Individual State Agency Fiscal Note

Bill Number: 6182 SB	Title: Obesity Rx coverage	Agency: 107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Operating Expenditures from:

Non-zero but indeterminate cost and/or savings. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Julie Tran	Phone: 360-786-7283	Date: 01/16/2024
Agency Preparation:	Sue Eckroth	Phone: 360-725-1899	Date: 02/01/2024
Agency Approval:	SUMAN MAJUMDAR	Phone: 360-725-1319	Date: 02/01/2024
OFM Review:	Jason Brown	Phone: (360) 742-7277	Date: 02/06/2024

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Significant provisions of the bill and any related workload or policy assumptions that have revenue or expenditure impact on the responding agency by section number.

Please see attached narrative.

II. B - Cash receipts Impact

Cash receipts impact of the legislation on the responding agency with the cash receipts provisions identified by section number and when appropriate, the detail of the revenue sources. Description of the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explanation of how workload assumptions translate into estimates. Distinguished between one time and ongoing functions.

II. C - Expenditures

Agency expenditures necessary to implement this legislation (or savings resulting from this legislation), with the provisions of the legislation that result in the expenditures (or savings) identified by section number. Description of the factual basis of the assumptions and the method by which the expenditure impact is derived. Explanation of how workload assumptions translate into cost estimates. Distinguished between one time and ongoing functions.

Part III: Expenditure Detail

III. A - Operating Budget Expenditures

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. B - Expenditures by Object Or Purpose

Non-zero but indeterminate cost and/or savings. Please see discussion.

III. C - Operating FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.*

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout

Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: *FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.*

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

HCA Fiscal Note

Bill Number: **SB 6182** HCA Request #: 24-063 Title: **Obesity Rx Coverage**

Part I: Estimates

☐ No Fiscal Impact

Estimated Cash Receipts to:

NONE

Estimated Operating Expenditures from:

NONE

Estimated Capital Budget Impact:
NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Part II: Narrative Explanation

This bill provides prescription drug coverage for the treatment of obesity.

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Section 2 adds a new section to RCW 41.05 (State Health Care Authority) requiring any health plan offered to public employees and their covered dependents for plans renewed on or after January 1, 2025 to provide prescription drug coverage for glucagon-like peptide 1 agonists (GLP-1s) and other similar medications when prescribed by a health care provider for the treatment of obesity.

- Members must be determined to be obese or have a body mass index (BMI) value of at least 27 with at least one weight-related medical condition.
- "Obesity" is defined as a member with a BMI value of 30 or more.

Section 3 adds a new section to RCW 74.09 (Medical Care) requiring the Health Care Authority (HCA) to ensure that Medicaid managed care organizations provide prescription drug coverage for GLP-1s and other similar medications when prescribed by a health care provider for the treatment of obesity if the patient is determined to be obese, defined by a body mass index of 30 or more, or has a body mass index value of at least 27 with at least one weight-related medical condition.

II. B - Cash Receipts Impact

None

II. C – Expenditures

Fiscal impact is indeterminate but is expected to be significant.

This bill requires HCA's Public Employees Benefits Board, School Employees Benefits Board, and Apple Health programs to cover GLP-1s and other similar medications for the treatment of obesity if the patient is determined to be obese, defined by a body mass index of 30 or more, or has a body mass index value of at least 27 with at least one weight-related medical condition. Given the high cost of the relevant drugs and the large volume of potential eligibles, the fiscal impact of the proposed policy change is expected to be quite significant. While the fiscal impact is indeterminate, HCA projects that the potential impact could range between $1.7 billion to $3.1 billion annually.

Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) Programs

Fiscal impact is indeterminate but is expected to be significant.

HCA estimates that this bill would result in a significant claims liability in UMP, resulting in an impact to the state's contribution toward medical benefits for employees under the PEBB and SEBB programs (Employer Medical Contribution, or EMC) and retiree premiums.

Section 1 adds a new requirement to RCW 41.05 that requires PEBB and SEBB fully insured health plans and the state's self-insured Uniform Medical Plan (UMP) to provide coverage of glucagon-like peptide 1 agonists (GLP-

1s) for the treatment of obesity. Currently, all PEBB and SEBB plans do not provide coverage of GLP-1s for the treatment of obesity; expansion of coverage requirements for these drugs is assumed to result in significant cost impacts.

