MILLIMAN WHITE PAPER

GLP-1 medication trends in Utah

Commissioned by One Utah Health Collaborative

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Glucagon-like peptide-1s (GLP-1s) are a class of medication that were initially created to help manage type 2 diabetes but have received additional indications for the treatment of obesity and chronic heart disease.[1] With demand on the rise for these medications, this report delves into the implications for costs, utilization, and strategies for various stakeholders in the Utah healthcare sector.

In 2024, the One Utah Health Collaborative (the Collaborative) initiated an analysis of the historical usage of GLP-1 drugs in Utah and identified strategies for managing their future use. The Collaborative engaged Milliman to conduct this analysis and findings are detailed in this report. Obesity has become a serious health issue in the United States as it is believed to contribute to deadly conditions such as diabetes, cardiovascular death, heart attack, and stroke. Similar to the rest of the nation, Utah is experiencing increasing rates of obesity, where approximately 31.0% of the state's population is affected.[2] Byetta, the first GLP-1 receptor agonist, was approved by the U.S. Food and Drug Administration (FDA) in 2005 to manage blood sugar levels in type 2 diabetic patients as an injection given daily or weekly.[3] Since the introduction of Byetta, the number of products in the market has continued to grow and currently 10 GLP-1 brands are available, with more expected in the pipeline.

Recently, some of the GLP-1s have gained additional FDA approval for indications other than the initial approval for diabetes treatment. The FDA approved Wegovy (semaglutide) in June 2021 and Zepbound (tirzepatide) in November 2023 for use in chronic weight management in adults with obesity or who are overweight with at least one weight-related condition such as high blood pressure, type 2 diabetes, or high cholesterol.[4] Additionally, in March 2024, the FDA approved a new indication for Wegovy for use in adults with cardiovascular disease and either obesity or overweight indications to reduce the risk of cardiovascular events such as cardiovascular death, heart attack, and stroke problems.[5] Most recently, the FDA approved an indication for Zepbound for sleep apnea[6] and semaglutide for use in adults with chronic kidney disease and type 2 diabetes.[7] Additional indications are expected in the future.

While some of these new GLP-1 drugs have FDA approval as anti-obesity medications (AOMs), they have not yet been widely covered by state Medicaid agencies, Medicare, or commercial plans for this indication.

Due, in part, to the newly added indications for GLP-1s, the demand for these medications has dramatically increased, causing high costs for plans and contributing to supply issues for the pharmaceutical companies. Figure 1 provides a list of these medications with

[1] FDA (March 8, 2024). FDA Approves First Treatment to Reduce Risk of Serious Heart Problems Specifically in Adults With Obesity or Overweight. News release. Retrieved November 8, 2024, from https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or.
[2] Utah Department of Health and Human Services (October 22, 2024). "Complete Health Indicator Report of Obesity among Adults." Public Health Indicator Based Information System (IBIS). Retrieved November 22, 2024, from https://ibis.utah.gov/ibisph-view/indicator/complete_profile/Obe.html.
[3] Cleveland Clinic. GLP-1 Agonists. Retrieved November 8, 2024, from https://my.clevelandclinic.org/health/treatments/13901-glp-1-agonists.
[4] FDA (June 4, 2021). FDA Approves New Drug Treatment for Chronic Weight Management, First Since 2014. News release. Retrieved November 8, 2024, from https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014.
[5] FDA (March 8, 2024), op cit.
[6] FDA (December 2024). FDA Approves First Medication for Obstructive Sleep Apnea. Retrieved February 24, 2025, from https://www.fda.gov/news-events/press-announcements/fda-approves-first-medication-obstructive-sleep-apnea .
[7] Munz K.. (January 2025). FDA Expands Semaglutide Use for CV, Kidney Risks in T2D, CKD. American Journal of Managed Care. Retrieved February 24, 2025 from https://www.ajmc.com/view/fda-expands-semaglutide-use-for-cv-kidney-risks-in-t2d-ckd

pertinent information about their FDA approvals indications for obesity or other conditions, Medicare coverage, and availability shortage.

