2025 HOUSE HUMAN SERVICES

HB 1452

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1452
1/28/2025

Relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

9:17 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:

- Antiobesity costs

9:02 a.m. Representative Nelson, District 14, introduced the bill, #32119.

9:18 a.m. Arik Spencer, President and CEO of the Greater North Dakota Chamber, testified in opposition and submitted testimony, #32120.

Additional written testimony:
Brent Hella, Internal Medicine, Weight Loss Physician, IMA Healthcare, submitted testimony in favor, #31506.
Peter Pitts, President, Center for Medicine in the Public Interest, submitted testimony in favor, #31944.
Sara Wiedrich submitted testimony in favor, #32005.
Matt Prokop, American Diabetes Association, submitted testimony in favor, #32024.
Leah Vukmir, Senior Vice President of State Affairs, National Taxpayers Union, submitted testimony in favor, #32031.
Tracy Zvenyach, Director of Policy, Obesity Action Coalition, testified in favor, #32041.
Rebecca Fricke, Executive Director, NDPERS, submitted neutral testimony, #32045. Dylan Wheeler, Head of Government Affairs, Sanford Health Plan, submitted testimony in opposition, #32052.
Michelle Mack, Senior Director, State Affairs, Pharmaceutical Care Management Association, submitted testimony in opposition, #32062.

9:21 a.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

HB 1452
January 28, 2025

Dear North Dakota Legislators,

As a board-certified weight loss physician in North Dakota for the past 20 years, I have witnessed firsthand the challenge obesity poses for our state's residents. The addition of the GLP-1 class of medications over the past 5 year has revolutionized the management of weight loss. These injectable medications offer a highly effective, safe and generally well tolerated tool to combat weight related illnesses (sleep apnea, hypertension, arthritis, chemical dependency?). The high costs however make them inaccessible to many, leaving a gap in care for many who would benefit most.

Beyond weight loss, GLP-1 meds are/will contribute to the improvement in quality of life, mood, self confidence of fellow North Dakotans. Life expectancy and reduction of overall healthcare costs will also likely be a positive outcome. The widespread availability of these treatments through all insurance providers in the state would ensure fairer access.

My main frustration with this class to date been the cost. I would like the State of North Dakota to work with other state agencies to have companies justify the price US patients pay compared to other countries. If this bill is not passed, it is in state's best interest to assure the safety of compounded GLP products many are turning to.

I believe a lifetime cap on these medications and the need for patient accountability is reasonable. We find as patients meet their health/weight goals, these medications in many can be weaned (to every two to three weeks for example). If one's goal weight is achieved and maintained with these medications for between 12-18 months, they often can be safely stopped/weaned/dose decrease and eventually changed to other cheaper maintenance therapies.

Thank you for your time and consideration.

Brent Hella, MD
ima Healthcare
Fargo, ND

RE: House Bill 1452

Testimony of Peter J. Pitts
President, Center for Medicine in the Public Interest
Former FDA Associate Commissioner

Good morning. My name is Peter Pitts. I am the President of the Center for Medicine in the Public Interest and a former Associate Commissioner of the Food and Drug Administration.

New, better medications are the best and swiftest way for this country to cut down on our health care expenses. By more effectively combating disease and improving patients' lives, drugs reduce long-term medical costs and bolster the overall economy.

Nowhere is this more true or urgent than when it comes to battling obesity.

Obesity afflicts 44% of American adults. According to a new article in the New England Journal of Medicine, if 10% of Medicare beneficiaries with obesity used a GLP-1 receptor agonist drug (such as Wegovy, or Ozempic, or Zepbound), the annual cost to Medicare could be as much as $26.8 billion. But the folks at CMS are talking about the costs while remaining silent on the benefits.

Let's look at a more balanced equation.

In 2023, according to the U.S. Joint Economic Committee, obesity caused $5,155 in average excess medical costs per person diagnosed as obese. That's $520 billion in preventable health care costs — an impressive return on investment.

When payors, state, federal, and private look at GLP-1 receptor agonists, they mustn't see only the cost. That's like the FDA reviewing only risks while ignoring benefits when considering new medicines. It must be about value. And when it comes to measuring value, we must embrace a comprehensive view of cost and benefit.

Regarding GLP-1 receptor agonists, the proper denominator isn't cost; it's value. Choosing only to only discuss costs without context is dishonest and deleterious to public health.

This is especially important because obesity rates are higher for lower-income people and in communities of color. Minus a more comprehensive view of costs and benefits relative to new medical technologies such as GLP-1 receptor agonists, we are redlining these populations out of safe and effective treatment options. That's the opposite of health equity.

Many insurance providers (most notably the Centers for Medicare and Medicaid Services) are worried that helping America successfully combat obesity will break the national health care piggy bank. Nothing could be more incorrect and shortsighted.

As Otto von Bismarck said, "Only a fool learns from his own mistakes. The wise man learns from the mistakes of others."

Let's make one thing crystal clear — helping America slim down must be a national priority lest we allow obesity and the diseases that often come with it (heart disease, stroke, diabetes, osteoarthritis, and some cancers, to name a few) to bury us both financially and literally.

Focusing on short-term costs while ignoring long-term benefits (to patients and our national treasury) is ignoring reality. It's worth remembering the wise words of President John Adams, who said, "Facts are stubborn things."

My organization is a 501(c)3, so I am not allowed to suggest that you vote for any specific piece of legislation.

I can, however, in my professional judgement, predict that if House Bill 1452 becomes law, that the people of North Dakota will be healthier and that your overall health care expenses will go down. Both of those things are important – and in that order.

Thank you for the opportunity to testify on this important piece of legislation.

TO: House Human Services Committee
DATE: 1/27/2025
RE: HB 1452

Madam Chair and members of the House Human Services Committee. My name is Sara Wiedrich and I am a family nurse practitioner who specializes in diabetes management. I am writing to express my strong support for House Bill No 1452, relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date

As a nurse practitioner and resident of North Dakota, I believe this legislation is a crucial step toward addressing the growing health crisis related to obesity and its associated diseases.

Obesity is a complex, chronic condition that affects millions of individuals and places a significant burden on both public health and healthcare systems. According to the Centers for Disease Control and Prevention (CDC), in North Dakota, approximately **36.1% of adults** are classified as obese. This rate is above the national average and underscores the urgency of addressing obesity within our state. Despite efforts in diet, exercise, and other lifestyle interventions, many individuals continue to struggle with obesity, often due to factors beyond their control, such as genetics, environment, and metabolism. Antiobesity medications, when used as part of a comprehensive treatment plan, can play a critical role in helping individuals achieve and maintain a healthier weight, which can lead to improved overall health and a reduction in the risk of serious, life-threatening conditions.

Obesity is linked to numerous health conditions, including but not limited to:

- **Heart Disease** (including coronary artery disease)
- **Stroke**
- **High Blood Pressure (Hypertension)**
- **Type 2 Diabetes**
- **Sleep Apnea**
- **Osteoarthritis** (particularly in weight-bearing joints)
- **Fatty Liver Disease**
- **Breast Cancer, Colon Cancer, and Endometrial Cancer**
- **Depression and Anxiety**
- **Infertility and Polycystic Ovary Syndrome (PCOS)**
- **Chronic Kidney Disease**

Unfortunately, for many individuals, the high cost of these medications is a barrier to access. By ensuring that insurance plans cover these treatments, we would make antiobesity medications more accessible to those who need them most, and reduce the long-term healthcare costs associated with obesity-related illnesses.

Obesity affects millions of individuals across all ages and socioeconomic backgrounds in the United States. Beyond its impact on physical and mental well-being, obesity carries a solid financial burden that echoes throughout the nation's healthcare system, economy, and society. **A report released by the Milken Institute in 2020 shows that the annual cost and the economic impact of obesity in the United States exceeds $1.4 trillion**. This number includes costs associated with obesity treatment and obesity-related conditions and costs associated with attendance and productivity at work as they relate to obesity. The specific cost of treating obesity-related conditions in North Dakota isn't widely reported, however we can consider broader trends and estimates for the U.S. as a whole, and apply them to our state for a rough idea.

