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Correspondence Memorandum

Date: June 16, 2022

To: Group Insurance Board

From: Tricia Sieg, Pharmacy Benefits Program Manager
Office of Strategic Health Policy

Subject: Weight-Loss Drug Coverage Options Review

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) not add weight-loss drugs to the 2023 non-Medicare Formulary. The Board instructs ETF present a holistic view of weight loss programming at the November 16, 2022, Board meeting.

Background

At the May 18, 2022 Board meeting, ETF recommended against adding coverage of weight-loss drugs, also known as anti-obesity medications (AOMs), to the non-Medicare pharmacy formulary for 2023 (Ref GIB | 5.18.22 | 5C pages 5-6). After discussion, the Board deferred the issue and requested a special meeting to further discuss adding coverage of weight-loss drugs to the non-Medicare pharmacy formulary. The Board asked ETF to gather information regarding the cost of all weight-loss drugs that could be provided to members through the Board's Pharmacy Benefit Manager (PBM), Navitus Health Solutions (Navitus). In addition, the Board asked ETF to examine coverage of AOMs by other state public employee plans.

Weight-Loss Drug Cost

As reported in the May 18, 2022, Board meeting memo, Segal, the Board's actuary, calculated that adding weight-loss drugs would cost between $20 million-$30 million. Segal estimated that 20% of Group Health Insurance Program (GHIP) members are overweight or obese and that 3% of those members would take an AOM. Given the GHIP's membership, Segal estimated the number of people who would take an AOM would be around 1,300 members. Looking at the weight-loss drug market, Segal found the price of the two top brand name drugs—Wegovy and Saxenda—drive nearly all the drug spend in AOMs, so they used a blended price of $1,600 per script based upon publicly-available pricing estimates. This was a price before any rebates, cost-sharing, or a negotiated price by the Board's PBM. Given these calculations and assumptions, Segal estimated the yearly price to add weight-loss drug coverage to the non-Medicare formulary would be $25 million. Because this was an estimate, Segal submitted the cost

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 06/23/2022

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of adding weight-loss drugs to the non-Medicare formulary as being a $20 million-$30 million increase.

After the May 18, 2022 Board meeting, Navitus informed Segal of its negotiated rates for all drugs in the class. This new price information lowers Segal's estimated cost for adding weight-loss drugs to the formulary to be in the range of $12 million-$17 million.

In preparing the cost estimate on weight-loss drugs for the Board for the May meeting and the June meeting, Segal assumed that each weight-loss drug would require a prior authorization (PA) request be filed by a member's treating subscriber before any weight-loss drug prescription would be filled. A new PA form is required to be filed yearly for weight-loss drugs by Navitus.

It should be noted that while Segal used the utilization rate of 0.6% or 1,300 members, Segal believes this number is low. Other states' data shows the rate to be closer to 2% in calendar year 2021 and increasing.

The Obesity Action Coalition's (OAC's) June 6, 2022, correspondence to the Board, as well as other correspondence received earlier this year, referenced information about the economic value and impact of weight-loss drugs on obese adults. This information is from a 2021 study sponsored by Novo Nordisk, the maker of Wegovy and Saxenda, and conducted by medical professionals affiliated with the sponsor (Ding, et al., 2021). The Novo Nordisk study showed the maximum savings for those who reduce weight to an overweight Body Mass Index (BMI) from obese was $1,200 per year and for those who moved from obese to healthy BMI was $2,400 per year, with a midpoint overall estimate of $135 per month or $1,600 per year (Ding, et al., 2021). Segal, using the information from the study, estimates that this could potentially save up to $2 million annually if a member can maintain a lower weight. However, ETF and Segal found little additional evidence published about weight-loss drugs and cost-effectiveness. The majority of research available is about expected medical costs related to obesity. The cost-effectiveness of weight-loss drugs needs to be examined from not only the pharmacy spend aspect but also the medical aspect. Expenses for drugs and medical care to treat side-effects caused by taking a weight-loss drug should also be examined, as well as the cost of the exercise and dietary expenses that are needed for members to have the best results when taking weight-loss drugs.

The length of time a person takes a weight-loss drug depends on how well it helps that person lose weight. If a person has lost enough weight to improve their health and they have not had serious side effects, a doctor may suggest the patient take the drug indefinitely. If a person hasn't lost at least five percent of their body weight after three to six months on a full dose of the drug, a doctor will probably change the weight-loss medication (Mayo Clinic Staff, 2020). All anti-obesity medications are prescribed along with a lifestyle program that addresses eating and exercise. Some doctors also combine weight-loss medications and surgery to reduce the size of the stomach, which is known as an endoscopic procedure (Katella, 2022).

