S. HRG. 118–473

WHY IS NOVO NORDISK CHARGING AMERICANS WITH DIABETES AND OBESITY OUTRAGEOUSLY HIGH PRICES FOR OZEMPIC AND WEGOVY?

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING NOVO NORDISK'S HIGH PRICES FOR OZEMPIC AND WEGOVY FOR PATIENTS WITH DIABETES AND OBESITY

SEPTEMBER 24, 2024

Printed for the use of the Committee on Health, Education, Labor, and Pensions

Available via the World Wide Web: *http://www.govinfo.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

57–255 PDF WASHINGTON : 2025

C O N T E N T S

STATEMENTS

TUESDAY, SEPTEMBER 24, 2024

Page

COMMITTEE MEMBERS

Sanders, Hon. Bernie, Chairman, Committee on Health, Education, Labor, and Pensions, Opening statement 1
Cassidy, Hon. Bill, Ranking Member, U.S. Senator from the State of Louisiana, Opening statement 6

WITNESSES

Jørgensen, Lars Fruergaard, President and Chief Executive Officer, Novo Nordisk, Bagsværd, Denmark 8
Prepared statement 11

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.
Sanders, Hon. Bernie:
CVS Health, Melissa Schulman 62
Blue Cross Blue Shield Michigan, Daniel J. Loepp 64
United Health Group, Andrew Witty 65
Cigna Group, Kristin Julason Damato 67
North Carolina State Health Plan, Dale R. Folwell 69
JAMA Network, Estimated Sustainable Cost-Based Prices for Diabetes Medicines 74
Doctors for America, Undersigned by 253 Physicians & Health Professionals 87
Estimating the Lives That Could be Saved by Expanded Access to Weight-Loss Drugs, Dr. Alison Galvani, Yale School of Public Health 116
GLP-1 Patient Stories 167
Budd, Hon. Ted:
Letter to Senator Budd from the Speaker North Carolina House of Representatives, Tim Moore 132
Cassidy, Hon. Bill:
FTC Sues Pharmacy Insurance Managers, Alleging Unfair Drug Prices, Daniel Gilbert 165

WHY IS NOVO NORDISK CHARGING AMERICANS WITH DIABETES AND OBESITY OUTRAGEOUSLY HIGH PRICES FOR OZEMPIC AND WEGOVY?

Tuesday, September 24, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:04 a.m., in room 562, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Kaine, Hassan, Smith, Luján, Hickenlooper, Markey, Cassidy, Collins, Braun, Marshall, Romney, Tuberville, and Budd.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Health, Education, Labor, and Pensions will come to order. And I want to begin by thanking Mr. Lars Jørgensen, the CEO of Nova Nordisk, for being with us today for this important hearing.

The issue that we are discussing this morning is not complicated. It has everything to do with the chart behind me, which shows that Novo Nordisk's diabetes drug Ozempic is sold in Canada for $155, in Denmark for $122, in France for $71, and in Germany for $59. In the United States, Nova Nordisk charges us $969, over 15 times more than they sell that product in Germany.

Wegovy, Nova Nordisk weight loss drug is even more expensive, as the chart behind me also shows. Wegovy is sold for $265 in Canada, $186 in Denmark, $137 in Germany, and $92 in the United Kingdom. In the U.S., the list price for Wegovy is $1,349 a month, nearly 15 times as much as it cost in the United Kingdom.

What we are dealing with today is not just an issue of economics, it is not just an issue of corporate greed. It is a profound moral issue. Novo Nordisk has developed game changing drugs, which if made affordable, can save the lives of tens of thousands of Americans every year, and significantly improve the quality of life of millions more if made affordable. If not made affordable, Americans throughout this country will needlessly die and suffer.

As representatives of the American people, we cannot allow that to happen. And let's be clear, the outrageously high cost of Ozempic, Wegovy, and other prescription drugs is directly related to the broken, dysfunctional, and cruel healthcare system in our

Country. While the current system makes huge profits for large drug companies like Novo Nordisk, huge profits for insurance companies, and huge profits for PBMs. It is failing the needs of ordinary Americans.

The United States today, we spend almost twice as much per capita on healthcare than the people of any other country, nearly $13,500 for every man, woman, and child over 17 percent of our GDP. Yet, despite this huge and unsustainable expenditure, we are the only major country on earth not to guarantee healthcare to all people as a human right.

Further, despite all of that spending, our healthcare outcomes are not particularly good. Today, over 85 million Americans are uninsured or underinsured. Over 60,000 die each year because they don't get to a doctor when they should, and our life expectancy, which is actually declining in many parts of the country, is far below most other wealthy countries. So, what does all of this have to do with Mr. Jørgensen, Novo Nordisk, and our hearing today? A lot.

The simple truth is that we pay by far the highest prices in the world for prescription drugs, and that is a major factor in the healthcare crisis we experience. How does that happen? What's the connection? First, one out of four Americans are unable to afford the prescription drugs that their doctors prescribe. Insanely, that means that millions of Americans go without the treatment that their doctors recommend. The result, some will actually die, and others will become much sicker than they should, and millions will unnecessarily end up in emergency rooms or hospitals at great expense to our healthcare system. How crazy is that?

Second, one of the reasons that hospital costs—it's not just prescription drugs—hospital costs in this country are rapidly rising, has to do with the very high cost of prescription drugs. In my hospital in Burlington, Vermont, the CEO there tells me that 20 percent of his budget goes to the high cost of prescription drugs, and there are treatments now that cost hundreds of thousands of dollars a year.

Third, a significant reason for the high cost of insurance policies. If you're upset out there that you're paying very high amounts of money for your insurance, it has to do to a significant degree with the high cost of prescription drugs. Yes, millions of Americans with decent health insurance pay minimal amounts for their prescription drugs. That's the good news. The bad news is that they're paying a fortune in premiums, deductibles, and copayments for the insurance that covers those drugs. I should also add that if you're a taxpayer in this country, you're paying higher taxes than you should because of the inflated cost that Medicare, Medicaid and other public health programs pay for prescription drugs.

Now, that is the overview and why the issue that we are discussing today is so important. It impacts every aspect of our healthcare system, the Federal budget, private insurance. Now, let's get to the particulars with regard to Novo Nordisk, Ozempic, and Wegovy.

Ozempic and Wegovy are different brand names for the same drug, Semaglutide. These drugs are transformative new treatments

for diabetes and obesity that help people control their blood sugar and lose weight. Both are manufactured by Novo Nordisk, and both are on track to be some of the bestselling and most profitable drugs in the history of the pharmaceutical industry. In fact, since 2018, Nova Nordisk has made nearly $50 billion in sales off of these two drugs.

Importantly, for Members of this Committee, 72 percent of that revenue comes from sales in the United States of America. In other words, the United States is Novo Nordisk cash cow for Ozempic and Wegovy. And given that these drugs will need to be taken over the course of a lifetime, it's not a one-time drug. You take it for your whole life. Novo Nordisk can expect to receive tens of billions in sales and huge profits from these drugs year after year after year.

Now, why does Novo Nordisk charge the American people such outrageously high prices for Ozempic and Wegovy? Are they acting illegally by charging us some such high prices? Are they violating the law? No, they're not. What they're doing is perfectly lawful. They are simply taking advantage of the fact that until very recently, the United States has been the only major country on earth not to negotiate the cost of prescription drugs. In other words, Novo Nordisk, and other drug companies, not just Novo Nordisk, can charge us as much as the market can bear, and that is precisely what they are doing.

Now, in a few minutes, Mr. Jørgensen makes his presentation. We look forward to hearing from him. I suspect that he will tell us that the healthcare system here in the United States is complex, and that there is a difference between the list price and the net price as a result of the rebates that PBMs receive.

This Committee has begun to do some serious work with regard to PBMs. And if he says that he is correct. But even factoring in all of the rebates that PBMs receive, the net price for Ozempic is still nearly $600, over nine times as much as it cost in Germany. And the estimated net price of Wegovy is over $800, nearly four and a half times as much as it cost in Denmark.

What must also be understood is that not everybody can take advantage of the net price of these drugs. If you are uninsured, you pay the fullest price. If you have a large deductible, you pay the full list price. If you have co-insurance, the percentage of the price you pay at the pharmacy counter is based on the list price. And let's be clear, 75 percent of Americans, over 190 million people with insurance, are unable to access Wegovy through their insurance policies.

Mr. Jørgensen may also tell us that Novo Nordisk is afraid that if it substantially reduced the list price for Ozempic and Wegovy, PBMs may limit coverage for these drugs. Well, Mr. Jørgensen, let me ease your concerns. I'm delighted to announce today that I have received commitments in writing from all of the major PBMs that if Novo Nordisk substantially reduced the list price for Ozempic and Wegovy, they would not limit coverage.

In fact, all of them told me they would be able to expand coverage for these drugs if the list price was reduced. I ask unanimous

consent to insert the letters I received from the PBMs making this commitment into the record.

[The following information can be found on page 62 in Additional Material:]

The CHAIR. Now, let me share with the Committee some other important information that we have uncovered as part of our investigation. Last week, I received a letter from over 250 doctors urging us to do everything that we can to substantially lower the price of these drugs.

This should come as no surprise. What these doctors are telling us is that if the price of Ozempic and Wegovy is not substantially reduced, many of their patients who have diabetes and obesity, especially lower income Americans, often minority Americans, will be unable to afford these drugs. Some of these patients will unnecessarily die, and others will suffer a significant decline in their quality of life. I ask unanimous consent to enter that letter into the record.

[The following information can be found on page 87 in Additional Material:]

The CHAIR. Earlier this year, Dr. Allison Galvani, an epidemiologist at Yale University, conducted a study on Wegovy. And what she found, and I hope Mr. Jørgensen pays attention to this, is that over 40,000 lives a year could be saved if Wegovy were made widely available and at an affordable price to Americans who need the drug. 40,000 lives. I ask anonymous consent to insert that study into the record.

[The following information can be found on page 116 in Additional Material:]

The CHAIR. A few months ago, Dr. Melissa Barbara, a healthcare economist at Yale University, conducted a study on the cost of manufacturing Ozempic. And what she found is that Ozempic can be profitably manufactured for less than $5 a month.

We all know the cost of production is not the only expense by far for a drug company. Pharmaceutical companies spend great sums of money on research and development to find new treatments with many of these products not coming to market. We all understand that. But it is important to know that this drug can be manufactured profitably for a few dollars a month.

We may hear from Mr. Jørgensen that Novo Nordisk spent $21 billion on research and development since 2018, and I take his word on that. What he may not tell you is that Novo Nordisk spent $44 billion on stock buybacks and dividends over that same time period. In other words, since Ozempic came onto the market in 2018, Novo Nordisk spent over twice as much on stock buybacks and dividends than it spent on research and development.

Let's be clear, outrage over the high cost of Ozempic and other prescription drugs is not a partisan political issue, as I expect every person on this Committee understands. It's not a Democratic issue, it's not a Republican issue. I'm an Independent, not an Independent issue. The vast majority of the American people are sick and tired of paying outrageously high prices for prescription drugs.

For example, Dale Folwell, the Republican Treasurer of the State of North Carolina, has told us that if he did not discontinue covering Wegovy for some 20,000 state workers in North Carolina, he would've been forced to double health insurance premiums for teachers, firefighters, and police officers in his state. Regardless, if this drug was needed or not, he would've had to double health insurance premiums in North Carolina. Blue Cross Blue Shield of Michigan also announced they would have to discontinue covering Wegovy because it was too expensive.

When we talk about differing political views, I will tell you that Elon Musk, not one of my great political allies, recently posted on Twitter, and I quote, "Solving obesity greatly reduces risk of other diseases, especially diabetes, and improves quality of life. We do need to find a way to make appetite inhibitors available to anyone who wants them." And Mr. Musk is right.

Further, not only must we be concerned about lack of access to these drugs, we have also got to take a serious look at the financial implications of what happens if the prices of these drugs are not substantially reduced. Bottom line, if just half of the adults in our Country with obesity took weight loss drugs like Wegovy at current prices, the cost would be astronomical and would have a devastating financial impact on our Country, and on Federal, and state budgets.

Best estimate that I have seen suggests that if half the adults in our Country took these weight loss drugs, it would cost $411 billion a year. $411 billion. And that is more than what Americans spent on all prescription drugs at the pharmacy counter in 2020 or 2022. In other words, the outrageously high prices of these drugs could bankrupt Medicare, and radically increase premiums to absolutely unaffordable rates. This does not have to happen. It does not have to happen.

Over the last several months, I and my staff have been talking to a number of major generic pharmaceutical companies. These are large companies that supply hundreds of millions of prescriptions to many millions of Americans. And what these CEOs have told me is of enormous consequence. They have studied the matter and they have told me that they can sell a generic version of Ozempic, the exact same drug that Novo Nordisk is manufacturing to Americans for less than $100 dollars a month. $100 dollars a month.

Novo Nordisk charges us $969 a month for Ozempic. These generics can sell it to us for less than $100 dollars. Let's be clear, nobody here is asking Novo Nordisk to provide charity to the American people. Novo Nordisk has already made billions of dollars in profit, off of these products, and in the coming years will make billions more. All we are saying, Mr. Jørgensen, is treat the American people the same way that you treat people all over the world. Stop ripping us off.

A few months ago, President Biden and I wrote an op-ed which appeared in USA Today, and here's what the President and I said. "If Novo Nordisk and other pharmaceutical companies refuse to substantially lower prescription drug prices in our Country and end their greed, we will do everything within our power to end it for them. Novo Nordisk must substantially reduce the price of Ozempic

and Wegovy. As Americans, we must not rest until every person in our Country can afford the prescription drugs they need to lead healthy, happy, and productive lives." From the op-ed from the President and myself.

That's what President Biden and I wrote a few months ago, and that's what I believe. Prescription drugs in this country must be affordable, and we must not be forced to pay far higher prices than people in other countries for the same exact product. This is especially true when we face a national emergency in terms of the twin epidemics of diabetes and obesity, which if not addressed with lower cost drugs, could cost us tens of thousands of lives and an unimaginable amount of money. Congress and the Administration have a moral responsibility to act now, act boldly, and to protect the American people.

Senator Cassidy, you are now recognized for an opening statement.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Chair Sanders. Nearly 1 in 3 Americans live with obesity. Nearly 1 in 10 have type 2 diabetes. I'm a physician. I'm very aware of the implications of that. There are so many complications. Obesity leads to more chronic disease than any other condition, taking lives and causing almost $173 billion in healthcare spending a year.

It's almost impossible to bring down healthcare costs unless we effectively address obesity. Now we have GLP–1s. They have the promise to address both obesity and the complications that result. They're expensive. Now, we can argue about the net versus the list, but they're expensive. But let me say, without a profit motive, without something in return, it's unclear that these drugs are—any drug is going to be developed. There is a tension. A tension between the need to incentivize innovation and the ability to afford that innovation. And we are here struggling with that balance.

Now, if anyone thinks going after big pharma is the silver bullet, that if you do that, boom, healthcare costs and drug costs go down, then they don't understand what happens with pricing a drug. There is no silver bullet. But as my friend Angus King says, there is silver buckshot. You do a little bit here and a little bit there, and it adds up. So, the drugs become more affordable given that we still have to preserve the profit incentive for the creativity, for drug companies to invest in order to develop the drugs that are going to positively affect the burden of disease in our society.

This is a simple example I've used before. When I was in medical school, one of the most common surgeries was removing a portion of someone's stomach because of peptic ulcer disease. And then a drug called cimetidine came out, Tagamet. And within 6 months, that surgery was rarely performed. Tagamet is so simple, it's now sold over-the-counter, but it has saved so many people having disabling surgery.

Now that is an example, but now we're speaking about Alzheimer's, and cancer, and obesity, and the complications from obesity. And I think we have to be realistic. It is a profit motive that

incentivizes creative people with capital to go in and find that cure. So as this Committee examines the affordability of GLPs, we have to also examine how do we preserve that incentive for the innovation that is the tension.

How do we preserve? Because, by the way, if we stop developing new drugs, Alzheimer's won't be cured, cancer won't be cured, and better drugs to address obesity and the complications of the metabolic syndrome will not either.

Back to this hearing. There are serious questions that need to be asked. What has contributed to the high price of Ozempic and Wegovy? What are American patients actually paying for these drugs at the pharmacy counter? Frankly, what are Germans actually paying? They may pay some money at the counter, but I suspect that the health plan is also paying something. So, what is the true cost relative to the true cost to us?

By the way, I'm particularly concerned with folks with health savings accounts because the Chair is right, if there is a list price, which is really high, and they have a drug benefit tied to their HSA, then that begins to drain their HSA. And I have always been an advocate of how do we make that health savings account more useful? But if it's being drained for a high list price, it is less useful. I'm about that. So, what can we do to make sure that Americans have access to an affordable cost, and at the same time, we have adequate incentive so that someone out there with an incurable disease knows that there might be hope along the way?

I appreciate, Mr. Jørgensen, for attending the hearing. I look forward to your answers. Now, it's important to note that while drug manufacturers play a significant role in determining the cost of a drug, the problem's greater. It's more complex than the actions of any one industry. So, we need to make a serious effort to navigate the network of perverse incentives throughout our healthcare system, including taking a substantive look at health insurance benefit designs, price, transparency, regulatory barriers, and the perverse effects of government discount programs have on prices that Americans pay at the commercial market.

This Committee has a long history of engaging in real bipartisan efforts to lower the cost of healthcare. Last year, Chair Sanders and I worked on the PBM Reform Act to address misaligned incentives affecting PBMs to lower the price patients pay for their prescriptions. The Committee passed this legislation with overwhelming bipartisan support. By the way, we need to get this across the finish line and signed into law. And this is the kind of bipartisan work needed to tackle the high costs patients face for GLP and for all drugs.

Thanks again for coming today, Mr. Jørgensen. I look forward to you explaining how to balance this tension between innovation and affordability.

With that, I yield.

The CHAIR. Thank you, Senator Cassidy. We will now turn to our witness panel. For the awareness of all Senators and the witness, Ranking Member Cassidy and I have reached an agreement where we will both have an equal amount of time to ask the witness ques-

tions, and all other Members will have 7 minutes to ask the witness questions.

Our sole witness today is Mr. Lars Jørgensen. Mr. Jørgensen has been with Novo Nordisk since 1991, and was appointed President and CEO of the company in January, 2017. Mr. Jørgensen, thank you very much for being with us. You may proceed with your testimony.

STATEMENT OF LARS FRUERGAARD JORGENSEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NOVO NORDISK, BAGSVAERD, DENMARK

Mr. JORGENSEN. Chairman Sanders, Ranking Member Cassidy——

The CHAIR. Sorry. Make sure the mic is on there.

Mr. JORGENSEN. It is on. Maybe I'll move this. Can you hear me now?

The CHAIR. Yes. Much better.

Mr. JORGENSEN. Chairman Sanders, Ranking Member Cassidy, Senators, thank you for the opportunity to speak again before the Health, Education, Labor, and Pension Committee on behalf of Novo Nordisk. Last year, I was asked to testify about patients living with diabetes and insulin affordability. This year I volunteered to appear before the Committee on policy solutions for patients living with obesity and the challenges they face navigating the complex U.S. healthcare system. I appreciate the opportunity to engage here today.

For decades, our public discourse about obesity and to some extent, too, diabetes, was based on misinformation and blame. These conditions were treated as a personal choice, a failure of willpower. No one was talking about how these are chronic diseases and treatable diseases.

With the discovery of Semaglutide and the development of Ozempic and Wegovy, our collective understanding of these diseases fundamentally changed. But this shift was not a forgone conclusion. This was a long and winding road. It began more than 100 years ago when our company was formed. Novo was founded on the mission to not only treat but defeat diabetes to 1 day find a cure. And it was built on the idea that our success must be measured by looking at more than our financial sustainability, but also our societal and environmental sustainability.

To this day, Novo maintains its unique ownership structure that protects its mission. The Novo Foundation is among the top three largest foundations in the world, rivaling the Gates Foundation, and it serves as our controlling shareholder. For over 100 years, the foundation has supported initiatives that improve health and sustainability of the planet. This ensures that our time and resources are focused on unlocking cures for chronic diseases.

Senator CASSIDY. Mr. Jørgensen, can you push—pull that microphone a little bit closer to you?

Mr. JORGENSEN. Yes. Sorry about that. It's better now?

Senator CASSIDY. Can you work on a medicine for bad hearing? Okay. That be next——

[Laughter.]

Mr. JORGENSEN. It's not really our expertise, but maybe one day. This ensures that our time and resources are focused on unlocking cures for chronic diseases, not on daily stock fluctuations. And our focus on this mission is how Ozempic and Wegovy we came about.

In the early 1990's, Novo Nordick's scientist, Dr. Lotte Bjerre Knudsen, then a junior researcher in our labs set out to take a hormone that naturally decays in the body within minutes, and to make it last long enough to become a medicine to combat diabetes. It took years before she and her team evolved and solved that puzzle, and more than a decade longer to turn the research into Liraglutide, our pioneering once-daily GLP–1 medicine.

After this discovery, many believed that innovating beyond Liraglutide was, at best, unnecessary, and at worst impossible, including most of our competitors. However, another tenacious team of Novo scientist refused to give in. In November, 2004, these scientists created 12 milligrams of Semaglutide, an even more potent molecule to combat diabetes. Even after that, it was still 14 years more in the making until Ozempic was finally approved. And another 4 years after that until Wegovy was approved.

We didn't stop there. In 2017, we launched the largest clinical trial in the history of the company, enrolling more than 17,000 patients across 41 countries. We demonstrated Semaglutide dramatic reduction in mortality for those suffering from cardiovascular disease and living with obesity. And because of our commitment to health discovery, we can now say that Liraglutide is the only weekly GLP–1 on the market that is FDA approved to reduce the risk of a major adverse cardiovascular events, which is the No. 1 cause of death in America today. We are also conducting even more clinical trials to understand how Semaglutide may affect and treat chronic kidney disease, liver disease, and Alzheimer's disease.

But we know these discoveries are only effective if patients can access them. So along with the scoring revolutionary medicines, we have committed to expanding manufacturing capacity. It took over 50 years to advance our science and manufacturing capacity for insulin production to meet demand. Today, we can provide insulin to nearly 30 million patients.

But patients living with type 2 diabetes and obesity can't wait another 50 years. That is why since the beginning of last year, we have committed over $30 billion to expand manufacturing capacity. To put the $30 billion in perspective, this is 20 percent more than the entire U.S. Space Program, is also four times the amount that Congress has set aside for National Electrical Vehicle Charging Network.

Our commitment includes $4 billion in new investments to expand our facility in North Carolina, on top of the $5 billion we have already invested there creating thousands of construction jobs and manufacturing jobs in the state. We spent these resources because we can't afford not to. Type 2 diabetes has cost U.S. approximately $413 billion every year, and obesity cost the U.S. $1.7 trillion, and we all know the physical and emotional toll these diseases make.

You have said that our amazing medicines can't help patients if they can't afford them. That is true. It's also true that the full value of Ozempic and Wegovy can only be realized if patients can access them. Patients need both affordability and access. That's why we afford to secure public and private insurance coverage for patients with type 2 diabetes and patients with obesity.

We are pleased to say that Ozempic is covered by 99 percent of all commercial plans by Medicare and by Medicaid in 50 states. And while Wegovy, it was only recently approved by the FDA in 2021, today, it's covered by half of the commercial plans, as well as over 20 state Medicaid plans, the Department of Veterans Affairs, the military, the Indian Health Service, and for all Federal employees. And hopefully soon, for seniors.

With that said, it's clear that patients too often struggle to navigate the complex U.S. healthcare system. It's also clear that no single company alone controls such vast and complicated policy changes. So, what I can promise is that Novo will remain engaged and work with this Committee on policy solutions through addressing the structural issues that harm patients and drive up cost.

I can also commit that we'll never stop driving chains to defeat serious chronic diseases like diabetes and obesity. I appreciate the Committee's focus on ensuring patients living with chronic diseases can have affordable access to the medications they need, and look forward to your questions. Thank you very much.

[The prepared statement of Mr. Jørgensen follows:]

PREPARED STATEMENT OF LARS JØRGENSEN

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for the opportunity to participate in today's hearing. I appreciate the chance to speak about Novo Nordisk's decades of work developing glucagon-like peptide 1 agonists, or "GLP-1s." These include semaglutide, the GLP-1 active ingredient in our FDA-approved products Ozempic® and Wegovy®.

These innovative medicines are part of a groundbreaking drug category with the potential to improve and extend the lives of millions of Americans.

Our company is grateful for Chairman Sanders's recognition that "scientists at Novo Nordisk deserve great credit for developing these drugs." As a company committed to improving the health and quality of patients' lives, Novo Nordisk is proud of the extensive research and development that our scientists have devoted toward enabling patients to receive innovative medicines that drive safe and effective therapeutic outcomes. Without fanfare or guarantee of success, Novo Nordisk researchers worked tirelessly for decades toward discovering and developing molecules that can treat and prevent some of the most persistent and costly public health challenges in the United States and around the world. The work of these scientists, researchers, and personnel has not only made Novo Nordisk the industry leader in treating diabetes and obesity, but it has also radically altered the medical management of these complicated and devastating chronic diseases and opened the door to new possibilities and avenues of inquiry for other serious chronic diseases—including heart, kidney, liver, and Alzheimer's diseases.

Their collective work embodies our company's core values and illustrates the power of our unique ownership structure, which is unlike any other major pharmaceutical company in the world. The Novo Nordisk Foundation, one of the largest charitable foundations in the world, is the controlling shareholder of Novo Nordisk. This structure was intended to build and sustain an enterprise that would take risks for the benefit of patients, invest in early science, and spend the time and resources needed to investigate and develop research that could one day unlock a cure for diabetes and other serious chronic diseases.

Under the Foundation's stewardship, this is exactly what Novo Nordisk has done —allowing us to prioritize long-term scientific efforts over short-term financial gain. In 2023 alone, Novo Nordisk spent $4.2 billion on diabetes and obesity research and development—a 37 percent increase from the previous year, and 50 percent more than the diabetes and obesity research and development budget of the entire National Institutes of Health. Our research and development

("R&D") spending has more than doubled since 2020, and we recently spent billions on our new U.S. research and development hub in Lexington, Massachusetts. Novo Nordisk intends to continue increasing the amount of our investment in R&D as a percentage of our total sales, meaning we will devote more to discovering new therapies and cures each year. I was humbled to see that Novo Nordisk was ranked the most innovative pharmaceutical company in the world just a few months ago.[1]

We welcome the opportunity to provide clarity on challenges in the U.S. health care system. Notably, the system enables hundreds of millions of Americans to access medicines, including Novo Nordisk medicines, at costs of between $25 and $50 per month. However, the complexities of the system unfortunately reduce access and affordability for many Americans. We are eager to work with this Committee to address these systemic issues so that everyone who can benefit from our medicines is able to get them.

In the meantime, Novo Nordisk is doing our part. Since Ozempic® was first introduced in 2018, the *net* price—the amount that Novo Nordisk is actually paid for our medicines—has declined by about 40 percent in the U.S. Today, Ozempic® is the lowest cost once-weekly GLP-1 medicine on the market in the United States. The net price of Wegovy® has similarly declined since its launch less than three years ago.

Currently, more than 80 percent of U.S. patients with insurance coverage for Ozempic® or Wegovy® are paying $25 or less for each prescription, and 90 percent of U.S. patients pay $50 or less. Under current market conditions, we expect that net prices will continue to decline for both Ozempic® and Wegovy®.

This testimony provides significant information on a number of issues that that are central to today's hearing: (I) a snapshot of the medical and financial toll that type 2 diabetes and obesity take on America, (II) details on Novo Nordisk's groundbreaking GLP-1 medications, Ozempic® and Wegovy®, (III) an overview of Novo Nordisk's decades of effort and investment to discover and develop these drugs and bring them to American patients, (IV) insight into how Novo Nordisk's unique ownership structure enabled it to pursue these groundbreaking medications when virtually no one else would, and (V) how Novo Nordisk is working to address patient affordability and access within the confines of the complex U.S. healthcare system.

I. The True Cost of Type 2 Diabetes and Obesity

Type 2 diabetes and obesity are chronic diseases that put an enormous strain on patients suffering from them; families across America; the entire U.S. healthcare system; and the economy as a whole. To fully understand the impact that GLP-1 medications can have, it is important to understand the toll and scale of these diseases.

Type 2 diabetes mellitus is a disease that occurs when the body stops responding normally to insulin, the important hormone that helps transform blood sugar into energy, leading to high blood sugar. Unfortunately, there is a tendency to confuse and muddle the distinctions between

---

[1] Matthew Herper, *Analysis of pharmaceutical R&D ranks Novo Nordisk and Johnson & Johnson above their peers*, Stat News (May 16, 2024), https://www.statnews.com/2024/05/16/pharma-research-development-rankings/.

type 1 and type 2 diabetes—both are very serious diseases, but they are distinct. Patients with type 1 diabetes must take insulin every day, and need to manage their disease with real-time glucose monitoring.[2] Type 2 diabetes is a progressive and insidious disease that worsens over time.[3] While some patients with type 2 diabetes may not require insulin injections in the same way as those living with type 1 diabetes, living with type 2 diabetes also exacts a serious toll. Patients routinely suffer from headaches, exhaustion, thirst, and depression.[4] Moreover, without proper and stable treatment, these symptoms can quickly advance to even more serious complications.

As one expert has observed, in diabetes hospitals, "[p]eople come in with amputated limbs and compromised cognitive functions and heart problems or they can barely move—they're miserable and depressed."[5]

Some of the most serious potential complications include high blood pressure, high cholesterol, heart disease, gastroparesis, kidney disease, stroke, amputations, blindness, and nerve damage.[6] Many of these complications have shared risk factors such that having one of them can compound or worsen others. And, unfortunately, complications from type 2 diabetes are disproportionately likely to be experienced by communities of color.[7]

The Centers for Disease Control and Prevention ("CDC") estimates that 38 million Americans are living with diabetes today, and as many as 36 million of these patients have type 2 diabetes.[8] An additional 98 million Americans are prediabetic and at risk for developing type 2 diabetes.[9] And around the world, there are more than a billion people who are either living with diabetes or are prediabetic and at risk of developing the disease.[10]

---

[2] *About Type 1 Diabetes*, CDC (accessed May 22, 2024), https://www.cdc.gov/diabetes/about/about-type-1-diabetes.html.

[3] Vivian A. Fonseca, *Defining and Characterizing the Progression of Type 2 Diabetes*, Diabetes Care (Nov. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2811457/.

[4] *E.g.*, Divya Gopisetty et al., *How Does Diabetes Affect Daily Life? A Beyond-A1C Perspective on Unmet Needs*, Clinical Diabetes (April 1, 2018), https://diabetesjournals.org/clinical/article/36/2/133/32827/How-Does-Diabetes-Affect-Daily-Life-A-Beyond-A1C; Christopher J. Bulpitt et al., *Association of Symptoms of Type 2 Diabetic Patients With Severity of Disease, Obesity, and Blood Pressure*, Diabetes Care (Jan. 1, 1998), https://diabetesjournals.org/care/article/21/1/111/19852/Association-of-Symptoms-of-Type-2-Diabetic.

[5] Matt Reynolds, *What the Scientists Who Pioneered Weight-Loss Drugs Want You to Know*, Wired (June 12, 2023), https://www.wired.com/story/obesity-drugs-researcher-interview-ozempic-wegovy/.

[6] Paraskevi Farmaki et al., *Complications of the Type 2 Diabetes Mellitus*, Curr. Cardiology Rev. (Nov. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7903505/.

[7] J. Sonya Haw et al., *Diabetes Complications in Racial and Ethnic Minority Populations in the USA*, Curr. Diab. Rep. (Jan. 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7935471/.

[8] *National Diabetes Statistics Report*, CDC (accessed May 22, 2024), https://www.cdc.gov/diabetes/php/data-research/index.html; *see Statistics About Diabetes*, Am. Diabetes Ass'n (accessed May 22, 2024), https://diabetes.org/about-diabetes/statistics/about-diabetes.

[9] *Statistics About Diabetes*, *supra* note 8.

[10] *See IDF Diabetes Atlas, 10th edition 2021*, Int'l Diabetes Found. (accessed May 9, 2024), https://diabetesatlas.org/data/en/world/

Obesity is also a serious chronic metabolic disease with important genetic and environmental inputs, as the American Medical Association recognized in 2013.[11] Obesity has been classified as a global health epidemic by both the CDC and the World Health Organization,[12] and more than 40% of American adults—over 100 million people—are now living with obesity,[13] with that number expected to continue to grow if we fail to successfully prevent and treat this disease.

Obesity also increases the risk of many other health problems, including type 2 diabetes, cardiovascular disease, strokes, several cancers, chronic kidney disease, and early death.[14] Hundreds of thousands of Americans die from obesity-related conditions every year.[15]

Adding to the physical costs of this chronic disease, individuals living with obesity face serious mental health risks as well. Throughout our society, individuals suffering from obesity suffer from a false-yet-persistent social stigma that obesity is a moral failing or a lack of willpower. Living in the shadow of this stigma can negatively impact social relationships, educational performance, professional outcomes, and long-term mental health.[16] This narrative has permeated public discourse for decades and has unfairly stigmatized patients for what we now know is a complex, chronic, and treatable disease.

There is no question that diabetes and obesity cause tangible harms in the lives of tens of millions of Americans, spawn myriad related diseases, and take a heavy financial toll on the U.S. healthcare system and on society. The American Diabetes Association estimates that type 2 diabetes alone costs American society $413 billion annually, with $307 billion in direct medical costs and $106 billion in indirect costs like lost productivity, unemployment due to chronic disability, and premature death.[17] The economic toll of the obesity epidemic is even greater. The *annual* impact of obesity and overweight on the American economy exceeds $1.7 trillion each year, including $481 billion in direct healthcare costs and $1.24 trillion in lost economic

---

[11] Sara Berg, *With U.S. obesity rate over 40%, 3 treatment keys for doctors*, Am. Med. Ass'n (July 20, 2023), https://www.ama-assn.org/delivering-care/public-health/us-obesity-rate-over-40-3-treatment-keys-doctors.

[12] *See Causes of Obesity,* CDC (accessed May 22, 2024), https://www.cdc.gov/obesity/basics/causes.html; Rohana Haththotuwa, Chandrika Wijeyaratne & Upul Senarath, *Worldwide epidemic of obesity*, Obesity & Obstetrics, (accessed May 22, 2024), https://www.sciencedirect.com/science/article/abs/pii/B9780128179215000011.

[13] *Overweight & Obesity Statistics*, Nat'l Institute of Diabetes & Digestive & Kidney Diseases (accessed May 23, 2024), https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity.

[14] Steven J. Atlas et al., *Medications for Obesity Management: Effectiveness and Value*, Inst. for Clinical & Econ. Rev. (Aug. 31, 2022), https://icer.org/wp-content/uploads/2022/03/ICER_Obesity_Evidence_Report_083122.pdf.

[15] Zachary J. Ward et al., *Excess mortality associates with elevated body weight in the US and demographic subgroup: A modelling study*, The Lancet (April 28, 2022), https://doi.org/10.1016/j.eclinm.2022.101429.

[16] Zara Abrams, *The burden of weight stigma*, Monitor on Psychology, Am. Psych. Ass'n (March 1, 2022), https://www.apa.org/monitor/2022/03/news-weight-stigma; *see also* Gina Kolata, *We Know Where New Weight Loss Drugs Come From, But Not Why They Work*, N.Y. Times (Aug. 17, 2023), https://www.nytimes.com/2023/08/17/health/weight-loss-drugs-obesity-ozempic-wegovy.html.

[17] Emily D. Parker et al., *Economic Costs of Diabetes in the U.S. in 2022*, Diabetes Care (Jan. 2024), https://doi.org/10.2337/dci23-0085.

productivity.[18] Obesity is also a leading cause of cardiovascular disease, which is the leading cause of death in the United States—and which costs over $315 billion annually in direct medical costs.[19]

Obesity also places an extraordinary strain on patients' personal finances, as those with diagnosed obesity incur more than twice the out-of-pocket health care costs of patients without an obesity diagnosis.[20] Studies also show that total per patient healthcare spending rises substantially as patient body mass index ("BMI") increases. Even within the subset of patients living with obesity (those with a BMI above 30), total healthcare spending for patients in the highest BMI group (40+) is more than double that of patients in the 30-34 BMI group.[21]

The World Obesity Federation expects the economic costs from excess weight and obesity to reach three percent of global GDP each year by the middle of the next decade; this is similar to the global impact of COVID-19 in 2020.[22] Absent therapeutic intervention, the global cost of obesity-related complications is expected to rise to over $4 trillion by 2035—higher than the entire gross domestic product of nearly every individual country in the world.[23] The price of treating complications that arise from these diseases continues to be astronomical, and it's a price that American taxpayers have had to bear for many years—including directly through Medicare.

