozempic-became-celebrity-weight-loss-sensation> [https://perma.cc/M4AD-BKYD].

38. Ingram, *supra* note 35.

39. Montero et al., *supra* note 28.

deaths.⁴⁰ However, a new study led by researchers at Yale School of Public Health and the University of Florida found that broadening access to these highly effective drugs could prevent “up to 42,027 deaths a year in the United States.”⁴¹ The study was done with integrated data, combining different BMIs, obesity prevalence rates, and current limitations to access, specifically due to high cost and insurance structures.⁴² Under the access and cost limitations in place at the time of the study, an estimated 8,592 lives are saved annually with GLP-1s, with the majority of these individuals having private insurance.⁴³ These findings highlight the significant potential increased access to these drugs could have on reducing mortality rates on a national scale, reinforcing the importance of lowering costs and expanding access to this drug.⁴⁴

In addition, obesity mounts an immense economic burden throughout the country, with medical costs projected to exceed \$170 billion yearly.⁴⁵ Obese individuals, especially those from lower socioeconomic backgrounds, face additional healthcare costs and spend, on average, \$1,800 more annually than those without obesity.⁴⁶ These studies underscore the importance of addressing obesity with these new and highly effective GLP-1 medications as well as implementing policies that will remove barriers to access and high prices.

D. Compounded GLP-1s

Compounded drugs are custom formulations prepared by compounding pharmacies to address specialized patient needs that cannot be met by traditional pharmaceuticals.⁴⁷ Traditionally, the compounding process begins when a prescriber responds to a specific patient need by writing a prescription.⁴⁸ The prescriber chooses the active ingredient, dosage, dosage form, etc.⁴⁹ However, the inactive ingredients may be tailored to the patient, such as in cases when a patient has a documented allergy.⁵⁰ The compounding pharmacist will then

40. Obesity and overweight, *supra* note 3.

41. See Colin Poitras, *Expanding Access to Weight-Loss Drugs Could Save Thousands of Lives A Year, Study Finds*, YALE SCH. PUB. HEALTH (Oct. 16, 2024), <https://medicine.yale.edu/news-article/expanding-access-to-weight-loss-drugs-could-save-thousands-of-lives-annually-study-finds/> [https://perma.cc/5NRK-GXCE].

42. *Id.*

43. *Id.*

44. *See id.*

45. Abhishek Pandey et al., *Estimating the lives that could be saved by expanded access to weight-loss drugs*, 121 PROC. NAT’L ACAD. SCI. 1, 1 (2024).

46. *Id.*

47. *Human Drug Compounding*, U.S. FOOD & DRUG ADMIN. (Feb. 18, 2026), <https://www.fda.gov/drugs/guidance-compliance-regulatory-information/human-drug-compounding> [https://perma.cc/D4CN-QMH6].

48. *The Clinical Utility of Compounded Bioidentical Hormone Therapy: A Review of Safety, Effectiveness, and Use: An Overview of Compounding*, at 29, in NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE (2020).

49. *Id.*

50. *Id.*

formulate and dispense the medication to the patient.⁵¹ Historically, compounding has played an important role in personalized medicine by allowing providers to create formulations that are otherwise unavailable on the market.⁵²

Compounded drugs have become increasingly popular in the boom of GLP-1 medications; however, they are not FDA-approved.⁵³ The FDA's authority to regulate prescription drugs stems from the Food, Drug, and Cosmetic Act ("FDCA"); this does not give the FDA similar authority for compounded pharmaceuticals.⁵⁴ This lack of oversight increases the risk of potential adverse effects, leaving patients vulnerable to potentially ineffective or unsafe treatment.⁵⁵ However, there is some oversight to protect consumers. Under federal law, compounding pharmacies are required to source the active pharmaceutical ingredient ("API") of their formulations from an FDA-approved supplier.⁵⁶ While this provides some oversight, the regulatory framework may still be inadequate to adequately protect consumers.

II. THE CURRENT UNITED STATES HEALTHCARE SYSTEM

The United States healthcare system is one of the most expensive and complex in the world, yet it ranks poorly in performance when compared to other nations.⁵⁷ The U.S. spends more on healthcare than any other high-income nation, over 16% of its GDP in 2022, with projections to exceed 20% by 2035.⁵⁸ Despite the nation's high spending, the U.S. ranks last in overall healthcare performance in a study with nine other high-income nations.⁵⁹

Unlike most developed countries that provide universal healthcare, the U.S. relies on a mix of private and public insurance: publicly financed Medicare and

51. *Id.*

52. *See id.*

53. Nikhil Sood & Rohini Gard, *Global Rise of Compounded Weight-Loss Medicines A Worrisome Trend*, 9 *ENDOCRINE SOCIETY* 1,1 (2025).

54. *The Clinical Utility of Compounded Bioidentical Hormone Therapy*, *supra* note 48; Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301-399(f) (2024).

55. *Compounding and the FDA*, U.S. FOOD & DRUG ADMIN. (Sep. 16, 2025), <https://www.fda.gov/drugs/human-drug-compounding/compounding-and-fda-questions-and-answers> [<https://perma.cc/BK2L-HQUV>].

56. *Bulk Drug Substances Used in Compounding Under Section 503A of the FD&C Act*, U.S. FOOD & DRUG ADMIN. (Sep. 26, 2024), <https://www.fda.gov/drugs/human-drug-compounding/bulk-drug-substances-used-compounding-under-section-503a-fdc-act> [<https://perma.cc/3SLM-CLY5>]; 21 U.S.C. § 353(a) (2024).

57. David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System*, COMMONWEALTH FUND (Sep. 19, 2024), <https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024> [<https://perma.cc/9PFL-7967>].

58. *Id.*

59. *Id.*

Medicaid coexist with privately funded market plans.⁶⁰ Regarding health insurance, as of 2022, around 48.7% of citizens had private insurance through their employers, 6.3% had private insurance through health insurance marketplaces, 21.2% had Medicaid, 14.6% had Medicare, 1.3% were on other public insurance, and 8% were uninsured.⁶¹ Insurance in the U.S. is administratively complex, and this fragmentation imposes a substantial bureaucratic burden.⁶²

Medicaid and Medicare, which together account for 34% of the U.S. health insurance market, provide government-funded coverage to specific populations.⁶³ Medicaid is a network of statewide programs administered by state governments following broad national guidelines established by federal statutes, regulations, and policies.⁶⁴ Low-income adults, pregnant individuals, children, elderly individuals, and individuals with disabilities are eligible for Medicaid.⁶⁵ Medicaid coverage varies by state, but certain services must be covered, including doctor visits, inpatient and outpatient hospital services, mental health services, necessary medications, prenatal and maternity care, and preventive care, such as immunizations, mammograms, and colonoscopies.⁶⁶

In contrast, Medicare provides health care coverage for people aged 65 or older, individuals of any age with certain disabilities, and people of any age with end-stage renal disease (“ESRD”).⁶⁷ This program, administered by the federal government, has four parts: Part A, B, C, and D.⁶⁸ Part A covers hospital insurance, including inpatient hospital, inpatient skilled nursing facilities, hospice, and some home health services.⁶⁹ Part B covers medical insurance, including services from doctors and other health care providers, outpatient care, durable medical equipment, home health services, and many preventative services.⁷⁰ Part C, also known as Medicare Advantage (“MA”), offers an alternative to Original Medicare through a private insurance plan that is

60. Rossa Tikkanen et al., *International Health Care System Profiles: The United States*, COMMONWEALTH FUND, <https://www.commonwealthfund.org/international-health-policy-center/countries/united-states> [https://perma.cc/4CK4-GDUD] (last visited Nov 23, 2024).

61. *US Healthcare System Overview: Background*, ISPOR, <https://www.ispor.org/heor-resources/us-healthcare-system-overview/background> [https://perma.cc/3PML-JK22] (last visited Nov 23, 2024).

62. Cyril F. Chang, David M. Mirvis & Asos Mahmood, *The High Cost of American Health Care: Understanding the Deeper Roots of the Crisis*, 34 HEALTH CARE ANALYSIS 1 (2025).

63. *US Healthcare System Overview: Background*, *supra* note 61.

64. MEDICARE AND MEDICAID BASICS, CTRS. FOR MEDICAID & MEDICARE SERV. 3 (2024).

65. *Id.*

66. *Id.* at 6.

67. *Id.* at 3.

68. *Id.* at 2.

69. *Id.*

70. *Id.*

Medicare-approved.⁷¹ These MA plans include Part A and B, usually Part D.⁷² Lastly, Part D is the Prescription Drug Benefit, where private insurance companies approved by Medicaid provide prescription drug coverage.⁷³

In March 2010, the Patient Protection and Affordable Care Act, also referred to as the Affordable Care Act (“ACA”), was signed into law.⁷⁴ This comprehensive health care reform expanded health care coverage across the United States by expanding access to Medicaid for individuals with income up to 138% of the federal poverty level, creating new health insurance exchange markets where individuals can purchase insurance, and requiring employers that do not provide such insurance to pay penalties.⁷⁵

The ACA has been regarded as the most comprehensive piece of health care reform legislation in recent history. Most notably, the law transformed health care by expanding health insurance for 20 million Americans.⁷⁶ Prior to 2010, the uninsured rate was 16%; by 2016, it was at an all-time low of 9%.⁷⁷ Additionally, the ACA protects people with preexisting conditions from discrimination. This is called “guaranteed issue,” which means that “insurers must issue policies to anyone and can no longer turn away people based on health status.”⁷⁸ Yet even as the ACA has transformed healthcare in the U.S., there are still major drawbacks for Americans, including cost and access to prescription drugs.