Weight-loss drugs are also a way to treat people who undergo bariatric surgery, but experience inadequate weight loss or weight regain (Standford, et al., 2018). As stated in the January 20, 2022, memo to the Board regarding the 2020 benefit change review of bariatric surgery (Ref. GIB | 02.16.2022 | 7A), ETF continues to analyze bariatric surgery outcomes and costs, and plans to bring another review of said outcomes and costs to the Board in 2023.

Other States Weight-loss drug Coverage
On Tuesday, May 24, 2022, ETF posed the following questions to the State and Local Government Benefits Association (SALGBA) list serve:

1. Does your health or pharmacy benefits coverage include weight-loss medications?
2. If yes:
    a. Which medications are included for coverage?
    b. What utilization rate for these medications have you seen amongst your eligible membership population? (i.e., of those eligible, how many utilize the benefit annually?)
    c. What is the average cost per member per month for these medications?
    d. Have you identified an improvement in health and/or a reduction in health care costs associated with diseases related to obesity amongst the membership who utilize these medications? If yes, please share your results if possible.
3. If no, why has your organization not included weight-loss medication coverage to date?

Staff received responses from 20 states. Most said they do not cover weight-loss drugs. Most cited the high cost of the drugs and the indeterminate long-term effectiveness of their use. None responded that their state did not cover weight-loss drugs due to state law or statute. However, two states wrote that they have a “policy” that does not allow for coverage.

Three states responded that they cover weight-loss drugs for their employees and provided information and/or data. Two of those three states have a copay structure similar to the Board’s. The third state charges a 35% coinsurance, which is significantly higher than 20% with $50 maximum the Board’s members would pay for most weight-loss drugs.

For 2021, the cost of weight-loss drugs in the two states with similar copay structures varied between $4.00-$7.00 per member per month (PMPM). Segal found that PMPM costs adjusting for rebates would be $2.50-$4.50.

Segal has a large state client that previously provided weight-loss drug coverage for their state employees and added Wegovy in 2022. This change has increased their

projected weight-loss drug total costs by more than 50%. This creates a range of 2022 expectations of $3.75-$6.75 PMPM. With 212,000 members, this state's costs would be $9 million-$17 million. This calculation is consistent with Segal's estimates for the Board's cost increase if weight-loss drugs were added to the non-Medicare formulary.

Segal has observed in the weight-loss drug market nearly 80% of the drugs utilized were the high-cost brands, representing 94% of the total cost of weight-loss drugs.

Member Weight-Loss Drug Experience
Navitus allows Commercial, Exchange, and Medicaid clients to opt into covering weight-loss pharmacotherapy. Navitus estimates that between 12.5% and 15% of their Commercial and Exchange clients have opted-in and added weight-loss drug coverage.

Medicaid programs around the country have the option to add weight-loss to their drug formularies. The Wisconsin Medicaid program is one of those programs that does cover weight-loss drugs. Wisconsin Medicaid covers 10 different weight-loss drugs. In addition to all weight-loss drugs requiring PA, there are also other criteria required including for some of the drugs that a member lose 10 pounds in 90 days. If the member does not lose 10 pounds in 90 days, they are taken off the drug and the member must wait six months before requesting another controlled substance anti-obesity drug.

Other weight-loss drugs covered by Wisconsin Medicaid also only allow for coverage for one month, 90 days, or 180 days. On other drugs like Saxenda, Wisconsin Medicaid allows only two weight loss attempts during a member's lifetime. If the member fails to lose at least five percent of their weight from baseline twice, then any additional PA forms filed with Wisconsin Medicaid will not be approved.

With the Medicaid Best Price Policy, a drug manufacturer must offer state Medicaid Programs the best price given to any other purchaser with a mandatory rebate of 23.1% off the list price (Baghdadi, 2017).

Plan sponsors that offer Medicare Part D coverage cannot add weight-loss drugs to their formularies. Federal Statute 42 USC 1395W-102 prevents the Center for Medicare and Medicaid Services (CMS), which creates the Medicare Part D drug formulary, from including coverage for weight-loss drugs.