Obesity-related medical care costs have mirrored the rising rates of obesity in the US. As the disease of obesity continues to impact individuals across the nation, the burden on the healthcare system has become increasingly evident. Individuals with obesity tend to spend more on healthcare compared to those without obesity, primarily due to the increased prevalence of obesity-related health conditions. **According to the CDC, as of 2019, medical costs for adults with obesity were $1,861 higher than those without obesity.**

The costs associated with treating obesity-related conditions are not only a concern for individuals with obesity but also pose a significant financial challenge for the healthcare industry.

The direct costs of obesity primarily revolve around healthcare expenditures, as individuals with obesity are at a higher risk of developing various obesity-related health conditions. These direct costs can include:

- **Medical Treatment:** Medical consultations, diagnostic tests, prescription drugs, and surgical procedures contribute significantly to the direct costs of obesity.
- **Preventive Services:** This includes weight management programs, nutritional counseling, physical activity interventions, and behavioral therapies. The expenses associated with these preventive services add to the direct costs of obesity.
- **Diagnostic Testing:** These tests are necessary to diagnose, monitor disease progression, and evaluate treatment effectiveness, resulting in additional healthcare expenses.
- **Bariatric Surgeries:** These surgeries, including gastric bypass and gastric sleeve procedures, come with significant costs, including pre-operative evaluations, surgical fees, hospital stays, and post-operative care.
- **Medications:** These may include drugs for diabetes, hypertension, dyslipidemia, and other associated diseases. The costs of these medications contribute to the direct expenses associated with obesity.

The secondary costs of obesity extend beyond direct healthcare expenditures and encompass many economic, social, and environmental factors. These costs arise as a result of the widespread implications that obesity has on various aspects of society. Here are some critical secondary costs associated with obesity:

- **Reduced Workforce Productivity:** Obesity can lead to decreased work performance, increased absenteeism, and higher rates of disability. This results in lost productivity for employers, lower economic output, and decreased overall workforce efficiency.
- **Education and Training:** Obesity can adversely affect educational attainment and job training. Individuals with obesity may face challenges accessing quality education and skill development programs, limiting their employment opportunities and potentially requiring additional resources for remedial education.
- **Reduced Quality of Life:** Obesity can have a significant impact on an individual's quality of life, leading to increased healthcare utilization, diminished social interactions, and decreased overall well-being. The associated costs include psychological counseling, social support programs, and reduced life satisfaction.
- **Environmental Impact:** Obesity contributes to environmental costs through increased energy consumption, transportation requirements, and the production of excess waste. This includes higher fuel consumption for transportation, increased greenhouse gas emissions, and waste management expenses associated with excess food consumption.

This information demonstrates the huge financial impact obesity has on both individuals and the healthcare system. Addressing obesity early, through prevention and effective management, could help reduce these costs over time.

I urge you to support this legislation and to consider the positive impact it will have on improving the health and well-being of individuals struggling with obesity. Ensuring insurance coverage for antiobesity medications will not only improve individual outcomes but will also contribute to the broader public health goal of reducing the societal impact of obesity.

Thank you for your time and attention to this important matter. I look forward to seeing the positive changes this legislation will bring about for many individuals and families in North Dakota.

Sincerely,
Sara Wiedrich

RESOURCES:

CDC Obesity Data and Statistics, Updated 1/30/2024. Retrieved from https://www.cdc.gov/obesity/data-and-statistics/index.html

"Weighing Down America: 2020 Update" co-authored by Claude Lopez, Joseph Bendix, and Ken Sagynbekov. Retrieved from https://milkeninstitute.org/content-hub/news-releases/economic-impact-obesity-increased-14-trillion-says-milken-institute

"How Much Does Obesity Cost the US?" Obesity Medicine Association. Retrieved from https://obesitymedicine.org/blog/health-economic-impact-of-obesity/

House Bill 1452
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 1452.

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 1452.

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

Thank you very much for your consideration.

---

[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

4511 North Himes Ave., Suite 250
Tampa, FL 33614

(800) 717-3117
(813) 872-7835
Fax: (813) 873-7838

info@obesityaction.org
www.ObesityAction.org

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

4511 North Himes Ave., Suite 250
Tampa, FL 33614

(800) 717-3117
(813) 872-7835
Fax: (813) 873-7838

info@obesityaction.org
www.ObesityAction.org

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

TESTIMONY OF REBECCA FRICKE

House Bill 1452 – Antiobesity Medication Coverage

Good Morning, Mr. Chairman and members of the committee. My name is Rebecca Fricke and I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appreciate the committee taking the time to analyze House Bill 1452, which requires a pilot program under the NDPERS health insurance related to coverage of antiobesity medication. I am here today on behalf of the NDPERS Board to provide information in a neutral capacity so the policy makers are able to make an informed decision regarding the bill.

House Bill 1452 does the following:

- Enacts a new section to chapter 54-52.1 relating to antiobesity medications
- Requires NDPERS health plan cover at least two antiobesity medications approved by the US Food and Drug Administration (FDA) for chronic weight management in patients with obesity.
    - Coverage criteria for all antiobesity medication may not be more restrictive than FDA approved criteria
    - Coverage may include cost-sharing consistent with other pharmaceutical coverage
- NDPERS must notify policyholders about this coverage:
    - When annual information is made available
    - In any other mailing to policyholders
- Notification must be prominent and in writing
- Under the provisions of NDCC 54-03-28, the bill applies to NDPERS health insurance plan for a pilot program during the 2025-2027 biennium.

Our consultant, Deloitte Consulting, provided analysis which is attached to my testimony: A few overview points include:

- The current NDPERS health insurance plan only provides GLP-1 coverage for individuals diagnosed with diabetes.
- The Bill mandates that cost-sharing be consistent with other pharmaceutical coverage, as well as, that the criteria be at most restrictive as the FDA criteria for medications. Therefore the cost for policyholders on a cost-sharing basis should be affordable but will result in additional costs to the plan.

- With greater access to affordable antiobesity medications, policyholders may be able to better manage obesity and reduce the incidence of obesity-related chronic diseases.
    - However, the antiobesity/GLP-1 market is in an early stage and long-term data and studies remain on the horizon, with long-term effects still evolving.
    - Long-term cost savings are anticipated, but the amounts are unknown with significant uncertainty and may take years to be known.
- The bill stipulates that any two FDA approved antiobesity medications can be covered to satisfy compliance but GLP-1s are becoming the predominant antiobesity medications. Therefore it is likely that GLP-1s will be the antiobesity medication covered by the Program.
    - For their financial analysis, Wegovy and Zepbound were used as they are the two most popular drugs. If other drugs were used in lieu of these two, the costs may be different.
- The bill requires that any and all mailings to policyholders contain prominent notification of this coverage. This would pertain both to mailings that are relevant to prescription drug coverage and those that are not. This could result in administrative impact that could be wide-ranging and extensive.

Deloitte estimates that the bill would have a financial impact on the NDPERS health insurance plan and estimates an increase in premium of approximately 8.3%, or $72,000,000, in the 2025-2027 biennium. The financial impact was derived from a combination of multiple modeling scenarios and underlying assumptions. I encourage you to review Deloitte's analysis to learn more about these and additional factors that may affect the financial impact of the bill.

An amendment, which is attached to this testimony, that we ask be considered is to exclude the NDPERS Medicare Part D Plan. Given retirees pay 100% of the premium, we ask that they be excluded from the pilot program under NDPERS by adopting this amendment.

Mr. Chairman, I appreciate the committee taking the time to learn more about the impact this bill will have to our state. This concludes my testimony, and I'd be happy to answer any questions the committee may have.

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1452

Introduced by

Representatives Nelson, Mitskog

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Antiobesity medication.

1. The prescription drug component of the health insurance benefits coverage must include coverage of at least two antiobesity medications approved by the United States food and drug administration with an indication for chronic weight management in a patient with obesity.
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 be subject to cost-sharing requirements, including a deductible, copayment, coinsurance, or annual or maximum benefit provision, provided the requirements are consistent with requirements applicable to other pharmaceutical coverage under the health insurance benefits coverage.
4. The insurer shall provide notice to policyholders 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 policyholders when annual information is made available, or in any other mailing to policyholders.