FIGURE 1: SUMMARY OF GLP-1 MEDICATIONS AVAILABLE

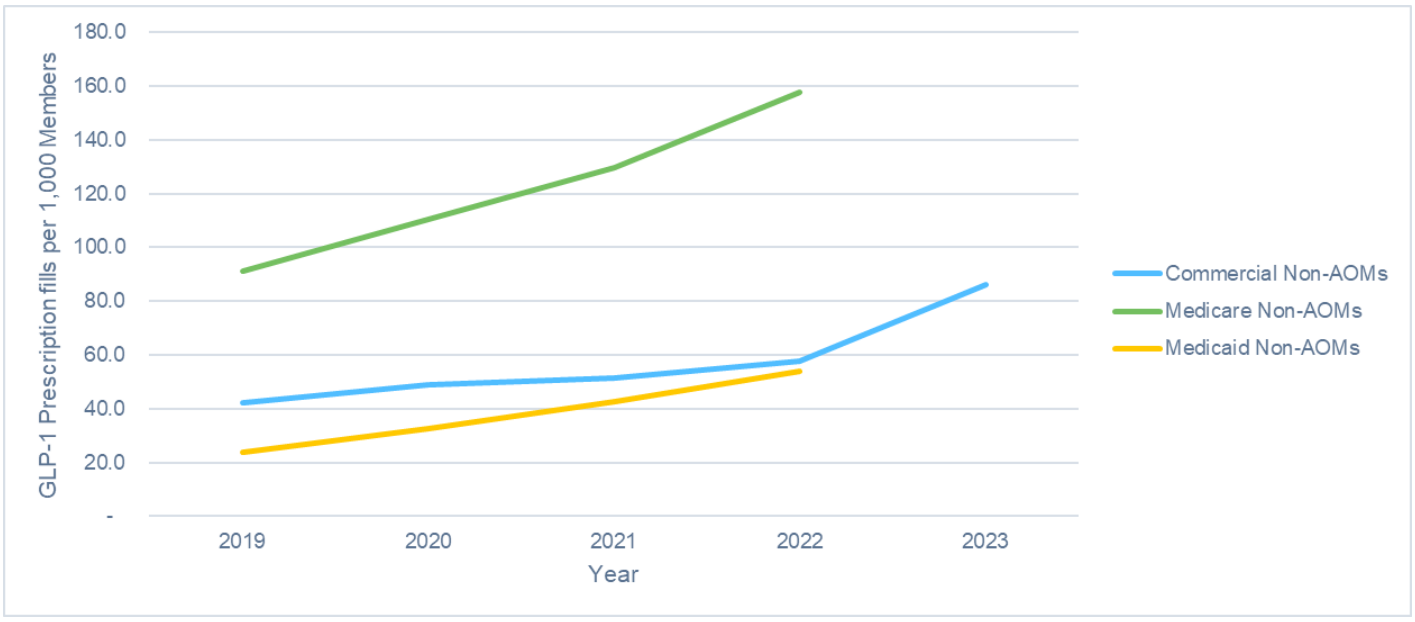
MEDICATION	FDA Approval Date[8]	AOM / Non-AOM	Medicare-Covered	FDA Drug Shortage[9]	Notes
Byetta (Exenatide)	4/28/2005	Non-AOM	Yes	No	
Victoza (Liraglutide)	1/25/2010	Non-AOM	Yes	Yes	
Tanzeum (Albiglutide)	4/15/2014	Non-AOM	Yes	No	
Trulicity (Dulaglutide)	9/18/2014	Non-AOM	Yes	Yes	
Saxenda (Liraglutide)	12/23/2014	AOM	No	Yes	Available in higher doses than Victoza
Adlyxin (Lixisenatide)	7/27/2016	Non-AOM	Yes	No	Discontinued
Bydureon BCise (Exenatide extended release)	10/20/2017	Non-AOM	Yes	No	Discontinued
Ozempic (Semaglutide injection)	12/5/2017	Non-AOM	Yes	No	
Rybelsus (Semaglutide tablet)	9/20/2019	Non-AOM	Yes	No	
Wegovy (Semaglutide)	6/4/2021	AOM	Yes*	No	Available in higher doses than Ozempic. * CMS approved Medicare coverage to reduce the risk of heart attack and stroke in adults with cardiovascular disease who are either obese or overweight.
Mounjaro (Tirzepatide)	5/13/2022	Non-AOM	Yes	No	
Zepbound (Tirzepatide)	11/8/2023	AOM	No	No	

Landscape study

The following is a summary of historical cost and utilization of GLP-1s in the state of Utah. The summary is based on the Utah All-Payer Claims Database (APCD), for commercial (2019-2023 data available) and Medicaid markets (2019-2022 data available), and the Centers for Medicare and Medicaid Services (CMS) 100% Research Identifiable Files (RIF), for Medicare (2019-2022 data available). Figure 2 illustrates the utilization per 1,000 members for non-AOMs and Figure 3 shows the total allowed cost by year and payer (commercial, Medicaid, and Medicare) from 2019 to 2023, where available.

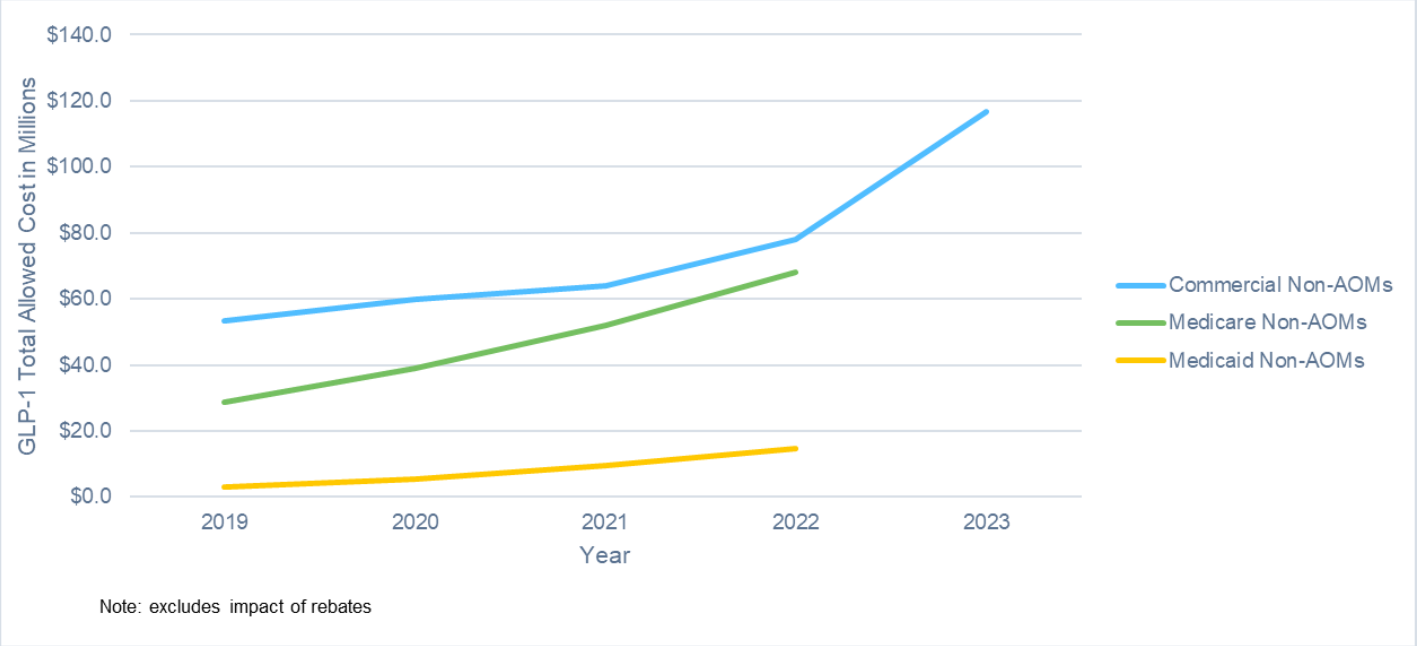
[8] FDA. Drugs@FDA: FDA-Approved Drugs. Retrieved February 24, 2025, from https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process.
[9] FDA. FDA Drug Shortages, as of February 24, 2025. Retrieved February 24, 2025, from https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm.

