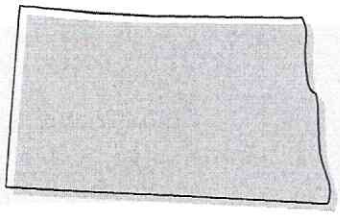
House Bill 1452

- This bill provides coverage for FDA approved GLP-1s for state employees 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 and provides notice requirements;
    - 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.
- This concept is not new:
- North Dakota has already acknowledged the benefit of these medications to get our citizens healthier and save on long term healthcare.
    - Last session we gave legislative authority for the Insurance Commissioner to make them part of North Dakota's Essential Health Benefits covered under the state's Affordable Care Act;
- This bill would keep the public plans in parity with each other. If it's important for our citizens, it should be important for our state employees or Medicaid recipients, many who need it most.
- 25 states already offer some kind of coverage through either state employee plans, Medicaid, small group markets or a combination.
- 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%
- Obesity contributes to chronic conditions like heart disease, diabetes, and hypertension that need expensive ongoing care.
- Our state employee plan already covers these medications for diabetes, this bill would invest in preventive measures that would reduce future health expenses and make our members' lives better.
- 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. We owe it to our hard-working state employees to give them the same opportunities to live healthier and happier lives.

- I will let others address the fiscal note on the bill as I believe there a few things to consider with that and some additional information on utilization rates included with my tes, but ultimately covering these drugs will not only improve the health of our employees, it should decrease our healthcare costs long term.



The State of Obesity in North Dakota

208,510
Adults living with obesity[1,2,a]

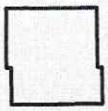
35.2%
Percentage of adults with obesity[2]

Prevalence of obesity varies depending on the population[3]:

- **28.5%** Blacks
- **34.7%** Whites
- **37.3%** Hispanics
- **35.6%** Seniors (aged ≥65 years)

[a]Obesity is defined as BMI ≥30 kg/m^2. Class 2 or 3 obesity is defined as BMI ≥35 kg/m^2.[4]
BMI=body mass index.

These counties have the highest percentage of people with obesity in North Dakota[5]:



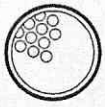
49%
Rolette

47%
Sioux

42%
Benson

Obesity is a major risk factor for cardiometabolic disease.[6]
In North Dakota, the prevalence of cardiometabolic comorbidities of obesity include:

31.1%
Hypertension[7]



33.5%
High cholesterol[8]

9.5%
Diabetes[9,b]

[b]Estimates do not differentiate between type 1 and type 2 diabetes (T2D). T2D accounts for 90-95% of all diabetes cases and the data presented here are more likely to be characteristic of T2D.

National Obesity Statistics

The direct and indirect costs of obesity for employers

Employees with obesity can incur up to a **2.5x increase in costs** vs employees of normal weight[10,c]

Absence due to illness or injury is **increased 128%** for employees with obesity, or **3 additional days** per year[11]

$14,341 to $28,321
Cost per employee with obesity per year[10,d]

$271 to $542
Annual productivity loss per employee with obesity[11]

[c]Includes medical, pharmacy, sick days, disability, presenteeism, and workers' compensation costs. Cost increase depends on class (severity) of obesity.

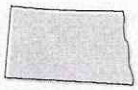
[d]Range is based on class (severity) of obesity.

Anti-obesity Medications (AOMs) and Coverage for North Dakota Residents[12]

AOMs are FDA-approved medications for the management of obesity.

Nationwide Coverage[a]

AOMs are covered by over 90% of National Pharmacy Benefit Managers.



North Dakota Plan Coverage[a]

AOMs are covered on the following plans in North Dakota:

- State Employee Health Plan(s)

[a]Coverage data as of January 2023.

