Obesity Treatment Analysis Advisory Group

Meeting #5

July 24, 2026

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Meeting Logistics

- Advisory group meetings will be recorded and posted on OIC's website
- OIC has established a webpage for this advisory group
- Please use the raised hand function or chat to pose questions

Today's Agenda

Time	Item	Who
3:00-3:05	Welcome; agenda Questions/Concerns	Delika Steele, Policy Analyst – Health
3:05-3:45	Obesity Treatment Analysis Draft Report feedback	Casey Hammer · Milliman
3:45-4:00	Additional comments/questions/concerns	Advisory group members
4:00-4:05	Questions and next steps	Delika Steele, Policy Analyst – Health Advisory group members
4:05-4:30	TBD – extra time if needed	

The diabetes population is not fully removed from obesity-GLP-1 uptake

- **What the report does:** From the study population with obesity, the analysis excludes enrollees who have a pharmacy claim for a branded diabetes-specific GLP-1 (Victoza, Ozempic, Rybelsus, Mounjaro, Trulicity, Byetta, Bydureon) from the weight-loss-GLP-1 uptake projection. This is a drug-claim-based exclusion but fails to exclude all patients with diabetes.

- **Why it is a problem:** Diabetes is a covered indication for GLP-1s; even the carrier survey results show that all carriers cover GLP-1 for diabetes. Therefore, if an enrollee with obesity and diabetes goes on to initiate a GLP-1, the current coverage policies would cover that use (and would be filled with the diabetes GLP-1) and should not be attributed to an obesity coverage mandate. The pharmacy claims-based exclusion that this study uses removes only enrollees already filling a diabetes GLP-1. It leaves in enrollees with obesity or overweight who have type 2 diabetes but are not currently on a GLP-1 (e.g., managed on metformin, newly diagnosed, or untreated). Counting them in obesity-GLP-1 uptake therefore attributes cost to the mandate that is not incremental to it, overstating the mandate's premium impact.

The diabetes population is not fully removed from obesity-GLP-1 uptake

- **Supporting evidence:** The report's own adherence sources use a stricter, diagnosis-based exclusion: reference 46 (Gleason et al., JMCP 2024) excluded members with a diabetes diagnosis or any antidiabetic drug claim, and reference 45 (Rodriguez et al.) stratifies the entire analysis by type 2 diabetes status. The eligible-population definition should be consistent with the inputs used downstream. It should be also noted that even the new Medicare Bridge program (reference here) excludes beneficiaries with diabetes.

- **Recommended change:** Exclude enrollees with a type 2 diabetes diagnosis (or any antidiabetic pharmacy claim) from the incremental obesity-GLP-1 uptake. Efforts should also be made to exclude a certain percentage who are forecasted to receive surgical intervention for obesity and also a certain percentage who would receive a GLP-1 for obstructive sleep apnea (another covered indication in some plans, according to the survey). **If the decision is made to keep enrollees with diabetes in (which I do not advocate), then the analysis must also include expected GLP-1 cost off-sets for the diabetes population (higher) and adherence (higher).**

The cost-offset schedule is truncated at 10% weight loss

What the report does: Exhibit 14 applies healthcare cost offsets at only two thresholds — ≥5% and ≥10% weight loss (about $940 and $1,810 per enrollee per year in 2028). These derive from Thorpe & Joski (2024): $670 for ≥5% and $1,286 for ≥10% in the employer-sponsored population, trended and geographically adjusted. Every enrollee reaching 10% or more is assigned the 10% offset.

Why it is a problem: Thorpe's analysis reports an ordinal gradient of savings at 5%, 10%, 15%, 20%, and 25% weight loss (Table 2)— not two points. For example, in the employer-sponsored population in the Thorpe reference, a 25% reduction was associated with $2,849 less per year (a 34% reduction in spending), more than double the $1,286 used for the ≥10% tier in the current study. **By capping all high responders at the 10% cost offset, the analysis completely discards the steepest part of the savings curve — precisely the range that modern GLP-1s, especially tirzepatide, reach.**

The cost-offset schedule is truncated at 10% weight loss

Supporting evidence: Thorpe KE, Joski PJ. Estimated Reduction in Health Care Spending Associated With Weight Loss in Adults. JAMA Netw Open. 2024;7(12):e2449200. The paper states it presented changes in spending associated with 5%, 10%, 15%, 20%, and 25% reductions; employer-sponsored endpoints run from $670 (5%) to $2,849 (25%).

