

MILLIMAN WHITE PAPER

Commercial drug trends

Looking to 2026 and onward

Brian Anderson, MBA
Rebekah Bayram, FSA, MAAA, FCA
Andy Dressler, ASA, MAAA

Marc Guieb, PharmD, RPh
Niharika Tarimela, MSIS
Jason Mui

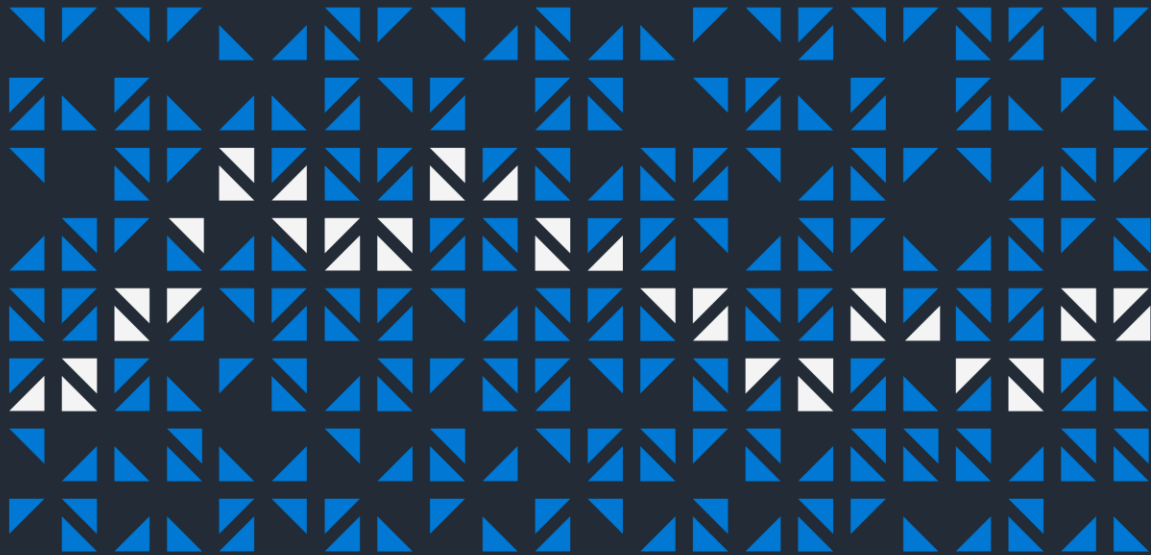


Table of contents

| | |
|---|----------|
| EXECUTIVE SUMMARY | 1 |
| METHODOLOGY AND CONCEPTS | 1 |
| EMERGING TRENDS | 2 |
| 1. WEIGHT LOSS DRUGS – GLP-1 AGONISTS | 2 |
| 2. ANTIDIABETICS | 3 |
| 3. BIOSIMILARS | 3 |
| 4. METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH) DRUGS | 4 |
| SUPPLEMENTAL INFORMATION | 4 |
| 1. PHARMACY CONCEPTS | 4 |
| A. Rebates and AWP discounts | 4 |
| B. Generic dispensing rates (GDRs) | 5 |
| 2. TOP DRUGS BY COST | 6 |
| 3. TOP DRUGS BY COUNT | 7 |
| 4. 2023 - SEASONALITY BY MONTH | 8 |
| 5. GEOGRAPHY | 8 |

Executive summary

Recent changes in legislation and manufacturer pricing strategies have upended the traditional financials of the pharmacy benefits market. Manufacturer rebates, which have long been a centerpiece of the market, are falling out of favor, and a shift toward lower up-front product costs is becoming more common. As a result of this, the projection of average wholesale price (AWP) and ingredient cost trends has become a more important exercise now than ever before.

The effects of average manufacturer price cap (AMP cap) removal have resulted in lower list prices for many drugs. Most notably, the list prices of many biosimilars, insulins, and certain inhalers have decreased significantly as manufacturers look to avoid higher rebate payments. In addition, the commercial market is still awaiting the potential effects of the Medicare Drug Price Negotiation Program (MDPNP), which begins in 2026. It's unclear whether manufacturers will use these new pricing benchmarks in the commercial market or if they will go in the opposite direction and use the commercial market to offset Medicare market losses.

