House Bill 1451

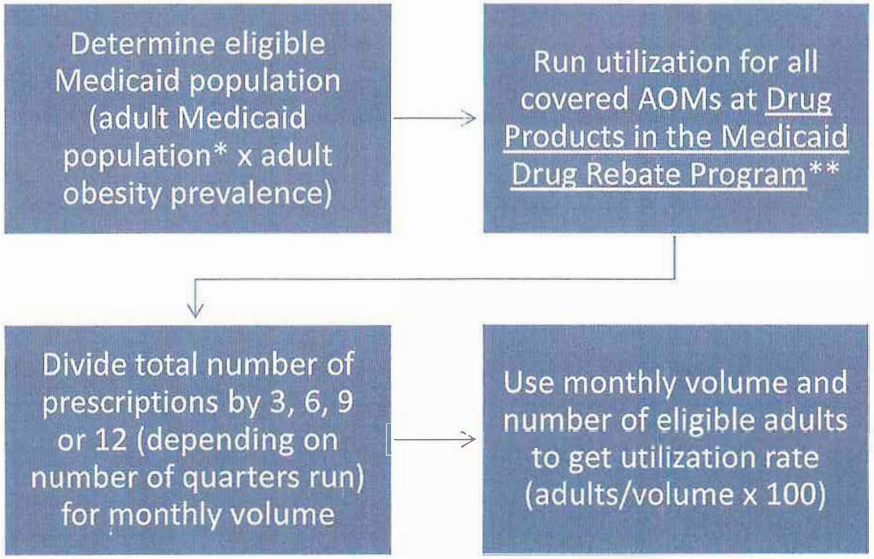
- This bill provides coverage for FDA approved GLP-1s for Medicaid and Medicaid Expansion recipients to treat obesity and obesity related heart disease and to reduce cardiovascular risk;
- The bill states coverage may not be more restrictive than the FDA and allows for cost-sharing options;
    - Currently, that includes only those with a body mass index (BMI) of 30 or greater, or a BMI of 27 or greater with a weight-related health condition.
- Coverage must be treated the same as other illnesses
- It does not preclude the undertaking of utilization management to determine the medical necessity for treatment of obesity, provided all appropriate medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness or condition;
- Finally it provides for notice requirements;
- 14 states already cover some type of FDA approved GLP-1s to treat obesity for Medicaid recipients; all states cover them for diabetes.
- North Dakota has already acknowledged the benefit of these medications to treat obesity in order to prevent diabetes and heart disease and to get our citizens healthier and save on long term healthcare costs.
- Last session, we gave legislative authority for the Insurance Commissioner to include them as part of North Dakota's Essential Health Benefits covered under the state's Affordable Care Act;
- This bill along with HB 1452 would keep the public plans in parity with each other. If we are saying it should be covered for those on the exchange, we should also cover it for Medicaid recipients, many who need it most.
- North Dakota has one of the highest obesity rates in the nation at 35%-with Benson County, Rolette County, and Sioux County at over 40%
- Private insurers in ND have started recognizing the positive impact of these medications—with a number of them offering coverage of GLP-1s starting this year. Those on Medicaid should have the same opportunities to live

healthier and happier lives, especially when the federal government will match the state spending.

- We shouldn't ask our citizens to get sicker before we will cover healthcare costs when there are options to prevent it.

Calculating Anti-Obesity Medication (AOM) Medicaid Utilization

How to Calculate Utilization



*Kaiser Family Foundation

**https://data.medicaid.gov/dataset/0ad65fe5-3ad3-5d79-a3f9-7893ded7963a

2024 6 Month Utilization of Anti-Obesity Medications in Medicaid

Michigan 1.95% *Coverage since 2022*	**Hawaii** 0.1% *Coverage prior to 2020*	**Virginia** 0.92% *Coverage prior to 2020*
Kansas 2.15% *Coverage since 2013*	**Minnesota** 3.16% *Coverage since 2021*	**California** 0.13% *Coverage since 2023*
Delaware 1.44% *Coverage since 2016*	**Mississippi** 0.78% *Coverage since 2023*	**Rhode Island** 1.33% *Coverage prior to 2020*
Pennsylvania 1.15% *Coverage since 2022*	**New Hampshire** 1.03% *Coverage prior to 2020*	**Wisconsin** 2.28% *Coverage prior to 2020*

Impact on Healthcare Costs Resulting from Anti-Obesity Medication Coverage in the Commercial and Medicaid Markets

Commissioned by Novo Nordisk, Inc.

