Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

January 31, 2025

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peña-Melnyk
Chair, House Health & Government Operations Committee
Rm 241, House Office Bldg.
Annapolis, MD 21401-1991

RE: SB 594, Ch. 778/HB 986, Ch. 777 of the Acts of 2024) - Maryland Medical Assistance Program - Coverage for the Treatment of Obesity - Required Study (MSAR# 15768)

Dear Chairs Beidle and Peña-Melnyk:

Pursuant to the requirements of Senate Bill (SB) 594/House Bill (HB) 986, *Maryland Medical Assistance Program - Coverage for the Treatment of Obesity - Required Study* (Chapters 777/778 of the Acts of 2024), the Maryland Department of Health (MDH) respectfully submits this study related to the impact of providing comprehensive coverage for the treatment of obesity.

If further information is needed please contact Sarah Case-Herron, Director, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

Enclosure

cc: Erin McMullen, Chief of Staff
Ryan Moran, Deputy Secretary, Health Care Financing & Medicaid Director
Tricia Roddy, Deputy Medicaid Director
Alyssa Brown, Director of Innovation, Research, and Development
Sandra Kick, Director of Medical Benefits Management
Athos Alexandrou, Director of Pharmacy Services
Sarah Case-Herron, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Maryland Medical Assistance Program - Coverage for the Treatment of Obesity - Required Study

(Chapters 777 and 778 of the Acts of 2024)

Maryland Department of Health

December 2024

Introduction

House Bill (HB) 986/Senate Bill (SB) 594, *Maryland Medical Assistance Program - Coverage for the Treatment of Obesity - Required Study* (Chapters 777 and 778 of the Acts of 2024), requires the Maryland Department of Health (MDH) to submit a study assessing the impact of providing comprehensive coverage for the treatment of obesity within the Maryland Medical Assistance Program (Medical Assistance Program).[1]

As defined in the legislation, comprehensive coverage for the treatment of obesity includes:

1) Intensive behavioral therapy;

2) Bariatric surgery; and

3) United States Food and Drug Administration (FDA)-approved anti-obesity medication, specifically any medication approved by the FDA with an indication for chronic weight management in patients with obesity.

The following report examines the impact of expanding the Medical Assistance Program's current coverage of anti-obesity treatments.

Overview of Medical Assistance Program's Existing Coverage

The Medical Assistance Program provides coverage of bariatric surgery and intensive behavioral therapy for participants who meet certain clinical criteria. Coverage of anti-obesity medications is currently limited to individuals with an obesity diagnosis and certain comorbidities.

Intensive Behavioral Therapy: HealthChoice Diabetes Prevention Program

The HealthChoice Diabetes Prevention Program (DPP) is covered by the Medical Assistance Program's managed care program, HealthChoice.[2] DPP is an evidence-based program established by the Centers for Disease Control and Prevention (CDC) to prevent or delay the onset of type 2 diabetes through lifestyle changes.[3] DPP participants must be between 18 and 64 years old, be overweight or obese (defined by BMI), and have elevated blood glucose levels or a history of gestational diabetes mellitus. A referral is not required to participate in DPP.

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[1] Maryland, General Assembly, Senate. SB 594, *Maryland Medical Assistance Program – Coverage for the Treatment of Obesity – Required Study,* 2024. *Maryland General Assembly*. https://mgaleg.maryland.gov/2024RS/bills/sb/sb0594E.pdf Maryland General Assembly, House. HB 986, *Maryland Medical Assistance Program – Coverage for the Treatment of Obesity – Required Study*, 2024. *Maryland General Assembly*. https://mgaleg.maryland.gov/2024RS/bills/hb/hb0986T.pdf

[2] State of Maryland, Maryland Department of Health, Maryland Medical Assistance Program. *Managed Care Organizations Transmittal No. 133: HealthChoice Diabetes Prevention Program Transmittal No. 1*, 30 Sept, 2019, https://health.maryland.gov/mmcp/Documents/HealthChoice%20DPP/PT%2009-20%20Coverage%20of%20National%20Diabetes%20Prevention%20Program%20for%20HealthChoice%20Enrollees%2C%20Effective%20September%201%2C%202019.pdf