5. This section does not apply to the Medicare Part D prescription drug coverage plan.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - PRESCRIPTION DRUG COVERAGE - ANTIOBESITY MEDICATION - REPORT TO LEGISLATIVE ASSEMBLY. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the seventieth legislative assembly to repeal the expiration date for this Act and to extend the coverage of prescription drug benefits for antiobesity medication to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the prescription drug benefits for antiobesity medication requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 3. APPLICATION. This Act applies to health benefits coverage that begins after June 30, 2025, and which does not extend past June 30, 2027.

SECTION 4. EXPIRATION DATE. This Act is effective through June 30, 2027, and after that date is ineffective.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: January 15, 2025

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0747.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data were reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contain errors or anomalies that were unknown at the time the data were provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The current Bill creates and enacts a new section to chapter 54-52.1 of the North Dakota Century Code relating to antiobesity medications.

The proposal stipulates that the Program must cover at least two antiobesity medications approved by the United States Food and Drug Administration (FDA) for chronic weight management in patients with obesity. Coverage criteria for all antiobesity medication may not be more restrictive than FDA approved criteria, and coverage may include cost-sharing consistent with other pharmaceutical coverage.

NDPERS must notify policyholders about this coverage when their annual information is made available, or in any other mailing to policyholders, and the notice must be prominent and in writing.

IMPLICATIONS OF BILL

The intent of the proposed Bill is for the Program to expand access to antiobesity medications for patients with obesity. NDPERS will need to update their policies to ensure compliance, as well as give notice of the updated coverage. This will likely result in increased demand and utilization of these medications by individuals with obesity, which may lead to improved health outcomes over time.

As the Bill mandates that cost-sharing be consistent with other pharmaceutical coverage, as well as that coverage criteria be at most as restrictive as the FDA criteria for these medications, the costs ought to remain affordable for policyholders on a cost-sharing basis in comparison to other pharmaceutical coverage, but will likely result in additional costs to the plan.

With greater access to affordable antiobesity medications, policyholders may be able to better manage obesity and reduce the incidence of obesity-related chronic diseases. By potentially helping with comorbidities, these individuals may see long-term cost savings. Note, however, that the antiobesity/GLP-1 market is in an early stage, where long-term data and studies remain on the horizon, and consensus about long-term effects is still evolving. As such, though long-term cost savings due to weight-loss are anticipated, the amounts are unknown, and significant uncertainty remains. It is assumed that those potential savings would take multiple years (i.e., outside the scope of the 2025-2027 biennium) to materialize. It is also possible that long-term side effects could materialize with costs that may offset any savings attributable to a reduction in comorbidities.

In addition, GLP-1 drugs may receive FDA approval for new indications beyond diabetes or weight management. For example, Zepbound received FDA approval in December 2024 for the treatment of moderate to severe obstructive sleep apnea in adults with obesity. The potential impacts of such indications are not considered in the analysis, given the lack of concrete or predictive data around such alternative indications.

The Program's insurer will have to adjust premiums to accommodate this potential increase in antiobesity drug usage, as well as the potential long-term cost savings from the improved health outcomes. This may be seen through an initial increase in healthcare costs that may be offset by long-term savings through a reduction in obesity-related chronic diseases, though uncertainty surrounding the long-term effects of antiobesity drug usage presents challenges in understanding the magnitude of such offsetting costs.

While the proposal stipulates that any two FDA approved antiobesity medications can be covered to satisfy compliance, GLP-1s are becoming the predominant antiobesity medications. Therefore, it is most likely that GLP-1s will be the antiobesity drugs covered by the Program.

In addition, the Bill mandates that any and all mailings to policyholders contain prominent notification of this coverage. This would pertain both to mailings that are relevant to prescription drug coverage, as well as those that are not. As such, the administrative impact would likely be wide-ranging and extensive.

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated that the proposed legislation will have a financial impact on the Uniform Group Insurance Program. The financial impact was derived from a combination of multiple modeling scenarios and underlying assumptions, as further outlined within this memorandum. For purposes of a fiscal estimate, and given the volatility in the adoption and usage of GLP-1 medications in the future, more conservative modeling assumptions were considered, resulting in a fiscal impact estimate of approximately $72,000,000 (approximately 8.3% of total premium) in the 2025-2027 biennium ending 6/30/3027.

The Uniform Group Insurance Program currently covers GLP-1s solely to treat diabetes. The Program does not cover GLP-1 drugs as antiobesity medications. An internal GLP-1/GIP Drug Claims Cost Model was utilized to estimate the additional cost of covering Severe Obesity on the Uniform Group Insurance Program. The model uses US Census data, as well data and assumptions for GLP-1 drugs published by Harvard, the CDC, and Milliman to estimate the financial impact of GLP-1/GIP drugs. Some of the primary modeling considerations include but are not limited to: population eligible for coverage, utilizers of the treatment, medication adherence rates in the initial year vs. second year, population turnover, treatment cost – inclusive of cost per script and dosage considerations, potential drug price rebates/discounts, and member cost sharing.

Eligible Population

The analysis considered the range of Severe Obesity coverage that would be available to individuals based off the FDA criteria, which has approved the use of GLP-1 drugs for members meeting the definition of obesity (BMI of 30.0 or higher) or that have a BMI of 27.0 with a weight-related health condition.

Assumptions around the population eligible for the benefit were analyzed under varying BMI levels, with further analysis conducted on the utilization rates of the drugs for those that are eligible for the benefit. For example, it is estimated that more than 50% of the North Dakota state population has BMI levels at 27 or higher, whereas approximately 35% of the population has BMI levels of 30 or greater. These estimates can vary by more than 10% if analyzing population averages versus including or excluding outliers (for example, bottom/top 5% of the population). For purposes of the fiscal estimate, analysis of BMI levels of 27.0 or higher were utilized, with varying assumptions on the take-up rate for the treatment.

Utilizers

In consideration of the actual utilizers of the treatment, the modeling analyzed the percentage of potential treatment uptake in year 1, with considerations for treatment adherence in year 1, assumptions for the percentage of users continuing treatment into year 2, treatment adherence in year 2, as well as the impact of population turnover. The analysis considered how those assumptions may vary between the active and retiree populations.

The estimate of total utilizers can vary materially based on the above assumptions. For example, modeling indicates that average duration of treatment could be as low as 6 scripts/year, which could reduce treatment costs by as much as 50% in comparison to 100% adherence. For the analysis, a combination of scenarios was utilized in the development of the total utilizers. Scenarios assuming higher treatment uptake and better medication adherence in year 1 and 2 were selected for purposes of developing the fiscal estimate.

Treatment Costs

The analysis considered the potential impact of rebates/discounts offered to plans to cover GLP-1 drugs for weight loss. For purposes of the fiscal estimate, it is assumed that manufacturers will not fully honor rebate payments. The manufacturer of the GLP-1 drug Wegovy, has publicly stated that if plans cover GLP-1 drugs for weight loss but limit access for coverage, then they may not provide rebates or discounts to plans that limit access. If GLP-1 manufacturers view the FDA coverage criteria as a limit to access, then they may refuse to provide rebates. For example, manufacturers have refused to provide rebates to the State of North Carolina and the University of Texas health plans, which have included limitations to their GLP-1 drug access[1].

Estimated rebates/discounts for GLP-1 drugs can be approximately 40%, if not greater; therefore, the ability for NDPERS to receive rebates on the weight-loss treatment regimens can materially affect the fiscal impact of the Bill. Member cost sharing provisions also impact the potential net

financial cost of the Bill to the Program and was considered in the modeling and development of the estimated treatment costs.

Caveats and Other Modeling Considerations

As noted above, there are a variety of factors that may materially influence the financial impact of the proposed Bill. For purposes of developing a fiscal estimate, more conservative assumptions were utilized. However, the combination of factors and actual implementation of the legislation could result in a range of financial costs, both materially less than or greater than those outlined in this analysis.

