2025 HOUSE HUMAN SERVICES

HB 1451

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1451
1/28/2025

Relating to medical assistance prescription drug benefits for antiobesity medication.

9:01 a.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Treatment funds
- Medicaid expansion

9:02 a.m. Representative Nelson, District 14, introduced the bill and submitted testimony in favor, #32106.

9:12 a.m. Brendan Joyce, Pharmacy & Clinical Services Director with the Department of Health and Human Services, testified neutrally and submitted testimony, #31870.

Additional written testimony:

Amanda Schmitcke submitted testimony in favor, #31365.
Casey McPherson, Alliance for Patient Access, submitted testimony in favor, #31973.
Matt Prokop, American Diabetes Association, submitted testimony in favor, #32007.
Leah Vukmir, Senior Vice President of State Affairs, National Taxpayers Union, submitted testimony in favor, #32030.
Tracy Zvenyach, Director of Policy, Obesity Action Coalition, submitted testimony in favor, #32040.

9:16 a.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

I am in favor of this bill.

Obesity is a medical diagnosis, just like any other medical diagnosis given by a trained medical professional. The same as diabetes, chronic lung disease, high blood pressure… you name it. The difference is the drugs prescribed to treat these diagnosed medical conditions are covered by your insurance plan. The drugs now used to treat obesity are not.

An obesity diagnosis is something that is given to someone like me, who has struggled with their weight their whole life – since childhood. Its not just a matter of what you eat or how much you exercise. Yes, that's a HUGE part of it, but even with those parts kept up on a regular basis not all bodies regulate the same way, and these new medications assist in regulating so that OUR bodies can behave like the average person's body can.

Additionally, by covering these medications, and allowing patients availability to these, it will decrease the propensity for patients like me to have future diagnosis of diseases such as high blood pressure, high cholesterol or diabetes that will require additional medications. Like I alluded to before, my weight has been an ongoing fight for me ever since I can remember – and the aforementioned diseases run in my family. I am currently doing everything I can to try to maintain my weight, but no matter what I do, working with my healthcare professional (currently using other weight loss medications that are approved and, on the market,) I still am in the obese category, and struggle every day with my weight. These new medications, the GLP-1 medications, work differently, and have found a way for people like me to finally manage this disease.

As it stands now, it is unfair that with a medical diagnosis, and a medicine available for the diagnosis, that it is not covered as other prescriptions are, on the drug coverage plan that we are currently covered by under PERS.

I kindly ask that you give this bill a DO PASS.

Thank you for taking the time to read my testimony.

NORTH Dakota | Health & Human Services
Be Legendary.

Testimony
House Bill No. 1451
House Human Services Committee
Representative Ruby, Chairman
January 28, 2025

Chairman Ruby, and members of the House Human Services Committee, I am Brendan Joyce, Pharmacy & Clinical Services Director with the Department of Health and Human Services (Department). I appear before you to provide neutral testimony on House Bill No. 1451, which requires expenditures not in Governor Armstrong's budget.

The Social Security Act subsection 1927 allows Medicaid programs to exclude drugs when used for anorexia, weight loss, or weight gain. States can choose to add coverage for anti-obesity medications by filing a state plan amendment. After numerous discussions with several physicians, the Department elected to cover a limited number of oral anti-obesity medications starting in December 2023. The Department has continuously covered bariatric surgery but would have to add coverage for intensive behavioral therapy as required in this Bill. Also, the requirement for providing notice to enrollees would be a new process for the Department.

Some current language in House Bill No. 1451 causes some additional concern. Line 9 states "comprehensive coverage" which could be interpreted to mean all. We cannot predict what future treatments will arrive, nor could we predict the costs. Also, this could restrict the Department's ability to procure bids for supplemental rebates for the drugs.

Lines 12-22 are unnecessary for a Medicaid program as federal law already provides the requirements for drug coverage. Simply stating that the Department must add coverage for these services would be sufficient and would help avoid conflicts and confusion between state and federal requirements. For example, there is nothing in state law requiring the same for diabetic or hypertension medication or treatment.

The Department prepared the fiscal note using other state Medicaid programs' recent experience in adding coverage of anti-obesity medications. The Department projects that this bill will increase net spend by the Department by $4.4 million in total funds. The increase for drug costs would be equivalent to a 10% increase in the pharmacy budget, and the other costs are as noted in the fiscal note.

This concludes my testimony. I would be happy to try to answer any questions the committee may have. Thank you.

