NORTH DAKOTA
Insurance Department

Insurance.ND.gov | Insurance@ND.gov | (701)328-2440 | 600 E Boulevard Ave | Bismarck, ND 58505

North Dakota EHB Benchmark Plan

Changes Coming in 2025

"We have heard from consumers in every corner across the state about what is important for them when they go to a healthcare facility or pharmacy and utilize their health insurance policy," said Insurance Commissioner Jon Godfread. "The healthcare needs of North Dakotans evolve, and we have done extensive research to determine how insurance policies can best support as many consumers as possible. This approval comes after studying our options, taking public comment, and with legislative approval. It was a long process, but in the end, will benefit North Dakota consumers who purchase their health care through the ACA marketplace."

At the time of implementation, it will have been ten years since the last update to the ACA Benchmark Plan. NDID did extensive research and has attempted to be responsive to new medical breakthroughs that stand to get North Dakotans well while also creating long term savings. Please find information about the process and implementation of the 2025 ACA Benchmark Plan Revisions:

What is the EHB Benchmark Plan?

Answer: The Affordable Care Act requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include items and services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

What population does the EHB Benchmark Plan affect?

Answer: The Affordable Care Act non-grandfathered health plans in the individual and small group. This does not affect PERS.

When will the new benefits take effect?

Answer: January 1, 2025

When was the last change to the ACA Benchmark Plan?

Answer: 2015

What was the process for the EHB Benchmark Plan revisions for Plan Year 2025?

Answer:

- The legislature directed that a Health Care Cost Study was completed in 2019.
- A Healthcare Cost Study was conducted and released in 2020 to the legislature and Interim Healthcare Committee, identifying areas to improve the cost of health care.
- Data was collected during the Healthcare Cost Study and thereafter from hospitals and insurers.
- A second round of inquiries were made to the insurance companies. Cost information was gathered on different potential ideas

- A resolution was passed in the legislature (HCR3011).
  - This was a high-level summary of the focus areas to be considered for revisions to the EHB Benchmark Plan. At the time, emphasis from both the NDID Commissioner and the NDID Division Director was provided that included information the plan would be developed more with input from CCIIO/CMS.
  - At the time, the only written testimony was received by Sanford Healthcare Plan (in support) on multiple occasions. The North Dakota Board of Pharmacy was neutral. No other testimony was provided by insurers.
- NDID and the procured consultants sought input from providers regarding potential cost savings inclusions to the EHB Benchmark Plan.
  - Throughout the gathering of information (from providers and stakeholders) the EHB Benchmark Plan Revisions continued to evolve, while considering the best and newest cost savings opportunities in the industry. The goal is to address the high cost of healthcare in the state of North Dakota, while taking the advice of the best in their fields, including Mayo Clinic.
- NDID procured an actuarial firm to provide an actuarial analysis of the potential cost savings ideas
  - NovaRest won the procurement
  - After gathering many options, an actuarial report was prepared by NovaRest.
  - Some options were determined to be too expensive (or didn't result in the necessary savings/meet the generosity test)
  - The actuaries researched whether the cost savings benefit additions met the typicality standard and PMPM restrictions – all with the goal to reduce the cost of healthcare in North Dakota.
- NDID and the consultants met with federal CMS/CCIIO to identify cost savings options (March – April 2023)
  - Discussions with CCIIO and CMS continued in person and virtually to identify the best cost savings available for inclusion in the Revised EHB Benchmark Plan
- NDID revised the Revised EHB Benchmark Plan consistent with the high-level overview laid out in the Resolution
- NDID published the Plan for comment. Not only did NDID publish the ACA Revised Benchmark Plan, they also published a summary and the actuarial report for review by stakeholder (April 17, 2023)
  - Once the EHB Plan Revisions were drafted, NDID decided to provide an extended (well beyond minimum requirements with CCIIO or CMS) comment period for stakeholders.
- NDID emailed stakeholders requesting comment
  - Going above and beyond the posting requirements, NDID also decided to notify stakeholders via email. This was an attempt to get the important feedback necessary before proceeding to the final stages of review.
  - The Public Comment Period was open for an extended period of time of 15 days.
  - Items available (with stakeholder email notification to inspect and comment) included the ND Benchmark Plan document, Appendix C EHB Summary of Benefits Chart, and the 24-page actuarial report which outlined all of the cost assumptions and research conducted to price out the benefits to the satisfaction of CCIIO/CMS. The actuarial report clearly illustrates the generosity difference for each change to the EHB. This is how a reader is able to understand the per member per month impact in the first year. As indicated previously, the goal of the revisions is to dramatically drive down the cost of health care in the state of North Dakota over a period of years.
- NDID received one comment from a carrier regarding the GLP1 and GIP medication regarding cost sharing. (May 1, 2023)
  - NDID confirmed with CCIIO/CMS that cost sharing is allowed. Insurers generally are free to set cost sharing for specific EHB, provided that the insurer limits overall cost sharing for the EHB to the annual limitation on cost sharing, meets AV requirements, and the benefit design is not discriminatory.
  - For additional information about compliance, please visit HERE.
- NDID Closed the Comment Period (May 1, 2023)
- NDID submitted the Revised Benchmark Plan for review to CMS/CCIIO (May 2, 2023)
- NDID made revisions to the Revised Benchmark based on CMS feedback (May – July, 2023)
- CCIIO/CMS approved the 2025 ACA Benchmark Plan (August 28, 2023)
- NDID Issued a Press Release announcing the Federal approval
- Stakeholders began asking questions
- NovaRest Identified a typo in the narrative of the Actuarial Report. NovaRest revised the narrative to fix the typo (which did not affect the modeling or PMPM) and reissued the corrected Actuarial Report.
- NDID published the Revised Actuarial Report on their website.
- NDID submitted Revised Actuarial Report to CCIIO/CMS.
- NDID held stakeholder meeting to discuss any outstanding questions.
- NDID issued this FAQ and additional information (Exhibit A) with actuarial comments.