The obesity GLP-1 agonist drug class continues to drive significant increases in spend for plan sponsors that elect to cover them. For this class of drugs, which currently only includes Wegovy and Zepbound but is expected to expand, we project an overall gross cost increase between 21% and 40% annually among commercial plans from 2024 to 2026. However, this increase can vary heavily from plan to plan depending on coverage elections and utilization management strategies.

Based on drug mix through 2023, we project an overall gross cost increase between 11% and 14% annually among commercial plans from 2025 to 2026. This represents a decrease in growth compared to last year's two-year projection. In developing this projection, we considered historical claims data and factors that include but are not limited to anticipated patent losses, drug pipeline developments, and manufacturer price changes. The actual increase in costs will be highly dependent on responses across the industry to weight loss drug utilization, drug pricing decreases related to AMP cap removal, the potential effect of the MDPNP, and other significant market events.

Methodology and concepts

This report provides insights into pharmacy cost and utilization trends based on our analysis of Milliman's proprietary Milliman Consolidated Health Cost Guidelines™ Sources Database (CHSD). This multiyear, multiple-line-of-business, longitudinal claims database includes claims information from several national and regional health plans and represents more than 80 million lives. We analyzed commercial pharmacy claims information from claims filled between the years 2020 and 2023 to project gross pharmacy trend into 2026. We also report on various metrics in the supplemental information section. Note that information provided in this report may differ from other Milliman reports, like the Health Trend Guidelines™ (HTGs), based on differences in data sources and date ranges of analyzed claims.

In addition to providing historical cost and utilization trends, this report also discusses factors that may have influenced these trends and their potential future implications. These elements can be used to project future pharmacy costs either at an aggregate level or at more-granular drug class levels. Projections can then be used for budgeting purposes or as part of an RFP or market check exercise. Note that the information and exhibits provided in this report are intended to help increase the understanding of the pharmacy benefits space and to serve as a starting point for further investigation. Information derived from this large dataset represents a general baseline for future research; however, it must be considered within the context of varying plan designs and membership. The appropriateness of applying this research to a plan's projections may vary.

FIGURE 1: TERMINOLOGY

| TERM | DESCRIPTION |
|---|---|
| Total drug cost (gross cost) | Also known as allowed cost; represents the cost of the drug to the plan and the member as reported in CHSD claims data. It reflects discounts off AWP, dispensing fees, and taxes but not rebates and administrative fees. |
| Wholesale acquisition cost (WAC) | The price wholesalers pay to manufacturers for drugs, not including purchasing discounts or rebates. Pharmaceutical manufacturers often set rebates as a percentage of WAC. |
| Average wholesale price (AWP) | A reference price meant to represent the average price retail pharmacies pay to wholesalers for drugs, not including purchasing discounts. For brand drugs, published AWP list prices are equal to WAC plus 20%. Pharmacy benefit manager (PBM) pricing guarantees are often set based on a discount off AWP. |
| PMPM | This acronym represents the term “per member per month.” |
| Claims | Unless otherwise stated, claims are counted as equivalent 30-day claims. For example, a 90-day claim counts as three claims. |
| Drug type | Brand and generic definitions have been set using indicators and logic based on Medi-Span. |
| Specialty | The definition of specialty drug has been set using pre-defined CHSD logic developed by clinicians at Milliman. |

Emerging trends

1. WEIGHT LOSS DRUGS – GLP-1 AGONISTS

Marketwide spend for obesity GLP-1 agonists continues to increase disproportionately compared to other drug classes, driven by drug innovation and continued demand amongst patients. For this class of drugs, we project an overall gross cost increase between 21% and 40% annually among commercial plans from 2024 to 2026. It's important to note that one component of this high trend is attributable to the increasing number of plans adopting new coverage for this class; one survey estimated that as of Q4 2024, only 28% of employers cover GLP-1 drugs for weight loss.¹

Manufacturers of GLP-1 products are highly invested in researching indications for their use outside of weight loss and diabetes. In Q4 2024, the Food and Drug Administration (FDA) approved Zepbound as the first drug treatment for obstructive sleep apnea, and, in Q3 2025, the drug was approved to treat metabolic dysfunction-associated steatohepatitis (MASH). A phase 2 clinical trial published in February 2025 suggested that semaglutide, the active ingredient in Ozempic and Wegovy, may reduce alcohol and tobacco cravings.² Novo Nordisk also conducted two phase 3 clinical trials, the EVOKE and EVOKE Plus clinical trials, to determine if semaglutide has a beneficial effect on patients with early Alzheimer's disease.³ These trials failed to achieve their primary outcomes.⁴ Nevertheless, manufacturers are continuing to explore expanded indications for these drugs.