A. Cost

A notable consequence of the United States’ mixed healthcare system is the comparatively high cost of prescription drugs.⁷⁹ Cross-analyses of drug pricing across countries found that U.S. prescription prices were 278% higher than those in other countries.⁸⁰ Public perception reflects this, with nearly 79% of

71. *Id.*

72. CTRS. FOR MEDICARE & MEDICAID SERVS., *Parts of Medicare*, Medicare.gov, <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare> [<https://perma.cc/9RSA-W9J5>] (last visited May 5, 2026).

73. MEDICARE AND MEDICAID BASICS, *supra* note 64, at 2.

74. *See* 42 U.S.C. §§18001-18122.

75. Jared Ortaliza, Matt McGough & Cynthia Cox, *The Affordable Care Act 101*, KFF (Oct. 8, 2025), <https://www.kff.org/health-policy/101-the-affordable-care-act/?entry=table-of-contents-what-did-the-aca-change-about-health-coverage-in-the-u-s> [<https://perma.cc/8XF8-RAKD>].

76. Nicole Rapfogel, Emily Gee & Maura Calsyn, *10 Ways the ACA Has Improved Health Care in the Past Decade*, CTR. FOR AM. PROGRESS (Mar. 23, 2020), <https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade/#:~:text=The%20ACA%20generated%20one%20of,races%20and%20ethnicities%20have%20narrowed> [<https://perma.cc/8TQH-6YE3>].

77. *Id.*

78. *Id.*

79. Andrew W. Mulcahy, Daniel Schwam & Susan L. Lovejoy, *International Prescription Drug Price Comparisons: Estimates Using 2022 Data*, RAND (Feb. 1, 2024), https://www.rand.org/pubs/research_reports/RRA788-3.html [<https://perma.cc/LGH7-8LSV>].

80. *Id.*

Americans believing that the cost of prescription drugs is unreasonable.⁸¹ These elevated prices stem from a combination of factors, including market exclusivity, patent periods, limited government price regulation, and reduced generic competition.⁸² As a result, this has led to affordability challenges for many patients, forcing some to ration their GLP-1 medications or forgo weight-loss treatment altogether, further amplifying health disparities in the United States.⁸³

An important factor contributing to the high prices of prescription medications is FDA market exclusivity, which allows drug manufacturers to hold monopolies over their medications for a set period.⁸⁴ During this time, competitors are restricted from producing generic alternatives, leading to inflated prices for consumers as the original manufacturer corners the market.⁸⁵ The time period differs for different kinds of drugs; most new drugs get an exclusivity period of five years.⁸⁶ For many new drugs, there are no cheaper generic alternatives due to these monopolies, in addition to drug patents.⁸⁷

Patents, which legally exclude others from making, selling, distributing, or importing a drug, differ from market exclusivity.⁸⁸ Patents are granted by the U.S. Patent and Trademark Office (“USPTO”), while market exclusivity is within the purview of the FDA.⁸⁹ Additionally, patents protect the intellectual property, while market exclusivity guarantees no generics are made during that period.⁹⁰ If a patent is granted, a drug manufacturer may have up to 20 years of intellectual property protection.⁹¹

Drug manufacturers may adopt “patent strategies” in order to maintain their

81. Rachel Dolan & Marina Tian, *Pricing and Payment for Medicaid Prescription Drugs*, KFF (Jan. 23, 2020), <https://www.kff.org/medicaid/5-key-facts-about-medicaid-prescription-drugs/> [https://perma.cc/UWT4-L82D].

82. See S. Vincent Rajkumar, *The High Cost of Prescription Drugs: Causes and Solutions*, 10 BLOOD CANCER J. 1, 1 (2020).

83. Alissa S. Chen et al., *Cost-Related Prescription Drug Rationing by Adults with Obesity*, 7 JAMA NETWORK OPEN 1, 1 (2024); see Ameet Sarpatwari et al., *Glucagon-Like Peptide-1 Receptor Agonist Order Fills and Out-of-Pocket Costs by Race, Ethnicity, and Indication*, 6 JAMA HEALTH FORUM 1, 2 (2025).

84. Aaron S. Kesselheim, Jerry Avorn & Ameet Sarpatwari, *The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform*, 316 JAMA 858, 860 (2016).

85. *Id.*

86. Aaron S. Kesselheim, *Determinants of Market Exclusivity for Prescription Drugs in the United States*, COMMONWEALTH FUND (Sep. 13, 2017), <https://www.commonwealthfund.org/publications/journal-article/2017/sep/determinants-market-exclusivity-prescription-drugs-united> [https://perma.cc/USP5-B2GD].

87. Rajkumar, *supra* note 82.

88. Kristi Martin, *How Drugmakers Use the Patent Process to Keep Prices High*, COMMONWEALTH FUND (Nov. 13, 2025), <https://www.commonwealthfund.org/publications/explainer/2025/nov/how-drugmakers-use-patent-process-keep-prices-high> [https://perma.cc/Y2QM-QVFM].

89. *Id.*

90. *Id.*

91. *Id.*

monopoly, which can further increase drug prices.⁹² One such strategy is a “patent thicket,” in which a pharmaceutical company builds an overlapping system of patents on a single drug by obtaining multiple patents on the drug’s composition, manufacturing, and formulation.⁹³ While each individual patent may differ, collectively they create a dense web of legal protections that can significantly delay generic competition.⁹⁴ As a result, even after the original patent on a drug’s active ingredient expires, competitors may face substantial legal barriers to entry into the market.⁹⁵ Generic drugs may become available after the original patent expires, allowing competition within the market.⁹⁶

The United States pharmaceutical industry has historically operated under a comparatively “hands-off” regulatory approach with respect to drug pricing. Unlike many countries that directly regulate prescription drug prices, the United States has relied on the market and stakeholders to set prices.⁹⁷ In 2003, Medicare was prohibited from negotiating lower drug prices with the industry.⁹⁸ This restriction was partially scaled back in 2022 for high-cost drugs.⁹⁹ However, there is still a lack of government intervention that gives pharmaceutical manufacturers the power to set high drug prices.

Additionally, with government-funded insurance, such as Medicaid and Medicare, prescription drug prices are determined by a complex set of policies that draw on price benchmarks.¹⁰⁰ Price benchmarking is the “practice whereby market analysis, cost estimating tools, affordable cost targeting, and design/manufacturing analysis are used to establish the fair market price.”¹⁰¹ However, determining the price of a drug in the United States is not a simple process, as many actors play a role in pricing and reimbursements, and each may rely on different pricing benchmarks at various stages of the drug supply chain.¹⁰² In addition, there is a lack of transparency about the actual sticker prices paid for medications, as rebates, discounts, and negotiations are often not made public.¹⁰³ Together, these factors complicate efforts to identify a single, consistent price for any drug, often at the expense of consumers who require

92. *Id.*

93. *Id.*

94. *See id.*

95. *See id.*

96. *See* Kesselheim, Avorn & Sarpatwari, *supra* note 84.

97. *See* Paul Ginsburg & Steven Lieberman, *Government Regulated or Negotiated Drug Prices: Key Design Considerations*, BROOKINGS (Aug. 30, 2021), <https://www.brookings.edu/articles/government-regulated-or-negotiated-drug-prices-key-design-considerations/> [https://perma.cc/XJ6N-3DXR].

98. H.R.1, 108th Cong. (2003) (enacted).

99. H.R. 5376, 117th Cong. (2022) (enacted).

100. Anna Hung & Sean Dickson, *A Primer on Prescription Drug Pricing Benchmarks in the United States*, 31 J. MANAG. CARE SPEC PHARM. 1326, 1326 (2025).

101. WORLD BANK, *Price Benchmarking: Works, Goods and Non-Consulting Services in World Bank-Financed Projects* 1 (2023).

102. *See id.*

103. *See Id.*

these drugs.

Additionally, several other factors may affect prescription drug prices, such as competition, Medicare Part D, pharmaceutical rebates, and pharmacy benefit managers.¹⁰⁴ Market exclusivity and patents allow brand-name drug manufacturers to set high prices, especially when there is little competition.¹⁰⁵ Rebates negotiated between manufacturers and insurers reduce overall spending but do not lower consumers' out-of-pocket costs.¹⁰⁶

Another contributor to high drug costs is pharmacy benefit managers ("PBMs"), which serve as "middlemen" in the pharmaceutical industry.¹⁰⁷ PBMs negotiate drug pricing for consumers on behalf of insurers, employers, and government health plans.¹⁰⁸ By negotiating, PBMs wield a large amount of power and are often a major influence in drug pricing.¹⁰⁹ However, PBMs often operate with limited transparency to consumers and the public, making reform difficult.¹¹⁰

These pricing dynamics are particularly evident in the market for GLP-1s. Ozempic, Wegovy, and other GLP-1s are highly effective but come at a high price. Without insurance, the monthly cost of these medications has ranged from \$1,000 to \$1,350 per month in the United States.¹¹¹ Bariatric surgery, despite being a major medical procedure, resulted in lower out-of-pocket costs for weight-loss patients compared to 12 to 18 months of GLP-1 therapy.¹¹² For many Americans, these medications remain financially out of reach, and many who qualify for GLP-1s forgo treatment altogether due to the high cost, with roughly 40% of GLP-1 prescriptions going unfilled.¹¹³ The high cost of GLP-1s stems from a variety of factors, which complicate lowering the cost of the drug.