Self-insured plan impact and state costs

The Uniform Medical Plan (UMP) is the state's self-insured health plan, governed under RCW 41.05 (State health care authority). The pharmacy benefit for the UMP is administered by Moda. GLP-1s are currently not covered for the indication applied in this bill, therefore there are two main cost implications facing the UMP should this legislation pass as written:

Increased Prior Authorization (PA) costs

HCA assumes this legislation does not prohibit UMP from requiring prior authorization (PA) of weight loss medications for the treatment of obesity to ensure medical necessity, as defined under section 1 of this bill, when a member requests a prescription for a GLP-1 or non-GLP-1 weight loss medication. As a component of Moda's pharmacy benefit relationship (PBM) for UMP, Moda charges $50 per PA review. This cost analysis assumes PA would be required for GLP-1 and non-GLP-1 product coverage determination in UMP. Prior authorization costs are paid out of fund 439 (Uniform Medical Plan Benefits Administration Account) and fund 494 (School Employees' Benefits Board Medical Benefits Administration Account).

Increased claims liability

UMP claims liability is assumed to increase significantly resulting from both the projected increase in utilization of GLP-1 and similar products and the associated cost of these medications. Increases to UMP claims liability will impact fund 721 (Public Employees' and Retirees' Insurance Account) and fund 493 (School Employees' Insurance Account).

Unit cost of weight loss medications in UMP

For the purposes of this analysis, the assumed net-of-rebate unit cost for GLP-1 products is approximately $1,080 per utilizing member per month. Non GLP-1 products authorized for use by the Food and Drug Administration (FDA) for weight loss are generally much lower in cost and are not assumed eligible for rebate, with unit costs ranging from less than $50 per month to approximately $620 per month; for the purposes of this cost analysis, it is assumed the average unit cost of a non-GLP-1 product is $120 per utilizing member per month.

Utilization assumptions

According to the Centers for Disease Control (CDC), approximately 32% of Washington adults and 11.4% of children enrolled in commercial plans are considered obese (defined as having a BMI of > 30 for adults or a BMI >95th percentile for children). Given this assumption for prevalence of obesity, the relative size of the UMP population at the time of this analysis, and data obtained from a recent survey of adults who are currently trying to lose weight, the estimated utilization of weight loss medications in UMP is assumed to range between 4% and 14% of the PEBB and SEBB populations. This assumption includes an estimate for the percentage of children with obesity relative to adults.

Drug mix assumptions

Based on historical data on prior authorization requests for weight loss medications in UMP, coupled with the assumption that the efficacy of GLP-1s is higher when compared to non-GLP-1 medications for weight loss, HCA

assumes that utilization of GLP-1 medications will range from eighty percent (80%) to ninety-five percent (95%) of total weight loss drug utilization in UMP (non-GLP-1 utilization ranging from five percent (5%) to twenty percent (20%)). These drug mix estimates were applied to the low and high end of the range of estimates detailed below, respectively.

Based on the above-mentioned assumptions, and the wide range of possible outcomes, the fiscal impact of this legislation is difficult to estimate. Should any aspect of this analysis deviate from actual results, the resulting fiscal impact will change. Given what we know today, and the provided assumptions, HCA assumes the following range of fiscal impact:

Increased Prior Authorization (PA) costs

Assuming utilization of weight loss medication is between four percent (4%) and fourteen percent (14%) of the PEBB and SEBB populations, and that each member request will require a prior authorization review to determine medical necessity, HCA assumes prior authorization costs will increase by approximately:

- PEBB (non-Medicare and Medicare): between $546,800 and $1,903,800 annually
- SEBB: between $230,000 and $810,000 annually

Increased claims liability

Given the possible range of utilization of weight loss medications in UMP, the cost of these medications and assumed variation in members utilizing GLP-1 versus non-GLP-1 weight loss medications, HCA assumes the total claims liability in UMP could increase by approximately:

- PEBB (non-Medicare and Medicare): between $87,000,000 and $354,000,000 annually
- SEBB: between $37,000,000 and $151,000,000 annually

UMP Classic Medicare is a Medicare plan offering Creditable Drug coverage, and therefore Federal laws and coverage requirements do not preempt state coverage requirements. Furthermore, UMP Classic Medicare currently receives the full value of the Medicare explicit subsidy (the state's contribution toward retiree premiums). Any increase in UMP Classic Medicare plan claims liability will result in premium increases that are fully borne by retirees. An increase in projected claims liability for UMP Classic Medicare members is assumed to be offset by equal increases in program revenue received via UMP Classic Medicare retiree premiums. Should this legislation pass as written, applying the same assumptions for drug cost, utilization, and drug mix notes above, HCA estimates that UMP Classic Medicare retirees could pay between approximately $14,000,000 and $56,000,000 more in annual premium attributed to this coverage change alone.

