Eligibility and Costs of GLP-1 Products for Medicaid Enrollees under the BALANCE Model: State-Level Estimates

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Summary

In December 2025, CMS announced the BALANCE model, which lets state Medicaid programs cover GLP-1 drugs for obesity at prices CMS negotiated with manufacturers, as long as the state adopts a standard set of clinical eligibility criteria.[1,2] As of August 2026, only Indiana had publicly announced participation in BALANCE, with 29 states declining to join, many of them citing cost.[3] To our knowledge, the scope and potential costs of BALANCE for states has not been defined. In this study, we estimate state-level eligibility and implied incremental costs for coverage of GLP-1 products for obesity for Medicaid adults ages 19 to 64 in all 50 states and DC, using the 2024 Behavioral Risk Factor Surveillance System (BRFSS) scaled to current CMS enrollment counts. We developed a range for estimated eligibility by producing two estimates: a diagnosis-based estimate (based on self-reported height and weight and conditions a doctor has diagnosed) and a measurement-based estimate (based on measured BMI and lab values imputed from the National Health and Nutrition Examination Survey [NHANES]). We estimated that 10.4 million (32.0%) to 12.9 million (39.8%) Medicaid enrollees would be eligible for GLP-1 coverage under BALANCE. Because Medicaid already covers GLP-1s for type 2 diabetes, we count as newly eligible only enrollees without diabetes: 6.2 million under the diagnosis-based estimate and 8.7 million under the measurement-based estimate. At the $245 monthly price offered to states under BALANCE, total federal and state spending on GLP-1 drugs for newly eligible enrollees was estimated to increase by $1.8-2.6 billion a year (4-5% increase in total net drug spending) at 10% uptake and $9.1-12.9 billion (19-27% increase in total net drug spending) at 50% uptake. Of this, under the federal match, incremental increases in state spending would be $0.25-1.1 billion a year at 10% uptake and $1.3-5.5 billion at 50% uptake. Similar results were obtained using national-level data from NHANES.

Background

Medicaid programs must cover GLP-1s for medically accepted uses such as type 2 diabetes, but coverage for obesity is optional, and only 13 states offered it in January 2026, down from 16 in 2025. Under BALANCE, CMS negotiated prices and coverage terms with Novo Nordisk and Eli Lilly. A participating state must apply the model's eligibility criteria in both fee-for-service and managed care, and it may cover more people but not fewer.[4] States were offered $245 a month for Wegovy, and Indiana has said it will pay $85.16 of that per enrollee each month, with the federal government covering the rest.[3] State applications closed July 31, 2026, with start dates through January 1, 2027; states that miss that date may join later only with CMS approval.[5] On the Medicare side, CMS postponed BALANCE in Part D and extended a temporary demonstration, the Medicare GLP-1 Bridge program, covering GLP-1 for weight loss through 2027.[6] Cost analyses of BALANCE so far have focused on Medicare. Dusetzina and colleagues estimated that full participation would save Medicare about $933 million in 2027 relative to the negotiated price for semaglutide, enough to treat roughly 550,000 additional beneficiaries.[7] We are not aware of comparable estimates for state Medicaid programs.

Data and methods

We use the 2024 BRFSS (2023 for Tennessee, which is missing from the 2024 file) with the primary sample being respondents ages 19 to 64 who report Medicaid as their primary source of coverage and are not pregnant.[8,9] We count an enrollee as eligible if they meet any of the BALANCE criteria the survey can measure: type 2 diabetes; a BMI of 35 or higher; a BMI of 30 or higher with chronic kidney disease; or a BMI of 27 or higher with prediabetes, a prior heart attack, or a prior stroke. BRFSS does not identify sleep apnea, MASH, heart failure with preserved ejection fraction, uncontrolled hypertension as BALANCE defines it, or peripheral artery disease, so both the diagnosis-based and measurement-based estimates exclude some eligible enrollees. We apply each state's weighted share eligible to its average adult enrollment in the CMS Medicaid and CHIP Performance Indicator data for March through May 2026, after removing enrollees 65 and older and pregnant enrollees.[10,11]