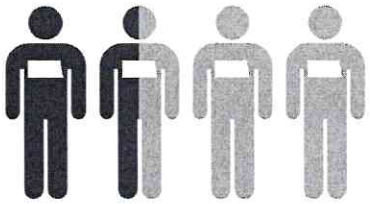
References: 1. U.S. Census Bureau. 2020: ACS 1-year estimates subject tables. Accessed March 31, 2023. https://data.census.gov/table?t=Age+and+Sex&g=0100000US$0400000&y=2021&tid=ACSST1Y2020.S0101&moe=false&tp=true **2.** Nutrition, physical activity, and obesity: data, trends and maps. Centers for Disease Control and Prevention website. Accessed March 31, 2023. https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByTopic&islClass=OWS&islTopic=OWS1&go=GO **3.** BRFSS prevalence & trends data: BMI categories. Centers for Disease Control and Prevention website. Accessed February 13, 2023. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=&islTopic=&islYear=&rdRnd=58747 **4.** What is obesity? Obesity Medicine Association website. Accessed February 13, 2023. https://obesitymedicine.org/what-is-obesity/ **5.** County health rankings model: adult obesity. County Health Rankings & Roadmaps website. Accessed May 3, 2023. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/diet-and-exercise/adult-obesity?year=2023&tab=1&state=38 **6.** Regan JA, Shah SH. Obesity genomics and metabolomics: a nexus of cardiometabolic risk. *Curr Cardiol Rep.* 2020;22(12):174. **7.** BRFSS prevalence & trends data: high blood pressure. Centers for Disease Control and Prevention website. Accessed March 31, 2023. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=&islTopic=&islYear=&rdRnd=58747 **8.** BRFSS prevalence & trends data: high cholesterol. Centers for Disease Control and Prevention website. Accessed March 31, 2023. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=&islTopic=&islYear=&rdRnd=58747 **9.** BRFSS prevalence & trends data: diabetes. Centers for Disease Control and Prevention website. Accessed March 31, 2023. https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByTopic&irbLocationType=StatesAndMMSA&islClass=&islTopic=&islYear=&rdRnd=58747 **10.** Ramasamy A, Laliberté F, Aktavoukian SA, et al. Direct and indirect cost of obesity among the privately insured in the United States: a focus on the impact by type of industry. *J Occup Environ Med.* 2019;61(11):877-886. **11.** Cawley J, Biener A, Meyerhoefer C, et al. Job absenteeism costs of obesity in the United States: national and state-level estimates. *J Occup Environ Med.* 2021;63(7):565-573. **12.** Data on file. Novo Nordisk, Inc. Plainsboro, NJ.

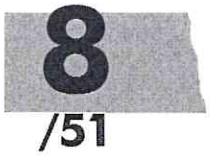
NORTH DAKOTA

Obesity Fact Sheet

ADULT OBESITY FACTS:

Obesity affects more than 35.1% of North Dakotans.





North Dakota is ranked 8/51 in states impacted by obesity.

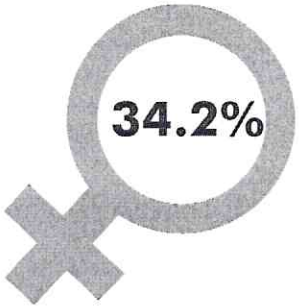
North Dakotans Affected by Obesity by Race

33.1% Caucasians

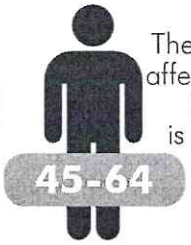
23.5% African Americans

40.2% Hispanics

More than 36.0% of male North Dakotans are affected by obesity.



More than 34.2% of female North Dakotans are affected by obesity.



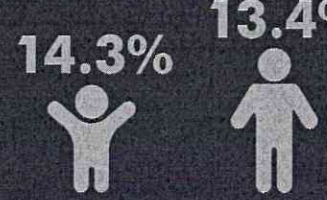
The age group most affected by obesity in North Dakota is 45-64 (39.4%).

39th North Dakota ranks 39th in adults with Type 2 Diabetes (9.6%).

CHILDREN AFFECTED BY OBESITY IN NORTH DAKOTA:

North Dakota IS NOT one of 15 states that receives CDC grant funds for training to help with obesity prevention in Early Childhood Education settings.