In addition to some of the primary modeling assumptions described above, other external factors that could affect the financial impact of the Bill include, but are not limited to:

- Actual BMI demographics of the NDPERS population
- Gender breakdown of eligible members – as treatment take-up rates, medication adherence, and BMI levels typically vary by gender
- Changes in single/family contract distribution and percentage of adults who may be eligible for treatment over the biennium
- The type of GLP-1 drug being used. While Wegovy, Ozempic, and Zepbound are popular drugs, more drugs are expected to be introduced to the market, pending FDA approval. There are over 100 GLP-1 drugs in development, including oral medication. The increase in the number of GLP-1 drugs can impact the overall cost of drugs
- The weight loss that will be sustained by members using GLP-1 drugs
- The dosage of a GLP-1 prescription to treat obesity can be different than the dosage to treat diabetes. This may affect the cost per prescription for a weight loss diagnosis compared to that for diabetes
- The adherence rate for GLP-1 drugs for weight loss may fluctuate compared to diabetes
- GLP-1 drugs for weight loss may lower the impact of other comorbidities for members. Therefore, other medical costs may be avoided as members lose weight when utilizing a GLP-1 drug, though there is considerable uncertainty around the degree to which (or even whether) such long-term health outcomes are realized
- GLP-1 drugs for weight loss are not maintenance drugs. Members may taper off these drugs as they manage their weight. Therefore, the utilization can taper off over time and could lower cost to the plan, though it is possible that members could "rebound" after cycling off such drugs, which would limit cost savings.
- FDA approval for alternate treatment regimens in addition to diabetes and chronic weight management may impact the Program's utilization of GLP-1 drugs and/or the overall cost of drugs as market demand changes and new GLP-1 drugs enter the market

Moreover, the Bill mandates that all mailings to policyholders contain prominent notification of this coverage. This notification requirement is not commonly a requirement for employers and is often a requirement for the plan sponsors. How the notification requirements will be interpreted and implemented is unknown; however, it is likely the administrative impact could be material given the volume of policyholder-facing materials encompassed by this provision. The modeling and fiscal

impact estimate does not include a specific adjustment for this potential administrative change, but should be considered within the context of the aggregate biennium cost and Program impact.

Other Considerations

The preceding analysis was done under the assumption that GLP-1s will be the antiobesity drugs covered by the Program due to their increasing use as antiobesity medications. However, the FDA has approved a total of six antiobesity medications: "orlistat (Xenical, Alli), phentermine-topiramate (Qsymia), naltrexone-bupropion (Contrave), liraglutide (Saxenda), semaglutide (Wegovy), and tirzepatide (Zepbound)."[2] Out of these six drugs, only liraglutide, semaglutide, and tirzepatide are GLP-1s. Setmelanotide (IMCIVREE) is another non-GLP-1 approved by the FDA but is limited to individuals with specific genetic disorders.[2]

This bill's financial analysis considers Wegovy and Zepbound, as these are the two most popular drugs. However, if any of these other drugs were added to the Program's coverage in lieu of Wegovy and Zepbound, then the costs may be different.

Additionally, as mentioned previously, policyholders may see long-term cost savings due to better management of obesity and a potential reduction in the incidence of obesity-related chronic diseases. These potential savings were not fully analyzed and excluded from the fiscal impact estimate. The antiobesity/GLP-1 market is in an early stage, and significant uncertainty and unknowns exist with regard to long-term impacts. While costs savings attributable to improved health outcomes resulting from reduced comorbidities is plausible, it is also possible that long-term side effects materialize whose costs overwhelm any savings realized by improved health outcomes.

---

[1] Business Insider. (2024). "2 major employers said they stopped paying for weight-loss drugs like Wegovy after the drugmaker threatened to penalize them"

[2] National Institute of Diabetes and Digestive and Kidney Diseases. (2024). Prescription Medications to Treat Overweight & Obesity. U.S. Department of Health and Human Services, National Institutes of Health. https://www.niddk.nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity

SANFORD HEALTH PLAN

Chairman Ruby and Members of the House Human Services Committee –

Good Morning, my name is Dylan Wheeler – Head of Government Affairs for Sanford Health Plan; testifying today in opposition to HB1452. As a general standing policy position, Sanford Health Plan opposes coverage mandates – this is due to a number of reasons. Primarily, coverage mandates inevitably lead to increased health insurance premiums – this is due to spreading the cost of the new coverage across the entire health insurance pool. In addition, coverage mandates take away from health plans adapting to consumer and market demands – if cost effectiveness, medical efficacy, and data supported – health plans react to new coverages. On the other hand, health plans may adopt a new coverage to compete in the market and draw new members – offering a distinct plan design and different benefits from a competitor. Coverage mandates take that incentive and innovation out of the market place.

Today, and recognize the bill before committee is limited to the NDPERS health plan, I wanted to address a number of concerns with the proposed coverage mandate for anti-obesity medications. We consistently talk about the rising cost of health care at the Capital – oftentimes specifically talking about the cost of prescription drugs. One of the most volatile, costly, and highly utilized prescription drug on the market today are GLP1 medications; for example, Mounjaro, Wegovy, Ozempic, etc. You may have seen advertisements on TV with a catchy slogan, or seen these endorsed on social media to support weight-loss. One big red flag on this bill is contained on Page 1, lines 21 through 24 and Page 2, lines 1-2. This language would require health plans to tell members in a "prominent position[]" that coverage of these medications is available. Health plans are not advertisers for big pharmaceutical companies – nor should they be. The pharmaceutical industry sees the financial upside of having coverage in a "prominent position" – hence the requirement found in this bill.

Finally, regarding the substance of the bill and some perspective on what this all means. First, this bill calls for coverage for chronic weight management in a patient with obesity. This section lacks clarity as to eligible population. By contrast, the North Dakota Insurance Department recently approved coverage in the ACA marketplace for weight-loss medications for morbid obesity (i.e. BMI of 40 or above). We contend that the decision to cover these in the ACA marketplace – like this very bill – was understudied, underpriced and premature. Consider an example from North Carolina, where, similar to this bill, the North Carolina Public Employees Health Plan started to cover these medications. However, by April, a mere 4 months into coverage, they ceased coverage – citing the astronomical cost and underestimated utilization of these medications. In addition, the clinical efficacy of these medications – both in the near and long term – is not clear. To the contrary, according to a recent study published in the journal JAMA – noted that nearly 30% of patients discontinued use of GLP1 medications, and – importantly, in the trial population, patients had a rapid increase in weight after discontinuing, and also developed worsening cardio metabolic parameters[1]. It seems like each month, there is a new study on the outcomes related to these medications or the FDA is considering a new indication for coverage.

Which leads to the final concern in the bill – Page 1, lines 14-15, require that a health plan cannot have more restrictive criteria than that of the FDA. While the substantive provisions of the bill call for treatment of chronic weight management, the FDA is exploring new clinical indications for these medications. This bill would be on a foundation to grow in terms of required coverage – not just for weight management.

---

[1] *Khan SS, Ndumele CE, Kazi DS. Discontinuation of Glucagon-Like Peptide-1 Receptor Agonists. JAMA. 2025;333(2):113–114. doi:10.1001/jama.2024.22284*

In conclusion, the future of treatment for chronic disease – here, obesity – is on a upward trajectory, which is a great thing. However, pre-emptively covering weight-loss medications at a time when there is no generic competition, substantial financial risk, and lack of long-term empirical evidence, is a questionable approach.

We look forward to learning more about these medications, and how we can partner with employers, families, individuals, policymakers, and all others to take a holistic approach to weight management and consider the role of these medications as part of that equation.

Dylan C. Wheeler

Head of Government Affairs

Sanford Health Plan

State Health Plan

FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

MARCH 7, 2024

Statement Regarding GLP-1 Coverage

At the January 25, 2024, State Health Plan Board of Trustees, the board voted to remove GLP-1 and GIP-GLP-1 agonist medications from State Health Plan coverage for the purpose of weight loss effective April 1, 2024. These medications will still be covered for members managing diabetes. Read on for more information. Scroll to the bottom of this page for RFI Responses.