[3] Maryland Department of Health, HealthChoice Diabetes Prevention Program, https://health.maryland.gov/mmcp/Pages/HealthChoice-DPP.aspx

In DPP, a trained lifestyle coach leads CDC-approved lessons in a group setting, in-person or online, over the course of a year. Lessons focus on healthy eating, physical activity, managing stress, and sustainability.[4]

To the extent that a participant requires specialty mental health services related to an eating disorder, such as binge eating disorder, or other behavioral health diagnosis, services are covered by the Medical Assistance Program's Behavioral Health Administrative Services Organization (BHASO).

Bariatric Surgery

Bariatric surgery is covered for participants who meet certain clinical criteria in both the fee-for-service (FFS) program and HealthChoice.[5] An individual must be diagnosed with obesity, defined as having a body mass index (BMI) of ≥ 40 kg/m^2 or ≥ 35 kg/m^2 with at least one comorbidity that is refractory to medical management. Applicable comorbidities include type 2 diabetes mellitus, cardiovascular disease, and clinically significant obstructive sleep apnea. Bariatric surgery must have prior authorization.

Medicaid Coverage for Anti-Obesity Drugs

Overview

State Medicaid Programs administer their pharmacy benefits in accordance with federal statute and in alignment with guidance provided by the Centers for Medicare and Medicaid Services (CMS).[6] Section 1927(d)(2) of the Act allows states to exclude certain drugs including "agents when used for anorexia, weight loss, or weight gain" from Medicaid coverage. In turn, Part D, Medicare's outpatient drug benefit, does not cover drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Historically, drugs used for weight loss have been excluded from the definition of covered Part D drugs, regardless of their use for treatment of individuals with obesity. According to a recent KFF survey, 13 states have voluntarily elected to cover at least one anti-obesity medication for the purpose of treating obesity as of August 2024.[7]

Recent FDA approvals in tandem with proposed rulemaking have shifted the landscape with respect to coverage of anti-obesity drugs in the Medicaid Program.

In early March 2024, the FDA approved a new indication for the use of the anti-obesity medication Wegovy to "reduce the risk of cardiovascular death, heart attack, and stroke in adults with cardiovascular disease and either obesity or overweight."[8] CMS directed state Medicaid Programs to cover Wegovy for

[4] HealthChoice Diabetes Prevention Program Fact Sheet: https://health.maryland.gov/mmcp/Documents/HealthChoice%20DPP/MDH_Medicaid_Healthchoice_Diabetes%20Prevention%20Program_Member_One%20Pager_0821.pdf

[5] Bariatric Surgery (Weight Reduction Surgeries) Clinical Criteria: https://health.maryland.gov/mmcp/Documents/Gastric%20Bypass%20-%20Clinical%20Criteria.pdf

[6] Medicaid Prescription Drugs: https://www.medicaid.gov/medicaid/prescription-drugs/index.html

[7] Medicaid Coverage of and Spending on GLP-1s: https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-and-spending-on-glp-1s/#footnote-644390-1

[8] "FDA Approves First Treatment to Reduce Risk of Serious Heart Problems Specifically in Adults with Obesity or Overweight." *U.S. Food and Drug Administration*, FDA, 8 Mar. 2024,

cardiovascular conditions, and issued guidance regarding coverage through Medicare Part D.[9] The drug must be covered for patients who have cardiovascular disease AND are either obese or overweight. The FDA is expected to approve the anti-obesity medication Zepbound for individuals with obesity and sleep apnea in early 2025.

In November 2024, the Biden Administration announced a new interpretation of the statute prohibiting Medicare coverage of drugs used for weight loss purposes and issued a proposed rule which includes the reinterpretation.[10] If implemented, these changes would require Medicaid and Medicare Part D to cover anti-obesity medications for individuals with an obesity diagnosis. CMS reasons that the reinterpretation of the statutory exclusion of agents when used for weight loss, recognizes "[i]ncreases in the prevalence of obesity in the United States and changes in the prevailing medical consensus towards recognizing obesity as a disease."[11] The proposed rule is open to public comment through January 27, 2025. At the time of the drafting of this report, it is unclear whether the rule will be finalized under the incoming Trump Administration.