CHILDREN AFFECTED BY OBESITY



COST OF OBESITY IN NORTH DAKOTA:

The total cost of obesity in North Dakota **$5.0 BILLION**

The cost of obesity for Medicare in North Dakota **$4.81 BILLION**

The cost of employment for the population with obesity is **$3.88 BILLION** more than the normal weight population.

NATIONAL COST OF OBESITY:

$1.7 TRILLION The total cost of obesity

Healthcare costs for individuals affected by obesity is **34% HIGHER**

$1.24 TRILLION The total indirect cost of obesity

$480 BILLION The total direct healthcare cost of obesity

$14 BILLION The direct costs of childhood obesity

For people living with obesity, **28.2%** of their annual healthcare costs are spent treating obesity-related conditions.

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Sixty-eighth Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 3, 2023

HOUSE CONCURRENT RESOLUTION NO. 3011
(Representative Weisz)
(Senator Lee)

A concurrent resolution urging the Insurance Commissioner to facilitate a change in the essential health benchmark plan for future Affordable Care Act health plans.

WHEREAS, the state has the opportunity to make changes in the essential health benchmark plan for future plan years in accordance with federal requirements and through coordination with federal contacts; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan restricted cost-sharing for diabetes, providing a limited cost-sharing for a 30-day supply of covered insulin drugs, not to exceed $25, regardless of the quantity or type of insulin, and of covered medical supplies for insulin dosing and administration, not to exceed $25, regardless of the quantity or manufacturer of supplies; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan coverage for one hearing aid per hearing-impaired ear every 36 months or more often if there is a significant change in the insured's hearing status as determined by the licensed physician or audiologist; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes-related diagnosis, or a chronic illness or condition that could be managed through nutritional or weight loss programs, up to 12 sessions every policy year, if prescribed by the insured's physician; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if recommended by a board-certified medical practitioner based on health-related impacts or on further deterioration in disease state due to gum disease; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan coverage for position emission tomography scans for an insured who has a prostate cancer diagnosis, including an insured who is in remission or who is cured, which would include at least two different types of position emission tomography scans upon initial diagnosis if requested by a physician, and one position emission tomography scan every 6 months for the life of the insured; and

WHEREAS, the Insurance Commissioner should add to the essential health benchmark plan steps to address the opioid epidemic, including limiting the first fill of opioid prescriptions to 7 days, removing barriers for drugs used in the treatment of opioid use disorder or opioid replacement drugs; and requiring coverage for an easy-to-use overdose antidote when prescribing high-dose opioids;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF NORTH DAKOTA, THE SENATE CONCURRING THEREIN:

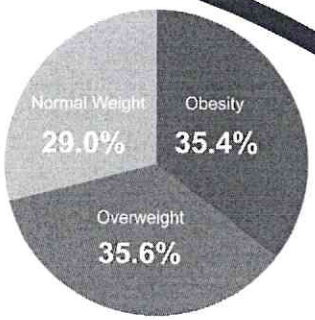
That the Sixty-eighth Legislative Assembly urges the Insurance Commissioner to facilitate a change in the essential health benchmark plan for future Affordable Care Act health plans; and

BE IT FURTHER RESOLVED, that the Secretary of State forward a copy of this resolution to the Insurance Commissioner.

Obesity Facts: Cost, Coverage, and Potential Savings

North Dakota

Obesity's Impact on North Dakota



ND Adult Obesity/Overweight Prevalence

By 2030, it is projected that **53.9%** of **North Dakotans** will have obesity**

Cost of Coverage for Anti-Obesity Medications (AOMs)