Alliance for Patient Access

January 27, 2025

Representative Robin Weisz
Chair, House Human Services Committee
600 East Boulevard Avenue
Bismarck, ND 58505

Representative Matthew Ruby
Vice Chair, House Human Services Committee
600 East Boulevard Avenue
Bismarck, ND 58505

RE: SUPPORT: HB 1451 – Medical assistance prescription drug benefits for antiobesity medication

Dear Chair Weisz and Vice Chair Ruby:

On behalf of the Alliance for Patient Access (AfPA), we are writing to express our strong support of HB 1451, which would require North Dakota Medicaid to include comprehensive coverage for the treatment of obesity. As you are aware, patients with obesity now have FDA-approved pharmacologic options to treat the chronic disease of obesity. However, ensuring patients can access appropriate obesity care is paramount to addressing the obesity epidemic.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials. AfPA also manages an Obesity Initiative, convening health care providers across specialties dedicated to ensuring a patient-centered approach to obesity treatment.

The obesity epidemic in the United States is no secret. The New England Journal of Medicine predicts that 1 in 2 adults will have obesity by 2030, while 1 in 4 adults will have severe obesity. As you consider the overall health and well-being of North Dakotans, these numbers are impossible to ignore. Obesity is not an insular disease; we know it is related to a host of other diseases including certain cancers, heart disease, stroke and type 2 diabetes. Furthermore, obesity is expensive. The aggregate annual medical costs due to obesity among adults in the United States is over $260 billion. Total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, are estimated to be $91.6 billion per year, approximately 30% of Medicare spending.[1]

Importantly, in recent years, the FDA has approved several therapies for the treatment of obesity, meant to be used in conjunction with lifestyle changes. These treatment options have been revolutionary in ensuring patients and providers have additional tools to handle this complicated disease. Proper and effective treatment of obesity would benefit patients through improved health outcomes, as well as the health care system in the form of savings.

Given the impact of obesity, HB 1451 is an important step toward addressing this treatable disease. This legislation ensures that Medicaid beneficiaries will have access to the full complement of obesity treatment. Allowing patients and providers to access the full regimen of treatment options will have a significant impact on North Dakotans living with obesity.

[1] https://www.jmcp.org/doi/10.18553/jmcp.2021.20410

It is for these reasons that we believe HB 1451 is crucial to solving North Dakota's obesity epidemic. We respectfully request you allow this bill to advance through the legislative process, as it is imperative patients and providers have access to all available tools to treat obesity. If we can provide further details or answer any questions, please reach out to cmcpherson@allianceforpatientaccess.org or (202)951-7097.

Sincerely,

Josie Cooper
Executive Director
Alliance for Patient Access

CC:

Rep. Karen Anderson
Rep. Jayme Davis
Rep. Clayton Fegley
Rep. Dawson Holle
Rep. Carrie McLeod
Rep. Brandon Prichard
Rep. Mike Beltz
Rep. Gretchen Dobervich
Rep. Kathy Frelich
Rep. Dwight Kiefert
Rep. Todd Porter
Rep. Karen Rohr

House Bill 1451
Proponent Testimony
Matt Prokop
Director, State Government Affairs
American Diabetes Association®

January 28, 2025

Chairman Rudy and Members of the House Human Services Committee:

Thank you for the opportunity to express our support for HB 1451.

The American Diabetes Association (ADA) strongly supports providing comprehensive access to the evidence-based interventions to treat and manage the chronic disease of obesity in accordance with ADA's clinical Standards of Care. These interventions include intensive lifestyle modification counseling, obesity medications, and bariatric/metabolic surgery as recommended by a health professional.

Obesity is a complex, multifactorial, common, serious, relapsing, and costly chronic disease that serves as a major risk factor for developing conditions such as heart disease, stroke, type 2 diabetes, renal disease, non-alcoholic steatohepatitis, and 13 types of cancer (which make up 40 percent of all cancer diagnoses).[1] Additionally, obesity contributes to many chronic and costly conditions including sleep apnea and increases the rate of physical injury including falls and sprains by 48 percent.[2]

ADA's 2025 Standards of Care reviewed the evidence and demonstrate that obesity management can delay the progression from prediabetes to type 2 diabetes. Additionally, with greater than 10 percent BMI reduction other significant health benefits can be achieved.

North Dakota ranks nineteenth in states impacted by obesity.[3] 71% of North Dakotans are experiencing overweight (35.6%) or obesity (35.4%).[4]

On behalf of your constituents who are experiencing overweight or obesity and may have or be at risk for diabetes, I urge you to support HB 1451.

If you have any questions, please contact me at mprokop@diabetes.org.