FIGURE 2: STATE OF UTAH PRESCRIPTION FILLS PER 1,000 MEMBERS FOR NON-AOM GLP-1, 2019-2023



MARKET	2019	2020	2021	2022	2023
Commercial Non-AOMs	42.3	48.7	51.2	57.5	86.0
Medicare Non-AOMs	91.0	110.5	129.7	157.5	
Medicaid Non-AOMs	23.8	32.5	42.7	53.9	

FIGURE 3: STATE OF UTAH TOTAL ALLOWED COST FOR NON-AOM GLP-1 (IN MILLIONS), 2019-2023



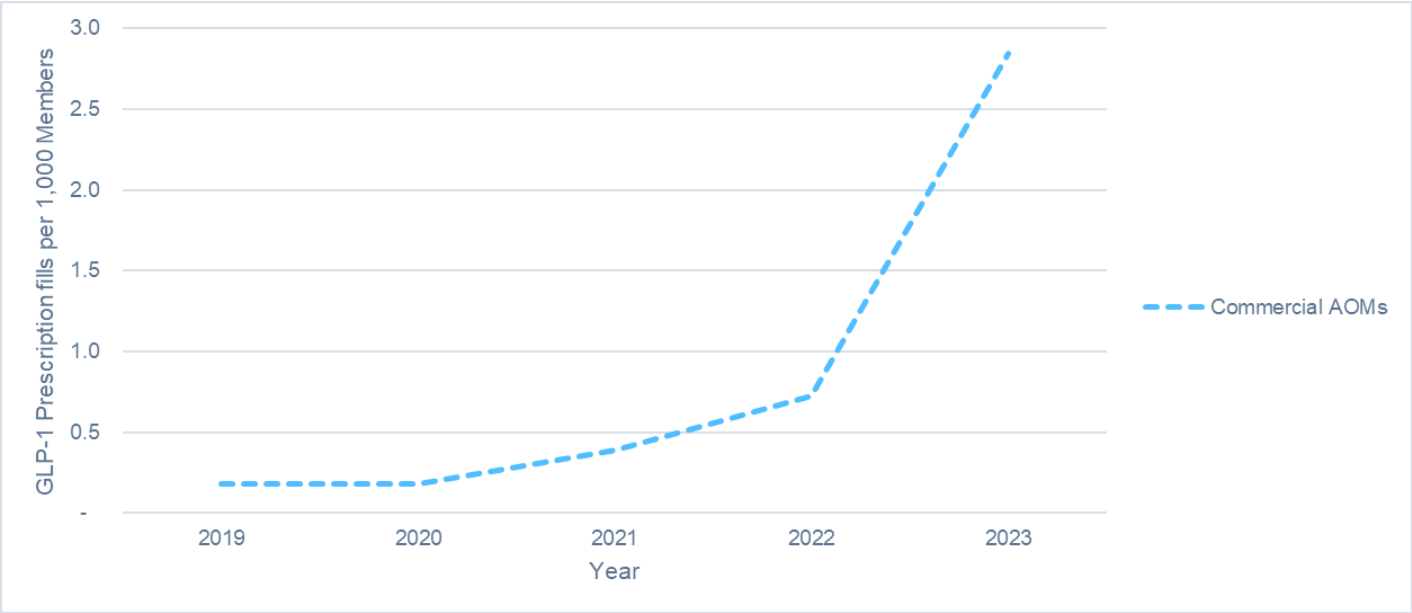
MARKET	2019	2020	2021	2022	2023
Commercial Non-AOMs	$53.4	$59.8	$64.0	$77.9	$116.7
Medicare Non-AOMs	$28.6	$39.0	$51.9	$68.2	
Medicaid Non-AOMs	$3.0	$5.3	$9.7	$14.7	

Figure 2 shows a steady increase in usage for the Medicare and Medicaid populations while the commercial utilization rate increased more slowly through 2022 and more steeply between 2022 and 2023.

Figure 3 shows a steady increase in the total allowed cost for the non-AOMs for all lines of business. Note that allowed costs exclude manufacturer rebates. Rebates vary by plan and partially offset gross costs.

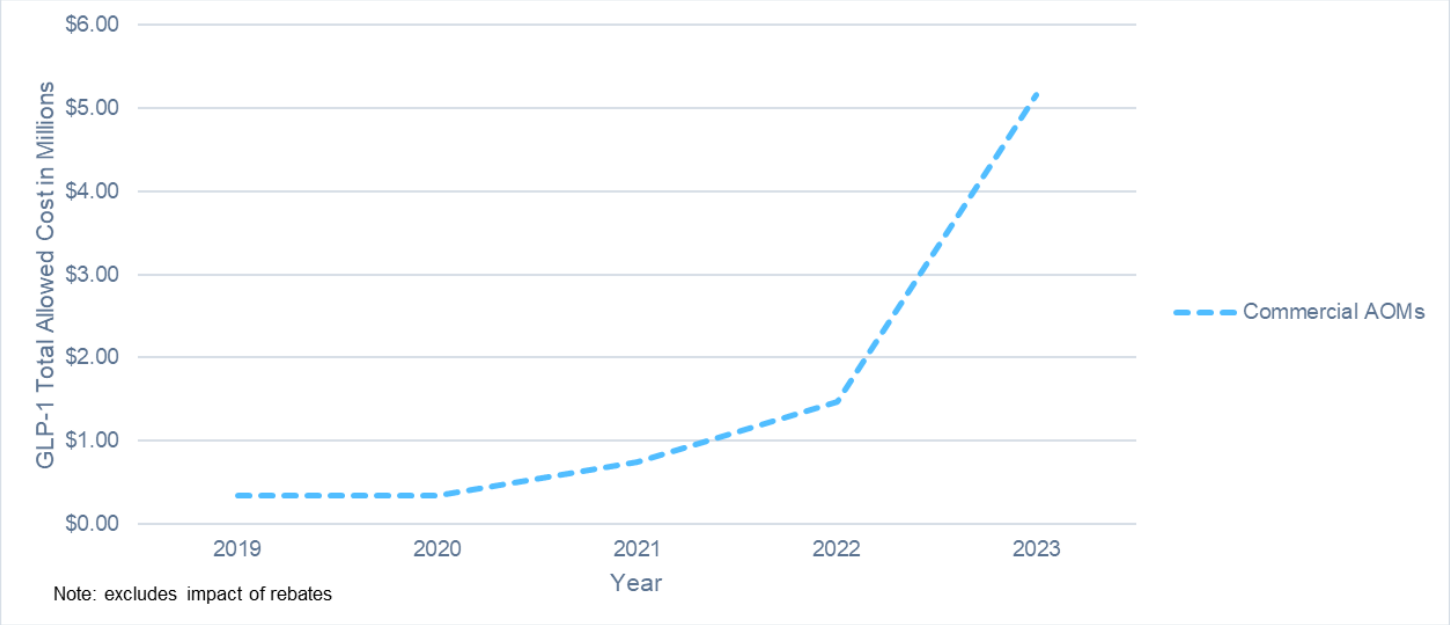
Figure 4 illustrates the utilization per 1,000 members for AOMs and Figure 5 shows the total allowed cost by year for commercial payers from 2019 to 2023. Utah Medicaid and all Medicare plans are prohibited from covering AOM GLP-1s for weight loss indications and are not included in Figure 4. The utilization per 1,000 members and total cost for AOM GLP-1s is much lower than for non-AOM GLP-1s, in part because many plans in the commercial market do not cover AOM GLP-1s.