First, Novo Nordisk and Eli Lilly maintain substantial control over the GLP-

104. *Prescription Drug Spending*, U.S. GOV'T ACCOUNTABILITY OFF., <https://www.gao.gov/prescription-drug-spending> [<https://perma.cc/V4WV-2D4W>] (last visited Feb. 16, 2025).

105. Rajkumar, *supra* note 82.

106. Steven Lieberman, Paul Ginsburg & Erin Trish, *Sharing Drug Rebates with Medicare Part D Patients: Why and How*, BROOKINGS INSTITUTION (Sep. 14, 2020), <https://www.brookings.edu/articles/sharing-drug-rebates-with-medicare-part-d-patients-why-and-how/> [<https://perma.cc/WC5T-R8QQ>].

107. FED. TRADE COMN'N, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, U.S. FED. TRADE COMN'N OFF. OF POL'Y PLANNING 1 (July 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf [<https://perma.cc/5NNK-E4H90>].

108. *Id.*

109. *Id.*

110. *See id.*

111. NOVOCARE, *Explaining Ozempic List Price*, <https://www.novocare.com/diabetes/products/ozempic/explaining-list-price.html> [<https://perma.cc/QSR8-WH6P>] (last visited May 8, 2026); NOVO PRICING, *Wegovy*, <https://www.novopricing.com/wegovy.html> [<https://perma.cc/6ZLE-3FBP>] (last visited May 8, 2026) (pricing for a one-month supply of Wegovy is \$1,349.02 and Ozempic is \$1027.51, for those uninsured).

112. Salvatore Docimo Jr. et al., *A Cost Comparison of GLP-1 Receptor Agonists and Bariatric Surgery: What is the Break Even Point?*, 38 SURGICAL ENDOSCOPY 6560, 6564 (2024).

113. Kesselheim, Avorn & Sarpatwari, *supra* note 84.

1 market through a combination of FDA market exclusivity and USPTO patent protections. In a study of ten GLP-1s, the average protection period was an average of 18.3 years after FDA approval.¹¹⁴ Although some of Novo Nordisk's primary patents for semaglutide expire in 2026, secondary patents may extend the company's market control until at least 2033.¹¹⁵ This means that no drugmaker can produce a true generic version of Ozempic that is approved by the Food and Drug Administration ("FDA") until 2033.¹¹⁶ In the absence of a generic version, medication prices remain high because competition is restricted, allowing Novo Nordisk to set premium pricing for its medications in the United States.

The pricing of GLP-1s is also influenced by insurance coverage limitations. Although some GLP-1 drugs are covered for diabetes treatment, insurance coverage for obesity treatment remains inconsistent.¹¹⁷ Under the terms of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Part D plans are currently prohibited from covering anti-obesity medications.¹¹⁸ Despite this, there have been recent strides in securing obesity coverage under government-funded insurance programs, however employer insurance plans remain reluctant to broadly cover these medications.¹¹⁹ As approximately half of Americans receive health insurance through their employers, these coverage decisions have a large impact nationwide.¹²⁰ Additionally, GLP-1 prices may be affected by other factors, such as price benchmarking, PBMs, and pharmaceutical rebates; however, they are usually not public knowledge.¹²¹ Overall, the pricing of GLP-1s remains convoluted, though several reforms could help reduce costs.

114. Rasha Alhiary et al., *Patents and Regulatory Exclusivities on GLP-1 Receptor Agonists*, 330 JAMA 650, 652 (2023).

115. *The year of Ozempic: an IP take*, HEALTH TECH WORLD (July 21, 2025), <https://www.htworld.co.uk/insight/features/the-year-of-ozempic-an-ip-take-red23/> [https://perma.cc/4EKP-UP4H].

116. Gerardo Sison, *When will Ozempic go generic?*, SIGNLECARE: CHECKUP (Mar. 3, 2025), <https://www.singlecare.com/blog/when-will-ozempic-go-generic/> [https://perma.cc/J2PR-58ZU].

117. See Elizabeth Williams, *Medicaid Coverage of and Spending on GLP-1s*, KFF (Jan. 16, 2026), <https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/> [https://perma.cc/R3UV-3X8T].

118. *Part D / Prescription Drug Benefits*, CTR. FOR MEDICARE ADVOC., <https://medicareadvocacy.org/medicare-info/medicare-part-d/#:~:text=medically%20appropriate%20diagnoses.,Excluded%20Drugs,yet%20have%20Part%20B> [https://perma.cc/VTQ8-BBUQ] (last visited Mar. 25, 2026); H.R.1, 108th Cong. (2003) (enacted).

119. *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patients*, WHITE HOUSE (Nov. 6, 2025), <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/> [https://perma.cc/MCT8-DF85]; *GLP-1 Drugs: 2025 Pulse Survey (United States)*, INT'L FOUND. EMP. BENEFIT PLANS (2025), [https://www.ifebp.org/detail-pages/resource/survey/glp-1-drugs-\(u.s.\)--2025-pulse-survey](https://www.ifebp.org/detail-pages/resource/survey/glp-1-drugs-(u.s.)--2025-pulse-survey) [https://perma.cc/LN5L-5AWC].

120. *US Healthcare System Overview: Background*, *supra* note 61.

121. WORLD BANK, *supra* note 101 at 1; FED. TRADE COMN'N, *supra* note 107, at 1.

B. Access

While drug shortages are less prominent than high drug costs, they have been a persistent challenge in the United States. Within just the first quarter of 2024, the American Society of Health-System Pharmacists (“ASHP”) reported 323 active drug shortages, surpassing the previous record of 320 in 2014.¹²² From 2022 to 2025, the FDA’s drug shortage list included GLP-1s used for weight loss, specifically Ozempic and Wegovy, further illustrating that drugs in high demand are especially susceptible to shortages.¹²³

Drug shortages of GLP-1 receptor agonists such as dulaglutide, semaglutide, and tirzepatide began in late 2022 and continued into early 2023.¹²⁴ Novo Nordisk, a major supplier of GLP-1s, has noted that shortages are due to the increased demand for the drug as well as supply chain issues.¹²⁵ The shortages have unevenly affected product doses for patients and created significant access barriers for patients using these drugs for glycemic management, weight loss, and cardiovascular risk reduction.¹²⁶ All GLP-1 shortages were resolved in early 2025, except for liraglutide injections.¹²⁷

Additionally, strategies to manage these shortages were significantly lacking due to the lack of generic alternatives and the monopoly on the newly FDA-approved brand-name drugs.¹²⁸ The exclusivity granted through these patents and market protections limits competition, preventing cheaper options

122. ASHP reports record high number of drug shortages, AM. HOSP. ASS’N (Apr. 12, 2024), <https://www.aha.org/news/headline/2024-04-12-ashp-reports-record-high-number-drug-shortages#:~:text=ASHP%20tracked%20a%20record%20323,of%20320%20shortages%20in%202014> [https://perma.cc/Z7VG-EGPF].

123. Jacqueline A. Corrigan-Curay, *Declaratory Order: Resolution of Shortages of Semaglutide Injection Products (Ozempic and Wegovy)*, U.S. FOOD & DRUG ADMIN. (Feb. 21, 2025), <https://www.fda.gov/media/185526/download> [https://perma.cc/NG45-45HL]; Judi Abbott Curry, Marina Plotkin & Megan Pollastro, *GLP-1 Weight-Loss Drugs Off Shortage List: Deadlines to Stop Compounding*, HARRIS BEACH MURTHA CULLINA PLLC (Mar. 24, 2025), <https://www.harrisbeachmurtha.com/insights/glp-1-weight-loss-drugs-off-shortage-list-deadlines-to-stop-compounding/> [https://perma.cc/4J2M-FSJN].

124. Heather P. Whitley, Jennifer M. Trijillo & Joshua J. Neumiller, *Special Report: Potential Strategies for Addressing GLP-1 and Dual GLP-1/GIP Receptor Agonist Shortages*, 41 CLINICAL DIABETES 467, 467 (2023).

125. NOVO NORISK A/S, *Company Announcement No. 80/2021: Novo Nordisk Announces Supply Chain Challenges for Wegovy in the U.S.*, NOVO NORISK (Dec. 17, 2021), <https://ml-eu.globenewswire.com/Resource/Download/cf92a50b-0b7a-4fe2-9e42-1113ad5840c2> [https://perma.cc/DF2M-PZB8].

126. *Id.*

127. Corrigan-Curay, *supra* note 123; U.S. FOOD & DRUG ADMIN., *Drug Shortage Detail: Liraglutide Injection*, https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Liraglutide%20Injection&st=c&tab=tabs-1 [https://perma.cc/PRN6-NBR3] (last visited May 9, 2026).