Thank you very much for your consideration

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[1] Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/risk-factors/obesity.html?CDC_AAref_Val=https://www.cdc.gov/cancer/obesity/
[1] Finkelstein EA, Chen H, Prabhu M, Trogdon JG, Corso PS. The relationship between obesity and injuries among U.S. adults. Am J Health Promot. 2007 May-Jun;21(5):460-8. doi: 10.4278/0890-1171-21.5.460. PMID: 17515011.
3 https://www.obesityaction.org/wp-content/uploads/ND.2024.pdf
4 https://www.obesityaction.org/wp-content/uploads/ND.2024.pdf

Matt Prokop
Director, State Government Affairs
1 (402) 519-5019 Ext. 5019
mprokop@diabetes.org

NATIONAL TAXPAYERS UNION

Tuesday, January 28, 2025

The Honorable Matthew Ruby
Human Services Committee, North Dakota Legislative Branch
600 East Boulevard Ave
Bismarck, ND 58501

Dear Chairman Ruby and members of the Human Services Committee,

Thank you for the opportunity to provide my perspective on House Bills 1451 and 1452. I write to you in my capacity as Senior Vice President of State Affairs at National Taxpayers Union — the oldest taxpayer advocacy organization in the country, as well as someone who is a former Wisconsin state senator and former pediatric nurse practitioner. My diverse background gives me a unique view of the policy you are discussing today. While NTU has registered today's testimony in support of the legislation, as the following remarks will indicate, an elegant fiscal balance can and should be established that serves taxpayers now and in the future.

As a taxpayer advocacy organization, NTU has engaged state and federal lawmakers on important questions surrounding the fiscal impact of legislation and regulations on the healthcare space. As a former state lawmaker, I know the challenges you face as legislators as you balance the goal of sound public health policy while being accountable to taxpayers. And as a former pediatric nurse practitioner, I have witnessed firsthand the dramatic increase in obesity and chronic illness in our society and am fully aware of the current threats and potential solutions to our nation's health problems.

Recently, NTU submitted comments to the Centers for Medicare and Medicaid Services (CMS) on innovative approaches to reduce health care costs. Please see our comments, which advocate for an informed, measured approach to the deployment of prescription drugs in more settings, specifically the use of Anti-Obesity Medications (AOMs). In this testimony, you will see clear evidence of the prospect of the longer-term economic and fiscal benefits that can occur when people improve their overall health through AOMs.

Estimates published in the New England Journal of Medicine in 2019 projected that 53.9% of North Dakotans would reach an obese condition in 2030. This dangerous and costly

trajectory can and should be addressed by all who are concerned with the public health of your citizens.

As you consider possible solutions to this crisis, please give thoughtful deliberation on how pharmaceutical innovation can both improve patient outcomes and control taxpayer expenditures in government health plan offerings. I have reviewed the fiscal analysis of House Bill No. 1452 and completely understand the reservations that such a note might cause as you consider the legislation.. The $72 million estimate assumes premiums will rise approximately 8% and applies that rate across various insured individuals, but does not include a longer-term calculation of the likely reduction in health care expenditures that may result from the improvement in health outcomes and a decrease in overall obesity rates.

Evidence is mounting that AOMs can, over time, reduce the cost of health care. Such evidence can be found in our CMS comments mentioned above and studies by reputable medical journals such as the Journal of the American Medical Association generally support the notion that weight loss in adults reduces overall health care spending.

If judiciously introduced with an eye toward minimizing administrative burdens and managing government's near-term phase-in costs, these medications can offer the promise of greater public and economic health for your state over the long run. As part of a phase-in, you could set limits every year for the total amount the state will reimburse, or you could begin with a pilot program limited to the most obese and at-risk patients. As market competition starts to drive down the prices of these drugs, you could always widen their availability as the benefits of reduced comorbidities take hold in the obese community. You could also include a per-patient lifetime coverage cap, as well as requirements for patients to participate in counseling to encourage adherence to the treatments instead of wasting money on those who drop out of the regimen prematurely.

It is my sincere hope that you will consider some of the policy suggestions included in this letter as a way to help improve healthcare outcomes for the good people in your state.

Thank you for your time and consideration. Please reach out with any further questions.

Respectfully submitted,

Leah Vukmir
Senior Vice President of State Affairs
National Taxpayers Union
lvukmir@ntu.org

Obesity Action Coalition

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January 28, 2025

North Dakota State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

RE: Support for House Bills 1451 and 1452 to improve access to evidence-based obesity treatments

Dear Representatives Nelson, Mitskog and O'Brien,

The Obesity Action Coalition (OAC) appreciates the opportunity to express support for the advancement and passage of House Bills 1451 and 1452 to amend North Dakota's Century Code, relating to medical assistance prescription drug benefits for obesity medications and to create and enact a new section to chapter 54-52.1 of the Century Code, relating to minimum standards for coverage of obesity medications for state employees.