What benefits has CCIIO/CMS approved to be updated in the 2025 ACA Benchmark Plan?

Answer:

- Insulin/Insulin supplies: Limits out-of-pocket costs for diabetes, providing limited cost sharing for a 30-day supply of covered insulin drugs and of covered medical supplies for insulin dosing and administration.
- Hearing aids: Coverage for one hearing aid per hearing-impaired ear every 36 months or more when deemed medically necessary by a licensed physician or audiologist.
- Nutritional benefits: Coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes-related diagnosis or chronic illness or condition that could be managed through nutritional or weight loss programs (up to 12 sessions every policy year if deemed medically necessary by the insured's physician).
- Weight loss drugs: Coverage for the use of glucagon-like peptide-1 (GLP1) and gastric inhibitory polypeptide (GIP) drugs as therapy for the prevention of diabetes and treatment of insulin resistance, metabolic syndrome, or morbid obesity.
- Periodontal disease: Coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if deemed medically necessary by a board-certified medical practitioner.
- PET scans: Coverage for positron emission tomography (PET) scans of an insured who has a prostate cancer diagnosis, including at least two different types of PET scans upon 2 initial diagnoses and one PET scan every 6 months for the life of the insured. Also provided without a cancer diagnosis.
- Opioids: Limit opioid prescriptions to 7 days, removing barriers such as prior authorization for drugs used in the treatment of opioid use disorder or opioid replacement drugs and requiring prescription drugs for an easy-to-use antidote when prescribing high-dose opioids.

Can Insurers utilize Prior Authorization and Copays with the EHB Benchmark Plan?

Answer: EHB regulations do not prohibit insurers from applying reasonable medical management techniques. An insurer could use prior authorization but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence based.

Can Insurers use cost sharing with the EHB Benchmark Plan?