At the State Health Plan Board of Trustees meeting held on January 25, 2024 (/board-trustees-meeting-materials), the board voted to remove GLP-1 and GIP-GLP-1 agonist medications from State Health Plan coverage for the purpose of weight loss effective April 1, 2024. These medications will still be covered for members managing diabetes.

It is estimated that continuing to cover this class of medications for weight loss would result in a premium increase of $48.50 per subscriber per month, doubling the premium for all individual subscribers, even those not taking these medications.

The cost of these medications was projected to exceed $170 million in 2024, jumping to more than $1 billion over the next six years. This exceeds the amount the State Health Plan spends on cancer, rheumatoid arthritis, and chemotherapy medications.

Further, the State Health Plan faces a $4.2 billion budget gap over the next five years, and the recently enacted budget from the State Legislature funded the Plan by $240 million less than was requested over the next two years.

The State Health Plan simply can't afford these medications at the manufacturer's current price point. Maintaining the current benefit structure for these medications will significantly impair the State Health Plan's strategic financial goals, reduce its solvency for current and future members, and halt the State Health Plan's ability to lower member and family premiums.

Please note that the State Health Plan does cover other weight loss medications: Phentermine, Adipex-P, Orlistat, Qsymia, Benzphetamine, Diethylpropion, and Phendimetrazine and members are encouraged to discuss any change in medications with their provider.

State Health Plan members are encouraged to review all the information related to the recent board meetings on our website (/board-trustees-meeting-materials).

GLP-1 Request for Information

State Treasurer Dale R. Folwell, CPA, and the State Health Plan (Plan) issued a Request for Information (RFI) in April 2024 (https://www.nctreasurer.com/news/press-releases/2024/04/22/treasurer-folwell-and-state-health-plan-issue-request-information-glp-1-drugs), asking the public for help in lowering the cost of GLP-1 drugs for treating obesity. The RFI is the latest attempt by the Plan to find a way to provide these obesity medications for its members in a financially sustainable way. It is estimated that if the Plan's Board of Trustees had continued to cover this class of medications for weight loss it would result in a premium increase of $48.50 per subscriber per month, doubling the premium for all individual subscribers, even those not taking these medications. Currently, the Plan faces a $4.2 billion budget gap over the next five years. The most recently enacted budget from the state legislature funded the Plan by $240 million less than was requested over the budget period.

Treasurer Folwell's Request to the United States Department of Health and Human Services regarding the unaffordability of GLP-1s (/documents/folwell-request-usdhhs-glp1/download?attachment)

Below are the RFI responses the Plan received. The Plan is actively reviewing the responses.

RFI RESPONSES	
INFORMATIONAL RESPONSES	**RESPONSES**
• Alliance for Women's Health & Prevention (/media/3468/download?attachment) • Eli Lilly (/media/3470/download?attachment) • Public Citizen (/media/3473/download?attachment)	• Abacus Health Care (/media/3474/download?attachment) • AmventureX dba Biocoach (/media/3469/download?attachment) • Betr Health (William Ferro) (/betr-health-william-ferro/download?attachment) • Caremark PCS Health, LLC (/media/3475/download?attachment) • Castlight Health (/media/3476/download?attachment) • Compounding Doctors (Mark Anthony Bates) (/compounding-doctors-mark-anthony-bates/download?attachment) • CoreLife (/media/3537/download?attachment)

- Deloitte Consulting (/media/3478/download?attachment)
- Express Scripts (/media/3479/download?attachment)
- Form Health (/media/3471/download?attachment)
- Heuro Health (/media/3481/open)
- Intellihealth (/media/3480/download?attachment)
- MakoRX, OneFul Health Inc and Dooable Health (/media/3463/download?attachment)
- Revelation Pharma Corp 1a (/media/3536/download?attachment)
- Revelation Pharma Corp 1b (/media/3535/download?attachment)
- Sanjeevani Corporation (/media/3534/download?attachment)
- Signature RX (/media/3464/download?attachment)
- Switchbridge (/media/3466/download?attachment)
- TruDataRX (/media/3465/download?attachment)
- Virta Medical (/media/3477/download?attachment)

	• Waltz Health (/media/3467/download?attachment)

January 28, 2025

The Honorable Matthew Ruby, Chair House Human Services Committee
The Honorable Kathy Frelich, Vice Chair House Human Services Committee
North Dakota House Human Services Committee
North Dakota State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **HB 1452 – Relating to Minimum Standards for Coverage of Antiobesity Medication**
PCMA Testimony in Opposition to HB 1452

Dear Chair Ruby, Vice Chair Frelich, and Members of the Committee:

My name is Michelle Mack, and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, they do so because PBMs help lower the costs of prescription drug coverage.

PCMA appreciates the opportunity to provide testimony on HB 1452, a bill that would require health insurance benefits coverage to include at least two (2) antiobeseity medications. PCMA respectfully opposes HB 1452.

About 3.8 million people in the United States — four times the number two years ago — are now taking the most popular weight-loss drugs, according to the IQVIA Institute for Human Data Science, an industry data provider. The medications are injected weekly and have sticker prices as high as $16,000 a year.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

The unfettered price increases of prescription drugs puts patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays, and deductibles. While health plans pay the vast amount of their members' prescription drug costs, drug manufacturers' price increases have forced health plans to create new benefit designs that keep monthly premiums as low as possible—but require some members to shoulder more of the cost before their deductible is met.

Significant changes in benefit design, like those required in this bill, can affect the overall cost of a health plan and, in turn, affect consumers' premiums. Eventually, all members bear these higher costs through higher premium rates.

A competitive private market is the best way to manage drug costs and mandating coverage for plan sponsors reduces competition in the market and increases prices.

It is for these problematic provisions noted above that we must respectfully oppose HB 1452.

Thank you for your time and consideration. Please contact me should you have any questions or concerns.

Sincerely,

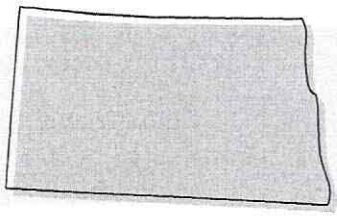
Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

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]

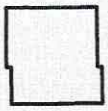
35.2%
Percentage of adults with obesity[2]

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]:



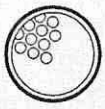
49%
Rolette

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.

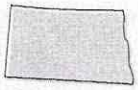
[d]Range is based on class (severity) of obesity.

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.

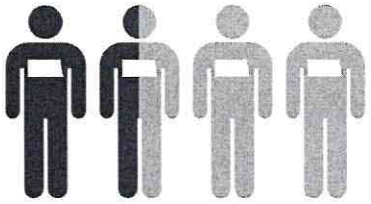
References: 1. U.S. Census Bureau. 2020: ACS 1-year estimates subject tables. Accessed March 31, 2023. https://data.census.gov/table?t=Age+and+Sex&g=0100000US$0400000&y=2021&tid=ACSST1Y2020.S0101&moe=false&tp=true **2.** Nutrition, physical activity, and obesity: data, trends and maps. Centers for Disease 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.

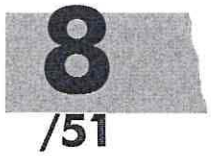
NORTH DAKOTA

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.

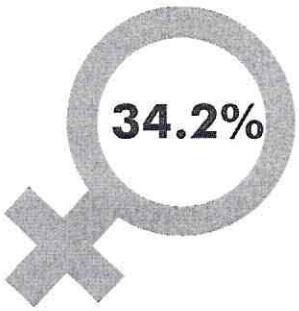
North Dakotans Affected by Obesity by Race

33.1% Caucasians

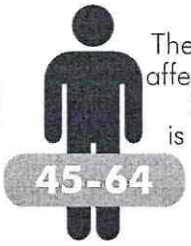
23.5% African Americans

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.