The OAC is the leading national non-profit organization dedicated to giving a voice to individuals affected by the disease of obesity. We are pleased to express our strong support for passage of House Bills 1451 and 1452, to improve access to prescription drug coverage (obesity medications) for people living with obesity. The OAC proudly serves 230 members living in North Dakota and is backed by more than 85,000 members across the United States.

We applaud these pieces of legislation, as they would improve access to obesity care (obesity medications) and update state policies into alignment with advances in science and clinical standards. We agree that North Dakota medical assistance coverage, including Medicaid, must include comprehensive coverage for the treatment of obesity, which includes coverage for intensive behavioral therapy, metabolic and bariatric surgery, and obesity medications approved by the Food and Drug Administration (FDA). Throughout the past decades, the prevalence of obesity has skyrocketed across our country and in North Dakota – with 36 percent of adults and 15 percent of children (ages 6 - 17) in the state currently affected by obesity.[1]

As you know, obesity is a complex chronic disease driven by strong biology, not by personal choice. A 2023 report found that treating obesity can reduce diabetes (-8.9%), hypertension (-2.3%), heart disease (-2.6%), cancer (-1.3%), and disability (-4.7%) over 10 years in private insurance coverage and Medicare.[2] The same assumptions can also be applied to Medicaid and state employee health plans. This report provides strong evidence to support Medicaid investment in obesity care.

[1] Trust for America's Health, State of Obesity 2024: Better Policies for a Healthier America. https://www.tfah.org/report-details/state-of-obesity-2024/

[2] Alison Sexton Ward, PhD, Bryan Tysinger, PhD, PhuongGiang Nguyen, Dana Goldman, PhD and Darius Lakdawalla, PhD. Benefits of Medicare Coverage for Weight Loss Drugs. USC Schaeffer, 2023.

Obesity Action Coalition

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As a voice for people living with obesity, OAC looks forward to working with the state of North Dakota to ensure Medicaid recipients access to comprehensive obesity care for this complex and chronic disease. We would be happy to meet and share further information and perspectives of people living with obesity. Should you have questions or need additional information, please reach out to our Policy Advisor, Chris Gallagher at chris@potomaccurrents.com. Thank you.

Sincerely,

Joe Nadglowski
President & CEO
Obesity Action Coalition

House Bill 1451

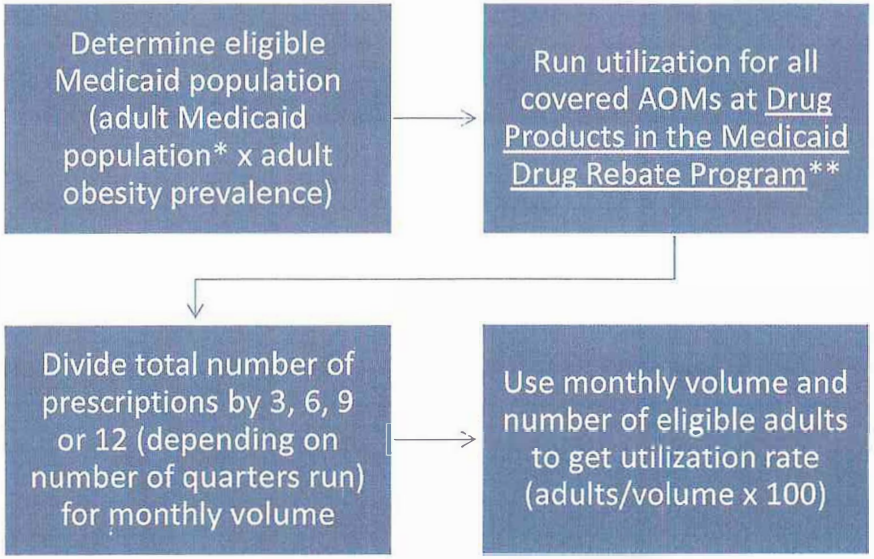
- This bill provides coverage for FDA approved GLP-1s for Medicaid and Medicaid Expansion recipients to treat obesity and obesity related heart disease and to reduce cardiovascular risk;
- The bill states coverage may not be more restrictive than the FDA and allows for cost-sharing options;
    - Currently, 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

Milliman

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).