Answer: Under Federal law, insurers generally are free to set cost sharing for specific EHB, provided that the insurer limits overall cost sharing for the EHB to the annual limitation on cost sharing, meets AV requirements, and the benefit design is not discriminatory.

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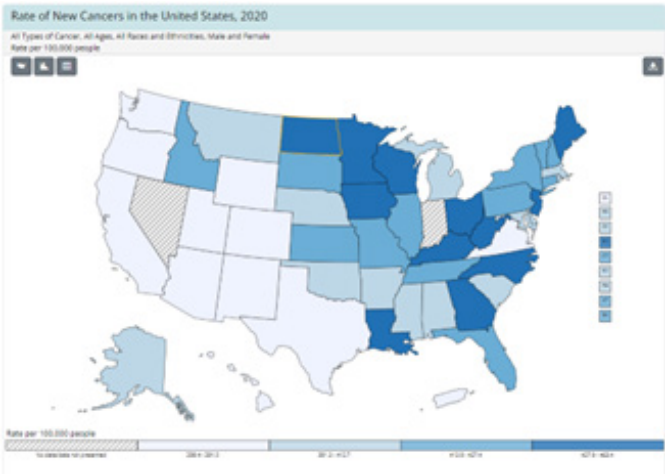
Why were diabetes prevention and morbid obesity drugs included in the essential health benchmark plan coverage for dietary or nutritional screening, counseling, and therapy for obesity, diabetes related diagnosis, or a chronic illness or condition?

- Consistent with the Resolution, the chronic condition of morbid obesity has been shown to be best managed (in the most cost-effective way) through weight loss programs that include GLP1 or GIP drugs, if prescribed by the insured's physician;
- NDID is prioritizing driving down health care costs with addressing the known cost drivers in the population.

- The below research provides pertinent information about why the essential health benchmark plan includes the use of GLP1 and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity:
  - There is a surge in cancer diagnoses in individuals under 50:
    - "Globally, cancer is a significant cause of morbidity and mortality, resulting in a large disease burden. According to Global Cancer Statistics 2020, breast cancer with the largest number of 2.3 million new cases accounted for 11.7% of all cancers, followed by lung cancer (11.4%), colorectal cancer (CRC) (10.0 %), while lung cancer was the main cause of cancer death (1.8 million deaths, 18%), followed by CRC (9.4%), liver (8.3%) cancer.1 Cancer is generally more prevalent in adults over 50 years, but the incidence of early-onset cancer (<50 years) has increased worldwide. In comparison to later-onset cancer, the increase of early-onset cancer has significant personal and societal ramifications. Moreover, early-onset cancer and the adverse impacts of some corresponding cancer treatments may result in additional health issues during subsequent life cycle, which would considerably increase the disease burden associated with early-onset cancers."
    - "Except for dietary risk factors, alcohol use, high BMI, tobacco consumption, high fasting plasma glucose and low physical activity contributed to early-onset CRC. Of these risk factors, high BMI, particularly obesity, has been identified as a strong risk factor for early-onset CRC. The increasing prevalence of obesity in younger generations has led to a substantial increase in early-onset CRC cases.41 According to research, obesity is associated with an OR of 1.4 for early-onset CRC.42 Besides, individuals with high fasting plasma glucose and diabetes have a higher risk of developing early-onset CRC, as demonstrated by previous studies,43 and it was recommended to conduct CRC screening earlier for those with diabetes than for the general population.44 Taken together, in addition to focusing on traditional lifestyle risk factors, dietary modifications will have a positive impact on lowering the incidence burden of early-onset CRC."
    - "Furthermore, changes in diet, lifestyle and environment since the turn of the 20th century, resulting in increased rates of obesity, physical inactivity, westernised diets and environmental pollution, may have affected the incidence of early-onset cancer."
  - The economic burden of cancer care is immense:
    - "National costs for cancer care were estimated to be $190.2 billion in 2015. Assuming constant future costs, we project costs to be $208.9 billion in 2020 (2020 U.S. dollars), an increase of 10 percent that is only due to the aging and growth of the U.S. population. These cost estimates include cancer-attributable costs for medical services and oral prescription drugs. National medical services costs were largest for those diagnosed with female breast, colorectal, lung, and prostate cancers and non-Hodgkin lymphomas. National oral prescription drug costs were highest for those diagnosed with female breast, leukemia, lung, and prostate cancers."
  - Additional information about the burden of cancer on North Dakotans can be found here.
  - North Dakota leading in the rate of new cancer diagnoses:



Source: CDC

- North Dakota is 11th in the Nation for the rate of new cancers:

Leading Cancer Cases and Deaths, All Races and Ethnicities, Male and Female, 2020

In 2020, the latest year for which incidence data are available, in the **United States, 1,603,844 new cases of cancer** were reported, and **602,347 people died** of cancer. For every 100,000 **people, 403 new cancer cases were reported** and **144 people died** of cancer.

Cancer is the second leading cause of death in the United States, exceeded only by heart disease. **One of every five deaths in the United States is due to cancer.**

Attention users: *Use caution when interpreting 2020 data. The COVID-19 pandemic disrupted health services, leading to delays and reductions in cancer screening, diagnosis, and reporting to some central cancer registries. This may have contributed to the decline in new cancer cases for many sites in 2020.*

Rate of New Cancers in the United States, 2020

All Types of Cancer, All Ages, All Races and Ethnicities, Male and Female
Rate per 100,000 people

95% Confidence Interval: Hide Show
Show 50 entries

Area	Cancer Type	Year	Sex	Race	Age-Adjusted Rate	Case Count	Population
Kentucky	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	463.4	26,240	4,477,251
Iowa	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	455.1	18,381	3,163,561
Maine	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	449.5	9,151	1,350,141
West Virginia	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	447.5	11,445	1,784,787
New Jersey	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	443.3	50,346	8,882,371
Minnesota	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	436.4	30,505	5,657,342
Georgia	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	434.0	53,485	10,710,017
Louisiana	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	433.8	24,734	4,645,318
Wisconsin	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	431.3	32,961	5,832,655
Ohio	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	428.9	65,151	11,693,217
North Dakota	All Types of Cancer	2020	Male and Female	All Races and Ethnicities	428.2	3,843	765,309

Source: CDC

Cancer burden: North Dakota

All Types of Cancer, 2020

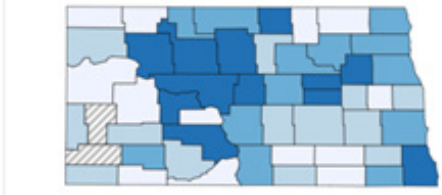
In **North Dakota** in **2020**, there were **3,843 new cases of cancer**. For every 100,000 people, **428 cancer cases were reported.**

The same year, there were **1,308 people who died of cancer.** For every 100,000 people in **North Dakota**, 139 died of **cancer.**

Attention users: *Use caution when interpreting 2020 data. The COVID-19 pandemic disrupted health services, leading to delays and reductions in cancer screening, diagnosis, and reporting to some central cancer registries. This may have contributed to the decline in new cancer cases for many sites in 2020.*

Rate of New Cancers in North Dakota

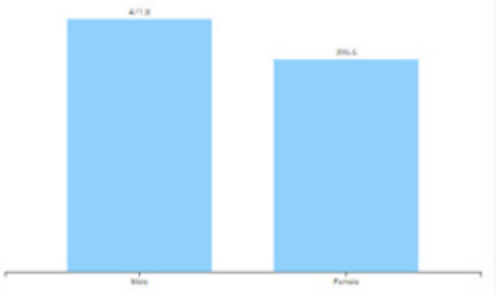
All Types of Cancer, All Ages, All Races and Ethnicities, Male and Female, 2016-2020
Rate per 100,000 people