1. Health Affairs Forefront. (October 11, 2024). Annual family premiums for employer coverage rise 7% in 2024. Retrieved January 8, 2026, from <https://www.healthaffairs.org/content/forefront/annual-family-premiums-employer-coverage-rise-7-2024>.

2. Hendershot, C. S., et al. (2025). Once-weekly semaglutide in adults with alcohol use disorder: A randomized clinical trial. *JAMA Psychiatry*, 82(4), 395–405. <http://doi.org/10.1001/jamapsychiatry.2024.4789>

3. Cummings, J. L., et al. (2025). Evoke and Evoke+: Design of two large-scale, double-blind, placebo-controlled, phase 3 studies evaluating efficacy, safety, and tolerability of semaglutide in early-stage symptomatic Alzheimer's disease. *Alzheimer's Research & Therapy*, 17(1), 14. <https://doi.org/10.1186/s13195-024-01666-7>

4. Novo Nordisk. (November 24, 2025). Novo Nordisk A/S: Evoke phase 3 trials did not demonstrate a statistically significant reduction in Alzheimer's disease progression [Press release]. Retrieved January 8, 2026, from <https://www.novonordisk.com/content/nncorp/global/en/news-and-media/news-and-ir-materials/news-details.html?id=916462>.

In addition to indication expansion, novel GLP-1 products are also in clinical trials. Amycretin, a long-acting GLP-1 and amylin receptor agonist researched as both an injection and an oral treatment, has entered phase 3 clinical trials. So far, the highest doses tested in phase 1 and phase 2 clinical trials resulted in body weight reductions up to 24.3%.⁵ Amycretin has the potential to surpass the efficacy of existing weight loss drugs and may contribute to the drug class's continued utilization growth in future years. CagriSema is also being explored as an improvement to semaglutide, creating a combination product that adds cagrilintide to provide additional weight loss efficacy. The phase 3 REDEFINE 1 trial showed an average of 20.4% baseline weight loss at 68 weeks.⁶

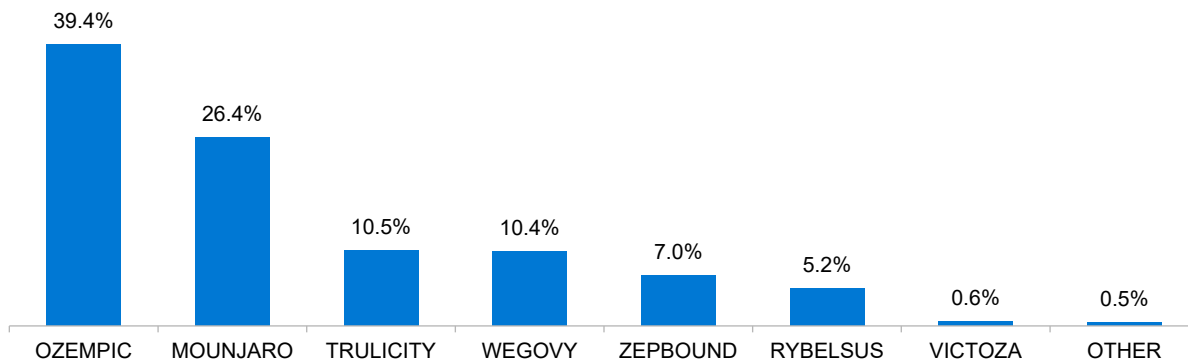
2. ANTIDIABETICS

We expect list price trends for brand insulin products to become more stable after the significant reduction seen at the end of 2023 and early 2024. We project an AWP increase of up to 3% annually among commercial plans from 2024 to 2026, which we mostly attribute to typical year-to-year price inflation.