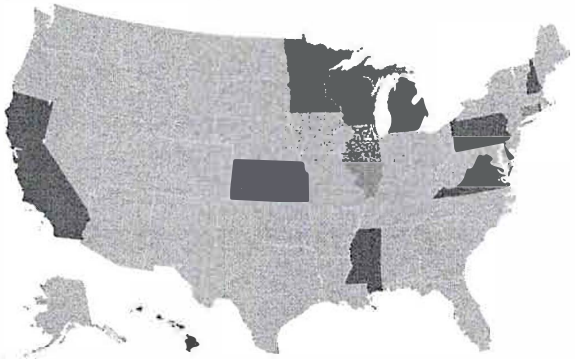
The models rely on data and information as input to the models. We have relied upon certain data and publicly available information, for this purpose and accepted it without audit, though we reviewed for reasonability. To the extent that the data and information provided is not accurate, or is not complete, 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*

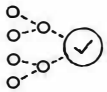
Milliman

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

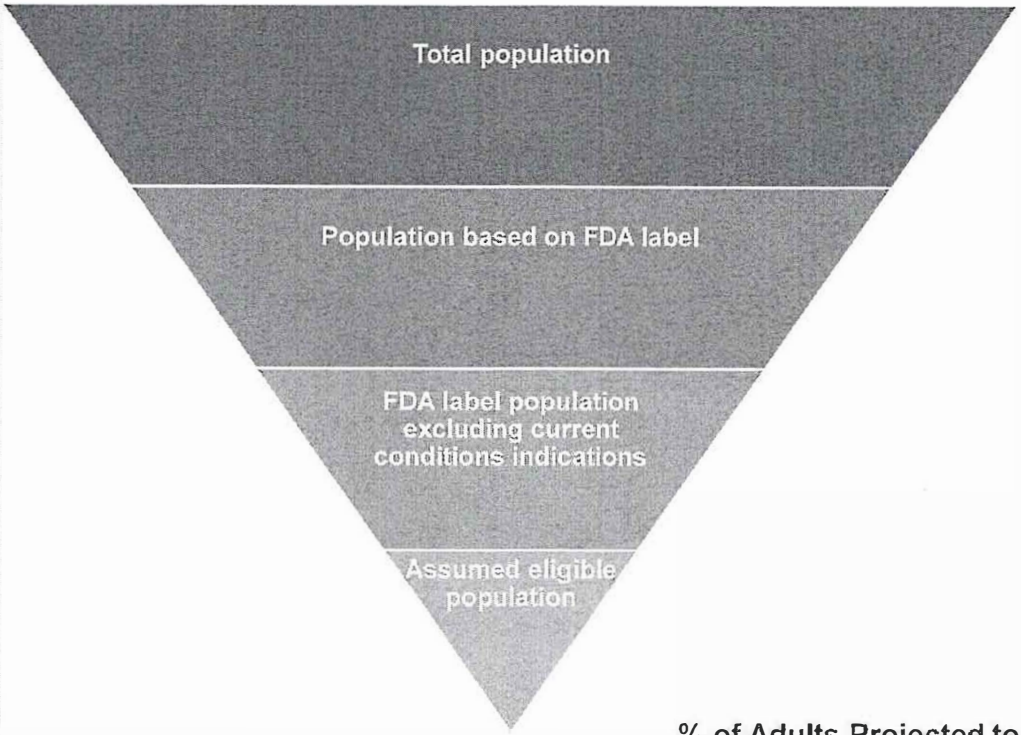


- **Transformed Medicaid Statistical Information System (T-MSIS)**
  - Comprehensive dataset managed by the Centers for Medicare & Medicaid Services (CMS)
  - Captures all individuals who have received Medicaid or CHIP-covered services[1]
  - Relied on data from 2021 to preliminary 2022 (the most recent 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]

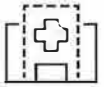
Commercial: 6.1 scripts/year and 42% drop-off[3]

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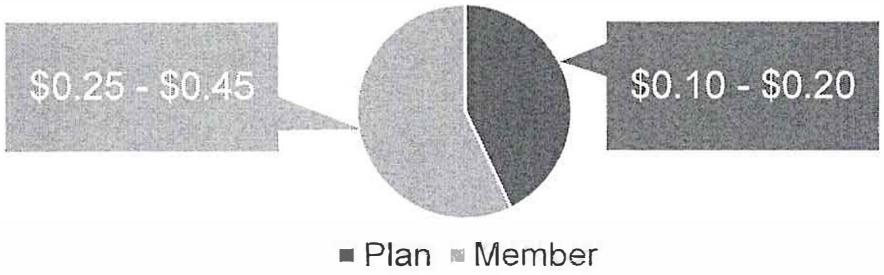
Average Net PMPM Impact to Commercial and Medicaid Markets for Expanded Indications, 2025-2029*