Recommended change: Apply the full 5/10/15/20/25% offset schedule, mapping each modeled weight-loss band to its corresponding Thorpe offset, rather than collapsing everything above 10% into a single value. This requires modeling a weight-loss distribution (see Issue 3) rather than two thresholds.

GLP-1 effectiveness rests on an old-drug, adherence-heavy evidence base

What the report does: Exhibit 15 sets year-1 GLP-1 response at 14–16% for ≥5% weight loss and 6–21% for ≥10%, citing references 40–47.

Why it is a problem: The evidence base actually contains the right modern data, yet the assumption falls below it. Reference 41 (SURMOUNT-1) is a high-efficacy tirzepatide trial, and reference 44 (Gasoyan et al., 2025) is a real-world study that directly reports the semaglutide and tirzepatide weight-loss distribution; both sit far above the 15% assumed. The remaining sources pull the figure down: reference 40 (Squire) is a single-clinic real-world study limited to semaglutide and liraglutide with no tirzepatide; references 42 (Khera 2016) and 43 (Calderon) are dominated by older agents (orlistat, lorcaserin, naltrexone-bupropion, phentermine-topiramate, liraglutide), and reference 42 contains neither semaglutide nor tirzepatide; and references 45, 46, and 47 are adherence, persistence, and discontinuation studies rather than efficacy studies. Over-weighting the old-drug and persistence sources, and/or an over-aggressive adherence adjustment, drags the class figure below every genuine current-generation efficacy or effectiveness value in the report's own basket.

GLP-1 effectiveness rests on an old-drug, adherence-heavy evidence base

Supporting evidence:

- SURMOUNT-1 (tirzepatide, treatment-regimen estimand, week 72): ≥5% weight loss in 85–91% of participants and ≥10% in 69–84%, versus the report's 15% and 13% medium assumptions.
- Reference 44 (Gasoyan et al., 2025) — **a Cleveland Clinic real-world cohort** of adults with overweight or obesity but without type 2 diabetes who initiated semaglutide or tirzepatide in 2021–2023, all-comers including discontinuers, measured at one year: semaglutide ≈ 57% at ≥5% and ≈ 36% at ≥10%; tirzepatide ≈ 73% at ≥5% and ≈ 56% at ≥10%. These are the report's own cited figures and are entirely based on real-world observations. Because the cohort falls entirely within the shortage years it likely understates steady-state performance — **yet it still exceeds the Milliman 15% assumption several-fold**, and even the study's early-discontinuation subgroup reached about 35% at ≥5%. There is no reason to further downward adjust performance from these estimates.

GLP-1 effectiveness rests on an old-drug, adherence-heavy evidence base

Recommended change: Anchor GLP-1 effectiveness to the agents that will actually be dispensed post-mandate (semaglutide and tirzepatide; also consider orforglipron, which the report notes it excluded), weight the evidence by projected market share, and keep efficacy and adherence as separate modeled steps rather than conflating them within a single "effectiveness" figure.

The effectiveness table is internally inconsistent and likely double-discounts dropout

Internal inconsistency: In Exhibit 15, the high-assumption GLP-1 row shows ≥10% weight loss at 21% while ≥5% is only 16%. Because everyone who loses ≥10% has by definition lost ≥5%, the ≥10% share cannot exceed the ≥5% share; this cell is mathematically impossible. The medium column (13% of 15%) implies that about 87% of all 5% responders also reach 10%, which is implausibly high relative to observed data (roughly 63–77%). These rows appear to have been constructed independently without enforcing the nesting constraint.

The effectiveness table is internally inconsistent and likely double-discounts dropout

Likely construction and its risks: The report describes taking published effectiveness and adjusting it downward for real-world adherence. If that adjustment was implemented as trial efficacy multiplied by a separately sourced persistence rate, three problems follow, all pushing the estimate down:

- **Possible double-counting of dropout.** SURMOUNT-1's headline figures are the treatment-regimen estimand, which already reflects discontinuation within the trial. Multiplying by a full real-world persistence factor would penalize dropout twice. The persistence adjustment should represent only the incremental real-world dropout beyond what the trial estimand already captures.
- **A false-independence assumption.** Response and persistence are positively correlated — patients who lose more weight are more likely to stay on therapy (reference 45 found each 1% of weight loss associated with roughly 3% lower discontinuation hazard). Multiplying the two as independent events understates the joint probability of responding and persisting.
- **An arithmetic mismatch.** Even a generous version of this method (a class-blended efficacy times a real-world persistence rate) lands well above the 14–21% shown. The reported figures are difficult to reproduce from any transparent combination of the cited sources.