It is apparent that any drug therapies able to reduce the prevalence of these expensive and deadly diseases will provide enormous personal, economic, and societal value to individuals, families, and communities across the country. Researchers at the University of Southern California have projected that insurance coverage of the new generation of effective weight-loss therapies would save the Medicare program as much as $245 billion in the first decade alone, with savings accruing mostly to Medicare Part A by reducing the number of inpatient hospital stays and the corresponding demand for highly skilled nursing care.[24] The same study concluded that the overall

---

[18] Hugh Waters & Marlon Graf, *America's Obesity Crisis*, Milken Institute 1 (Oct. 2018), https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB.pdf.

[19] *See Heart Disease Facts*, CDC (accessed May 22, 2024), https://www.cdc.gov/heart-disease/data-research/facts-stats/; *see also* RTI International, *Cardiovascular Disease: A Costly Burden For America – Projections Through 2035*, American Heart Association and American Stroke Association 10 (2017), https://www.heart.org/-/media/Files/About-Us/Policy-Research/Fact-Sheets/Public-Health-Advocacy-and-Research/CVD-A-Costly-Burden-for-America-Projections-Through-2035.pdf.

[20] Imani Telesford et al., *How have costs associated with obesity changed over time*?, Peterson-KFF Health System Tracker (accessed May 22, 2024), https://www.healthsystemtracker.org/chart-collection/how-have-costs-associated-with-obesity-changed-over-time/.

[21] *See* Brigit Kyei-Baffour et al., *Health Spending Varies for Patients Likely to Have Obesity*, Avalere (Nov. 3, 2023), https://avalere.com/insights/health-spending-varies-for-patients-likely-to-have-obesity.

[22] *See* World Obesity Fed'n, *Press Release: Economic impact of overweight and obesity to surpass $4 trillion by 2035* (March 2, 2023), https://www.worldobesityday.org/assets/downloads/World_Obesity_Atlas_2023_Press_Release.pdf.

[23] *Id.* Of the nearly 200 countries in the world, only four—the United States, China, Japan, and Germany—report a gross domestic product higher than $4 trillion. *GDP (current US$)*, World Bank (accessed May 24, 2024), https://data.worldbank.org/indicator/NY.GDP.MKTP.CD.

[24] *See* Alison Sexton Ward et al., *Benefits of Medicare Coverage for Weight Loss Drugs*, USC Schaeffer Center White Paper Series (April 18, 2023), https://healthpolicy.usc.edu/research/benefits-of-medicare-coverage-for-weight-loss-drugs/.

cumulative social benefit would be even greater, reaching nearly $1 trillion over the next ten years.[25] And a recent analysis by Goldman Sachs concluded that increased utilization of GLP-1 medications could add as much as an additional 1 percent to U.S. gross domestic product over the next four years due to a reduction in health problems like heart attacks, strokes, and diabetes.[26] One study estimates that for each Medicare patient able to receive anti-obesity treatment, the Medicare system would see $6,800 to $7,200 of cost savings over 10 years from reduced usage of ambulatory care and prescription drugs—again, that's per patient.[27] Therefore, apart from the essential human impact, drugs that could meaningfully address the diabetes and obesity epidemics also have the potential to be fiscally transformative. That means discussions about the cost of treatment must necessarily start with the value, tangible and intangible, as well as the savings, that GLP-1 medications provide.

II. Novo Nordisk's Groundbreaking GLP-1 Medications

Novo Nordisk's GLP-1 medications, including Ozempic® and Wegovy®, have the potential to transform the lives of countless people living with diabetes, obesity, and other chronic diseases.

In developing these drugs, Novo Nordisk has pioneered something revolutionary. Our groundbreaking class of GLP-1 medications, including our latest achievement—semaglutide—meaningfully treats and manages these chronic diseases, with proven positive health outcomes for comorbidities and related conditions. As the *New York Times* said: "Every so often a drug comes along that has the potential to change the world. Medical specialists say the latest to offer that possibility are the new drugs" like Ozempic® and Wegovy®.[28] And as the *Financial Times* put it, this medication has "enormous potential to boost public wellbeing and slash healthcare costs throughout the world."[29]

Ozempic® was approved by the Food and Drug Administration ("FDA") in 2017 for the treatment of type 2 diabetes. It increases the body's production of insulin, a hormone that lowers blood sugar levels, and reduces production of glucagon, which increases blood sugar levels.[30] As the *New York Times* reported this year, Ozempic® is "changing diabetes treatment," as many patients "have been able to lower their insulin doses after starting Ozempic[®], and some have

---

[25] *Id.*

[26] Matthew Fox, *The more Americans who take Ozempic, the faster the US economy could grow, Goldman Sachs says*, Business Insider (April 26, 2024), https://www.businessinsider.com/us-economy-faster-growth-ozempic-glp-1-weight-loss-drugs-2024-2.

[27] Fang Chen et al., *Ten-year Medicare budget impact of increased coverage for anti-obesity intervention*, J. Med. Econ. (Aug. 19, 2019), https://pubmed.ncbi.nlm.nih.gov/31378108/.

[28] Kolata, *supra* note 16.

[29] Financial Times Editorial Board, *The promise of anti-obesity drugs*, Financial Times (Sept. 6, 2023), https://www.ft.com/content/a6e0ccbd-66b4-4e5d-9a9a-002b95b0d19f.

[30] Manoj Kumar Mahapatra, Muthukumar Karuppasamy & Biswa Mohan Sahoo, *Semaglutide, a glucagon like peptide-1 receptor agonist with cardiovascular benefits for management of type 2 diabetes*, R. Endocrine & Metabolic Disorders (2021), https://ncbi.nlm.nih.gov/pmc/articles/PMC8736331/.

been able to go off insulin entirely."[31] And while the first GLP-1 agonists were introduced to treat patients with diabetes by promoting insulin production, studies indicated that they also regulate the body's response to food, creating a sensation of fullness and reducing the desire to continue eating.[32]

As Novo Nordisk's scientists dug deeper into the innovation that created Ozempic®, they uncovered a new possibility: a treatment that could bend the curve on the global obesity epidemic. According to prominent medical experts in the U.S., any such medication would be a "holy grail" of medicine.[33] I will detail Novo Nordisk's extensive efforts to identify and prove both the efficacy and the safety of this treatment later in my testimony.

In clinical trials, adults taking Wegovy® lost an average of about 15 percent of their body weight[34]—meaning a person who began the trial weighing 232 pounds lost an average of about 35 pounds. Wegovy® was approved by the FDA in 2021 as a treatment for obesity,[35] and the medicine was first sold in the U.S. that June, two full years before it was made available anywhere else in the world—even in Denmark, the global headquarters of Novo Nordisk. As of today, the United States is one of only a handful of countries where Wegovy® is sold.

To be clear: While Ozempic® and Wegovy® share the same molecule, they are not the same. Rather, Wegovy® and Ozempic® are different products, approved separately by the FDA based on their own respective clinical development programs, with different indications, dosages, prescribing information, titration schedules, formulations, and delivery devices. As such, they are not interchangeable. To understand their efficacy and in order to seek and secure FDA approval to treat different diseases and populations, Novo Nordisk conducted separate clinical trials and significantly invested in research for both diabetes and obesity.

Novo Nordisk has not merely opened the door to transforming the treatment paradigm around type 2 diabetes and obesity. We continue to make significant investments in the science to learn more. Indeed, we conducted additional large-scale clinical trials involving tens of thousands of people in dozens of countries around the world that proved semaglutide can not only effectively

---

[31] Dani Blum, *How Ozempic Is Changing Diabetes Treatment*, N.Y. Times (May 13, 2024), https://www.nytimes.com/2024/05/13/well/live/insulin-ozempic-diabetes.html; *see also* Paresh Dandona, Ajay Chaudhuri, and Husam Ghanim, *Semaglutide in Early Type 1 Diabetes,* N. Engl. J. Med. (2023) https://www.nejm.org/doi/full/10.1056/NEJMc2302677.

[32] John Blundell et al., *Effects of once-weekly semaglutide on appetite, energy intake, control of eating, food preference and body weight in subjects with obesity*, Diabetes, Obesity & Metabolism (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5573908/; *see also* Susan Cornell, *A review of GLP-1 receptor agonists in type 2 diabetes: A focus on the mechanism of action of once-weekly agents*, J. Clinical Pharm. & Therapeutics (2020), https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/jcpt.13230; Jean-Pierre Gutzwiller et al., *Glucagon-like peptide-1 promotes satiety and reduces food intake in patients with diabetes mellitus type 2*, Am. J. Physiology (May 1999), https://pubmed.ncbi.nlm.nih.gov/10233049/.

[33] *E.g.*, Eric Topol, *The New Obesity Breakthrough Drugs*, Ground Truths (Dec. 10, 2022), https://erictopol.substack.com/p/the-new-obesity-breakthrough-drugs.

[34] *Novo Nordisk receives FDA approval for Wegovy™ to treat adults with obesity based on unprecedented efficacy for a prescription medicine in clinical trials*, Novo Nordisk (June 4, 2021), https://www.novonordisk-us.com/media/news-archive/news-details.html?id=62113.

[35] *Id.*

treat obesity—in the SELECT trial, semaglutide was also shown to reduce the risk of major adverse cardiovascular events like heart attacks and strokes in adults with established cardiovascular disease and either obesity or overweight by 20%. Semaglutide is the only weekly GLP-1 medication on the market that is FDA-approved to reduce the risk of these major adverse cardiovascular events—which are the number one cause of death in the United States.[36] The FLOW trial showed semaglutide to reduce the progression and mortality of kidney disease in adults with diabetes and chronic kidney disease by 24%, and that the risks of major cardiovascular events and death from any cause were significantly lower in the semaglutide group than in the placebo group.[37]

These drugs can result in significant and sustained health improvement and have the potential to be transformative for the millions of Americans struggling with type 2 diabetes and obesity. As one expert has said, "[o]besity is associated with 200 other obesity-related diseases. . . . If we treat this one disease, we can potentially impact the health of so many patients in many different ways."[38] The panoply of benefits and applications for GLP-1 medications like semaglutide is not yet known, and scientists are exploring its potential to treat a range of serious conditions. Our researchers are continuing to learn more about the diseases of diabetes and obesity, and what impact GLP-1s may have on other disease states. For example, we have trials underway examining the use of semaglutide for treatment of liver disease and Alzheimer's disease, and there are some studies by others that show that GLP-1s may have the ability to treat or improve Parkinson's or various forms of addiction.[39] We are investing substantial resources, time, and

---

[36] *See* Seth S. Martin et al., *2024 Heart Disease and Stroke Statistics: A Report of US and Global Data From the American Heart Association*, Circulation, A Journal of the American Heart Association (Jan. 2024) https://www.ahajournals.org/doi/10.1161/CIR.0000000000001209; *see also* FDA Office of Media Affairs, *FDA Approves First Treatment to Reduce Risk of Serious Heart Problems Specifically in Adults with Obesity or Overweight*, U.S. Food & Drug Administration (Mar. 8, 2024), https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or.

[37] The landmark SELECT study, funded by Novo Nordisk, demonstrated that semaglutide reduced the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) by 20% in adults with overweight or obesity and established cardiovascular disease. This trial involved more than 17,000 adults across 41 countries and 800 investigator sites. *See Company announcement No 50 / 2023*, Novo Nordisk (Aug. 8, 2023), https://www.novonordisk.com/news-and-media/news-and-ir-materials/news-details.html?id=166301. Additionally, Novo Nordisk's FLOW study demonstrated a 24% reduction in kidney disease progression and mortality in adults with type 2 diabetes and chronic kidney disease. Like the SELECT study, this trial was funded by Novo Nordisk and involved thousands of patients across hundreds of investigator sites in 28 countries. *See Company announcement No 20 / 2024*, Novo Nordisk (March 5, 2024), https://www.novonordisk.com/content/nncorp/global/en/news-and-media/news-and-ir-materials/news-details.html?id=167028; *Ozempic® (semaglutide) injection 1 mg demonstrated reduction in risk of kidney disease-related events in Phase 3 FLOW trial presented at the 84th Scientific Sessions of the American Diabetes Association*, Novo Nordisk (June 24, 2024), https://www.novonordisk-us.com/media/news-archive/news-details.html?id=168527.

[38] Benjamin Mueller, *Obesity Treatment Relieves Heart Failure Symptoms, Drugmaker's Study Finds*, N.Y. Times (Aug. 25, 2023), https://www.nytimes.com/2023/08/25/health/weight-loss-drug-heart-failure.html.

[39] *See R&D Pipeline*, Novo Nordisk (accessed May 23, 2024), https://www.novonordisk.com/science-and-technology/r-d-pipeline.html; *see also* Nat'l Inst. on Alcohol Abuse & Alcoholism, *Semaglutide shows promise as a potential alcohol use disorder medication* (March 13, 2024), https://www.niaaa.nih.gov/news-events/research-update/semaglutide-shows-promise-potential-alcohol-use-disorder-medication; Wassilios G. Meissner, et al., *Trial of Lixisenatide in Early Parkinson's Disease*, N. Engl. J. Med. (April 2024) https://www.nejm.org/doi/pdf/10.1056/NEJMoa2312323.

dollars into these studies—and while it will be years before many of them yield conclusive findings, our researchers are optimistic about identifying even more ways in which these medicines can change and potentially save lives.

All of these findings make plain that the development of GLP-1 drugs like Ozempic® and Wegovy® has been a monumental step forward for public health. GLP-1 drugs were named the 2023 Breakthrough of the Year by *Science* magazine, and experts describe them as "medical breakthroughs" on par with advancements like gene therapy and the mRNA technologies that produced COVID vaccines.[40] In April, Dr. Lotte Bjerre Knudsen—the Novo Nordisk scientist who led the company's work on liraglutide, the company's pioneering first GLP-1 medicine—was awarded a 2024 Breakthrough of the Year Award from the American Association for the Advancement of Science ("AAAS").[41] Just last week, Dr. Knudsen was honored with the Lasker-DeBakey Clinical Medical Research Award—often referred to as one of America's Nobel Prizes.[42] And as researchers around the world continue to explore uses and applications of GLP-1 therapies, I am humbled to note that the work of our scientists and their contemporaries has been heralded as so groundbreaking that it could be considered for a Nobel Prize.[43]

III. Novo Nordisk's Massive Investment to Create These Groundbreaking Medications and Bring Them to Market

On average, it takes 10 to 15 years to develop a new drug from initial discovery through regulatory approval.[44] However, the journey to develop these medications and bring both Ozempic® and Wegovy® to market required a much longer than average sustained investment by Novo Nordisk. Since the early 1990s, our scientists encountered many roadblocks and observed competitors pulling the plug on their research, or simply refusing to invest in GLP-1 medications at all. But year after year, we persisted.

Dr. Knudsen, now our chief scientific adviser, was in the vanguard of Novo Nordisk's GLP-1 work as a frontline researcher beginning in the 1990s. She knew that GLP-1 was a short-lasting gut hormone that was rapidly broken down by other enzymes, unable to last long enough within the human body to serve as a medicine. Despite this, she still believed that GLP-1 had the potential to stimulate insulin and alter appetites. It took years of work before Dr. Knudsen and her team were finally able to alter the GLP-1 molecule to "hide" it from those enzymes—but even still,

---

[40] Jennifer Couzin-Frankel, *Obesity meets its match: Blockbuster weight loss drugs show promise for a wider range of health benefits*, Science (Dec. 14, 2023), https://www.science.org/content/article/breakthrough-of-the-year-2023.

[41] Meagan Phelan, *Innovators Who Fought to Unlock GLP-1 Drug for Obesity Awarded Mani L. Bhaumik Breakthrough of the Year Award*, American Association for the Advancement of Science (April 4, 2024), https://www.aaas.org/news/innovators-glp-1-obesity-bhaumik-breakthrough.

[42] Gina Kolata and Stephanie Nolen, *Research That Led to Obesity Drugs Wins Major Medical Prize*, N.Y. Times (Sept. 19, 2024), https://www.nytimes.com/2024/09/19/health/2024-lasker-awards-ozempic-wegovy-glp-1.html; *see also Lasker Awards*, NIH (accessed Sept. 21, 2024) (Lasker Awards are "America's Nobels"), https://www.nih.gov/about-nih/what-we-do/nih-almanac/lasker-awards.

[43] *See* Megan Molteni & Elaine Chen, *GLP-1 drugs are transforming diabetes, obesity and more. Could a Nobel be next?*, Stat News (Sept. 30, 2023), https://www.statnews.com/2023/09/30/weight-loss-ozempic-nobel-prize-science/

[44] *Research & Development Policy Framework*, PhRMA (accessed May 16, 2024), https://phrma.org/policy-issues/Research-and-Development-Policy-Framework.

they couldn't get past human kidneys, which flushed it out from the bloodstream within minutes. But instead of giving up, our scientists dedicated their efforts to find a way to protect GLP-1 from this degradation process. Along the way, the project faced obstacles, including questions about whether there was a viable medicine to be had at all, and it was very nearly cancelled.

But our researchers prevailed, and over the course of many more years, Dr. Knudsen and her team finally succeeded—finding a way to further disguise GLP-1 in reservoirs of a naturally-occurring protein called albumin, allowing it to stay in the bloodstream for hours and even slip across the brain-blood barrier to bind to neurons in the part of the brain responsible for food intake.[45] And then, through the course of *yet another decade*, her team worked tirelessly to transform these insights into actual, usable medication—resulting in liraglutide, Novo Nordisk's pioneering once-daily GLP-1 medicine.

Many in the pharmaceutical industry believed that liraglutide would represent the pinnacle of potential achievement in the GLP-1 medicine category. Some suggested that we could have stopped there, given the molecule's promise. Indeed, others suggested that we would have *no choice* but to stop there, because it would be *impossible* to create a GLP-1 medicine that could last in the body for any longer—after all, natural GLP-1 itself has a half-life of less than two minutes, and it took many years to develop a medicine with a half-life that could be measured in hours. But another team, led by Drs. Jesper Lau, Thomas Kruse, and Paw Bloch, resolved to begin a new wave of innovation. They were determined to create a novel, even more potent GLP-1 drug—one that would stay in the bloodstream for days, and that could be injected *weekly* instead of every 24 hours.[46] After several more years, and after facing down and overcoming many new obstacles, they did just that. These scientists created the revolutionary semaglutide compound, with a half-life of 165 hours—more than ten times longer than the half-life of liraglutide, and with even more powerful effects.[47]

Throughout the decades, Novo Nordisk constantly pushed this research forward, funding study after study to understand whether these drugs worked and could be used to improve the lives of those with chronic diseases. We even continued funding expensive new trials after the drugs had already been approved by the FDA, because we wanted to find out if there were even more ways they could help patients. The landmark SELECT study that demonstrated semaglutide's effect on those suffering from established cardiovascular disease and either obesity or overweight was the largest clinical trial in Novo Nordisk history, enrolling more than 17,000 patients across 41 countries and 800 investigator sites. The median pivotal clinical trial alone costs more than $40,000 per enrolled patient.[48] Each time that we believe we have identified a potential new

---

[45] *See* Lotte Bjerre Knudsen & Jesper Lau, *The Discovery and Development of Liraglutide and Semaglutide*, Frontiers in Endocrinology (April 12, 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6474072/pdf/fendo-10-00155.pdf.

[46] *See, e.g.*, *id.*; Jesper Lau et al., *Discovery of the Once-Weekly Glucagon-Like Peptide 1 (GLP-1) Analogue Semaglutide*, J. Med. Chem. (2015), https://pubs.acs.org/doi/10.1021/acs.jmedchem.5b00726.

[47] Jesper Lau et al., *supra* note 46.

[48] Thomas J. Moore et al., *Estimated Costs of Pivotal Trials for Novel Therapeutic Agents Approved by the US Food and Drug Administration, 2015-2016*, JAMA Internal Medicine (Nov. 1, 2018), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2702287.

indication for semaglutide, we must fund another set of large studies to prove that the drug is safe and effective for that purpose.

The total investment that we have made in the treatment of these chronic diseases through our revolutionary category of GLP-1 medications is difficult to comprehensively quantify. The company's spending dates back to the early 1990s—predating our existing finance system—and sprawls across many categories of expenses. But even under an extraordinarily conservative approximation, we have invested *well over $10 billion dollars* to develop our groundbreaking GLP-1 medicines without knowing if any of the work would result in safe and effective medication that could be provided to the general public.[49] We undertook more than 100 phase II and III clinical trials for our GLP-1 medicines over the course of more than three decades, collecting more than 135,000 person-years of data.[50]

Moreover, these figures do not capture the full picture and cost of what it took to get to where we are today—because for every drug that works, there are nine that fail.[51] That is, for every medication that advances all the way to human testing, 90% still fail during phase I, II, and III clinical trials.[52] And of the one-in-ten medications that do make it to the market, only a minority actually turn a profit.[53] Nevertheless, we continued with studies, trials, and lines of research over the years when both academia and the pharmaceutical industry showed little interest in exploring these treatments—all for a stigmatized disease wrongly considered to be the result of patients' moral failure,[54] and when no success was guaranteed.

Just a few years ago, we invested more than $150 million in a growth hormone deficiency drug that never saw commercial success. We recognize that failures like this are the cost of taking big risks to find innovative new therapies. But this means that drugs that succeed, like Ozempic® and Wegovy®, bear a heavy burden. They must return the investment in not only themselves, but in each of the far more numerous drugs that failed—and fund the next breakthrough.

This is the cycle that enables companies like Novo Nordisk to continually reinvest in the future, enabling continued innovation focused on improving patients' lives. In fact, despite having approved treatments on the market for over a decade, Novo Nordisk has only made a profit on medication for obesity in the past two years.

Novo Nordisk also continues to invest in innovations that make it easier for patients to take their medications. For years, Novo Nordisk has worked to create ever more innovative injection

---

[49] Novo Nordisk emphasizes that this is an extremely conservative estimate, and the true expense required to develop these medicines likely substantially exceeds this amount.

[50] Each "person-year" is a year of data contributed by an individual participant in a study.

[51] Duxin Sun et al., *Why 90% of clinical drug development fails and how to improve it?*, Acta Pharmaceutica Sinica B (Feb. 11, 2022), https://pubmed.ncbi.nlm.nih.gov/35865092/.

[52] *Id.*

[53] John A. Vernon et al., *Drug development costs when financial risk is measured using the Fama-French three-factor model*, Health Economics (Aug. 2010), https://pubmed.ncbi.nlm.nih.gov/19655335/.

[54] Kolata, *supra* note 16 ("'There was very little interest in the industry in doing this,' said Dr. [Richard] Di Marchi, now at Indiana University. 'Obesity was not thought to be a disease. It was looked at as a behavioral problem.'").

pens, combining patient insight with engineering excellence, making drug delivery as simple and painless as possible to help overcome this fear. Each of these inventions increased dosing accuracy, portability, ease of use, and improved quality of care while reducing patient pain.[55]

While all of these research and development expenses are essential elements of the cost of these drugs, none of them are accounted for in the often-cited Yale study published in *JAMA*. That study was intended to estimate the hypothetical ***future*** costs of producing generic versions of GLP-1 medications like semaglutide. As the authors of the study make clear, the study's calculation of profitability included neither the cost of researching and developing Novo Nordisk's GLP-1 medications, nor the significant costs of developing the first-in-the-world manufacturing facilities to meet demand.[56]

Producing these medications at the scale needed to meet current (and rising) demand is complicated and expensive, as Novo Nordisk knows well. Our company was founded to bring insulin to the people of Europe, but manufacturing complex peptide treatments like insulin is extraordinarily difficult to do—and we spent the first five decades after insulin's discovery trying to find a way to scale production sufficiently to serve all patients who could benefit from it. Semaglutide is also a complex peptide, and, today, we are once again hard at work trying to solve the same challenge: increasing production capacity and closing the gap between supply and demand.

Since just the beginning of last year, Novo Nordisk has committed to spending over $30 billion on expanding our manufacturing capacity—more than double our company's entire net profit in 2023. The overwhelming majority of this investment is being directed towards GLP-1 medication production. We announced our most recent investment of $4.1 billion to expand our production facility in North Carolina just this past June, which we predict will ultimately create 1,000 good-paying jobs—in addition to the more than 3,000 construction jobs that the expansion will create.[57] That investment comes on top of the $6 billion already committed there, and the thousands of jobs we have already created in the state.[58] And just a few months ago, Novo Nordisk spent $11 billion to acquire three manufacturing sites in Indiana, Italy, and Belgium from Catalent,

---

[55] *See, e.g.*, Jakob Oest Wielandt et al., *FlexTouch: A Prefilled Insulin Pen with a Novel Injection Mechanism with Consistent High Accuracy at Low- (1 U), Medium- (40 U), and High- (80 U) Dose Settings*, J. Diabetes Sci. Tech. (Sept. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208880/; Thomas Sparre et al., *Development of an Insulin Pen is a Patient-Centric Multidisciplinary Undertaking: A Commentary*, J. Diabetes Sci. Tech. (May 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9158249/.

[56] *See* Melissa J. Barber et al., *Estimated Sustainable Cost-Based Prices for Diabetes Medicines*, JAMA Network Open 10 (March 27, 2024), https://shorturl.at/hzAQV.

[57] *See* Annika Kim Constantino, *Novo Nordisk to build $4.1 billion North Carolina facility to boost output of Wegovy, Ozempic*, CNBC (June 24, 2024), https://www.cnbc.com/2024/06/24/novo-nordisk-nc-facility-wegovy-ozempic-output.html.

[58] *Novo Nordisk announces 4.1 billion USD investment to expand US manufacturing capacity*, Novo Nordisk (June 24, 2024), https://www.novonordisk.com/news-and-media/news-and-ir-materials/news-details.html?id=168528; *Who we are: North Carolina*, Novo Nordisk (accessed Sept. 8, 2024), https://www.novonordisk-us.com/about/who-we-are/north-carolina.html.

one of the largest drug manufacturing contractors in the world.[59] This is in addition to our announcements in late 2023 that we would invest $8 billion in manufacturing facilities in France and Denmark to increase production.[60]

We continue to evaluate potential additional investments in expanding manufacturing capacity, and intend to maintain elevated levels of capital expenditures—more than $7 billion each year—through at least 2026. We are making these investments so that we can manufacture enough GLP-1 medications to meet the need for them. If we are unable to build out sufficient production capacity to supply enough semaglutide, it would deprive many patients of revolutionary therapies for their diseases—to the overall detriment of society.

Our multibillion-dollar investments in North Carolina have created jobs for thousands of Americans at more than double the average local income, and North Carolina is the only place outside of Denmark where we manufacture the active pharmaceutical ingredient (API) semaglutide. The company also owns facilities in New Hampshire and California; in total, Novo Nordisk employs more than 8,000 people across the United States.[61]

Novo Nordisk has made all these investments while reducing our carbon footprint. In 2020, we achieved our goal of using 100% renewable energy across all global production, including in the U.S., where our North Carolina facility is completely powered by a nearby, purpose-built, 105-megawatt solar farm.

And while we continue to invest to build our capacity to serve patients, we are concerned that others may be exploiting patients and putting their safety at risk. Certain foreign manufacturers are claiming to provide "semaglutide." To be clear, Novo Nordisk manufactures the only FDA-approved semaglutide. In fact, testing has shown that many of these non-FDA approved products often contain high levels of impurities that can pose significant harm to patients. Data from the FDA shows that there have been over 500 reports of adverse events associated with these unapproved products, including **more than 300 serious events, over 100 hospitalizations, and 10 deaths**.[62] The total number of adverse events from these unapproved compounded "semaglutide" products alone is now more than twice the number of adverse events that the FDA

---

[59] *Press Release: Novo Nordisk to acquire three fill-finish sites from Novo Holdings A/S in connection with the Catalent, Inc. transaction*, Novo Nordisk (Feb. 5, 2024), https://www.novonordisk.com/news-and-media/news-and-ir-materials/news-details.html?id=167017; Novo Holdings and Catalent, *Press Release: Novo Holdings to Acquire Catalent*, Business Wire (Feb. 5, 2024), https://www.businesswire.com/news/home/20240204431488/en/Novo-Holdings-to-Acquire-Catalent.

[60] *Press Release: Novo Nordisk invests more than 16 billion Danish kroner in expansion of production facilities in Chartres, France*, Novo Nordisk (Nov. 23. 2023), https://www.novonordisk.com/content/nncorp/global/en/news-and-media/news-and-ir-materials/news-details.html?id=166350; *see also Press Release: Novo Nordisk invests more than 42 billion Danish kroner in expansion of manufacturing facilities in Kalundborg, Denmark*, Novo Nordisk (Nov. 10, 2023), https://www.novonordisk.com/content/nncorp/global/en/news-and-media/news-and-ir-materials/news-details.html?id=166342.

[61] Novo Nordisk, Annual Report 2023, https://www.novonordisk.com/content/dam/nncorp/global/en/investors/irmaterial/annual_report/2024/novo-nordisk-annual-report-2023.pdf.

[62] *See generally* FDA Adverse Event Reporting System (FAERS) Public Dashboard, U.S. Food & Drug Administration, https://www.fda.gov/drugs/questions-and-answers-fdas-adverse-event-reporting-system-faers/fda-adverse-event-reporting-system-faers-public-dashboard.

received for all compounded drugs in 2022 combined.[63] While we support the use of compounding pharmacies for their intended purpose—to combine ingredients to create a medication tailored to the unique needs of an individual patient—neither Congress nor the FDA intended for compounding pharmacies to sell large volumes of compounded drugs across state lines and as an alternative to FDA-approved medicines.[64] We strongly oppose compounding of non-FDA approved "semaglutide" products that puts patients at risk, especially given that risk has been associated with serious adverse events, hospitalization, and death. We hope Congress will look into the risks from these companies that are deceiving the public and putting patient safety at risk.

IV. How Novo Nordisk's Unique Corporate Structure Enabled GLP-1s—And So Much More

Novo Nordisk is uniquely positioned to take the long view. Unlike any other major drug company, our controlling shareholder is a charitable foundation, and our mission is to *defeat* diabetes and serious chronic diseases. Our structure comes from the foresight and values of our founders. It began when a husband and wife from Copenhagen, August and Marie Krogh, a professor and physician respectively, visited the United States in 1922 and learned that people with diabetes were being treated with insulin. Mrs. Krogh was a physician who herself had type 2 diabetes, but she also treated patients with type 1 diabetes in her practice. After meeting with the two Canadian researchers who discovered insulin, including Dr. Frederick Banting, Mr. and Mrs. Krogh received permission to bring that innovative therapy back to Denmark. Chairman Sanders has rightfully praised Dr. Banting for his commitment to ease suffering and save human lives. The Kroghs shared Dr. Banting's commitment, and we hold true to their values today through the unique structure they pioneered.

The controlling shareholder of Novo Nordisk is the Novo Nordisk Foundation—a charitable foundation that traces its roots to our founders over 100 years ago. The Foundation is owned by no one; instead, it is governed by an independent Board of Directors that is legally obligated to govern it in accordance with the mission laid out in its bylaws. As a result, Novo Nordisk cannot be acquired or subjected to a hostile takeover, freeing us from the pressures of daily stock market fluctuations.

The Foundation's overriding vision is to improve people's health and the sustainability of society and the planet. Since its inception, it has pursued a dual mission of supporting philanthropic purposes—more precisely scientific, humanitarian, and social causes—and ensuring a stable basis for the companies in the Novo Group. It is chartered under Danish law to ensure that the companies it owns (1) make a significant difference in improving the way people live and work, and (2) conduct their activities in a financially, environmentally, and socially responsible way.[65] The Foundation has never strayed from that approach.

---

[63] *Id.*

[64] *See FDA's Human Drug Compounding Progress Report: Three Years After Enactment of the Drug Quality and Security Act*, U.S. Food & Drug Administration (Jan. 2017), https://www.fda.gov/media/102493/download.

[65] *See generally Charter for companies in the Novo Group*, Novo Nordisk Foundation (accessed May 22, 2024), https://novonordiskfonden.dk/en/who-we-are/goal-and-values/charter/.

This principled and persistent approach—including a laser-like focus on treating and defeating diabetes and related chronic diseases—enabled Novo Nordisk to continue to invest in unlocking the potential of GLP-1s, even as other companies shied away.

Novo Nordisk is the single largest private funder of diabetes research and education in the world, thanks in part to investments made through the Foundation. **We spent $4.2 billion on diabetes and obesity research and development in 2023 alone—50 percent more than the diabetes and obesity R&D budget of the entire National Institutes of Health**.[66] That investment in research and development will only continue to grow, as we intend to increase the amount of our investment in R&D as a percentage of our total sales—meaning billions more for discovering new therapies and cures each year. And last year, we reached more than 40 million patients globally with our diabetes medications, a 12% increase from the year before.[67] We have 10 new potential diabetes treatments in the research pipeline, and we will never give up on our efforts to find a cure.[68]

The Novo Nordisk Foundation has awarded thousands of grants worth approximately $5 billion over the last five years alone towards three focus areas: health, sustainability, and the life science ecosystem—including more than $1.3 billion in grants in 2023.[69] Many of the Foundation's efforts are directed to work in partnership with institutions in the United States, including:

- The Pandemic Antiviral Discovery initiative to catalyze discovery and early development of antiviral medicines for future pandemics, in partnership with the Gates Foundation,
- The Novo Nordisk Foundation CO2 Research Center to discover solutions to capture and recycle carbon dioxide from the atmosphere, in partnership with Stanford University,
- The Novo Nordisk Foundation Quantum Computing Programme to create a working quantum computer, in partnership with MIT,
- The Pioneer Center for Landscape Research in Sustainable Agricultural Futures, paving the way for a green transition in the agriculture industry, in partnership with Colorado State University, and

---

[66] Novo Nordisk spent $4.8 billion on R&D in 2023, with 87 percent of that total allocated to diabetes and obesity care. Annual Report 2023, *supra* note 61, at 56. The NIH reported spending of $2.8 billion on these categories in 2023. NIH Research Portfolio Online Reporting Tools, *Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)*, NIH (March 31, 2023), https://report.nih.gov/funding/categorical-spending#/ ($1.3 billion for diabetes, $1.2 billion for obesity, and $269 million for childhood obesity in 2023).

[67] Novo Nordisk, Annual Report 2023 at 15 and 90, https://www.novonordisk.com/content/dam/nncorp/global/en/investors/irmaterial/annual_report/2024/novo-nordisk-annual-report-2023.pdf.

[68] *Id.* at 27.

[69] *Annual Impact Report 2023: Societal Impact of the Novo Nordisk Foundation*, Novo Nordisk Foundation vi (2024), https://novonordiskfonden.dk/app/uploads/Novo-Nordisk-Foundation-2023-Annual-Impact-Report.pdf.

- The Novo Nordisk Foundation Center for Genomic Mechanisms of Disease at Broad Institute of MIT and Harvard, to pave the way for better diagnostics, improved treatments, and the development of precision medicine by exploring human gene regulation in connection with common complex diseases.

The Novo Nordisk Foundation also funds the BioInnovation Institute ("BII"), an international incubator founded in 2018 that helps inventors and scientists build new companies focused on improving human and planetary health.[70] Nearly 90 start-ups working to improve human and planetary health have launched from the BII in the last six years.[71]

This work is funded through Novo Nordisk's dividends and buybacks.[72] When we are fortunate enough to discover a successful treatment in the fight against chronic diseases, our profits fuel the Novo Nordisk Foundation to further deliver on its charitable mission in support of better health and a sustainable environment for the U.S. and the world.

V. Novo Nordisk's Commitment to Patient Access

We agree that, when innovative medicines like Ozempic® and Wegovy® have transformative effects on public health and address massive drivers of health care costs, American patients should benefit from these savings. But the modern U.S. health care system is a complex ecosystem with many players, and we do not control what patients pay for their medications. Unfortunately, the U.S. system has created unintended consequences that can harm patients and interfere with affordable access to prescription drugs.

The U.S. healthcare system is dominated by middlemen who play a key role in both patient access and costs—the vertically-integrated healthcare conglomerates made up of insurers, pharmacy benefit managers ("PBMs"), specialty pharmacies, and opaque group purchasing organization contractors ("GPOs"). As a *New York Times* investigation found this summer, these conglomerates and their PBMs "operate in the bowels of the health care system and cloak themselves in such opacity and complexity that many people don't even realize they exist" while "driving up drug costs for millions of people, employers and the government" and "extract[ing] billions of dollars in hidden fees" from pharmaceutical companies.[73]

Today, the three biggest PBMs control prescription drug access for more than 80 percent of the market, exercising near-total control over the ability of hundreds of millions of Americans to get the medicines they need at affordable prices, and each of these PBMs is owned by one of

---

[70] BioInnovation Institute Foundation, *BII Impact Report*: *A year in review*, BioInnovation Institute 1, 4 (2024), https://bii.dk/wp-content/uploads/Impact_Report_2023_FINAL_WEB-2.pdf.