Medicare allows for the coverage of drugs that are typically excluded, when they are used to manage specific chronic diseases (e.g., drugs used to treat acquired immunodeficiency syndrome (AIDS) wasting and cachexia). Therefore, by recognizing obesity as a chronic disease, CMS would permit the coverage of anti-obesity medications used to reduce excess body weight or maintain weight reduction for individuals with an obesity diagnosis. Medicare would continue to prohibit coverage of these medications for those without an obesity diagnosis, other FDA-approved indication, or for cosmetic purposes, and coverage by Medicaid for weight loss purposes not tied to an obesity diagnosis would be at state discretion.

The new interpretation, as it applies to Medicaid, would require all state Medicaid Programs to cover anti-obesity medications for individuals with an obesity diagnosis as covered outpatient drugs. If the proposal is finalized, all states, not just the 13 with voluntary coverage today, will need to expand their coverage for these drugs.

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

[9] Part D Coverage of Anti-Obesity Medications with Medically Accepted Indications (March 20, 2024), https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-4-march-18-22

[10] Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P):
https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-and-technical-changes-medicare-advantage-program-medicare-prescription

[11] Federal Register / Vol. 89, No. 237, page 99341:
https://www.govinfo.gov/content/pkg/FR-2024-12-10/pdf/2024-27939.pdf

Anti-Obesity Medications in the Maryland Medical Assistance Program

The Medical Assistance Program covers Byetta, Ozempic, Trulicity, Victoza, Bydureon, Mounjaro, Rybelsus, and Wegovy for FDA-approved indications other than obesity. Byetta, Ozempic, Trulicity, Victoza, Bydureon, Mounjaro, and Rybelsus are all covered when used to treat type 2 diabetes. In March 2024, the FDA approved a new indication for the use of the anti-obesity medication Wegovy to "reduce the risk of cardiovascular death, heart attack, and stroke in adults with cardiovascular disease and either obesity or overweight."[12] Subsequently, in alignment with Medicare and at the direction of CMS, the Medical Assistance Program began to cover Wegovy for participants who are overweight or obese and have cardiovascular disease. MCO coverage was effective September 2024 and aligns with clinical criteria implemented by MDH.[13]

MDH has some pre-existing mitigation strategies for managing the costs of certain drugs, including a risk corridor for high-cost low volume drugs, the hepatitis C risk pool, and a mitigation policy for moderate cost high volume drugs.[14] If coverage is expanded to include anti-obesity drugs, substantial participant demand and need is expected to drive a significant fiscal impact to MDH, and by extension, the MCOs. MDH anticipates it would implement a risk corridor based mitigation strategy in the HealthChoice Program as a result. The structure of the risk corridor is yet to be determined. Examples of existing risk corridors in place for the CY 2025 HealthChoice contract year, where drugs are excluded or included in capitation rates, are summarized below.

- *High-cost low volume drug risk mitigation policy:* Implemented effective January 1, 2021, this policy is designed to protect the HealthChoice program from utilization fluctuations related to very high-cost drugs. The policy covers both Physician Administered Drugs and retail pharmacy drugs that had an expected annual cost of over $400,000 for CYs 2021 to 2023. This threshold was changed to $500,000 for CY 2024.

  Under this mitigation policy, costs of the High-Cost Low Volume drugs are removed from the rate-setting base data and are not included in the standard capitation rate paid to HealthChoice MCOs. The MCOs are still responsible for authorizing, managing, and paying all claims related to the high-cost drugs, and invoice MDH for any incurred expenses on a quarterly basis. The MCOs are expected to develop and adhere to medical necessity criteria to ensure that all instances of utilization of drugs subject to the policy follow best clinical practices. MDH reserves the right to audit medical necessity criteria and review the utilization of all High-Cost Low Volume Drugs to ensure adherence to appropriate criteria.