Kristin Niakan, MPH

APRIL 2024

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Caveats, qualifications, and limitations

The analysis underlying estimates of changes in healthcare costs associated with anti-obesity medication coverage in the Medicaid and commercial markets was funded by Novo Nordisk.

This presentation is intended for the sole benefit of the attendees of the National Council of Insurance Legislators meeting and should not be distributed in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit or create a legal liability to any third party, even if we permit the distribution of this information to such a third party.

We have relied on information provided in the public domain, including Milliman's Consolidated Health Cost Guidelines Sources™ Database (CHSD), State Drug Utilization Data (SDUD) from CMS, and the Transformed Medicaid Statistical Information System (T-MSIS) datasets from CMS in preparing this presentation. Results and conclusions in this presentation may not be appropriate if this information is not accurate.

This presentation and Q&A are not intended to be opinion or advice, nor is it intended to be legal advice. Any statements made during the presentation and subsequent Q&A shall not be a representation of Milliman or of their views or opinions, but only of those of the presenters.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate projected Medicaid and commercial claim costs, including member cost sharing, plan liability, and government funding. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

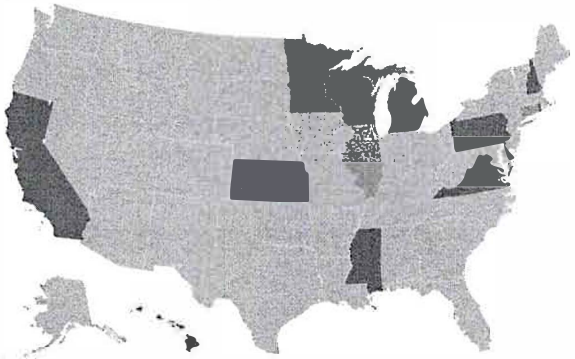
The models rely on data and information as input to the models. We have relied upon certain data and publicly available information, for this purpose and accepted it without audit, though we reviewed for reasonability. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output, may not be appropriate for any other purpose. Actual results will certainly vary for specific stakeholders due to differences in demographics, trends, discount arrangements, formulary, utilization patterns, and rebate arrangements, among other factors.

Background: Anti-Obesity Medication (AOM)[1] coverage in Medicaid and Commercial markets

Coverage of AOMs remains limited due to cost and benefit coverage philosophy concerns

Medicaid

- State Medicaid programs are currently **not required to cover AOMs.**
- There are **at least 12 states that offer coverage of GLP-1s[2] for chronic weight management.**[3]
- There are **at least four states that provide coverage of only non-GLP-1 AOMs.**



No Coverage | Covered | Future Coverage

Commercial

- According to external research, **43% of plans covered weight loss medications** and an additional 28% are considering adding coverage in the near future.[4]
- A 2003 law[5] prohibits Medicare from covering weight loss drugs. **Commercial insurers often take cues about what to cover from the federal program.**
- Many plans consider these medications **lifestyle drugs,** and thus they are excluded from coverage.

1. *Anti-Obesity Medication (AOM)*
2. *Glucagon-like peptide 1 (GLP-1)*
3. *As of December 2023 - https://www.milliman.com/-/media/milliman/pdfs/2024-articles/1-18-24_glp1-agonists-in-medicaid-utilization-growth-and-management.ashx*
4. *Pharmaceutical Strategies Group's 2023 Trends in Drug Benefit Design Report: https://www.mmitnetwork.com/aishealth/spotlight-on-market-access/commercial-payers-wrestle-with-managing-weight-loss-drug-coverage-2/*
5. *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf*

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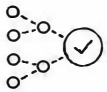
Key data sources for study

Commercial

- Milliman's proprietary claims database, the **Consolidated Health Cost Guidelines™ Sources Database (CHSD)**
- Includes longitudinal claims and enrollment data for over 60 million members annually
- Data limited to the commercial (group and individual) market
- Relied on data from 2021 to Q3 2023
- Developed assumptions from cohort payers with robust AOM coverage