The MDPNP is expected to reduce gross costs of a class of antidiabetic drugs called sodium-glucose transport 2 (SGLT2) inhibitors, which includes drugs like Farxiga and Jardiance. While prices negotiated under the MDPNP only apply to Medicare lines of business, trends in this line of business often extend into the commercial market, so it is likely that, in the near future, these drugs will be priced with lower allowed amounts and, consequently, lower rebates.

We also continue to observe high utilization trends for antidiabetic GLP-1 drugs and project a utilization increase between 20% and 31% from 2024 to 2026, with Mounjaro and Ozempic comprising about 66% of the market share for the class.

FIGURE 2: GLP-1 RECEPTOR AGONISTS: UTILIZATION BY PRODUCT IN 2024 (PERCENT OF DAYS SUPPLY)



3. BIOSIMILARS

The biosimilar market continues to experience significant pricing changes as plans decide amongst many available strategies:

- Reference and/or biosimilar product coverage exclusions
- Biosimilar rebate guarantee exclusions and rebate credits
- Low WAC versus high WAC
- Utilization management policies

5. Novo Nordisk. (June 20, 2025). Novo Nordisk advances early-stage obesity medication, amycretin, to phase 3 clinical development based on early-phase clinical trial results in people with obesity or excess weight, published in The Lancet [Press release]. PR Newswire. Retrieved January 8, 2026, from <https://www.prnewswire.com/news-releases/novo-nordisk-advances-early-stage-obesity-medication-amycretin-to-phase-3-clinical-development-based-on-early-phase-clinical-trial-results-in-people-with-obesity-or-excess-weight-published-in-the-lancet-302487500.html>.

6. Garvey, W. T., et al. (2025). Coadministered cagrilintide and semaglutide in adults with overweight or obesity. The New England Journal of Medicine, 393(7), 635–647. <http://doi.org/10.1056/NEJMoa2502081>

In Q1 2025, the first biosimilars to Stelara became available on the market. We expect the adoption of Stelara biosimilars to reflect similar trends seen in the Humira market, namely, the widespread adoption of PBM private labels such as OptumRx's Nuvaia.⁷ The use of private label products should lead to faster adoption of Stelara biosimilars than was seen in 2023 with Humira biosimilars.

4. METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH) DRUGS

Rezdiffra was approved in March 2024 as the first treatment for MASH, a liver condition often found in those with high cholesterol, Type 2 diabetes, or obesity, which is projected to affect 27 million people in the U.S. by the year 2030.⁸ The drug's approval will likely encourage other manufacturers to pursue their own treatments within this therapeutic class. The FDA approved this indication for Wegovy based on positive results from the recent ESSENCE phase 3 clinical trial.⁹ Zepbound is not currently approved to treat MASH.

Supplemental information

1. PHARMACY CONCEPTS

Please note that any values in this section are subject to change as Milliman contributor data are updated. The supplemental information section includes values for the year 2024 that are annualized based on data from January 1, 2024, to September 30, 2024, so 2024 values are also likely to change when new data become available.

A. Rebates and AWP discounts

Manufacturer rebate payments and AWP discounts are key components to consider when determining the net cost of drugs to plans. Rebate payments are made to PBMs by manufacturers in return for formulary coverage. AWP discounts are discounts off of list prices from payments made to pharmacies. The true net cost of a product to a plan is the amount paid to the pharmacy minus the rebate payment.

Because manufacturer list prices are only one component of net cost, decreases in list prices don't always result in decreases in true net cost. Market-changing events, such as patent losses and legislative pressures, can lead to drug price decreases; however, those decreases can be offset by the lessening of rebates paid to plan sponsors and their PBMs. Based on our work in the pharmacy benefits space, we have observed the following:

1. Rebates for preferred brand drugs, often expressed as a percentage of WAC, can have extremely high variance.
2. Based on Milliman's MyRxConsultant Performance Benchmarking, the median AWP discount for brand drug claims filled at less than an 83-day supply at a retail pharmacy was approximately 18.75% in 2023. For generic drugs under the same conditions, the median AWP discount was 84.5%.
3. The Milliman Medical Index projects that, on average, rebates will be approximately 31% to 33% of total allowed drug costs in 2025.¹⁰

7. Maas, A. (January 16, 2025). Optum's Nuvaia is sole distributor of first Stelara biosimilar, Wezlana. AIS Health. Retrieved January 8, 2026, from <https://aishealth.mmitnetwork.com/blogs/spotlight-on-market-access/optum-s-nuvaia-is-sole-distributor-of-first-stelara-biosimilar-wezlana>.