Includes Cost Offsets**

Commercial

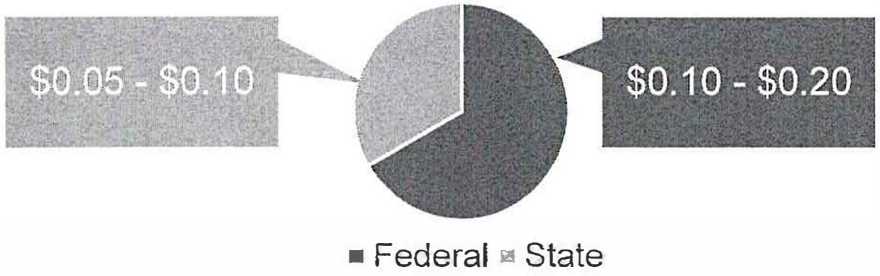
$0.35 - $0.65



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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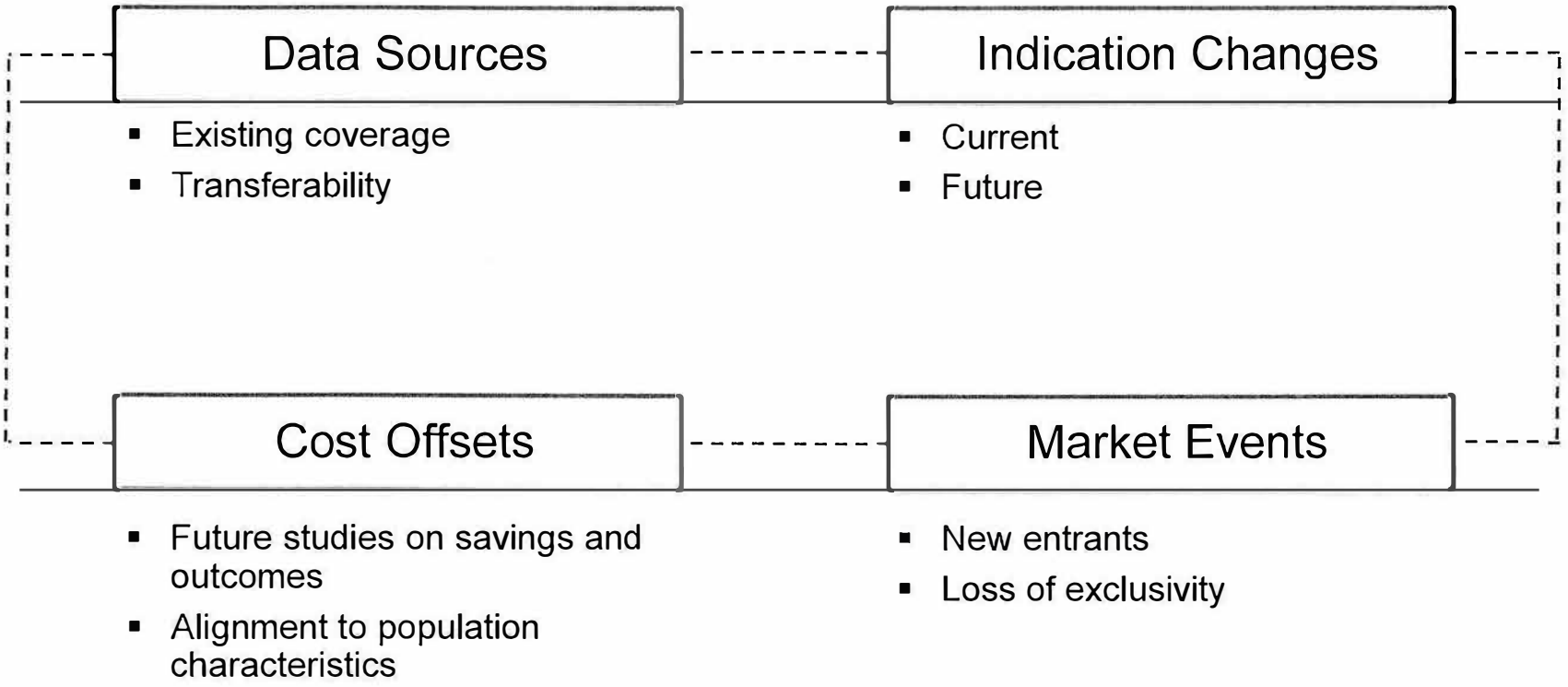
**Reflects an average annual PMPM cost assuming Medicaid enrollment changes consistent with MACPAC Federal estimates (https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected) and a commercial population without membership changes over the five-year time 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



Milliman

Thank you

Kristin Niakan

Kristin.niakan@milliman.com

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1451
2/10/2025

relating to medical assistance prescription drug benefits for antiobesity medication

9:00 a.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Members Absent: Representative K. Anderson

Discussion Topics:

- BMI requirements

9:00 a.m. Lacee Anderson, NovaNordsk, testified in favor and submitted testimony, #36597.