- A 2024 analysis by Milliman[2] estimated the **average, nationwide per-member-per-month (PMPM) cost** of adding AOM coverage to state Medicaid programs and commercial plans over a five-year period from 2025 to 2029.
- Milliman's analysis included estimating the cost of coverage both with and without cost offsets resulting from lower healthcare costs due to treating obesity.
  - For Medicaid, the state-level cost is estimated to be **$0.04 to $0.07 PMPM** with cost offsets and **$0.05 to $0.09 PMPM** without cost offsets.
  - For commercial plans, the cost to insurers is estimated at **$0.11 to $0.19 PMPM** with cost offsets and **$0.53 to $0.93 PMPM** without cost offsets.
- Viewing these cost estimates within the broader context of total spending for Medicaid and commercial health plans:
  - North Dakota Medicaid's per member per PMPM spending averaged $1,083.42 in FY2022[1]
  - National PMPM for commercial drug spending averaged $103 in 2018[2]

Impact on North Dakota Families

- Obesity causes **over 1,145** premature deaths in North Dakota annually†
- Obesity imposes **over $77 million** per year in increased medical costs for state households
- Healthcare costs are **34% higher** for people living with obesity*

Impact on North Dakota Employers

- Reduced economic activity in North Dakota attributable to obesity: **$1.02 billion**†
- Health-related absenteeism and disability costs: **$105 million**
- Fewer ND adults in the workforce: **7,447**
- Higher healthcare costs for employers: **$131 million**

Impact on State Government

- Detrimental impact on state budget: **$113 million** per year†
- Higher Medicaid costs: **$37 million** per year
- Reduced state and local tax revenues: **$48 million** per year

Potential to Improve: A **5% - 25% weight loss** among North Dakota adults under age 65 could potentially save the state **$941 million - $2.3 billion** in medical costs over 10 years†

* Obesity Action Coalition, "North Dakota Obesity Fact Sheet," https://www.obesityaction.org/advocacy/resources/state-resources/state-obesity-fact-sheets/

** Ward, Bleich, Cradock, Barrett, Giles, Flax, Long, & Gortmaker, "Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity," https://www.nejm.org/doi/10.1056/NEJMsa1909301

† Global Data, "Obesity Economic and Labor Force Impact per Million U.S. Population,"https://www.globaldata.com/health-economics/US/perMillion/Obesity-Impact-Per-Million-Population-Factsheet.pdf
Fact Sheet analysis applies the study's estimated impact per million U.S. population, extending these estimates to each state based on 2020 Census population data. This approach is intended to provide a broad estimate and should be considered illustrative only.)

[2] Milliman, "Impact of anti-obesity medication coverage in the Medicaid and commercial markets," June 11, 2024. https://www.milliman.com/-/media/milliman/pdfs/2024-articles/6-10-24-impact-of-anti-obesity-medications-coverage-in-commercial-and_medicaid.ashx

[1] MACPAC, "Exhibit 22. Medicaid Benefit Spending per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group," June 29, 2024. https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-fye-enrollee-by-state-and-eligibility-group/.

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NORTH DAKOTA

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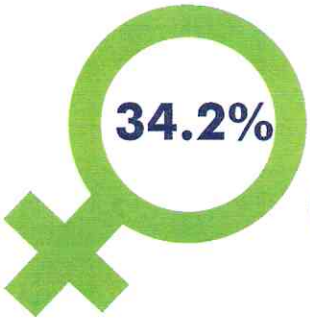

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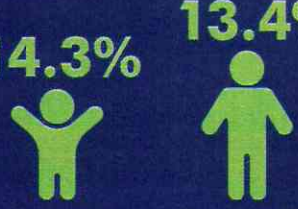

Ages 2-4 Ages 10-17

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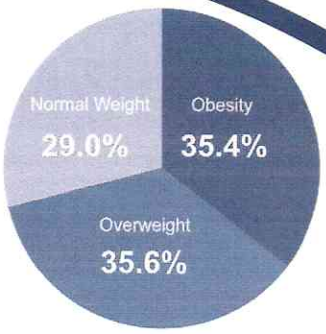

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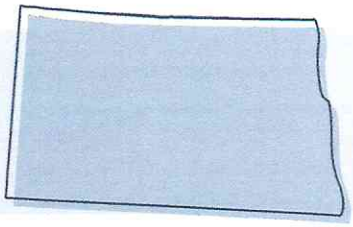

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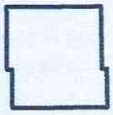

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9.5%
Diabetes[9,b]

[b]Estimates do not differentiate between type 1 and type 2 diabetes (T2D). T2D accounts for 90-95% of all diabetes cases and the data presented here are more likely to be characteristic of T2D.