8. Gores, M. & Scott, K. (January 2024). Emerging from the shadows: A new era for NASH. IQVIA. Retrieved January 8, 2026, from <https://www.iqvia.com/-/media/iqvia/pdfs/library/white-papers/emerging-from-the-shadows-a-new-era-for-nash.pdf>.

9. Sanyal, A. J. (2025). Phase 3 trial of semaglutide in metabolic dysfunction – associated steatohepatitis. The New England Journal of Medicine, 392(21), 2089–2099. <http://doi.org/10.1056/NEJMoa2413258>

10. Bell, D., Clarkson, J., Jensen, B., Liner, D., Man, A., Naugle, A., & Timcheck, A. (May 2025). 2025 Milliman Medical Index: How have healthcare costs changed over the past 20 years? Milliman. Retrieved January 8, 2026, from <https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/2025-Milliman-Medical-Index.pdf>.

Drugs with the same clinical effect may differ substantially by list price as well as by the amount of rebates paid by the manufacturer. Following are hypothetical examples that illustrate potential offsetting effects on net prices.

1. Brand drug with a lowered WAC/AWP:

- A drug with a \$1,000 AWP and 20% discount would have an ingredient cost paid to the PBM of \$800. Assuming that the plan receives a \$200 rebate on this drug, the net cost would be \$600.
- If a market event, such as new legislation, were to encourage a significant change in a drug's AWP, downstream effects on pricing would likely occur, changing discounts and rebates.

2. Competitor products with different pricing structures:

- Drug A represents a drug with a \$1,000 gross cost and a \$300 rebate. Drug B represents a drug with a \$600 gross cost and no rebate. The net cost of Drug B is \$100 less than Drug A.
- The current standard PBM pricing models may have economic incentives for the PBM to prefer Drug A instead of Drug B, despite the lower net cost, due to the contractual requirement to achieve minimum rebate guarantees.
- Additionally, depending on the plan's benefit design, Drug B may not in fact result in a lower net plan liability after cost sharing, given the gross cost discount is distributed across both plan and member payments, whereas the rebate on Drug A is kept by the plan.

3. Patent loss:

- The net cost of a competitor product can be either less or more than that of its reference product counterpart once rebates are considered. It is true that generics and biosimilars are often cheaper options, but this is not always the case, particularly prior to multiple manufacturers producing a competitive product.
- Drug A represents a reference drug with a \$1,000 gross cost and a \$300 rebate. Drug B represents newly launched generic competitor with a \$600 gross cost and no rebate. The manufacturers of Drug A could increase their rebate payment to some amount equal to or more than \$400, incentivizing PBMs to prefer the reference drug over its generic competitor.

Note that other stakeholders within the distribution chain may react to these changes in varying ways, further complicating drug pricing.