[12] FDA Approves First Treatment to Reduce Risk of Serious Heart Problems Specifically in Adults with Obesity or Overweight:
https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or

[13] Wegovy Clinical Criteria:
https://health.maryland.gov/mmcp/Documents/Wegovy%20Preauthorization%20Criteria%208_23.pdf

[14] See pages 118-124 of the CY25 HealthChoice Managed Care Organization Agreement:
https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202025%20HealthChoice%20MCO%20Agreement.pdf

- *Hepatitis C risk pool:* The risk pool includes Hepatitis C treatments in the capitation rates while controlling for differences in treatment volume across MCOs. In 2025, the method funds Hepatitis C by including the expenses in the capitation rating cohorts. After the contract period has ended, the Hepatitis C prescriptions provided by MCO will be compared to the amount funded via the capitation rates, and a risk pool will be calculated to protect MCOs from adverse selection. The risk pool will not be budget neutral, meaning that MDH will add/remove dollars to the initial Hepatitis C funding provided via the capitation rates. Additionally, the cost per prescription used in developing the capitation rates will be adjusted via a risk corridor based on the actual cost per prescription for the MCO. The risk corridor is two-sided with a band of +/- 4%. If the amount in capitation for claims is insufficient, MDH will make a payment to the MCO. If the amount in capitation for claims exceeds cost, the MCO will make a payment to MDH. Claims costs are measured after incorporating drug rebates.
- *Moderate Cost High Volume Drug mitigation policy:* This risk corridor includes moderate cost, high volume drugs in the capitation rates while controlling for differences in treatment volume across MCOs for calendar year 2025. GLP-1 prescription drugs for the treatment of diabetes are excluded from this risk corridor. The estimated payment threshold of $30M will be used to incorporate a risk corridor for a drug or a class of drugs. After the contract period has ended, the prescriptions for the drug or class of drugs provided by each MCO will be compared to the amount funded via the capitation rates, and a risk pool will be calculated to protect MCOs from adverse selection. The risk pool will not be budget neutral, meaning that MDH will add/remove dollars to the initial funding provided via the capitation rates. The cost per prescription used in developing the capitation rates will be adjusted via a risk corridor based on the actual cost per prescription for the MCO. The risk corridor is two-sided with a band of +/- 2%. If the amount in capitation for claims is insufficient, MDH will make a payment to the MCO. If the amount in capitation for claims exceeds cost, MDH will make a payment to MDH. Claims costs are measured after incorporating drug rebates

Fiscal Impact Analysis

Overview

MDH partnered with the Hilltop Institute at the University of Maryland, Baltimore County (Hilltop) and MDH's rate-setting actuary, Optumas, to conduct a fiscal analysis of the impact of implementing coverage of anti-obesity medications. As of the time of writing this report, it is unclear whether the proposed rule will be finalized by the incoming administration. As such, this report presents two different fiscal analyses.

The first model assumes that the Biden Administration reinterpretation *will not* be finalized and the Medical Assistance Program will cover anti-obesity medications at state option. In this scenario, the Medical Assistance Program will be responsible for the cost of covering medications to all participants, subject to federal matching funds. This includes participants who are dually eligible for Medicaid and Medicare. Part D coverage would not offset these costs.

The second model assumes that the reinterpretation *will* be finalized and all state Medicaid Programs will be required to cover anti-obesity medications. In this instance, Medicare will cover the medication costs of dually eligible participants. Costs will be subject to federal matching funds. Assumptions of the analysis are discussed below.

MDH notes that costs associated with participants currently using anti-obesity medications for approved indications are excluded from the projections.[15]

Assumptions

Eligible Participants

Current enrollment data for both the FFS program and HealthChoice were trended forward for a state fiscal year (FY) 2026 enrollment projection. As obesity diagnoses are often underreported in claims data, MDH assumed 34.1 percent of participants would be considered obese based on CDC-reported data for Maryland.[16] Participants aged 12 and up were included in projections, aligning with FDA-approved use of anti-obesity medications.