FIGURE 4: STATE OF UTAH PRESCRIPTION FILLS PER 1,000 MEMBERS FOR AOM GLP-1, 2019-2023



MARKET	2019	2020	2021	2022	2023
Commercial AOMs	0.2	0.2	0.4	0.7	2.8

FIGURE 5: STATE OF UTAH TOTAL ALLOWED COST FOR AOM GLP-1 (IN MILLIONS), 2019-2023

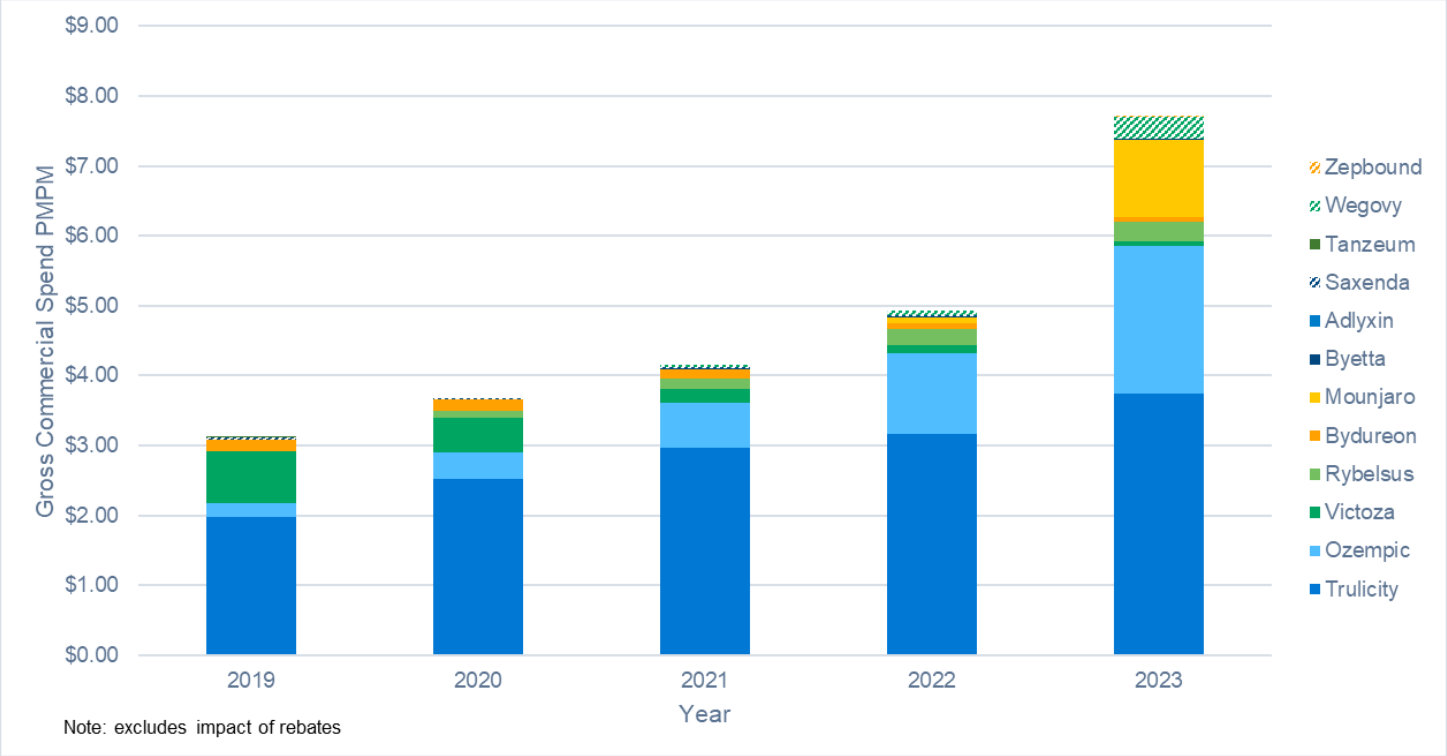


MARKET	2019	2020	2021	2022	2023
Commercial AOMs	$0.34	$0.33	$0.74	$1.46	$5.16

Both Figures 4 and 5 show increases in commercial AOM usage, as some commercial plans have expanded coverage for AOM GLP-1s, and new drugs have gained FDA approval (Wegovy June 2021, Zepbound November 2023). Additionally, there has been increasing media and marketing attention on these drugs which has contributed to these increases in utilization.