[71] *Id.* at 7.

[72] *See Annual Impact Report 2023*, *supra* note 69, at 4-5.

[73] *See* Rebecca Robbins & Reed Abelson, *The Middlemen: The Opaque Industry Secretly Inflating Prices for Prescription Drugs*, N.Y. Times (June 21, 2024), https://www.nytimes.com/2024/06/21/business/prescription-drug-costs-pbm.html.

the largest health insurance companies in the United States.[74] As the Federal Trade Commission found in July: these "dominant PBMs can often exercise significant control over which drugs are available" and "at what price."[75]

Last year, these three PBMs appeared before this Committee and explained that they negotiate lower drug prices for their "customers."[76] The PBMs' customers, however, are often their own corporate parent healthcare conglomerates—not American patients. In practice, this means that PBMs negotiate large undisclosed payments from drug manufacturers that lower the price of medicines, called "rebates," that they then provide to their corporate affiliates, rather than applying those dollars to lower the cost actual patients pay for their medications at the pharmacy counter.[77] And while PBMs negotiate low net prices for their corporate parents, those insurers design their plans such that nearly half of all patients' out-of-pocket spending for brand medication is based on the full list price, with the insurer collecting the difference.[78] Meanwhile, the PBMs continue to create further complexities to enrich themselves and their corporate parents, including through the creation of offshore rebate aggregator entities which—as one PBM executive put it—are intended to "create a fee structure that can be retained and not passed on to a client."[79] It also includes the creation of offshore "private labeling" entities: new companies that enter exclusive deals to procure medicines that other generic manufacturers are already making—but that the PBMs can then include on their own formularies at higher prices, pocketing the profits.[80]

Overall, we pay 75 cents of every dollar of medicine we sell back into this complex system in rebates, discounts, and fees—meaning the "net" price Novo Nordisk ultimately receives for the medicines it sells is far below the published "list" price. And while the rebates we pay to PBMs and insurers as a share of each dollar earned have increased dramatically over the last decade, this has not resulted in a proportionate reduction in out-of-pocket costs for patients at the pharmacy counter. Instead, as the *New York Times* investigation concluded, PBMs "steer patients toward pricier drugs, charge steep markups on what would otherwise be inexpensive medicines and extract billions of dollars in hidden fees."[81]

---

[74] United State Federal Trade Commission Office of Policy Planning, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drugs Costs and Squeezing Main Street Pharmacies* (July 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

[75] *Id.* at 3.

[76] *Examining the Need to Make Insulin Affordable for All Americans: Hearing before the S. Comm. On Health, Educ., Lab., and Pensions,* 118th Cong. 60 (May 10, 2023) (statement of Heather Cianfrocco, CEO of OptumRx), https://www.congress.gov/118/chrg/CHRG-118shrg54476/CHRG-118shrg54476.pdf.

[77] *See, e.g.*, *Follow the Dollar: Understanding How the Pharmaceutical Distribution and Payment System Shapes the Prices of Brand Medicines*, PhRMA (Nov. 2017), https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Org/PDF/D-F/Follow-the-Dollar-Report.pdf.

[78] Andrew Brownlee & Jordan Watson, *The Pharmaceutical Supply Chain, 2013–2020*, Berkeley Research Group (Jan. 7, 2022), https://www.thinkbrg.com/insights/publications/pharmaceutical-supply-chain-2013-2020/.

[79] *Pharmacy Benefit Managers*, *supra* note 74 at 22.

[80] *Id.* at 27–29.

[81] *See* Robbins et al., *supra* note 73.

As an independent study found last year, the gap between list prices and net prices persists even for the newest generation of GLP-1 medications like Ozempic® and Wegovy®.[82] In fact, the net price of Ozempic®—the amount that Novo Nordisk is actually paid for the medicine—has declined by about 40 percent since its introduction in the U.S., and the net price of Wegovy® has similarly declined since its launch less than three years ago.

Because of this complexity in the U.S. healthcare system—with PBMs asking that more money be paid to them in the form of rebates, discounts, and fees each year—unilateral manufacturer cuts to list prices do not consistently alleviate the cost burden on patients, and may in fact create harmful unintended consequences.

Indeed, last year, we announced that we would voluntarily reduce the list price of several of our insulin products in January 2024, including our Levemir® basal insulin, by as much as 75 percent. At that time, I personally cautioned the Committee that reducing list prices could actually harm patients if it resulted in PBMs dropping medications from their "formularies"—because formularies control what prescription drugs are covered by patient insurance and dictate which products patients have access to under their prescription plans.[83] Unfortunately, that is precisely what happened. In 2023, before we lowered the price of Levemir®, it was available on formulary to *90 percent* of U.S. patients with coverage from commercial insurance or Medicare. In 2024, after Novo Nordisk dropped the price, Levemir® was available on formulary to just *36 percent* of those patients. Ultimately, Levemir®'s loss of access to the vast majority of patients in the U.S. was a fundamental consideration in our decision to discontinue the medication.[84]

In short, manufacturer list price cuts may actually have the opposite of the intended effect on patient choice, costs, and access. Thus, to effectively address what patients actually pay at the pharmacy counter for their prescriptions, it is essential to consider the role each actor in the system plays—as this Committee recognized when it called the heads of the three dominant PBMs to testify in May of 2023, alongside myself and the CEOs of Sanofi and Eli Lilly. This is why we have committed to work on *systemic changes* to address these true drivers of cost, and why we have concerns about oversimplifying the full and complex reality of the American healthcare system. Moreover, we are concerned that oversimplification can also turn well-meaning policies into significant unintended consequences that negatively impact patients.

For instance, any such changes must not harm or weaken the incentives for innovation in the American prescription drug ecosystem. Manufacturers are willing to invest significant resources and money in risky moonshots that often take 10 to 15 years to potentially yield any results in no small part because of the strong intellectual property protections the U.S. provides if they succeed. Those incentives also often enable the American people to access groundbreaking therapies like Ozempic® and Wegovy® before anyone else in the world—indeed, the United States

---

[82] Benedic N. Ippolito & Joseph F. Levy, *Estimating the Cost of New Treatments for Diabetes and Obesity*, American Enterprise Institute, 2-3 (Sept. 2023), https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208.

[83] *Examining the Need*, *supra* note 76, at 84 (statement of Lars Fruergaard Jørgensen, CEO of Novo Nordisk).

[84] Of course, Levemir® is no longer under patent, and any biosimilar manufacturer is welcome to create and market a generic version of the insulin.

was the first country to get access to these groundbreaking therapies and remains one of a handful of countries where Wegovy® is sold.

Policymakers considering changes should also take care to ensure that Americans continue to benefit from access to many different choices of medicine. Today, patients in the United States have access to 85% of all of the new medicines launched since 2012. In Europe, by contrast, patients have access to less than 40% of the new medicines launched during the same time period, on average.[85] It is important that American patients and their health care professionals continue to have the ability to choose the therapy that is right for them.

The U.S. system must also continue to benefit from the forces of competition, which are already at work in the GLP-1 market. Today, Novo Nordisk faces significant competition in the GLP-1 market from multiple market participants, including from U.S. pharmaceutical company Eli Lilly. Even more GLP-1 medications are expected to come to market in the coming months and years from several different manufacturers, with analysts predicting that as many as 13 new offerings will progress toward approval over the next five years.[86] At the same time, Novo Nordisk's compound patent on its first GLP-1 medications based on the liraglutide molecule—Victoza® for diabetes and Saxenda® for obesity—has already expired, and one manufacturer launched a generic version of Victoza® this past June.[87]

In due course, as provided by federal law, other manufacturers will be able to produce generic versions of Ozempic® and Wegovy® without having to invest in additional research and development. This will likely have substantial effects on the market. As the FDA has said, "[w]ithin a year of the first generic approval, we often see prices fall by more than 75 percent compared to the brand price."[88] Indeed, we expect substantial competition at the time of generic entry.

The U.S. system also now has a dedicated statutory channel for addressing drug prices in the Medicare program through the Inflation Reduction Act ("IRA"). Based on its duration in the market, and assuming it meets the other statutory criteria established by Congress, Ozempic® is eligible for price negotiation with Medicare under the IRA in less than a year. The federal government is the largest single purchaser of prescription drugs in the world, and those negotiations will likely exert a substantial effect on prices in the commercial insurance market as

---

[85] PhRMA, Global Access to New Medicines Report 45 (April 2023), https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Report-PDFs/A-C/2023-04-20-PhRMA-Global-Access-to-New-Medicines-Report-FINAL-1.pdf.

[86] Abigail Beaney, *Obesity: Six trials to watch over the next 12 months*, Clinical Trials Arena (June 20, 2023), https://www.clinicaltrialsarena.com/features/obesity-trials-to-watch/; *see also* Marc Iskowitz, *Why the obesity drug market is about to get a lot more crowded*, Medical Marketing and Media (April 26, 2024), https://www.mmm-online.com/home/channel/why-the-obesity-drug-market-is-about-to-get-a-lot-more-crowded/.

[87] *Teva Announces Launch of Authorized Generic of Victoza® (liraglutide injection 1.8mg), in the United States*, Teva Investor Relations (June 24, 2024), https://ir.tevapharm.com/news-and-events/press-releases/press-release-details/2024/Teva-Announces-Launch-of-Authorized-Generic-of-Victoza-liraglutide-injection-1.8mg-in-the-United-States/default.aspx.

[88] Ryan Conrad & Kristin Davis, *Estimating Cost Savings from New Generic Drug Approvals in 2021*, U.S. Food & Drug Admin. 3 (Sept. 2023), https://www.fda.gov/media/172608/download?attachment.

well. At the same time, competing GLP-1 products from Eli Lilly will not be subject to government price-setting under the IRA for another ten years.

As a result of the various market pressures described above—as well as the fact that the net prices of Ozempic® and Wegovy® have already substantially decreased (for Ozempic®, by about 40 percent) since their introduction—any study with cost estimates premised on the idea that our GLP-1 medications will be priced the same ten years from now as they are today in the U.S. are not credible. Such assertions and conclusions run afoul of the general experiences of bringing a biopharmaceutical product to market, and contradict the actual market realities already observable for Ozempic® and Wegovy®.

Novo Nordisk will continue working to ensure that Americans are able to affordably access these groundbreaking medications in the existing system. Our company has already undertaken important affordability initiatives for patients with type 2 diabetes who cannot afford the price of their GLP-1 medicine, including offerings that reduce the price at the pharmacy counter to as little as $25 for a one-month supply of Ozempic® for patients with commercial insurance facing large co-pays—for example, because they have not satisfied their insurance plan's deductible yet. Our Patient Assistance Program provides free Ozempic® to patients in need who are uninsured or receive insurance through Medicare and whose household income falls below 400% of the federal poverty line (approximately $120,000 for a family of four).[89] Since 2019, we have saved nearly 7 million American patients more than $1.7 billion towards our semaglutide products through our Savings Card and e-Voucher programs.

Ultimately, however, the most wide-reaching way that we are working to address patient access and affordability in the United States is by convincing PBMs and insurers to put these new therapies on insurance formularies. This requires us to pay substantial rebates and discounts to the PBMs, and these efforts are working. Currently, Ozempic® is covered by 99 percent of U.S. commercial insurance plans. And Wegovy®, a much newer medication, is already covered by approximately half of all commercial insurance plans, as well as 21 state Medicaid plans, the Department of Veterans Affairs, the Indian Health Service, military healthcare, and plans for federal employees—with the majority of patients with insurance coverage for Wegovy® paying $25 or less per 28-day supply.

Unfortunately, the same prejudicial stigma that attaches to people living with obesity has reared its head in the national debate about whether these same patients should have their medication covered by basic commercial insurance or Medicare. This would be unthinkable for patients living with any other serious chronic disease.

Novo Nordisk is confident that even more insurers will cover our GLP-1 medications in the coming months and years. Plan sponsors will not be able to ignore the cost savings and lifetime benefits accruing to patient health that make the medications a tremendous value. We remain confident that Medicare will ultimately see this value as well. As Milliman found in a February

---

[89] *See* NovoCare, *Patient Assistance Program*, Novo Nordisk (accessed April 30, 2024), https://www.novocare.com/diabetes/help-with-costs/pap.html.

2024 report, Medicare stands to see cost savings of as much as $5.8 billion over ten years from covering anti-obesity medicines like Wegovy®.[90]

* * *

Novo Nordisk is proud of the work that our scientists, researchers, and personnel have done to advance innovation and to improve the lives of people with chronic diseases, including diabetes and obesity. And I am proud to be here today to represent them. We are humbled to see how Ozempic® and Wegovy® have already helped so many Americans, and we agree that affordable access to these important treatments is essential for patients in Medicare, Medicaid, and the commercial markets. Novo Nordisk remains committed to working with policymakers to advance solutions that support access and affordability for all patients.

I look forward to answering your questions and engaging in meaningful discussions on these important topics.

###

[90] Maddie Cline et al., *Milliman Report: Impact of Anti-Obesity Medication Coverage in Medicare Part D*, Milliman 1, 7 (Feb. 23, 2024), https://www.milliman.com/-/media/milliman/pdfs/2024-articles/3-6-24_impact-of-covering_anti-obesity-medications-in-medicare-part-d.ashx (even in the most conservative, high-uptake scenario modeled by Milliman, Medicare would see increased costs of 75 cents per member per month).

The CHAIR. Thank you very much, Mr. Jørgensen.

Mr. Jørgensen, this Committee, and you and others have talked a lot about list prices. You make the point that we have a complicated system and you're certainly right.

We talked about list prices, we've talked about rebates, we've talked about net prices. But at the end of the day, under your best-case scenario, the price you are charging Americans for Ozempic is still nearly $600. That's with all of the rebates and all of the discounts, that's over nine times as much as people in Germany pay for the product. And the price you are charging for Wegovy to Americans is over $800, nearly four and a half times as much as it cost in Denmark.

Very briefly, and number of people going to be asking you questions, please tell me why you think it is appropriate to charge Americans nine times more for the same exact product that you sell in Germany. And by the way, correct me if I am wrong here, but I assume that when you sell Ozempic for $59 a month in Germany, you are making a profit there. Am I correct on that?

Mr. JORGENSEN. Senator, let me start by acknowledging and sharing your wish to have affordable medicines for Americans. And there's been a number of numbers mentioned here. And I think it's important to say that these are not comparable data. When I mentioned that it's really important for us to secure access to patients and affordability, we are hard at work in making sure that patients have access via the insurance schemes. And today, 80 percent of all Americans with insurance have access to these medicines at $25 or less for a month's supply. So, it's a price point at the pharmacy counter we have to talk about.

The CHAIR. Let me just interrupt you, if I might. You are correct that many people pay $25 a month for Ozempic. But what you're forgetting to mention is that many of those people are paying outrageously high prices for the insurance that covers Ozempic and other drugs. So simply this is a pass due to the insurance companies. Bottom line is you are charging the American people substantially more for the same exact drug than you are charging people in other countries. And my question is why?

Mr. JORGENSEN. Senator, I appreciate the question. Let me try to explain how I see it. We launched Ozempic in 2018. We have had it on the market for some years. During those years, our price has declined by 40 percent. I mentioned that patients with insurance have access to the $25 or less for 80 percent of the cases. And if you look in this period in Medicare where there's broad coverage premiums have not gone up in the same period. The insurance companies and their PBMs, the big conglomerate of illegal entities, they have more than doubled, actually close to tripled their profit.

The fact that we can actually secure that 99 percent of people with insurance have access, that there's a copay at the pharmacy of $25 or less without premiums going up in Medicare while profit goes up for, for the middlemen, I think is a concerning data point.

The CHAIR. Well, I would simply say that most Americans would be surprised to learn that insurance rates are not going up in my state. They're going up by 14 percent. But once again, you are not

answering my question. It's a very simple question. In Germany, they're paying $59 for Ozempic. In the United States, we pay $969. And again, even with all of the discounts, we are still paying very substantially more than the people of any other country. And you are selling—as I understand, 72 percent of your revenue comes from the United States. That right, roughly?

Mr. JORGENSEN. If it's based on our accounts, you're right. I don't have the number from the top of my head.

The CHAIR. Okay. So, you're making huge amounts of money in this country and you're charging us far more. And you haven't given me an answer as to why. Let me ask you another question. A recent study from Yale University has estimated, as I mentioned earlier, that 40,000 lives in America could be saved each and every year if Novo Nordisk substantially reduced the price of Wegovy and made it available to everyone who needs this drug at an affordable price. From a moral perspective, does it bother you knowing that keeping the price of Ozempic and Wegovy so high in the United States could lead to the preventable deaths of tens of thousands of Americans?

Mr. JORGENSEN. Senator, we are very committed to make sure that Americans have access at an affordable price point for our medicines. There's nothing we would rather see happen. We have just announced $30 billion investments to increase capacity to serve these patients. There is a market we have to operate in and we negotiate hard to make sure that Americans have access. We negotiate against the PPMs and give them significant rebate discounts and fees.

The CHAIR. Mr. Jørgensen, you're not answering the question. And look, as you may know, I'm a great respecter of the people of Denmark. I think you have a social system, which is very progressive. But I'm asking you a simple question as a decent human being.

What studies tell us is that because of the very high price of your products, 40,000 people a year may die in America and you have not increased production is fine. But what I am asking you is if you don't act, 40,000 people a year could die, is this acceptable to you?

Mr. JORGENSEN. Any prospects of patients not getting access to the medicine they need, I think, is terrifying. And we have to solve this challenge together. I mentioned in my opening that I don't think any one company can solve that alone. I wish there were more at the table today so we could have discussion about how we do that together.

We don't decide the price for patients. That's set by the insurance companies. I do acknowledge that there are patients who have poor insurance or no insurance. And if you in the U.S. do not have insurance, if you have a low income, we actually have support programs to help those patients. I'm proud about those.

But they are not a real solution because patients should have access to medicines via insurance. Because if you live with a chronic disease like type 2 diabetes, obesity, these are complex diseases that requires access to physicians. They're comorbidities you need to have treatment for. So, I strongly believe we need to solve this

within insurance. And when you are in insurance, there is access to our medicine.

The CHAIR. Well, Mr. Jørgensen, this Committee has heard from insurance companies, we've heard from PBMs, we've heard from everybody in the world and everyone blames everybody else. But you still have not answered my question. It's a very simple question. Why Nova Nordisk is charging Americans substantially higher prices for these drugs than the people in other countries?

Let me get to another issue. Mr. Jørgensen, you have told this Committee that you are concerned that if you substantially lowered the list prices of Ozempic and Wegovy in the United States, PBMs may take these drugs off of their formularies and deny access to the patients who need these drugs. I think you used insulin as an example even.

However, I have received commitments in writing from the major PBMs that if Novo Nordisk lowered its list price, they would not limit access to Ozempic and Wegovy, and would not take these drugs off of their formularies. Given this fact, will you commit today that Novo Nordisk will substantially reduce the list price of these drugs in the United States so that the American people are not paying higher prices, far higher prices for these drugs than the people in Europe and Canada?

Mr. JORGENSEN. Thank you, Senator, for that information. That's new information for me. Anything that will help patients get access to affordable medicine we'll be happy to look into. I'd just like to make a comment also that the experience as you also allude to yourself from insulin is one of when we had a discussion last year in the hearing on insulin. We actually lowered insulin pricing. That had a consequence.

When we dropped some of the insulin prices, we had our products dropped from formulary coverage. So, less patients got access to those insulins. So, I have a bit of concern how this could play out, but anything that can help patients get access to the medicines they need at affordable price point, we'll be happy to collaborate around that.

The CHAIR. All right. Are you prepared to have Novo Nordisk sit down with the PBMs who have made that commitment to me that they will not take your products off of the formulary, sit in a room with us and work on an agreement?

Mr. JORGENSEN. I'll be happy to. As I said, do anything that helps patients. And I don't know under which conditions such a promise comes. I haven't seen any of that.

The CHAIR. Okay. I will get you the—they're in writing, and I'll get you the letters. All right. That's it for me right now. Senator Cassidy, do you want to ask?

Senator CASSIDY. I defer to Senator Collins for her 7 minutes of questions.

Senator COLLINS. Thank you very much, Senator Cassidy. Mr. Jørgensen, you testified that the net price of what your company is actually paid for Ozempic has declined by about 40 percent since its introduction. Is that correct?

Mr. JORGENSEN. Yes, that's correct.

Senator COLLINS. But the question remains, how do we get relief to patients at the pharmacy counter? As Senator Cassidy mentioned, this Committee's examined the role of the middlemen, the PBMs, in inflating costs. And more than a year ago in May 2023, our Committee reported a comprehensive bill that reformed PBM practices. And the whole purpose of that bill was to ensure that consumers got relief at the pharmacy counter.

Unfortunately, the Senate Majority Leader and the Chairman have not brought that bill to the Senate floor in more than a year. Could you give us some indication of what the impact on cost to consumers would be on prices if we had enacted that PBM reform bill?

Mr. JORGENSEN. Yes. Thank you, Senator, for that question. If we look at it today, PBMs and their insurance companies, or I think typical insurance companies that own PBMs, a number of legal entities set up to extract fees from the U.S. system, they are rewarded based on list price. So, they get a fee based on list price. So, the higher list price, the more fee they get for the same job. Which means that, in our experience, products that comes with a low list price get less coverage. It's less attractive.

That becomes troublesome for patients because patients who do not have insurance or have high deductible plans are then asked to pay the list price. We pay on average 74 percent in rebates, discounts, and fees, and even more when we are into Medicaid 340B, ET cetera. So, if we did our business based on net price instead of list price, that would mean that our products would be much more affordable for patients. And if we simply paid the PBMs a small fee for the limited risk and contribution they make, I think patients would be significantly better off.

Senator COLLINS. For every dollar that you sell in medicine, how much of that dollar goes to rebates, fees, and discounts that largely do not get passed on to the patient?

Mr. JORGENSEN. Yes, for every dollar we make we give 74 cents to the PBMs insurance companies.

Senator COLLINS. 74 cents of every dollar. Let me switch to another issue just to make sure that I understood. In your opening statement, you seem to say that your largest shareholder is a nonprofit charity foundation. Is that correct?

Mr. JORGENSEN. Yes, that's correct.

Senator COLLINS. Let me turn to another issue. Recently, your company discontinued production of Levemir, and that is a popular, long-lasting basal insulin. Ironically, just yesterday I heard from a mother from Denmark, Maine, whose daughter takes Levemir and feels that it has unique benefits for her clinical situation. So, making a sudden switch or change in her medication is very much of concern to this mother, what led to this discontinuation?

Mr. JORGENSEN. Yes. Thank you, Senator. Any decision to stop supplying any medicine is a very difficult decision because we acknowledge that different patients have different needs. In the case of Levemir, we actually lowered the list price in the U.S. by 65 percent last year. Just realized that after we dropped the price of Levemir, the PBMs dropped coverage. So, it went from being on 90

percent of insurance schemes to being only on some 35 percent. So, we see a dramatic lowering of volumes.

As I mentioned in my opening, we serve 30 million people living with type 1 diabetes in need of insulin. And it's difficult for us to run high volume manufacturing lines with small products because it prohibits us from actually serving all those patients. So, it was a difficult choice we had to make to make sure that we could sustainably supply enough insulin for all people with type 1 diabetes. But I do acknowledge that it comes with some stress for individual patients, unfortunately.

Senator COLLINS. Well, I hope that you will be giving guidance to these families because for some of them, this is a real blow and they're very concerned about the impact. I want to go back to the cost issue, which is critically important. How does your company help individuals who are part of low-income families, do not have insurance, and simply cannot afford your drugs?

Mr. JORGENSEN. Yes. Thank you, Senator. It's important for us that we also try to help the most vulnerable patients. So, we have worked hard to make sure that's coverage in Medicaid for our medicines. And we also have patient support programs.

For instance, if you live with type 2 diabetes and you are in need of a product like Ozempic, you can contact Novo Nordisk. And if you make less than 400 percent of the national poverty line, which as illustration is $120,000 as a household income, you can get free Ozempic from Novo Nordisk. And I believe we're the only company having such a support program.

Senator COLLINS. If your household makes less than $120,000, you can participate in your patient assistance program?

Mr. JORGENSEN. Yes. And I don't think it's an ideal situation because, honestly, patients should have access to insurance. Because if you live with type 2 diabetes, you're also at risk of having cardiovascular disease, kidney disease. So, you need a range of medical support. So, I think we should have, as a shared objective, we really make sure that people have access to proper insurance. And when they have that, we can work with different mechanisms to make sure that when they're at the pharmacy counter, they can pick up our medicines for $25 or less in most cases. But that's difficult when you don't have insurance.

Senator COLLINS. My time has expired. Thank you.

The CHAIR. Senator Luján.

Senator Luján. Thank you, Mr. Chairman. Mr. Jørgensen, thank you for being here, sir. In your opening statement, you said, "Patients need both affordability and access." I very much appreciate you saying that. Now, Wegovy and Ozempic are groundbreaking drugs that are making a huge difference in people's lives. The ability to quiet food, noise, and successfully manage their weight after so many failed attempts is truly a life-changing innovation.

But to make a positive difference in people's lives, they have to be able to afford it as well. I've heard from New Mexicans about unaffordability. I'll share a story that I heard from Bernadette. She's a mother of three in Albuquerque, New Mexico. In October of 2023, Bernadette was prescribed Wegovy for diabetes and a liver

condition. Her insurance denied coverage of Wegovy three times. Bernadette's Wegovy prescription would've cost about $1,000 after a $300 discount.

Her doctor then prescribed Ozempic. After two appeals, Bernadette's health insurance company approved her prescription. Even with health insurance, Bernadette's Ozempic prescription would've cost around $1,000 a month. Bernadette made the difficult decision to not pay $12,000 annually for either Wegovy or Ozempic, both prescriptions prescribed by her doctors. She now goes without.

According to *JAMA*, the adult Hispanic population in the United States has 45.6 percent obesity incidents. Black and Hispanic people are more predisposed to having type 2 diabetes, a condition related to obesity. The median household income in New Mexico is $62,268, or $5,189 a month. The median household income for Hispanic families across the United States is $65,540, or $5,461 a month.

Even with a 40 percent reduction in the list price, the cost of these drugs represent a huge part of the monthly income of new Mexicans and Hispanic Americans. I also heard through your testimony, the coupons or things of that nature that are included from the list price. Why don't you just sell the drug at the coupon price if you're willing to give people a coupon that can afford it instead of that list price that we see on that board?

Mr. JORGENSEN. Thank you, Senator, for bringing up that question and also addressing this, the needs of Hispanic and Black populations. I think that's really, really important. It is not our intention that anyone should pay the list price. The list price is the starting point for our negotiation against the PBMs and insurance companies in bringing coverage of our medicines to patients. And in particular, those you mentioned here in having a bigger need.

We see that when there is insurance company coverage, there is a price point of the $25 I mentioned for 80 percent of patients. And you can say, what about the remaining 20 percent? The price point is $50 or less for 90 percent of the cases. And then there are remaining 10 percent where there are either a situation without insurance, or you can say low quality insurance where insurance schemes have high deductibles or certain restrictions on use of the products.

It's important for me to say we don't set the price for those patients. That's a function of the insurance scheme. But for those who fall outside of insurance and actually including the income level you mentioned, we have a support program where we try to help them.

Senator Luján. Well, and Mr. Chairman, if I may, Mr. Jørgensen, Bernadette had insurance. Couldn't afford it. No. So, I appreciate the statistics and the numbers. She's a real person, mother of three. There's a problem here. I've not quite understood the notion of list prices with pharmaceutical companies and then the price that they're willing to sell the drug at so they can still make a profit. It sounds like a game to me and a game that I don't understand. But a game I certainly open a bipartisan way that we can get to the bottom of.

I very much appreciate Senator Collins' line of questioning at the opening as well, legislation that's moved out of this Committee deserves to be heard on the floor. And I certainly hope we can get there.

I'm going to move on. Before I do, while I appreciate very much that the Indian House Service and the VA include coverage for obesity and for other reasons of this drug, it's still high. It's still a high cost. And when we look at those programs as a whole, I'm still very concerned as to what's happening in that space. But I look forward to visiting with your team more about that into the future.

Mr. Jørgensen because of the work that was done with the Inflation Reduction Act, Medicare can finally negotiate the price that seniors pay for prescription drugs and Medicare. In your written testimony, you have acknowledged that Ozempic may be listed in the negotiations due to its high cost. Despite these contentions that Medicare negotiation will resolve the price, Novo Nordisk has attempted to block the law when Medicare sought to negotiate the prices of insulins. These insulins, by the way, had the list prices of almost $6,000 annually.

Now, as we both know, the court rejected that as well. My question for you, Mr. Jørgensen, when you mentioned in your written testimony that you expect Ozempic, your diabetes product will be included in Medicare's list of drugs for negotiations, yes or no, should Ozempic be selected for negotiation, will you commit to not initiating legal action to stop it?

Mr. JORGENSEN. Senator, thank you for bringing up that question. So, we share the objective of making products accessible and affordable for patients. No doubt about that. On the IRA negotiation, we have had some concerns that if it's a real negotiation, I support that. But if it's a price setting, I think it'll have unintended negative consequences to access to patients for innovation.

It's been described as a negotiation, but it's actually a setting of a maximum price. So, I don't know what price will end up having for our insulins. I don't know if the PBMs will include it on formulary at all because of that lower price and impact on rebating.

I have nothing against negotiating pricing with the objective of improving affordability for patients. But if it's not a fair negotiation, but actually price setting, I think it'll have negative consequences on the innovation being brought to Americans.

Senator Luján. Mr. Chairman, as I close, my time has expired. I would remind you, Mr. Jørgensen, of those words that you used in your opening statement again, "Patients need both affordability and access." I certainly hope that rings true. And I would encourage you to sit down with Chairman Sanders and the Committee staff associated with that PBM letter to find a place where you will lower those prices, and do the right thing, and send the message to everyone. Because your drugs will save people's lives. 40,000 more people that can't get them today, many in the community that don't get them today, and I certainly hope we can get to that place. Thank you, Mr. Chairman.

The CHAIR. Thank you.

Senator Cassidy.

Senator CASSIDY. I'll defer to Senator Budd.

Senator BUDD. Thank you, Ranking Member. Thank you, Chair. Mr. Jørgensen, thank you for being here.

According to reports, the North Carolina State Healthcare Plan attempted to limit coverage of one type of obesity drug, the GLP–1 that we're talking about today for enrollees to avoid raising premiums. Now, however, CVS Caremark, the state healthcare plans, PBM informed them that they would lose $54 million in discounts if coverage was limited. So, Mr. Jørgensen, do you know if these allegations are true?

Mr. JORGENSEN. I have to admit, I don't know all the details of the specifics of North Carolina, but I don't think we stopped paying these rebates.

Senator BUDD. I received a letter from North Carolina Speaker of the House, Tim Moore, and it includes data on the State Health Plan's Board of Trustees blaming the Inflation Reduction Act, not drug spending on the plan's shortfalls. So, I ask unanimous consent to enter the letter into the record, Mr. Chairman.

The CHAIR. Without objection.

[The following information can be found on page 132 in Additional Material:]

Senator BUDD. Thank you.

Mr. Jørgensen, could you describe in as simple terms as possible how Federal programs like the 340B Drug Discount Program and reimbursement for prescription drugs through Medicare Part B actually lead to higher prices, and I would say, higher list prices?

Mr. JORGENSEN. Well, when we set a list price, we have to take into consideration what are the rebates we have to pay, because unless we pay rebates into the system too, when we negotiate against the PBMs, we're not getting access to the formulary. So, a high list price is more likely to lead to more access to patients. And on top of that comes additional payments we have to give when we are in Medicaid, when we are in 340B programs, ET cetera, where there are additional payments, we have to make to make products affordable.

It leads to higher prices for those patients who then do not have access via insurance or some of these programs because they're faced with a list price. And really nobody should pay the list price, because that's not how we intend to do business. But we don't control the price set for the patients that's done by the insurance schemes. We only negotiate against the PBMs to make sure that we can move products to patients. But whether patients get insurance coverage and what price they pay, we have no impact on.

Senator BUDD. It seems like an industry with a lot of strange incentives. Last November *The Wall Street Journal* reported that PBMs often favor drugs with higher list prices. And I appreciate my colleague, Senator Collins line of questioning. But the favoring drugs with higher list prices is because PBMs are reimbursed based on a percentage of the drugs list price.

As I understand it, that means PBMs are going to make more money if they cover the higher priced drugs. So, here's for an example, insulin. One type of insulin had a list price of $274, while an

unbranded version of the same insulin had a list price of $25. And even though the unbranded version was $250 cheaper, the PBM didn't cover the cheaper version. So, and my understanding is only half of Americans have insurance coverage for that cheaper insulin.

This is a direct result of PBMs facing or favoring the more expensive type of insulin. So, I understand, and I appreciate your statement earlier that whatever's best for patients, and I believe that you and the many great team members that you have at Novo. So, Mr. Jørgensen, are there ways to reduce these perverse incentives? And we're asking for suggestions here, and perhaps this will come in ongoing discussions with the Committee. But in your time here, do you have some suggestions to reduce these perverse incentives to deliver savings and value to the patients in need?

Mr. JORGENSEN. Thank you, Senator. We should really unite around what help patients and if you have the industry making big risks in R&D, making big commitments into manufacturing, and then we have to negotiate against PBMs and their insurance companies not taking much risk and yet benefiting from a significant deal to the list price. I think that's absurd. So, if we could stop linking their income to a list price, I think that would create an incentive that is not as absurd as it is today.

I would prefer doing business on the net price where I compete against competitors based on what is the real price for our medicine and what is the value of the medicine. And these are medicines that are addressing societal challenges that are paramount. And we talk about the cost of the medicine, but it's really the cost of the diseases that's breaking the system.

We have to find a way where we transact in a way where it becomes much more transparent. What is the real price of the medicine to really adopt the medicine and mitigate the societal cost that diabetes and obesity is putting on the U.S. healthcare system and economy?

Senator BUDD. As you observe, kind of outside looking in, what changes would you suggest that we consider to move from a list price scenario? So, where you could, and other companies and competitors even could compete on a net price scenario? And do you believe that would be better for patients?

Mr. JORGENSEN. Yes. If we passed on the rebates we pay to the PBM, and the insurance companies, and group purchasing organization, whatever they're called, if we pass that on to patients then they are faced with the net price at the pharmacy counter. I think that would dramatically change it to a much more affordable system where it's the value of the medicine for the patient, the prescriber that determines what products is being used, not who gives the highest rebate.

Anything that opens up transparency and make it, really competitive in a free-market context where you compete on price and value of medicines, I think, would be a great benefit for American citizens.

Senator BUDD. Thank you, Mr. Chairman.

The CHAIR. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman. Thank you for holding this important hearing about outrageous prices that Americans pay for prescription drugs compared to the rest of the world. I remain deeply concerned that pharmaceutical companies continue to put profits over patients. Patients deserve access to affordable prescription drugs. We have taken meaningful steps to lower prescription drug costs. For example, working with Chairman Sanders and other Members of this Committee, we secured commitments from three companies to cap the cost of asthma inhalers at no more than $35 per month out of pocket.

Moreover, by allowing Medicare to negotiate drug prices for the first time ever, 150,000 Wisconsinites will soon see significant savings on 10 of the most widely used and costly medications. Insulin is now capped at $35 per month for Medicare patients, and next year, out-of-pocket costs will be capped at $2,000. But there is much more work to be done, and I'm committed to working with my colleagues to find more ways to lower the cost of prescription drugs and hold pharmaceutical manufacturers accountable for outrageous prices.

Today, I would like to begin by discussing patient access to medications. Mr. Jørgensen, your company was originally founded to provide insulin to patients with diabetes. For diabetic patients, the inability to access insulin can be life threatening. Without access to their prescribed medications, patients would be left to scramble to find alternatives, or they would be faced with rationing their supplies.

Mr. Jørgensen, you and your company have attributed shortages of your products, including GLP–1 and insulin to manufacturing capacity. You have noted in your testimony that the overwhelming majority of your company's recent manufacturing investment is to expand production of GLP–1 medications. However, there have been reports of looming discontinuation of insulin products and ongoing shortages of insulin products. So, is Novo Nordisk shifting manufacturing capacity away from insulin to prioritize manufacturing of GLP–1 drugs?

Mr. JORGENSEN. Thank you, Senator, for raising these important questions. And you're right, we have 100-year history in diabetes. We are committed as ever to diabetes. We are one of very few companies who are still doing research in insulin. We actually have, I would, say a breakthrough insulin being reviewed by the FDA, and we hope to launch that in the U.S. market in a couple of years. So, we are as committed to insulin as we have always been.