Uptake

Both models present a lower and upper bound. The lower bound assumes a treatment uptake rate of 15 percent while the upper bound assumes a rate of 25 percent. These rates indicate that of 100 obese members, it is projected that between 15 and 25 members will receive treatment for obesity through an anti-obesity medication.

Utilization

The models take into account study findings indicating a high percentage of discontinued treatment among anti-obesity medication users.[17,18] To derive the estimated number of prescriptions or monthly utilization of the medications, Optumas studied calendar year 2022 and 2023 HealthChoice claims data of those participants currently using anti-obesity medications for other indications. Participants averaged 5.3 prescriptions a year, aligning with study findings on discontinued treatment rates.

Cost per Participant

The models assume an average monthly cost of $1,290 per participant. This cost is based on the current average cost per year for anti-obesity medication utilization observed in the Medical Assistance

[15] At the time of the writing of this report, the FDA has not approved the use of Zepbound for individuals with sleep apnea and a comorbid obesity diagnosis. Therefore, these projected costs are incorporated into both Model One and Model Two.
[16] Centers for Disease Control and Prevention. Adult Obesity Prevalence Maps. U.S. Dept of Health and Human Services; 2023: https://www.cdc.gov/obesity/data-and-statistics/adult-obesity-prevalence-maps.html
[17] Treatment Modification After Initiating Second-Line Medication for Type 2 Diabetes: https://www.ajmc.com/view/treatment-modification-after-initiating-second-line-medication-for-type-2-diabetes
[18] 60% of patients stop weight-loss drugs too soon. Here's how to fix that.: https://www.advisory.com/daily-briefing/2024/05/30/weight-loss-drugs

Program.[19] MDH notes that costs may fluctuate depending on the specific prescription. To the extent that utilization favors a certain medication, the cost per participant may shift.

Rebates

As defined by federal statute, brand name drugs are subject to a rebate of 23.1 percent of the Average Manufacturer Price (AMP) or the difference between AMP and the "best price" (i.e. lowest price) of the medication on the market, whichever is greater.[20] For the purposes of this report, the models assume these medications are subject to a statutory rebate of 23.1 percent of AMP. MDH notes that at this time, anti-obesity medications are all brand-name drugs. If generic or bioequivalent medications come on the market, this amount would change. States may negotiate with the manufacturers for supplemental rebates as well. The rebate projections included in the models are for estimation purposes only. Rebate amounts for a specific drug are proprietary and confidential information. In addition, rebates are shared between the federal government and states.[21]

Model One

Model One depicts the total fiscal impact of the Medical Assistance Program covering anti-obesity medications at state option. Fifteen percent uptake results in 42,436 additional participants using anti-obesity medications for the purpose of treating obesity only. This is in addition to those participants already using these medications for other indications and includes individuals eligible for both Medicare and the Medical Assistance Program. Total fiscal impact amounts to $292.5 million. Estimated rebates amount to $67.6 million, resulting in a net total cost of $225.0 million ($132.5 million federal funds, $92.4 million state general funds). Assuming a 25 percent uptake results in 82,558 additional participants using anti-obesity medications, with a total fiscal impact of $569.1 million. Estimated rebates amount to $131.5 million, resulting in net total costs of $437.7 million ($257.8 million federal funds, $179.8 million state general funds).

Table 1. Model One (Medicaid-Only Coverage): Fiscal Impact of Anti-Obesity Medications, FY 2026

	Lower Bound ***15% Uptake***	**Upper Bound** ***25% Uptake***
FY 2026 Projected Enrollment	1,240,000	1,240,000
Total Participants with Obesity Diagnosis	401,223	401,223

[19] Based on calendar year 2021 through 2024 utilization data, Ozempic is the most utilized medication (49 percent), followed by Trulicity (44 percent). Therefore, the costs of these medications have a larger impact on the average cost used in this analysis compared to other medications covered by the Medical Assistance Program.
[20] "Payment for Covered Outpatient Drugs." *Compilation of the Social Security Laws Act §1927*, Social Security Administration, www.ssa.gov/OP_Home/ssact/title19/1927.htm. Accessed 27 Dec. 2024.
[21] Medicaid Drug Rebate Program: https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html#:~:text=These%20rebates%20are%20paid%20by,drugs%20under%20the%20Medicaid%20Program.