About The OAC

OAC Obesity Action Coalition

The Obesity Action Coalition (OAC) exists to serve the needs of and give a voice to the individuals affected by the disease of obesity while helping them along their journey toward better health through education, advocacy and support.

Please visit www.ObesityAction.org to learn more about the disease of obesity, treatment options, weight bias and much more.

References:

- Centers for Disease Control
- Clinical Chemistry
- Milken Institute
- Obesity Action Coalition
- Trust for America's Health

If you have any questions regarding the above information or if you would like to receive free educational materials on obesity, please contact the OAC National Office at (800) 717-3117 or info@obesityaction.org.

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:

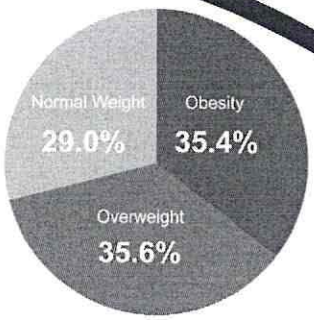
That the Sixty-eighth Legislative Assembly urges the Insurance Commissioner to facilitate a change in the essential health benchmark plan for future Affordable Care Act health plans; and

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/.

[2] Milliman, "Estimating the Impact of Pharmacy Costs on Total Health", May 2019. https://www.milliman.com/-/media/milliman/importedfiles/ektron/estimating-impact-pharmacy-costs.ashx.

NORTH DAKOTA

Obesity Fact Sheet

ADULT OBESITY FACTS:

Obesity affects more than 35.1% of North Dakotans.

8 /51

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

36.0%

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

34.2%

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

14.3% Ages 2-4

13.4% Ages 10-17

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.

About The OAC

OAC
Obesity Action Coalition

The Obesity Action Coalition (OAC) exists to serve the needs of and give a voice to the individuals affected by the disease of obesity while helping them along their journey toward better health through education, advocacy and support.

Please visit www.ObesityAction.org to learn more about the disease of obesity, treatment options, weight bias and much more.

References:

- Centers for Disease Control
- Clinical Chemistry
- Milken Institute
- Obesity Action Coalition
- Trust for America's Health

If you have any questions regarding the above information or if you would like to receive free educational materials on obesity, please contact the OAC National Office at (800) 717-3117 or info@obesityaction.org.

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/

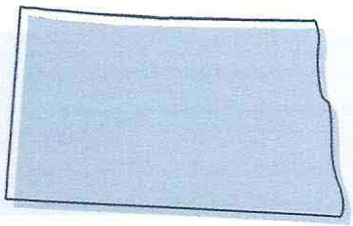
** Ward, Bleich, Cradock, Barrett, Giles, Flax, Long, & Gortmaker, "Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity," https://www.nejm.org/doi/10.1056/NEJMsa1909301

†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.)

†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/.

[2] Milliman, "Estimating the Impact of Pharmacy Costs on Total Health", May 2019. https://www.milliman.com/-/media/milliman/importedfiles/ektron/estimating-impact-pharmacy-costs.ashx.



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/m². Class 2 or 3 obesity is defined as BMI ≥35 kg/m².[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.

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.

Stateline is part of States Newsroom, a nonprofit news network supported by grants and a coalition of donors as a 501c(3) public charity. Stateline maintains editorial independence. Contact Editor Scott S. Greenberger for questions: info@stateline.org.

SHALINA CHATLANI 𝕏

Shalina Chatlani is a a health care and environmental justice reporter for Stateline.

MORE FROM AUTHOR

Greater North Dakota Chamber

GREATER NORTH DAKOTA CHAMBER
HB 1452
House Human Services Committee
Chair Matthew Ruby
January 28, 2025

Mr. Chairman and members of the Committee, my name is Arik Spencer, and I am the President and CEO of the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1452.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing the state government could do to help your business, the top answer was to make healthcare more affordable, not more expensive, which HB 1452 may do in 2027.

Last fall, the Insurance Commissioner approved small group insurance premium increases between 6.3 and 15.3 percent for the 2025 plan year. Healthcare and prescription drug coverage mandates, like HB 1452, increase business burdens and costs. These increases leave employers with hard decisions when it comes to compensation packages. Do they continue offering employer-sponsored health insurance, or do they provide cost-of-living raises to help employees pay for rent and groceries?

The bill's fiscal note validates our cost concerns with an estimated NDPERS premium increase of 8.3%, or $72,000,000, in the 2025-2027 biennium. If this bill were only applicable to state employees, we would not have an issue. We will be the first to say that employers should have autonomy in developing compensation packages. However, this bill specifically includes a requirement that PERS draft a bill for the next legislative session applying this to the private sector.

As drafted, rather than making healthcare more affordable, this will increase costs for businesses by shifting them to the employer. Especially when you consider there are at least five the other bills this session that include mandates that either would or could be applied in the future. These costs add up, and they don't go away.

701.222.0929 ndchamber@ndchamber.com ndchamber.com PO Box 2639 • Bismarck, ND 58502

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1452
2/10/2025

relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

9:06 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:

- Proposed amendments relating to BMI requirements
- Proposed amendments relating to part D programs

9:06 a.m. Lacee Anderson, NovaNordsk, testified in favor and submitted testimony, #36598.

9:12 a.m. Dylan Wheeler, Head of Government Affairs of the Sanford Health Plan, testified in opposition.

9:21 a.m. Derrick Hohbein, Chief Operating and Financial Officer of NDPERS, provided neutral testimony, #36613.

Additional written testimony:
Matt Prokop, American Diabetes Association, submitted testimony in favor, #36526.

9:33 a.m. Chairman M. Ruby closed the hearing.

Jackson Toman, Committee Clerk

February 10, 2025

Chairman Rudy and Members of the House Human Services Committee:

We appreciate the opportunity to provide comments in support of HB 1452.

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 1452.

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

25.0747.01001
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. 1452

Introduced by

Representatives Nelson, Mitskog

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Antiobesity medication.

1. The prescription drug component of the health insurance benefits coverage must include coverage of at least two antiobesity medications, approved by the United States food and drug administration with an indication for chronic weight management in a patient with obesity, 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. ~~3.~~ The coverage provided under this section may be subject to cost-sharing requirements, including a deductible, copayment, coinsurance, or annual or maximum benefit provision, provided the requirements are consistent with requirements

applicable to other pharmaceutical coverage under the health insurance benefits coverage.

~~4.~~3. The insurer shall provide notice to policyholders 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 policyholders when annual information is made available, or in any other mailing to policyholders.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - PRESCRIPTION DRUG COVERAGE - ANTIOBESITY MEDICATION - REPORT TO LEGISLATIVE ASSEMBLY. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the seventieth legislative assembly to repeal the expiration date for this Act and to extend the coverage of prescription drug benefits for antiobesity medication to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the prescription drug benefits for antiobesity medication requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 3. APPLICATION. This Act applies to health benefits coverage that begins after June 30, 2025, and which does not extend past June 30, 2027.

SECTION 4. EXPIRATION DATE. This Act is effective through June 30, 2027, and after that date is ineffective.

TESTIMONY OF REBECCA FRICKE

House Bill 1452 – Antiobesity Medication Coverage

Good Morning, Mr. Chairman and members of the committee. My name is Rebecca Fricke and I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appreciate the committee taking the time to analyze House Bill 1452, which requires a pilot program under the NDPERS health insurance related to coverage of antiobesity medication. I am here today on behalf of the NDPERS Board to provide information in a neutral capacity so the policy makers are able to make an informed decision regarding the bill.

House Bill 1452 does the following:

- Enacts a new section to chapter 54-52.1 relating to antiobesity medications
- Requires NDPERS health plan cover at least two antiobesity medications approved by the US Food and Drug Administration (FDA) for chronic weight management in patients with obesity.
    - Coverage criteria for all antiobesity medication may not be more restrictive than FDA approved criteria
    - Coverage may include cost-sharing consistent with other pharmaceutical coverage
- NDPERS must notify policyholders about this coverage:
    - When annual information is made available
    - In any other mailing to policyholders
- Notification must be prominent and in writing
- Under the provisions of NDCC 54-03-28, the bill applies to NDPERS health insurance plan for a pilot program during the 2025-2027 biennium.

