A STUDY OF NEW JERSEY ASSEMBLY BILL 5200

REQUIRES HEALTH INSURANCE COVERAGE OF PRESCRIBED ANTI-OBESITY MEDICATION

Report to the New Jersey Assembly

December 8, 2023

Mandated Health Benefits Advisory Commission

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INTRODUCTION

The Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A5200 (see Appendix I for a copy of the legislation), a bill that requires health insurers (health, hospital, and medical service corporations, commercial individual and group health insurers, health maintenance organizations, health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs, the State Health Benefits Program (SHBP), and the School Employees' Health Benefits Program (SEHBP) to provide coverage of prescribed anti-obesity medication (AOM).

Specifically, A5200 would expand New Jersey statutory law to require health insurance coverage to provide benefits to any person covered for expenses incurred in obtaining prescribed anti-obesity medication. "Anti-obesity medication" is defined for the purposes of the bill as any medication approved by the United States Food and Drug Administration for chronic weight management in patients with obesity.

The Mandated Health Benefits Advisory Commission Act (N.J.S.A.17B:27D-1 et seq.) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The Act does not ask the Commission to recommend whether or not to enact the legislation, and the Commission does not do so here. The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections. The MHBAC has sought to include information from a number of reputable sources that it found credible but recognizes that opinions and analyses may differ.

LEGISLATIVE HISTORY

In the Assembly, A5200 was introduced on February 16, 2023, and was referred to the Assembly Financial Institutions and Insurance Committee.

A similar bill, A5259, was introduced on February 28, 2023, and was referred to the Assembly Health Committee. A5259 would require SHBP, SEHBP, Medicaid, and NJ FamilyCare to cover AOMs, but would not apply to the commercial markets regulated by the New Jersey Department of Banking and Insurance. Another bill, A4781 and S3259, would establish a similar but more expansive mandate for health insurance plans to provide coverage for obesity treatment, which coverage would include preventive care, nutrition counseling, behavioral therapy, bariatric surgery, and AOMs. The bill would apply to health, hospital, and medical service corporations, commercial individual and group health insurers, health maintenance

organizations, health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs, the SHBP, the SEHBP, and Medicaid. A4871 was introduced on October 17, 2022, and was referred to the Assembly Financial Institutions and Insurance Committee; S3259 was introduced on October 31, 2022, and was referred to the Senate Commerce Committee.

As of the date of the issuance of this report, no version of this legislation has been considered in either the Assembly or the Senate.

SOCIAL IMPACT

The Centers for Disease Control and Prevention (CDC) recently reported that, in the period from 1999-2000 to 2017-2020, obesity prevalence in the United States rose from 30.5% to 41.9%; over the same period the prevalence of severe obesity increased from 4.7% to 9.2%.[i] Obesity prevalence was highest among non-Hispanic Black adults (49.9%) and adults aged 40-59 years (44.3%). The CDC reported that obesity, which is associated with heart disease, stroke, type 2 diabetes, and certain cancers, is among the leading causes of preventable, premature deaths.[ii]

A 2021 study with a very large sample size found that obesity resulted in excess annual medical expenditures of nearly $173 billion, or $1,861 per adult, compared to the costs of those who were not obese.[iii] The excess annual medical cost of severe obesity was estimated at $3,097 per adult.[iv] According to a Milken Institute study comparing the economic and social costs of obesity in the US between 2014 and 2018, those costs rose from $976 million (or 5.57% of GDP) in 2014 to roughly $1.39 trillion (or 6.76% of GDP) in 2018.[v] The Milken Institute study calculated that the cost of lost workdays and lost employee output was $1.02 trillion in 2018.[vi] Obesity can have negative impacts on productivity through increased absenteeism and the use of more sick days, physical limitations at work, and health conditions associated with excessive weight, including fatigue, sleep apnea, and mental health challenges.[vii]

MEDICAL EVIDENCE

The American Medical Association (AMA) and the National Institutes of Health have recognized obesity as a chronic, relapsing disease, rather than a transitory condition primarily associated with behavioral and environmental factors.[viii] [ix] This means that many AOMs will need to be taken for a long duration or for a lifetime to achieve and maintain weight loss. The AMA has also adopted a position of supporting health insurance coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve outs.[x]

As of November 8, 2023, eight drugs have received FDA approval for long-term weight management and are currently on the market. They are presented in Table 1 with a bit of information for each.

