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Testimony In Opposition to LD 627
An Act to Require Insurance Coverage for Glucagon-like Peptide-1 Receptor Agonist Medication
March 20, 2025

Senator Bailey, Representative Gramlich, and Members of the Health Coverage, Insurance, and Financial Services Committee.

My name is Dan Demeritt, the Executive Director of the Maine Association of Health Plans. Insurance coverages offered or administered by our member plans provide access to care and better outcomes for many of the Mainers who receive coverage through an employer plan or the individual market. Our mission as an association is to improve health by promoting affordable, safe, and coordinated health care.

The Maine Association of Health Plans is opposed to LD 627 and provides the following information on existing coverage, costs, and the policy deficiencies of the bill as drafted.

GLP-1 Expanding Coverage and Costs

Commercial Plans Provide Medically Necessary Coverage For GLP-1s
FDA-approved GLP-1 receptor agonist medications are generally covered for a growing list of medically necessary conditions including diabetes and cardiovascular disease. Utilization management tools like prior authorization and step therapy and tying coverage to other treatments are essential in helping to improve outcomes and control costs.

Weight Loss Coverage Limited / Excluded in Private and Public Plans
Most private health plans are not required to cover medications solely for weight loss due to the high cost and because there is limited research on the long-term clinical benefit of taking them.

- $35 Billion in Projected Medicare Costs: Medicare is currently prohibited by federal law from covering weight loss agents in its Part D program. The CBO projects a $35 billion spending increase over ten years if weight loss agents are added.

  The CBO Medicare projections forecast only $650 in health-related savings and $4,300 in direct federal cost for each user of anti-obesity medications.[1]

- Medicaid Coverage in 13 States: The Social Security Act makes coverage for weight loss agents optional under state Medicaid programs. National Medicaid spending on GLP-1s increased by over 500% between 2019 and 2023.[2]

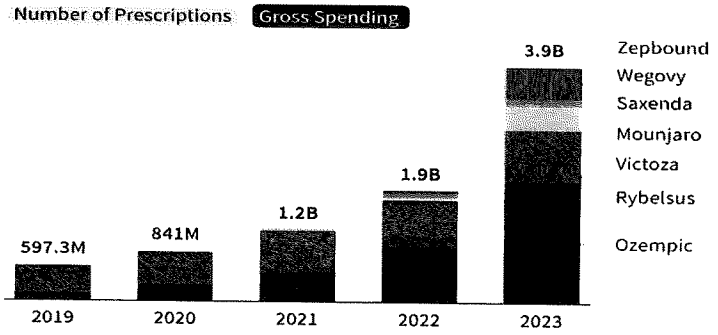
[1] https://www.cbo.gov/system/files/2024-10/60441-medicare-coverage-obesity.pdf

[2] https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-and-spending-on-glp-1s/, accessed March 17, 2025

Figure 2

Medicaid Prescriptions and Gross Spending on GLP-1s has Increased Rapidly in Recent Years

Gross Medicaid spending on select GLP-1s (glucagon-like peptide-1s)



Note: Gross spending is Medicaid spending before rebates. This includes GLP-1s approved for obesity treatment (Saxenda, Wegovy, and Zepbound) and corresponding formulations approved to treat type 2 diabetes (Ozempic, Rybelsus, Victoza, and Mounjaro). State Medicaid coverage of obesity medications is limited, but drugs to treat type 2 diabetes would be covered by Medicaid in all states (see "Medicaid Coverage of and Spending on GLP-1s" for more information).

Source: KFF analysis of 2019-2023 State Drug Utilization Data, accessed October 2024. KFF

$53 Million MaineCare GLP-1 Projection for 2027: Testimony from the Maine Department of Health and Human Services opposing GLP-1 coverage in MaineCare is included. The bill that was before the Health and Human Services Committee is more restrictive than LD 627, limiting prescribers to primary care providers or bariatric specialists and requiring prior authorization.

The Committee voted LD 480 "Ought Not to Pass" on March 11.

Costs Force States to Rescind Coverage: Colorado, North Carolina and West Virginia have already eliminated coverage in their state employee plans over cost concerns with states like Connecticut, Delaware, and New Mexico struggling to cover skyrocketing costs.[3] [4]

Massachusetts is making it clear to carriers that coverage for GLP-1 for weight loss is at their discretion in state-regulated plans.[5]

Policy Deficiencies in LD 627 as Drafted

No Coverage Limits -- Sec. 1. Proposed 24-A MRSA §4320-W(1,2) Requires state-regulated health plans to provide coverage for any GLP-1approved by the FDA prescribed by a health care provider without defining the covered condition or references to medical necessity as defined in Title 24-A §4301-A.

[3] https://www.politico.com/news/2025/02/12/ozempic-state-budgets-00202932

[4] https://www.multistate.us/insider/2025/3/17/glp-1-weight-loss-drugs-coverage-under-medicaid-and-other-health-plans

[5] https://www.mass.gov/doc/filing-guidance-notice-2025-h-coverage-of-glp-1-drugs/download

Higher Premiums and Cost Shifting -- Sec. 1. Proposed 24-A MRSA §4320-W(3): Limiting costs shares to out-of-pocket costs to $35 per 30-day supply will drive up premiums and shift the cost to other members.

No Ability to Manage Utilization – Sec. 1. Proposed 24-A MRSA §4320-W(4): Prohibiting prior authorization prohibits carriers from ensuring the prescribed medication is based on medical necessity. Carriers would also lose the ability to link coverage to additional treatments and therapies proven to improve outcomes. Prohibiting prior authorization could also lead to overprescribing or misuse, resulting in higher overall healthcare costs and strain on the healthcare system.