Rate per 100,000 people

Rate of New Cancers, All Races and Ethnicities, Both Sexes

All Types of Cancer, 2020
Rate per 100,000 people

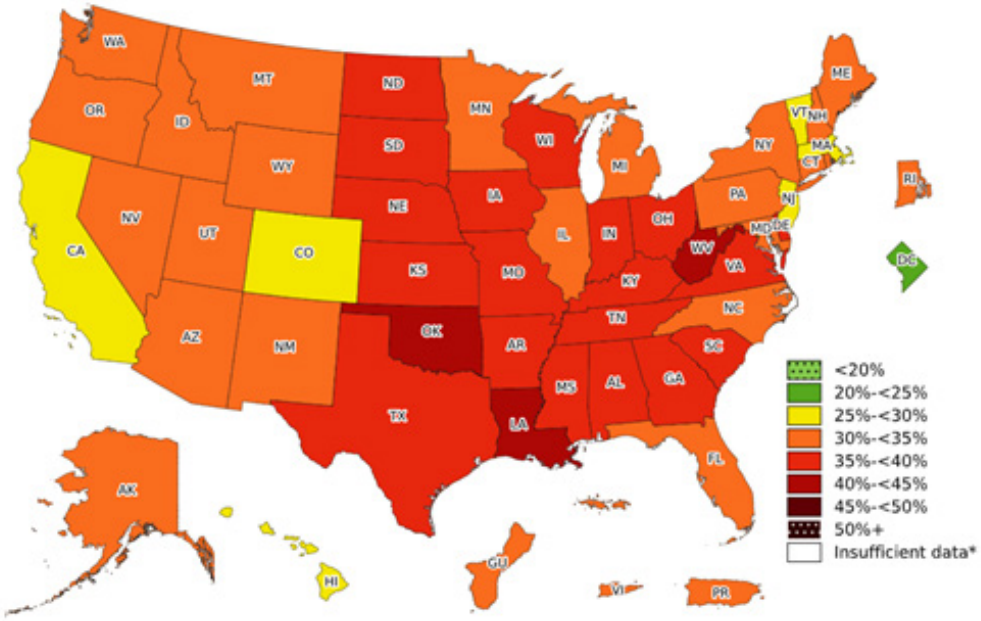


Source: CDC

- Obesity is a leading cancer risk factor:
  - "Obesity or excess body fat is a major global health challenge that has not only been associated with diabetes mellitus and cardiovascular disease but is also a major risk factor for the development of and mortality related to a subgroup of cancer. . . The relationship between obesity and cancer is rather complex. Obesity is not only associated with an increased risk of cancer but may also increase the risk of cancer recurrence and mortality in cancer survivors Hence, the management of obesity as an early intervention in patients with early-stage cancer is important to improve cancer outcomes."
- Not only does obesity and excess weight contribute to the increased incidence of cancer but it also causes complications in treatment.
  - "Obesity increases several cancer treatment-related adverse effects. Lymphedema is a complication of axillary lymph nodal surgery and radiation in women with breast cancer. The risk of lymphedema in women with breast cancer is several-fold higher compared with women with normal body weights. Likewise, chemotherapy-induced peripheral neuropathy is a common side effect of several anti-cancer agents and has been associated with impaired quality of life. Some cohort studies have shown higher rates of taxanes and platinum-related neuropathy in obese patients. Recent evidence also highlights that excess body fat has been associated with a high risk of treatment-related cardiotoxicity. A meta-analysis of 15 studies involving 8745 women with early-stage breast cancers who received adjuvant anthracyclines and trastuzumab showed that obesity was associated with a 47% increased risk of cardiac toxicities. Obesity also increases radiation therapy-related toxicities. A systematic review and meta-analysis of 38 studies involving 15,623 breast cancer survivors showed that a BMI of >25 was associated with an 11% risk of radiation-related acute dermatitis in breast cancer [117]. Several reports also support an association between high BMIs and surgical complications in cancer patients. . . . **Obesity is a one of the major but preventable global health crises that has been linked to major chronic illness and several cancers, with increased morbidity and mortality."**
  - **Source: NIH**
- Adults with obesity have medical costs 100% higher than those that dont:
  - "Adults with obesity in the United States compared with those with normal weight experienced higher annual medical care costs by $2,505 or 100%, with costs increasing significantly with class of obesity, from 68.4% for class 1 to 233.6% for class 3. The effects of obesity raised costs in every category of care: inpatient, outpatient, and prescription drugs. Increases in medical expenditures due to obesity were higher for adults covered by public health insurance programs ($2,868) than for those having private health insurance ($2,058). In 2016, the aggregate medical cost due to obesity among adults in the United States was $260.6 billion. The increase in individual-level expenditures due to obesity varied considerably by state (e.g., 24.0% in Florida, 66.4% in New York, and 104.9% in Texas)."
- $172 Billion in health care costs associated with excessive weight:
  - "Higher health care costs are associated with excess body weight across a broad range of ages and BMI levels, and are especially high for people with severe obesity. These findings highlight the importance of promoting a healthy weight for the entire population while also targeting efforts to prevent extreme weight gain over the life course."
- Obesity is a chronic disease. North Dakota is ranked 18th in the nation regarding obesity.
- Cost summary ($173B annually)