National Obesity Statistics

The direct and indirect costs of obesity for employers

Employees with obesity can incur up to a **2.5x increase in costs** vs employees of normal weight[10,c]

Absence due to illness or injury is **increased 128%** for employees with obesity, or **3 additional days** per year[11]

$14,341 to $28,321
Cost per employee with obesity per year[10,d]

$271 to $542
Annual productivity loss per employee with obesity[11]

[c]Includes medical, pharmacy, sick days, disability, presenteeism, and workers' compensation costs. Cost increase depends on class (severity) of obesity.

[d]Range is based on class (severity) of obesity.

GOVERNMENT & POLITICS

States consider high costs, possible savings of covering weight-loss drugs for their workers

Covering weight-loss drugs could result in lower spending on chronic diseases associated with obesity.

BY: **SHALINA CHATLANI** - JANUARY 27, 2025 5:00 AM

Russell Wooten and his grandchildren spend time at home in Hendersonville, N.C. GLP-1s helped the 54-year-old public employee lose 40 pounds, but the North Carolina State Health Plan no longer covers the expensive weight loss drugs. (Courtesy of Russell Wooten)

Russell Wooten of Hendersonville, North Carolina, has spent much of his life struggling with obesity, often carrying 260 pounds on his 6-foot-3 frame. He repeatedly starved himself to lose weight, then gained it back by binge eating comfort foods. The cycle left him feeling "depressed and distraught."

In February 2023, Wooten began taking Wegovy, one of a class of drugs called GLP-1s. Long prescribed to patients with Type 2 diabetes and cardiovascular conditions, these medications balance blood sugar levels, but they also curb hunger signals and can help people lose significant amounts of weight.

Wegovy helped Wooten, a custodian at a local public school, lose 40 pounds. But his joy was short-lived: Last April, the North Carolina State Health Plan for teachers and other public employees stopped covering the drug for weight loss. The list price for Wegovy tops $1,300 per month – far more than Wooten can afford on his $45,000 salary.

"It was working for me. I was exercising. I felt better than I had in a very long time," said Wooten, 54. "It's like somebody giving you a Ferrari and then taking it away."

The skyrocketing popularity of the weight-loss drugs is fast becoming a state budgetary concern. In deciding whether to cover the medications, policymakers must choose between the long-term benefits of reducing obesity among public employees and their families – which could cut spending on the treatment of chronic diseases – and the short-term costs.

Separately, 13 state Medicaid programs, including North Carolina's, have opted to cover GLP-1s for obesity. But Medicaid is jointly funded by the federal government and the states, and drugmakers are required to offer significant rebates to those programs in exchange for coverage of their products. The insurance plans that cover public employees largely have to bear the costs themselves.

About a dozen states last year considered legislation that would have added coverage of GLP-1 weight-loss medications to state health plans, Medicaid, or policies offered on Affordable Care Act marketplaces. Most failed or didn't advance. West Virginia, like North Carolina, had been covering the drugs for state employees but stopped doing so. Its move affected far fewer people, however, because its initiative was a limited pilot program.

Meanwhile, Illinois last year approved coverage for its public employees, and Connecticut officials say they will keep covering the drugs, which they began doing in 2023, despite the high price tag.

"North Carolina is wrong, because when employees are healthy, they're more productive," said Connecticut Comptroller Sean Scanlon, a Democrat.

Costs and benefits

Dr. Nicholas Pennings, chair of family medicine at Campbell University in Buies Creek, North Carolina, saw many patients on the employee state health plan gain back the weight they had lost

after their GLP-1 coverage ended. That's because obesity is a chronic condition that can be caused by genetics, emotional dependency and lack of healthy food access, Pennings said.