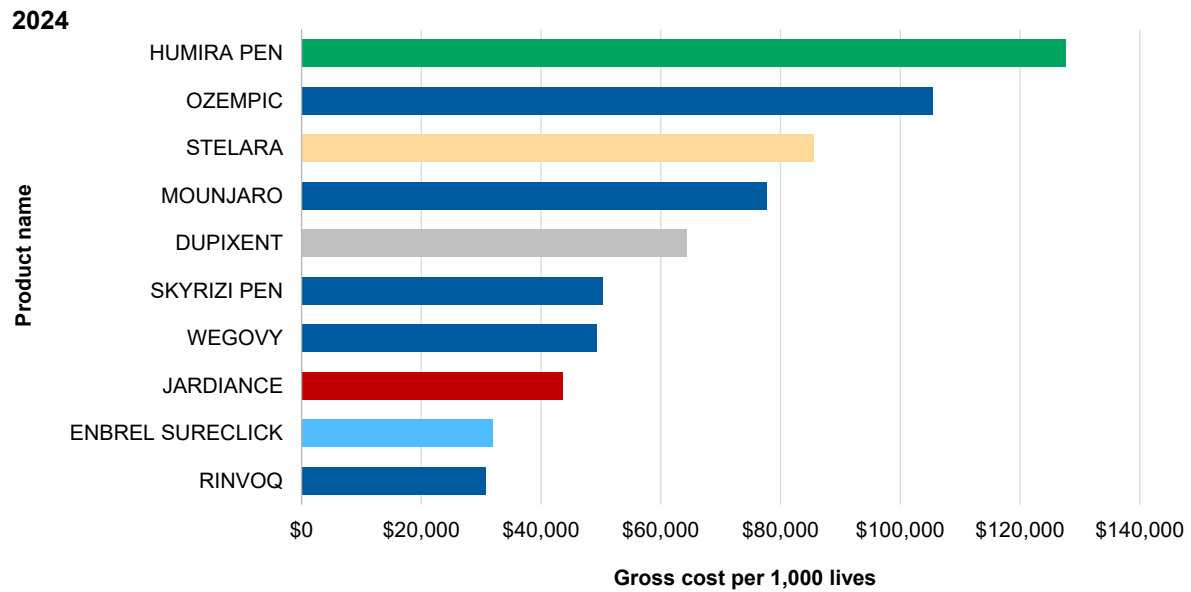
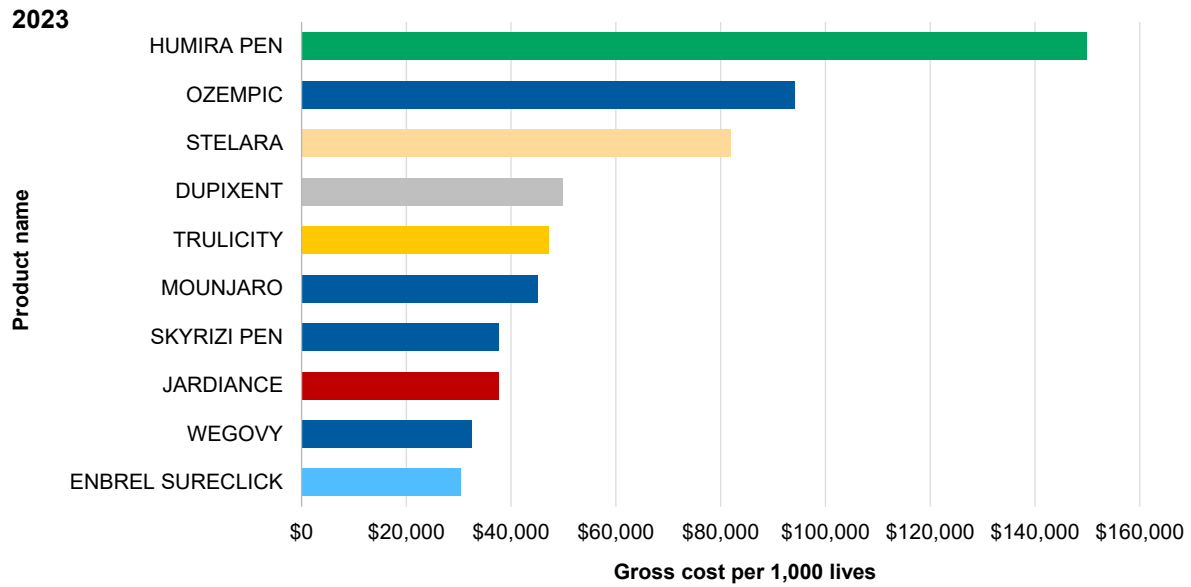
B. Generic dispensing rates (GDRs)

Because generic drugs tend to cost less for plans and members than brand drugs, the release of new generics causes brand utilizers to shift their utilization to generic alternatives over time. Utilization trends will differ by drug depending on the nature of the condition being treated. We examined cost and utilization data for several drugs with notable generic launches and observed the following:

- GDR increases significantly in the year following a generic launch before mostly levelling out. It is common for GDR to exceed 90% for drugs with generic options available.
- Relative to utilization trends before the generic launch, utilization trends increased between 10% and 27% per year (across the brand and generic combined). For medical conditions that have utilization that is relatively inelastic to drug pricing, we would expect this increase to be on the lower end of the scale. But rationing and affordability may account for at least some increase even in those cases.
- Relative to AWP trends before the generic launch, annual AWP per-claim trends for reference product drugs decreased between 6% and 17% after generic launch. In addition to this list price decrease, AWP discounts increase as patients transition from the brand to the deeper-discounted generic alternative.