The two estimates differ only in how BMI, prediabetes, and kidney disease are measured; type 2 diabetes, prior heart attack, and prior stroke are diagnosed conditions in both. To build the measurement-based estimate, we use NHANES 2021–2023, where the same respondents self-report their weight and conditions and are also weighed and given blood tests.[12] We fit these models on all NHANES adults ages 20 and older, modeling measured BMI, prediabetes defined by HbA1c, and kidney disease defined by eGFR as functions of characteristics the two surveys share (self-reported BMI, age, sex, race and ethnicity, education, income, general health, and diagnosed conditions). The models include an indicator for income at or below 138% of the federal poverty level, interacted with these characteristics, so the gap between self-reported and measured values can differ for lower-income adults, who most resemble Medicaid enrollees. Samples limited to NHANES adults with Medicaid or low incomes had too few cases of reduced kidney function to fit the models reliably, and NHANES asks about kidney disease, heart attack, and stroke only at ages 20 and older. We then use those models to impute measured values for each BRFSS respondent 50 times and combine the results across imputations. In the diagnosis-based estimate, respondents with missing BMI are assumed to have the same BMI distribution

as other respondents with the same diabetes status; counting all of them as ineligible lowers the national share to 29.9%.

As a national check, we compare the aggregated BRFSS estimates with a separate analysis of NHANES 2021–2023, in which respondents are weighed and give blood and urine samples, so BMI, HbA1c, and kidney function are measured rather than self-reported. The NHANES analysis covers adults ages 18 to 64 who report Medicaid and not Medicare and uses the survey weights for respondents who completed the NHANES physical examination. Its eligibility criteria are broader than those in the BRFSS analysis: it also counts undiagnosed diabetes and oral diabetes medication; adds dyslipidemia or arthritis with a BMI of 27 or higher, heart failure, uncontrolled hypertension, and coronary heart disease or angina; and defines kidney disease by urine albumin. The NHANES eligible share is therefore expected to exceed the BRFSS estimates, and it serves as a check on their direction and rough size rather than as an exact match (Table 1).

To estimate incremental spending under BALANCE, we multiplied the number of newly eligible enrollees (those eligible under BALANCE who do not have type 2 diabetes) by the $245 monthly price states were offered and by 12 months, giving $2,940 per enrollee-year. We present two uptake scenarios: 10%, which matches the first-year uptake CMS actuaries assumed for Medicare, and 50% as an upper bound. Because we assumed a full year of use, uptake should be interpreted as the share of newly eligible enrollees treated for a full year, not the share who ever start treatment. The primary estimates are combined federal and state spending at the offered price. They do not include pharmacy dispensing fees, administrative costs, manufacturer-funded lifestyle programs, or any offsets from lower prices on existing GLP-1 use or from reduced medical spending. To estimate the state share, we used each state's fiscal year 2027 regular federal matching rate and the 90% rate for the ACA expansion group. Because it was not possible to identify which enrollees are expansion adults, we constructed a range for the state share, with the lower bound using the diagnosis-based count and assuming all newly eligible enrollees in expansion states are expansion adults and the upper bound using the measurement-based count and matching all enrollees at the regular rate. In the ten states that had not expanded Medicaid as of November 1, 2026, all enrollees were matched at the regular rate. We then compared estimated spending under BALANCE with Medicaid's net spending on outpatient prescription drugs in fiscal year 2024.

Findings

Diagnosis-based estimate. 10.4 million of the 32.5 million Medicaid adults ages 19 to 64 (32.0%) are eligible. Of these, 4.2 million qualify through type 2 diabetes and can already get GLP-1 coverage. The other 6.2 million (19.1% of enrollees) would be newly eligible under BALANCE, most of them (5.2 million) because their BMI is 35 or higher.

Measurement-based estimate. 12.9 million of the 32.5 million Medicaid adults ages 19 to 64 (39.8%) are eligible. Of these, 4.2 million qualify through type 2 diabetes, the same as in the diagnosis-based estimate. The other 8.7 million (26.9% of enrollees) would be newly eligible, most of them (6.1 million) because their BMI is 35 or higher.

The measurement-based estimate is 2.5 million greater than the diagnosis-based estimate (95% CI 2.0–3.1 million). This is attributable to the newly eligible population for GLP-1 products, since the type 2 diabetes count is the same in both estimates, and most of it comes from measured BMI being higher than self-reported BMI and from undiagnosed prediabetes. The measurement-based estimate is higher in every state, and the 95% confidence interval for the difference excludes zero in 38 of 51 states.