Table 1. 8 FDA-Approved Drugs for Long-term Weight Management

Drug	Medication Class	Modality	Effectiveness
Alli (Orlistat)	Lipase inhibitor	Reduces the amount of fat absorbed in the gut after eating	Lower dose version of Orlistat, better tolerated, 85% of the efficacy of Xenical
Contrave (Bupropion-Naltrexone)	Combination of an antidepressant and an opioid receptor antagonist	Decreases cravings and appetite by affecting the pleasure-reward areas of the brain	At 56 weeks of a study, 40% of participants lost at least 5% of body weight, 20% of participants lost at least 10%
Imcivree (Setmelanotide)	Melanocortin receptor agonist	Helps control hunger and appetite in people with specific, very rare genetic deficiencies	At 1 year, 80% of participants with specific, very rare genetic deficiencies lost at least 10% of body weight, 40% of participants with a different genetic disposition lost 10%
Qsymia (Phentermine-Topiramate)	Combination of a medication similar to amphetamines and an anti-seizure medication	Works in the brain to reduce appetite	In a 1-year study at the maximum dose, 70% of participants lost at least 5% of body weight, nearly 50% of participants lost 10% or more
Saxenda (Liraglutide)	Glucagon-like-peptide receptor agonist (GLP-1)	Regulates appetite by stimulating the GLP-1 receptor in the brain	At 56 weeks of a study, 63% of participants lost at least 5% of body weight, 33% of participants lost at least 10%
Wegovy (Semaglutide)	Glucagon-like-peptide receptor agonist (GLP-1)	Regulates appetite by stimulating the GLP-1 receptor in the brain	Average weight loss of 15% of body weight when combined with lifestyle interventions, 86% of participants lost at least 5% of body weight and about 70% lost at least 10%. Weight loss results of 5% and 10% of body weight better than the other FDA-approved GLP-1 drug (Saxenda)

Drug	Medication Class	Modality	Effectiveness
Xenical (Orlistat)	Lipase inhibitor	Reduces the amount of fat absorbed in the gut after eating	Loss of 5% of body weight in one-year, reduced risk of type 2 diabetes
Zepbound (Tirzepatide)	Glucose-dependent insulinotropic polypeptide (GIP) and GLP-1	Increases feelings of fullness and reduces appetite	Average weight loss of 18% of body weight in trial with non-diabetics; average weight loss of 12% in trial for participants with type 2 diabetes

Sources: Phuoc Anh (Anne) Nguyen, "7 FDA-Approved Drugs for Weight Management," verywell health, August 14, 2023. Accessed 10/4/23. 7 FDA-Approved Drugs for Weight Management (verywellhealth.com); Doris Munoz-Mantilla, "Top Weight Loss Medications," Obesity Medicine Association, September 5, 2023. Accessed 10/4/23. Top Weight Loss Medications - Obesity Medicine Association; and US Food and Drug Administration, "FDA Approves New Medication for Chronic Weight Management," November 8, 2023. Accessed 11/8/23. FDA Approves New Medication for Chronic Weight Management | FDA

An analysis of more than 200 papers and studies on FDA-approved weight loss medications found that when the use of AOMs achieved a total body weight loss of 5-10%, it was "associated with a reduction in the risk of various metabolic, skeletal, and anatomical complications of obesity…."[xi] The authors postulated that weight loss greater than 15% of body weight might be needed to achieve measurable improvements in cardiovascular outcomes for obese patients.