When there's been challenges in supply it's not because we are taking capacity away. There is a market now where insulin pricing is going down dramatically. I am concerned about the long-term supply of insulin because we have 100-year commitment to that, and we will keep producing insulin. But I think it's becoming difficult for new companies to get in. I think it's very difficult for biosimilar manufacturers to get into this market because they can simply not get on formulary.

Right now, entry and pricing is declining still by 10, 20 percent year over year. If this market structure continues, it'll be challenging to supply insulin. And this is in dire contrast to the public

narrative around in insulin price going up. So, if it's dramatically going down for manufacturers, biosimilars are not willing to start producing insulin and cost goes up for patients. I think that's a good example of how this system is not working.

But to answer your question, we will keep producing insulin. We are committed to patients in need of insulin.

Senator BALDWIN. How will your company ensure that the manufacturing capacity for critical insulin products remains stable within your company? I know you were talking a lot about other companies, but how will you ensure that manufacturing capacity within Novo Nordisk remains stable?

Mr. JORGENSEN. That's a commitment we have made a priority, we have made in the company. And I mentioned the discontinuation of Levemir as a difficult choice to make, because when a product is going down significantly in volume, it actually ends up, you can say, destroying the ability to produce enough on the line. Because every time you have to produce a different product, you lose a capacity. So, we focus our manufacturing to make sure that we can still supply the 30 million people around the world who need insulin from an onwards.

We continue to do research and development to make sure that people with type 1 diabetes, who I agree with what has been mentioned today, probably live the most difficult life of all in terms of having a lifesaving medicine they rely on each and every day, and they need a company they can trust for supplying high quality products that live up to FDA requirements, ET cetera. And we are committed to do that.

Senator BALDWIN. I have your commitment that notwithstanding the manufacturing capacity that you're creating for GLP–1, that you will continue to have a focus on providing critical insulin, you will not reduce your manufacturing capacity in that area?

Mr. JORGENSEN. The world market for insulin is actually declining, so there's less demand, but we are committed to supply to the patient that has been using our insulin for years also into the future. And we'll keep investing in innovation because using insulin is probably the most difficult pharmaceutical intervention patient does.

Staying in range is difficult. And we have a major innovation in weekly insulin coming, something most physicians would say would be impossible to do. Yet, our committed researchers cracked the code and we hope we are approved for that in the U.S. in the coming years' time. And that will simplify how people who rely on insulin can dose their insulin and take some of the fear away.

Senator BALDWIN. Thank you.

The CHAIR. Senator Cassidy.

Senator CASSIDY. I will defer to Senator Marshall.

Senator MARSHALL. Thank you, Dr. Cassidy. And thank you, Chairman Sanders. Mr. Jørgensen, welcome and thank you for attending this hearing.

Look, Novo Nordisk is not the villain in this story. Novo Nordisk is not the villain in this story. They're a hero. We should be here celebrating this miracle innovation that's responding to this dia-

betic epidemic we have in this country. It's a miracle drug. 38 million Americans with diabetes that we're helping out. This nation is spending $250, maybe $350 billion a year treating diabetes, not to mention the loss of work. And here's a drug that's going to help us treat the problem.

We all agree on this Committee, across the Senate, that the cost of healthcare is too much and that prescription drugs are too high, especially the out-of-pocket expenses. But we need to figure out who the villain is, who is the real culprit here? Who's making the money?

On this particular poster, you've said it once, you've said it twice, everybody up here said the same thing. Whatever the cost is, whichever number we want to use, Novo Nordisk keeps 24 percent of it, and the PBMs extract 74 percent. 26, and 74 percent. So really, the PBMs are making the bank here.

Let's talk about PBMs for a second here. The real, the real culprit in this room, in this story. So, these three big parent companies, the three big PBMs control 80, 85 percent of the industry. Their gross revenue last year was $800 billion. Their parent companies' gross revenue, $800 billion.

This Committee's worked so hard on PBM reform. We've not passed our delinking bill. And I would ask the Chairman to consider bringing the delinking bill back to the Committee, and let us mark it up as well. In that linking Bill, PBMs would receive a flat fee for their efforts as opposed to a percentage of the sale. So, we go to a flat fee model number, and there just can't possibly be enough transparency on this issue.

I came to Congress to save Medicare. The people of Kansas sent me here to save Medicare. I cannot save Medicare without a miracle drug for Alzheimer's. We're spending, I think, way over $200 billion on Alzheimer's disease. So, if we thwart the innovation that this type of company does, it tells people to stop researching drugs that are going to solve Alzheimer's.

Mr. Jørgensen, let's talk about research and development for a second. How many years have you been researching diabetes? And then eventually, probably decades ago, you started going down this Ozempic path, and how many other rabbit holes have you-all been down?

Mr. JORGENSEN. Yes, thank you, Senator, for the question. We have 100-year research effort in diabetes. And the past three decades we have been researching the GLP–1s in starting in diabetes, and then in obesity. And when we started the obesity research efforts, everybody thought it was a stupid idea——

Senator MARSHALL. Sorry to get through this. So, you've spent three decades specifically on the GLP–1 model, and I'm sure that there was lots of molecules that didn't work out. And at the end of the day, you've spent in excess of $10 billion of research. And then how much money are you going to spend on research this year, approximately?

Mr. JORGENSEN. We are spending approximately 14 percent of our turnover on research.

Senator MARSHALL. Okay. I want to make a quick point here, that companies like yours benefit from the Trump tax cut, the research and development dollars. The tax cut on that expired. Is that true that doing research in this country, you benefited from that tax cut?

Mr. JORGENSEN. We have no, say, funding support from the NIH whatsoever in our research efforts. We benefit from tax benefits in different situations.

Senator MARSHALL. The R&D, I would write the R&D off over a year as opposed to 5 or 10 years, would be a significant—would prevent you from—or decrease your reinvestment opportunities.

Mr. JORGENSEN. Yes, perhaps. I don't know the specific data in terms of how much we benefited from it.

Senator MARSHALL. The one thing I am disappointed in your company, all big pharma, is the marketing that they do. I think that the marketing is very influential. I really think that Congress needs to go back and revisit that as well. I think that the marketing is so good. There's people on this drug that shouldn't be on it and are being taken advantage of. And so, I do think we need to go back and look at that.

Again, instead of coming after the hero of this story, we need to look in a mirror. America needs to look in a mirror. That nutrition is a big problem in this country and lack of activity. The Chairman, Ranking Member, all of us have worked on Community Health Center Fund, the center of funding. I think that's where the opportunities to work on the nutrition problems remains.

It's frustrating to me that Congress can spend $1 trillion dollars on the military. Medicare can spend $1 trillion dollars, but we can't spend $3 billion on primary care, $3 billion to address the primary care needs of this country, which I think would have a big impact on driving down the need for these types of expensive drugs.

America, I said it for 20 years as a physician, that America suddenly wants to drive through healthcare, and we want to drive through a fast-food service that gives me gives medicine to fix our problem rather than addressing the real challenges before us, which is our nutrition in this country is horrible. So, I think that's something we need to continue to work on.

The other thing we can still work on is bringing competition, promoting competition to you. We'll bring this price down. We've passed legislation, the President signed legislation that helps drive biosimilars and generics to market more efficiently. There's several in the hopper, so to speak, but still, the FDA remains very inefficient. Very inefficient. The FDA should focus on the safety of the drugs, and then let the physicians and the patient decide if they're right for them. And that type of a model will drive down that process by years.

I'll just close, one more time, emphasizing that this Committee needs to demand that the leader bring our PBM reform to the floor, but we need to include that delinking bill. There are other opportunities to drive this price down. Again, Novo Nordick is not the villain in this story.

Thank you. I yield back.

The CHAIR. Thank you.

Senator Hassan.

Senator HASSAN. Thanks, Mr. Chair, and to you and Senator Cassidy for this hearing. Mr. Jørgensen, this year, Novo Nordic abruptly discontinued the drug Levemir. And I know Senator Collins raised this with you, but I want to follow-up on it a bit. Levemir is a critical insulin product, and one of the few long-acting insulins approved for use during pregnancy.

By discontinuing Levemir in January 2024, Novo Nordisk interrupted the diabetes care plans of millions of Americans with only a few weeks' notice. Will Novo Nordisk agree to provide any interested company with the necessary information and drug formulation to make Levemir?

Mr. JORGENSEN. Senator, thank you for the question. Any decision to take a product off the market is a very, very difficult decision. And I have to explain why we had to do that. We last year reduced the price for Levemir. We dropped the price yet to find that PBMs dropped access to Levemir. So much less patients have access to it.

Senator HASSAN. I understand that, but my question is, now that you're not making it and there are still patients who need it, will you provide necessary information and drug formulation to other pharmaceutical companies that decide they want to make it?

Mr. JORGENSEN. We have given a year's notice. More than the weeks you mentioned.

Senator HASSAN. Sir, my question is a direct one, please answer it or tell me you're not going to.

Mr. JORGENSEN. We have collaborated and followed-up with all those that were brought forward as potential manufacturers, but we have not found anyone interested in manufacturing it. And if there is a company interested in manufacturing it, or the government wants to manufacture it, we'll be happy to collaborate. The reality is that the market is disappearing for Levemir because of how it's contracted. And I don't make a decision like that and an easy decision.

Senator HASSAN. I understand. And have you worked actively to find a manufacturer to take on Levemir? It sounds like you've had some conversations, but are you continuing the outreach, because there are some patients who really need this medication?

Mr. JORGENSEN. Yes. The companies we know of have not shown interest. All the companies that have been mentioned as potential partners on this, we have discussed with and none have come forward as being interested.

Senator HASSAN. I will follow-up with you in writing to ask for specific steps that you'll continue to take over the next, let's say, 3 months to find a manufacturer for this drug.

Senator HASSAN. I'd like to move on, if I can, because in response to a question from Senator Luján about your pricing of Ozempic and Wegovy, you said if you drop the price of these obesity drugs, PBMs would take them off their formularies. But here's what the PBMs say. Cigna, Express Scripts, the question they were asked is, if Novo Nordisk lowered the list price for Ozempic and Wegovy to-

morrow, and the net cost stayed the same or went down, would your PBM limit access?

Here's what Cigna Express Scripts said. "No. If Novo Nordisk lowered their list price for Ozempic and Wegovy tomorrow to a price that was the same or lower than current net cost, that change by itself would not result in less favorable formulary placement. To support this claim, the company provided an example. It did not disfavor a competing weight loss product, Eli Lilly's Zepbound, even as it launched at a list price 20 percent lower than Wegovy.

Here's what UnitedHealth Group, Optum RX, said. "No. Assuming the net price remains the same or lower, lowering the medicine's list price would not lead to less favorable formulary placement by Optum Rx, particularly for high-demand drugs like Ozempic and Wegovy. To be clear, lower list prices and lower net prices support formulary placement and access"

CVS Caremark said something similar. It said, "This simple answer is no. In fact, we can point to recent history as a proof point when Novo Nordisk drastically reduced the price of their insulin NovoLog in 2023. It did not result in a less favorable formulary placement with Caremark."

They were also asked if Ozempic and Wegovy were available for $100 per month or less, what impact do you expect that it would have on coverage and access? Cigna Express says, "If Novo Nordisk lowered the price for plan sponsors to $100 or less per patient per month, we would expect the vast majority of our clients to expand coverage and access to these products for diabetes and weight loss assuming clinical evidence continues to support efficacy and safety."

CVS said, "Lower list prices would open up access for obesity treatment." In particular UnitedHealth Group Optum RX said, "Given the significant price differential for these products across borders, a decision by Novo Nordisk to align U.S. pricing more closely with those in other countries would meaningfully increase access for U.S. patients.

With that in mind, would you please commit to lowering the list price of these drugs?

Mr. JORGENSEN. Senator, allow me to share a few points before I answer your question——

Senator HASSAN. Yes.

Mr. JORGENSEN [continuing]. Is that Okay? So, the experience we have is one of losing access when we lower price. I know you can always find specific plans that did include insulin with a lower price, but the broad totality is that less patients have access to our medicines when we have lowered the price. I understand that perhaps the PBMs have changed their mind, and I'll be happy to collaborate with them on this because anything that helps patients to get access and affordability, we are supportive of.

The rebates that were shown, before we hand those out, they're not in our books. So, if we can go through a de-linking model or any model where we do business based on net price, I'll be more than happy for that. But it's not how history has told us.

Senator HASSAN. Well, but you've now got these companies publicly committing to continuing access and increasing access if the list prices are lowered. So, I would strongly recommend that with these companies on the record, they represent a huge amount of the covered patient population in the United States, that you consider strongly lowering the list price.

Lastly, I just want to note that one way of reducing drug prices is encouraging the entry of generic and biosimilar medications, which can provide lower cost options for patients. So, I will follow-up with you to, I hope, get a commitment that Novo Nordisk will not stand in the way of other companies coming up with lower cost versions of these drugs if the companies currently have them in development.

Senator HASSAN. Thank you, Mr. Chair.

The CHAIR. Well, I just want to pick up on Senator Hassan's important point. We have in writing, and we will certainly share it with you, commitments from the three major PBMs that if you substantially lower your list price, they would not limit coverage.

Now, what I'm hearing from you is that you are prepared, if an audit is prepared, to sit down and work with those three companies. I am prepared to negotiate that work with you. Do I get your commitment that you will sit down do with the three companies to make sure that they keep that commitment?

Mr. JORGENSEN. Yes. Anything that can help patients get access, I'm supportive of, and that also includes collaborating and negotiating with anyone who can help that.

The CHAIR. All right. But picking up on Senator Hassan's point, if in fact they keep their commitment, are you then prepared to substantially lower the list prices in the United States?

Mr. JORGENSEN. I have to understand what this entails because when I hear statements that PBMs would accept a low list price product, it needs to go all the way to patients. So, it means that they talk about insurance companies being their clients, it's actually their owners. So, it needs to get to insurance schemes, and it needs to get to the patients because——

The CHAIR. I am aware of that. But I'm asking you, again, will you work with this Committee and the PBMs?

Mr. JORGENSEN. Yes.

The CHAIR. No. 2, if in fact they keep their word, I understand that it's complicated, will you in fact substantially lower list prices in this country?

Mr. JORGENSEN. If it works in a way where patients get access to a more affordable medicine, and we have certainty that it actually happens and not like when we load list price prior rounds around that less people got access to our medicines.

The CHAIR. Right. I understand that. We will be positive toward that. We will be in touch with you and the PBMs to work on this. And I want to thank Senator Hassan for that line of questioning.

Senator Cassidy.

Senator CASSIDY. I'll defer to Senator Romney.

Senator ROMNEY. My goodness. Senator Cassidy, thank you very much. Appreciate that.

Mr. Chairman and Ranking Member, appreciate the chance to have this witness here. Appreciate your willingness to be here. I don't know whether it's voluntary or not, but given the nature of our hearing, so which are mostly opportunities for us to talk and you to listen. I appreciate your willingness to be here.

I guess there were a couple of models that one could have for developing new drugs. One was the idea of a patent, which we'd say we want the private sector to invest massive amounts of money to developing new products, new innovations. And then if one works, to have a patent to allow you to charge whatever you want to recoup a return on investment and make potentially enormous profit. That's one model.

The other model is to say, no, we, the government are going to develop drugs, and we're going to spend our money and keep the price down. Sometimes we live in a fantasy land, which is we want you to invest and the industry generally to invest massive amounts of money, but then we want you to keep the prices low. Like, that's fantasy land. That's not real. That's not reality.

You, under our system, are able to charge whatever you believe the market will bear and get as big a profit as you could possibly get. I presume that's—you have taken—you're a fiduciary for your shareholders. You're trying to maximize your profit. Is that right?

Mr. JORGENSEN. Senator, I agree with you that I'm not aware of any government that has developed a product. So, it's typically done in the private sector. And that can only happen if there's patent protection. I don't think we set our price in a way where we just look at our shareholders because we have also an obligation to set a price that it's available and affordable for patients.

Senator ROMNEY. Yes. There's no question long-term. Your profit is going to be enhanced if people believe that you are good guys, not bad guys. And so, there are a number of considerations in considering what's the best return. But there are a number of folks that would like you to invest a lot, but then to limit what you can get back and somehow ascribe malevolent intent if you charge a high price. It's like that's the system we have. There are alternative systems which is, no, no, we're going to limit how much you can get back in.

I look around the world, I don't recall a lot of drugs coming from China, and Russia, and North Korea, and Iran. We don't see a lot of innovation coming from there. But yes, I would love a setting where you invested massive money, but then you gave us the products cheap. I mean, that's just not reality. And I mean, I wish there were a way of that to happen, but I don't see how that happens.

I very greatly appreciate the innovations that have been made by the industry. I do wonder what the reason is for the differences in price between what's available here in this country and what's available in some other countries. And I'm not now just talking about Wegovy and Ozempic. And I don't know the pricing differences to the extent they exist around the world, but we in this country often talk about how products are much cheaper in Can-

ada, and the UK, and France, and Germany than they are here. Why is that? Why are we so out of line with the rest of the world in terms of the pricing that comes from the industry, not necessarily your own company, but the industry at large?

Mr. JORGENSEN. Yes. I think there are Senator a number of differences when if you, for instance, compare U.S. and European market. And if you look at all the innovation that's made, a lot of it is made in this country. So, the economic activity taking place here, all of those innovative products in 80 percent, 85 percent of the cases get to the market in the U.S. It's only around 40 percent in Europe.

In Europe, there's a sanction of healthcare. There's a rationing of who gets access. So, the latest innovations are not getting to my countrymen, but they are in most cases getting to the U.S. So, there's a different perspective in how you look at innovation. And when you look at the diseases we're talking about here, diabetes and obesity, these are very, very expensive diseases. And we talk about the cost of the medicine, but typically in these diseases, the cost of the medicine is less than 10 percent of the total disease burden.

If you look at chronic kidney disease where we have shown in our data that for people living with type 2 diabetes and start using Ozempic, you reduce the risk of developing chronic kidney disease by 24 percent. And actually, a quarter of all Medicare costs goes to people living with kidney disease.

Using innovation is a really big opportunity for driving down the cost of the U.S. healthcare system. And there is a general openness for that type of innovation in the U.S. market, which is not always the case in Europe. That comes with a cost, but it also leads to significant benefits for the individual Americans, but also for the healthcare system in saved cost for these chronic diseases.

Senator ROMNEY. I would anticipate that in European countries that don't have access to some of the lifesaving products that are available here, that there would be a huge hue and cry on the part of the public saying why can't we have these products? But those that are available in both places, I don't understand why the price should be different. If the French, and the Germans, and the Canadians honor our patents, would the companies not be free then to charge the same price there that they charge here? Why charge a lower price there than is charged here?

Mr. JORGENSEN. Senator, that's a great question. When we compare the prices, it's not unable to comparison. It's typically different prices that's being compared, and it's typically the list price in the U.S. And in the U.S., there's not one price, there are a number of different prices.

When we sell our products in Medicaid, in VAs, we get a really, really low price. We even have support programs where we pay for the medicine for Americans. There are no other place where we give products away for free. That's only in the U.S. When I look at the government, what the government pays for our insulins, that is now less than what many governments pay in Europe. But that's typically lost in the whole translation and referencing to list pricing, which is not the price we get. So, unfortunately, as also the

Chairman said at the opening, it is a very complex market and very complex healthcare system that creates a lot of misunderstandings.

Senator ROMNEY. Yes. I must admit, I agree. The complexity of our PBM system is such that it's very hard for us to figure out just exactly who's getting what and why. And I happen to believe that one of the reasons our healthcare cost is so expensive, particularly as it relates to pharmaceuticals, is the opaque nature of our pricing in this country. Thank you, Mr. Jørgensen.

The CHAIR. Senator Hickenlooper.

Senator HICKENLOOPER. Thank you, Mr. Chair. Thank you, Mr. Jørgensen, for taking the time and indulging us for all these questions. I think there's some unique histories in the United States in terms of government's ability to negotiate prices. We don't have to go into that now, but it is a part of it. Certainly, we're seeing PBMs come here and they point the finger in one direction, and the large pharmaceutical companies point their finger in the other direction. I think most Americans hear that as a hustle, as a rigged game. And they're pointing, get it out of here.

You look at diabetes diagnoses, they're expected to rise considerably over the coming decades. By 2030, they're saying 55 million Americans will have type 2 diabetes. We could see a nearly 700 percent rise in the number of young people with type 2 diabetes in the next 40 years.

Obviously, this is a miracle drug, and I think by any measure, we should recognize that right off the bat. And I think the point that the lower price—offering a lower price insulin made the axis of that specific drug Levemir, whichever one it was, decrease by almost more than half. That should be frightening. And at some point, we might want to figure out how to get the PBMs representatives and the pharmaceutical companies here together, and let both sides in an open discussion suggest solutions to this because it's not sustainable going forward.

One point I want to make, we have a company in Colorado calledHealth that's leading the way to address some of the issues around weight management and long-term solutions to patients with type 2 diabetes. And in a recent study, they provide coaches and help people navigate what they're eating and when they exercise.

found that patients with type 2 diabetes who stopped taking a GLP–1 and remained on a nutrient or a nutrition therapy program, did not regain weight after a year and had similar blood sugar control as those who are still on the drug.

Now, obviously, many patients may have an aggressive form of obesity, the appetites that—I don't know, you can argue that the appetites in people have evolved over 90 percent of the time in our evolutionary history. We were hunters and gatherers. So that's a very hard thing for many people to control. But for those patients who can control it, a company like Virta Health can really provide benefits. Are you doing any studies to look at that as a kind of a combined therapy or an alternative therapy that people can move on to that's less expensive?

Mr. JORGENSEN. Yes. Thank you Senator. I think you raise a really good point that also alludes to that patients are different. We probably know of people who live with say, an aggressive form of obesity. And no matter what they do, they put on weight. And most likely, they'll have to be on really efficacious new innovations in the future to manage their weight.

But we might also get to know of patient segments where after efficacious treatment and perhaps with a coaching solution, they can change lifestyle to a degree that the coaching motivates them to reinforce that. And they can do without medicine. It's still a bit early days. And I think we have to acknowledge that for long we have looked at people with obesity, and to some degree, type 2 diabetes as a self-inflicted condition.

I think we should be careful about saying that if you just get a coach and get this digital report, you're taking care of—because then I think we are letting patients down in need of significant help. But I believe that there'll be a market for such a solution and it can coexist with our products, and it can also help take the burden off the healthcare system over time. So, we don't want to move people on medicines and keep them on medicines they do not need. But I also note that many Americans will need to have help, of course, for a long time.

Senator HICKENLOOPER. I raised the question. I was specifically trying to make sure that there are different groups of people, and obviously, the notion that we everyone can control their appetites is ridiculous. And I think we have disadvantaged people that have differing genetic makeup and physiological character. We put them in unfair positions.

Let me go off on a different direction and talk a little bit about sugar, and diabetes, and then some of the other issues that can arise. Roughly, almost three quarters of our food supply in the United States now is made of what we call ultra processed foods. Researchers have started studying the possible connection between these ultra processed foods with higher rates of diabetes and then also dementia later in life.

Certainly, researchers are still working to understand the exact connection here. So, I'm not saying this is thought or has been consequentially defined, but there is evidence that diabetes can lead to higher rate of inflammation as well as damaged blood vessels, which could impact cognitive functioning as we age.

Can you speak on research that Novo Nordisk has done on testing the effectiveness of GLP–1s or GLP-like pharmaceuticals in reducing the risk of dementia. As the company, have you guys got research on this connection that would be optimistic?

Mr. JORGENSEN. Yes. Thank you, Senator. You raise a really good point. And our GLP–1 medicine, Semaglutide, works in an anti-inflammatory way, which has tremendous benefits for patients. It not only lowers weight, but it also reduces risk of cardiovascular disease because of these anti-inflammatory properties.

We are now also testing it out in Alzheimer's disease where we hope we can show in data, end of next year, that being on this medicine can bring benefit for people with Alzheimer's disease. So,

this whole cardiometabolic disease state that is leading to a number of comorbidities is actually also a leading cause of number of cancers. We aspire to show in continued massive investments in R&D that we can document these benefits and have them FDA-approved.

Senator HICKENLOOPER. Great. Thank you. And I'll just end with in terms of the whole tenor of the discussion that Henry Ford was famous for coming in and actually dramatically reducing his prices so as to dramatically increased volume and dramatically succeeded in a level that nobody really imagined. And I think you, with a miracle drug like this, you might have that same potential where actually lowering the price could dramatically change not only the success of the pharmaceutical, but also the success of the business.

The CHAIR. Senator Cassidy.

Senator CASSIDY. Thank you, Mr. Jørgensen, thank you for being here. Mr. Jørgensen, you had mentioned that—just to clarify for the record, that Ozempic would be available with a patient assistant program, a PAP, if they were insured but they had a high deductible. You did not mention that for Wegovy. So, if a patient has a high deductible and or has a health savings account and they're taking Wegovy for obesity, is there a patient assistant program for them? Is there some other assistance for them to be able to afford?

Mr. JORGENSEN. Yes. So first to clarify what we have on Ozempic. If you have an income less than 400 percent of the national poverty line, you can qualify for free Ozempic if you have a high deductible plan. Unfortunately, when you're inside insurance, if you actually got, say, a product for free from Novo Nordisk, or you bought it at, say, a cash program, the insurance company would not count that against your deductible. So, it wouldn't help you.

Senator CASSIDY. Wait a second though. If I have a high deductible health plan with a health savings account and say the drug is whatever it is, $900, and I've got a deductible of $2,000—let me make sure I understand this one—that your patient assistant program would not assist them. And you're saying it's because our net price is whatever it is, $600, would be willing to make it more affordable, but that this would not—the patient would not benefit. I lost you there. I lost you there.

Mr. JORGENSEN. Yes. So, if you instead—so when you're in the deductible space, we have still given the rebate to the PBM, but it's not shared with the patient. And if you went out and bought, say, a lower price product, because we also have a cash program, that spend would not count against your deductible because you have to spend that within, say, insurance. So, it wouldn't help the patient. And that's a function of insurance scheme design. That's not something we control.

Senator CASSIDY. No, it actually would help the patient on the other hand, because she'd be paying much less, but now she's paying $900. But I think I'm hearing from you, in the contractual relationship that you have with the PBM, that actually seems to be what is first being considered is contractual relationship between your company and the PBM and not the bottom line for the patient. Because the bottom line for the patient, she's paying $900 in-

stead of nothing. Is that a fair statement? So, let's assume that she has less than 400 percent of Federal poverty. So, she's less than 400 percent of Federal poverty and she's got a high deductible plan and/or a high deductible HSA. So, she would not qualify for the patient assistant program.

Mr. JORGENSEN. She would not, but even if she did, she would still have the deductible.

Senator CASSIDY. I get that, but she would use that for another thing. She'd use that for an Urgent Care visit as opposed to the drug benefit.

Mr. JORGENSEN. Yes, that's true. We feel it's not appropriate to have deductible plans for patients living with chronic diseases that on an ongoing basis needs to have access to the healthcare. So, when they come to the beginning——

Senator CASSIDY. That was a value judgment on the basis of the company for the patient. I'll just say that because oftentimes those policies are otherwise more affordable. Let me ask, if the patient is uninsured, would she qualify for this less than 400 percent of Federal poverty being able to get the patient assistant program?

Mr. JORGENSEN. Yes, for the diabetes product. We have not yet established it for the obesity program. We have a cash offering at approximately half the price that patients can use. We feel that right now, where we are building, say, insurance coverage and also negotiating access to Medicaid, that's our focus. And that's where we're giving priority to now in terms of supporting patients.

Senator CASSIDY. Let me move on. One of the tensions here that I mentioned is innovation versus the ability to afford. And I just want to echo what Marshall and Romney said. The fact that you-all and others are doing research on the impact of these drugs to prevent Alzheimer's is fantastic. I mean, this could possibly be part of what makes Alzheimer's less of a scourge. And that takes money.

When someone says they can produce it for $5, but they're not going to produce the $30 billion-worth of research, that would find another indication for how we go forward. So, I think we need to acknowledge there is that, but it is my impression that the United States is paying for this research and that the other countries are not.

I'm sure that Chairman Sanders asked, if you're making money in Germany, of course you're making money in Germany, you're making money on the margin. But I don't think I—it's my impression, if you will, that it's not the Germans who are paying for the ongoing research as to another indication.

Now, I say that you don't have to respond to it, but I'm going to surmise that to be the case. The Trump administration proposed international reference pricing in which you took a market basket of developed countries; Germany, Japan, Great Britain, whomever, and you put them as a market basket. And the U.S. would pay some multiple. Now, from my mind, that would force your company and others to go back to the Europeans and say, wait a second, no longer is the United States going to pay full freight for the re-

search. You also have to contribute. They may pay a little bit more, but nonetheless, you have to pay a little bit more.

What thoughts do you have about the international reference pricing that was proposed by the Trump administration?

Mr. JORGENSEN. Senator, thanks for bringing that up. I think, again, we need to really get into what is then the price we're talking about, because if you——

Senator CASSIDY. Okay. Now, I will accept that you have to design it correctly, but I'm asking more about the concept. Frankly, I think the Trump administration had kind of a—there were some flaws with it, but if you could address those flaws, what about the concept that there should be a market basket, and if the U.S. is not going to pay for all of the R&D, maybe more, but not all, and that in effect, this may force the companies to negotiate a little bit harder with the Europeans. Conceptually, what do you think about that?

Mr. JORGENSEN. I think it should be fair in who pays for innovation. I mentioned also before that a significant of the innovation never is launched in Europe. So, a number of the breakthrough therapies only make it to Americans. So, Americans benefit from the——

Senator CASSIDY. I accept that. But I'm going to come back to the concept. Let's assume that we could imagine a way in which some of the flaws of the previous proposal were addressed. What about the concept of yes, there'll be a market basket of developed countries that typically are paying full freight. It wouldn't be the PEPFAR Program in Africa paying pennies on the dollar, and that the U.S. would pay some multiple, but it would be a lower multiple than we're currently paying.

Mr. JORGENSEN. We'll be happy to look at that. I think we'll find that the perceived multiple is much lower than we actually think. I just mentioned the example of insulin. Today, the U.S. Government pays less for insulin than typical European governments. Yet, we talk about insulin being more expensive in the U.S. than it is in Europe. That's not the case for the manufacturer. So, we need to decompose the complexity to get to what is the real price, and I'll be happy to contribute to——

Senator CASSIDY. I accept that. I also want to point out. There's been a lot of faith being placed in PBM saying that they would pass through a lower price. But I do want to point out on the 20th, The Washington Post had an article speaking about how the Federal Trade Commission has indicted the three largest PBMs for manipulating the price of insulin.

One of them said rebates is our sweet drink, or something like that. And so, I'm hoping that they would be sincere on that. But I will note, and by the way, they dispute that—PBMs are disputing this, but there was this file by the FTC and with the Chairman's permission, I'll submit that for the record.

The CHAIR. No objection.

[The following information can be found on page 165 in Additional Material:]

Senator CASSIDY. Then, my last question before I move on, before I kind of let others go is—I'll stop there. I may have a second round, but I'll stop there.

The CHAIR. Senator Kaine.

Senator KAINE. Thank you, Mr. Chair. And I want to pick up right there. I am very proud of the work that this Committee and Congress has done on the prescription drug pricing issues, the Inflation Reduction Act, capping insulin, capping and then progressively reducing out-of-pocket costs for folks under Medicare Part D. Negotiated pricing, supported all of those things.

The great thing about the IRA, it passed by one vote. So, I'd tell everybody I was the deciding vote on all of these matters. We were all the deciding vote, all of us who voted yes. And some of those provisions weren't loved by the pharmaceutical companies, but I've voted for them and I'm proud of them.

But I have come to conclude along with a number of my colleagues that the focus on pharmaceutical companies is something I support. We're letting PBMs get away scot-free. One industry researches, one doesn't. One industry produces lifesaving treatments, one doesn't. One industry is super-duper profitable and another one profitable.

The one that's the super-duper profitable is the one that's not doing any research and not producing any lifesaving innovations. One industry is under fairly intense scrutiny by this Committee in Congress and one isn't. And it's the one that's the super-duper profitable one that is not researching and not producing products that is getting away scot-free.

In May 2023, we passed a great bill out of this Committee. I think it was actually four bills. And if I remember by memory, I think the votes were; 18 to 3, 18 to 3, 19 to 2, and 20 to 1. Overwhelming bipartisan bills, finally to regulate PBMs. And I'm disappointed that those bills haven't gone anywhere.

I turn on my TV, and I see the PBMs running all kinds of ads against Congress, telling Congress not to vote for this scary PBM reform bill. If we're going to bring prescription drug prices down even more, we shouldn't let up on having Mr. Jørgensen and other CEOs here and pressing them. But we got to get serious about the PBM reform piece of it.

Mr. Jørgensen, you were here, I'm just going to go into this. You were here in May 2023, and I asked you a question about the connection between list price and formulary placement. And I will say, Chairman Sanders, this was the single best hearing I've attended in 12 years in the Senate. The hearing where you had both the PBMs and the pharmacy CEOs together. Because you're familiar with the phenomenon and everybody blames the party that's not in the room. We had them all at the same table.

You and your two CEO colleagues testified that PBMs prefer the drug with a higher list price, and it's difficult, if not impossible, to get a formulary placement for a drug with a lower list price. And that's because they often make a profit on the discount or rebate, they can negotiate off a list price. And this perverse incentive artificially keeps drug prices too high.

Then I followed up and asked this question to the PBM witnesses, and I asked about this, and as you might expect, they were not direct in their answer. I asked one witness, "So you do not have any fee structure in your company where you collect a fee based on the percentage of the list price." The response I received after a long pause, "We certainly may have a few in our client base." Everybody in the room knew that answer was a complete dodge. And that was over a year ago.

Senators Marshall, Tester, and I had been working for over a year on a bill that would address this issue. The DRUG Act would delink the list price of a drug from PBM profits in favor of a flat fee. We had hoped that might have been included in the markup this Thursday. I'm sorry that it won't be, but we're going to continue to make it happen.

Color me skeptical that an industry that is now giving us pie in the sky statements about what they're willing to do, but that's all, that's also buying advertisements on TV trying to attack Congress for doing PBM reform, color me skeptical that they're going to come to the table and suddenly have a conversion experience, and start doing the right thing.

But I guess one evidence of whether they're doing the right thing is since you were here in May 2023, have PBMs changed their practices, or are they continuing to favor higher price drugs on the formulary and make it difficult to put lower price drugs on the formulary?

Mr. JORGENSEN. Thank you, Senator for the question. We have not seen a wide uptake of the insulins where we lower the price. They can always find special formularies where, where they're present, but we have reduced access to those insulins compared to other insulins. So, like you, I'm also a bit skeptical, but I'm willing to explore the opportunity of what we can do together all of us to benefit patients living with these diseases.

Senator KAINE. I mean, as a general matter, you might think if the PBM saw the HELP Committee vote a bill out to the floor that was going to put some significant regulation on it by an overwhelming bipartisan margin, they would think, man, maybe we better improve a little bit. I've seen no evidence of improvement. I see ads on TV attacking Congress and telling them not to do PBM reform. So, I want to get the balance right here. I'm going to continue to vote with this Committee to focus on pharmaceutical companies and bring down prices. And if the pharmaceutical companies don't want to negotiate for prescription drug pricing under Medicare, I stand with those who think negotiation is a good idea.

But we're letting a huge part of this problem that afflicts the everyday American who's trying to afford prescription drugs. We're letting them go scot-free, and we've got a good bill on the floor right now that I think with some improvement could do a great job. And, I hope we'll take it up, and I hope we'll devote the same attention and focus to the PBMs as we do to the pharma companies.

With that, Mr. Chair, I yield back.

The CHAIR. Senator Braun.

Senator BRAUN. Thank you, Mr. Chairman. We've had so many discussions like this, and I wish I had a big something to hold up, but I want to just talk about this. It has nothing to do with pharma. It happens, it has everything to do with a system that's broken with no transparency, no competition, barriers to entry, and by the way, a consumer who doesn't have the tools to really measure what the best value is.

This is a case in California that impacted a sophisticated, self-insured plan and it had a psychiatric underpinning to it. But how that could ever end up being $4 million, that's what the company paid for that case. A self-insured company that's going to be a lot more sophisticated than any individual would be. Cigna, the insurance company, got $2.5 million of what the company paid.

Another multiplan, TPA, got about $700,000. The provider that actually provided the service, in other words, to affect the cure or the remedy, got $875,000. They are suing the insurance company because they think they didn't get paid enough. And who got screwed was the company and the patient when it was a $4 million claim. And the provider that provided all the services charged only 875 and they made a profit.

That means the claim was probably 10 times the amount of the underlying cost of the service. That's one side of healthcare. Hospitals used to be about one-third of the healthcare dollar. Practitioners, nurses, and doctors, maybe independent pharmacists, throw them in there, at about one-third. And then pharma and insurance splitting the other third. So, the whole thing has gotten convoluted.