Uptake Percentage	15%	25%
Participant Uptake	60,183	100,306
Average Months of Utilization	5.3	5.3
Projected Months of Utilization	321,120	535,200
Monthly Cost per Participant	$ 1,292	$ 1,292
Total Cost	$ 414,894,905	$ 691,491,508
Existing Utilization Cost*	$ 122,350,239	$ 122,350,239
Total Additional Users	42,436	82,558
Total Funds (Cost Increase)	$ 292,544,666	$ 569,141,269
Estimated Rebate Amount	$ 67,577,818	$ 131,471,633
Total Costs (Net Rebate)	$ 224,966,848	$ 437,669,636
Federal Funds	$ 132,527,970	$ 257,831,182
State General Funds	$ 92,438,878	$ 179,838,453

**Based on participants using medications for indications other than obesity.*

Model Two

Model Two demonstrates the fiscal impact of covering anti-obesity medications if the reinterpretation of current federal statute is finalized. Medicare, and thus state Medicaid Programs, would be required to cover anti-obesity medications. In this scenario, Medicare, rather than the Medical Assistance Program, would be responsible for costs associated with dually eligible individuals. At 15 percent uptake, 32,351 additional participants would use anti-obesity medications. Total fiscal impact amounts to $221.0 million. Estimated rebates amount to $51.1 million, resulting in a total net cost of $170.0 million ($106.8 million federal funds, $63.2 million state general funds). Assuming 25 percent uptake results in 65,858 additional participants and total costs of $449.9 million. Estimated rebates amount to $103.9 million, resulting in a net cost of $346.0 million ($217.3 million federal funds, $128.6 million state general funds). MDH notes that there may be a period of time between the finalization of the reinterpretation and Medicare Part D covering the medications. The Medical Assistance Program would be required to cover costs of medications for dually eligible individuals until a new Medicare Part D contract year begins.

Table 2. Model Two (Medicaid and Medicare Coverage): Fiscal Impact of Anti-Obesity Medications, FY 2026

	Lower Bound *15% Uptake*	Upper Bound *25% Uptake*
FY 2026 Projected Enrollment	1,046,000	1,046,000
Total Participants with Obesity Diagnosis	335,069	335,069
Uptake Percentage	15.0%	25.0%
Participant Uptake	50,260	83,767
Average Months of Utilization	5.3	5.3
Projected Months of Utilization	265,754	442,923
Monthly Cost per Participant	$ 1,292	$ 1,292
Total Cost	$ 343,360,502	$ 572,267,504
Existing Utilization Cost*	$ 122,350,239	$ 122,350,239
Total Additional Users	32,351	65,858
Total Funds (Cost Increase)	$ 221,010,263	$ 449,917,264
Estimated Rebate Amount	$ 51,053,371	$ 103,930,888
Total Cost (Net Rebates)	$ 169,956,892	$ 345,986,376
Federal Funds	$ 106,766,920	$ 217,348,642
State General Funds	$ 63,189,972	$ 128,637,735

**Based on participants using medications for indications other than obesity*

Other Considerations

To manage increased utilization of these medications, the Medical Assistance Program may require additional staffing to handle denial reviews. In addition, the Medical Assistance Program's pharmacy benefit manager (PBM) may require additional staffing to review increased prior authorizations specific to anti-obesity medications. To the extent that additional staffing is required, total costs will increase by an estimated $918,421 ($459,211 federal funds, $459,211 state general funds).

Covering anti-obesity medications in the Medical Assistance Program, due to the high cost of individual prescriptions, will have a direct impact on MCO rate setting and capitation. Specifically, MDH will need

to implement a risk corridor with the MCOs. Risk corridors generally enable MDH and MCOs to share in potential savings generated or share in the risk when revenues fall short of expected expenditures.