Pharmaceutical manufacturer Novo Nordisk recently announced the results of its 5-year study of the impact of the use of semaglutide in preventing major adverse cardiovascular events (MACEs, defined as cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke). The double-blind trial of more than 17,000 adults aged 45 and above compared the effects of treatment with semaglutide to a placebo in overweight and obese subjects with established cardiovascular disease but no prior history of diabetes. The trial demonstrated "a statistically significant…reduction in MACE of 20% for people treated with semaglutide…compared to placebo."[xii] In addition to the overall impact, treatment with semaglutide also led to "superior MACE reduction" in all 3 components of MACE. One set of researchers argued that such direct evidence that the use of medications for weight loss can result in statistically significant improvements in cardiovascular and stroke outcomes for obese patients was essential for bolstering the proposition that AOMs could be a cost-effective component of insurance coverage for obesity.[xiii]

Notwithstanding the findings from smaller trials of AOMs with diabetic patients, researchers have suggested there is a need to expand clinical trials into larger prospective studies of longer duration to confirm those findings.[xiv] For example, one trial involving diabetic subjects looking at the impact of liraglutide versus placebo on cardiovascular death, non-fatal myocardial infarct, and non-fatal stroke after a median follow up of 3.8 years, found modest reductions in the

composite of all three outcomes (13%) and a more impressive reduction in the risk of cardiovascular death (22%) among diabetic subjects receiving liraglutide. A similar study of semaglutide showed a more pronounced reduction in the risk of the composite outcome measures (26%), but no difference in deaths among subjects receiving semaglutide versus placebo. Other trials have suggested a possible neuro-protective effect of GLP-1 agonists in reducing "the risk of dementia and age-related cognitive decline…associated with diabetes and obesity."[xv] Another promising pathway for AOM research is the effect of combining two or more medications to achieve greater impacts on weight loss.[xvi]

Although there are potential medical benefits of GLP-1 medications, there are also potential gastrointestinal side effects, which may contribute to low medication adherence and early discontinuation of therapy. In a recent study, more than 68% of patients did not maintain GLP-1 therapy for 12 months.[xvii] Common reported side effects for patients taking AOMs include nausea, diarrhea, vomiting, and constipation, which side effects are frequently associated with starting the medication or increasing the dosage being taken. More potentially serious, but much rarer, side effects include acute pancreatitis, thyroid tumors, acute kidney problems, and heart rate increases.[xix] Adverse gallbladder events associated with the use of GLP-1 receptor agonists (RAs) have also occurred. "Use of GLP-1 RAs may be associated with increased risk of gallbladder or biliary diseases because GLP-1 inhibits gallbladder motility and delays gallbladder emptying….In addition, marked weight loss…which occurs in some patients using GLP-1 RAs, has been associated with a high risk of gallbladder disorders.[xx]

OTHER STATES

A recent report published by the Kaiser Family Foundation found that 16 Medicaid programs were covering at least one weight-loss or anti-obesity medication for the treatment of obesity for adults as of July 1, 2023. The states were California, Minnesota, Wisconsin, Michigan, Kansas, Mississippi, Virginia, Delaware, Pennsylvania, Hawaii, New Hampshire, Connecticut, Rhode Island, Texas, Louisiana, and South Carolina. For Texas, Louisiana, and South Carolina, coverage was limited to one medication, Orlistat/Xenical. Ten of these states reported that patients needed to demonstrate a comorbidity, as well as being obese, in order to obtain coverage. A few other states noted that they imposed a body mass index minimum or preauthorization requirements when covering these drugs. Five other states indicated that, while they did not currently cover them, they were evaluating or considering adding these drugs to their Medicaid coverage (Illinois, Massachusetts, New Mexico, Utah, and Vermont).[xxi]