States. Under the diagnosis-based estimate, the share eligible ranges from 22.0% in New Hampshire to 46.5% in West Virginia; under the measurement-based estimate, it ranges from 31.8% in Vermont to 52.1% in West Virginia (Table 2). In Indiana, 230,000 enrollees (35.2%) are eligible under the diagnosis-based estimate and 276,000 (42.3%) under the measurement-based estimate; 143,000 and 189,000, respectively, would be newly eligible.

National benchmark. The NHANES analysis puts type 2 diabetes at 14.9% of Medicaid adults ages 18 to 64, compared with 12.8% in the BRFSS estimates; the NHANES figure is higher partly because it also counts undiagnosed diabetes and anyone taking oral diabetes medication. With its broader criteria, the NHANES analysis finds about 48% of Medicaid adults (about 12.7 million) eligible, above both the BRFSS measurement-based estimate (39.8%) and the BRFSS diagnosis-based estimate (32.0%) (Table 1). That ordering is what the differences in definitions predict, and the eligible counts are of similar magnitude.

Implications

At the $245 monthly price states were offered, we estimate that full participation in BALANCE would increase federal and state spending by $1.8 billion a year under the diagnosis-based estimate and $2.6 billion under the measurement-based estimate; at 50% uptake, it would rise by $9.1 billion to $12.9 billion. Summed across states, the estimated states' share would be $0.25 billion to $1.09 billion a year at 10% uptake and $1.26 billion to $5.45 billion at 50% uptake, or 14% to 42% of the total. These cost estimates do not account for offsets. For example, in states that already cover obesity drugs, the $245 price would replace higher prices on existing Wegovy and Zepbound use.

Table 1. National benchmark: NHANES 2021–2023 compared with BRFSS-based estimates, Medicaid adults

Measure	NHANES 2021–2023	BRFSS, diagnosis-based	BRFSS, measurement-based
Population	Medicaid, no Medicare, ages 18–64	Medicaid, not pregnant, ages 19–64	Medicaid, not pregnant, ages 19–64
Enrollees (millions)	26.6	32.5	32.5
Type 2 diabetes, % (millions)	14.9% (4.0)[a]	12.8% (4.2)	12.8% (4.2)
BMI ≥35, % (millions)	26.2% (7.0)[b]	16.0% (5.2)[c]	18.8% (6.1)[c]
Eligible, % (millions)	48% (12.7)[d]	32.0% (10.4)	39.8% (12.9)

Notes: Shares are of enrollees in each population. NHANES estimates come from a separate national analysis using measured BMI and HbA1c and NHANES examination weights; respondents with missing measurements are counted as not eligible. BRFSS estimates are those in Table 2 (US row).

[a]NHANES counts diagnosed diabetes, HbA1c ≥6.5%, or oral diabetes medication; BRFSS counts diagnosed diabetes only. [b]All adults with measured BMI ≥35, including those with type 2 diabetes. [c]Adults with BMI ≥35 who do not have type 2 diabetes (those with type 2 diabetes are counted under that pathway first). [d]Adults 18–64 only, derived by subtracting the ages 12–17 pathway from the NHANES total; NHANES criteria are broader (adds dyslipidemia or arthritis with BMI ≥27, heart failure, uncontrolled hypertension, and coronary heart disease or angina, and defines kidney disease by urine albumin).

Table 2. Medicaid adults ages 19–64 estimated to be eligible for GLP-1 coverage under BALANCE, by state