The state's contribution toward employee medical premiums, known as the Employer Medical Contribution (EMC) is benchmarked off the non-Medicare UMP Classic (PEBB) and UMP Achieve 2 (SEBB) plan bid rates. As plan cost liability increases in each of these plans, the State's contribution toward employee medical premiums is also expected to increase. While the EMC is benchmarked off the UMP projected costs, it is applied PEBB and SEBB member plan premiums across the non-Medicare portfolio. This bill applies to not only the self-insured UMP offerings, but also the fully insured plans offered in PEBB and SEBB (see fully insured plan assumed impacts noted below).

Based on the assumed range of possible non-Medicare plan liability increases in UMP, it is assumed the EMC could increase by approximately five percent (5%) up to twenty percent (20%) in the PEBB program

and between six percent (6%) up to twenty five percent (25%) in the SEBB program. The EMC is calculated using the UMP projected plan liability and then applied uniformly across all PEBB and SEBB plan offerings. While the EMC is expected to increase resulting from increased claims liability in UMP, any claims liability that exceeds that which is absorbed by the EMC will result in increased member premiums. Based on these assumptions, the following is the assumed possible range of impact to EMC projected expenditures:

- PEBB non-Medicare: between $83,000,000 and $340,000,000 annually
- SEBB: between $104,000,000 and $425,000,000 annually

Key Assumptions:

- Unit costs of GLP-1 medications, net of assumed rebates, are assumed to be $1,080 per utilizing member per month. Unit cost of non-GLP-1 medications vary and is assumed to be approximately $120 per utilizing member per month; there are no assumed rebate assumptions for non-GLP-1 medications.
- HCA does not include any assumptions for cost offsets resulting from members who may discontinue use of maintenance medications to treat weight-related medical condition(s).
- HCA does not include any assumptions for cost offsets resulting in lower incidence of cardiovascular conditions, diabetes or other complicating diagnoses related to obesity resulting from member utilization of GLP-1s and similar medications for weight loss.
- HCA assumes between four percent (4%) and fourteen percent (14%) of the population could utilize weight loss medications, given assumed prevalence of diabetes in the population and assumptions regarding induced utilization of these medications resulting from this legislation requiring coverage for weight loss indications.
- Given known side effects and possible adverse reactions to the medications, HCA assumes fifty percent (50%) of members utilizing GLP-1s will discontinue utilization of medications six months after beginning a treatment course.
- Given known side effects and possible adverse reactions to the medications, HCA assumes seventy percent (70%) of members utilizing non-GLP1s will discontinue utilization of medications six months after beginning a treatment course.
- Based on historical data on prior authorization requests for weight loss medications in UMP coupled with the assumption that the efficacy of GLP-1s is higher when compared to non-GLP-1 medications for weight loss, it is assumed that utilization of GLP-1 medications will range from eighty percent (80%) to ninety-five percent (95%) of total weight loss drug utilization in UMP (non-GLP-1 utilization ranging from five percent (5%) to twenty percent (20%)). These drug mix assumptions were applied to the low end and high end of the estimates provided, respectively.
- HCA does not assume any future changes in enrollment, plan bid rates or plan mix that may impact the results of this analysis.
- Should any aspect of this analysis deviate from actual results, the resulting fiscal impact will change.

Fully insured plan impact and member premiums

PEBB and SEBB fully insured plan offerings note the potential for increases to member premiums for program plan offerings. Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Northwest and Premera plans currently do not cover GLP-1 medications for weight loss; this legislation would result in a change to current coverage practices and therefore an increase to projected plan cost liability resulting in an increase to PEBB and SEBB member premiums. Both Kaiser and Premera estimate a potential premium increase

ranging from approximately three to five percent (3% - 5%), representing approximately $22 to $28 per member per month (PMPM).

While the EMC is calculated using the UMP projected plan liability, the state's contribution toward medical premiums is applied uniformly across all PEBB and SEBB plan offerings. The EMC, as noted above, is assumed to increase by more than that assumed in the fully insured plan cost estimates. Because the EMC is assumed to increase by more than the projected increase in fully insured member premiums, assuming no other influences that may result in increases above and beyond what is required as a result of this legislation, the relative impact of this legislation on fully insured member premiums is assumed to be absorbed by the increase in the EMC resulting in a net-neutral change to fully insured member premiums and a subsequent significant increase in state expenditures.

PEBB Medicare Advantage plan impacts
State laws (except as it relates to initial licensing and solvency) are pre-empted by Federal laws for Medicare Advantage (MA) and Part D offerings provided by a Medicare Advantage Organization. Coverage-related State laws are preempted under Federal statutes and CMS regulations and therefore do not apply to federally regulated plans (42 U.S.C. § 1395w-26(b)(3); 42 U.S.C. § 1395w-112(g); 42 CFR 422.402; 42 CFR 423.440).