Wegovy received FDA approval for weight loss in 2021. Some state Medicaid programs placed it on their preferred drug lists, permitting low-income program participants access to the name-brand obesity drug at a greatly reduced cost. Those states were California, Connecticut, Delaware, Michigan, Minnesota, Pennsylvania, Rhode Island, Virginia, and Wisconsin.[xxii] By

statute, state Medicaid programs receive a drug manufacturer's best price when that drug is placed on a preferred list (about 20% lower than prices offered to private insurers); in exchange manufacturers can supply the drug to a potentially large pool of patients. The Medicaid program can also negotiate a substantial supplemental rebate, "after a state agrees to preferentially cover a manufacturer's drug over a competitor's drug…."[xxiii] While the negotiated final price is confidential, it has been low enough that those 9 states have been willing to cover Wegovy, giving them the opportunity to measure the impact of the drug on future overall medical costs. According to another source, New Hampshire is also among the states where the state's Medicaid program covers Wegovy.[xxiv]

DISCUSSION

The empirical evidence demonstrating the efficacy of AOMs for weight loss for obese patients is conclusive. The issue is whether spending on pharmacotherapies is and will be cost effective for payers. One study put the cost for a year's worth of semaglutide after rebates and discounts at $13,618, or approximately $1,135 per month.[xxv] The list price for the newest FDA-approved AOM, Eli Lilly's Zepbound, is $1,060 per month.[xxvi] As a recent journal article suggested, "Ongoing research will…be needed to evaluate the efficacy of these medications…on long-term patient outcomes and health care system costs," in order to make that determination. The authors expressed optimism that expanded coverage of AOMs "could help reduce disparities in obesity rates and contribute to efforts to address health inequities in the United States…."
On the other hand, it is incumbent on health care stakeholders to guarantee that AOMs are equitably available to the millions of people affected by obesity. As one group of authors stated, "Newer AOMs hold promise, but uneven access to these medications could exacerbate obesity disparities."[xxix]

A study of the actual experiences of patients taking GLP-1 medications, conducted by two pharmacy benefit managers (PBMs), raised concerns about patients' adherence to treatment. The study found that 32% of patients were taking their AOM consistently at one year, and 27% of those continuing to take the drug were still taking it consistently during the following year.[xxx] With 68% of those who started taking a GLP-1 medication stopping use within 12 months, the model estimated that 26% of the spending on those drugs was wasted.[xxxi] Several factors might explain why patients chose to stop taking the medication, including side effects, cost barriers, and the inconvenience of the prior authorization process. It is also important to bear in mind that the limited empirical evidence suggests that patients will need to take AOMs over the long-term, and possibly for the rest of their lives. Another study, for instance, demonstrated that patients who discontinued use of the GLP-1 medication regained two-thirds of the weight lost after being off the drug for one year. Both the necessary duration of use and the high rate of discontinuation of use are important considerations when undertaking a cost-benefit analysis of these drugs.

FINANCIAL IMPACT

A recent analysis asserted, "Newer AOMs are not deemed cost-effective at their current prices…and would have to take 40% to 60% price reductions to meet commonly accepted willingness-to-pay thresholds in cost-effectiveness analyses."[xxxiii] A study by the American Enterprise Institute (AEI) estimates that the net prices received by pharmaceutical companies are actually 48% to 78% below list prices, potentially falling within the cost-effectiveness parameters established in the previous study cited.[xxxiv] The AEI authors examined prices for Wegovy, specifically approved as an AOM, and for three FDA-approved diabetes medications frequently used as AOMs (i.e., Ozempic, Rybelsus, and Mounjaro). The authors looked at prices paid by commercial purchasers, government buyers, and those paying cash, after rebates and coupons were applied. The results are summarized in Table 2.

Table 2. Estimated Discount from List to Net Price, Select GLP-1 Drugs, First Quarter of 2023

	Wegovy	**Ozempic**	**Rybelsus**	**Mounjaro**
List Price Monthly	$1349	$936	$936	$1023
Average Discount from List Price to Net Payment	48%	69%	64%	79%
Implied Net Price Monthly (Received by Manufacturer)	$701	$290	$337	$215

Source: Ippolito and Levy, American Enterprise Institute, September 2023. Accessed 10/23/23. **Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf (aei.org)** The MHBAC has not independently verified this pricing. We cannot confirm if this chart includes inflated rebates/discounts.

