Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

March 20th, 2025

Senator Donna Bailey
Representative Lori Gramlich
Members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services
Cross Building, Room 220
100 State House Station
Augusta, ME 04333

Senator Bailey, Representative Gramlich, and members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services;

I am Meg Garratt-Reed, Executive Director of the Office of Affordable Health Care.

Thank you for the opportunity to testify today. While the Office acknowledges the current inequity in access to GLP-1 medications based on cost, we do not believe that a coverage mandate is the right solution, so would encourage members to vote no on this bill. A coverage mandate would eliminate any leverage that insurers and purchasers have to negotiate lower prices for these drugs, and require consumers to bear the burden of whatever price is demanded by pharmaceutical manufacturers in the form of higher premiums.

A study published in early 2024 estimated net (after rebate) prices for the GLP-1s for obesity ranging from $717-761 per month, or $8,500-9,000 per year.[1] Maine is one of 40 states where more than 30% of the population meets the clinical definition of obesity, so providing coverage of GLP-1s to even a fraction of the eligible population could be enormously expensive. North Carolina's state employee health plan recently ceased coverage of GLP-1s for the treatment of obesity after determining that continued coverage of the drugs would require an increase in premiums of nearly $50 per member per month.[2] If this bill passes, small businesses and many individuals in Maine's fully-insured market would likely experience significant premium increases.

While there is reason to believe that the use of GLP-1s for the treatment of obesity could prevent other health conditions and therefore generate savings in the long term, current evidence does not suggest that the cost of the drugs at available price points would be offset by those savings. In 2024 the Congressional Budget Office assessed the fiscal impacts of both costs and savings to the Medicare program from

[1] Hernandez and Sullivan, "Net prices of new antiobesity medications," Obesity, a Research Journal, January 16th, 2024. https://onlinelibrary.wiley.com/doi/full/10.1002/oby.23973
[2] North Carolina State Health Plan, "Statement Regarding GLP-1 Coverage," March 7, 2024. https://www.shpnc.org/blog/2024/03/07/statement-regarding-glp-1-coverage

covering GLP-1s, and found that the increased spending would not be offset by lower spending on other health care services, even though Medicare currently pays less on average for GLP-1s than commercial payers and the analysis assumed lower prices in future years as a result of Medicare drug price negotiations.[3] More recently, researchers from the University of Chicago published findings from a microsimulation model estimating lifetime effects of Semaglutide and Tirzepatide, and their conclusion was that the drugs were not cost-effective at their current price point when considering averted chronic illness and impact on length and quality of life.[4]

Ultimately, the evidence base for these drugs may evolve over the coming years, given that their approval for the treatment of obesity is relatively recent. It is also important to note that all GLP-1 formulations for weight loss were in shortage from 2022-2025, although recently shortages of Semaglutide and Tirzepatide were declared resolved by the FDA early this year. When drugs are in shortage status, there is little incentive for manufacturers to negotiate rebates with purchasers since demand is already outpacing supply. Additionally, there are several additional iterations of GLP-1s in clinical trials at this time, as well as pharmaceuticals with other mechanisms of action for the treatment of obesity which show some promise of equal or greater effectiveness.[5] It may be premature to require coverage of GLP-1s given how the landscape of available treatment and competition may evolve over the coming years.

The Office agrees that the cost of medications should not be a determining factor in access to safe and effective treatments, and would encourage legislators and others to continue to urge the federal government to use its authority to take action to directly reduce the price of prescription drugs. In the absence of that action, the state should consider other means to provide more equitable access to GLP-1s for residents when there is more clarity about how manufacturers will approach market growth in coming years. This could include considering clinical criteria that ensure coverage for specific populations most likely to benefit from the drugs, or requiring coverage when other less-costly interventions have been unsuccessful. Additionally, as more options for treatments become available, the Office would encourage purchasers to consider collaborative efforts to exert leverage in price negotiations, including by pursuing alternative payment models like outcomes-based contracts.

Thank you for your time, and I welcome any questions.

Sincerely,

M. E. Garratt-Reed

Meg Garratt-Reed, Executive Director
Office of Affordable Health Care

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[3] Congressional Budget Office, "How Would Authorizing Medicare to Cover Anti-Obesity Medications Affect the Federal Budget?," October, 2024. https://www.cbo.gov/publication/60816

[4] Hwang, Laiteerapong, Huang, et al, "Lifetime Health Effects and Cost-Effectiveness of Tirzepatide and Semaglutide in US Adults," JAMA Health Forum, March 14th, 2024. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2831205

[5] Melson, Ashraf, Papamargaritis, and Davies, "What is the pipeline for future medications for obesity?," International Journal of Obesity, February 2024. https://pubmed.ncbi.nlm.nih.gov/38302593/