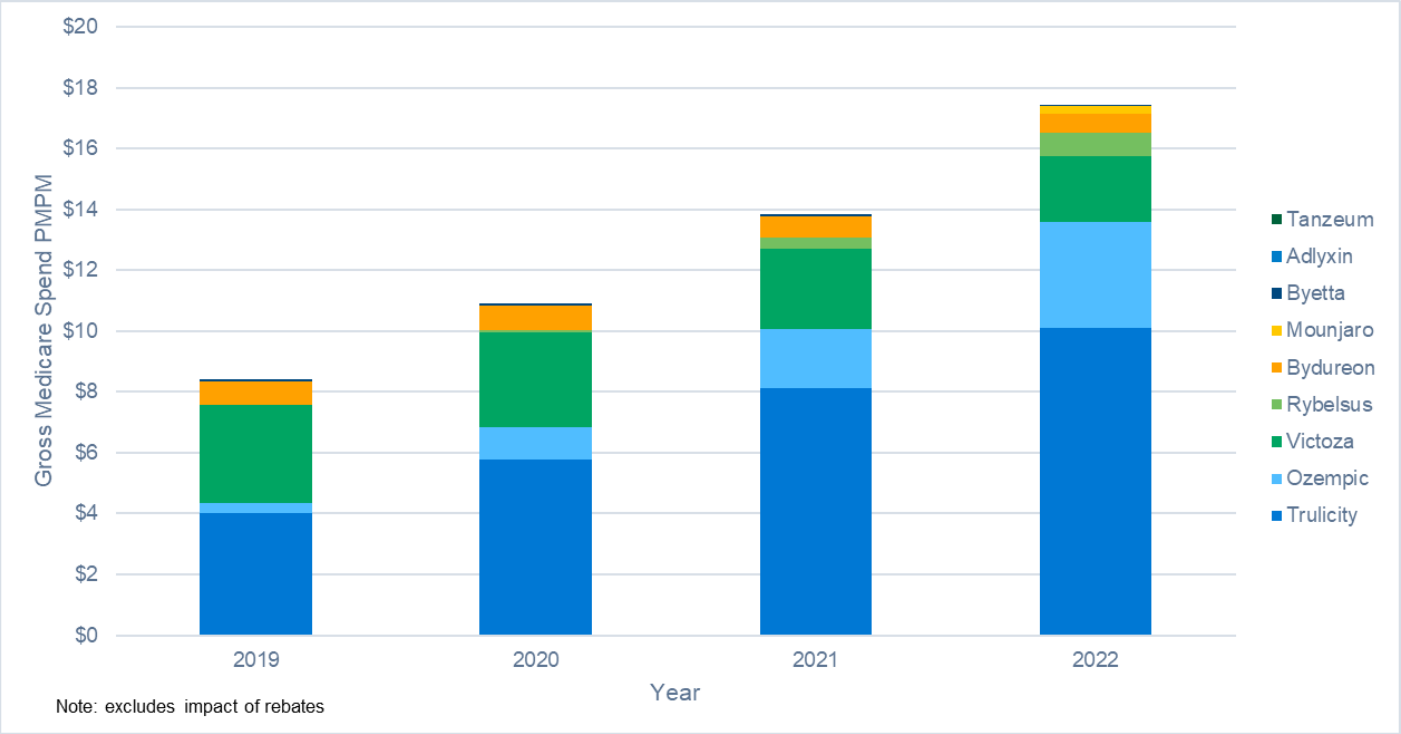
Figures 6 to 8 show the allowed spend (gross of rebates and cost sharing) per member per month (PMPM) for commercial, Medicaid, and Medicare by individual GLP-1 drugs. Trulicity, released in 2014, has been very popular, with the highest market share among GLP-1 drugs in recent years. The commercial and Medicaid spend PMPM is declining but growing in the Medicare market. Ozempic, released in 2017, and Mounjaro, released in 2022, are increasing across all markets.

FIGURE 6: ALLOWED COMMERCIAL SPEND PMPM BY YEAR FOR GLP-1 AGONISTS, 2019-2023



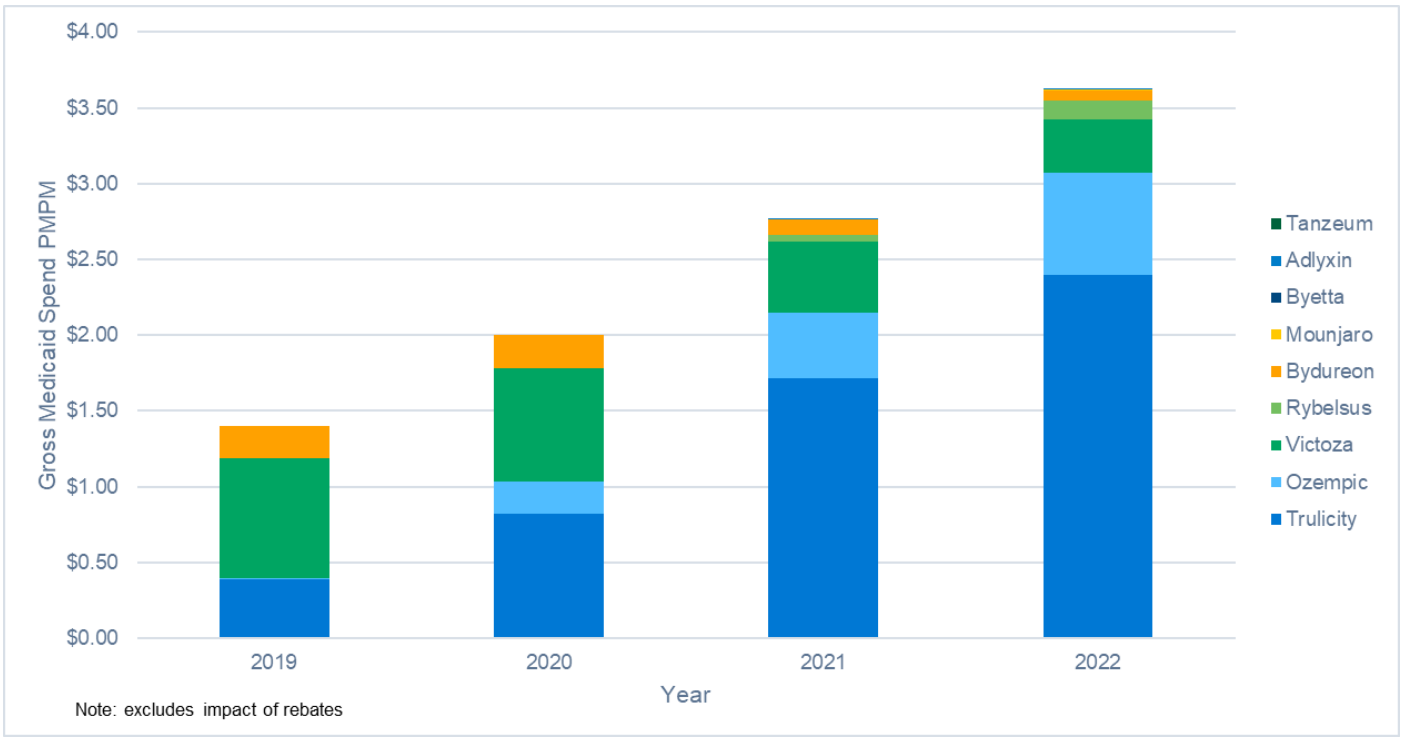
MEDICATION	2019	2020	2021	2022	2023
Zepbound	$0.00	$0.00	$0.00	$0.00	$0.00
Wegovy	$0.00	$0.00	$0.02	$0.07	$0.31
Tanzeum	$0.00	$0.00	$0.00	$0.00	$0.00
Saxenda	$0.02	$0.02	$0.03	$0.02	$0.02
Adlyxin	$0.00	$0.00	$0.00	$0.00	$0.00
Byetta	$0.01	$0.01	$0.01	$0.01	$0.01
Mounjaro	$0.00	$0.00	$0.00	$0.09	$1.11
Bydureon	$0.16	$0.16	$0.14	$0.09	$0.07
Rybelsus	$0.00	$0.09	$0.15	$0.23	$0.28
Victoza	$0.73	$0.50	$0.19	$0.12	$0.06
Ozempic	$0.20	$0.39	$0.65	$1.14	$2.10
Trulicity	$1.98	$2.52	$2.96	$3.17	$3.75