When New Mexico updated its essential health benefits-benchmark plan in 2020, the state relied on a study finding that expanding weight loss drug coverage to patients with obesity, rather than limiting coverage to patients with morbid obesity, would not materially increase premiums.[xxxv]

North Carolina's state employee health plan, which covers more than 740,000 public employees, retirees, and their dependents, covers the GLP-1 drugs Wegovy and Saxenda. Over 23,000 state health plan members were using the AOMs during the first half of 2022, costing the plan $52.3 million, or an average cost of more than $800 per member per month over those 6 months. State spending on Wegovy and Saxenda are projected to pass $170 million in 2024 and exceed $1 billion in the next 6 years.[xxxvi]

North Carolina's Treasurer asked the board that oversees the state employee health program to drop coverage for the drugs, due to the high cost. The board responded by instituting a temporary halt to insurance coverage for new AOM users, effective January 1, 2024; the board

intends to restart discussions of the state plan's coverage of AOMs soon thereafter. The issue for North Carolina's state employee health plan is the high net cost for these drugs, after discounts and rebates. As the Treasurer stated, "We are not questioning the efficacy of the drugs, but we simply can't afford these medications at the manufacturer's current price point."[xxxvii]

Other states have also struggled with balancing access and cost. In Connecticut, for example, the state employee plan, which covers about 265,000 employees, was on course to spend $30 million this year on a class of diabetes drugs. Since July of this year, state health plan members looking to use newer AOMs must first take part in a clinical lifestyle management program called "Flyte," after which providers might prescribe weight loss medication.[xxxviii] The University of Texas, a very large employer in the state with 116,000 employees, dropped coverage for weight loss drugs in September, reportedly after seeing costs for the medications rise from about $1.5 million per month to $5 million per month over an 18-month period ending in May 2023.[xxxix] Further, with respect to access and reported cost estimates, it should be noted that reports of shortages of certain AOMs could be impacting both access to the medications and the cost estimates being reported.[xl]

The SHBP and SEHBP together cover more than 800,000 active and retired members in New Jersey. The consulting firm Aon conducted a 2024 SHBP rate setting analysis for the State of New Jersey, utilizing claims data for 2022 and the first quarter of 2023. Aon reported that the utilization of AOMs, such as Wegovy and Saxenda, from the previous year increased 67% for active local government employees and 57% for active state government employees.[xli] Aon projected overall prescription plan price increases of 9.0% for 2024 for the active employees and early retirees covered by local and state government health plans, not all of which can be ascribed to greater costs associated with AOMs.[xlii]

Referring to AOMs, the AEI study discussed above points to a "robust discovery pipeline for similar drugs suggest[ing] that more competing treatments may come to market in the coming years."[xliii] More competition has the potential to drive down net prices for AOMs, as manufacturers vie for market share and formulary placement. In fact, the AEI authors specifically identified Eli Lilly's newly approved drug as having the potential to shake up the AOM market. As the authors phrased it, "If Mounjaro is also approved for obesity, we anticipate that competition for formulary placement will likely put downward pressure on net prices…."[xliv]