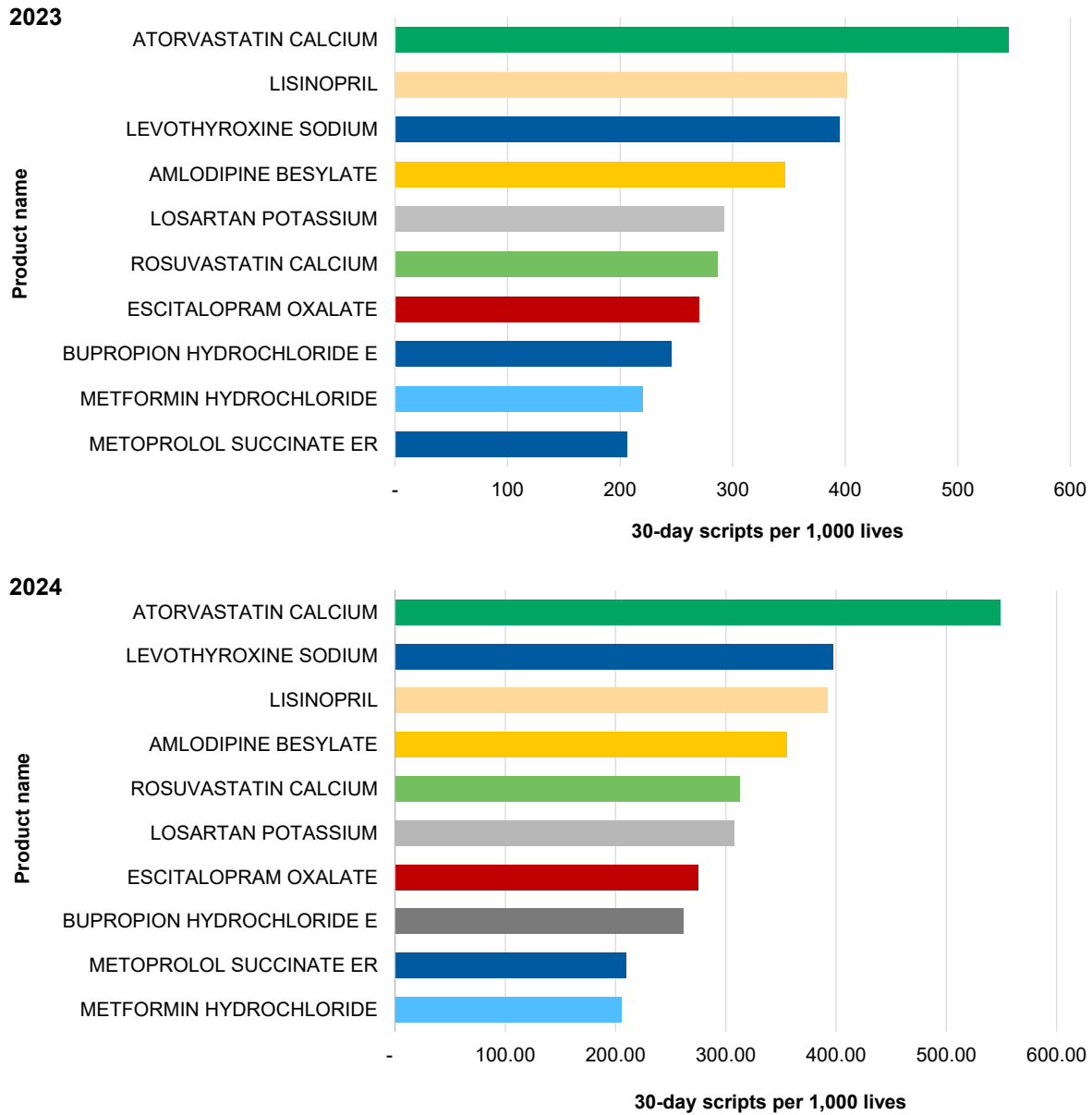
2. TOP DRUGS BY COST

FIGURE 3: 2023 AND 2024 – TOP DRUGS BY COST



3. TOP DRUGS BY COUNT

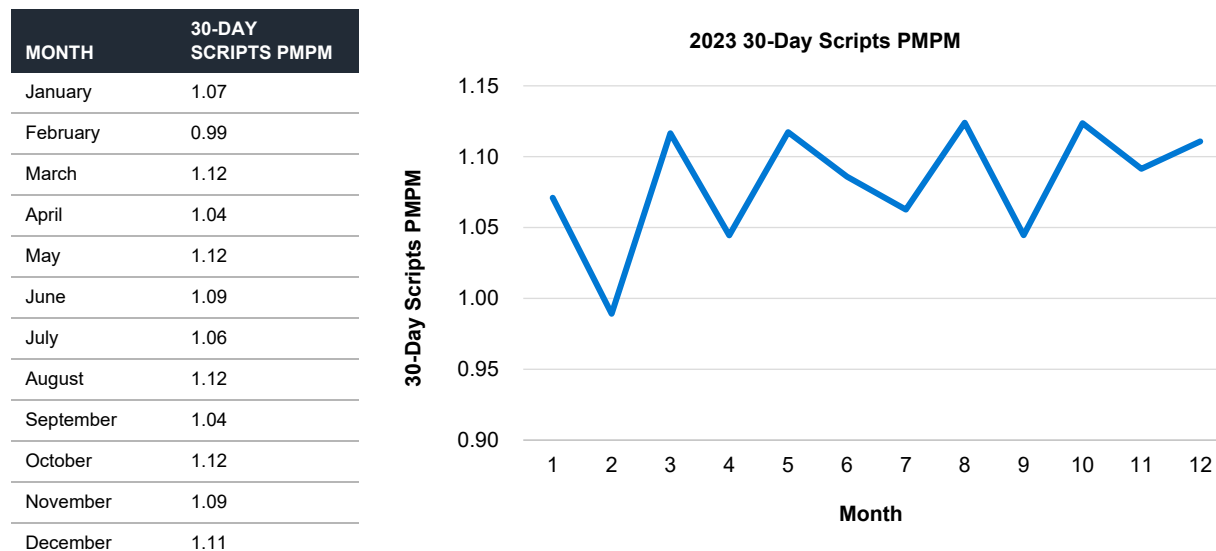
FIGURE 4: 2023 AND 2024 – TOP DRUGS BY 30-DAY SCRIPTS



Note: Top drugs by 30-day scripts exhibit excludes vaccines.

4. 2023 - SEASONALITY BY MONTH

FIGURE 5: 2023 – SEASONALITY BY MONTH



Note: Seasonality will vary depending on plan design, days in the month, and weekend days in the month.

5. GEOGRAPHY

FIGURE 6: 2023 AND 2024 SCRIPTS PMPM AND GROSS COSTS BY REGION

| REGION | 2023 | | 2024 | |
|---------------|---------------------|------------------------------|---------------------|------------------------------|
| | 30-DAY SCRIPTS PMPM | GROSS COST PER 30-DAY SCRIPT | 30-DAY SCRIPTS PMPM | GROSS COST PER 30-DAY SCRIPT |
| West | 0.95 | \$150.80 | 0.98 | \$153.52 |
| Upper Midwest | 1.06 | \$147.51 | 1.07 | \$154.60 |
| Lower Midwest | 1.03 | \$144.62 | 1.03 | \$149.69 |
| Northeast | 1.20 | \$157.91 | 1.19 | \$161.66 |
| Southeast | 1.15 | \$143.98 | 1.14 | \$152.52 |

Regions, based on the Department of Health and Human Services (HHS):

- Lower Midwest: Arkansas, Louisiana, New Mexico, Oklahoma, Texas
- Northeast: Connecticut; Delaware; Maine; Maryland; Massachusetts; New Hampshire; New Jersey; New York; Pennsylvania; Puerto Rico; Rhode Island; Vermont; Virgin Islands; Virginia; Washington, D.C.; West Virginia
- Southeast: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
- Upper Midwest: Colorado, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, South Dakota, Utah, Wisconsin, Wyoming
- West: Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com



CONTACT

Brian Anderson
brian.anderson@milliman.com

Rebekah Bayram
rebekah.bayram@milliman.com

Andy Dressler
andy.dressler@milliman.com

Marc Guieb
marc.guieb@milliman.com

Niharika Tarimela
niharika.tarimela@milliman.com

Jason Mui
jason.mui@milliman.com