TESTIMONY OF BOB CAREY

SUPERINTENDENT

MAINE BUREAU OF INSURANCE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

In Opposition to L.D. 627

An Act to Require Insurance Coverage for Glucagon-like Peptide-1 Receptor Agonist Medication

Presented by Representative Stover

Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services

March 20, 2025 at 1:00pm

Senator Bailey, Representative Gramlich, and members of the Health Coverage, Insurance and Financial Services Committee, I am Bob Carey, Superintendent of the Bureau of Insurance. I am here today to testify in opposition to LD 627.

Originally prescribed for individuals with diabetes, GLP-1 medications are now widely touted as a weight loss drug. This development has occurred despite the fact that, to date some GLP-1s have not been approved by the Food and Drug Administration (FDA) to treat obesity.

While these drugs have proven beneficial to many, they are a relatively new treatment for weight loss, and their long-term impact remains uncertain. Several

studies have shown that a large percentage of people prescribed these drugs for weight loss do not take them long enough to achieve meaningful benefits. A study by the BCBS Association found that 30% of people discontinued use after the first month and 58% discontinued use before reaching a clinically meaningful level of weight loss. Researchers with Evernorth Research Institute and the University of Pittsburgh Medical Center found that 36% of patients prescribed a GLP-1 for weight loss stopped taking the medication after 3 months and 50% discontinued the drug after 12 months.

Today, these medications cost more than $1,000 per month and are designed to be taken monthly for several years. LD 627 would mandate that these drugs be covered with no guardrails, no ability for insurers to apply prior authorization, and member cost sharing that cannot exceed $35 per script.

The Bureau believes the proposal would add significantly to health insurance premiums for individuals and employer groups that obtain coverage through Maine's fully insured market. This would come at a time when health insurance premiums are increasingly unaffordable. In Maine today, a health plan with a $10,000 deductible costs a family of four over $21,500 in annual premiums.

No state has passed a mandate requiring health plans cover these drugs. In fact, several states – including North Carolina and Colorado – are pulling back on covering these medications for their state employees due to spiraling costs.

Earlier this month, the two largest insurers in Massachusetts – Blue Cross Blue Shield of Massachusetts and Point 32 Health (which includes Harvard Pilgrim Health Care) – reported massive 2024 operating losses due in part to their covering

GLP-1s for weight loss. Blue Cross costs for GLP-1s doubled in one year – from $150 million to $300 million – and are projected to double again in 2025 unless significant changes are made to coverage guidelines for these drugs.

Most commercial insurers in Maine cover GLP-1s for diabetes, but they routinely apply prior authorization controls that limit coverage to policyholders with certain clinical conditions or co-morbidities.

In balancing the potential benefits of this bill in terms of medical treatment versus cost, the Bureau urges the committee to consider the wider impact of state-mandated benefits on the health insurance market. The cumulative costs of all state-mandated benefits can significantly increase the cost of health insurance. In this case, passage of this mandate would – on its own – have a material adverse effect on health insurance premiums.

This cost increase impacts the affordability of health insurance for Maine citizens who have insurance plans regulated by the Bureau. Furthermore, when health insurance costs get too high, more employers may shift to self-funded plans, which are not subject to state-mandated benefits. These self-funded plans are also not subject to consumer protections provided to people enrolled in fully insured plans, and the Bureau has no direct authority to oversee most self-funded plans. In addition, as the cost of fully insured health plans increases, consumers may be tempted to move from the regulated market to sham policies that lure people with low premiums but fail to provide health benefits when policyholders seek care.

As written, LD 627 does not include an exception from the first dollar coverage requirements for health savings account (HSA) qualified high-deductible

health plans as defined in the Internal Revenue Code, Section 223(C)(2). If the Committee moves forward with this bill, it should amend the bill to include an exception for HSA-qualified high-deductible health plans.

If the committee chooses to move this legislation forward, the Bureau requests amending the effective date of the mandate to January 1, 2027 to allow time for implementation and for carriers to price the benefit. We also request removing the requirement for the Bureau of Insurance to complete an education campaign. As a regulatory agency, the Bureau does not have the medical expertise or resources to complete this requirement. If this requirement is passed into law we would need to engage outside consultants, and thus we would request a fiscal note be added to account for the costs incurred by the Bureau of Insurance for the proposed education campaign.

Finally, the Bureau reminds the committee of the requirements of Title 24-A M.R.S. § 2752, which provides for a review and evaluation of a mandated benefit proposal by the Bureau of Insurance before the bill may be enacted. These reviews include an evaluation of the financial impact, social impact and medical efficacy of the mandated benefit. If a report is required it could cost the Bureau up to $20,000 for outside contract consulting work plus staff time, estimated at a cost of $1,600 to collect information, review consultant work, and prepare the final report. We anticipate that current resources will allow us to conduct up to two studies during the current legislative session, and we will need a minimum of eight weeks to complete each report to ensure a high-quality evaluation.

Thank you, I would be glad to answer any questions now or at the work session.