An additional consideration is that the federal Patient Protection and Affordable Care Act requires states to defray the cost of any health insurance benefit mandate enacted after December 31, 2011, that is part of an insurance plan sold on a state exchange that is in addition to the state's essential health benefits (EHBs) and related to specific care, treatment, or services. ((P.L. 111-148 § 1311(d)(3) & 45 CFR 155.170). Federal law requires (1) the state to identify benefit mandates that are in addition to the state's EHB, and (2) insurers to report the cost of those benefits back to the state (i.e., excess cost reports). The state must then defray the cost of the additional mandates by making the appropriate payment directly to an enrollee or to the insurer

on the enrollee's behalf (45 CFR 155.170). A 2017 federal final rule (§ 19) changed the entity responsible for identifying mandates and receiving excess cost reports from the state's exchange to the state. Defrayment does not apply to the large group market. For more information on State-required benefits, please refer to this CMS FAQ on Defrayal of State Additional Required Benefits. As part of the HHS Notice of Benefit and Payment Parameters for 2025 proposed on November 24, 2023, for plan years beginning on or after January 1, 2027, CMS is proposing revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process.[xlv] The process of updating the state's EHB-benchmark plan could create a pathway to adding benefits to the benchmark plan that may not trigger defrayal provided certain parameters are met. Thus, although this is a state-by-state analysis and no such analysis has been performed for New Jersey, AOMs may trigger the federal defrayment requirements.

Lastly, the Institute for Clinical and Economic Review (ICER), an evidence review organization that examines access and effectiveness, published a report on treatments for obesity management advising that: "All stakeholders have an important role to play in ensuring that people living with obesity have access to effective medications as a core benefit of health care insurance coverage."[xlvi] The 2022 report included reviews of subcutaneous semaglutide (Wegovy, Novo Nordisk), liraglutide (Saxenda, Novo Nordisk), phentermine/topiramate (Qsymia, Vivus Pharmaceuticals), and bupropion/naltrexone (Contrave, Currax Pharma). ICER found that semaglutide used for weight loss would achieve common thresholds for cost-effectiveness if priced between $7,500 – $9,800 per year. ICER noted, "Even at a fair price, only 0.2% of eligible patients could be treated before creating a significant budget impact problem."[xlvii]

CONCLUSION

Balancing Social Impact, Medical Evidence, and Financial Impact

The social and healthcare costs of treating obesity have been increasing for years. AOMs have demonstrated a strong record of helping obese patients lose weight and maintain weight loss, when taken persistently. Consistent empirical results from future research with larger sample sizes and longer durations are needed to prove the connection between weight loss and meaningful, positive impacts on health outcomes, such as reductions in cardiovascular events and deaths, strokes, diabetes, and multiple other diseases. The cost effectiveness of AOMs will hinge both on their demonstrated impact on reducing other healthcare costs and on the actual net prices paid for the medications. As stated by Antonio Ciaccia, CEO and Founder of 46brooklyn, an Ohio-based drug pricing think tank, "States are going to have to figure out if it's worth the investment."[xlviii]

ENDNOTES

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[xliii] Ippolito and Levy, *op. cit.*

[xliv] *Ibid.*

[xlv] Federal Register, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program," November 24, 2023. Accessed 12/7/23. Federal Register :: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program

[xlvi] Institute for Clinical and Economic Review, "Medications for Obesity Management: Effectiveness and Value, Final Evidence Report," October 20, 2022. Accessed 12/7/23. ICER_Obesity_Final_Evidence_Report_and_Meeting_Summary_102022.pdf

[xlvii] Institute for Clinical and Economic Review, "ICER Publishes Final Evidence Report and Policy Recommendations on Treatments for Obesity Management," October 20, 2022. Accessed 11/20/23. ICER Publishes Final Evidence Report and Policy Recommendations on Treatments for Obesity Management - ICER

[xlviii] Belloni, *op. cit.*

ASSEMBLY, No. 5200

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED FEBRUARY 16, 2023

Sponsored by:
Assemblywoman CAROL A. MURPHY
District 7 (Burlington)
Assemblyman JOHN F. MCKEON
District 27 (Essex and Morris)
Assemblywoman SHANIQUE SPEIGHT
District 29 (Essex)

Co-Sponsored by:
Assemblymen Wimberly and Catalano

SYNOPSIS

Requires health insurance coverage of prescribed anti-obesity medication.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 5/8/2023)