Map: Overall Obesity

Prevalence† of Obesity Based on Self-Reported Weight and Height Among U.S. Adults by State and Territory, BRFSS, 2022



Was there actuarial analysis and estimated PMPM impact calculated for the weight loss drugs that can be shared?

Answer: Please see page 19 and 20 of the REVISED Actuarial Report and Exhibit A attached hereto.

Can you share the methodology or research for which drugs were determined to be included? (For example is it all of the GLP-1s? Just those FDA approved for weight loss? Or something else?)

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

Would it be beneficial to edit the language within the document to not call out specific medications?

Answer: The documents have been approved by the federal government. The timeline for requested edits to documents was during the exposure period in April and May.

Will Prior Authorization be allowed to ensure members utilizing the drugs meet FDA approved guidelines?

Answer: EHB regulations do not prohibit insurers from applying reasonable medical management techniques. An insurer could use prior authorization, but could not implement prior authorization in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and evidence-based.

What are the specific coverage requirements for weight loss drugs as opposed to GLP-1s used for diabetes management?

The EHB change added GLP-1s and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity. Other requirements for diabetes management have not changed.

If the PMPM for weight loss drugs is significant, how does the DOI intend to decide which other of the benefits that were included in the EHB study will be eliminated?

Answer: NDID has already received approval based on the generosity test, after our actuarial review and independent review from the federal government. Please see the REVISED Actuarial Report. Further revisions to the 2025 EHB Benchmark Plan are not possible as the federal revision process period is closed, after approval was received. However, additional revisions to the EHB Benchmark Plan would follow a similar process for 2026 and beyond.

Could NDID, Novarest, and Jennifer Hammer please walk through plans the process by which it arrived at the PMPM for nutritional counseling, in particular, the projected PMPM of weight-loss medication?

Answer: Regarding the weight loss drugs, NovaRest did not have cost and utilization data to leverage as these drugs are relatively new (such as Wegovy) or are expected to receive approval soon (such as Mounjaro). NovaRest followed a first principles approach by estimating the eligible population in accordance with the FDA criteria, estimating the number of people who will use the benefit, assuming people will use a full 12 months and applying the cost information that is publicly available (which was $14,000 annually rather than the $1,400 due to a typo). The nutritional counseling estimate was done by estimating the total chronic disease in North Dakota, estimating the additional services to be offered over the requirements in the previous EHB-Benchmark Plan, applying the estimated cost of services and applying cost-savings assumption as explained in the (REVISED Actuarial Report). The cost-savings assumption was not applied to the weight-loss drug estimate to allow for conservatism.