Research findings to date on the potential for savings associated with use of GLP-1s has been mixed and therefore are not included in MDH's model.[22] A recent study by the pharmacy benefits manager (PBM) Prime Therapeutics found that individuals using anti-obesity medications did not experience a reduction in medical events.[23] Additionally, those using anti-obesity medications for weight management have a higher cost of care in the second year of taking the medications by an average of $4,206, compared to those using the drugs for a diabetes diagnosis. Other research has indicated that not all anti-obesity medications are cost-effective compared to receiving no treatment.[24] In addition, other studies find that cost-effectiveness may increase if medications are used alongside other treatments, rather than using medications alone.[25] Medication adherence may also impact long-term outcomes and savings. Prime Therapeutics found that 85 percent of individuals using anti-obesity medications for weight management were no longer taking the medication after two years.[26] This aligns with earlier research on the use of GLP-1s for diabetes indicating that individuals struggle with long-term medication adherence.[27]

MDH further notes that potential long-term savings are more likely to be realized by Medicare, rather than the Medical Assistance Program. This is due to the fact that the impact of comorbidities that often accompany obesity is typically experienced in the older population.

Conclusion

[22] See e.g., ICER Publishes Evidence Report on Treatments for Obesity Management (August 31, 2022) https://icer.org/news-insights/press-releases/icer-publishes-evidence-report-on-treatments-for-obesity-management/#:~:text=%E2%80%94%20Greater%20weight%20loss%20was%20seen,common%20thresholds%20for%20cost%2Deffectiveness%20%E2%80%94. Finding that "When used for weight loss among patients with obesity (and not treatment of diabetes), semaglutide does not meet typical cost-effectiveness thresholds at its current estimated net price" where the annual expected net price for semaglutide is $13,618 and ICER Health-Benefit Price Benchmark (HBPB) suggesting the highest US price a manufacturer should charge for a treatment, based on the amount of improvement in overall health patients receive from that treatment, is $7,500-$9,800.

[23] Prime Therapeutics GLP-1 research: Year-2 cost of care is $4,200 higher for patients with obesity: https://www.primetherapeutics.com/w/prime-therapeutics-glp-1-research-year-2-cost-of-care-is-4-200-higher-for-patients-with-obesity

[24] Cost-effectiveness analysis of 4 GLP-1RAs in the treatment of obesity in a US setting (February 2022): https://pmc.ncbi.nlm.nih.gov/articles/PMC8904982/. Finding that as "GLP-1RAs are novel medications with high price tags, our results suggest that GLP-1RAS are not economical alternative measures for weight loss" however "modelling results found that Semaglutide (1 mg) was associated with the lowest costs per patient in achieving treatment targets of weight loss among the 4 GLP-1RAs."

[25] Bariatric Surgery Is More Cost Effective Than Newer Weight Loss Drugs Alone: https://www.facs.org/media-center/press-releases/2024/bariatric-surgery-is-more-cost-effective-than-newer-weight-loss-drugs-alone/

[26] Prime continues to lead industry on GLP-1 research: 1 in 7 stays on GLP-1 drugs for weight loss after two years (July 10, 2024): https://www.primetherapeutics.com/w/prime-continues-to-lead-industry-on-glp-1-research-1-in-7-stays-on-glp-1-drugs-for-weight-loss-after-two-years

[27] Treatment Modification After Initiating Second-Line Medication for Type 2 Diabetes (December 2023): https://www.ajmc.com/view/treatment-modification-after-initiating-second-line-medication-for-type-2-diabetes. Finding that 50.3% of patients taking a GLP-1 for diabetes discontinued treatment.

The impacts of anti-obesity medications on the general population and the long-term effects associated with new lines of treatment continue to be researched. The changing landscape of research, FDA approval of new drugs, and market availability may have a great effect on coverage of these medications in the future. MDH will continue to monitor the federal environment as well as coverage in other states moving forward.