Then we're talking today about your industry and I come from the world of distribution. And in any other industry, there's full transparency, competition. The consumer drives the dynamic. That's why you don't get by with all the stuff we're talking about. Your business is largely one of heavy fixed cost. Is that correct?

Mr. JORGENSEN. Yes, that's correct. And research.

Senator BRAUN. Yes, which that'd be part of it. Research. What are your variable costs, generally, on a drug like this as a percentage of your—whatever you're selling it for?

Mr. JORGENSEN. That's perhaps 20 percent.

Senator BRAUN. It's very low. Are you making a profit on your Ozempic product when you're selling it to Australia for $87 and you're selling it to the U.S. for 936? Are you making a profit at $87?

Mr. JORGENSEN. Yes, we are. And the price you mentioned in the U.S. is not what we get. That's the list price.

Senator BRAUN. What are you getting in the U.S.? What price?

Mr. JORGENSEN. I mentioned that on the average for our products, we give 74 percent in rebates to PBMs——

Senator BRAUN. That was a chart that Senator Marshall——

Mr. JORGENSEN. Yes.

Senator BRAUN [continuing]. Held up that PBMs are making 74 percent and you're getting 26. So, you've got a screwed-up industry, No. 1. When I've talked to other pharma folks, they regret that

PBMs ever came into it. It would seem like since you make the product that you could disassemble them or do something that would go around it, if in fact this place won't do something about it. Have you ever thought of that?

Mr. JORGENSEN. It's very difficult, Senator, because they control what insurance is put in front of patients. So, they have integrated themselves with insurance companies. And we negotiate against the PBMs, but they're owned by the insurance companies. So, no matter what we do, they decide what products patients——

Senator BRAUN. Okay. And I think we—that's kind of the conundrum, but you're making a profit at $87. And of the $936, it would be the list price, is that total being split between you and the PBM? I know you give big discounts to the PBM. Why do you give them such large discounts for them to make that much money?

Mr. JORGENSEN. On this, we have a high list price and give them rebates. We are not making it, the insurance formulary. So, they make a fee based on the list price. So, you mentioned distribution. They don't get a flat fee for the distribution they give.

Senator BRAUN. After you give the discounts and you do everything, what is your revenue on Ozempic, roughly?

Mr. JORGENSEN. I don't have that number from the top of my head. So, on every——

Senator BRAUN. That'd be something I think it ought to be on the top of your head because most of us would want to see that so you can make the case against PBMs. And that basic lack of transparency, that to me comes from the top, the cloaks, the system in general is what is impacting the future of why in our own Country it's 18 percent of our GDP. And from Canada to Europe, it's 10 to 12 percent of our GDP. Eastern Europe is 6 to 7 percent.

Yes, rationing is maybe going to be one of the results, but it should never be to where something's going to cost that much more here versus there when you're making a profit on it. And until you figure that out, everyone's going to think your industry's screwed up.

Mr. JORGENSEN. I'm not sure if it was a question, but I just want to say that since we launched a product like Ozempic in 2018, the price we get has gone down by 40 percent. So, there's a——

Senator BRAUN. That's good. And it looks like Lilly has got something similar.

Mr. JORGENSEN. Yes.

Senator BRAUN. They sense competition, and theirs is gone down by 40 to 50 percent. And that's what we need more of. And until you put it out there, expose the PBMs in terms of what they're getting, and you get consumers engaged in it, you're not going to solve the problem. You're going to end up having government as your business partner because when you operate like an unregulated utility, you're going to get government regulating you. And I think there's a strong interest in that happening.

Unless you, hospitals, insurance take the bull by the horns, you're going to increasingly be in more conversations like this. And I want to end on this. So why should the Europeans and everyone else be taking advantage of the fact that we do the R&D? Why

don't you charge them more to where there's at least not a 10 to 1 differential to where you share the costs across the world, not put it on the burden of a place. It's now borrowing 30 cents on every dollar for whatever's provided through government and to where you're, you're jabbing it through the private insurance side.

Now, why is there that kind of difference? Why don't you charge them more in Europe?

Mr. JORGENSEN. Senator, we might also do that in the future, but actually the price differential you mentioned is not the real price differential. I think that's part of the problem that we are not in charging as much in the U.S. as you——

Senator BRAUN. I think you're hiding behind your opaqueness and you need to promote transparency for your own good. It'd be easier to understand. Thank you, Mr. Chairman.

The CHAIR. Thank you, Senator Braun, and thank you Mr. Jørgensen. Let me just make a few remarks. Senator Braun, and I come from different perspectives, but occasionally we agree that the system is broken. Senator Braun said, "the industry is screwed up." Is that the right quote? I don't agree that it's screwed up. It's enormously profitable as a company that makes huge profits. Top 10 pharmaceutical companies made up $100 billion dollars in profit last—it's not screwed up. They're making huge amounts of money.

I think Mr. Jørgensen, you are not quite correct when you talk about 79 percent rebates on Ozempic and Wegovy. That may be, in general. My understanding, it's a 40 percent rebate. I believe, I have heard that in fact the product that after all of the rebates from the PBMs, it's your product is about, for Ozempic, about $600.

Mr. JORGENSEN. Can I clarify that please? So, our price has gone down by 40 percent since launch and already when we launched it, there was a significant rebate. So, the rebate has gone up by 40 percent since launch on top of launch rebate.

The CHAIR. All right. My understanding is that factoring in, and we all agree, it is a complicated and broken system. I would point out, and you correct me if I'm wrong, Mr. Jørgensen, that in your beautiful country, Denmark, anybody can walk into a doctor's office, go to the hospital. How much do they pay out-of-pocket?

Mr. JORGENSEN. In Denmark, we have a healthcare system that is tax paid.

The CHAIR. Yes. How much does an individual pay out of—if I'm in the hospital 2 weeks in Denmark, how much do I pay out of pocket.

Mr. JORGENSEN. To go to the hospital?

The CHAIR. Yes.

Mr. JORGENSEN. Zero.

The CHAIR. Zero. You go to any doctor, zero. And you are spending a little bit more than half as much per capita as we are. So, they provide quality care for all of your people and almost half of what we do. All right? That's a simple system that my mind makes sense. We have a complicated system not only in healthcare but in prescription drugs as well.

But the point that I want to make is that factoring in all of the rebates, we heard a lot about rebates, I agree with much of the criticism factoring in all of the rebates that PBMs receive. The net price of Ozempic is still nearly $600. Over nine times as much as it costs in Germany. And the estimated net price of Wegovy is over $800, nearly four and a half times as much as it costs in Denmark.

I know Senator Romney and others said, well, how is that? So why is it so much less expensive in Europe? And the answer is obvious. In the United States of America, we are the only major country on Earth that does not, has not negotiated prices. So, you can charge us any price that you want. Other drug companies can charge us any price that they want, as much as the market will bare. And that's what you do.

Understandably, you charge us far more than other countries because they negotiate and regulate prices. Now, the good news, and I share the concerns and the skepticism about PBMs, but we have, as I've mentioned to you, and we'll share with you statements from the three major PBMs, that they would not penalize Novo Nordisk in terms of formula placement if you substantially lowered list prices. And I look forward to sitting down with you, your representatives, and the three PBMs to make sure that happens. Senator Cassidy, your closing remarks?

Senator CASSIDY. Yes. Mr. Jørgensen, again, thank you for coming here. I'm sure it's like getting your eye and teeth pulled. We spoke though about those patients who have high deductible plans or health savings accounts, and often they have them because that is what is affordable and works best for them. And it's been my concern that it seems as if the system has been set up to drain those in order to subsidize other actors within the system, knowing that your current negotiations with PBMs offer no relief for them.

I would say that if we are truly concerned about people who are trying to purchase insurance, trying to do the best thing for their family, and then they have a system which manipulates that process to drain their savings in order to pay for a drug as great as your drug is, that's wrong.

If you look demographically, the people who have the greatest incidence of a high BMI, of obesity, are going to be folks who are probably the lowest two to three quintiles of the American population. Those who might be more likely to have that high deductible policy because that is what's more affordable to them.

There's just kind of this train wreck of those who are trying to do the right thing by their family, by their own health, are the ones who have no allowance made for them in these negotiations between pharma and between PBMs, that is separate from being the profits, which I thoroughly agree to drive innovation. Because I'm all about that innovation, but I'm all about that family. So, as you-all go forward on that, that would be something I think would relieve tension between policymakers and companies such as yours and the PBMs if more consideration were given to them. With that, I close.

The CHAIR. Thank you, Senator Cassidy. That is the end of our hearing today. I want to thank Mr. Jørgensen for his participation. For any Senators who wish to ask additional questions, questions

for the record will be due in 10 business days, Tuesday, October 8th at 5 p.m.

The CHAIR. I ask a unanimous consent to enter the record 10 statements from patients, doctors, and others concerned about the high cost of Ozempic and Wegovy.

[The following information can be found on page 167 in Additional Material:]

The CHAIR. The Committee stands adjourned.

ADDITIONAL MATERIAL

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

September 16, 2024

Chairman Bernie Sanders
United States Senate
Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Chairman Sanders:

I am writing in response to your inquiries dated September 9, 2024 related to the high prices for new formulations of treatments for diabetes and obesity. We appreciate having the opportunity to answer your questions.

You asked if CVS Caremark would limit access to Ozempic and Wegovy tomorrow if the manufacturers lowered their list prices and the net cost stayed the same or went down. You further clarified the question by asking if the list price reduction *by itself* would result in less favorable formulary placement for Ozempic and Wegovy. The simple answer is no. In fact, we can point to recent history as a proof point. When Novo-Nordisk drastically reduced the price of their insulin, Novolog, in 2023, it did *not* result in a less favorable formulary placement with Caremark.

You also asked if Ozempic and Wegovy were available for $100 per month or less, what impact do you expect that would have on coverage and access? We expect a price drop to $100 would incentivize our public and private clients to increase coverage and access for GLP1s. The price drop would also certainly make GLP1s much more affordable for those who are purchasing the drug without insurance.

There is simply no way for our clients to make these drugs available to everyone who will eventually qualify at their current price points. In fact, if every adult with obesity received a GLP-1 prescription at the current price point, costs would surpass $1.2 trillion annually – more than America currently spends on all drugs, combined. We expect these numbers to increase dramatically as the FDA approves use of these drugs for treatment of a range of other metabolic diseases.

Already, non-specialty cost trend is the highest we've seen in recent history. Wegovy, Mounjaro and Ozempic alone are driving approximately 93% of the non-specialty upward cost trend we are seeing for Caremark customers. Between skyrocketing demand, supply challenges and price hikes, the costs are overwhelming. Lower list prices would open up access for obesity treatment, in particular.

CVSHealth

1275 Pennsylvania Ave NW, Suite 700
Washington, D.C., 20004

In closing, we, CVS Caremark, are not waiting for list prices to drop to make GLP1s more accessible to patients. In 2023, for example, nearly 25 percent of those covered by our plans paid less than $25 for a GLP1 and the average monthly member out of pocket cost across our entire book of business was less than $58.

Sincerely,

Melissa Schulman
Senior Vice President
Government and Public Affairs

DANIEL J. LOEPP
President & CEO
Blue Cross Blue Shield of Michigan

September 13, 2024

The Honorable Bernard Sanders
Chair, U.S. Senate Committee on Health, Education, Labor and Pensions
U.S. Senate
332 Dirksen Building,
Washington, D.C. 20510

Dear Senator Sanders,

Thank you for your letter regarding the high drug prices for glucagon-like peptide 1 (GLP-1) receptor agonists and the opportunity to address your questions.

At Blue Cross Blue Shield of Michigan, our top priority is making prescription drugs available when our members need them. We share your concern with unpredictable and exorbitant prescription drug costs, including for GLP-1s, and how this negatively impacts affordability and accessibility for patients.

Blue Cross carefully considers a variety of factors – including efficacy, safety and cost – when determining coverage and formularies. For the 2024 plan year, we have benefit offerings that cover Ozempic and Wegovy, but the high costs of these drugs make access and coverage across the industry untenable. Without significant reductions to the drug cost, these coverage decisions have to be re-evaluated frequently. From 2022 to 2023, our costs for GLP-1 drugs grew by more than $350 million for Blue Cross. These higher-than-historical GLP-1 drug trends are directly impacting American's pocketbooks. If costs were to be lowered by 90 percent or more to $100 or less per month, we anticipate this would significantly increase coverage and access to these drugs.

Blue Cross works hard to address rising drug costs in variety of ways, including our efforts as a founding member of the Campaign for Sustainable Rx Prices coalition; and remains committed to working with policymakers to find solutions that address the root cause of high drug costs and ensure access to affordable health care.

Thank you for the opportunity to address this concerning issue.

Sincerely,

Daniel J. Loepp

UNITEDHEALTH GROUP

9900 Bren Road East, Minnetonka, Minnesota 55343

September 16, 2024

U.S. Senator Bernard Sanders
Chairman
U.S. Senate Committee on Health, Education, Labor and Pensions
Washington, D.C. 20510

Dear Chairman Sanders:

We share your concerns about the high prices of prescription medicines and look forward to continued discussions about solutions to lower health care costs and improve outcomes for all Americans.

Regarding your specific questions:

1. **If Novo Nordisk lowered the list price for Ozempic and Wegovy tomorrow, and the net cost stayed the same or went down, would Optum Rx limit access? More specifically, would the list price reduction by itself result in less favorable formulary placement for Ozempic and Wegovy?**

   No. We prioritize our choices based on the evidence supporting medical appropriateness and lowest net cost.

   We believe list prices for medicines are too high and support policy solutions and manufacturer actions that lead to lower list prices. Assuming the net price remains the same or lower, a manufacturer lowering a medicine's list price would not lead to less favorable formulary placement by Optum Rx – particularly for high-demand drugs like Ozempic and Wegovy.

   Leveraging competitive forces is a key component of how pharmacy benefit managers (PBMs) reduce the cost of medicines and provide affordable benefit options for clients. To be clear, lower list prices and lower net prices support formulary placement and access.

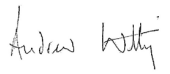
2. **If Ozempic and Wegovy were available for $100 per month or less, what impact do you expect that would have on coverage and access?**

   As you note, the prices drug manufacturers set in the United States are far higher than those charged in other comparable countries – including for Ozempic and Wegovy. Given the significant price differential for these products across borders, a decision by Novo Nordisk to align U.S. pricing more closely with those in other countries would meaningfully increase access for U.S. patients.

   At a net price of $100 or less, health plans, employers, unions, and governments would be better able to manage the cost of these products for such a large patient population while maintaining an affordable overall prescription drug benefit. Optum Rx will continue to engage clients on how to provide access to these drugs to deliver better affordability and long-term health outcomes for patients.

Thank you for your attention to the important issue of prescription drug affordability. Please feel free to reach out if you have additional question or if we can be of further assistance.

Sincerely,



Andrew Witty
Chief Executive Officer
UnitedHealth Group

Kristin Julason Damato
Senior Vice President
Global Public Policy & Government Affairs
The Cigna Group
701 Pennsylvania Avenue, NW
Suite 720
Washington, DC 20004
Telephone (202) 719-5557
Facsimile (202) 719-6755
Kristin.JulasonDamato@TheCignaGroup.com

September 16, 2024

The Honorable Bernard Sanders
Chair
U.S. Senate Committee on Health, Education, Labor, and Pensions
468 Senate Dirksen Office Building
Washington, DC 20510

Re: September 9, 2024 Letter

Dear Chair Sanders:

On behalf of The Cigna Group, thank you for writing to request additional points of view regarding the cost of glucagon-like peptide-1 (GLP-1) agonists. Drug manufacturers can and should do more to lower the cost of medicines for the U.S. health care system. Express Scripts welcomes manufacturers lowering their list price and maintaining discounts for payers trying to reasonably expand coverage to better serve patients. Please find our responses to your questions below.

1. **If Novo Nordisk lowered the list price for Ozempic and Wegovy tomorrow, and the net cost stayed the same or went down, would Express Scripts limit access? More specifically, would the list price reduction by itself result in less favorable formulary placement for Ozempic and Wegovy?**

   Response: No, if Novo Nordisk lowered their list price for Ozempic and Wegovy tomorrow to a price that was the same or lower than current net cost, that change by itself would not result in less favorable formulary placement. Formulary placement decisions for any drug are based on current medical evidence of a drug's clinical efficacy first and then competitiveness of its net pricing relative to competing drugs. Take for example, Eli Lilly's Zepbound, which launched at a list price over 20% less expensive than Wegovy. Given Zepbound's potential savings to Express Scripts' clients and to patients, it was expedited through our formulary development process after its approval in November 2023 and added to our standard formularies within two weeks of being available.

2. **If Ozempic and Wegovy were available for $100 per month or less, what impact do you expect that would have on coverage and access?**

   Response: If Novo Nordisk lowered the price of Ozempic and Wegovy for plan sponsors to $100 or less per patient, per month, we would expect the vast majority of our clients to expand coverage and access to these products for diabetes and weight loss assuming clinical evidence continues to support efficacy and safety. Express Scripts' program EncircleRx was created to respond to robust desire from our clients to cover these medications for a variety of treatments; however, the high effective net cost (i.e., the cost of the product accounting for net rebate) continues to be the most significant barrier to additional coverage and affordable access for patients.

Respectfully,

Kristin Julason Damato

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

3200 Atlantic Avenue • Raleigh, NC 27604 • Phone: 919-814-4400 • Fax: 919-814-5817 • www.shpnc.org

Septembers 13, 2024

Senator Bernard Sanders
Chair, United States Senate Committee on Health, Education, Labor and Pensions ("HELP")
428 Senate Dirksen Office Building
Washington, DC, 20510

RE: Senate HELP Committee Inquiry Regarding Certain GLP-1 Prescription Medications

Dear Senator Sanders,

Thank you for your letter, dated September 9, 2024, regarding the excessive pricing of GLP-1 medications such as Ozempic and Wegovy. I share your concerns about the potential for these drugs to bankrupt our healthcare system. In fact, they have already created serious financial challenges for the North Carolina State Health Plan for Teachers and State Employees ("Plan"), which covers more than 750,000 North Carolina public employees, teachers, retirees, and their dependents.

The excessive cost of these drugs is a major contributor to the $1.3 billion budget shortfall the Plan is facing over the next three years. As a result, the Plan's Board of Trustees ("Board") had to make the difficult decision to remove coverage for GLP-1 drugs when prescribed for weight loss, rather than raise employee and family premiums and make Plan coverage unaffordable for our members. This decision was not made lightly.

Last year alone, weight-loss GLP-1s cost the Plan more than $100 million after rebates, accounting for over 10% of our pharmacy spending. Continuing to cover these medications would have driven costs to $170 million by 2024 and over $1.2 billion within five years. To absorb these costs, we would have had to double premiums for all employees and their families—a burden that would be untenable for the teachers, state employees, and retirees we serve, especially at a time when salaries and benefits have not kept pace with inflation.

For additional context, the cost of this medication would pay for 4% COLA supplement for each of the more than 250,000 retired teachers and state employees in North Carolina next year. And the annual cost per user of a weight-loss GLP-1, exceeds the entire annual pension amount for more than 70,000 of those retirees.

Even though we no longer cover GLP-1 medications for weight loss, the cost of covering these drugs for diabetes continues to stretch our resources. Maintaining coverage for these medications at their current prices limits our ability to continue to provide affordable healthcare in a fiscally responsible manner to the families and individuals we serve.

This is why it is particularly frustrating—and frankly offensive—to hear the CEO of Novo Nordisk blame employer and state health plans for the high price his company decides to set for its medications. Novo Nordisk charges Americans nearly fifteen times more for GLP-1 drugs than it does in other countries, and yet, despite our efforts, we have been unable to secure fair pricing for our members. We have repeatedly sought to negotiate in good faith with the manufacturers of these drugs, but every reasonable offer we have proposed has been rejected.

In a recent interview on NBC, the CEO of Novo Nordisk called my concerns about the cost of the medication "unfounded," and provided statistics saying that the cost share for most US citizens who have coverage is only $25. What he failed to acknowledge is that here in the U.S., it's taxpayers and employees, like those in the North Carolina State Health Plan who teach protect and serve are stuck paying the for his company's price gouging through higher premiums and taxes. There's no good reason why Americans should pay so much more than people in other countries, and it shows how out of touch Novo Nordisk is with the financial strain they're putting on our health plan and others like it.

It is clear that these manufacturers, including Novo Nordisk, have no interest in offering fair prices. They remain in a position of power over us, intent on squeezing a government health plan that serves those who teach, protect, and serve our communities to boost their corporate profits.

As one of the largest payers of healthcare in North Carolina, the Plan would, subject to action of our Board, gladly respond to lower prices if manufacturers were willing to make them available. If these drugs were priced fairly, I would recommend to our Board to immediately adjust our coverage to ensure greater access for our members.

The issue is not about misaligned incentives—it is about the manufacturers' refusal to offer reasonable and fair pricing to our members.

Please find my response to your inquires attached to this letter. I appreciate your interest in this problem and look forward to working with you to improve the Plan's ability to provide quality health benefits in a fiscally sustainable manner.

Sincerely,

Dale R. Folwell, CPA
Treasurer
State of North Carolina

ATTACHMENT A

In your September 9, 2024 letter you made two inquires of the Plan. These inquiries were:

> "1. If Novo Nordisk lowered the list price for Ozempic tomorrow, and the net cost stayed the same or went down, would the North Carolina State Health Plan limit access? More specifically, would the list price reduction by itself result in less favorable formulary placement for Ozempic in your plan?"
>
> "2. If Ozempic and Wegovy were available for $100 per month or less, what impact do you expect that would have on coverage and access?"

As an initial matter, I need to note that North Carolina state law empowers the State Treasurer of North Carolina ("Treasurer") to set benefits for the North Carolina State Health Plan ("Plan") subject to the approval of the Board of Trustees of the Plan ("Board"). N.C. Gen. Stat. §§ 135-48.22, 135-48.30. The Board is an independent decision-making body and speaks and acts through its own official actions. N.C. Gen. Stat. § 135-48.20. Additionally, the Plan maintains a closed formulary and develops and maintains this formulary with the approval of a pharmacy and therapeutics committee ("P&T Committee"). Thus, in answering these questions, I can speak to what I might recommend to the Board in your hypothetical scenarios; I cannot speak for or bind the Board or P&T Committee regarding what they might approve.

If Novo Nordisk were to lower the list price of Ozempic, as they did with their insulin products last year, and the net cost stayed the same or decreased, our Plan would certainly not limit access or move Ozempic to a less favorable formulary tier. In fact, I would welcome the opportunity to avoid the complexity of relying on rebates.

Our formulary decisions are driven by both overall cost and clinical effectiveness. We understand how complicated drug pricing can be, and we know that list prices often do not reflect the actual costs we bear. List prices can be misleading, as the net cost after rebates and discounts is what truly impacts us. That is why the Plan conducts detailed analyses to cut through the noise and make the best financial decisions for our members.

If Ozempic were priced at $100 per month or less, it would likely become the most cost-effective GLP-1 option for treating type 2 diabetes. This would prompt us to re-evaluate its placement and could lead to it becoming a preferred option over higher-cost alternatives. As always, any changes to coverage would be reviewed by the physicians and pharmacists on our P&T Committee to ensure the clinical effectiveness matches the financial savings and would be subject to Board action.

As for Wegovy, which is currently excluded from coverage for weight loss due to its high cost, a price reduction to $100 per month would similarly lead us to reassess its value. At that price point, Wegovy would not only be cost-effective but could also result in savings by reducing obesity-related medical expenses (this is projected but remains unproven). Over time, reduced medical costs might fully offset the cost of the medication at that price, positively impacting the Plan's budget. Consequently, I would recommend that the Board remove its current exclusion as applied to Wegovy. If the exclusion were lifted, coverage would be designed to ensure both clinical value and financial sustainability for the Plan.

A price reduction of that magnitude for either medication would have a significant impact, enabling broader access and possibly resulting in medical cost savings through improved health outcomes for our Plan members.

I appreciate the opportunity to address these important issues, and I remain committed to ensuring that the North Carolina State Health Plan provides access to quality healthcare while responsibly managing the financial pressures caused, in part, by excessive drug prices. We are ready and willing to work with manufacturers if they bring their prices in line with reasonable and sustainable levels. I look forward to continuing this conversation and working together to find solutions that benefit our healthcare system and the people we serve.

CC:

Senator Bill Cassidy
455 Dirksen Senate Office Building,
Washington, DC 20510

Senator Thom Tillis
113 Dirksen Senate Office Building
Washington, DC 20510

Senator Ted Budd
304 Russell Senate Office Building
Washington, DC 20510

Representative Don Davis (NC-01)
1123 Longworth House Office Building
Washington, DC 20515

Representative Deborah Ross (NC-02)
1221 Longworth House Office Building
Washington, DC 20515

Representative Gregory Murphy (NC-03)
407 Cannon House Office Building
Washington, DC 20515

Representative Valerie Foushee (NC-04)
Longworth House Office Building, 1716
Washington, DC 20515

Representative Virginia Foxx (NC-05)
2462 Rayburn House Office Building
Washington, DC 20515

Representative Kathy Manning (NC-06)
307 Cannon House Office Building
Washington, DC 20515

Representative David Rouzer (NC-07)
2333 Rayburn House Office Building
Washington, DC 20515

Representative Dan Bishop (NC-08)
2459 Rayburn House Office Building
Washington, DC 20515

Representative Richard Hudson (NC-09)
2112 Rayburn House Office Building
Washington, DC 20515

Representative Patrick McHenry (NC-10)
2134 Rayburn House Office Building
Washington, DC 20515

Representative Chuck Edwards (NC-11)
1505 Longworth House Office Building
Washington, DC 20515

Representative Alma Adams (NC-12)
2436 Rayburn House Office Building
Washington, DC 20515

Representative Wiley Nickel (NC-13)
1133 Longworth House Office Building
Washington, DC 20515

Representative Jeff Jackson (NC-14)
1318 Longworth House Office Building
Washington, DC 20515

JAMA Network Open.

Original Investigation | Diabetes and Endocrinology

Estimated Sustainable Cost-Based Prices for Diabetes Medicines

Melissa J. Barber, PhD; Dzintars Gotham, MBBS; Helen Bygrave, MBBS; Christa Cepuch, MPH

Abstract

IMPORTANCE The burden of diabetes is growing worldwide. The costs associated with diabetes put substantial pressure on patients and health budgets, especially in low- and middle-income countries. The prices of diabetes medicines are a key determinant for access, yet little is known about the association between manufacturing costs and current market prices.

OBJECTIVES To estimate the cost of manufacturing insulins, sodium-glucose cotransporter 2 inhibitors (SGLT2Is), and glucagonlike peptide 1 agonists (GLP1As), derive sustainable cost-based prices (CBPs), and compare these with current market prices.

DESIGN, SETTING, AND PARTICIPANTS In this economic evaluation, the cost of manufacturing insulins, SGLT2Is, and GLP1As was modeled. Active pharmaceutical ingredient cost per unit (weighted least-squares regression model using data from a commercial database of trade shipments, data from January 1, 2016, to March 31, 2023) was combined with costs of formulation and other operating expenses, plus a profit margin with an allowance for tax, to estimate CBPs. Cost-based prices were compared with current prices in 12 countries, collected in January 2023 from public databases. Countries were selected to provide representation of different income levels and geographic regions based on the availability of public databases.

MAIN OUTCOMES AND MEASURES Estimated CBPs; lowest current market prices (2023 US dollars).

RESULTS In this economic evaluation of manufacturing costs, estimated CBPs for treatment with insulin in a reusable pen device could be as low as $96 (human insulin) or $111 (insulin analogues) per year for a basal-bolus regimen, $61 per year using twice-daily injections of mixed human insulin, and $50 (human insulin) or $72 (insulin analogues) per year for a once-daily basal insulin injection (for type 2 diabetes), including the cost of injection devices and needles. Cost-based prices ranged from $1.30 to $3.45 per month for SGLT2Is (except canagliflozin: $25.00-$46.79) and from $0.75 to $72.49 per month for GLP1As. These CBPs were substantially lower than current prices in the 12 countries surveyed.

CONCLUSIONS AND RELEVANCE High prices limit access to newer diabetes medicines in many countries. The findings of this study suggest that robust generic and biosimilar competition could reduce prices to more affordable levels and enable expansion of diabetes treatment globally.

JAMA Network Open. 2024;7(3):e243474.
Corrected on April 22, 2024. doi:10.1001/jamanetworkopen.2024.3474

Key Points

Question What could prices of insulins, sodium-glucose cotransporter 2 inhibitors (SGLT2Is), and glucagonlike peptide 1 agonists (GLP1As) be if they were closer to the cost of production?

Findings In this economic evaluation of manufacturing costs, estimated cost-based prices per month were US $1.30 to $3.45 for SGLT2Is (except canagliflozin), and $0.75 to $72.49 for GLP1As, substantially lower than current market prices in nearly all comparisons. Twice-daily mixed human insulin NPH could cost $61 per year, while basal-bolus treatment with insulin glargine and aspart could cost $111 per year, with reusable pen formulations having the lowest estimated prices.

Meaning The findings of this study suggest that insulins, SGLT2Is, and GLP1As can likely be manufactured for prices far below current prices, enabling wider access.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

While the burden of diabetes is increasing worldwide, health systems are faced with unaffordable medicine prices. There were an estimated 537 million people living with diabetes (PLD) worldwide in 2021, 90% of whom live in low- and middle-income countries (LMICs).[1] Health expenditures directly related to diabetes have tripled in the past 15 years.[1] Major challenges remain in accessing insulin and newer treatments for type 2 diabetes (T2D).[2-9]

Insulin analogues offer different pharmacokinetic profiles that allow insulin needs to be matched more closely, enable more convenient dosing regimens, and, in some cases, reduce the rate of adverse events.[10] Newer treatments for T2D—sodium-glucose cotransporter 2 inhibitors (SGLT2Is) and glucagonlike peptide 1 agonists (GLP1As)—are now recommended for first-line treatment of T2D for patients with additional cardiovascular risk factors or obesity, independent of metformin use.[11]

Understanding the cost of manufacture can support health systems to target a reasonable price during negotiations with pharmaceutical manufacturers. Earlier analyses by some of the authors of the study reported herein estimated the cost of manufacturing certain diabetes medicines, including insulins,[12-14] finding that estimated cost-based prices were far below the market prices for insulin analogues at the time. Manufacturing cost estimates for some GLP1As (semaglutide and liraglutide) were recently published in the context of obesity treatment.[15] This study develops methods for estimating pharmaceutical manufacturing costs, updates cost analyses for insulins,[12] and provides, to our knowledge, the first published manufacturing cost estimates for SGLT2Is and GLP1As for the treatment of diabetes.

Methods

This economic evaluation study estimated the cost of production for insulins, SGLT2Is, and GLP1As, and, based on this, a sustainable cost-based price (CBP), and compared CBPs with the current lowest reported prices in 12 countries, collected in January 2023 from public databases. Cost-based prices were defined as prices that would be expected in competitive markets that afford manufacturers sustainable returns, while avoiding excessive profit margins. The protocol was submitted to the institutional review board at the Harvard T.H. Chan School of Public Health, which determined that this research was not human research as defined by Department of Health and Human Service regulations 45 CFR 46.102(e) or the US Food and Drug Administration (FDA) regulations. This study followed the relevant portions of the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) reporting guideline.

We included all SGLT2Is, GLP1As, and insulins approved by the FDA or European Medicines Agency in all available formulations. We did not include combination products, except for 70/30 mixed human insulin NPH, which was included due to its widespread use.

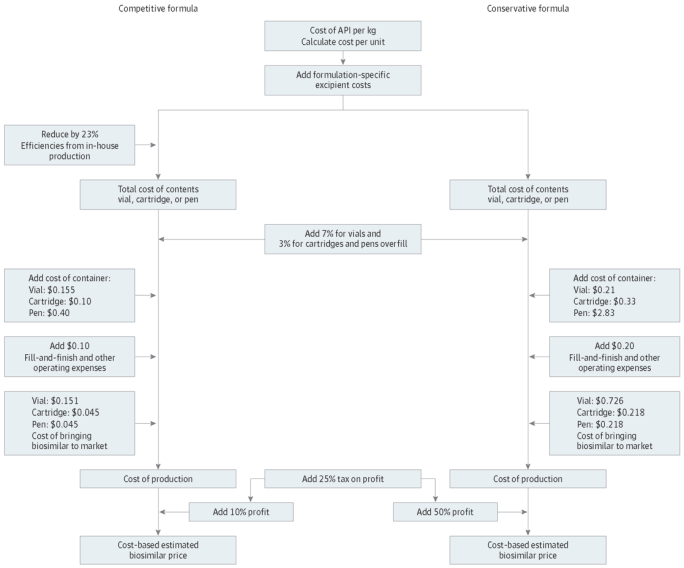
The cost of manufacture for medicines in a range of different therapeutic areas has been estimated.[12-14] The methods of these earlier studies served as a starting point for our approach. The cost of the active pharmaceutical ingredient (API) is the first input to which we add the costs of formulation and secondary packaging, logistical costs, profits, and an allowance for tax. A range of CBPs was produced using a competitive formula that assumes large-scale production and a conservative formula that assumes smaller production volumes and/or higher operating or profit margins (**Figure 1** and **Figure 2**). Average API market prices were estimated by statistical analysis of international API shipment data (January 1, 2016, to March 31, 2023) available from a trade database (weighted least-squares regression model) (eMethods in Supplement 1), supplemented with direct solicitation from manufacturers and inference of costs based on product similarity if data could not be identified using the aforementioned means. Costs of specialized injection devices were derived from interviews with industry experts. Further details on API analysis and cost modeling are described in the eMethods and eTables 1-5 in Supplement 1.

Current market prices were collected for 12 countries from public databases (eMethods, eTable 6 in Supplement 1), including 4 high-income countries (France, Latvia, the UK, and the US) and 9 middle-income countries (Bangladesh, Brazil, China [data available only for insulins], El Salvador, India, Morocco, the Philippines, and South Africa). Countries were chosen based on the availability of data on prices and an intention to provide geographic and economic diversity in the sample. We were not aware of a publicly available medicines price database for any low-income country. For each country, we report the lowest price identified for each medicine and each formulation across different manufacturers and package sizes.

Statistical Analysis

Statistical analyses were performed in R, version 4.2.2 (R Foundation for Statistical Computing). Costs and prices are reported in 2023 US dollars. No inflation adjustment was undertaken as the collected cost inputs represent 2023 costs.

Figure 1. Cost-Based Estimated Price Algorithm for Insulins and Injectable and Glucagonlike Peptide 1 Agonists (GLP1As)



API indicates active pharmaceutical ingredient.

Results

When formulated in vials, the CBPs for regular human insulin (RHI) and insulin NPH were between 97% lower to 24% higher than the lowest current market prices, while CBPs for insulin analogues were 25% to 97% lower than the lowest current market prices (**Table 1**, **Figure 3**; eFigure 4, eFigure 5, and eResults in Supplement 1). For insulin cartridges, CBPs were 61% to 98% lower than the lowest current market prices, except for detemir, for which the CBP was 38% to 66% lower than the lowest current market prices (Table 1, Figure 3; eFigure 4, eFigure 5, and eResults in Supplement 1). For prefilled pens, CBPs for RHI and insulin NPH were 7% to 88% lower than the lowest current market prices. For insulin analogues, the CBPs for prefilled pens were 52% to 96% lower than the lowest current market prices (Table 1, Figure 3; eFigure 4, eFigure 5, and eResults in Supplement 1). The estimated cost of treatment per person per year was as low as US $61 using twice-daily mixed insulin NPH and US $111 using basal-bolus treatment with insulin glargine and aspart (**Table 2**).

Estimated cost-based prices per month were US $1.30 to US $3.45 for SGLT2 inhibitors (except canagliflozin) and US $0.75 to US $72.49 for GLP1 agonists (Table 1). For dapagliflozin and empagliflozin, CBPs were lower than the current lowest market prices, while the CBP of canagliflozin overlapped with the lowest current market prices (Table 1, Figure 3; eFigure 2 in Supplement 1). Cost-based prices per month for GLP1As were all substantially below the lowest current market prices (Table 1, Figure 3; eFigure 3 in Supplement 1). Further details on prices and API cost data used in estimating CBP are presented in the eMethods, eTable 4, eFigure 1, and eResults in Supplement 1.