FIGURE 7: ALLOWED MEDICARE SPEND PMPM BY YEAR FOR GLP-1 AGONISTS, 2019-2022



MEDICATION	2019	2020	2021	2022
Tanzeum	$0.00	$0.00	$0.00	$0.00
Adlyxin	$0.00	$0.00	$0.00	$0.00
Byetta	$0.09	$0.07	$0.06	$0.06
Mounjaro	$0.00	$0.00	$0.00	$0.26
Bydureon	$0.75	$0.79	$0.72	$0.60
Rybelsus	$0.00	$0.08	$0.37	$0.76
Victoza	$3.23	$3.10	$2.63	$2.17
Ozempic	$0.34	$1.06	$1.93	$3.50
Trulicity	$4.02	$5.79	$8.13	$10.09

FIGURE 8: ALLOWED MEDICAID SPEND PMPM BY YEAR FOR GLP-1 AGONISTS, 2019-2023



MEDICATION	2019	2020	2021	2022
Tanzeum	$0.00	$0.00	$0.00	$0.00
Adlyxin	$0.00	$0.00	$0.00	$0.00
Byetta	$0.00	$0.00	$0.00	$0.00
Mounjaro	$0.00	$0.00	$0.00	$0.01
Bydureon	$0.21	$0.22	$0.11	$0.06
Rybelsus	$0.00	$0.00	$0.04	$0.12
Victoza	$0.79	$0.75	$0.47	$0.36
Ozempic	$0.01	$0.21	$0.43	$0.67
Trulicity	$0.39	$0.82	$1.71	$2.40

POTENTIAL COST AND UTILIZATION TRENDS

While Milliman only had historical data through 2023 (through 2022 for Medicare and Medicaid) for their analysis, according to an analysis by Morningstar and Pitchbook, the total spend on GLP-1 drugs is expected to grow to $217 billion dollars nationwide in 2031 (roughly six times the current spend of $36 billion in 2023). Despite an expected 10% to 15% decline in net price due in part to the

development of new GLP-1 drugs by additional manufacturers and increased competition, the expected increase in total spend is due to an expected overall increase in utilization.[10]

Utah market

The Utah experience is similar to nationwide commercial and Medicaid experience. A 2023 Milliman study showed GLP-1 fills for 2022 that only include results for liraglutide, semaglutide, and tirzepatide for commercial experience nationwide was 14 to 22 per 1,000 members. Medicaid experience was 9 to 14 per 1,000 members.[11]

According to the CMS RIF data, the average nationwide utilization in 2022 was 202 fills per 1,000, while Utah is lower, at 158 fills per 1,000, as seen in Figure 2 above.

FACTORS AFFECTING AVAILABILITY, UTILIZATION, AND COST

Several factors affect the availability, utilization, and cost of GLP-1 drugs. While GLP-1 drugs used to treat type 2 diabetes are not new, there has been a recent rise in the prevalence of these drugs, and new GLP-1s are gaining FDA approval for additional indications such as weight loss and cardiovascular disease.

Market demand for these drugs, especially for weight loss, has increased through celebrity endorsement and increased advertising. In June 2023, an article stated that the hashtag #ozempic on TikTok had 931.8 million views.[12]

Off-label use has likely also contributed to increased demand for GLP-1s. Ozempic has FDA approval for the treatment of diabetes but not weight loss. Wegovy, which has the same active ingredient as Ozempic, has FDA approval for the treatment of obesity and was introduced in 2021. The Health Care Cost Institute analyzed the percentage of new Ozempic users who had a diabetes or prediabetes diagnosis within one year prior to their first fill of Ozempic and found that it decreased from 92% in 2018 to 77% in 2021. During that same period the percentage of new Ozempic users who had an obesity diagnosis without a diabetes or prediabetes diagnosis increased from 4% in 2018 to 13% in 2021.[13] This off-label usage could dramatically increase utilization, impacting the availability of GLP-1s for their approved indications, and it may further impact utilization and availability as new indications are approved, such as Alzheimer's disease, heart failure, chronic kidney disease, and nonalcoholic steatohepatitis.[14] To combat off-label usage, many payers have implemented prior authorization and requirements that a valid diabetic or other indication is met before a GLP-1 can be covered by a health plan.