Medicaid

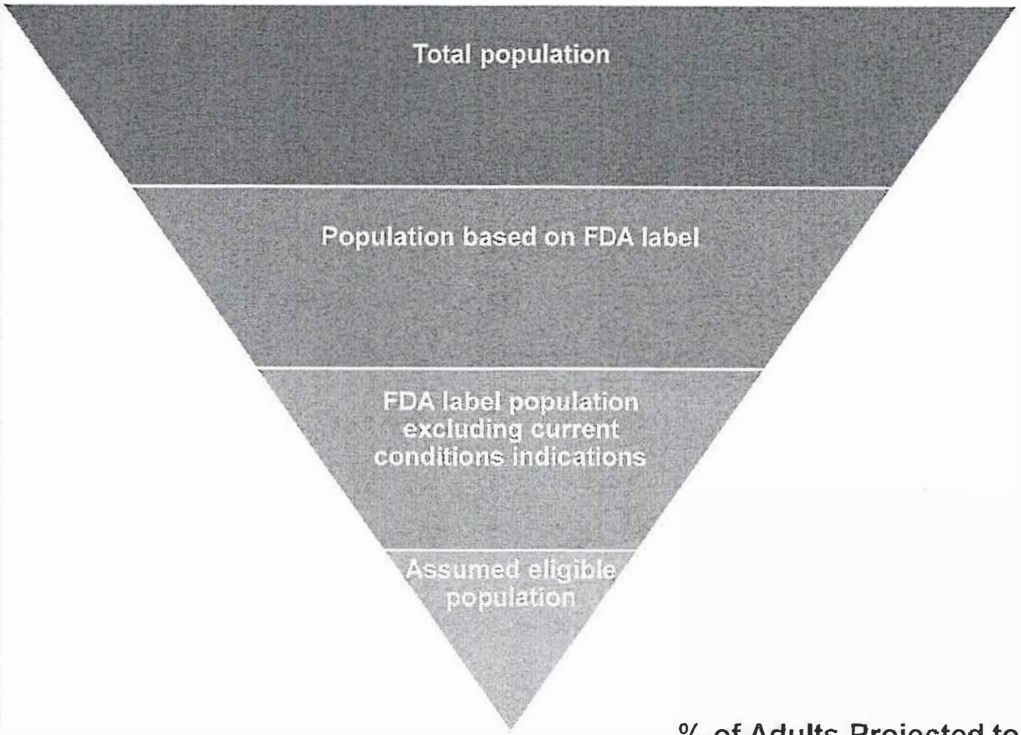


- **Transformed Medicaid Statistical Information System (T-MSIS)**
  - Comprehensive dataset managed by the Centers for Medicare & Medicaid Services (CMS)
  - Captures all individuals who have received Medicaid or CHIP-covered services[1]
  - Relied on data from 2021 to preliminary 2022 (the most recent available data)
  - Informed eligible Medicaid population, AOM uptake, and AOM scripts per utilizer assumptions
- **State Drug Utilization Data:** Quarterly drug utilization data provided by CMS based on MDRP participation
  - Informed Medicaid market share assumptions
  - Relied on data from 2021 to Q3 2023

1. https://www.medicaid.gov/dq-atlas/welcome. Although states are expected to report information on each field, data quality concerns arise where some states submit incomplete information because the data was not collected or technical difficulties arose in reporting.

Theoretical Framework for Estimating AOM Costs

Eligible Population, Uptake Estimation, and resulting assumptions



Eligible population

- Align with FDA labels of leading products
  - Overweight + comorbidity or obesity
- Consider other GLP-1 indications
  - Type 2 diabetes
  - Cardiovascular disease (CVD)[1]
- Focus on incremental AOM utilization
- Depending on timeframe, future potential indications should be considered.
  - Chronic kidney disease (CKD)
  - Nonalcoholic steatohepatitis (NASH) / Metabolic dysfunction-associated steatohepatitis (MASH)

Uptake among eligible population

- Review historical uptake among populations (i.e., plans and/or state Medicaid programs) that currently provide coverage of AOMs
- Uptake assumptions should consider the intended utilization management (UM) criteria and potential for off-label use
- Distribution of adults and children will impact overall population costs
- Forward looking uptake assumptions should consider new AOMs which may not be reflected in historical data due to recency of FDA approval

% of Adults Projected to Initiate AOM Therapy*

Commercial	Medicaid
0.9%	0.4%

[1] https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or

[2] *Denominator includes populations ineligible or unlikely to be prescribed an AOM (i.e. pregnant, institutionalized, concurrent use of GLP-1). These populations are excluded from the "Population based on FDA label" population.*

Theoretical Framework for Estimating AOM Costs

Development of key assumptions and resulting assumptions

Market share Distribution

- Review existing market share in populations with coverage
- Account for products that have recently launched and may not be present in data period (e.g., Zepbound Q4 2023 approval)[1]
- Adjust market share for UM criteria and anticipated market events (e.g. patent loss)
- Account for AOMs which are / are not approved for children
- For a Medicaid population, consider states that have a single preferred drug list (PDL) that would have lower generic dispensing rates

Scripts per utilizer

- Estimate the number of script per year patients will fill
- Assumptions may be based on analogs (e.g., Ozempic, Trulicity) where data is not sufficient
- Segment the population into "non-adherent" and "adherent" patients, for example:
- Adherent: Patients with 9 scripts/year
- Non-adherent: Patients with 2 scripts/year
- This may vary depending on population (e.g. children, dual-eligible, etc.)