Where is the worksheet showing NovaRest's mathematical assumptions and calculations. The language in the Department's April estimation of the costs show several factors taken into consideration, but do not show how these factors were combined and ultimately calculated. For example, there are several statistics cited in the population that qualifies for on-label use of the medication (people within certain BMI ranges) however, there is no assumption for off-label use. I was also surprised to read NovaRest assume utilization would be "similar to usage of nutritional counseling."

Answer:

- NovaRest has provided the necessary Revised Actuarial Report. Please also see Exhibit A for additional information.
- Regarding Off-Label Usage, insurers must comply with North Dakota Century Code.
- Please NOTE: Whether or not off label usage is required does not change the population. It may change the treatment drug utilized but the cost of those drugs is similar.

NovaRest cited the homepage of "goodrx.com" as their citation for commercially-covered GLP1 and GIP medications. Coverage of these medications has shifted dramatically since the beginning of the year due to explosion of utilization. It is difficult to understand what data NovaRest pulled from goodrx.com at the time the calculations were performed and if it is reflective of the availability of these medications in the commercial market today. It is probable NovaRest assumed a broader availability of these medications through commercial insurance than what is available today due to exploding costs and utilization.

Answer: NovaRest agrees that prescription drug costs are expected to vary widely across the market, and change often. For their estimate, they relied upon public information as of the time of the projection. Please note the REVISED Actuarial Report. The assumptions including a review of the publicly available information for the two drugs that currently have FDA approval (Saxenda and Wegovy), as well as the one that is expected to receive FDA approval this year (Mounjaro).

Did NovaRest apply long-term $3-4 PMPM savings in year one of mandated coverage of GLP1 and GIP medications?

Answer: No, the savings estimate for the nutritional counseling component was done over a 25-year basis. The savings was the average annual over the 25 years. The savings in year one would be very small compared to savings in later years. Savings in out years for the GLP1 and GIP medications is unknown (and was not applied to the assumptions). Even though, it can reasonably assumed that there may be a large cost savings where there is the reduction of frequency and severity of cancer or cardiovascular events, due to patients having received treatment for obesity, a diabetes related diagnosis, or a chronic illness or condition, NovaRest assumed a worst case scenario. They conservatively did not assume savings in future years for the GLP1 and GIP drugs.

We would like the Department to comment on why the GLP1 and GIP drugs for treatment of morbid obesity were not presented in the initial information and data request so that carriers would have had adequate opportunity to provide input ahead of the final public comment period. The additional benefits proposed in the information and data request under the category of nutritional counseling made no mention of GLP1 and GIP drugs, yet they are included in the new EHB benchmark plan. The first notation that nutritional counseling included coverage for GLP1 and GIP drugs did not appear until April, when it should have been noted in the initial data request so that carriers could have provided more specific cost analysis for this coverage. In addition, the legislative resolution did not contemplate the inclusion of these drugs as an expansion of nutritional counseling as a signal that they would be included.

Answer: The EHB Benchmark Plan Revisions was an evolving process. NDID sought extra input beyond any necessary requirements. Throughout the whole process, the Resolution was not necessary and not all inclusive. It was a high-level summary of the potential benefit designs. The GLP1 and GIP medications are therapy for the previously noted conditions in the Resolution. There was extensive process, and lack of review by stakeholders does not negate that.

What percentage of the eligible population was assumed to utilize the new coverage in plan year 1?

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

What is the percentage of the obesity percentage that is publicly available?

Answer: Please see the Revised Actuarial Report and Exhibit A attached hereto.

9/22/2023

MEMORANDUM

Re: North Dakota EHB Benchmark Plan Discussion Regarding NovaRest's GLP-1 and GIP Assumptions

In North Dakota's application for the EHB Benchmark Plan, NovaRest's primary objective was to determine the estimated value of benefits in order to align with CMS typicality and generosity benchmarks. This included assessing the value of "the use of glucagon-like peptide-1 (GLP-1) and Gastric Inhibitory Polypeptide (GIP) drugs (specifically semaglutide and tirzepatide) as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity."