AN ACT concerning health insurance coverage for certain anti-obesity medication and supplementing various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. a. A hospital service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

c. The provisions of this section shall apply to all hospital service corporation contracts in which the hospital service corporation has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

2. a. Every medical service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits to any named subscriber or other person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

c. The provisions of this section shall apply to all medical service corporation contracts in which the medical service corporation has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

3. a. Every health service corporation contract that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits to any named

subscriber or other person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

c. The provisions of this section shall apply to all health service corporation contracts in which the health service corporation has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

4. a. Every individual policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S. 17B:26-1 et seq., or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits to any named insured or other person covered thereunder for expenses incurred obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the policy.

c. The provisions of this section shall apply to all health insurance policies in which the insurer has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

5. a. Every group policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to N.J.S.17B:27-26 et seq., or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide benefits to any named insured or other person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the policy.

c. The provisions of this section shall apply to all health insurance policies in which the insurer has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

6. a. Every enrollee agreement that provides hospital or medical expense benefits and is delivered, issued, executed, or

renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide health care services to any enrollee or other person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The health care services shall be provided to the same extent as for any other medical condition under the enrollee agreement.

c. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

7. a. Every individual health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide benefits to any person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

8. a. Every small employer health benefits plan that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this State on or after the effective date of this act, shall provide benefits to any person covered thereunder for expenses incurred obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the health benefits plan.

c. The provisions of this section shall apply to all small business health benefits plans in which the carrier has reserved the right to change the premium.

d. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

9. a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act, that provides hospital or medical expense benefits shall provide benefits to any person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

c. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

10. a. The School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide benefits to any person covered thereunder for expenses incurred in obtaining prescribed anti-obesity medication.

b. The benefits shall be provided to the same extent as for any other medical condition under the contract.

c. For the purpose of this section, "anti-obesity medication" means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patients with obesity.

11. This act shall take effect on the 90th day next following enactment and shall apply to policies and contracts that are delivered, issued, executed, or renewed on or after that date.

STATEMENT

This bill requires health insurance coverage of prescribed anti-obesity medication.

Specifically, under the bill, health insurance carriers (including insurance companies, hospital service corporations, medical service corporations, health service corporations, health maintenance organizations authorized to issue health benefits plans in New Jersey, and any entities contracted to administer health benefits in connection with the State Health Benefits Program and School Employees' Health Benefits Program) will be required to cover prescribed anti-obesity medication that is approved by the U.S. Food and Drug Administration.

It is the intent of the sponsor of this bill that access to obesity medication be expanded and that greater attention be placed on obesity as a disease. Since 2013, the American Medical Association has recognized obesity as a disease requiring treatment and prevention efforts. According to the World Health Organization, obesity leads to a range of non-communicable

diseases such as type 2 diabetes, cardiovascular disease, hypertension, stroke, various forms of cancer, and various mental health issues. It is estimated that almost one-third of American adults and 17% of American children ages two to 19 are obese. Globally, more than one billion people are considered to be obese, with an additional 167 million people expected to become obese by 2025. By expanding access to FDA-approved anti-obesity medication such as “Wegovy,” more individuals will be able to affordably access this effective treatment.

NEW JERSEY GENERAL ASSEMBLY

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COMMITTEES
FINANCIAL INSTITUTIONS AND INSURANCE, CHAIR
BUDGET
ENVIRONMENT AND SOLID WASTE
JUDICIARY
INTERGOVERNMENTAL RELATIONS COMMISSION

September 13, 2023

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, NJ 08625

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institutions and Insurance Committee, I respectfully request the Commission review and prepare a written report of A-5200, which requires health insurance coverage of prescribed anti-obesity medication.

If you have any questions, please do not hesitate to contact Mark Iaconelli, Jr., Esq., Deputy General Counsel, at 609-847-3500.

Thank you for your immediate attention to this matter.

Sincerely,

John F. McKeon

CC: Mark Iaconelli, Jr., Esq.
Deputy General Counsel
Assembly Majority Office