128. Whitley, Trijillo & Neumiller, *supra* note 124.

for weight loss from entering the market.¹²⁹ This monopoly further exacerbates supply chain issues, as no alternative producers can step in to meet the growing demand for these drugs.¹³⁰ Without policy intervention to allow generic production or regulations to ensure equitable supply distribution of these medications, shortages are likely to occur again, creating additional barriers for patients who rely on these life-changing medications for diabetes or weight management.¹³¹

As of February 2025, Medicare did not cover GLP-1 medications for weight loss, only for diabetes.¹³² This impacted a large portion of elderly individuals who could potentially benefit from these medications.¹³³ Furthermore, for those on Medicaid, coverage varies across states, often imposing strict criteria for patients to meet.¹³⁴ Weight-loss drugs are included in a small group of drugs that can be excluded from coverage by states.¹³⁵ As of January 2026, 13 state Medicaid programs have announced coverage for obesity treatment under fee-for-service (“FFS”) programs.¹³⁶ For those on private insurance, coverage may be inconsistent and inadequate, with high deductibles and copays they cannot afford.¹³⁷

Limited access to GLP-1 medications has contributed to the emergence of compounded alternatives.¹³⁸ While the FDA normally restricts compounded drugs, this restriction is lifted for drugs in shortage, essentially a regulatory loophole.¹³⁹ During the drug shortages, many people turned to compounded versions of GLP-1s.¹⁴⁰ This can be dangerous for consumers, as compounded

129. INITIATIVES FOR MEDICINES, ACCESS, AND KNOWLEDGE (I-MAK), *The Heavy Price of GLP-1 Drugs: How Financialization Drives Pharmaceutical Patent Abuse and Health Inequities for GLP-1 Therapies* 1, 3 (2025).

130. *See id.*

131. *See* U.S. DEP’T OF HEALTH & HUM. SERVS., *Policy Considerations to Prevent Drug Shortages and Mitigate Supply Chain Vulnerabilities in the United States* 2 (Apr. 2, 2024).

132. Tony Pugh & Kimberly Lankford, *When Will Medicare Cover Ozempic, Other Weight-Loss Drugs?*, AARP (Feb. 7, 2026), <https://www.aarp.org/medicare/faq/does-medicare-cover-ozempic-weight-loss-drugs/#federal-ban> [<https://perma.cc/E5PT-V3U6>]; Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173; Social Security Act § 1927(d)(2), 42 U.S.C. § 1396r—8.

133. Lou Portero, *Older Adults Face Disproportionate Barriers to Sustained GLP-1 Medication Access*, URB. HEALTH TODAY (Jan. 1, 2026), <https://www.urbanhealthtoday.com/post/older-adults-face-disproportionate-barriers-to-sustained-glp-1-medication-access> [<https://perma.cc/58R8-FBKA>].

134. Williams, *supra* note 117.

135. *Id.*; 42 U.S.C. § 1396r-8(d)(2) (1990).

136. Williams, *supra* note 117.

137. Pandey et al., *supra* note 45, at 1-2.

138. *Id.* at 4.

139. *See* FOOD AND DRUG ADMIN., *Compounding When Drugs Are On FDA’s Drug Shortage List*, U.S. FOOD AND DRUG ADMIN. (Aug. 8, 2025), <https://www.fda.gov/drugs/human-drug-compounding/compounding-when-drugs-are-fdas-drug-shortages-list> [<https://perma.cc/E6GX-J7TA>]; Jared Dudding, *Navigating Access: The Future of Compounded GLP-1 Receptor Agonists for Weight Loss*, 122 MO. MED. 252, 252 (2025).

140. *See* Dudding, *supra* note 139.

drugs do not undergo the same FDA approval process and scrutiny that other drugs on the market do.¹⁴¹ As of 2025, over 1,000 adverse events involving compounded GLP-1s have been reported by public health agencies.¹⁴² These reports are usually related to dosing errors, as compounded GLP-1s often require consumers to draw their own dosage in an insulin needle, rather than pre-set doses that brand-name GLP-1s offer.¹⁴³ During a shortage, compounding is allowed in certain circumstances: for 503A pharmacies, for formulations created after a patient is prescribed, and for 503B pharmacies in bulk drug compounding.¹⁴⁴ However, as the shortage has ended, the FDA has begun phasing out compounded GLP-1s, with a grace period that ended in April 2025.¹⁴⁵ Additionally, the FDA has moved forward with a proposed rule to exclude GLP-1s from 503B compounding pharmacies if a shortage occurs again.¹⁴⁶ This further limits access to GLP-1s, especially for those who cannot afford the brand-name GLP-1s.

III. THE CURRENT CANADIAN HEALTHCARE SYSTEM

Canada has a decentralized, universal, publicly funded health system called Canadian Medicare.¹⁴⁷ In this system, health care is funded and administered primarily by the country's 13 provinces and territories.¹⁴⁸ Each individual province and territory has its own insurance plan, and each receives cash assistance from the federal government on a per-capita basis.¹⁴⁹ Additionally,

141. *Id.* at 253.

142. *Id.*

143. FOOD AND DRUG ADMIN., *FDA Alerts Health Care Providers, Compounders, and Patients of Dosing Errors Associated with Compounded Injectable Semaglutide Products*, U.S. FOOD AND DRUG ADMIN. (July 26, 2024), <https://www.fda.gov/drugs/human-drug-compounding/200Bfda-alerts-health-care-providers-compounders-and-patients-dosing-errors-associated-compounded> [<https://perma.cc/SD9L-EGXE>].

144. *503A v. 503B Pharmacies*, OLYMPIA, <https://www.olympiapharmacy.com/blog/compounding-503a-vs-503b/> [<https://perma.cc/C72T-XFYC>] (last visited May 9, 2026).

145. FOOD & DRUG ADMIN., *FDA Clarifies Policies for Compounders as National GLP-1 Supply Begins to Stabilize*, U.S. FOOD & DRUG ADMIN. (Apr. 1, 2026), [https://www.fda.gov/drugs/drug-alerts-and-statements/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize#:~:text=%5B2/21/2025%5D%20FDA%20has%20determined%20the%20shortage%20of,glucagon%2Dlike%20peptide%201%20\(GLP%2D1\)%20medication%2C%20is%20resolved](https://www.fda.gov/drugs/drug-alerts-and-statements/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize#:~:text=%5B2/21/2025%5D%20FDA%20has%20determined%20the%20shortage%20of,glucagon%2Dlike%20peptide%201%20(GLP%2D1)%20medication%2C%20is%20resolved) [<https://perma.cc/P6VW-LCST>].

146. FOOD & DRUG ADMIN., *FDA Proposes to Exclude Semaglutide, Tirzepatide, and Liraglutide From 503B Bulks List*, U.S. FOOD & DRUG ADMIN. (Apr. 30, 2026), <https://www.fda.gov/news-events/press-announcements/fda-proposes-exclude-semaglutide-tirzepatide-and-liraglutide-503b-bulks-list> [<https://perma.cc/P283-K4JG>].

147. Sara Allin, Greg Marchildon & Alice Peckham, *International Health Care System Profiles: Canada*, COMMONWEALTH FUND, <https://www.commonwealthfund.org/international-health-policy-center/countries/canada> [<https://perma.cc/D9K6-YGVP>] (last visited Mar. 25, 2026).

148. *Id.*

149. *Id.*

about two-thirds of Canadians have private insurance.¹⁵⁰

Benefits differ according to individual insurance plans; however, each plan provides medically necessary hospital and physician services free at the point of use. For any excluded services, including outpatient prescription drugs and dental care, provinces and territories provide some coverage for targeted groups.¹⁵¹ A founding principle of the Canadian health system is access to healthcare based on need rather than ability to pay.¹⁵²

The Canadian Health Act, adopted in 1984, lays out various criteria and conditions that must be met for provinces and territories to receive federal funding.¹⁵³ This includes plans being administered and operated as non-profit, plans covering all health services covered by hospitals, physicians, and dentists, and plans for insured residents receiving uniform health services.¹⁵⁴ The federal government then provides funding to the decentralized system through the Canada Health Transfer, but each individual province and territory is ultimately responsible for managing and delivering services.¹⁵⁵

A. Cost

While Canada has a universal publicly funded system that covers hospital and physician services, prescription drugs are not covered by every province.¹⁵⁶ Despite this, it is well known that Canada has more affordable prescription drug prices than the United States.¹⁵⁷

The primary reason for these lower costs is Canada's use of government price controls. In 1987, the Canadian government set up the Canadian Patented Medicine Prices Review Board ("PMPRB"), which regulates medication prices in Canada and limits the maximum price that can be charged.¹⁵⁸ The PMPRB helps ensure that pharmaceutical manufacturers do not charge "excessive"

150. *Id.*

151. *Id.*

152. Danielle Martin et al., *Canada's universal health-care system: achieving its potential*, 391 LANCET 1718, 1718 (2018).

153. Allin, Marchildon & Peckham, *supra* note 147.

154. *Id.*

155. DEP'T OF FIN. CAN., *Canada Health Transfer*, GOV'T CAN., <https://www.canada.ca/en/departement-finance/programmes/federal-transfers/canada-health-transfer.html> [<https://perma.cc/7PTE-CSR8>] (last visited Feb. 16, 2025).