Recently, insurers raised concerns regarding our estimate of obese members, suggesting that it should have been higher and based on more up-to-date sources. At the time of our estimate, we relied on a CDC source for obesity rates in North Dakota, which we considered reliable. While more recent sources may indicate a higher rate of obesity, we argue that the population eligible for this benefit is more restrictive than obesity. Our estimate was intentionally conservative to encompass not only morbidly obese individuals but also those using these drugs to manage insulin resistance and metabolic syndrome. We also believe many obese members using GLP-1 and GIP drugs are using them as treatment for diabetes, which is not the intended population as the EHB Benchmark Plan did not make changes to required diabetes benefits. We believe our conservative estimate, based on obese members, still falls within a reasonable range to capture the intended population.

Insurers indicated that NovaRest did not reasonably document assumptions, particularly for the utilization regarding GLP-1 and GIP drugs. The actuarial report was determined to be sufficient for the purpose of demonstrating compliance with the generosity and typicality benchmarks by the intended users of the document (NDID and CMS), as demonstrated by the approval of the application. NovaRest's actuarial report indicates "usage of GLP-1 and GIP drugs to the formulary as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome or morbid obesity would be similar to usage of nutritional counseling" and noted "AARP found usage rates for nutritional counseling under 1% for eligible Medicare enrollees." NovaRest assumed 1% of members eligible would utilize the benefit for a full 12 months in year 1. We feel using a full 12 months provided additional conservatism, since we believe that many members will discontinue use before 12 months.

We acknowledge that we did not have access to a benefit analysis conducted by other states or insurers for the intended population, making it challenging to compare our 1% assumption. Traditionally weight loss treatments are underutilized. This includes nutritional counseling as discussed above, but a similarly low level of utilization has been demonstrated for bariatric surgery, which is already an EHB available to members in North Dakota. Additionally, we believe the low level of utilization is supportable for the following reasons:

1. Diet and Exercise: The FDA approvals for drugs like Wegovy and Saxenda stipulate their use in conjunction with a reduced calorie diet and increased physical activity, which are often challenging for individuals to maintain long-term.
2. Cost: We estimated a significant annual cost for GLP-1 and GIP drugs, and the benefit does not prohibit cost sharing. Insurers are likely to apply cost sharing, resulting in substantial out-of-pocket expenses for members, making it unaffordable for many.

3. Alternatives: The EHB Benchmark Plan already covers nutritional counseling and bariatric surgery, which we believe are more cost-effective alternatives. GLP-1 and GIP treatment is not a mandated treatment for the intended population.

Insurers have pointed out higher utilization rates than our initial assumptions, but we lacked claims data at the time of valuing the benefit. Even if claims data were available, it would have likely been 2021 claims data which reflects a partial year for Wegovy. Insurers are likely considering data from 2022 and emerging 2023, which we did not have access to.

However, we question whether insurers are accurately assessing the intended population. While there has been increased publicity and celebrity endorsements around GLP-1 and GIP drugs, we contend that this increased utilization is not specific to preventing diabetes and treatment for the intended population of morbidly obese individuals or those with insulin resistance and metabolic syndrome. The majority of GLP-1 and GIP drugs are approved for diabetes management, which does not reflect the intended benefit or the intended population. Additionally, we do not believe off-label use is required to be considered for the generosity and typicality benchmark analysis. The EHB Benchmark Plan does not disallow medical management, which we expect insurers will use to ensure usage is restricted to the intended population.

Regarding cost savings, insurers inquired whether we included a $3-4 per member per month (PMPM) savings assumption in year 1 for GLP-1 and GIP drugs for the intended population. We chose not to include such an assumption for conservatism due to the lack of utilization data and long-term impact studies. We firmly believe that this benefit has the potential to reduce healthcare costs for various conditions, including the prevention of diabetes, cardiovascular disease, and cancer, among others. Diabetes alone incurs significant costs, including insulin and related products, amputation, renal disease, and increased expenses associated with comorbidities arising from diabetes and morbid obesity.