Additional written testimony:
Randy Pate, Principal of Randolph Pate Advisors LLC, submitted neutral testimony, #36522.

Matt Prokop, American Diabetes Association, submitted testimony in favor, #36525.

9:06 a.m. Chairman M. Ruby closed the hearing.

Jackson Toman, Committee Clerk

February 10, 2025

To the Honorable Members of the House Human Services Committee North Dakota State Legislature

Re: Written Testimony on HB 1451

Dear Chairman Ruby and Members of the Committee:

My name is Randy Pate, and I serve as Principal of Randolph Pate Advisors LLC, a consulting practice based in Arlington, Virginia. I previously served as Deputy Administrator of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare & Medicaid Services from 2017 to 2020. I am writing to provide background information regarding HB 1451 that I hope will be helpful as the Committee considers the bill.

In my current work, I have partnered with Novo Nordisk in developing a toolkit of recommendations and considerations for states to expand access to the full range of obesity treatments for patients who need it, including behavioral intervention, anti-obesity medications (AOMs), and surgery. While I accepted Novo Nordisk's edits and comments on the toolkit, I retained final editorial authority over its contents. I would like to share some key data points and analysis that may be helpful to the committee's deliberations.

Projected Health and Economic Burden of Obesity in North Dakota

By 2030, 53.9% of North Dakotans are projected to have obesity, which will contribute to a significant increase in chronic disease prevalence and healthcare costs. A recent Global Data study analyzed the economic and labor force impact of obesity per million U.S. population. When applied to North Dakota, these estimates indicate the state could be losing up to $1.02 billion in economic activity annually due to obesity-related health issues. Furthermore, obesity results in approximately 7,400 fewer adults in the workforce and higher employer healthcare costs totaling $131 million per year in the state.[1]

Expanding AOM Coverage in Medicaid as a Fiscally Responsible Investment

A 2024 Milliman analysis estimates that adding AOM coverage to state Medicaid programs will have a cost impact of $0.04 - $0.07 per member per month (PMPM) with cost offsets, or $0.05 - $0.09 PMPM without cost offsets. These "cost offsets" represent savings generated by reducing obesity-related healthcare costs, including fewer hospital visits, reduced medication costs for

[1] 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. Analysis applies the study's estimated impact per million U.S. population, extending these estimates to North Dakota based on 2020 Census population data. This approach is intended to provide a broad estimate and should be considered illustrative only.

comorbidities like diabetes and heart disease, and lower disability expenditures. These savings help mitigate the overall financial impact on the Medicaid program.[2]

To put this in context, North Dakota Medicaid's average PMPM spending in fiscal year 2023 was $936, of which $64 PMPM was allocated to pharmacy spending.[3] The estimated cost of adding AOM coverage ($0.04 - $0.09 PMPM) represents just 0.004% to 0.01% of total Medicaid PMPM spending, and only 0.06% to 0.14% of current pharmacy PMPM spending. This demonstrates that expanding AOM coverage would likely require a relatively small investment compared to existing Medicaid expenditures while offering significant long-term health benefits.

North Dakota's Leadership in Expanding AOM Coverage

Finally, it is worth noting that North Dakota is among the first states in the country to expand AOM coverage to the ACA-compliant individual and small group health insurance markets by amending its Essential Health Benefits (EHB) benchmark. The actuarial analysis indicates that this change is estimated to increase premiums by less than 1%, further demonstrating that expanding AOM coverage is both affordable and fiscally responsible.[4] This benefit change went into effect for plan year 2025.

Thank you for the opportunity to provide this information to the Committee. The full version of my toolkit, "Broadening Coverage to Combat the Obesity Crisis: A Toolkit for State Innovation," is available online at https://randolphpateadvisors.com/state-options-for-addressing-the-obesity-crisis/.

Respectfully submitted,

Randolph Pate, JD, MPH

Principal

Randolph Pate Advisors LLC

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[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

[3] North Dakota Department of Health and Human Services, Medicaid Spending Report: Fiscal Year 2023 (Legislative Task Force Report, 2024) at 14. https://ndlegis.gov/sites/default/files/pdf/committees/68-2023/25.5159.02000presentation930report.pdf#:~:text=In%20FY%202023%2C%20an%20average,by%20the%20Medicaid%20continuous%20coverage

[4] NovaRest, "North Dakota Essential Health Benefit Benchmark Plan Actuarial Report and Certification," June 2023. https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/North%20Dakota%20EHB-BP%20Update%20PY2025%20-%20Actuarial%20Report%20and%20Certification%209.18.2023.pdf?utm_source=chatgpt.com

February 10, 2025

Chairman Rudy and Members of the House Human Services Committee:

We appreciate the opportunity to provide comments in support of HB 1451.