156. Allin, Marchildon & Peckham, *supra* note 147.

157. Julie Ingram, *Why Are Drugs Cheaper in Canada?*, VERYWELL HEALTH (Feb. 12, 2024), <https://www.verywellhealth.com/america-versus-canada-drug-prices-8567551> [<https://perma.cc/6BHQ-2BGV>]; see *Canadian Insulin is Cheaper than American Insulin: Why?*, INSULIN OUTLET (Jan. 24, 2022), <https://insulinoutlet.com/why-is-canadian-insulin-cheaper-than-american-insulin/> [<https://perma.cc/7B3Z-F4EU>].

158. Kiran Altaf, *Why is medication so much cheaper from Canada?*, RXCONNECTED (Mar. 17, 2026), <https://www.rxconnected.com/blog/canadian-pharmacy/why-is-medication-so-much-cheaper-from-canada> [<https://perma.cc/U7TN-XNHF>]; GOV'T CAN., *PMPRB Guidelines*, GOV'T CAN., <https://www.canada.ca/en/patented-medicine-prices-review/services/legislation/about-guidelines/guidelines.html> [<https://perma.cc/DQ4U-KKBD>] (last visited Apr. 10, 2026).

prices for patented drugs by reviewing and limiting the maximum prices that may be charged within the Canadian market.¹⁵⁹

Additionally, in Canada, prescription drugs are given a market exclusivity period of eight years that prevents generics from being produced.¹⁶⁰ Different from exclusivity protection, prescription drug patents guarantee protection for up to 20 years, beginning once the patent application is filed.¹⁶¹ Market exclusivity begins once a product hits the market, therefore warranting a shorter time length.¹⁶² Together, exclusivity and patents create layered protections for a newly approved drug.

As of 2023, in Canada, the uninsured price for one month of Ozempic averages at 250-300 USD and Wegovy is listed at \$400-570 USD.¹⁶³ However, this is impacted by the provincial government structure, as pricing may differ between parts of the country.¹⁶⁴ For example, one healthcare platform only offers GLP-1s to five of the ten provinces, and of the five, prices can range anywhere from 200 to 450 USD.¹⁶⁵

Even with the moderate pricing, Canada continues to make great strides in further lowering the cost of this weight loss treatment. In April 2026, Canada became the first G7 country to approve a generic semaglutide injection, specifically a generic Ozempic.¹⁶⁶ The generic was possible because Novo Nordisk did not renew its patent in Canada, which is the only country it has not renewed.¹⁶⁷ A result of this generic will likely be a lower cost of the brand-name, as the generic will drive up competition and change the market.¹⁶⁸ A second generic was also approved for use in early May.¹⁶⁹ It is predicted that with two

159. *See id.*

160. Alirod, *Prescription Drug Patents and Generic Drugs in Canada*, IP LAW ALLARD UBC (Apr. 1, 2024), <https://iplaw.allard.ubc.ca/2024/04/01/prescription-drug-patents-canada/> [<https://perma.cc/CRP9-A9XD>].

161. *Id.*

162. *Id.*

163. *Ozempic for Weight-Loss in Canada: Your Ultimate Guide*, WALK IN (Dec. 18, 2025), <https://walkin.ca/blog/ozempic-canada/> [<https://perma.cc/33N2-FG8S>].

164. Felix Team, *How Much Do Ozempic Treatments Cost in Canada?*, FELIX (Apr. 22, 2026), <https://www.felixforyou.ca/blog-posts/how-much-does-ozempic-cost-in-canada/> [<https://perma.cc/8CVE-8K88>].

165. *Id.*

166. HEALTH CAN., *Canada Becomes the First G7 Country to Approve a Generic Version of Semaglutide*, GOV'T CAN. (Apr. 28, 2026), <https://www.canada.ca/en/health-canada/news/2026/04/canada-becomes-the-first-g7-country-to-approve-a-generic-version-of-semaglutide.html> [<https://perma.cc/B356-TM59>]; HEALTH CAN., *Regulatory Decision Summary for Semaglutide Injection*, GOV'T CAN. (Apr. 28, 2026), <https://dhpp.hpfb-dgpsa.ca/review-documents/resource/RDS1776954365092> [<https://perma.cc/NF6Q-6VUL>].

167. Jules Adam, *Did Novo Open the Canadian Market to GLP-1 Generics?*, LABIOTECH (June 16, 2025), <https://www.labiotech.eu/in-depth/novo-nordisk-semaglutide-patent-expiration-canada/> [<https://perma.cc/4HY4-NP3W>].

168. *See Ozempic for Weight-Loss in Canada: Your Ultimate Guide*, *supra* note 163.

169. *Regulatory Decision Summary for Apo-Semaglutide Injection*, HEALTH CAN. (May 1, 2026), <https://dhpp.hpfb-dgpsa.ca/review-documents/resource/RDS1777640768488> [<https://perma.cc/RC3Q-38YQ>].

generics in the market, they will lower GLP-1 costs by about 50% of the current pricing.¹⁷⁰

B. Access

Access to GLP-1 receptor agonists in Canada depends on various factors, such as supply chain issues and the country's patchwork-style framework for health insurance.¹⁷¹ A recent study found that prescription drug shortages were less frequent in Canada, even with the vast supply chain issues occurring globally.¹⁷² In regard to GLP-1 receptor agonists, Canada faced a supply chain shortage of semaglutide, tirzepatide, and dulaglutide from October 2023 to January 2025.¹⁷³ This drug shortage was due to the high worldwide demand for the drug, specifically for weight loss purposes, which posed a threat to those who rely on the drug for type 2 diabetes and were unable to access it.¹⁷⁴ Canada's government took various steps to resolve the supply chain issues including "mobiliz[ing] and shar[ing] information regularly with a broad range of stakeholders on supply, work[ing] with manufacturers to monitor supply levels, and facilitated issuance of recommendations to health care professionals to mitigate the shortage of Ozempic and other GLP-1 receptor agonists by collaborating with clinical experts from different specialties."¹⁷⁵

In response to the Canadian government's actions, companies such as Novo Nordisk Canada and Eli Lilly Canada, the two largest suppliers of Ozempic, asked pharmacists to limit refill prescriptions for patients to a 30-day supply.¹⁷⁶ One province, British Columbia, amended its own regulations to limit the sale or dispensing of Ozempic to non-Canadian residents in situations where there

170. See *Ozempic for Weight-Loss in Canada: Your Ultimate Guide*, *supra* note 163.

171. See CANADIAN MED. ASS'N, *Can You Get GLP-1 Drugs in Canada?* (last visited Apr. 28, 2026), <https://www.cma.ca/healthcare-for-real/can-you-get-glp-1-drugs-canada> [<https://perma.cc/5VTU-AA26>]; Josh Recamara, *GLP-1 Cost Surge Puts Pressure on Canadian Drug Plans: Report*, INS. BUS. (Apr. 8, 2026), <https://www.insurancebusinessmag.com/ca/news/breaking-news/glp1-cost-surge-puts-pressure-on-canadian-drug-plans-report-571024.aspx> [<https://perma.cc/467L-AGF4>].

172. See Mina Tadrous et al., *Differences in Drug Shortages in the US and Canada*, 332(22) JAMA 1912 (2024).

173. HEALTH CAN., *Drug shortages in Canada: Fiscal year 2023 to 2024 in review*, GOV'T CAN. (Nov. 20, 2024), <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-shortages/2023-2024-review.html> [<https://perma.cc/ET2M-8F49>]; HEALTH CAN., *Supply of Ozempic and other GLP-1 Receptor Agonists: Notice*, GOV'T CAN. (Jan. 27, 2025), <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-shortages/information-consumers/supply-notice/ozempic.html> [<https://perma.cc/58XH-3BCT>].

174. HEALTH CAN., *Drug shortages in Canada*, *supra* note 173.

175. *Id.*

176. *Response to the intermittent shortages of Ozempic, Mounjaro and Trulicity*, DIABETES CAN. (Dec. 6, 2023), <https://www.diabetes.ca/media-room/news/response-to-the-anticipated-ozempic-supply-disrupt> [<https://perma.cc/4KX6-PPT7>].

are supply chain issues.¹⁷⁷ These actions have significantly reduced supply chain issues in Canada, and as of January 27, 2025, the Canadian government has issued an update that the supply of Ozempic and GLP-1 receptor agonists has stabilized and is available across the country.¹⁷⁸

Public health insurance coverage of GLP-1s varies among provinces because prescription drug coverage is administered at the provincial level.¹⁷⁹ Most provincial plans provide coverage for type 2 diabetes treatment, but coverage for weight loss is less common.¹⁸⁰ If covered for weight-loss, many provinces may list the drug as “limited use,” meaning a doctor has to “confirm it meets special medical rules.”¹⁸¹ Other provinces may require step therapy or prior authorization before covering the drug under public insurance.¹⁸²

For patients with employer-based insurance, access to GLP-1 receptor agonists may be less likely. A survey conducted by the International Foundation of Employee Benefit Plans Canada in 2025 found that 56% of employers cover GLP-1 drugs, but only for diabetes.¹⁸³ Of the employers surveyed in the study, only 31% of them cover GLP-1 drugs for diabetes and weight loss.¹⁸⁴ For those employers who do not offer GLP-1 drugs for weight loss, 35% stated that they were not considering offering coverage for these drugs (with 30% unsure).¹⁸⁵

As GLP-1 drugs become increasingly accessible for weight loss management, insurance plan sponsors face consequential decisions about whether to cover these drugs.¹⁸⁶ These drugs have raised cost concerns for benefit providers as the benefit of weight-management and chronic disease prevention may not be realized during the period employees are covered under their employer’s health plan.¹⁸⁷ As employees frequently switch jobs or retire, employers may bear the immediate cost of covering GLP-1 treatments without

177. Press Release, Gov’t B.C., Province takes actions to prevent shortage of diabetes drug (Mar. 28, 2023), <https://news.gov.bc.ca/releases/2023HLTH0031-000398> [<https://perma.cc/9GG9-UPBN>].