Section 2. Unallocated Language – Education Campaign: The top three pharmaceutical advertisers spent a collective $8.2 billion promoting their products in 2023.[6] A state-funded education campaign is an inappropriate role for the Bureau of Insurance and could further increase prescription drug consumerism.

Section 3. Application: Carriers are already developing their rates and products for the plan year beginning January 1, 2026. The effective date would need to be moved back to the start of 2027 for plans to account for the significant cost of this mandate in member premiums.

Mandate Study and State Defrayal Projections

LD 627 would be a new state mandate that is not a part of Maine's Essential Health Benefits. If the Committee has an interest in the proposal, it should request a mandate study by the Bureau of Insurance to help determine the premium impact, defrayal projections, medical efficacy, and the social and economic impacts of this proposal.

We strongly encourage a vote of ought not to pass on this proposal.

[6] https://www.statista.com/statistics/1411882/pharma-marketing-spend-worldwide/

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Testimony of the Maine Center for Disease Control
Maine Department of Health and Human Services

Before the Joint Standing Committee on Health and Human Services

In opposition to LD 480, *An Act to Support Healthy Weight by Providing MaineCare Coverage for Certain Weight Loss Medications*

Sponsor: Representative Graham
Hearing Date: March 4, 2025

Senator Ingwersen, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, my name is Courtney Pladsen and I serve as the Medical Director of the Office of MaineCare Services in the Maine Department of Health and Human Services. I am here today to testify in opposition of LD 480, *An Act to Support Healthy Weight by Providing MaineCare Coverage for Certain Weight Loss Medications.*

This bill seeks to require the Department of Health and Human Services (the "Department") to provide reimbursement under the MaineCare program for glucagon-like peptide-1 receptor agonists, referred to as GLP-1s, approved by the federal Food and Drug Administration (FDA) for the treatment of obesity. The bill requires the Department to restrict reimbursement to medications prescribed by a primary care provider or a bariatric specialist and requires prior authorization of the medication.

GLP-1s have been shown to be effective in treating several chronic conditions and show promise in addressing others. Current FDA-approved uses include treatment of diabetes, sleep apnea, chronic kidney disease, and obesity. MaineCare is required by federal law today to cover most FDA-approved drugs and already covers GLP-1s for the treatment of diabetes; as required by federal law, MaineCare also plans to cover the newly FDA-approved uses for the treatment of sleep apnea and chronic kidney disease. In the next year, three additional indications will likely receive FDA approval, including Congestive Heart Failure, Metabolic-Dysfunction Associated Steatohepatitis, and Alzheimer's. MaineCare will then cover GLP-1s for these indications as required by federal law.

However, coverage of FDA-approved drugs for treatment of obesity is currently an optional Medicaid benefit under federal law, and as of today, only 13 states have implemented this coverage. The Department has invested significant time exploring the use and coverage of GLP-1s for treatment of obesity under the MaineCare program. Our conclusion is that the cost of adding this coverage is prohibitive: after applying eligible drug rebates, the Department estimates coverage of GLP-1s for the treatment of obesity would cost over $42 million in State Fiscal Year (SFY) 2026 and $53 million in SFY 2027; general funds would make up $14.5

million and $18.4 million of these totals respectively. These estimates are consistent with information from the National Association of Medicaid Directors (NAMD), which noted that at least one state has reported $15 million in Medicaid expenses in a single fiscal quarter. Requiring MaineCare to cover GLP-1s for treating obesity would have a significant fiscal impact; this is untenable given MaineCare's current budget shortfall.

Studies have found that most individuals using GLP-1s for treatment of obesity did not stay on their prescribed treatment for the recommended minimum of 12 weeks, suggesting that they were unlikely to achieve clinically meaningful weight loss. Patients who were prescribed GLP-1s by providers with expertise in weight management and obesity, like endocrinologists and obesity specialists were more likely to complete 12 weeks of treatment. Primary care providers often do not have the training or resources to support patients with the necessary lifestyle modification education to prevent weight gain after discontinuing a GLP-1. A randomized placebo-controlled study evaluated the use of GLP-1s alone vs GLP-1s paired with an exercise program. A year after discontinuing the GLP-1s, individuals who were treated with medication alone regained on average 20 pounds, compared to only five pounds in the group who were also treated with an exercise program. The Department anticipates the coverage of GLP-1s will result in an increased demand for endocrinologists and obesity specialists, both a limited specialty type in Maine.

Finally, there is significant administrative expense associated with adding this coverage. This includes the cost and effort of establishing and implementing prior authorization policies and procedures and ensuring appropriate related staffing; pharmacy benefit system configurations to accommodate new reimbursement; and additional staff support to meet expected increased demands of MaineCare's Pharmacy Help Desk as members inquire about coverage. The Department would also need to request necessary state plan amendments from the Centers for Medicare & Medicaid Services and adopt routine technical rules upon federal approval. NAMD has estimated that implementing coverage of GLP-1s for the treatment of obesity would require at least two years for most states.

While the Department will continue to cover the use of GLP-1s for the treatment of diabetes, sleep apnea, and chronic kidney disease, and any new federally required indications, the Department believes reimbursement of GLP-1s for the purpose of treating obesity is not warranted at this time. To realize the full benefits of GLP-1s for both individuals and for the broader population health, other changes in our healthcare system are necessary. Adding coverage to these drugs alone, without strengthening the provider network for endocrinologists and obesity specialists and without improving access to nutrition education and exercise programming, will not improve health outcomes or produce cost savings.

Thank you for your time and attention. Considering the intricate nuances of GLP-1 drugs and the Department's extensive work to evaluate appropriate use, I appreciate this opportunity to provide clarifying information to the committee. I would be happy to answer any questions you may have and to make myself available for questions at the work session.