The greatest international spread of prices was seen for RHI in vials, with a factor of 103 difference across countries (Figure 3). Comparing different formulations for insulins, pen

Figure 2. Cost-Based Estimated Generic Price Algorithm for Sodium-Glucose Cotransporter 2 Inhibitors (SGLT2Is) and Oral Semaglutide

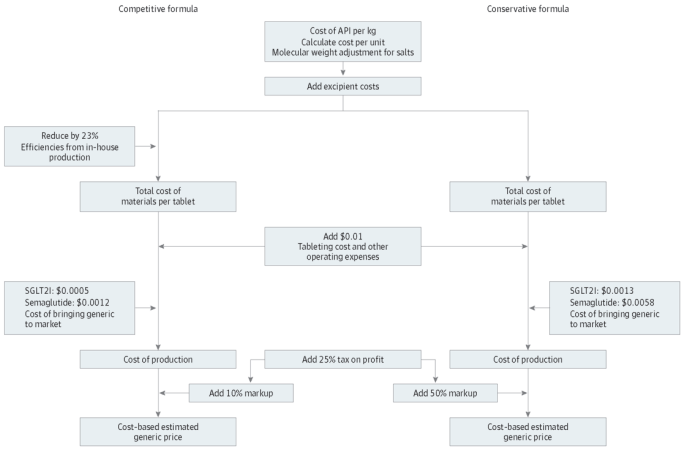


Table 1. Estimated Sustainable Cost-Based Prices, per Month

Medicine[a]	Cost per month, US$, range	
	Cost-based price[b]	Lowest market price
Insulins		
Human insulin		
Regular human insulin		
Vial	2.37-5.94	1.93-198.90
Cartridge	3.00-9.13	10.62-53.27
Prefilled	4.69-29.44	9.37-31.73
Insulin NPH		
Vial	2.40-5.98	1.93-198.15
Cartridge	3.02-9.17	10.71-30.70
Prefilled	4.71-29.48	9.37-251.40
Insulin NPH 70/30		
Vial	2.39-5.97	1.93-198.90
Cartridge	3.02-9.15	10.71-214.65
Prefilled	4.71-29.47	9.98-453.45
Insulin analogues (rapid acting)		
Insulin aspart		
Vial	4.86-10.59	19.42-208.35
Cartridge	5.39-13.61	13.95-256.65
Prefilled	7.08-33.92	25.48-268.20
Insulin lispro		
Vial	4.87-10.62	25.18-118.65
Cartridge	5.40-13.63	25.04-488.55
Prefilled	7.09-33.94	26.71-152.70
Insulin glulisine		
Vial	4.79-10.47	21.47-407.70
Cartridge	5.33-13.49	21.24-50.64
Prefilled	7.02-33.81	23.51-526.95
Insulin analogues (long acting)		
Insulin glargine		
Vial	4.25-9.46	28.95-142.65
Cartridge	4.81-12.52	27.47-65.25
Prefilled	6.50-32.83	14.92-142.05
Insulin degludec		
Vial	5.16-11.18	NA
Cartridge	5.69-14.15	51.19-98.55
Prefilled	7.38-34.45	56.33-488.25
Insulin detemir		
Vial	16.97-33.31	443.25-443.25
Cartridge	17.05-35.48	27.47-103.30
Prefilled	18.74-55.79	48.98-443.70
SGLT2Is		
Canagliflozin (200 mg daily)	25.00-46.79	17.76-364.60
Dapagliflozin (10 mg daily)	1.30-2.32	3.85-526.80
Empagliflozin (17.5 mg daily)	1.88-3.45	6.08-383.04
GLP1As		
Dulaglutide (1.12 mg once weekly)	7.05-17.40	22.20-227.25
Exenatide (7.5 µg twice daily)	0.75-4.46	58.75-577.66
Liraglutide (1.5 mg daily)	21.56-50.32	78.54-851.40
Semaglutide (injectable, 0.77 mg once weekly)	0.89-4.73	38.21-353.74
Semaglutide (oral, 10.5 mg daily)	38.62-72.49	71.15-643.04

Abbreviations: GLP1A, glucagonlike peptide 1 agonist; NA, not available; SGLT2I, sodium-glucose cotransporter 2 inhibitor.

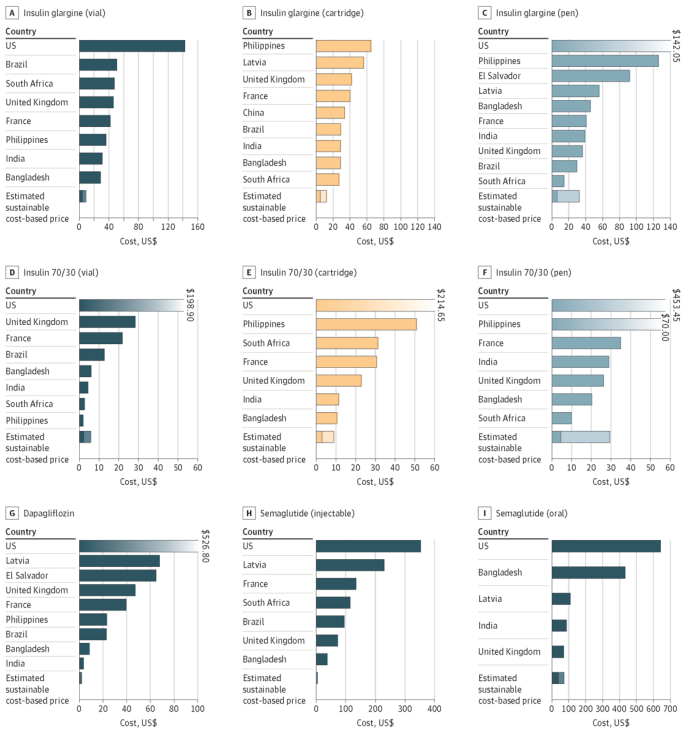
[a] For insulins, the price when using the typical 100 U/mL formulation is shown, and prices per month in the table assume average use of 50 U/d, based on Médecins Sans Frontières field experience. For SGLT2Is and GLP1 agonists, prices per month shown are based on World Health Organization defined daily doses, which represent a typical dosage (often an assumed average across different dosage regimens), a 30-day month, and use of the most cost-effective dosage form.

[b] For cost-based prices, the lower end of the range refers to the cost estimated through the conservative formula, and the upper through the competitive formula.

formulations were more expensive per treatment day than vials for 6 of 8 insulins where comparisons were possible (Table 1).

The lowest observed prices for insulin analogues exceeded the CBP by a factor of 1.3 to 38.9 in 12 countries of different income levels (Figure 3). In a minority of cases, the lowest available prices for

Figure 3. Lowest Market Prices and Cost-Based Prices (per Month, US Dollars)



Prices for a medicine per country are not shown if no data were found. The x-axis is scaled to allow best overall visual discernment, and in a small number of cases, prices exceed what can be displayed. Where prices in one country are far higher than most others, that bar is shown with a fading gradient and a data label to indicate the value. The stacked bars for cost-based prices represent the range between the competitive and conservative estimation formulae. Assumptions for calculating per-month prices are the same as outlined in footnote a of Table 1.

RHI and insulin NPH were within the range of CBPs (Philippines, South Africa, and India for vials; South Africa for disposable pens).

Discussion

Our findings suggest that, for nearly all insulins, SGLT2Is, and GLP1As, in nearly all countries surveyed, prices could be reduced substantially if robust generic/biosimilar manufacture was enabled.

Access to Insulin

It is estimated that only half of the 63 million people with T1D or T2D needing insulin worldwide can access the medicine.[4] Surveys have reported high rates of insulin rationing even in high-income countries, for reasons including price.[6,7]

Across all insulins, the highest prices were in the US, while the lowest prices were seen in China, France, the Philippines, and South Africa. The lowest observed prices for insulin analogues exceeded the CBP by a factor of 1.3 to 38.9 (Figure 3).

Using a low-cost reusable pen with insulin NPH 70/30 cartridges twice daily could bring annual insulin costs down to $61. Using a basal-bolus regimen of insulin glargine once daily and 3 insulin aspart injections, costs could be as low as $111 (Table 2). These estimates include the costs of insulin, injection devices, and needles, but exclude glucose monitoring, for which reported annual costs range from $98 to $1300.[16]

At present, Médecins Sans Frontières procures insulin for use in humanitarian programs at $3.70 for RHI or insulin NPH or insulin NPH 70/30 in a prefilled pen, $2.48 per RHI cartridge, $2.14 for insulin glargine in a prefilled pen (all containing 300 U), and $2.00 for human insulin in a vial (1000 U). These prices are all within our range of CBP estimates, except for RHI cartridges, for which the CBP was 26% to 76% lower (eTable 7 in Supplement 1).

For all insulins, CBPs were only slightly higher for disposable pens and cartridges compared with vials. However, current market prices were far greater for pen formulations than for vials, suggesting greater markups that are not justified by differences in manufacturing costs.

Access to SGLT2Is and GLP1As

Current treatment guidelines recommend starting an SGLT2I or GLP1A as soon as T2D is diagnosed in patients with established cardiovascular disease or multiple risk factors for cardiovascular disease

Table 2. Costs of Insulin Treatment per Person per Year, With Estimated Sustainable Cost-Based Prices vs Current Market Prices, Including Cost of Injection Devices

	US$/y, range[a]					
	Syringe and vial		Reusable pens with cartridges		Prefilled pen	
Regimen	Cost-based price[b]	Lowest market price	Cost-based price[b]	Lowest market price	Cost-based price[b]	Lowest market price
Basal-bolus regimens						
Insulin NPH BD plus RHI TDS, using 2 reusable pens	157-656	151-2999	96-176	189-575	112-413	169-1777
Insulin glargine OD + insulin aspart TDS	158-589	396-2602	111-213	312-690	127-450	301-2550
Mixed human insulin regimens						
Insulin NPH 70/30 BD	80-306	75-2654	61-138	154-2638	79-380	144-5539
Basal only (T2D)						
Insulin NPH OD	55-189	149-2528	50-127	144-389	68-370	125-1031
Insulin glargine OD	77-232	378-1852	72-168	347-810	90-410	192-1739

Abbreviations: BD, twice daily; OD, once daily; RHI, regular human insulin; T2D, type 2 diabetes; TDS, 3 times daily.

[a] Prices in the table assume average use of 50 U/d, based on Médecins Sans Frontières field experience. Costs per year include the cost of injection devices (pen or syringe and single-use needles), with assumed costs for these items available in the eMethods in Supplement 1. The cost of each reusable pen is spread over 2 years of use. One reusable pen is used for each type of insulin, so 2 pens are used in regimens in which 2 types of insulin are used.

[b] For cost-based prices, the lower end of the range refers to the cost estimated through the conservative formula, and the upper through the competitive formula.

or chronic kidney disease.[11] Based on these guidelines, SGLT2Is and GLP1As would be recommended for a large proportion of patients: for example, one-third of people living with T2D in LMICs have chronic kidney disease,[17] while 18% in upper middle-income counties and 27% in lower middle-income countries have coronary artery disease.[18]

Compared with insulin, far less literature is available on global access and pricing of SGLT2Is and GLP1As. A 2018 study interviewed experts in Cambodia, India, Pakistan, and Tanzania, finding that access to SGLT2Is and GLP1As was very limited.[8]

Our analysis suggests that major cost reductions could be achieved for the SGLT2Is dapagliflozin and empagliflozin and the GLP1As dulaglutide, exenatide, liraglutide, and oral and injectable semaglutide (Table 1, Figure 3). A recent study of the cost of production for liraglutide and injectable semaglutide as antiobesity treatments, using methods similar to those used herein, produced similar estimates to those in this analysis.[15]

Limited Competition

Three companies (Novo Nordisk, Eli Lilly, and Sanofi; considered the Big 3) control more than 90% of the global insulin market and 83% of the LMICs market.[19,20] It has been recognized for years that this oligopoly poses a major barrier to entry for new manufacturers and is a key factor in the lack of access to insulin in many world regions.[21,22] While at least 40 companies manufacture or market insulin globally, many of these companies operate under licensing or supply agreements with the Big 3. It has been estimated that the number of independent insulin manufacturers is only 10.[21,23] This limited number of manufacturers has come under government scrutiny: in the US, the state of California has filed a suit against the Big 3 insulin manufacturers, alleging excessive pricing and unfair business practices.[24]

Patents prevent competition and play a leading role in keeping prices high for a wide range of medicines. All SGLT2Is and GLP1As included in this study are under patent protection in the US and Canada, although patents vary in the extent that they block competitors. Generic products are not available in the US, Canada, or the UK, while generic versions are available for all 3 SGLT2Is in India, and a generic/biosimilar version for exenatide is available in India.[25,26] Biosimilars are currently available in the European Union for insulin glargine, insulin lispro, and insulin aspart.[27]

While most patents covering insulin compounds have expired, secondary patents (ie, patents that cover modifications including formulation, derivates, or method of use) play a role in delaying access to insulin biosimilar products. For example, in the US, plans for launch of one biosimilar insulin glargine product, which had already been approved by the FDA, were aborted following a patent infringement suit.[28] More than 70 secondary patents have been filed on insulin glargine in the US.[28] In addition, many insulin injection devices are still covered by patents.[29,30]

Access to Insulin in Pen Formulations

Approximately 60% of people using insulin globally use (reusable or disposable) pens, with up to 94% using pens in Europe.[31] The lack of access to devices adds major costs: Médecins Sans Frontières has found that syringes and needles needed to inject insulin cost around $60 per year.[32]

There are, in general, more active patents on insulin devices than on the drug itself.[29] Our interviews with device manufacturers also reflected a belief that intellectual property on devices was one of the main barriers to market entry for new manufacturers.

In some settings, people living with T1D visit a health facility twice a day to receive insulin. Better access to pen devices could enable increased self-management of T1D in these settings by requiring less training, reducing drug waste, being less prone to dosage errors, and enabling insulin injections outside the home. In 2023, the World Health Organization Essential Medicines List was expanded to include insulin formulation in cartridges and prefilled syringes, due to "ease of use, greater accuracy of dosing, and improved adherence."[33]

Analogue vs Human Insulin

With the market share made up by insulin analogues vs human insulin in LMICs steadily increasing,[19] some have expressed concerns that this will increase costs, as analogues have much higher prices in most cases.[22,34] This adds urgency to reducing prices for insulin analogues.[35]

Observed API market costs were higher for insulin analogues than for human insulin. However, with manufacturing processes for biologic agents rapidly improving in efficiency and the number of manufacturers increasing, it would not be surprising to see API costs for insulin analogues match or drop below the cost of human insulin API. Already now, in Chinese public tenders, the price of some insulin analogues is lower than prices for RHI or insulin NPH.[36]

Policy Considerations

Increasing costs for T2D treatment are already placing disproportionate burdens on LMICs: health expenditures for diabetes as a proportion of the gross domestic product are higher in South America, Central America, the Middle East, and North Africa than in Europe.[1] Additionally, a large proportion of primary care expenditures in LMICs are out-of-pocket, and about half of those expenditures are on medical goods.[37]

In countries with higher prices, major cost savings could be attained through increased availability of lower-cost generics/biosimilars. At the present, this is restrained by a mix of regulatory challenges, intellectual property barriers, and business practices discouraging competition.

Insulins and some GLP1As are biologics. Bringing a biosimilar agent to market is more expensive than for a small molecule (nonbiologic) medicine due to numerous factors, including the requirement to design a new cell line and downstream manufacturing process that yields a similar molecule and, in many cases, requirements to undertake a large clinical trial to prove clinical equivalency.

However, there are reasons to believe that the costs of bringing biosimilars to market may reduce in coming years. The FDA and the World Health Organization have recently updated their guidance for insulin biosimilars, no longer requiring comparative clinical trials if laboratory analyses and pharmacokinetic and pharmacodynamic studies show high similarity.[38,39]

Governments have a range of policy tools, procurement mechanisms, and legal avenues available to reduce the prices of unaffordable medicines. These include, for example, price controls and joint procurement between different countries (pooled procurement). For patented medicines, if agreement on an affordable price cannot be reached in negotiations with a manufacturer, many countries have compulsory licensing provisions in their legislation, which allow for generic importation and manufacture regardless of patents. In some cases, public sector manufacture, as is being pursued in California,[40] may also be important.

The Importance of Analyzing Costs of Manufacture

Pharmaceutical prices and manufacturing costs are shrouded in secrecy,[41] and pharmaceutical manufacturers do not publish breakdowns of manufacturing costs. Analyzing the costs of manufacturing can inform pharmaceutical cost containment policies and procurement negotiations. Some countries have used cost-plus price regulation, applying a formula to calculate a permissible maximum price based on costs of manufacture.[42]

We describe the estimated achievable generic/biosimilar prices presented in this study as sustainable, meaning prices that would be expected in competitive markets that afford manufacturers returns, while avoiding excessive profit margins. Thus, the methods used are not designed to calculate the lowest possible cost of manufacture. Instead, they are based on average costs based on current market rates for key inputs.

Analyzing the cost of production can also help health systems forecast what prices will be possible once generic competition occurs. For example, in the HIV/AIDS pandemic, there were claims that treatment would never be possible in LMICs due to inherently high drug costs.[43] Once generic manufacturers explained that medicines could be manufactured for under 3% of the original list price, massive treatment programs were established, transforming the deadly pandemic into a

manageable chronic disease. A similar pattern was seen for hepatitis C treatments approved over 2014-2017.[43]

A rare glimpse into pharmaceutical companies' internal cost data is provided in documents submitted by Sanofi to a bipartisan US Senate inquiry, listing the cost of goods sold (COGS) for 5 insulin glargine pens as $7.11 or about $1.42 each (this is listed as mgmt COGS, presumably describing COGS from the management perspective, as opposed to legal COGS).[44] This is similar to our lower-bound (competitive formula) estimate of $1.20 per pen (Table 2).

Limitations

This cost-modeling analysis has several limitations. Many components of manufacturing costs are not individually included in cost modeling, including capital investments, quality assurance and control, and regulatory and legal costs. We consider these costs to be accounted for as part of other components (for example, the assumption for cost of biosimilar development and the market costs of API would reflect capital investments and regulatory costs).

The cost of APIs was based on reported values of international shipments. This can be expected to increase the modeled product cost, as it is likely that in-house manufacture or domestic procurement would have lower costs of API.

In nearly all real-world scenarios, additional markups are added to product cost during distribution, such as import tariffs and wholesale distributor markups, which are not specifically included in the model. At the same time, a number of conservative assumptions, especially in the conservative model (giving the top of estimated CBP ranges) will overestimate the price in some settings, as was found for similar models in previous studies.[14] There is little transparency in medicine prices, and international comparisons continue to be limited and challenging.

Conclusions

The findings of this economic evaluation suggest that competitive biosimilar manufacture could lower costs: treatment with insulin in a reusable pen device could cost as little as $96 (human insulin) or $111 (insulin analogues) per year for a basal-bolus regimen, $61 per year using twice-daily injections of mixed human insulin (T1D), and $50 (human insulin) or $72 (insulin analogues) for a once-daily basal insulin injection (T2D). With a steadily increasing number of people living with diabetes requiring insulin, strategies must urgently be developed to reduce insulin prices and ensure affordable and reliable access in all parts of the world.

Prices could decrease to $1.30 per month for treatment with SGLT2Is and under $0.75 for treatment with GLP1As. Further price reductions will likely become possible once a robust global generic and biosimilar market emerges.

Given the potential for generic manufacture to substantially reduce prices and thus increase access to these treatments, mechanisms that enabled early generic manufacture in other diseases, such as HIV and hepatitis C, should also be considered for use in diabetes medicines.

ARTICLE INFORMATION

Accepted for Publication: January 29, 2024.

Published: March 27, 2024. doi:10.1001/jamanetworkopen.2024.3474

Correction: This article was corrected on April 22, 2024, to fix number of reported countries.

Corresponding Author: Melissa J. Barber, PhD, Edward S. Harkness Memorial Hall A, 367 Cedar St, Room 406, New Haven, CT 06510 (melissa.barber@yale.edu).

Author Affiliations: Yale Collaboration for Regulatory Rigor, Integrity, and Transparency (CRRIT), New Haven,

Connecticut (Barber); Program on Regulation, Therapeutics, and Law, Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital, and Harvard Medical School, Boston, Massachusetts (Barber); Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, Massachusetts (Barber); King's College Hospital, London, United Kingdom (Gotham); Médecins Sans Frontières Access Campaign, Geneva, Switzerland (Gotham, Bygrave, Cepuch).

Author Contributions: Drs Barber and Gotham had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: Barber, Gotham.

Drafting of the manuscript: Barber, Gotham.

Critical review of the manuscript for important intellectual content: All authors.

Statistical analysis: Barber.

Obtained funding: Barber, Bygrave, Cepuch.

Administrative, technical, or material support: Barber, Bygrave, Cepuch.

Supervision: Barber, Bygrave.

Conflict of Interest Disclosures: Dr Barber reported receiving personal fees from Médecins Sans Frontières during the conduct of the study and personal fees from the World Health Organization outside the submitted work. Dr Gotham reported receiving personal fees from Médecins Sans Frontières during the conduct of the study and has previously received payments (unrelated to this work) from the World Health Organization, the Medicines Patent Pool, Treatment Action Group, STOPAIDS UK, Global Justice Now, the World Intellectual Property Organization, and the Ada Lovelace Institute. Ms Bygrave reported being an employee of Médecins Sans Frontières during the conduct of the study. Ms Cepuch reported being an employee of Médecins Sans Frontières during the conduct of the study. No other disclosures were reported.

Funding/Support: This study was funded by Médecins Sans Frontières (Doctors Without Borders) Access Campaign.

Role of the Funder/Sponsor: Médecins Sans Frontières had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Data Sharing Statement: See Supplement 2.

Additional Contributions: We thank our colleagues at Médecins Sans Frontières; Kevin Croke, PhD (Harvard T.H. Chan School of Public Health), Margaret McConnell, PhD (Harvard T.H. Chan School of Public Health), and Ameet Sarpatwari, JD, PhD (Harvard Medical School), for thoughtful comments; as well as the anonymous industry experts who provided cost data. Thanks to Hannibal Taubes, AB, PhD candidate in East Asian Languages and Cultures, University of California, Berkeley, for support in translating documents from Chinese (uncompensated).

REFERENCES

1. International Diabetes Federation. Diabetes Atlas, 10th edition. 2021. Accessed January 23, 2024. https://diabetesatlas.org/idfawp/resource-files/2021/07/IDF_Atlas_10th_Edition_2021.pdf

2. Beran D, Colagiuri S, Ernoult N, et al. Failing to address access to insulin in its centenary year would be a catastrophic moral failure. *Lancet Diabetes Endocrinol*. 2021;9(4):194-196. doi:10.1016/S2213-8587(21)00048-6

3. Nelson AJ, Ardissino M, Haynes K, et al. Gaps in evidence-based therapy use in insured patients in the United States with type 2 diabetes mellitus and atherosclerotic cardiovascular disease. *J Am Heart Assoc*. 2021;10(2):e016835. doi:10.1161/JAHA.120.016835

4. Basu S, Yudkin JS, Kehlenbrink S, et al. Estimation of global insulin use for type 2 diabetes, 2018-30: a microsimulation analysis. *Lancet Diabetes Endocrinol*. 2019;7(1):25-33. doi:10.1016/S2213-8587(18)30303-6

5. Katte JC, Lemdjo G, Dehayem MY, et al. Mortality amongst children and adolescents with type 1 diabetes in sub-Saharan Africa: the case study of the Changing Diabetes in Children program in Cameroon. *Pediatr Diabetes*. 2022;23(1):33-37. doi:10.1111/pedi.13294

6. Gaffney A, Himmelstein DU, Woolhandler S. Prevalence and correlates of patient rationing of insulin in the United States: a national survey. *Ann Intern Med*. 2022;175(11):1623-1626. doi:10.7326/M22-2477

7. Pfiester E, Braune K, Thieffry A, Ballhausen H, Gajewska KA, O'Donnell S. Costs and underuse of insulin and diabetes supplies: findings from the 2020 T1 international cross-sectional web-based survey. *Diabetes Res Clin Pract*. 2021;179:108996. doi:10.1016/j.diabres.2021.108996

8. Medicines Patent Pool. Exploring the expansion of the Medicines Patent Pool's mandate to patented essential medicines. May 24, 2018. Accessed January 23, 2024. https://medicinespatentpool.org/news-publications-post/exploring-the-expansion-of-the-medicines-patent-pools-mandate-to-patented-essential-medicines-a-feasibility-study-of-the-public-health-needs-and-potential-impact/

9. Global Health & Population Project on Access to Care for Cardiometabolic Diseases (HPACC). Expanding access to newer medicines for people with type 2 diabetes in low-income and middle-income countries: a cost-effectiveness and price target analysis. *Lancet Diabetes Endocrinol*. 2021;9(12):825-836. doi:10.1016/S2213-8587(21)00240-0

10. World Health Organization. The selection and use of essential medicines (2021). January 27, 2022. Accessed January 23, 2024. https://www.who.int/publications/i/item/9789240041134

11. Davies MJ, Aroda VR, Collins BS, et al. Management of hyperglycaemia in type 2 diabetes, 2022: consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetologia*. 2022;65(12):1925-1966. doi:10.1007/s00125-022-05787-2

12. Gotham D, Barber MJ, Hill A. Production costs and potential prices for biosimilars of human insulin and insulin analogues. *BMJ Glob Health*. 2018;3(5):e000850. doi:10.1136/bmjgh-2018-000850

13. Gotham D, Barber MJ, Hill AM. Estimation of cost-based prices for injectable medicines in the WHO Essential Medicines List. *BMJ Open*. 2019;9(9):e027780. doi:10.1136/bmjopen-2018-027780

14. Hill AM, Barber MJ, Gotham D. Estimated costs of production and potential prices for the WHO Essential Medicines List. *BMJ Glob Health*. 2018;3(1):e000571. doi:10.1136/bmjgh-2017-000571

15. Levi J, Wang J, Venter F, Hill A. Estimated minimum prices and lowest available national prices for antiobesity medications: improving affordability and access to treatment. *Obesity (Silver Spring)*. 2023;31(5):1270-1279. doi:10.1002/oby.23725

16. Clinton Health Access Initiative. Market report of diabetes self-monitoring devices in LMICs. October 2021. Accessed January 23, 2024. https://haiweb.org/wp-content/uploads/2021/09/Market-Report_Self-monitoring-Devices-in-LMICs.pdf

17. Vos T, Lim SS, Abbafati C, et al; GBD 2019 Diseases and Injuries Collaborators. Global burden of 369 diseases and injuries in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet*. 2020;396(10258):1204-1222. doi:10.1016/S0140-6736(20)30925-9

18. Einarson TR, Acs A, Ludwig C, Panton UH. Prevalence of cardiovascular disease in type 2 diabetes: a systematic literature review of scientific evidence from across the world in 2007-2017. *Cardiovasc Diabetol*. 2018;17(1):83. doi:10.1186/s12933-018-0728-6

19. IQVIA. Understanding insulin market dynamics in low- and middle-income countries: producers, supply and costs. August 26, 2021. Accessed January 23, 2024. https://www.iqvia.com/insights/the-iqvia-institute/reports/understanding-insulin-market-dynamics-in-low-and-middle-income-countries

20. Congressional Research Service. Insulin products and the cost of diabetes treatment. 2018. Accessed January 23, 2024. https://sgp.fas.org/crs/misc/IF11026.pdf

21. World Health Organization. Keeping the 100-year-old promise: making insulin access universal. 2021. Accessed January 23, 2024. https://www.who.int/publications/i/item/9789240039100

22. Beran D, Ewen M, Laing R. Constraints and challenges in access to insulin: a global perspective. *Lancet Diabetes Endocrinol*. 2016;4(3):275-285. doi:10.1016/S2213-8587(15)00521-5

23. Beran D, Ewen M, Lepeska M, Laing R. Access to insulin: current challenges and constraints: update March 2017. 2017. Accessed January 23, 2024. https://haiweb.org/wp-content/uploads/2017/03/Issues_Paper_2017.pdf

24. People of the State of California v. Eli Lilly and Co; Novo Nordisk Inc; Sanofi-Aventis US LLC; Caremarkpcs Health LLC; CVS Health Corp; Express Scripts, Inc; OptumRx Inc; and DOES 1 through 100, inclusive 2023. Accessed January 23, 2024. https://oag.ca.gov/system/files/attachments/press-docs/2023.01.12%20-%20Eli%20Lilly%20Complaint.pdf

25. United States Food & Drug Administration. Orange Book: approved drug products with therapeutic equivalence evaluations. Accessed January 23, 2024. https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm

26. Health Canada. Patent register. Accessed January 23, 2024. https://pr-rdb.hc-sc.gc.ca/pr-rdb/index-eng.jsp

27. European Medicines Agency. Download medicine data. Accessed August 2, 2023. https://www.ema.europa.eu/en/medicines/download-medicine-data

28. I-MAK. Overpatented, overpriced special edition: Lantus (insulin glargine) 2018. Accessed January 23, 2024. https://www.i-mak.org/wp-content/uploads/2018/10/I-MAK-Lantus-Report-2018-10-30F.pdf

29. Luo J, Kesselheim AS. Evolution of insulin patents and market exclusivities in the USA. *Lancet Diabetes Endocrinol*. 2015;3(11):835-837. doi:10.1016/S2213-8587(15)00364-2

30. Van de Wiele VL, Kesselheim AS, Beran D, Darrow JJ. Insulin products and patents in the USA in 2004, 2014, and 2020: a cross-sectional study. *Lancet Diabetes Endocrinol*. 2023;11(2):73-75. doi:10.1016/S2213-8587(22)00354-0

31. Masierek M, Nabrdalik K, Janota O, Kwiendacz H, Macherski M, Gumprecht J. The review of insulin pens-past, present, and look to the future. *Front Endocrinol (Lausanne)*. 2022;13:827484. doi:10.3389/fendo.2022.827484

32. Médecins Sans Frontières. Access campaign—a century of neglect: challenges of access to insulin for diabetes care. 2020. Accessed January 23, 2024. https://msfaccess.org/sites/default/files/2020-01/IssueBrief_insulin_FINAL_web_Jan2020_ENG.pdf

33. World Health Organization. The selection and use of essential medicines 2023: executive summary of the report of the 24th WHO Expert Committee on Selection and Use of Essential Medicines. 2023. Accessed January 23, 2024. https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2023.01

34. Beran D, Besançon S, Ewen M, et al. Diabetes and the WHO model list of essential medicines. *Lancet Diabetes Endocrinol*. 2022;10(1):17-18. doi:10.1016/S2213-8587(21)00323-5

35. Devi S. Aid agencies turn attention to diabetes. *Lancet*. 2021;397(10279):1049-1050. doi:10.1016/S0140-6736(21)00658-9

36. Gan & Lee Pharmaceuticals. 2021 Annual report. 2021. Accessed January 23, 2024. https://www.ganlee.com/statics/home/Gan%20&%20Lee%20Pharmaceuticals%20Annual%20Report%202021.pdf

37. World Health Organization. Global expenditure on health: public spending on the rise? 2021. Accessed January 23, 2024. https://apps.who.int/iris/bitstream/handle/10665/350560/9789240041219-eng.pdf?sequence=1&isAllowed=y

38. Center for Biosimilars. A critical analysis of the FDA guidance on clinical immunogenicity testing of insulin. November 27, 2019. Accessed January 23, 2024. https://www.centerforbiosimilars.com/view/a-critical-analysis-of-the-fda-guidance-on-clinical-immunogenicity-testing-of-insulin

39. Kang HN, Wadhwa M, Knezevic I, Ondari C, Simao M. WHO guidelines on biosimilars: toward improved access to safe and effective products. *Ann N Y Acad Sci*. 2023;1521(1):96-103. doi:10.1111/nyas.14965

40. CalRx. Biosimilar insulin initiative. Accessed January 23, 2024. https://calrx.ca.gov/biosimilar-insulin-initiative/

41. Moon S. Removing the blindfold on medicines pricing. *BMJ*. 2018;360:k840. doi:10.1136/bmj.k840

42. World Health Organization. WHO guidelines on country pharmaceutical pricing policies. 2015. Accessed January 23, 2024. https://apps.who.int/medicinedocs/documents/s21016en/s21016en.pdf

43. Goemaere E, Ford N, Benatar SR. HIV/AIDS prevention and treatment. *Lancet*. 2002;360(9326):86-87. doi:10.1016/S0140-6736(02)09343-1

44. Sanofi. Documents produced by Sanofi. 2019. Accessed January 23, 2024. https://www.finance.senate.gov/imo/media/doc/Sanofi_Redacted.pdf

SUPPLEMENT 1.

eTable 1. Summary of Assumed Cost Input Variables
eMethods. Detailed Methods
eTable 2. Search Criteria and Salt Forms of Included Medicines
eTable 3. Criteria Used for Cleaning Export-Import Data
eTable 4. Costs of Active Pharmaceutical Ingredients
eFigure 1. Shipment-Level Scatterplots of API Exports
eTable 5. Bulk Excipient Costs
eTable 6. National Drug Price Sources
eResults. Detailed Results
eTable 7. Sustainable Costs for Diabetes Medicines, by Formulation
eFigure 2. Lowest Market Prices and Cost-Based Prices (per Month, US$): SGLT2 Inhibitors
eFigure 3. Lowest Market Prices and Cost-Based Prices (per Month, US$): GLP1 Agonists
eFigure 4. Lowest Market Prices and Cost-Based Prices (per Month, US$): Human Insulins
eFigure 5. Lowest Market Prices and Cost-Based Prices (per Month, US$): Insulin Analogues
eReferences

SUPPLEMENT 2.

Data Sharing Statement

DOCTORS FOR AMERICA

September 16, 2024

The Honorable Bernie Sanders
Chair
U.S. Senate Committee on Health,
Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
U.S. Senate Committee on Health,
Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

CC: Lars Fruergaard Jørgensen, Chief Executive Officer of Novo Nordisk; David A. Ricks, Chief Executive Officer of Eli Lilly and Company; Members of the U.S. Senate Committee on Health, Education, Labor and Pensions

Dear Chair Sanders and Ranking Member Cassidy,

On behalf of the undersigned 253 physicians and health professionals from across the country, we write to express our deep concern about the lack of patient access to novel non-insulin diabetes and weight loss medications due to exorbitant prices set by manufacturers. These drugs including glucagon-like peptide-1 (GLP-1) agonists such as semaglutide (marketed by Novo Nordisk as Ozempic for diabetes and Wegovy for weight loss) and dual GLP-1 and glucose-dependent insulinotropic polypeptide (GIP) agonists such as tirzapetide (marketed by Eli Lilly as Mounjaro for diabetes and Zepbound for weight loss) have been revolutionary in the management of chronic conditions of diabetes and obesity. However, even the most transformative medications cannot help our patients if they cannot afford them.