178. HEALTH CAN., *Supply of Ozempic*, *supra* note 173.

179. CANADIAN MED. ASS’N, *supra* note 171.

180. *See id.*

181. *See id.*; Questions and Answers: Executive Officer Notice to Pharmacies, Ont. Ministry of Health (Jan. 26, 2024), <https://www.ontario.ca/files/2024-01/moh-questions-answers-executive-officer-notice-pharmacies-en-2024-01-26.pdf> [<https://perma.cc/E945-C9XJ>].

182. *Alberta Drug Benefit List*, ALBERTA BLUE CROSS, https://idbl.ab.bluecross.ca/idbl/drugsList?sessionId=9LhOeo0SEoQjJoLddZSeM-Tl5_feN97SQ64IDD9P9leYSRtQgpeT!91776283?ptc=682006 [<https://perma.cc/K42U-GKUQ>].

183. *GLP-1 Drugs: 2025 Pulse Survey (Canada)*, INT’L FOUND. EMP. BENEFIT PLANS (2025), [https://www.ifebp.org/detail-pages/resource/survey/ghp-1-drugs-\(canada\)--2025-pulse-survey](https://www.ifebp.org/detail-pages/resource/survey/ghp-1-drugs-(canada)--2025-pulse-survey) [<https://perma.cc/8SUU-QP2M>].

184. *Id.* (increasing 14% since 2024).

185. *Id.*

186. David Kitai, *Plan sponsors may only have a few months to decide how they’ll cover obesity drugs*, BPM (Feb. 20, 2024), <https://www.benefitsandpensionsmonitor.com/benefits/group-health/plan-sponsors-may-only-have-a-few-months-to-decide-how-theyll-cover-obesity-drugs/383791> [<https://perma.cc/PBQ8-GXKP>].

187. *Id.*

ultimately benefiting from the long-term reduction in healthcare expenditures.¹⁸⁸

IV. COMPARISON

A. Cost

Weight loss drugs are significantly more expensive in the United States compared to Canada. In the United States, an uninsured, one-month supply of GLP-1 drugs is approximately \$1,000 for Ozempic and \$1,300 for Wegovy, while in Canada the average price is \$250 for Ozempic and \$450 for Wegovy.¹⁸⁹ As a result, GLP-1s are generally three to four times more expensive in the United States than in Canada. These elevated prices in the United States likely stem from a combination of factors, such as minimal government price regulation, market exclusivity/patent protection, and lack of insurance coverage.¹⁹⁰

Rather than directly regulating the prices of medications, the United States allows pharmaceutical manufacturers to set their own prices with limited government interference.¹⁹¹ As a result, drug manufacturers retain substantial pricing power, leading to higher costs for prescription drugs.¹⁹² By contrast, Canada utilizes a more “hands-on” approach to the pharmaceutical industry. The Canadian government manages and lowers drug pricing through the PMPRB, a federal quasi-judicial agency, which prevents high costs for medications by giving legal authority to regulate patented drug prices.¹⁹³ This form of government oversight limits the ability of pharmaceutical companies to maintain an unchecked monopoly on the drug market.

Additionally, the United States provides longer periods of market exclusivity than Canada. In the U.S., prescription drugs receive an average market exclusivity period of twelve and a half years, whereas Canada provides an eight-year exclusivity period.¹⁹⁴ While both countries have patent protections that may last roughly 20 years from the filing date, Canada has approved semaglutide generics to enter the market earlier than the U.S.¹⁹⁵ While the generic may have resulted from Novo Nordisk’s lack of a patent extension, this

188. *See id.*

189. NOVOCARE, *supra* note 111; NOVO PRICING, *supra* note 111; *Ozempic for Weight-Loss in Canada: Your Ultimate Guide*, *supra* note 163.

190. Rajkumar, *supra* note 82.

191. Ginsburg & Lieberman, *supra* note 97.

192. *Id.*

193. Altaf, *supra* note 158; HEALTH CAN., PROTECTING CANADIANS FROM EXCESSIVE DRUG PRICES: CONSULTING ON PROPOSED AMENDMENTS TO THE PATENTED MEDICINES REGULATIONS 3 (May 16, 2017), <https://www.canada.ca/content/dam/hc-sc/documents/programs/consultation-regulations-patented-medicine-document/con1-eng.pdf> [<https://perma.cc/M683-D8K5>].

194. Kesselheim, *supra* note 86; Alirod, *supra* note 160.

195. Martin, *supra* note 88; Alirod, *supra* note 160.

has allowed Canada to approve not one but two generic GLP-1s.¹⁹⁶

As a result of Canada's lower cost of prescription drugs, more Americans are trying to get GLP-1s across the border. In 2023, 15% of Ozempic prescriptions filled in Canada went to United States residents, which leaves Canadians with Type 2 diabetes without access to the drug.¹⁹⁷ Overall, the stark pricing differences between GLP-1s in the U.S. and Canada demonstrate the impact that government regulation, market exclusivity policies, and pharmaceutical pricing structures can have on the pharmaceutical industry.

B. Access

In addition to cost, Canada has generally provided more stable and equitable access to GLP-1s than in the U.S. Access to GLP-1s is not only dependent on cost, but also the supply chain stability and insurance coverage. While both countries experienced GLP-1 shortages following the rapid rise in demand for the drug, the two countries approached the shortage differently. The United States has experienced persistent shortages of GLP-1 medications from 2022 to 2025.¹⁹⁸ Despite the shortages, the U.S. has relied primarily on market forces and manufacturer-led production increases to address supply issues, with relatively limited government intervention. In contrast, Canada experienced these GLP-1 drug shortages from 2023 to 2024, and government officials took more direct steps to resolve the supply and preserve access. The Canadian government limited prescriptions to a 30-day supply¹⁹⁹ and one province restricted sales to non-Canadians, which helped stabilize availability to the drug.²⁰⁰

Insurance coverage also plays a large role in determining cost as well as access to GLP-1s. In the U.S., many insurers do not cover GLP-1s for obesity, only for diabetes treatment.²⁰¹ As a result, consumers are forced to pay out-of-pocket prices or forgo the drug altogether.²⁰² However, recent progress has been made to give coverage to Medicare beneficiaries.²⁰³ In Canada, public health insurance coverage varies by province; many provinces cover the drug only for

196. Reg. Decision, *supra* note 166; Adam, *supra* note 167; Reg. Decision, *supra* note 169.

197. A. Pawlowski et al., *Canada cracks down on U.S. patients buying Ozempic in British Columbia*, TODAY (Mar. 31, 2023), <https://www.today.com/health/news/ozempic-weight-loss-canada-rcna77601> [<https://perma.cc/777C-VLXG>].

198. *Companies find ways around end of GLP-1 shortages*, ADVISORY BOARD (May 27, 2025), <https://www.advisory.com/daily-briefing/2025/05/27/glp-1-compounders> [<https://perma.cc/E25V-PZRA>].

199. *Response to the intermittent shortages of Ozempic, Mounjaro and Trulicity*, *supra* note 176.

200. HEALTH CAN., *Drug shortages in Canada*, *supra* note 173.

201. Pandey et al., *supra* note 45, at 1.

202. Chen et al., *supra* note 83, at 1.

203. *Fact Sheet: President Donald J. Trump Announces Major Developments*, *supra* note 119.

type 2 diabetes.²⁰⁴ Additionally, many employer-based plans cover GLP-1 drugs for diabetes but not weight loss.²⁰⁵

V. POLICY PROPOSALS AND RECOMMENDATIONS

The comparative analysis between the U.S. and Canada reveals that cost and access disparities are not inevitable, but rather the result of deliberate policy choices. While recent expansions in Medicaid and Medicare coverage for GLP-1 medications mark a significant step towards affordability and accessibility, substantial barriers remain in the U.S. Accordingly, meaningful reform requires a multi-sided approach that addresses government intervention, insurance coverage, and patent exclusivity.

One key takeaway from the comparison of how the American and Canadian healthcare systems shape access and cost of GLP-1s is the amount of government intervention in each country. The Canadian government has significantly more control over prescription drug pricing and supply chain solutions than the United States does. The U.S. lack of control has led to significant consequences for pricing and access to GLP-1s for U.S. citizens.²⁰⁶ However, the United States may be taking a page from the Canadian playbook by allowing government-funded health insurance to cover GLP-1s for weight loss.