Our consultant, Deloitte Consulting, provided analysis which is attached to my testimony: A few overview points include:

- The current NDPERS health insurance plan only provides GLP-1 coverage for individuals diagnosed with diabetes.
- The Bill mandates that cost-sharing be consistent with other pharmaceutical coverage, as well as, that the criteria be at most restrictive as the FDA criteria for medications. Therefore the cost for policyholders on a cost-sharing basis should be affordable but will result in additional costs to the plan.

- With greater access to affordable antiobesity medications, policyholders may be able to better manage obesity and reduce the incidence of obesity-related chronic diseases.
    - However, the antiobesity/GLP-1 market is in an early stage and long-term data and studies remain on the horizon, with long-term effects still evolving.
    - Long-term cost savings are anticipated, but the amounts are unknown with significant uncertainty and may take years to be known.
- The bill stipulates that any two FDA approved antiobesity medications can be covered to satisfy compliance but GLP-1s are becoming the predominant antiobesity medications. Therefore it is likely that GLP-1s will be the antiobesity medication covered by the Program.
    - For their financial analysis, Wegovy and Zepbound were used as they are the two most popular drugs. If other drugs were used in lieu of these two, the costs may be different.
- The bill requires that any and all mailings to policyholders contain prominent notification of this coverage. This would pertain both to mailings that are relevant to prescription drug coverage and those that are not. This could result in administrative impact that could be wide-ranging and extensive.

Deloitte estimates that the bill would have a financial impact on the NDPERS health insurance plan and estimates an increase in premium of approximately 8.3%, or $72,000,000, in the 2025-2027 biennium. The financial impact was derived from a combination of multiple modeling scenarios and underlying assumptions. I encourage you to review Deloitte's analysis to learn more about these and additional factors that may affect the financial impact of the bill.

An amendment, which is attached to this testimony, that we ask be considered is to exclude the NDPERS Medicare Part D Plan. Given retirees pay 100% of the premium, we ask that they be excluded from the pilot program under NDPERS by adopting this amendment.

Mr. Chairman, I appreciate the committee taking the time to learn more about the impact this bill will have to our state. This concludes my testimony, and I'd be happy to answer any questions the committee may have.

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1452

Introduced by

Representatives Nelson, Mitskog

A BILL for an Act to create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 54-52.1 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Prescription drug coverage - Antiobesity medication.

1. The prescription drug component of the health insurance benefits coverage must include coverage of at least two antiobesity medications approved by the United States food and drug administration with an indication for chronic weight management in a patient with obesity.
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 be subject to cost-sharing requirements, including a deductible, copayment, coinsurance, or annual or maximum benefit provision, provided the requirements are consistent with requirements applicable to other pharmaceutical coverage under the health insurance benefits coverage.
4. The insurer shall provide notice to policyholders 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 policyholders when annual information is made available, or in any other mailing to policyholders.

5. This section does not apply to the Medicare Part D prescription drug coverage plan.

SECTION 2. PUBLIC EMPLOYEES RETIREMENT SYSTEM - PRESCRIPTION DRUG COVERAGE - ANTIOBESITY MEDICATION - REPORT TO LEGISLATIVE ASSEMBLY. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the seventieth legislative assembly to repeal the expiration date for this Act and to extend the coverage of prescription drug benefits for antiobesity medication to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the prescription drug benefits for antiobesity medication requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

SECTION 3. APPLICATION. This Act applies to health benefits coverage that begins after June 30, 2025, and which does not extend past June 30, 2027.

SECTION 4. EXPIRATION DATE. This Act is effective through June 30, 2027, and after that date is ineffective.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA
Tel: 612 397 4000
www.deloitte.com

Memo

Date: January 15, 2025

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0747.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data were reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contain errors or anomalies that were unknown at the time the data were provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The current Bill creates and enacts a new section to chapter 54-52.1 of the North Dakota Century Code relating to antiobesity medications.

The proposal stipulates that the Program must cover at least two antiobesity medications approved by the United States Food and Drug Administration (FDA) for chronic weight management in patients with obesity. Coverage criteria for all antiobesity medication may not be more restrictive than FDA approved criteria, and coverage may include cost-sharing consistent with other pharmaceutical coverage.

NDPERS must notify policyholders about this coverage when their annual information is made available, or in any other mailing to policyholders, and the notice must be prominent and in writing.

IMPLICATIONS OF BILL

The intent of the proposed Bill is for the Program to expand access to antiobesity medications for patients with obesity. NDPERS will need to update their policies to ensure compliance, as well as give notice of the updated coverage. This will likely result in increased demand and utilization of these medications by individuals with obesity, which may lead to improved health outcomes over time.

As the Bill mandates that cost-sharing be consistent with other pharmaceutical coverage, as well as that coverage criteria be at most as restrictive as the FDA criteria for these medications, the costs ought to remain affordable for policyholders on a cost-sharing basis in comparison to other pharmaceutical coverage, but will likely result in additional costs to the plan.

With greater access to affordable antiobesity medications, policyholders may be able to better manage obesity and reduce the incidence of obesity-related chronic diseases. By potentially helping with comorbidities, these individuals may see long-term cost savings. Note, however, that the antiobesity/GLP-1 market is in an early stage, where long-term data and studies remain on the horizon, and consensus about long-term effects is still evolving. As such, though long-term cost savings due to weight-loss are anticipated, the amounts are unknown, and significant uncertainty remains. It is assumed that those potential savings would take multiple years (i.e., outside the scope of the 2025-2027 biennium) to materialize. It is also possible that long-term side effects could materialize with costs that may offset any savings attributable to a reduction in comorbidities.

In addition, GLP-1 drugs may receive FDA approval for new indications beyond diabetes or weight management. For example, Zepbound received FDA approval in December 2024 for the treatment of moderate to severe obstructive sleep apnea in adults with obesity. The potential impacts of such indications are not considered in the analysis, given the lack of concrete or predictive data around such alternative indications.

The Program's insurer will have to adjust premiums to accommodate this potential increase in antiobesity drug usage, as well as the potential long-term cost savings from the improved health outcomes. This may be seen through an initial increase in healthcare costs that may be offset by long-term savings through a reduction in obesity-related chronic diseases, though uncertainty surrounding the long-term effects of antiobesity drug usage presents challenges in understanding the magnitude of such offsetting costs.

While the proposal stipulates that any two FDA approved antiobesity medications can be covered to satisfy compliance, GLP-1s are becoming the predominant antiobesity medications. Therefore, it is most likely that GLP-1s will be the antiobesity drugs covered by the Program.

In addition, the Bill mandates that any and all mailings to policyholders contain prominent notification of this coverage. This would pertain both to mailings that are relevant to prescription drug coverage, as well as those that are not. As such, the administrative impact would likely be wide-ranging and extensive.

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated that the proposed legislation will have a financial impact on the Uniform Group Insurance Program. The financial impact was derived from a combination of multiple modeling scenarios and underlying assumptions, as further outlined within this memorandum. For purposes of a fiscal estimate, and given the volatility in the adoption and usage of GLP-1 medications in the future, more conservative modeling assumptions were considered, resulting in a fiscal impact estimate of approximately $72,000,000 (approximately 8.3% of total premium) in the 2025-2027 biennium ending 6/30/3027.

The Uniform Group Insurance Program currently covers GLP-1s solely to treat diabetes. The Program does not cover GLP-1 drugs as antiobesity medications. An internal GLP-1/GIP Drug Claims Cost Model was utilized to estimate the additional cost of covering Severe Obesity on the Uniform Group Insurance Program. The model uses US Census data, as well data and assumptions for GLP-1 drugs published by Harvard, the CDC, and Milliman to estimate the financial impact of GLP-1/GIP drugs. Some of the primary modeling considerations include but are not limited to: population eligible for coverage, utilizers of the treatment, medication adherence rates in the initial year vs. second year, population turnover, treatment cost – inclusive of cost per script and dosage considerations, potential drug price rebates/discounts, and member cost sharing.