New drugs coming to market may help facilitate access to GLP-1s. Currently the GLP-1 market is dominated by Novo Nordisk (semaglutide) and Eli Lilly (tirzepatide, dulaglutide), but according to a study by Morningstar and Pitchbook, 16 new GLP-1 drugs are expected by 2029, with more manufacturers expected to gain market share.[15]

STRATEGIES FOR PAYERS, LEGISLATORS, AND OTHER GROUPS

GLP-1s are costly and adherence is necessary for managing diabetes and/or maintaining weight loss and seeing corresponding medical cost offsets, so stakeholders should consider strategies to manage appropriate use.

Payer strategies[16]

Because coverage of GLP-1s for weight loss indications is not mandated for commercial plans in Utah, commercial payers are in a position to evaluate their coverage of obesity, including whether or not to cover AOMs in their plans. Cost, efficacy, and potential health

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[10] Morningstar. Obesity Drug Market: The Next Wave of GLP-1 Competition. Retrieved November 8, 2024, from https://www.morningstar.com/lp/obesity-drug-market.
[11] Ally, A.J., Bell, D., Craff, M. et al. (August 2023). Payer Strategies for GLP-1 Medications for Weight Loss. Milliman White Paper. Retrieved November 8, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-28-23_glp-1s-for-weight-loss_20230824.ashx.
[12] Wojtara, M. et al. (June 6, 2023). Examining Off-Label Prescribing of Ozempic for Weight-Loss. Qeios. Retrieved November 8, 2024, from https://www.qeios.com/read/T6Y97S.
[13] Gordon, B.S. et al. (June 14, 2023). The Share of Ozempic Users With Diabetes Has Decreased Over Time, Indicating Increased Off-Label Use. Health Care Cost Institute. Retrieved November 8, 2023, from https://healthcostinstitute.org/hcci-originals-dropdown/topics/diabetes-and-insulin/ozempic-users-with-diabetes-have-decreased-over-time-indicating-increased-off-label-use.
[14] Brett, A.S. (December 27, 2023). Potential Indications for GLP-1 Receptor Agonists Keep Expanding. NEJM Journal Watch. Retrieved November 8, 2024, from https://www.jwatch.org/na56879/2023/12/27/potential-indications-glp-1-receptor-agonists-keep.
[15] Morningstar, Obesity Drug Market, op cit.
[16] Ally, A.J., Bell, D., Craff, M. et al., Payer Strategies for GLP-1 Medications for Weight Loss, op cit.

improvements and medical cost offsets should be considered when deciding to cover GLP-1s for weight management. A Milliman study illustrated a potential of 26% of wasted spend when patients do not sustain GLP-1 weight loss therapy for at least 12 months[17]

If a plan covers GLP-1s for weight management, various utilization management measures should be considered, including coverage exclusions, preauthorization (FDA-approved labeling at a minimum), quantity limits, and step therapy. Additionally, plans should consider a patient engagement strategy to ensure optimal value including lifestyle programs or behavior modification therapies and addressing adherence and persistency issues. Plans should also evaluate their pharmacy benefit manager (PBM) and pharmacy supply chain contracts to ensure optimal pricing. This could include the industry moving to consideration of a value-based care (VBC) design, where plans receive incremental discounts or additional rebates when agreed-upon measures like adherence or weight loss benchmarks are met for an individual patient. In 2017, Utah-based Select Health was part of a pilot program with Biogen to implement value-based contracting for multiple sclerosis drugs.[18]

Payers should also consider formulary rebate eligibility criteria when implementing any utilization management measures. By implementing stricter utilization management measures, payers could risk losing eligibility for rebates. Rebates for GLP-1s vary by market (commercial, Medicare, and Medicaid), but are estimated to reduce gross costs by roughly 40-60% based on Milliman analysis of data from SSR Health, LLC.

Medicare strategies

Medicare prescription drug coverage mandates are regulated by the federal government and implemented and enforced by CMS. Currently, Medicare only covers GLP-1s to treat type 2 diabetes and other Part D covered conditions, but not to treat obesity alone.[19] However, in a recent CY2026 proposed rule, CMS proposed expanding Medicare and Medicaid coverage to include AOMs[20]. Semaglutide recently received approval for chronic kidney disease (CKD)[21] and is expected to receive approval in the near future for metabolic dysfunction-associated steatohepatitis (MASH), which would be Medicare-covered indications.[22]

Regardless of these current coverage limitations, there are actions that could be taken to impact the cost and utilization of GLP-1s in Medicare. The Inflation Reduction Act of 2022 (IRA) allowed for the Secretary of Health and Human Services to negotiate the price of a limited number of drugs covered by Medicare. GLP-1s could be included on these drug negotiation lists in the future. However, drugs must be FDA-approved for a number of years before they are eligible for negotiation. Semaglutide will be eligible for negotiation in 2027 and tirzepatide in 2031.[23]

Medicaid strategies

Nationwide, 16 states cover at least one AOM under Medicaid.[24] As noted above, CMS recently proposed requiring AOM coverage across both Medicare and Medicaid. Currently, under Utah Administrative Rule §414-60-5 (11)(a), drugs specifically used for weight loss are excluded from coverage under Medicaid,[25] but Utah is considering adding coverage. A newly released report from the Utah

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[17] Ibid.
[18] Kelly, C. (August 8, 2017). Biogen Ventures Into Value-Based Contracts in Multiple Sclerosis. Citeline. Retrieved November 8, 2024, from https://insights.citeline.com/PS121212/Biogen-Ventures-Into-Value-Based-Contracts-In-Multiple-Sclerosis/.
[19] Congress.gov. "Text - H.R.1 - 108th Congress (2003-2004): Medicare Prescription Drug, Improvement, and Modernization Act of 2003." December 8, 2003. https://www.congress.gov/bill/108th-congress/house-bill/1/text.
[20] Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P). Available from: https://www.federalregister.gov/documents/2024/12/10/2024-27939/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare

[21] Munz K.. (January 2025). FDA Expands Semaglutide Use for CV, Kidney Risks in T2D, CKD. American Journal of Managed Care. Retrieved February 24, 2025 from https://www.ajmc.com/view/fda-expands-semaglutide-use-for-cv-kidney-risks-in-t2d-ckd
[22] Cline, M., Heinrich, A., Holcomb, K. et al. (February 23, 2024). Impact of Anti-Obesity Medication Coverage in Medicare Part D. Milliman Report. Retrieved November 8, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2024-articles/3-6-24_impact-of-covering_anti-obesity-medications-in-medicare-part-d.ashx.
[23] Neuman, T. & Cubanski, J. (May 18, 2023). What Could New Anti-Obesity Drugs Mean for Medicare? KFF. Retrieved November 8, 2024, from https://www.kff.org/policy-watch/what-could-new-anti-obesity-drugs-mean-for-medicare/.
[24] Hinton, E. et al. (November 14, 2023). Amid Unwinding of Pandemic-Era Policies, Medicaid Programs Continue to Focus on Delivery Systems, Benefits, and Reimbursement Rates: Results From an Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024. KFF. Retrieved November 8, 2024, from https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-pharmacy/.
[25] The full text of Utah Administrative Rule §414 is available at https://adminrules.utah.gov/public/rule/R414-60/Current%20Rules?searchText=R414-60.

Department of Health and Human Services estimates the total and state fund costs of covering GLP-1s for weight loss under Medicaid to be approximately $1.4 million and $300,000, respectively.[26]

To help manage utilization for Medicaid-covered drugs, the state maintains a preferred drug list (PDL). The legislature has authorized Utah Medicaid to require preauthorization use of any non-preferred drugs. As of October 1, 2024, Trulicity and Victoza are the only two preferred GLP-1s for diabetes management.

State legislature strategies

The Utah state legislature can impact coverage requirements for both Medicaid and fully-insured commercial coverage by enacting benefit coverage mandates. A detailed evaluation of any coverage mandates should be performed to ensure benefits outweigh costs.

Beyond benefit coverage mandates, state officials also manage state employee health plans. Utah's Public Employee Health Plan does not currently cover AOM GLP-1s but does have coverage for certain GLP-1s for diabetes management.[27] Many states are restricting coverage of GLP-1s. North Carolina is no longer covering AOM GLP-1s for state employees and Connecticut is piloting lifestyle management program step therapy. [28]

Other strategies

Compounding pharmacies are allowed to make compound versions of a commercially available drug if the active ingredients are listed on the FDA's drug shortage list. As of February 2025, Victoza, Saxenda, and Trulicity are on the FDA shortage list.[29] Compounded drugs are not the same product as brand-name equivalents and could have different outcomes. Often compounded drugs are cheaper than the brand-name equivalents, but the FDA has reported safety concerns with compounded semaglutide.[30] States are responsible for licensing and oversight of compounding pharmacies, and some states differ in both rules and enforcement. Several states restrict compounding for weight loss drugs.[31]

Some plan sponsors and members are considering purchasing cheaper GLP-1s outside the United States rather than purchasing through their pharmacy plans. The FDA disallows importing drugs to the United States with the following exemptions: if the drug isn't used to treat a serious condition and presents no known significant health risk, or if an effective treatment for a serious condition isn't available in the United States. Both of these exemptions are questionable for GLP-1s. Furthermore, drugs imported internationally lack FDA safety protections.[32]

Methodology and Assumptions

Results for this report were constructed using a variety of data sources. The Collaborative initiated the analysis which was conducted by Milliman using two large research databases.

- Medicare data: 2019 to 2022 CMS 100% Research Identifiable Files (RIF) for Medicare
  - CMS 100% Medicare RIF contains detailed administrative claims data for all patients covered by Medicare Part D, including Medicare Advantage plans and standalone Prescription Drug Plans.
- Commercial data: 2019 to 2023 Utah All-Payer Claim Database (APCD) using summaries provided by the Collaborative.
- Medicaid data: 2019 to 2022 Utah All-Payer Claim Database (APCD) using summaries provided by the Collaborative.

Results from both sources were limited to enrollees aged 12 and older and to plans that covered prescription drugs. Milliman used the APCD summaries provided by the One Utah Health Collaborative for Medicaid and commercial results and the CMS 100% RIF for the

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[26] Utah Department of Health and Human Services (October 1, 2024). Anti-Obesity Medications. Retrieved November 8, 2024, from https://le.utah.gov/interim/2024/pdf/00003416.pdf.
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Medicare results. Only claims where the member had corresponding eligibility information were included in the summary. Drug claims that contained a National Drug Code (NDC) for any of the drugs listed in the table in Figure 1 above were grouped together under a single drug name and included in the summary tables above. The allowed cost results are net of the inherent discount included in the drug record, but no adjustment for possible manufacturer rebates was made. Additionally, Milliman did not analyze cost and utilization for GLP-1s purchased by the patient outside of their insurance coverage.

Caveats

The material in this report represents the opinion of the authors and is not representative of the view of Milliman. As such, Milliman is not advocating for, or endorsing, any specific views contained in this report related to GLP-1 medications.

The information in this report is designed to provide the One Utah Health Collaborative with an overview of GLP-1s in Utah, including historical cost and utilization. This information may not be appropriate, and should not be used, for other purposes. Milliman does not intend this information to benefit any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to their specific needs.

Milliman has relied upon certain data and information for this purpose and reviewed the data for reasonability, but did not perform a detailed data audit. To the extent that the data and information provided are not accurate, or are not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- 2019 to 2022 CMS 100% Research Identifiable Files (RIF) for Medicare,
- Data from Utah's All Payer Claims Database (APCD) using summaries provided by the Collaborative, and
- Published papers, reports and articles cited throughout the report.

The American Academy of Actuaries requires its members to identify their credentials in their work product. Brent Jensen is a consulting actuary of Milliman, a member of the American Academy of Actuaries, and meets the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of the authors' knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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