		Diagnosis-based estimate			Measurement-based estimate			
State	Enrollees ages 19–64 (000s)	Eligible (000s)	% eligible	Newly eligible, no T2D (000s)	Eligible (000s)	% eligible	Newly eligible, no T2D (000s)	Illustrative annual cost, newly eligible (diagnosis-based), 10% uptake ($M)
United States	**32,507**	10,399	32.0	6,222	12,923	39.8	8,746	1,829
Alabama	221	87	39.2	49	106	47.9	68	14
Alaska	111	28	25.0	18	37	32.9	27	5
Arizona ‡	783	279	35.6	172	320	40.9	213	51
Arkansas	339	139	40.9	92	160	47.1	113	27
California	6,036	1,614	26.7	896	2,127	35.2	1,409	263
Colorado	601	164	27.3	105	211	35.0	151	31
Connecticut	459	181	39.5	105	217	47.2	141	31
Delaware	118	41	35.1	28	51	43.0	38	8
DC	127	40	31.5	23	53	41.4	35	7
Florida	958	267	27.8	155	346	36.1	234	46
Georgia ‡	448	149	33.2	109	178	39.8	138	32
Hawaii	200	66	33.1	37	78	39.0	49	11
Idaho	144	49	34.4	35	57	40.0	43	10
Illinois	1,339	413	30.8	240	524	39.1	351	71
Indiana †	653	230	35.2	143	276	42.3	189	42
Iowa	299	92	30.9	57	120	40.0	85	17
Kansas	97	38	39.0	25	43	44.5	31	7
Kentucky	649	252	38.9	123	304	46.8	175	36
Louisiana	587	226	38.5	153	271	46.2	198	45
Maine	164	46	28.4	31	59	35.9	43	9
Maryland	646	193	29.8	117	253	39.2	178	34
Massachusetts	723	196	27.1	115	254	35.2	174	34
Michigan ‡	1,132	383	33.8	250	476	42.1	343	74
Minnesota	476	144	30.2	70	179	37.5	106	21
Mississippi	162	59	36.5	38	74	45.8	53	11
Missouri	586	229	39.1	158	266	45.5	195	46
Montana ‡	105	32	30.7	22	38	36.0	27	6
Nebraska	137	50	36.4	35	59	42.9	44	10
Nevada	379	127	33.5	84	155	41.0	112	25
New Hampshire	73	16	22.0	6	25	33.9	15	2
New Jersey	789	180	22.8	100	262	33.2	182	29
New Mexico	335	132	39.5	92	152	45.3	111	27
New York	3,221	905	28.1	525	1,174	36.4	794	154
North Carolina	1,285	436	34.0	234	542	42.2	340	69
North Dakota	47	17	35.1	11	20	41.6	14	3
Ohio ‡	1,322	501	37.9	297	590	44.6	386	87
Oklahoma	410	157	38.2	93	184	44.9	120	27
Oregon	723	226	31.3	137	277	38.2	187	40
Pennsylvania	1,359	449	33.0	269	540	39.8	360	79
Rhode Island	146	44	30.2	27	53	36.5	36	8
South Carolina	294	96	32.8	61	127	43.3	92	18
South Dakota	53	17	32.4	13	21	40.0	17	4
Tennessee ‡	490	225	45.9	145	245	50.0	165	43
Texas	711	264	37.1	144	329	46.3	209	42
Utah	143	43	30.4	30	51	35.9	37	9
Vermont	77	18	23.9	12	24	31.8	18	3
Virginia ‡	752	289	38.5	183	331	44.1	225	54
Washington	845	248	29.4	173	308	36.4	232	51
West Virginia	262	122	46.5	64	137	52.1	79	19
Wisconsin	479	195	40.8	119	235	49.1	159	35
Wyoming	15	5	32.3	3	6	39.3	4	1

Notes: Eligible = meets at least one BALANCE criterion measurable in survey data (type 2 diabetes [T2D]; BMI ≥35; BMI ≥30 with chronic kidney disease; BMI ≥27 with prediabetes, prior heart attack, or prior stroke). Newly eligible = eligible without T2D (Medicaid already must cover GLP-1s for T2D). Lower bounds: sleep apnea, MASH, HFpEF, uncontrolled hypertension, and PAD are not measured.

Diagnosis-based: self-reported BMI and diagnosed prediabetes and kidney disease (BRFSS). Measurement-based: measured BMI, HbA1c-defined prediabetes, and eGFR-defined kidney disease, imputed from NHANES 2021–2023 (50 imputations). T2D, prior heart attack, and prior stroke are diagnosed in both.

Illustrative cost = newly eligible (diagnosis-based) × 10% × $245 × 12: one in ten filling a GLP-1 all year at the $245 monthly Wegovy price states were offered, before the federal match.

† Publicly committed to BALANCE. ‡ Still deciding as of August 2026 (Hooper 2026); CMS has not released a list. Sources: 2024 BRFSS (2023 for Tennessee); NHANES 2021–2023; CMS Medicaid and CHIP Performance Indicator data, March–May 2026, net of enrollees 65+ (KFF State Health Facts) and pregnant enrollees (BRFSS).

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