As you are aware, GLP-1 treatments are the result of over four decades' worth of research since the discovery of the GLP-1 hormone in 1984 at Massachusetts General Hospital and University of Copenhagen.[1] In fact, the critical discovery that enabled the GLP-1 hormone to be turned into treatments was federally funded and conducted by researchers at the Veterans Affairs Medical Center in the Bronx, NY.[2] This class of drugs has transformed the treatment of diabetes and obesity. GLP-1 and GIP agonists not only effectively lower blood sugar levels and weight, but they also reduce the risk of serious complications associated with diabetes and obesity. They have demonstrated benefits for cardiovascular health, reduce the risk of kidney complications, and improve sleep apnea. Multiple clinical trials evaluating once-weekly Ozempic and Mounjaro in comparison to standard of care treatments including daily insulin injections for type 2 diabetes

[1] Kolata G. We Know Where New Weight Loss Drugs Came From, but Not Why They Work. *The New York Times*. https://www.nytimes.com/2023/08/17/health/weight-loss-drugs-obesity-ozempic-wegovy.html. August 17, 2023.
[2] Pollack A. Lizard-Linked Therapy Has Roots in the Bronx. *The New York Times*. https://www.nytimes.com/2002/09/21/business/lizard-linked-therapy-has-roots-in-the-bronx.html. September 21, 2002.

demonstrated clear superiority in lowering key measures of blood sugar.[3,4] Pivotal trials supporting initial U.S. Food and Drug Administration (FDA) approval of Wegovy and Zepbound for the treatment of obesity demonstrated significant and sustained reduction in weight when taken consistently.[5,6] Wegovy received broader FDA approval for overweight or obese patients with pre-existing cardiovascular disease and thus, expanded coverage; results of a large clinical trial showed a 20% reduction in risk of major adverse cardiovascular events in patients receiving the drug compared to those receiving the standard of care[7]. As physicians, we follow these developments closely as we want to provide our patients with the best treatments possible.[8]

Unfortunately, as we've seen previously with other life-saving medicines in the United States, the price tags for these drugs are exorbitantly high and are being driven by what the market can bear rather than what patients can afford, with little correlation to the cost of production. Studies have shown that semaglutide can be manufactured for as little as nearly $5 per month,[9] substantially lower than the current U.S. list price of $968 for Ozempic or $1,349 per month for Wegovy. In contrast, Novo Nordisk has set the price of Wegovy at $92 in the United Kingdom and $186 in Denmark, clearly demonstrating that these drugs are being priced unfairly for our U.S. patients. For patients, these are not one-off prices they shoulder, but potentially life-long costs they will need to consider. For obesity, the drugs work while patients take them, but once off treatment, studies have found that patients regain the weight.[10]

Patients in the U.S. face multiple hurdles in accessing the drugs, which we as prescribers do our best to help them navigate. Unfortunately, being insured does not guarantee access to these drugs. Several payers, due to the high price of the treatments, limit their access, requiring patients to be enrolled in a lifestyle management program or to try other less effective medications before being able to access Wegovy or Zepbound for weight loss. Some state plans, like Blue Cross Blue Shield in Michigan, have taken measures to restrict access altogether due to

---

[3] U.S. Food and Drug Administration. Drug label for OZEMPIC (semaglutide) injection, for subcutaneous use. Published online December 5, 2017. https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/209637lbl.pdf
[4] U.S. Food and Drug Administration. Drug label for MOUNJARO (tirzepatide) Injection, for subcutaneous use. Published online May 13, 2022. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/215866s000lbl.pdf
[5] Wilding JP, Batterham RL, Calanna S, et al.: Once-weekly semaglutide in adults with overweight or obesity. N Engl J Med. 2021, 384:989-1002. 10.1056/NEJMoa2032183
[6] Jastreboff AM, Aronne LJ, Ahmad NN, et al. Tirzepatide Once Weekly for the Treatment of Obesity. *New England Journal of Medicine*. 2022;387(3):205-216. doi:10.1056/NEJMoa2206038
[7] Lincoff AM, Brown-Frandsen K, Colhoun HM, et al.: Semaglutide and cardiovascular outcomes in obesity without diabetes. N Engl J Med. 2023, 389:2221-32. 10.1056/NEJMoa2307563
[8] Lu Y, Liu Y, Jastreboff AM, et al. Eligibility for Cardiovascular Risk Reduction Therapy in the United States Based on SELECT Trial Criteria: Insights From the National Health and Nutrition Examination Survey. *Circulation: Cardiovascular Quality and Outcomes*. 2024;17(1):e010640. doi:10.1161/CIRCOUTCOMES.123.010640
[9] Barber MJ, Gotham D, Bygrave H, Cepuch C. Estimated Sustainable Cost-Based Prices for Diabetes Medicines. JAMA Netw Open. 2024;7(3):e243474. doi:10.1001/jamanetworkopen.2024.3474
[10] Wilding JPH, Batterham RL, Davies M, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension. *Diabetes Obes Metab*. 2022;24(8):1553-1564. doi:10.1111/dom.14725

the cost burden.[11] Earlier this year, North Carolina's State Health Plan also announced that they would no longer be covering Wegovy as well as another earlier generation GLP-1 also manufactured by Novo Nordisk. After being unable to negotiate fair prices for their beneficiaries, North Carolina state officials recently sent a letter to the U.S. Department of Health and Human Services urging the agency to take steps to license Novo Nordisk's and Eli Lilly's weight loss drugs to other manufacturers who can produce the treatments more affordably.[12] A 2023 report found that only 16 states provide Medicaid coverage of these drugs for weight loss[13] and earlier this year, a Kaiser Family Foundation poll found that, despite having insurance coverage, over half of patients report difficulty affording these medicines.[14]

Moreover, even for patients with diabetes, there are disparities in coverage of Ozempic and Mounjaro. A recent study found that prescriptions for Ozempic were more often filled or used by patients with private health insurance compared to those with Medicare and Medicaid despite higher burdens of type 2 diabetes in the latter populations.[15,16] Not surprisingly, the higher the out-of-pocket costs that patients were asked to pay, the less likely they were to start a GLP-1 agonist, even in the presence of compelling clinical indications for its use. Thus, the exorbitant prices of these medications are only further exacerbating health disparities among patients who cannot access or afford them.[17]

Lack of coverage, supply shortages and the unreasonable sticker prices of these medications are pushing patients to consider alternative options, which are often unsafe. Given the high demand for these therapies and the bottle-neck in access, online retailers are capitalizing on the demand and claiming to offer cheaper, unregulated "generic" versions.[18] The FDA has received adverse event reports for these versions, and has issued warning letters to stop illegally marketed

---

[11] Minemyer P. Allstate sells off employer voluntary benefits unit in $2B deal. *Fierce Healthcare*. https://www.fiercehealthcare.com/payers/allstate-selling-employer-voluntary-benefits-unit-2b-deal. August 15, 2024..

[12] Folwell D. Re: Need for Federal Action Due to Unaffordability of GLP-1 Weight Loss Drugs. Published online July 29, 2024. https://www.shpnc.org/documents/folwell-request-usdhhs-glp1/download?attachment

[13] Hinton E, Williams E, Raphael J, et al. 50 State Medicaid Budget Survey Fiscal Years 2023-2024 - Pharmacy - 10244. KFF. November 14, 2023. Accessed August 22, 2024. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-pharmacy/

[14] Montero A, Sparks G, Presiado M, Published LH. KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs. KFF. May 10, 2024. https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/

[15] Scannell C, Romley J, Myerson R, Goldman D, Qato DM. Prescription Fills for Semaglutide Products by Payment Method. *JAMA Health Forum*. 2024;5(8):e242026. doi:10.1001/jamahealthforum.2024.2026

[16] Ding D, Glied SA. Disparities in the Use of New Diabetes Medications: Widening Treatment Inequality by Race and Insurance Coverage. The Commonwealth Fund: Advancing Health Equity. doi:10.26099/vabp-0g69

[17] Montero et al, Ibid.

[18] Blum D. Ozempic Is Hard to Find. Some Pharmacies Are Offering Unauthorized Alternatives. *The New York Times*. https://www.nytimes.com/2023/05/16/well/live/ozempic-alternatives-semaglutide.html. May 16, 2023. Accessed August 22, 2024.

semaglutide.[19] When a drug such as semaglutide is in shortage, a compounded version of the drug can be prepared. However, these versions are not reviewed for quality, safety, or effectiveness.[20] Some patients are unaware of the risk of ordering semaglutide from an online retailer and some are willing to risk the danger because they simply cannot access the costly, regulated version through traditional means. If the prices of these medications are made more reasonable, then potential harms to our patients could be averted.

Simply put, these novel treatments are too expensive. A recent report by the Senate Committee on Health, Education, Labor, and Pensions (HELP) Committee found that wholesale coverage of these drugs for patients with obesity alone will break the bank: "Medicare spending on this class of drugs, called GLP-1s, has increased from $57 million in 2018 to $5.7 billion in 2022, while Medicaid spending for these drugs increased from $383 million to $1.8 billion in that time period."[21] If there is broader coverage with these prices in place, these costs will just be transferred onto patients in the form of higher premiums even if patients are not taking the medication. The same Senate HELP report estimates that treating even half of Medicare and Medicaid patients with obesity would cost almost the entire 2022 prescription drug budget. It will not be until 2027 that Medicare can secure a fairer price for Wegovy through drug pricing negotiations under the Inflation Reduction Act[22] - our patients and our healthcare system cannot wait that long.

As concerned physicians, we want our patients to have access to therapies that are regulated by the FDA to ensure their safety and efficacy. We want our patients to be able to access medications that can improve their health and quality of life, but we do not want to rob the American taxpayers to line the pockets of the pharmaceutical manufacturers.

Senators, we are asking you to do everything in your power to bring down the price of these novel diabetes and obesity drugs. Our patients deserve to have the best options available to them at a fair price.

Thank you,

Terry Adirim, MD, MPH, MBA

---

[19] Center for Drug Evaluation and Research. Medications Containing Semaglutide Marketed for Type 2 Diabetes or Weight Loss. FDA.gov. January 10, 2024. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/medications-containing-semaglutide-marketed-type-2-diabetes-or-weight-loss

[20] Center for Drug Evaluation and Research. Compounding and the FDA: Questions and Answers. FDA.gov. August 5, 2024. https://www.fda.gov/drugs/human-drug-compounding/compounding-and-fda-questions-and-answers

[21] Sanders B. *Breaking Point: How Weight Loss Drugs Could Bankrupt American Health Care*. United States Senate Health, Education, Labor, and Pensions Committee; 2024. https://www.sanders.senate.gov/wp-content/uploads/Wegovy-report-FINAL.pdf

[22] Rep. Yarmuth JA [D K 3. *Inflation Reduction Act of 2022.*; 2022. https://www.congress.gov/bill/117th-congress/house-bill/5376/text

Pediatric Emergency Physician
Former Acting Assistant Secretary of Defense
Rockville, Maryland

Kenneth Adler, MD
Psychiatrist
Toledo, Ohio

Reena Agarwal, MD, MPH
Primary Care Physician
Briarcliff Manor, New York

Heidi Appel, MD
Pediatric Critical Care Physician
Assistant Professor, Department of Pediatrics, Georgetown University School of Medicine
Arlington, Virginia

Sonia Arias-Franklin, MD
Obstetrician-Gynecologist
Assistant Professor of Obstetrics and Gynecology, UT Southwestern Medical School
Allen, Texas

Beth Armstrong, MD
Emergency Medicine
Kalamazoo, Michigan

Oneida Arosarena, MD
Head and Neck Surgeon
Professor, Department of Otolaryngology, Lewis Katz School of Medicine at Temple University
Huntingdon Valley, Pennsylvania

Philip Ballard, MD
Pediatrician
Professor of Pediatrics, UCSF School of Medicine
Bodega Bay, California

Roberta Ballard, MD
Pediatrician
Bodega Bay, California

Sahil Banka, MD
Interventional Cardiologist
Clinical Associate Professor in Cardiology, Drexel University College of Medicine
Philadelphia, Pennsylvania

Brent Baranko, MD
Orthopedic Surgeon
Salt Lake City, Utah

Paul Beach, MD, MPH
Primary Care Physician
Philadelphia, Pennsylvania

Karina M. Berg, MD, MS
Primary Care Physician and Geriatrician
Associate Professor of Medicine, Center on Aging, University of Connecticut School of Medicine
Farmington, Connecticut

Cheryl Bettigole, MD, MPH, MA
Primary Care Physician
Commissioner for the Philadelphia Department of Public Health
Philadelphia, Pennsylvania

Margaret Bia, MD
Nephrologist
Retired Professor Emeritus of Medicine (Nephrology), Yale School of Medicine
Guilford, Connecticut

Cary Bjork, MD
Primary Care Physician
Marquette, Michigan

Rachel Blair, MD
Endocrinologist
Boston, Massachusetts

Theresa Blumfelder, MD
Primary Care Physician
Las Vegas, Nevada

Sondra Bogursky, MD
Primary Care Physician/Pediatrician
Assistant Clinical Professor, Yale School of Medicine
New Haven, Connecticut

Jared Boyce, ScM
Medical Student (MD/PhD Candidate)
Madison, Wisconsin

Thomas Brandes, MD
Primary Care Physician
Grants Pass, Oregon

Nichole Brathwaite-Dingle, MD, MPH
Pediatrician
Richmond, Texas

Richard Bruno, MD, MPH
Primary Care/Preventative Medicine Physician
Portland, Oregon

Kevin Burns, MD, MPH
Addiction Medicine Physician
Medical Director, CalAIM
Los Angeles, California

Ealena Callender, MD, MPH
Obstetrician-Gynecologist
Silver Spring, Maryland

Anne W. Camp, MD
Endocrinologist
New Haven, Connecticut

Pascale Carbonara, MD
Internal Medicine Physician (Obesity Specialist)
Chestnut Hill, Massachusetts

Alison Case, MD
Primary Care Physician
Indianapolis, Indiana

Tania Chavez, NP
Nurse Practitioner
Santa Fe, New Mexico

Alissa S. Chen, MD, MPH
Primary Care Physician
New Haven, Connecticut

Angela Cole, RN
Registered Nurse
Erie, Michigan

Rushika Conroy, MD, MS
Pediatric Endocrinologist (Obesity Specialist)
South Portland, Maine

Lanie Cox, MD
Primary Care Physician
Spokane, Washington

Camilla Cracchiolo, RN
Nurse
Los Angeles, California

Margaret Daly, MD
Endocrinologist
Pittsford, Vermont

Ian Darnton-Hill, MBBS, PhD, MPH, MS
Public Health Nutritionist
New York, New York

Cindy Davis, MD
Obstetrician-Gynecologist
Chamberlain, South Dakota

Jennifer de Vries, MD
Anesthesiologist
Dayton, Ohio

James Deshotels, MSN, MPH
Nurse
Robertsville, Missouri

Elizabeth Dewey, MD
Primary Care Physician
Greensboro, North Carolina

Marina Donahue, FNP, CDCES
Nurse Practitioner
Boston, Massachusetts

Bipin Doshi, MD
General Surgeon
Fort Worth, Texas

Justin A. Dower, MD
Resident Physician
New Haven, Connecticut

Sheina Duncan, MD, MPH
Resident Physician
New Haven, Connecticut

Gabriela Elias, MD
Resident Physician
Fort Myers, Florida

Jean Engelkemeir, MD
Primary Care Physician
Chicago, Illinois

Noa Erlitzki, MS
MD/PhD Candidate, University of Pennsylvania Perelman School of Medicine
Philadelphia, PA

Utibe R. Essien, MD, MPH
Primary Care Physician
Assistant Professor of Medicine, UCLA
Los Angeles, California

Marc Henry Estriplet, MD, MPH
Primary Care Physician
New Haven, Connecticut

Fabrizia Faustinella, MD, PhD
Primary Care Physician
Professor, Department of Family and Community Medicine, Baylor College of Medicine
Houston, Texas

Jimmell Felder, MD
Pediatrician
Greenwood, South Carolina

Virginia Feldman, MD
Pediatrician
Portland, Oregon

Elizabeth Fildes, ED, RN
Nurse

Las Vegas, Nevada

Karen Filkins, MD
Physician
Emerald Isle, North Carolina

Tessa Fischer, MD
Primary Care Physician
Deerfield, Illinois

David Flood, MD, MSc
Primary Care Physician
Assistant Professor, Department of Medicine, University of Michigan
Ann Arbor, Michigan

Lauren Forbes, MD, MPH
Resident Obstetrician-Gynecologist
Norfolk, Virginia

Kenneth Frisof, MD
Primary Care Physician
Adjunct Assistant Professor, Family and Community Medicine, Northeast Ohio Medical University
Cleveland, Ohio

Benjamin D. Gallagher, MD
Primary Care Physician
Assistant Professor of Medicine, Yale School of Medicine
New Haven, Connecticut

Taryn Gallo, MD
Obstetrician-Gynecologist
Vero Beach, Florida

Alvaro Garza, MD
Public Health Physician
Modesto, California

Cameron Gettel, MD, MHS
Emergency Medicine Physician
Assistant Professor, Department of Emergency Medicine, Yale School of Medicine
New Haven, Connecticut

Andrew Gettinger, MD
Anesthesiologist

Emeritus Professor of Anesthesiology, Dartmouth Geisel School of Medicine
Hanover, New Hampshire

Ian Gilson, MD
Primary Care Physician
Milwaukee, Wisconsin

Lisa Glenn, MD
Primary Care Physician
Austin, Texas

Warren M. Gold, MD
Internal Medicine Physician
Professor Emeritus of Pulmonary, Critical Care, Allergy and Sleep Medicine, UCSF
San Francisco, California

Gale Gordon, MD
Pediatric Nephrologist
Los Angeles, California

Josephine R. Granner, PhD, BSN, RN
Nurse
Postdoctoral Fellow, Yale School of Medicine
New Haven, Connecticut

Cary P. Gross, MD
Primary Care Physician
Professor of Medicine, Yale School of Medicine
New Haven, Connecticut

Roy Guinto, DO
Endocrinologist
Clinical Assistant Professor of Medicine, University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

Ravi Gupta, MD, MSHP
Primary Care Physician
Assistant Professor of Medicine, Johns Hopkins University School of Medicine
Philadelphia, Pennsylvania

Anand Habib, MD, MPhil
Primary Care Physician
Postdoctoral Fellow, Yale School of Medicine
New Haven, Connecticut

Ellen Hall-Chave, MD
Primary Care Physician
Banks, Oregon

Nadine Halliburton-Foster, MD
Primary Care Physician
Cumming, Georgia

Ole-Petter R. Hamnvik, MB BCh BAO, MMSc
Endocrinologist
Brigham and Women's Hospital and Harvard Medical School
Boston, Massachusetts

Laura Hanks, PA
Physician Assistant
Portland, Oregon

Jamie Haraden, ARNP
Nurse Practitioner
Duvall, Washington

Lara Hart, MD
Obstetrician-Gynecologist
Assistant Professor of Obstetrics & Gynecology, Medical College of Georgia
Watkinsville, Georgia

Leslye Heilig, MD
Pediatrician
Great Barrington, Massachusetts

Lauren Herrmann, MD
Primary Care Physician
Louisville, Kentucky

David Herszenson, MD, MPH
Primary Care Physician
Bronx, New York

Adena M. Hicks, MD, MA, MPH
Primary Care Physician
Atlanta, Georgia

Bruce Hlodnicki, MD

Emergency Physician
Indianapolis, Indiana

Rebecca Hofer, MD
Primary Care Physician
New Haven, Connecticut

Louisa Holaday, MD, MHS
Primary Care Physician
Assistant Professor, Icahn School of Medicine at Mount Sinai
New York, New York

Allen Holloway, MD
Primary Care Physician
Phoenix, Arizona

Laboni Hoque, MD
Resident Physician
New Haven, Connecticut

Sarah Householder, MD
Resident Physician
New Haven, Connecticut

Claire Huang, MD
Cardiologist
New York, New York

Viviana Huang Chen, MD, MPP, FAAFP
Primary Care Physician
Adjunct Clinical Assistant Professor, Department of Family Medicine, Charles R. Drew University of Medicine and Science
Los Angeles, California

Linda Huffman, PA-C
Physician Assistant
Palm Beach Gardens, Florida

Dennis Michael Hughes, MD
Psychiatrist
Phoenix, Arizona

Kristin Huntoon, DO, PhD
Neurosurgeon

Assistant Professor of Neurosurgery, University of Arizona College of Medicine Tucson
Tucson, Arizona

Nadir Ijaz, MD, MHS
Pediatrician
New Haven, Connecticut

Joanna Ingebritsen, MD
Primary Care Physician
San Juan Bautista, California

Avanthi Jayaweera, MD
Resident Physician
Richmond, Virginia

Elena Jimenez Gutierrez, MD, MSc
Primary Care Physician
Assistant Professor, Department of Medicine, UT Health Science Center at San Antonio
San Antonio, Texas

Steven Joffe, MD, MPH
Pediatric Oncologist
Professor of Medical Ethics & Health Policy, University of Pennsylvania Perelman School of Medicine
Philadelphia, Pennsylvania

Gina Johnson, MD
Primary Care Physician
Sherman Oaks, California

Rebecca Jones, MD
Dermatologist
Whately, Massachusetts

Jagathi Kalluru, MD
Resident Physician
New Haven, Connecticut

Camilia Kamoun, MD
Pediatric Oncologist
Assistant Professor, University of North Carolina School of Medicine
Chapel Hill, North Carolina

Susan Kass, MSN
Nurse Practitioner

Portland, Oregon

Sylvia Kehlenbrink, MD
Endocrinologist
Boston, Massachusetts

Kate Kelley, MD, MPH
Primary Care Physician
Cleveland, Ohio

Patricia Kellner, MD
Primary Care Physician
Cleveland, Ohio

Lynne Kerr, MD, PhD
Pediatric Neurologist
Salt Lake City, Utah

Soochuen Kho, MD
Head and Neck Surgeon
Lake Sherwood, California

Leslie Klein, DO
Primary Care Physician
Los Angeles, California

Timothy Knauff, PA-C
Physician Assistant
Henderson, Nevada

Randi Kodroff, DO
Primary Care Physician
Washington, District of Columbia

Neda Laiteerapong, MD, MS
Primary Care Physician
Associate Professor of Medicine, University of Chicago
Chicago, Illinois

Alyssa Lambrecht, DO
Resident Physician
Millbury, Ohio

Lois Lambrecht, MD

Primary Care Physician
Bloomington, Indiana

Katharine Lamperti, MD
Anesthesiologist
Mercer Island, Washington

Rima Shah Leclere, MD, MPH
Primary Care Physician
Phoenix, Arizona

Giovanna Leddy, MD
Internal Medicine Physician (Obesity Specialist)
Chestnut Hill, Massachusetts

Danny Lee, MD
Primary Care Physician
Seattle, Washington

Eric Lester, MD
Oncologist
Saint Joseph, Michigan

Janet Leung, MD
Endocrinologist
Pittsburgh, Pennsylvania

Joseph Levitt, MD
Pulmonologist
Associate Professor, Department of Pulmonary, Allergy & Critical Care Medicine, Stanford
Palo Alto, California

Owen Linder, MD
Primary Care Physician
Safety Harbor, Florida

Carolyn Linek-Rajapaksha, MD
Pediatric Psychiatrist
Lutz, Florida

Kasia J. Lipska, MD, MHS
Endocrinologist
Associate Professor of Medicine, Section of Endocrinology and Metabolism, Yale School of Medicine
New Haven, Connecticut

Erin Lockard, MD
Primary Care Physician
Kansas City, Missouri

Justin Lowenthal, MD, PhD
Resident Doctor
Brigham and Women's Hospital
Boston, Massachusetts

Michelle Ludwig, MD, PhD, MPH
Radiation Oncologist
Associate Professor of Radiation Oncology, Baylor College of Medicine
Houston, Texas

Jing Luo, MD, MPH
Primary Care Physician
Associate Professor of Medicine, University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Kimberly Lynch, MD, MSHPM
Primary Care Physician
Los Angeles, California

Alma Magana, FNP
Nurse Practitioner
Lakewood, California

Janice Makela, MD
Internal Medicine Physician
Streamwood, Illinois

Jen Manne-Goehler, MD, ScD
Infectious Diseases Physician
Boston, Massachusetts

Shelly Maramonte, MD
Primary Care Physician
Concord, California

Lorraine Martinez, DO
Obstetrician-Gynecologist
Indian Mound, Tennessee

Jennifer McConnell, MD
Primary Care Physician
Columbus, Ohio

Ann McDonald, MD
Psychiatrist
East Stroudsburg, Pennsylvania

Marie E. McDonnell, MD
Endocrinologist
Associate Professor of Medicine, Harvard Medical School
Boston, Massachusetts

Julea McGhee, MD, MPH
Psychiatrist
Clinical Assistant Professor, USC Keck School of Medicine & David Geffen School of Medicine, UCLA
Los Angeles, California

Lisa McGonigal, MD, MPH
Primary Care Physician
Somerville, Massachusetts

Robert Meagher, MD
Pediatrician
Sacramento, California

Anish Mehta, MD, MPP
Primary Care Physician
Assistant Clinical Professor of Medicine, Icahn School of Medicine at Mount Sinai
Brooklyn, New York

Michael O. Mensah, MD, MPH, MHS
Psychiatrist
Division of Law and Psychiatry, Yale University School of Medicine
New Haven, Connecticut

Faisal Merchant, DO
Primary Care Physician
Anaheim, California

Barbara Messinger-Rapport, MD
Primary Care Physician
Cleveland, Ohio

Heather Metcalf, MD
Resident Physician
Augusta, Maine

Aaron Mitchell, MD, MPH
Oncologist
New York, New York

Amir Mohareb, MD
Infectious Diseases Physician
Assistant Professor of Medicine, Harvard Medical School
Boston, Massachusetts

Fabiola Molina, MD, MHS
Primary Care Physician
Assistant Professor of Medicine, Yale School of Medicine
New Haven, Connecticut

Victor M. Montori, MD, MSc
Endocrinologist
Professor of Endocrinology, Mayo Clinic
Rochester, Minnesota

Maryam Mooghali, MD, MSc
Resident Physician
New Haven, Connecticut

Mae Morgan, MD, MPH
Primary Care Physician
Atlanta, Georgia

John P. Moriarty, MD
Primary Care Physician
Professor, Division of General Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Thomas Moulton, MD
Pediatric Hematologist/Oncologist
Astoria, New York

Kathryn Nagel, MD
Primary Care Physician
Boston, Massachusetts

Laura Nally, MD
Pediatrician
Assistant Professor, Department of Pediatrics, Yale School of Medicine
New Haven, Connecticut

Jean Naples, MD, PhD
Primary Care Physician
Suffern, New York

Deanna Nardella, MD, MHS
Pediatrician
New Haven, Connecticut

Shawn Naseem, MD
Primary Care Physician
Pittsburgh, Pennsylvania

Richard Needleman, MD, MPH
Orthopedic Surgeon
Asheville, North Carolina

Jacob Newcomb, MD, FACEP
Emergency Medicine Physician
Long Beach, California

Cynthia Nkem, BS, MS
Medical Student
Nashville, Tennessee

Callie OBryant, MD
Resident Physician
Birmingham, Alabama

Eileen ODonnell, APRN
Nurse Practitioner
Clinton, Connecticut

Benjamin Oldfield, MD, MHS
Primary Care Physician
New Haven, Connecticut

Maisie Orsillo, DO
Primary Care Physician
New Haven, Connecticut

Nasrin Owsia, MD
Primary Care Physician
La Jolla, California

Tracy Paeschke, MD
Cardiologist
Colorado Springs, Colorado

Gayle Palmer, MD
Primary Care Physician
Mercer Island, Washington

William Palmer, MD
Primary Care Physician
Cornish, New Hampshire

Sharon Paltin, MD
Primary Care Physician
Laytonville, California

Darshan Patel, MD
Primary Care Physician
Lancaster, Pennsylvania

Judith Peter, RN
Nurse
Port Charlotte, Florida

Alan Peterson, MD
Primary Care Physician
Willow Street, Pennsylvania

Christine Petrin, MD, MPH
Internal Medicine & Pediatrics
Settlement Health
New York, NY

Quang Pham, MD, MPH
Primary Care Physician
McLean, Virginia

Matthew Pius, MD
Emergency Physician

Assistant Professor, Department of Emergency Medicine, Mount Sinai
New York, New York

Lisa Plymate, MD
Primary Care Physician
Seattle, Washington

Evan Pollack, MD
Primary Care Physician
Bryn Mawr, Pennsylvania

Suzanne Poppema, MD
Primary Care Physician
Seattle, Washington

R Scott Poppen, MD, MPA
Primary Care Physician
Draper, Utah

Raphael Pristoop, MD
Primary Care Physician
Washington, District of Columbia

Tracy L. Rabin, MD, SM
Primary Care Physician
Associate Professor, Department of Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Meera Ragavan, MD, MPH
Speciality Physician
Millbrae, California

Braveen Ragunanthan, MD, MPH, FAAP
Pediatrician
Mound Bayou, Mississippi

Peter Raich, MD
Oncologist
Loveland, Colorado

Reshma Ramachandran, MD, MPP, MHS
Primary Care Physician
Assistant Professor, Section of General Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Veena Ramaiah, MD
Pediatric Emergency Medicine Physician
Associate Professor of Pediatrics, The University of Chicago
Chicago, Illinois

Ben Ramsden-Stein, DO
Primary Care Physician
Santa Cruz, California

Michael Reddy-Miller, MD
Primary Care Physician
Nags Head, North Carolina

Irma Rey, MD
Primary Care Physician
Assistant Professor, College of Osteopathic Medicine, Nova Southeastern University
Miami, Florida

William Roberts, MD, MSc
Primary Care Physician
New Haven, Connecticut

Natalie Robiou, MD
Primary Care Physician
Media, Pennsylvania

Theresa Rohr-Kirchgraber, MD
Primary Care Physician
Professor of Medicine, Medical College of Georgia
Athens, Georgia

Julia Rosenberg, MD, MHS
Pediatrician
Assistant Professor, Department of Pediatrics, Yale School of Medicine
New Haven, Connecticut

David Rosenberg, DO
Pediatrician
Bayside, Wisconsin

Joseph S. Ross, MD, MHS
Primary Care Physician
Professor of Medicine and Public Health, Yale School of Medicine

New Haven, Connecticut

Victor Roy, MD, PhD
Primary Care Physician
Assistant Professor of Family Medicine & Community Health, University of Pennsylvania
Philadelphia, Pennsylvania

Aliye Runyan, MD
Obstetrician-Gynecologist
White Plains, New York

Akkaraju Sarma, MD
Primary Care Physician
Bensalem, Pennsylvania

Suzanne Saunders, APRN
Nurse Practitioner
Largo, Florida

Christopher Scannell, MD, PhD
Primary Care Physician
Los Angeles, California

Andrea Schauer, MD
Primary Care Physician
Walnut Creek, California

David Schneider, MD
Primary Care Physician
Santa Rosa, California

Gail Schonfeld, MD
Pediatrician
East Hampton, New York

Shayna Schor, MD
Resident Physician
New Haven, Connecticut

Dianne Schulze, PHN
Nurse
Lakeville, Minnesota

Jeremy Schwartz, MD

Primary Care Physician
Associate Professor, Section of General Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Kathryn Seitz, MD
Primary Care Physician
Denver, Colorado

Sneha Shah, DO, MS
Primary Care Physician
Los Angeles, California

Dein Shapiro, MD
Primary Care Physician
Bridgewater, New Jersey

Lee Shapley, MD
Primary Care Physician
Poughkeepsie, New York

Divya Shenoy, MD, MPH
Primary Care Physician
Washington, District of Columbia

Richard Sibson, DO
Physiatrist
Orlando, Florida

Darby Sider, MD
Primary Care Physician
Pompano Beach, Florida

Joshua Skydel, MD
Primary Care Physician
Clinical Fellow, Section of Rheumatology, Allergy & Immunology, Yale School of Medicine
New Haven, Connecticut

Joshua Skydel, MD
Resident Physician
Cheshire, Connecticut

Alyson Smith, PA-C
Physician Assistant
Lisle, Illinois

Natalie Sohn, MD
Primary Care Physician
Brooklyn, New York

Erica Spatz, MD, MHS
Cardiologist
Associate Professor, Section of Cardiovascular Medicine, Yale School of Medicine
New Haven, Connecticut

Kathryn Stahl, MD
Emergency Physician
Silver Spring, Maryland

Jennifer Anne Stasko, MD
Primary Care Physician
UPMC cmi
Delmont, Pennsylvania

Robert Steinbrook, MD
Primary Care Physician
Professor Adjunct of Internal Medicine, Yale School of Medicine
Washington, District of Columbia

Mark Stevens, MD
Primary Care Physician
Marquette, Michigan

Cecilia Strauch, MD
Primary Care Resident
Factoryville, Pennsylvania

Bruce J. Stringer, MD
Radiologist
Buffalo, New York

Kimberly Sue, MD, PhD
Primary Care Physician
Assistant Professor of Medicine, Yale University School of Medicine
New Haven, Connecticut

Eric Sullivan, MD
Primary Care Physician
Chicago, Illinois

Suzanne Swanson, MD
Obstetrician-Gynecologist
Oconto, Wisconsin

Vafa Tabatabaie, MD
Endocrinologist
Professor, Department of Medicine, Albert Einstein College of Medicine
Astoria, New York

Amerisa Tarabar, MD
Primary Care Physician
Assistant Professor, Department of Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Zoey L. Thill, MD, MPP, MPH
Primary Care Physician
St. Clair Shores, Michigan

Katherine Tildes, NP
Nurse Practitioner
Wilmington, North Carolina

Daniel G. Tobin, MD, FACP
Primary Care Physician
Associate Professor, Department of Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Walter Tsou, MD, MPH
Primary Care Physician
Former Health Commissioner of Philadelphia
Philadelphia, Pennsylvania

Stephen Urciuoli, MD
Primary Care Physician
Weston, Connecticut

Mary Ellen Vajravelu, MD, MSHP
Pediatric Endocrinologist
Assistant Professor of Pediatrics, University of Pittsburgh School of Medicine
Pittsburgh, Pennsylvania

Mohammed Vayani, MD
Resident Physician

New Brunswick, New Jersey

Rebecca J. Vitale, MD, MPH
Pediatric Endocrinologist
Assistant Professor of Medicine and Pediatrics, UNC Chapel Hill School of Medicine
Chapel Hill, North Carolina

Nancy Vo, MD
Geriatric Medicine Physician
Diamond Bar, California

Jonathan Walker, MD
Ophthalmologist
Fort Wayne, Indiana

William Wallin, MD
Primary Care Physician
Richmond, California

Clara Warden, MD
Resident Physician
New Haven, Connecticut

Joseph Whelihan, MD
Pediatrics Resident Physician
Philadelphia, Pennsylvania

Lacey Whitmire, MD, MPH
Primary Care Physician/Pediatrician
New Haven, Connecticut

Elizabeth Wiley, MD, JD, MPH
Primary Care Physician
Olympia, Washington

Abigail Wilpers, PhD, WHNP-BC
Women's Health Care Nurse Practitioner
Assistant Professor, Center for Global Women's Health, Penn Nursing
Philadelphia, Pennsylvania

Delaine Winn, MD
Resident Physician
New Haven, Connecticut

Anne Wise, MD, MPH
Primary Care Physician
Cleveland, Ohio

Nathan I. Wood, MD, MHS, DABOM
Primary Care Physician
Instructor of Medicine, Department of Internal Medicine, Yale School of Medicine
New Haven, Connecticut

Eileen Yager, MD
Pediatrician
Clinical Professor of Pediatrics, University of Colorado School of Medicine
Denver, Colorado

Annie W. Yang, MD
Primary Care Physician
West Haven, Connecticut

Anne Yoshino, MD
Primary Care Physician
Willow, Alaska

David Zajano, MD
Primary Care Physician
Phoenix, Maryland

Karen Zink, MD
General Surgeon
Portland, Oregon

Margaret Zupa, MD, MS
Endocrinologist
Assistant Professor of Medicine, University of Pittsburgh
Pittsburgh, Pennsylvania

Estimating the lives that could be saved by expanded access to weight-loss drugs

Abhishek Pandey, PhD[1]; Yang Ye, PhD[1]; Chad R. Wells, PhD[1]; Burton H. Singer, PhD[2,*]; Alison P. Galvani, PhD[1,*]

[1] Center for Infectious Disease Modeling and Analysis, Yale School of Public Health, New Haven, CT, USA

[2] Emerging Pathogens Institute, University of Florida, Gainesville, Florida, USA

***Corresponding authors:** Burton H. Singer & Alison P. Galvani

Competing Interest Statement: The authors have no competing interests

Keywords: obesity; diabetes; mortality; weight-loss drugs; drug access

Abstract

Obesity is a major public health crisis in the United States (US) affecting 42% of the population, exacerbating a spectrum of other diseases and contributing significantly to morbidity and mortality overall. Recent advances in pharmaceutical interventions, particularly glucagon-like peptide-1 (GLP-1) receptor agonists (e.g., semaglutide, liraglutide) and dual gastric inhibitory polypeptide and glucagon-like peptide-1 (GIP/GLP-1) receptor agonists (e.g., tirzepatide), have shown remarkable efficacy in weight loss. However, limited access to these medications due to high costs and insurance coverage issues restricts their utility in mitigating the obesity epidemic. We quantify the annual mortality burden directly attributable to limited access to these medications in the US. By integrating hazard ratios of mortality across body mass index categories with current obesity prevalence data, combined with willingness to take the medication, observed adherence to and efficacy of the medications, we estimate the impact of making these medications accessible to all those eligible. Specifically, we project that with expanded access, over 43,000 deaths could be averted annually, including more than 12,000 deaths among people with type 2 diabetes. These findings underscore the urgent need to address barriers to access and highlight the transformative public health impact that could be achieved by expanding access to these novel treatments.

Introduction

Obesity remains a formidable public health crisis in the United States (US), contributing substantially to both morbidity and mortality (1). It is a major risk factor for various chronic diseases, including cardiovascular disease, type 2 diabetes, and myriad forms of cancer. For example, the risk of endometrial cancer in people with severe obesity is seven times higher compared with the rest of the population who are not overweight (2). Among many other causes of mortality and morbidity, obesity is a risk factor for poor medical outcomes from a plethora of infectious diseases, surgical-site infections, and nosocomial infections (3). Compounding the challenge, the obesity prevalence in the US is skewed towards the vulnerable populations, including those with lower socioeconomic status and limited insurance coverage (4). Adults with obesity are likely to spend over $1800 more in medical costs per year than those without obesity (5). Altogether, the economic burden of obesity is immense, with estimated annual medical costs exceeding $170 billion (5).

Historically, the development of pharmaceutical interventions for weight loss has been fraught with challenges, including safety concerns and limited efficacy (6). However, a paradigm shift has occurred with the discovery that drugs originally intended for diabetes management, particularly glucagon-like peptide-1 (GLP-1) and dual gastric inhibitory polypeptide and glucagon-like peptide-1 (GIP/GLP-1) receptor agonists, can induce substantial weight loss (7). These next-generation medications, such as semaglutide, liraglutide, and tirzepatide, have demonstrated remarkable efficacy in clinical trials, resulting in weight reductions previously considered unattainable through pharmaceutical means alone (7). As a result, these medications are increasingly gaining approval from the U.S. Food and Drug Administration (FDA) for the treatment of obesity, ushering in a new era in obesity management (8).