Eligible Population

The analysis considered the range of Severe Obesity coverage that would be available to individuals based off the FDA criteria, which has approved the use of GLP-1 drugs for members meeting the definition of obesity (BMI of 30.0 or higher) or that have a BMI of 27.0 with a weight-related health condition.

Assumptions around the population eligible for the benefit were analyzed under varying BMI levels, with further analysis conducted on the utilization rates of the drugs for those that are eligible for the benefit. For example, it is estimated that more than 50% of the North Dakota state population has BMI levels at 27 or higher, whereas approximately 35% of the population has BMI levels of 30 or greater. These estimates can vary by more than 10% if analyzing population averages versus including or excluding outliers (for example, bottom/top 5% of the population). For purposes of the fiscal estimate, analysis of BMI levels of 27.0 or higher were utilized, with varying assumptions on the take-up rate for the treatment.

Utilizers

In consideration of the actual utilizers of the treatment, the modeling analyzed the percentage of potential treatment uptake in year 1, with considerations for treatment adherence in year 1, assumptions for the percentage of users continuing treatment into year 2, treatment adherence in year 2, as well as the impact of population turnover. The analysis considered how those assumptions may vary between the active and retiree populations.

The estimate of total utilizers can vary materially based on the above assumptions. For example, modeling indicates that average duration of treatment could be as low as 6 scripts/year, which could reduce treatment costs by as much as 50% in comparison to 100% adherence. For the analysis, a combination of scenarios was utilized in the development of the total utilizers. Scenarios assuming higher treatment uptake and better medication adherence in year 1 and 2 were selected for purposes of developing the fiscal estimate.

Treatment Costs

The analysis considered the potential impact of rebates/discounts offered to plans to cover GLP-1 drugs for weight loss. For purposes of the fiscal estimate, it is assumed that manufacturers will not fully honor rebate payments. The manufacturer of the GLP-1 drug Wegovy, has publicly stated that if plans cover GLP-1 drugs for weight loss but limit access for coverage, then they may not provide rebates or discounts to plans that limit access. If GLP-1 manufacturers view the FDA coverage criteria as a limit to access, then they may refuse to provide rebates. For example, manufacturers have refused to provide rebates to the State of North Carolina and the University of Texas health plans, which have included limitations to their GLP-1 drug access[1].

Estimated rebates/discounts for GLP-1 drugs can be approximately 40%, if not greater; therefore, the ability for NDPERS to receive rebates on the weight-loss treatment regimens can materially affect the fiscal impact of the Bill. Member cost sharing provisions also impact the potential net

financial cost of the Bill to the Program and was considered in the modeling and development of the estimated treatment costs.

Caveats and Other Modeling Considerations

As noted above, there are a variety of factors that may materially influence the financial impact of the proposed Bill. For purposes of developing a fiscal estimate, more conservative assumptions were utilized. However, the combination of factors and actual implementation of the legislation could result in a range of financial costs, both materially less than or greater than those outlined in this analysis.

In addition to some of the primary modeling assumptions described above, other external factors that could affect the financial impact of the Bill include, but are not limited to:

- Actual BMI demographics of the NDPERS population
- Gender breakdown of eligible members – as treatment take-up rates, medication adherence, and BMI levels typically vary by gender
- Changes in single/family contract distribution and percentage of adults who may be eligible for treatment over the biennium
- The type of GLP-1 drug being used. While Wegovy, Ozempic, and Zepbound are popular drugs, more drugs are expected to be introduced to the market, pending FDA approval. There are over 100 GLP-1 drugs in development, including oral medication. The increase in the number of GLP-1 drugs can impact the overall cost of drugs
- The weight loss that will be sustained by members using GLP-1 drugs
- The dosage of a GLP-1 prescription to treat obesity can be different than the dosage to treat diabetes. This may affect the cost per prescription for a weight loss diagnosis compared to that for diabetes
- The adherence rate for GLP-1 drugs for weight loss may fluctuate compared to diabetes
- GLP-1 drugs for weight loss may lower the impact of other comorbidities for members. Therefore, other medical costs may be avoided as members lose weight when utilizing a GLP-1 drug, though there is considerable uncertainty around the degree to which (or even whether) such long-term health outcomes are realized
- GLP-1 drugs for weight loss are not maintenance drugs. Members may taper off these drugs as they manage their weight. Therefore, the utilization can taper off over time and could lower cost to the plan, though it is possible that members could "rebound" after cycling off such drugs, which would limit cost savings.
- FDA approval for alternate treatment regimens in addition to diabetes and chronic weight management may impact the Program's utilization of GLP-1 drugs and/or the overall cost of drugs as market demand changes and new GLP-1 drugs enter the market

Moreover, the Bill mandates that all mailings to policyholders contain prominent notification of this coverage. This notification requirement is not commonly a requirement for employers and is often a requirement for the plan sponsors. How the notification requirements will be interpreted and implemented is unknown; however, it is likely the administrative impact could be material given the volume of policyholder-facing materials encompassed by this provision. The modeling and fiscal

impact estimate does not include a specific adjustment for this potential administrative change, but should be considered within the context of the aggregate biennium cost and Program impact.

Other Considerations

The preceding analysis was done under the assumption that GLP-1s will be the antiobesity drugs covered by the Program due to their increasing use as antiobesity medications. However, the FDA has approved a total of six antiobesity medications: "orlistat (Xenical, Alli), phentermine-topiramate (Qsymia), naltrexone-bupropion (Contrave), liraglutide (Saxenda), semaglutide (Wegovy), and tirzepatide (Zepbound)."[2] Out of these six drugs, only liraglutide, semaglutide, and tirzepatide are GLP-1s. Setmelanotide (IMCIVREE) is another non-GLP-1 approved by the FDA but is limited to individuals with specific genetic disorders.[2]

This bill's financial analysis considers Wegovy and Zepbound, as these are the two most popular drugs. However, if any of these other drugs were added to the Program's coverage in lieu of Wegovy and Zepbound, then the costs may be different.

Additionally, as mentioned previously, policyholders may see long-term cost savings due to better management of obesity and a potential reduction in the incidence of obesity-related chronic diseases. These potential savings were not fully analyzed and excluded from the fiscal impact estimate. The antiobesity/GLP-1 market is in an early stage, and significant uncertainty and unknowns exist with regard to long-term impacts. While costs savings attributable to improved health outcomes resulting from reduced comorbidities is plausible, it is also possible that long-term side effects materialize whose costs overwhelm any savings realized by improved health outcomes.

---

[i] This document is intended strictly for the client's internal use and not for any other third party. As such, Deloitte is not, by means of any resulting disclosure or publication of this document, rendering professional advice or services to any third party. This document and its contents should not be used by any third party as a basis for any decision or action. Deloitte shall not be responsible for any loss sustained by any third party who relies on this document or its contents.

About Deloitte: Deloitte refers to one or more of Deloitte Touche Tohmatsu Limited, a UK private company limited by guarantee, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.com/about for a detailed description of the legal structure of Deloitte Touche Tohmatsu Limited and its member firms. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP.

[1] Business Insider. (2024). "2 major employers said they stopped paying for weight-loss drugs like Wegovy after the drugmaker threatened to penalize them"

[2] National Institute of Diabetes and Digestive and Kidney Diseases. (2024). Prescription Medications to Treat Overweight & Obesity. U.S. Department of Health and Human Services, National Institutes of Health. https://www.niddk.nih.gov/health-information/weight-management/prescription-medications-treat-overweight-obesity

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1452
2/10/2025

relating to minimum standards for coverage of antiobesity medication; to provide for a report to the legislative assembly; to provide for application; and to provide an expiration date.

2:56 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

2:56 p.m. Representative K. Anderson moved a Do Not Pass.

2:56 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

2:57 p.m. Motion passed 11-2-0.

Representative Fegley will carry the bill.

2:58 p.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

REPORT OF STANDING COMMITTEE
HB 1452 (25.0747.01000)

Human Services Committee (Rep. M. Ruby, Chairman) recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1452 was placed on the Eleventh order on the calendar.