Therefore, for PEBB and SEBB Medicare advantage (MA) and Medicare Advantage plus Part D (MA-PD) plans there are no assumed premium impacts. Under Medicare, coverage may be provided for GLP-1 products that are FDA approved to treat obesity and Type 2 Diabetes if the member has Type 2 Diabetes. Per section 1860D-2(e)(2)(A) of the Social Security Act, medications for weight loss are excluded from coverage under Medicare Part D formularies.

Apple Health

Fiscal impact is indeterminate but is expected to be significant.

This bill requires HCA to cover medications prescribed by a health care provider for the treatment of obesity if the patient is determined to be obese, defined by a body mass index of 30 or more, or has a body mass index value of at least 27 with at least one weight-related medical condition. The fiscal impact of the proposed policy is expected to be quite significant given the high cost of the relevant drugs and the large volume of potential eligibles. While the number of eligible clients can be reasonably estimated, how this policy would impact provider prescribing behavior, including number of prescriptions or the mix of prescribed drugs, is unknown. In addition, given the known side effects, adherence to prescribed course of the medications may vary widely between clients. The dynamic nature of the future utilization of these drugs is therefore uncertain and currently unknown. As a result, the fiscal impact is indeterminate.

There are two primary classes of drugs used to treat obesity: Glucagon-Like Peptide-1 agonist (GLP-1) receptor products and non-GLP-1 medications. While the unit costs for these medications vary, the average cost of GLP-1 products is estimated to be approximately $1,200 per month and non-GLP-1 medications are estimated to be approximately $120 per month. For Apple Health utilization, HCA expects to receive about 30% in rebates for these drugs.

To provide a sense of the potential fiscal impact magnitude, HCA considers two hypothetical scenarios using the high and low end of the drug mix and utilization tendencies. The 'High' and 'Low' scenarios are made up of the high and low ends from each of the following two assumptions, respectively.

- Utilization: KFF Health Tracking Poll, July 2023 (KFF 2023) found that about 67% of the survey respondents who have been told by a health care provider that they were overweight or obese in the past five years were interested in taking prescription drugs for weight loss. It is assumed that the percentage of utilizers among potential eligibles would vary between a low of 50% to a high of 70%.
- Drug Mix: Assuming that the efficacy of GLP-1s is higher than non-GLP-1 medications for weight loss, it is assumed that the potential utilization of GLP-1 medications will range between a low 80% and a high 95% of total weight loss drug utilization.

There is evidence in the literature (Ganguly et al., 2018) that suggests that GLP-1 users adhere to their treatment regimen longer than non-GLP-1 users, but the relative rate at which clients would adhere to their prescriptions is unknown. For the purposes of estimating annual fiscal impact estimates, it is assumed that 50% of GLP-1 clients would adhere to their treatment for six months, while the other 50% would continue for the whole year. For non-GLP-1 clients, it is assumed that 70% would adhere for six months and 30% would continue for the entire year.

Considering both those who are obese and those who are overweight with at least one weight-related condition, it is estimated that about 500,000 Apple Health clients, aged 12 years and up, would meet the eligibility requirements of this bill. Given the possible range of utilization of weight loss medications among eligible Apple Health clients, the assumed variation the utilization of GLP-1 versus non-GLP-1 medications, and the cost of these medications, it is estimated that the total service-related impact for the Apple Health program could range from $1.5 billion (low) to $2.3 billion (high), net of rebates.

References

Ganguly, R., Tian, Y., Kong, S. X., Hersloev, M., Hobbs, T., Smolarz, B. G., Ramasamy,A., Haase, C. L., & Weng, W. (2018). Persistence of newer anti-obesity medications in a real-world setting. *Diabetes Research and Clinical Practice*, *143*, 348-356.

Montero, A., Sparks, G., Kirzinger, A., Valdes,I., & Hamel, L. (2023, August 4). KFF Health Tracking Poll July 2023: The Public's Views Of New Prescription Weight Loss Drugs And Prescription Drug Costs. https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/.

Part III: Expenditure Detail

III. A - Operating Budget Expenditure

Indeterminate

II. B - Expenditures by Object Or Purpose

Indeterminate

III. C - Operating FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part I and Part IIIA.

NONE

III. D - Expenditures By Program (optional)

NONE

Part IV: Capital Budget Impact

IV. A - Capital Budget Expenditures

NONE

IV. B - Expenditures by Object Or Purpose

NONE

IV. C - Capital Budget Breakout: Acquisition and construction costs not reflected elsewhere on the fiscal note and description of potential financing methods.

NONE

IV. D - Capital FTE Detail: FTEs listed by classification and corresponding annual compensation. Totals agree with total FTEs in Part IVB.

NONE

Part V: New Rule Making Required

Provisions of the bill that require the agency to adopt new administrative rules or repeal/revise existing rules.

NONE