Assumptions Used

Commercial: 85% GLP-1s

Medicaid: 94% GLP-1s[2]

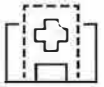
Commercial: 6.1 scripts/year and 42% drop-off[3]

Medicaid: 5.4 scripts/year and 51% drop-off[3]

1. https://www.fda.gov/news-events/press-announcements/fda-approves-new-medication-chronic-weight-management
2. *Single PDL state.*
3. *These represent adult values. Average script per year values are lower for children.*

Theoretical Framework for Estimating AOM Costs

Development of key assumptions and resulting assumptions



Gross costs and rebates

- Calculate gross cost using Wholesale Acquisition Cost (WAC) from Medi-Span or a similar source
- Account for rebates and annual net cost trend due to competition and other market dynamics
- Competitive forces within the class are likely to drive negative net cost trends
- Calculate the statutory rebates according to the Medicaid Drug Rebate Program (MDRP)
- Best Price for brands align with commercial rebate assumption
- Generics will likely have a 13% rebate, based on the Basic Rebate component of the MDRP
- Consider supplemental rebates (if applicable)

Healthcare cost offsets

- AOM use is expected to result in healthcare cost offsets (i.e., savings) from reduced healthcare utilization.
- Rely on literature such as "Weight Loss-Associated Decreases in Medical Care Expenditures for Commercially Insured Patients with Chronic Conditions"[2]
- Savings are most likely only achieved for adherent patients in subsequent years
- Consider populations that may not experience savings or are not represented in literature (e.g., children or dual eligibles)

Assumptions Used

~$300-$400 per 30-day commercial GLP-1 AOM net plan liability [1] starting in 2024 after patient cost share and rebates

Adult cohort using an AOM, changes in gross medical and Rx baseline costs:

- **Commercial: 14%**
- **Medicaid: 6% - 12%[3]**

1. https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208
2. https://journals.lww.com/joem/fulltext/2021/10000/weight_loss_associated_decreases_in_medical_care.5.aspx
3. *This represents the Non-Dual Adult population and the range of results.*

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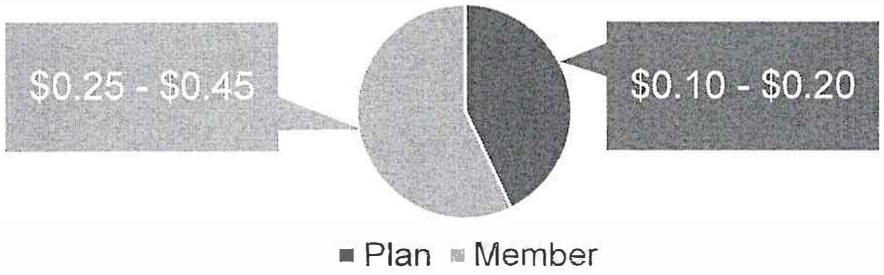
Average Net PMPM Impact to Commercial and Medicaid Markets for Expanded Indications, 2025-2029*

Includes Cost Offsets**

Commercial

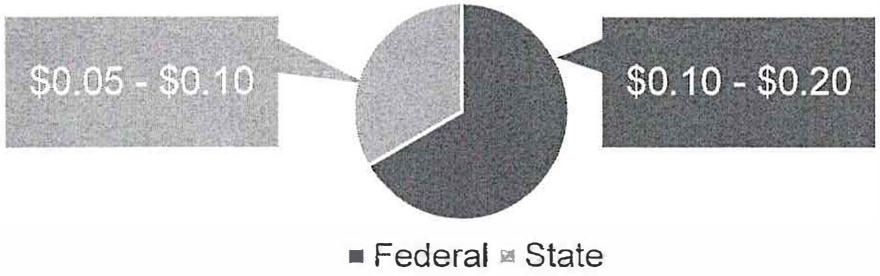
$0.35 - $0.65



Market	Stakeholder	Expanded Indications*** No Cost Offsets	Expanded Indications*** Including Cost Offsets
Commercial	Gross	$3.00 - $5.30	$2.50 - $4.45
	Net	**$0.85 - $1.50**	**$0.35 - $0.65**
	Member	$0.35 - $0.60	$0.25 - $0.45
	Plan	$0.55 - $0.95	$0.10 - $0.20