In North Carolina, where 70% of residents are overweight or obese, foods such as barbecue pork and peach cobbler are part of the local culture. Pennings said he has patients, including the children of state employees, who were doing well on GLP-1s but are now headed toward developing diabetes.

The North Carolina State Health Plan, which covers nearly 750,000 employees, retirees and their dependents, started paying for GLP-1s for weight loss in 2015. By 2023, 23,215 beneficiaries were on the drugs, up from 2,795 in 2021 – an increase of 731%. With various discounts and rebates, the health plan was projected to spend $170 million on the medications in 2024.

The state health plan spends a total of about $4.13 billion annually to provide coverage to people who work for state agencies, universities, community colleges and local school systems. Of that total, state taxpayer dollars cover about 84% and employee premiums cover the remainder.

In the long term, covering weight-loss drugs could result in lower spending on chronic diseases associated with obesity, such as diabetes, heart disease and certain types of cancer, researchers say. But Dale Folwell, the former Republican state treasurer of North Carolina who was in office when the plan stopped covering the medications, said it was an investment the state couldn't afford to make.

"The whole issue about weight-loss drugs and their cost came at us like a top fuel dragster at 300 miles an hour," Folwell said. "It's not emotional, it's not political, it's mathematical."

The state health plan currently has a $507 million deficit. Pharmacy benefit managers, the intermediaries in the drug supply chain, are supposed to use their bargaining power to negotiate lower drug prices, and Folwell said the state's PBM has secured rebates on the weight-loss drugs. But they weren't enough.

Brad Briner, who replaced Folwell as treasurer earlier this month, said the state considered cutting costs by limiting coverage to the most high-risk patients, but the state's current contract with its PBM would not allow that. He hopes that the state's next PBM

contract will allow more flexibility, and that the state will resume covering the drugs for at least some patients next year.

In the meantime, Briner said, eliminating coverage was the right decision.

"We've got to balance the books before we add GLP-1s back," said Briner, also a Republican.

As in North Carolina, more than 70% of West Virginia residents are overweight or obese. The state's Public Employee Insurance Agency, which oversees the state's health plan, in March 2024 ended its small pilot program that covered about 1,100 enrollees, due to concerns over cost and supply.

The agency said in an email that the program cost $1.3 million per month. If it had extended coverage to all potential eligible members, about 70,000 people, the projected cost would have been more than $1 billion annually.

Dr. Laura Davisson, director of the Medical Weight Management program at West Virginia University, one of the sites of the obesity treatment pilot program, wrote in an email to Stateline that her patients saw on average a 15% weight loss, which is "three times as much weight as lifestyle-only programs."

"The challenge is that the benefits of treating obesity, such as preventing long-term complications, may not become evident for several years," Davisson wrote to Stateline.

Staying the course

In Illinois, Democratic Gov. JB Pritzker pushed to provide coverage of the weight-loss drugs for public employees. The Pritzker administration estimates that doing so will cost the state $210 million in the first year, but some economists say the cost is likely to be as much as three times higher.

In Connecticut, the cost of covering the weight-loss drugs for public employees has skyrocketed from $7.7 million in 2020 to an estimated $40 million last year. The Connecticut state health plan has about 270,000 beneficiaries.

In an attempt to control costs, the state in 2023 began requiring patients seeking a GLP-1 prescription for weight loss to first enroll in a telehealth program to help them make lifestyle changes instead of using the medications.

Scanlon, the state comptroller, said the program has reduced GLP-1 usage but enrollment is surging. Now the state is looking for its next solution, he said.

"Our North Star has always been continuing coverage for people who want to get the help that they need and that they deserve," he said.

One thing Scanlon is not counting on, he said, is the price of the GLP-1 drugs coming down anytime soon.

"Trying to convince the makers of these drugs to make them cheaper is like me trying to convince my 2-year-old and 5-year-old not to want to eat candy in a candy store," Scanlon said.

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