Given the market dynamics and patent exclusivity, the best chance of lowering the cost of GLP-1 drugs and thereby increasing access for weight loss may be modeling Canada's approach and increasing government intervention within the healthcare market. In the absence of significant policy reform, market forces alone will likely keep GLP-1 drugs expensive and out of price range for most until Novo Nordisk's patents expire in 2033. Without generic competition, prices will remain high, limiting access for patients who cannot manage their weight without them.

However, if the U.S. follows Canada's approach of drug price regulation, the financial burden on consumers could be significantly reduced. These policy changes could fundamentally make weight-loss medications more affordable and thereby more accessible to the millions of Americans struggling with obesity and related health conditions.

204. Nicolas Valencia, *GLP-1 in Canada: What It Is, How It Works, and What Canadians Should Know*, IFINANCE (Jan. 6, 2026), <https://ifinancecanada.com/glp-1-in-canada-what-it-is-how-it-works-and-what-canadians-should-know/> [https://perma.cc/JFN7-8FVK]; CANADIAN MED. ASS'N, *supra* note 171.

205. *GLP-1 Drugs: 2025 Pulse Survey (Canada)*, *supra* note 183 (increasing weight loss coverage under employer-based insurance from 17% in 2024 to 31% in 2025).

206. See HEALTH CAN., *Drug shortages in Canada*, *supra* note 173.; Laurie Flynn, *What is behind the legal drug crisis in the US?*, STAN. MED. (Oct. 6, 2023), <https://med.stanford.edu/news/insights/2023/10/pharmaceuticals-pricing-generics-medicare.html> [https://perma.cc/C2RR-EH4Y].

A. Expand Federal Coverage Through Legislative Reform

While as of February 2025, Medicare was statutorily prohibited from covering weight loss drugs, the federal Treat and Reduce Obesity Act (“TROA”) aimed to change this.²⁰⁷ This bill would have expanded Medicare coverage for obesity treatments, specifically covering treatment from healthcare providers other than an individual’s primary care provider.²⁰⁸ The TROA has been introduced in every year since 2013 but has yet to advance.²⁰⁹ The lack of progress for the TROA may reflect a stigma that frames obesity as a lifestyle choice rather than recognizing it as a chronic disease.²¹⁰

However, in the 118th Congress for the 2023-2024 session, the original proposed bill expanded on previous versions by allowing Medicare’s Part D prescription drug benefit program to cover drugs that treat both obese and overweight individuals.²¹¹ This expansion would significantly broaden coverage for Medicare beneficiaries, as “two-thirds of beneficiaries are considered either obese or overweight, with 34% falling within the obesity category (BMI $\geq$ 30),”²¹² and an additional 29% classified as overweight (BMI 25-29.9) with a weight-related condition.²¹³ By expanding coverage to both groups, this legislation marks a more comprehensive and preventative approach, increasing early intervention among overweight individuals to prevent progression to obesity and consequential chronic diseases.

During the 2023-2024 session, the Ways and Means Committee voted the bill out of the committee and into the full House of Representatives.²¹⁴ However, the version voted on was amended and scaled back to limit coverage to individuals who had been taking a weight loss drug for a year prior to enrolling in Medicare. The amendments further limited coverage to individuals with obesity only, excluding the 29% of overweight Medicare beneficiaries with at

207. Pugh & Lankford, *supra* note 132; *Part D / Prescription Drug Benefits*, *supra* note 118; Treat and Reduce Obesity Act of 2023, H.R. 4818, 118th Cong. (2023).

208. *Id.*

209. *Treat and Reduce Obesity Act (TROA)*, NATIONAL MEDICAL ASSOCIATION (June 27, 2024), <https://nmanet.org/news/treat-and-reduce-obesity-act-troa/> [<https://perma.cc/4H7X-4UYQ>].

210. Simar S Bajaj et al., *Overcoming Congressional Inertia on Obesity Requires Better Literacy in Obesity Science*, 30 OBESITY (SILVER SPRING) 799, 800 (2022).

211. Treat and Reduce Obesity Act of 2023, *supra* note 207.

212. CONG. BUDGET OFF., *How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect Spending and Health?*, U.S. CONG. 2 (2024), <https://www.cbo.gov/publication/60816#footnote-045> [<https://perma.cc/7GJU-NE7C>] (data recent as of 2021, from the 2021 Medicare Current Beneficiary Survey).

213. *See id.* (83% of the 35% of overweight Medicare beneficiaries have a weight-related condition).

214. Berkeley Jr., *House committee passes bill that would allow Medicare to cover weight loss drugs*, NBC NEWS (June 27, 2024), <https://www.nbcnews.com/health/health-news/house-committee-passes-bill-allow-medicare-cover-weight-loss-drugs-rcna159248> [<https://perma.cc/4GZK-82WN>].

least one weight-related condition,²¹⁵ despite FDA guidance permitting these medications for both groups.²¹⁶ The bill died after not making it out of the House during the 2023-2024 session.²¹⁷

Even with the failed, scaled-back version of the bill, this proposed legislation was the first major step towards Medicare coverage for weight-loss medications. As discussions around weight-loss medications grow, advocates remain hopeful that legislative efforts will codify expanded coverage in upcoming sessions.²¹⁸ While the proposed bill did not pass in the 2023-2024 session, its introduction and committee approval lay the groundwork for renewed efforts in upcoming congressional sessions.

The passing of this bill would have far-reaching implications for healthcare, the pharmaceutical industry, and public health in the United States. By expanding Medicare coverage to include weight loss drugs, this bill would significantly expand access for older adults who could benefit from these treatments.²¹⁹ Notably, for obese individuals, this bill would increase access for 34% of Medicare beneficiaries.²²⁰ By extending coverage to this large and high-risk population, this bill could facilitate improved health outcomes across Medicare beneficiaries.

Additionally, although weight loss drugs are currently expensive, expanding Medicare coverage could reduce long-term healthcare costs by preventing obesity-related chronic conditions. Diseases such as diabetes, cardiovascular disease, and musculoskeletal disorders impose a substantial financial strain on the healthcare system, with approximately 86% of healthcare expenditures being attributable to chronic disease.²²¹ Furthermore, obesity alone costs the U.S. healthcare system nearly \$173 billion annually.²²² By promoting earlier and more effective intervention, this legislation has the potential to generate significant cost savings by reducing hospitalizations, surgical procedures, and long-term chronic disease management.

Expanding Medicare coverage for weight loss drugs may also set a precedent for broader insurance coverage, influencing both private insurers and Medicaid policies. Many private insurance plans currently exclude GLP-1

215. CONG. BUDGET OFF., *supra* note 212.

216. *Id.*; U.S. HOUSE COMM'N ON WAYS & MEANS, EXPLANATION OF CHANGES REFLECTED IN THE CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4818, TREAT AND REDUCE OBESITY ACT (June 27, 2024), <https://waysandmeans.house.gov/wp-content/uploads/2024/06/Ways-and-Means-Description-of-the-AINS-to-H.R.-4818-Green-Sheet.pdf> [<https://perma.cc/5U9F-QT7V>].

217. Treat and Reduce Obesity Act of 2023, *supra* note 207.

218. *Id.*

219. CONG. BUDGET OFF., *supra* note 212.

220. *Id.*

221. Halsted R. Holman, *The Relation of the Chronic Disease Epidemic to the Health Care Crisis*, 2 ACR OPEN RHEUMATOLOGY 167, 167 (2020).

222. *About Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 23, 2024), <https://www.cdc.gov/obesity/php/about/index.html> [<https://perma.cc/PP22-TXQQ>].

medications for weight loss or impose restrictive authorization requirements.²²³ If this bill is passed, private insurers may follow suit to stay competitive in the health insurance market, thereby increasing access for millions of Americans who rely on private insurance and employer-sponsored plans.

Despite the potential benefits of this bill, challenges and criticisms remain. Some policymakers argue that expanding Medicare coverage for weight-loss drugs could increase government spending, thereby increasing the financial burden on the Medicare program.²²⁴ Additionally, the 119th Congress had an agenda to reduce government spending,²²⁵ so it is unlikely there would be any movement on this bill until a shift in the politicization of Congress. To address these concerns, policymakers could implement cost-control measures such as price caps, reimbursement limits, and stricter eligibility requirements to prevent unnecessary spending. Measures to reduce unnecessary spending can already be seen in the amended version of the bill, restricting coverage to those who are obese and not just overweight.²²⁶

B. Implement and Expand Drug Pricing Reforms

Despite policymakers' failure to pass legislation expanding Medicare coverage for GLP-1s, the executive branch took matters into its own hands and made progress in lowering costs for Medicare beneficiaries. In November 2025, President Donald Trump announced an agreement between Eli Lilly and Novo Nordisk, called the "GENERating cost Reductions for U.S. Medicaid" ("GENEROUS").²²⁷ This agreement is two-fold, offering lower prices for uninsured Americans as well as Medicare and Medicaid beneficiaries.

In early 2026, TrumpRX, a prescription drug discount website for those uninsured, was launched.²²⁸ In the agreement with Eli Lilly and Novo Nordisk, the companies agreed to offer their GLP-1 medications (ZepBound and

223. Matthew McGough et al., *How many adults with private health insurance could use GLP-1 drugs*, PETERSON-KFF (Sep. 5, 2024), <https://www.healthsystemtracker.org/brief/how-many-adults-with-private-health-insurance-could-use-glp-1-drugs/> [https://perma.cc/56ZC-XBPV].