Medicaid

$0.15 - $0.25



Market	Stakeholder	Expanded Indications*** No Cost Offsets	Expanded Indications*** Including Cost Offsets
Medicaid	Gross	$0.65 - $1.20	$0.60 - $1.10
	Net	**$0.20 - $0.35**	**$0.15 - $0.25**
	Federal	$0.15 - $0.25	$0.10 - $0.20
	State	$0.05 to $0.10	$0.05 - $0.10

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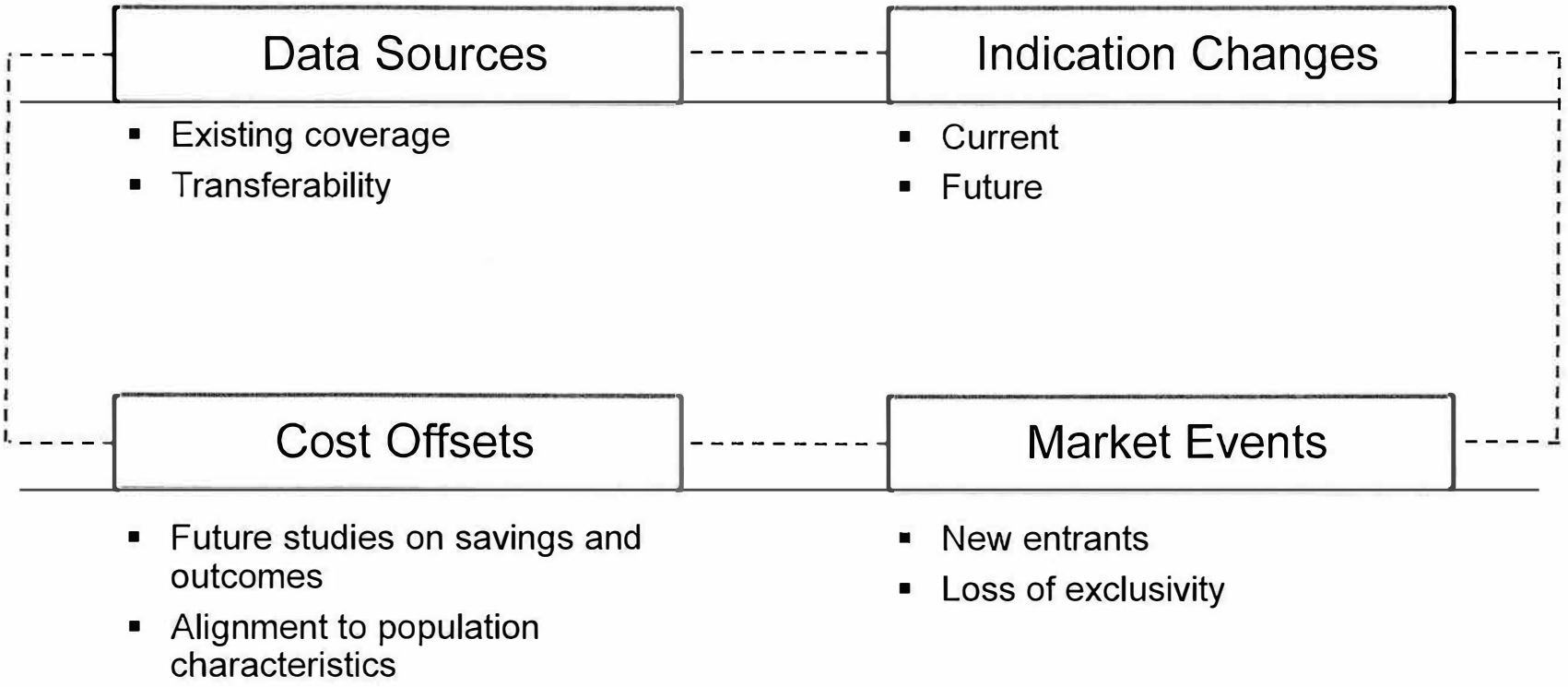
**Reflects an average annual PMPM cost assuming Medicaid enrollment changes consistent with MACPAC Federal estimates (https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected) and a commercial population without membership changes over the five-year time period. Totals may not tie exactly to shown sums due to rounding.*

***"Includes Cost Offsets" refers to assumed to the scenario assuming savings are achieved for adherent patients. No Cost Offsets assumes no savings achieved.*

****Expanded indications refers to removing members for future potential indications for CKD or NASH/MASH conditions.*

Key Considerations for Evaluating the Impact of AOM Coverage



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Thank you

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