The effectiveness table is internally inconsistent and likely double-discounts dropout

Recommended change: Disclose exactly how Exhibits 15 and 16 were constructed. Explicitly provide assumptions/calculations for % meeting weight loss thresholds, the primary source used, and the approach for combining results from different incretins, as well as any weighting factors. Further, for weight loss categories, enforce the nesting constraint across thresholds. Given that GLP-1s are responsible, according to this report, for 89% of the projected cost increase, having the correct, evidence-based categories of weight-loss (e.g, 5%, 10%, 15%, 20%, 25%) as reported in the literature is essential. Where possible, prefer directly observed real-world joint distributions (which already embed response, dropout, and their correlation) over a manufactured efficacy-times-persistence product — the report already cites one such distribution in reference 44 (Gasoyan et al., 2025), which reports the semaglutide and tirzepatide weight-loss bands directly.

Persistence inputs are drawn from the 2022–2024 GLP-1 shortage period

What the report does: The downward adherence adjustment relies on persistence measured in cohorts initiated largely in 2021–2023 (references 45–47), using coverage-gap definitions of non-persistence.

Why it is a problem: Semaglutide and tirzepatide were in FDA-recognized shortage for roughly three years — semaglutide from March 2022 until February 2025, and tirzepatide from December 2022 until December 2024. During that period, coverage gaps frequently reflected inability to obtain product, not a patient decision to stop. A persistence measure based on refill gaps therefore absorbs supply disruption as if it were patient behavior. Projecting that shortage-era persistence onto calendar years 2028–2029 — when the shortage will be long resolved — is a temporal-validity mismatch that understates go-forward treatment duration and, with it, cumulative savings.

Persistence inputs are drawn from the 2022–2024 GLP-1 shortage period

Supporting evidence: Marshall et al. (JMCP 2026;32(3):281), using the same Prime Therapeutics data source as reference 46, found one-year persistence nearly doubled from 33.2% in 2021 to about 61% in the first half of 2024, with the authors attributing the recovery to resolution of the shortages. Semaglutide persistence rose from roughly 33% to about 59–63%; tirzepatide entered at about 64% and held there. Reference 46 (Gleason, 2021 cohort) is the trough of this trend — the report is relying on the low point from a research group that has since published the recovery. 5

Recommended change: Re-anchor persistence to post-shortage (2024 and later), drug-appropriate data, and present the sensitivity.

Other comments

Please clarify the basis for the report's assumption that 12.7% of enrollees could use GLP-1 medications.

- The report states that 25–30% of enrollees may qualify.
- It also references CDC estimates indicating that 35% of citizens may qualify.
- These figures appear materially higher than the 12.7% assumption used in the report.

Other comments

The last paragraph of the Executive Summary states that expected health care cost savings will not fully offset the added coverage costs in the first two years following implementation.

- The cost impact data appears at the bottom of page 1.
- Please consider restating the actual cost impact in the final paragraph of the Executive Summary.
  - Using the current report's median values, the projected premium impact is $258.3 million in 2028, with a $20.6 million patient cost-share offset, and $403.8 million in 2029, with a $12 million patient cost-share offset.
- Including these figures would provide clearer context for the statement that expected savings will not fully offset the mandate's added costs.

Other comments

Page 6 states: “While the number of individuals using GLP-1s will increase, this dynamic will be more than offset by the additional rebates.”

- Please clarify this statement to avoid implying that rebates will offset the total cost of the mandate or that it will cover the total costs of increased GLP-1 medication utilization.

Other comments

Page 13, Health Care Offsets, states: “These savings will be shared by the insurer in the form of lower paid claims and premiums and the enrollee in the form of lower cost sharing and premiums.”

- Please clarify how premium savings are expected for insurers and enrollees as the report states premiums are projected to increase.
- Should the savings instead be characterized as lower paid claims for insurers and lower cost sharing for enrollees?

Other comments

Absent more detailed explanations of the underlying data and analyses, there are concerns with the accuracy of the numbers, rates, and forecasts in the report.

It is unclear what prevalence assumptions were used or what data sources those are based on other than unseen, internal Milliman research. The number 12.7% is shown in the report with no explanation of the basis for that assumption (this number seems low). Further, the use of different prevalence assumptions in different parts of the report is not clearly explained.

Other comments

There are concerns with the average weight loss assumption used on the offsetting savings calculations. There has been no explanation of the use of 5% weight loss assumption or expected variances should average weight loss be greater.

Next Steps

- Meeting recording and PowerPoint will be posted to the advisory group webpage
- Next meeting – TBD
- Final report incorporating feedback – September 1st

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