Medicare Part B covers obesity screenings and behavioral counseling given in a primary care setting to members with a BMI of 30 or more. Some Medicare Advantage plans, also known as Medicare Part C, provide coverage to support weight loss efforts such as gym or fitness program members or for a limited time healthy home meal delivery. If a member's BMI is 35 or higher, they have an underlying obesity-related health condition, and a medical professional deems it medically necessary, Medicare will cover bariatric surgery

Navitus currently has five weight-loss drugs available to be added to a client's non-Medicare formulary: Saxenda, Contrave, Qsymia, phentermine (the generic version of Qsymia), and Wegovy. These weight-loss drugs are for adults with BMIs of 27 or higher and a weight-related medical issue, and adults with a BMI of 30 or higher without a weight-related medical issue. Each drug carries a variety of black box warnings, safety risks, precautions, and adverse effects that are required to be listed on the drug by the United States Food and Drug Administration (FDA). The risks and precautions on these drugs vary from experiencing dry mouth and constipation to thyroid tumors and suicidal ideations.

There are reports in the media of more weight-loss drugs being studied and being prepared to be sent to the FDA for approval weekly. ETF monitors all of these reports and will keep the Board abreast of these developments.

Board Considerations
There are two options the Board could take moving forward on weight-loss drugs.

<u>Option One: Add coverage of the weight-loss drug class through the Board's PBM to the 2023 non-Medicare formulary.</u>
With this approach, all non-Medicare members could receive any of the currently covered and future covered weight-loss drugs that are approved by Navitus's Pharmacy and Therapeutics Committee. If a PA is required, the prescriber would have to fill out the required PA form and submit the form to Navitus. The PA form requires the prescriber to attest to the member meeting certain BMI thresholds and/or having some pre-existing conditions. The prescriber would need to fill out a PA form every year and show that the member has had a least a 5% weight reduction from the first day the drug was prescribed.

- Pros
  - The Board could offer another tool to help with weight reduction.
  - New Members who come to state service from a private sector company that covers weight-loss drugs would see uninterrupted coverage.
- Cons
  - As of May 31 year-to-date, non-Medicare pharmacy claims are up just over $11 million from the same time last year. Adding higher cost drugs that many people will take for the rest of their lives once on the drug would add to the Board's increasing pharmacy costs and insurance premium rates.
  - There have been no long-term study results released on how taking weight-loss drugs over an extended period (at least 5 years) can affect a person's health. Health researchers indicate this is critical to understanding the long-term impacts of a drug on overall health.
  - Very few members are requesting the addition of weight-loss drugs. In the past two years, one member has requested coverage to continue on a drug covered by a private-sector employer. However, some members have reached out over this same period and requested the Board cover or

reimburse for other aspects of weight loss like gym memberships, working with dietitians, or seeking assistance from a counselor.

- Adding higher cost weight-loss drugs to the drug formulary that could be taken by the members for a long time, or in some cases forever, without evidence of long-term cost-benefit could erase any savings that the Board may realize in reduced medical claims.
- Wis. Stats. § 40.03(6)(c) states in part that the Group Insurance Board, "*Shall not enter into any agreement to modify or expand benefits under any group insurance plan, unless the modification or expansion is required by law or would maintain or reduce premium costs for the state or its employees in the current or any future year…"*

<u>Option Two: Vote to not add weight-loss drugs to the 2023 non-Medicare Formulary. The Board instructs ETF present a holistic view of weight loss programming at the November 16, 2022, Board meeting.</u>

- Pros
  - ETF will continue to monitor available literature and will present a more holistic view of weight loss at the November 16, 2022, Board meeting. Information will be issued from the Institute for Clinical and Economic Review (ICER) which is set to release their report evaluating the prices companies are charging for weight-loss drugs and if those prices are fair and accurate in September of 2023. In addition, there is a chance that the states who responded to ETF's SALGBA survey may have data on improvement in health and/or a reduction in health care costs associated with diseases related to obesity amongst their membership who utilize these weight-loss medications in the future.
  - Not adding costly weight-loss drugs for 2023 will maintain or minimize any cost increase of the non-Medicare pharmacy formulary.

- Cons
  - The Board would not be able to make changes to the pharmacy, medical or wellness programs at the November 2022 meeting for 2023 coverage since rates have already been established and coverage of these drugs would increase rates. The first chance for the Board to act on any changes that would result from this comprehensive review would be at the May 2023 Board meeting where the Board would vote on changes to each program that would begin on January 1, 2024.
  - If many private sector companies decided to add weight-loss drug coverage in 2023 some state employees could leave state service and move to the private sector to gain coverage.

Staff will be available at the Board meeting to answer questions.

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