The ADA's mission is "to prevent and cure diabetes and to improve the lives of all people affected by diabetes." We lead the fight against the deadly consequences of diabetes and advocate for those affected by diabetes.

Obesity continues to be a significant public health epidemic in North Dakota. In North Dakota, 35.6 % of the adult population, have obesity.[1] The North Dakota adult obesity rate is projected to increase to 53.9% by 2030.[2] Obesity is the leading risk factor for type 2 diabetes and is linked to up to 53 percent of new cases of type 2 diabetes each year.[3] There are 200 medical conditions linked to obesity which include heart disease, high blood pressure, and multiple types of cancer.[4]

In addition to the major public health outcomes, obesity leads to significant health care costs. For people with obesity, per-patient-per-year health care expenditures are estimated to be $4,958 greater than for those without obesity.[5]

The American Diabetes Association's (ADA's) *Standards of Care in Diabetes* recognizes obesity as a chronic disease, resulting from a mixture of genetic, environmental, and behavioral factors.

We support comprehensive coverage for obesity treatment. This includes access to person centered interventions, including intensive behavioral and lifestyle treatment, obesity medications, and surgery.

Recent studies have shown that these treatments can lead to improved health.

In November of 2023, a study released in the New England Journal of Medicine showed that Semaglutide can reduce by 20% heart disease risk factors such as cardiovascular deaths, strokes, and heart attacks in people with obesity.[6]

Thank you for the opportunity to provide our testimony. We respectfully ask the committee to support HB 1451.

If you have any questions, please contact me at mprokop@diabetes.org.

Sincerely,
Matt Prokop
Director, State Government Affairs

1 https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-maps.html

2 https://www.nejm.org/doi/full/10.1056/NEJMsa1909301

3 https://diabetes.org/advocacy/obesity

4 https://www.ama-assn.org/topics/obesity

5 https://www.cdc.gov/obesity/adult-obesity-facts/index.html

6 Lincoff, A.M.et al. (2023). Semaglutide and cardiovascular outcomes in obesity without diabetes. New England Journal of Medicine, 389(24), 2221-2232. https://www.nejm.org/doi/10.1056/NEJMoa2307563

25.0748.01001
Title.

Prepared by the Legislative Council
staff for Representative Nelson
February 7, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1451

Introduced by

Representatives Nelson, Mitskog, O'Brien

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance prescription drug benefits for antiobesity medication.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance benefits - Prescription drug coverage - Antiobesity medication.

1. Medical assistance coverage, including Medicaid expansion coverage, must include comprehensive coverage for the treatment of obesity, which includes coverage for intensive behavioral therapy, bariatric surgery, and antiobesity medication approved by the United States food and drug administration for an enrollee with a body mass index of equal to or greater than thirty-five kilograms per square meter. The coverage must include maintenance doses of the antiobesity medication regardless of the enrollee's body mass index.

2. ~~The coverage criteria for antiobesity medication may not be more restrictive than the United States food and drug administration approved indications.~~

~~3.~~ The coverage provided under this section may not be different or separate from coverage provided for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, a benefit year maximum for deductibles, and copayment and coinsurance factors.

~~4.~~3. This section may not be construed to 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, condition, or disorder covered by medical assistance benefits.

~~5.~~4. The department shall provide notice to an enrollee regarding the coverage required by this section. The notice must be:

a. In writing;

b. Prominently positioned in any literature or correspondence; and

c. Provided to an enrollee when annual information is made available to an enrollee, or in another mailing to an enrollee, but no later than December 31, 2025.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1451
2/10/2025

relating to medical assistance prescription drug benefits for antiobesity medication

2:53 p.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman Ruby, Vice-Chairman Frelich, Representatives Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Committee action

2:54 p.m. Representative Holle moved a Do Not Pass.

2:54 p.m. Representative Frelich seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	Y
Representative Jayme Davis	N
Representative Gretchen Dobervich	N
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Nico Rios	Y
Representative Karen Rohr	Y

2:55 p.m. Motion passed 11-2-0.

Representative Holle will carry the bill.

2:55 p.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1451 (25.0748.01000)

Human Services Committee (Rep. M. Ruby, Chairman) recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1451 was placed on the Eleventh order on the calendar.