224. See Phill Swagel, *A Call for New Research in the Area of Obesity*, CONG. BUDGET OFF. (Oct. 5, 2023), <https://www.cbo.gov/publication/59590> [https://perma.cc/RD5S-G7KR].

225. Eliminating Leftover Expenses for Campaigns from Taxpayers (ELECT) Act of 2025, S.538, 119th Cong. (2025).

226. U.S. HOUSE COMM'N ON WAYS & MEANS, EXPLANATION OF CHANGES, *supra* note 216.

227. *Fact Sheet: President Donald J. Trump Announces Major Developments in Bringing Most-Favored-Nation Pricing to American Patient*, *supra* note 119; Emilee Ryon, *Medicare and Medicaid to Start Covering GLP-1 Drugs for Beneficiaries*, RITTER INS. MKTG. (Nov. 12, 2025), <https://ritterim.com/blog/medicare-and-medicare-to-start-covering-glp1-drugs-for-beneficiaries/#kit-thrive> [https://perma.cc/7229-QPRF].

228. *Fact Sheet: President Donald J. Trump Launches TrumpRX.gov to Bring Lower Drug Prices to American Patients*, WHITE HOUSE (Feb. 5, 2026), <https://www.whitehouse.gov/fact-sheets/2026/02/fact-sheet-president-donald-j-trump-launches-trump-rx-gov-to-bring-lower-drug-prices-to-american-patients/> [https://perma.cc/MDG4-ND93].

Wegovy/Ozempic, respectively) for a discounted price on TrumpRX.²²⁹ These low prices are currently available on the TrumpRX website, with an average price of \$346 per month for ZepBound injectables and \$350 per month for Ozempic and Wegovy injectables.²³⁰ Additionally, the new FDA-approved GLP-1 tablets have been added to TrumpRX.²³¹ However, individuals must certify that they are a U.S. resident who is not enrolled in any insurance plan, including Medicaid and Medicare, in order to receive the discounted price on TrumpRX.²³²

The agreement also addressed those on public insurance, however, not through TrumpRX. Both Eli Lilly and Novo Nordisk pledged to offer their GLP-1 medications for \$245 per month, with copays for Medicare beneficiaries set at \$50 per month.²³³ However, there are restrictions to receive the drug for obesity, including requiring patients to either have: “a BMI over 27 and established prediabetes or a cardiovascular disease, a BMI over 30 and uncontrolled hypertension, kidney disease, or heart failure, or a BMI over 35.”²³⁴ Additionally, Medicare beneficiaries must be opted in to the Medicare Part D Prescription Drug Benefit to obtain these discounted prices.²³⁵ A senior official in the current administration stated that with these restrictions, this agreement will “only expand coverage to 10% of Medicare beneficiaries.”²³⁶

For Medicaid, States will have to opt into this program to receive the discounted price from the GENEROUS deal.²³⁷ To opt in, states must issue a letter of intent to join the GENEROUS program, and then they may be invited to participate in the pricing negotiation later on. Because the GENEROUS program for Medicaid is opt-in, it is not possible to predict how many Medicaid beneficiaries may now be covered for GLP-1 medications.²³⁸ While this reform

229. *Id.*

230. *Id.* (falling from an average price of \$1,028 per month for Ozempic and \$1,349 for Wegovy).

231. *Wegovy Pill*, TRUMPRX, <https://trumprx.gov/p/wegovy-pill> [<https://perma.cc/NWR4-S6WA>] (last visited Apr. 22, 2026).

232. *See id.* (stating in fine print, “You confirm that you are NOT enrolled in insurance from any government, state, or federally funded medical or prescription benefit programs (Examples include Medicare, Medigap, VA, DOD, TRICARE, Medicaid, or any other state or federal medical/pharmaceutical benefit or assistance). Individuals with both commercial and government funded plans ARE considered a patient with government insurance. If you should begin to receive prescription benefits under any government insurance plan, you understand that you can no longer participate in this program.”).

233. Sydney Lupkin, *White House Strikes Deals for Lower Prices on Obesity Drugs*, NPR (Nov. 6, 2025), <https://www.npr.org/sections/shots-health-news/2025/11/06/nx-s1-5599122/wegovy-zepbound-price-deal> [<https://perma.cc/S3ZL-2U5N>].

234. *Id.*

235. Ryon, *supra* note 227.

236. Annika Kim Constantino, *Trump Announces Deal With Eli Lilly, Novo Nordisk to Slash Weight Loss Drug Prices, Offer Some Medicare Coverage*, CNBC (Nov. 6, 2025), <https://www.cnbc.com/2025/11/06/trump-eli-lilly-novo-nordisk-deal-obesity-drug-prices.html> [<https://perma.cc/JWK7-GXYJ>].

237. Lupkin, *supra* note 234.

238. Ryon, *supra* note 227.

represents a meaningful step toward addressing affordability of GLP-1s, there are still many barriers to access, including BMI restrictions in Medicare and opt-in policies in Medicaid.

Furthermore, while executive action can address issues in the short term, it is significantly less stable than legislative reform. Executive action can be modified, delayed, or entirely reversed by subsequent administrations.²³⁹ Without legislative reform codifying these insurance coverage expansions, these cost-reduction efforts are not guaranteed in the future.

C. Address and Prevent Supply Chain and Shortage Issues

While efforts such as the TROA and insurance coverage are critical steps to reduce cost, these actions alone will not ensure meaningful access if supply constraints repeat. The recent surge in GLP-1s has exposed significant vulnerabilities within the pharmaceutical supply chain, resulting in shortages for those in critical need of the drug for diabetes as well as obesity. As a result, any policy effort aimed at reducing costs must also be accompanied by reforms that address the underlying supply chain issues.

One potential strategy to stay ahead of drug shortages could be to authorize an agency to lead drug supply chain efforts. While the FDA is notified and reports when drugs are in a shortage, they are not accountable for preventing or notifying of a future shortage.²⁴⁰ An agency, or a designated part of the FDA, could focus on the drug supply in order to prevent future shortages. In addition, the FDA or a designated entity should be granted authority to access supply chain data from drug manufacturers to carry out this preventive effort.

D. Reform the Patent Process and Generic GLP-1s

Another significant barrier to the affordability of GLP-1 drugs is the absence of generic alternatives. Because no generic GLP-1s exist, many individuals turn to compounded versions for a cheaper option. However, these compounded GLP-1s may raise safety and regulatory concerns. Unlike generics, which must undergo rigorous testing and approval by the FDA, compounded medications do not always meet the same standards.²⁴¹ As a result, compounded GLP-1s may vary in potency, quality, and consistency.

The absence of generic alternatives allows manufacturers to gain significant

239. See Tristan Manalac, *Trump Scraps Biden's Proposed Medicare Coverage for Obesity Drugs*, BIOSPACE (Apr. 7, 2025), <https://www.biospace.com/policy/trump-scraps-bidens-proposed-medicare-coverage-for-obesity-drugs> [https://perma.cc/A4R7-G3GA].

240. *4 Ways the U.S. Can Strengthen Its Pharmaceutical Supply Chain*, JOHNS HOPKINS UNI. (Nov. 10, 2025), <https://washingtondc.jhu.edu/news/4-ways-to-strengthen-the-drug-supply-chain/> [https://perma.cc/DTF3-5D6F]; *Drug Shortages*, U.S. FOOD & DRUG ADMIN. (Oct. 23, 2025), <https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages> [https://perma.cc/34HL-8FDS].

241. *Human Drug Compounding*, *supra* note 47.

market control and maintain high prices, as seen in the comparison with Canada. The U.S. should consider reforms to prevent the abuse of strategic patenting practices that delay competition. Potential reforms could include higher scrutiny of multiple patents on the same drug and streamlining FDA approval processes for generics once allowed.

CONCLUSION

The rapid rise of GLP-1 receptor agonists such as Ozempic and Wegovy emphasizes the promise of pharmaceutical innovation but also the persistent inequalities embedded within modern healthcare systems. While these medications offer transformative benefits to long-term health, such as weight loss and chronic disease prevention, access to them is deeply shaped by the structural differences between the United States and Canadian healthcare system models.

In the U.S., high medication prices driven by market exclusivity, limited price regulation, and fragmented insurance coverage significantly restrict access, leaving many patients unable to afford or sustain treatment. Even with Medicaid and Medicare coverage, gaps in coverage for employer-based insurance continue to exclude large portions of the U.S. population from these weight-loss treatments. Compounding these challenges is the fear of future supply shortages and the emergence of unregulated compounded alternatives, further exacerbating health risks around this “blockbuster” medication.

By contrast, Canada’s healthcare system, while not without its own limitations, demonstrates how government intervention through price controls, coordinated responses to supply chain disruptions, and patent exclusivity periods can improve affordability and stabilize access. However, Canada’s provincial patchwork insurance structure reveals that lower prices alone do not guarantee universal access to the medication. This comparative analysis highlights a central issue in modern healthcare: the balance between pharmaceutical innovation and health equity.