Semaglutide, initially approved in 2017 for type 2 diabetes as Ozempic, expanded its use in 2021 with FDA approval as Wegovy for chronic weight management in individuals aged 12 and older with obesity (Body Mass Index (BMI) ≥ 30 kg/m²) or overweight (BMI ≥ 27 kg/m²) with at least one weight-related condition, such as hypertension, type 2 diabetes, or high cholesterol. Tirzepatide, another medication in this class, received approval in 2022 for type 2 diabetes as Mounjaro and most recently in November 2023 as Zepbound for chronic weight management in adults with similar criteria to Wegovy.

Despite their promise, widespread access to these medications remains a critical barrier to addressing the escalating obesity epidemic in the US. While semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro, Zepbound) have demonstrated efficacy in reducing body weight, their high cost, limited supply, and lack of comprehensive insurance coverage severely limit their accessibility. Without insurance, the monthly cost of these drugs can exceed $1,000, making them unaffordable for many patients (12). This is particularly concerning given that obesity prevalence is higher among economically disadvantaged populations, further entrenching health inequities.

Medicare, the largest US insurer for older adults, does not cover these medications solely for weight loss, impacting many elderly individuals who could benefit from them (9–12). For those

on Medicaid, coverage varies widely across states, often requiring patients to meet additional criteria. Additionally, private insurance coverage is inconsistent, especially as many Americans have inadequate insurance with high deductibles and copays they cannot afford. The cost barrier is further compounded by the ongoing need for these medications, as discontinuation often leads to weight regain, necessitating a long-term financial commitment from patients.

In this study, we quantify the potential reduction in annual mortality that could be achieved by expanding access to these innovative obesity medications. Utilizing established correlations between BMI and mortality risk, along with the obesity prevalence data, we estimate the number of lives that could be saved annually if effective weight loss medications were more accessible. The projections underscore the significant public health impact of these novel treatments, informing policy decisions and healthcare practices related to obesity management.

Results

In the US, more than 40% of adults are classified as obese (BMI ≥ 30; Figure 1A). By applying the hazard ratio for mortality across different BMI categories relative to the normal BMI category (BMI: 18.5–25), we estimate that 48.4% of the total annual deaths in the US occur among individuals categorized as obese (BMI ≥ 30; SI Table 1). According to the current FDA guidelines, more than 45% of the adult US population is eligible for the new weight-loss drugs, encompassing everyone with a BMI of 30 and above, as well as individuals with diabetes with a BMI between 25–30 (Figure 1A, B).

Considering insurance status, 54% of Medicaid recipients and 40% of uninsured individuals are eligible for weight-loss drugs (Figure 1C). State-level variations in obesity and diabetes prevalence result in a range of 34% to 56% of the eligible population, with West Virginia and Mississippi having the highest per capita eligibility (Figure 1D; SI Table 3).

As individuals gain access to these drugs, the distribution of the population by BMI categories is expected to shift towards healthier BMI ranges. Among individuals with diabetes, only 12.2% of those who are overweight (BMI: 25–30) or obese (BMI ≥ 30) on average currently use these weight-loss drugs. Access is even more restricted for obese individuals (BMI ≥ 30) without type 2 diabetes, among whom the current uptake is only 10.8%. Accounting for the adherence rate of people who take obesity drugs (27.2%) and diabetes drugs (48.9%), as well as the eligible individual's willingness to take the drug, we project how the US population's BMI distribution would shift. While willingness to take the drugs is implicit in the current uptake rate, our calculations regarding expanded access incorporate the willingness of 75% assessed in survey studies (Methods). Projecting on the basis of current uptake, the change in population distribution by BMI categories is expected to be only marginal (Figure 2), with approximately 1.8% of obese individuals lowering their BMI below 30 (SI Table 4). However, if the access is expanded to all eligible individuals, it would lead to a greater shift in the population distribution by BMI categories, with 12% of obese individuals moving to healthier BMI categories below 30 (SI Table 5). Moreover, 19% of those severely obese (BMI ≥ 40) would reduce their BMI below

40 (SI Table 5). Under a more optimistic scenario of higher willingness to take the drugs (89%) and 100% adherence rate, BMI distribution would shift substantially with 47.1% of obese individuals would have BMI lower than 30 (Figure 2; SI Table 6).

Based on the projected BMI distributions, we found that at the current uptake level, these weight-loss drugs have the potential to prevent 7,625 deaths annually [95% Uncertainty Interval (UI): 7,613 – 7,636], of which the majority (71%) is expected to be among individuals with private insurance. However, if access were expanded to all eligible individuals, the number of lives saved could rise by 43,719 annually [95% UI: 43,679 – 43,759], of which 12,124 [95% UI: 12,059 – 12,190] would be among overweight and obese individuals with type 2 diabetes (Table 1). With the expanded access, 10,159 [95% UI: 10,139 – 10,178] deaths averted would be among Medicare beneficiaries and 4,245 [95% UI: 4,241 – 4,249] would be among uninsured. Under the optimistic scenario of expanded access, as many as 171,749 [95% UI:171,591 – 171,907] annual deaths could be averted.

Considering the geographic distribution of obesity and diabetes on a per capita basis, expanded access to weight-loss drugs among eligibles could lead to an annual mortality reduction of 10 to 16 deaths per 100,000 population. While all states could achieve a reduction of at least 10 deaths per 100,000 population, West Virginia, Mississippi, and Oklahoma are expected to experience the largest per capita reduction (Figure 3). By solely expanding access to obese individuals without type 2 diabetes, more than 40% of the states could still expect a reduction of more than 10 deaths per 100,000 population.

Discussion

As a major risk factor for several chronic diseases, obesity is a national public health crisis. Our findings highlight the immense promise of the new generation of weight-loss drugs to mitigate the mortality and morbidity associated with obesity and diabetes. We estimated that if everyone eligible had access to these weight-loss drugs, the obesity prevalence would decline from 42% (13) to 37%, averting over 51,000 deaths every year. At the current level of uptake, our projections indicate that 7,625 lives would be saved annually, less than 15% of the deaths that could be averted if access were expanded.

Limited access stems from a combination of financial barriers, supply constraints, and restrictive insurance coverage. Although insurance typically covers these medications for diabetes treatment, coverage for weight loss is less consistent, often requiring patients to pay out-of-pocket or face restrictive insurance policies (14). Furthermore, 25.6 million Americans are uninsured (15) and more than 80 million are inadequately insured (16). Compounding the challenges, the high prices of these drugs are significantly more expensive in the US compared to other countries (17). Access challenges have created a market for counterfeit drugs, further complicating access and safety concerns (18). To address the concerns, the US Senate has

initiated an investigation regarding the excessive profit margins (19, 20) of these life-changing medications to expand availability to a wider population (21).

Currently those uninsured with diabetes or obesity have no access to these innovative weight-loss drugs, and access is challenging even for those with coverage. For example, despite the widespread need for these medications among elderly aged 65 and above, Medicare Part D only covers the medications for diabetes management or cardiovascular risk reduction (22). Our results show that expanded access to these drugs among elderly with obesity would lead to 10,159 fewer annual deaths among them. Adults under 65 on Medicaid face a higher risk of obesity, with a 27% greater likelihood compared to those with private insurance (23). Accounting for this disproportionate burden, we estimate that if access to these medications were expanded, 27% of the 33,560 annual deaths projected to be averted would occur among Medicaid beneficiaries. However, accessing these medications through Medicaid remains challenging and varies significantly by state.

While Ozempic is ostensibly covered for diabetes treatment under Medicaid in all states, access often involves additional steps, such as prior authorization or trying alternative medications first (28). Coverage for Wegovy, specifically for chronic weight management, is even more restricted under Medicaid (26, 27). Our state-level results demonstrate that high-burden states for obesity and diabetes such as West Virginia, Mississippi, and Oklahoma are likely to avert most per capita deaths by expanding access to all eligible. While Ozempic is covered under Medicaid for type 2 diabetes in these states, they all require prior authorization or step therapy (28–30). Access to Wegovy is similarly restricted, with Mississippi Medicaid not covering it for weight loss alone.

While our results are likely to be robust, several factors may influence them. For example, our estimates are based on available data regarding the effectiveness and utilization of these medications. Specifically, the hazard ratio for mortality stratified by BMI categories used in our calculations was based on a study among white adults in the US (31). However, another retrospective cohort study of US adults of all races found hazard ratios that are consistent with the estimates used for our study (32). Nonetheless, our estimates are conservative in many regards. For example, overweight individuals with a BMI between 27 and 30 are eligible for these weight loss drugs if they have comorbidities such as diabetes, hypertension, or high cholesterol according to FDA guidelines. In our analysis, we conservatively only considered individuals in the overweight-II category with type 2 diabetes as eligible. Also, we used data on semaglutide to parameterize the efficacy of these drug types. Initial data indicates that the most recently approved tirzepdatide may be even more efficacious (33).

Expanding access to obesity medications such as GLP-1 receptor agonists and dual GIP/GLP-1 receptor agonists, and prioritizing obesity as the primary condition for treatment could significantly reduce mortality rates and alleviate the economic burden of obesity-related healthcare costs. The treatment of obesity often leads to improvements in other chronic diseases, including cardiovascular disease and diabetes, as well as diseases that reduce quality of life, such as rheumatoid arthritis (34). Therefore, long-term benefits of improved access could

extend beyond mortality reduction, potentially decreasing obesity-related comorbidities with widespread. Even for acute infectious diseases, such as influenza and COVID-19, obesity is a major risk factor for elevated severity and mortality. Our findings provide compelling evidence for the transformative impact that expanded access to these medications could have on improving the public health of the nation. This underscores the urgency of addressing access barriers, including affordability, insurance coverage, and prescriber awareness. Such policies could galvanize a new era of American well-being and prosperity.

Methods

We first stratified the US population into seven categories based on their BMI: BMI < 18.5, BMI 18.5–25, BMI 25–27.5, BMI 27.5–30, BMI 30–35, BMI 35–40, and BMI ≥ 40 (31). We then expressed the annual mortality in the US as a linear combination of annual deaths in each BMI category, using hazard ratios of mortality for each category compared to the reference category (BMI: 18.5–25) (31). This allowed us to derive the annual mortality rates for individuals in each BMI category.

To assess the impact of new weight-loss drugs, we recalculated the annual mortality in the US by applying the BMI category-specific annual mortality rates to the new population distribution across various BMI categories resulting from the weight loss associated with drug use.

We calculated the new BMI distribution resulting from drug use as follows. Anthropometric reference data from the Centers for Disease Control and Prevention (CDC) (35) provided the age and gender-specific distribution of height, weight, and BMI. Through Monte Carlo sampling of height and weight for each age and gender group, we derived 1000 US population-level samples indexed by weight, height, BMI, age, and gender. Each population sample includes 100,000 people representing the US population stratified across the seven BMI categories.

Next, with each population sample, we modeled the proportion of individuals in each BMI category who would lose weight using diabetes/obesity drugs and calculated their projected BMI. If the new BMI fell into a different BMI category, the individuals were moved accordingly, and the proportion of the total population in each BMI category was recalculated.

The proportion of individuals within a specific BMI category who experience weight loss depends on multiple factors: the proportion of individuals eligible for weight-loss medications, the proportion of eligible willing to take the drugs, the adherence rate among those taking the drug, and the effectiveness of the drugs themselves. These medications can be prescribed for both obesity and type 2 diabetes, with varying eligibility criteria. According to FDA guidelines, obesity medications can be prescribed to individuals with a BMI of 30 or higher, or to those with a BMI between 27 and 30 who have at least one obesity-related condition such as diabetes, hypertension, or high cholesterol. In contrast, all individuals with type 2 diabetes are eligible for diabetes medications and would experience weight loss if their BMI is over 25. Therefore,

everyone with a BMI of 30 and above is considered eligible for weight-loss drugs. Of individuals with a BMI between 25 and 30, only those with diabetes are considered eligible in our study.

We used survey studies, prescription data, and cohort studies to parameterize the current uptake rate of the drugs among eligible populations for obesity and for diabetes as 10.8% (36) and 10.7%–13.6% (37, 38), respectively. Informed by Kaiser Family Foundation's health tracking poll, we took into account that the proportion of eligible individuals' willingness to use the drugs is 75% (39). In accordance with the clinical trials, we incorporate an adherence rate of 48.9% for individuals with diabetes (40) and 27.2% for individuals taking drugs solely for weight loss (41). Weight-loss drugs are associated with an average weight loss of 16.9% in individuals without type 2 diabetes (42). For individuals with type 2 diabetes, the weight loss is approximately 40% lower than that observed in those without diabetes (43).

We estimated annual deaths averted under two scenarios: the current uptake and expanded access. Assuming that drugs are fully accessible to everyone eligible, uptake under expanded access depends on individual-level decisions to take the drugs. We distributed the national estimates of averted deaths across insurance categories and US states, using the population size, proportion of individuals eligible for weight-loss drugs, and drug accessibility within each group as weights (SI Appendix). The proportion of the eligible population was calculated based on the prevalence of obesity, diabetes, and overweight/obesity among diabetic patients within each group.

For results stratified by insurance category, all adults aged 65 and over are on Medicare, while adults aged 18 to 64 are on Medicaid, private insurance, or are uninsured. Insurance coverage data for adults aged 18 to 64 was obtained from the CDC's National Health Interview Survey (44). The proportion of individuals eligible for obesity/diabetes drugs was informed by integrating the differential risks across insurance categories with national-level diabetes and obesity prevalence data (23, 25, 35, 45). Under the current access, high-cost weight-loss drugs would be prohibitive for people without insurance, leading to no averted deaths among this cohort. Under the expanded access scenario, we modeled equity of drug accessibility across all insurance categories. For state-level results, we assumed equal drug accessibility across all states for both scenarios. We normalized state-level prevalence of obesity, diabetes prevalence, and overweight/obesity among diabetic patients to align with national-level data (46, 47).

Acknowledgments

APG acknowledges support from Burnett Endowment and APG, YY, CRW and AP support from the Notsew Orm Sands foundation. The funding source had no influence on the methodology, analysis, or interpretation of the results.

References

1. K. M. Flegal, B. K. Kit, H. Orpana, B. I. Graubard, Association of all-cause mortality with overweight and obesity using standard body mass index categories: a systematic review and meta-analysis. *JAMA* **309**, 71–82 (2013).

2. Obesity and Cancer. (2022). Available at: https://www.cancer.gov/about-cancer/causes-prevention/risk/obesity/obesity-fact-sheet [Accessed 11 June 2024].

3. R. Huttunen, J. Syrjänen, Obesity and the risk and outcome of infection. *Int. J. Obes.* **37**, 333–340 (2013).

4. CDC, Adult obesity prevalence maps. *Obesity* (2024). Available at: https://www.cdc.gov/obesity/php/data-research/adult-obesity-prevalence-maps.html [Accessed 7 June 2024].

5. Z. J. Ward, S. N. Bleich, M. W. Long, S. L. Gortmaker, Association of body mass index with health care expenditures in the United States by age and sex. *PLoS One* **16**, e0247307 (2021).

6. G. Srivastava, C. M. Apovian, Current pharmacotherapy for obesity. *Nat. Rev. Endocrinol.* **14**, 12–24 (2018).

7. J. P. H. Wilding, *et al.*, Once-Weekly Semaglutide in Adults with Overweight or Obesity. *N. Engl. J. Med.* **384**, 989–1002 (2021).

8. K. Henderson, Lewis, C. E. Sloan, D. H. Bessesen, D. Arterburn, Effectiveness and safety of drugs for obesity. *BMJ* **384**, e072686 (2024).

9. S. Sidik, Beyond Ozempic: brand-new obesity drugs will be cheaper and more effective. *Nature* **619**, 19 (2023).

10. J. Cubanski, T. Neuman, N. Sroczynski, A. Damico, A new use for Wegovy opens the door to Medicare coverage for millions of people with obesity. *KFF* (2024). Available at: https://www.kff.org/medicare/issue-brief/a-new-use-for-wegovy-opens-the-door-to-medicare-coverage-for-millions-of-people-with-obesity/ [Accessed 6 May 2024].

11. Y. Noguchi, FDA approves Zepbound, a new obesity drug that will take on Wegovy. *HEALTHNEWSFL* (2023). Available at: https://health.wusf.usf.edu/npr-health/2023-11-08/fda-approves-zepbound-a-new-obesity-drug-that-will-take-on-wegovy [Accessed 6 May 2024].

12. K. D. Young, The push for Medicare to cover weight-loss drugs: An explainer. *The Journalist's Resource* (2023). Available at: https://journalistsresource.org/home/semaglutide-ozempic-wegovy-weight-loss-drugs-research/ [Accessed 6 May 2024].

13. CDC, Adult Obesity Facts. *Obesity* (2024). Available at: https://www.cdc.gov/obesity/php/data-research/adult-obesity-facts.html?CDC_AAref_Val=ht

tps://www.cdc.gov/obesity/data/adult.html [Accessed 5 June 2024].

14. U. Katie Kerwin McCrimmon, Wegovy vs. Ozempic: The truth about new “weight-loss” drugs. *UCHealth Today* (2023). Available at: https://www.uchealth.org/today/wegovy-vs-ozempic-the-truth-about-new-weight-loss-drugs/ [Accessed 7 June 2024].

15. J. Tolbert, P. Drake, A. Damico, Key facts about the uninsured population. *KFF* (2023). Available at: https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [Accessed 21 June 2024].

16. S. R. Collins, L. A. Haynes, R. Masitha, The state of U.s. health insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey. [Preprint] (2022). Available at: https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.

17. A. Watt, Semaglutide: a price and HTA comparison between US and top European markets. *Pharmaceutical Technology* (2023). Available at: https://www.pharmaceutical-technology.com/analyst-comment/semaglutide-price-comparison-us-europe/ [Accessed 7 June 2024].

18. Center for Drug Evaluation, Research, FDA warns consumers not to use counterfeit Ozempic (semaglutide) found in U.S. drug supply chain. *U.S. Food and Drug Administration* (2024). Available at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-warns-consumers-not-use-counterfeit-ozempic-semaglutide-found-us-drug-supply-chain [Accessed 24 June 2024].

19. B. N. Ippolito, J. F. Levy, Estimating the Cost of New Treatments for Diabetes and Obesity. (2023).

20. M. J. Barber, D. Gotham, H. Bygrave, C. Cepuch, Estimated Sustainable Cost-Based Prices for Diabetes Medicines. *JAMA Netw Open* **7**, e243474 (2024).

21. J. Ra, Sanders takes aim at US drug prices of Novo’s Ozempic and Wegovy. *Pharmaceutical Technology* (2024). Available at: https://www.pharmaceutical-technology.com/news/sanders-takes-aim-at-us-drug-prices-of-novos-ozempic-and-wegovy/ [Accessed 7 June 2024].

22. Expanding Access to Obesity Treatments for Older Adults. Available at: https://bipartisanpolicy.org/report/expanding-access-to-obesity-treatments-for-older-adults/ [Accessed 7 June 2024].

23. E. K. Mylona, *et al.*, The association of obesity with health insurance coverage and demographic characteristics: a statewide cross-sectional study. *Medicine* **99**, e21016 (2020).

24. M. A. Laura Joszt, Identifying the most prevalent and costly chronic conditions in Medicaid. *AJMC* (2017). Available at: https://www.ajmc.com/view/identifying-the-most-prevalent-and-costly-chronic-conditions-in-medicaid [Accessed 7 June 2024].

25. CDC, National Diabetes Statistics Report. *Diabetes* (2024). Available at: https://www.cdc.gov/diabetes/php/data-research/index.html [Accessed 7 June 2024].

26. F. Kritz, Does Medicaid cover anti-obesity medication? *Verywell Health* (2024). Available at: https://www.verywellhealth.com/does-medicaid-cover-anti-obesity-medication-8650269 [Accessed 8 June 2024].

27. Ways to gain coverage for Wegovy™. Available at: https://www.wegovy.com/coverage-and-savings/wegovy-coverage-options.html [Accessed 8 June 2024].

28. Preferred Drug List and Coverage Details. Available at: https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/Preferred-Drug-List.aspx [Accessed 7 June 2024].

29. Home - Mississippi Division of Medicaid. *Mississippi Division of Medicaid* - (2013). Available at: https://medicaid.ms.gov/ [Accessed 8 June 2024].

30. *Medicaid pharmacy: Actual acquisition cost of generic prescription drug products* (Bibliogov, 2012).

31. A. Berrington de Gonzalez, *et al.*, Body-mass index and mortality among 1.46 million white adults. *N. Engl. J. Med.* **363**, 2211–2219 (2010).

32. A. Visaria, S. Setoguchi, Body mass index and all-cause mortality in a 21st century U.S. population: A National Health Interview Survey analysis. *PLoS One* **18**, e0287218 (2023).

33. A. M. Jastreboff, *et al.*, Tirzepatide Once Weekly for the Treatment of Obesity. *N. Engl. J. Med.* **387**, 205–216 (2022).

34. G. Kolata, Doctors Test the Limits of What Obesity Drugs Can Fix. *The New York Times* (2024).

35. Vital and Health Statistics. (2021). Available at: https://www.cdc.gov/nchs/data/series/sr_03/sr03-046-508.pdf [Accessed 14 May 2024].

36. KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs. (2024). Available at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/ [Accessed 7 June 2024].

37. L. A. Eberly, *et al.*, Racial, Ethnic, and Socioeconomic Inequities in Glucagon-Like Peptide-1 Receptor Agonist Use Among Patients With Diabetes in the US. *JAMA Health Forum* **2**, e214182 (2021).

38. A. A. Nargesi, *et al.*, Patterns of medication use and prescription fills for cardioprotective anti-hyperglycemic agents in the United States. *bioRxiv* (2022).

39. A. Montero, G. Sparks, A. Kirzinger, I. Valdes, L. Hamel, KFF health tracking poll July 2023: The public's views of new prescription weight loss drugs and prescription drug costs. *KFF* (2023). Available at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-july-2023-the-publics-views-of-new-prescription-weight-loss-drugs-and-prescription-drug-costs/ [Accessed 13 June

2024].

40. R. Mody, *et al.*, Greater Adherence and Persistence with Injectable Dulaglutide Compared with Injectable Semaglutide at 1-Year Follow-up: Data from US Clinical Practice. *Clin. Ther.* **44**, 537–554 (2022).

41. P. P. Gleason, *et al.*, Real-world persistence and adherence to glucagon-like peptide-1 receptor agonists among obese commercially insured adults without diabetes. *J Manag Care Spec Pharm* 1–8 (2024).

42. J. P. H. Wilding, *et al.*, Once-Weekly Semaglutide in Adults with Overweight or Obesity. *N. Engl. J. Med.* **384**, 989–1002 (2021).

43. W. Ghusn, *et al.*, Weight Loss Outcomes Associated With Semaglutide Treatment for Patients With Overweight or Obesity. *JAMA Netw Open* **5**, e2231982 (2022).

44. Health Insurance Coverage. *National Center for Health Statistics* (2023). Available at: https://www.cdc.gov/nchs/fastats/health-insurance.htm [Accessed 21 June 2024].

45. A Profile of Uninsured Persons in the United States. (2008). Available at: https://cdn.pfizer.com/pfizercom/products/Profile_of_uninsured_persons_in_the_United_States.pdf [Accessed 21 June 2024].

46. Distribution of Body Mass Index Among Adults. *KFF* (2023). Available at: https://www.kff.org/other/state-indicator/distribution-of-body-mass-index-among-adults/?currentTimeframe=0&selectedDistributions=overweight-bmi-250-299--obese-bmi-30-399--severly-obese-bmi-of-40-or-higher&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [Accessed 21 June 2024].

47. United States Diabetes Surveillance System. *Centers for Disease Control and Prevention*. Available at: https://gis.cdc.gov/grasp/diabetes/diabetesatlas.html [Accessed 21 June 2024].

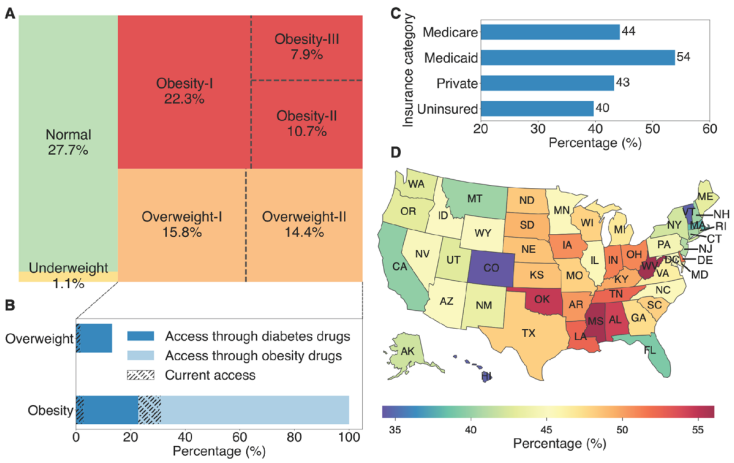


Figure 1: A) Distribution of the US adult population across BMI categories. B) Percentage of population eligible (solid) for weight-loss drugs and proportion that have current access (hatch). C–D) Percentage of eligible population among insurance categories (C) and states (D).

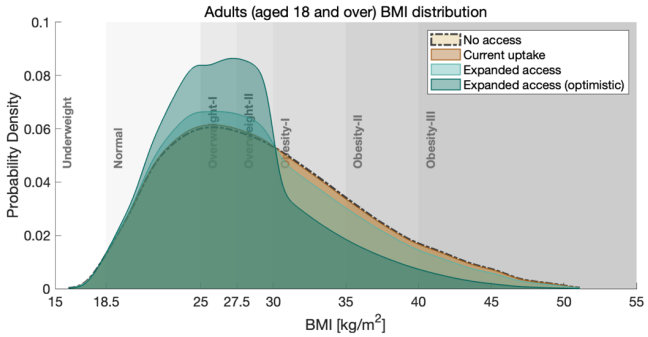


Figure 2: Distribution of the US population across BMI categories with various levels of uptake of weight-loss drugs among eligible individuals.

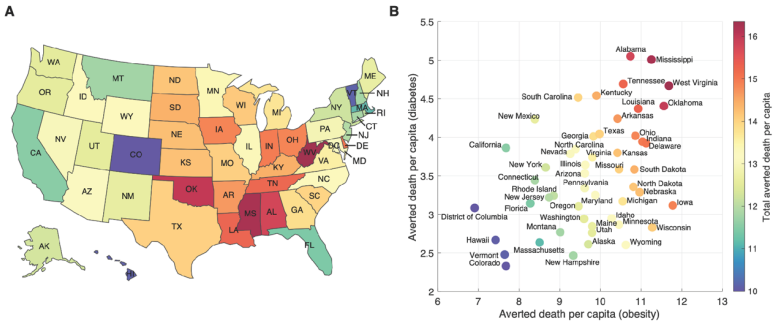


Figure 3: A) State-level annual deaths averted per 100,000 population. B) Distribution of averted deaths per capita among overweight and obese individuals with type 2 diabetes and obese individuals without type 2 diabetes.

Table 1: Mortality averted under the current level of access to weight-loss drugs among eligible and 100% access among eligible.

		Additional lives saved annually	
		No access to current uptake	Current to expanded access
		Mean [95% UI]	Mean [95% UI]
Age group	≥ 18	7,625 [7,613 – 7,636]	43,719 [43,679 – 43,759]
	18–64	6,884 [6,873 – 6,894]	33,560 [33,523 – 33,596]
	≥ 65	741 [737 – 744]	10,159 [10,139 – 10,178]
Drug access	Diabetes	2,332 [2,319 – 2,345]	12,124 [12,059 – 12,190]
	Obesity	5,293 [5,282 – 5,304]	31,595 [31,531 – 31,659]
Insurance category	Private	5,424 [5,416 – 5,433]	20,329 [20,305 – 20,352]
	Medicaid	1,459 [1,457 – 1,462]	8,986 [8,976 – 8,996]
	Medicare	741 [737 – 744]	10,159 [10,139 – 10,178]
	Uninsured	0 [0 – 0]	4,245 [4,241 – 4,249]

Office of the Speaker
North Carolina House of Representatives

TIM MOORE
SPEAKER OF THE HOUSE

September 23, 2024

Hon. Ted Budd
304 Russell Senate Office Building
Washington, DC 20510

Re: Response to State Treasurer Dale Folwell's Statements on the North Carolina State Health Plan

Dear Senator Budd,

Independence from government interference is the hallmark of a free and functioning economy. In North Carolina we are proud to be home to a pharmaceutical industry that provides jobs and economic growth for our communities. Over the past fifteen years, the General Assembly has sought to reduce burdensome regulatory barriers to allow businesses to innovate and create much-needed medical breakthroughs for the world. Additionally, preserving intellectual property is the bedrock of technological advancement and ensures that companies continue to create and push the boundaries of medical science for the benefit of all.

It is troubling to learn of State Treasurer Dale Folwell's position regarding State Health Plan ("Plan") coverage costs for weight loss drugs. He recently joined Senator Bernie Sanders at a forum that advocated for government price controls and the redistribution of privately owned intellectual property through compulsory licensure. Reckless ideas like these would destroy companies that have invested billions of dollars into North Carolina. Additionally, they seem to be scapegoating anti-obesity medicine coverage as the reason for the financial problems facing the Plan when data from the State Health Plan Board of Trustees tells a different story. The coverage loss is ultimately due to the failure of Treasurer Folwell to work out a deal with pharmacy benefit managers; the ones who negotiate the price, not the manufacturer.

On June 3, 2024, I received a letter from Treasure Folwell that specifically highlighted the financial challenges that the State Health Plan faces. He pointed to the need for more funding and identified the "Inflation Reduction Act, coupled with federal regulation changes," as the cause. Further, he stated that these federal regulations "significantly increased the cost of our Medicare Advantage Plans. From zero cost to hundreds of millions over the next several years."

16 WEST JONES ST. • (919) 733-3451 • RALEIGH, NC 27601

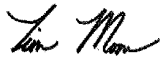
In a July 29, 2024, letter to DHHS Secretary Xavier Becerra, Treasurer Folwell went on to claim that increased costs were the result of "nonstop growth in pharmaceutical prices," with glucagon-like peptide weight loss drugs being a key driver. He further stated that the removal of weight loss drugs from the State Health Plan was because of "corporate greed." These statements do not necessarily align with data provided at a July 25, 2024, State Health Plan Board of Trustees meeting Financial Report.

In that report, data provided indicated that for 2023-24, net pharmacy claims were lower than expected while medical claims were much higher. Additionally, for 2024-2025, net pharmacy claims are the only portion of the Plan that are expected to decrease. Further, the report found that for 2025, Medicare Advantage costs were expected to rise over 487%. Future year projects estimated that Medicare Advantage premiums would jump from $0 to $159 by 2027 with medical claims increases being 2.5 times the net pharmacy cost increase.

Finally, beginning in the 2020 plan year, the State Health Plan instituted its "Clear Pricing Project" ("CPP") at the direction of the State Treasurer. The CPP is a referenced-based pricing model pegging Plan rates to 200% of Medicare's reimbursement for the same services. The new rates represented an increase for primary care physicians and behavioralists who signed onto the new network. However, the new rates also represented a substantial cut to hospitals throughout the state. Due to Treasurer Folwell's failure to effectively negotiate with the NC Healthcare Association, those hospitals refused to join the CPP. As a result, the Plan continues to operate two networks. Segal Consulting, the Plan's actuary, was provided a cost estimate for the CPP of $50 million for calendar years 2020 and 2021. Although the Plan assumed that the additional cost would eventually be eliminated, there is every reason to believe that it persists given that there has been no significant change in the makeup of the network. That additional $50 million represents a significant portion of the cost of the weight loss drugs Treasure Folwell claims have the potential to bankrupt the State Health Plan.

In sum, the Treasurer's math does not add up. While hurling accusations at a convenient target, he ignores the real data from his own Board of Trustees regarding the true cost drivers for the State Health Plan. Even worse, he has advocated for a solution that is tantamount to a socialist takeover of the pharmaceutical industry. I urge you to reject this irresponsible thinking and focus on the problems created by government overregulation and the so-called "Inflation Reduction Act." With proper action, we can limit runaway medical claims costs and continue to provide strong coverage to our state employee and retirees.

Sincerely,



Tim Moore
Speaker of the North Carolina House of Representatives

Enclosures (4):

Segal Projection Summary CY 2019 Q2
June 3, 2024, Letter from Treasurer Dale Folwell to NC General Assembly
July 25, 2024, NC State Health Plan Board of Trustees Financial Report
July 29, 2024, Letter from Treasurer Dale Folwell to DHHS Secretary Xavier Becerra

Segal Consulting
2727 Paces Powers Road NW, Suite 1400 Atlanta, GA 30339
T 678.306.3100 F 678.306.3190 www.segalco.com

September 19, 2019

Mr. Matthew T. Rish
Senior Director of Finance, Planning & Analytics
North Carolina State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

Financial Projection Summary – April-June 2019 (Q2)

Dear Mr. Rish:

Segal Consulting ("Segal") was selected to be the Consultant and Actuary for the North Carolina State Health Plan ("Plan"). Each quarter Segal provides a thorough analysis and 5-year projection of the Plan's financial position. This letter provides a summary of the financial updates for the 2nd quarter of 2019 and key assumptions included in the projections. Additional details can be found in the full report.

Q2 Experience – Apr-2019 to Jun-2019:

For the quarter, Segal collected the actual experience and compared it to what was projected from our prior quarterly report – Q1-2019 (as of Mar-2019). Since the projection is monthly, we summarize the emerging experience for the quarter and produce a detailed variance report. For the quarter ending Jun-2019, the Plan had a $35 million gain, detailed below.

CY 2019 Q2 – Financials (in Millions)				
	Projected	Actual	Change $	Gain/(Loss) %
Plan Revenue	$924.5	$927.9	$3.4	0.4%
Medical Claims	$609.2	$603.3	$5.8	1.0%
Rx Claims less Rebates	$190.5	$178.7	$11.7	6.2%
MA Premium	$43.4	$41.7	$1.7	3.9%
Administrative Expenses	$65.7	$52.9	$12.7	19.4%
Plan Expenses	$908.7	$876.7	$32.0	3.5%
Net Income/(Loss)	$15.9	$51.3	$35.4	
Ending Cash Balance	$1,261.3	$1,296.7	$35.4	2.8%

Plan Revenue was slightly higher than expected, mainly due to higher investment return than projected ($4 million). July revenue was reviewed and found to be consistent with our projection, requiring no additional adjustment.

The largest component of the Plan Expense gain came from lower Administrative Expense. As mentioned in our last report, the Plan has historically run lower than budget. Administrative Expense budgets are provided to Segal for the fiscal year.

The largest non-administrative gain for the quarter was for pharmacy claims, where the Plan experienced a $12M (or 6.2%) gain. Pharmacy claims, which had been running higher in the past, had a gain of $6M this quarter. Additionally, pharmacy rebates continued to run higher than expected, generating another $6M gain. There was also positive experience for the quarter on medical, producing a gain of about $6M (or 1.0%). The final component was a slight gain of $2 million on the Medicare Advantage premiums, due to a gain sharing payment.

This Income/(Loss) from the quarter becomes part of the Q2 12-month average, adding Q2-2019 experience and dropping Q2-2018. The impact rolls forward into future years. For 2019, the medical experience results in an annual savings of about $14M (or 0.5%). The pharmacy experience (claims less rebates) is generating a net gain of $29M (or 2.9%). The changes are compounded over future years.

With revenue assumed to be $3M higher, a $13M gain on Administrative expenses from Q2 experience, and a $1M gain from MA gain-sharing, the cash balance for Calendar Year 2019 is projected to be higher by $60M.

Quarterly Enrollment

Overall, the enrollment for the quarter was consistent with our prior projection, with slight movement between groups.

CY 2019 Q2 - Enrollment	Projected	Actual	Change in #	Change in %
Active & COBRA	498,886	499,757	871	0.17%
Non-Medicare Retiree	57,202	56,447	(755)	-1.32%
Medicare Members, Not MA	24,154	24,664	510	2.11%
MA Members	153,648	153,096	(552)	-0.36%
Total	**733,890**	**733,963**	**73**	**0.01%**

Total membership increased by 0.01%. Active enrollment for the quarter was slightly higher than projected, while retiree enrollment decreased slightly. The overall financial impact of the quarterly enrollment update was negligible, producing a net loss of $0.3M.

Q2 Projection Summary

With Q2-2019 experience, the Calendar Year 2019 Net Income projection is $60M more than the Q1-2019 projection. This experience has a compounding effect in future years. In addition to the updated experience, there were a number of changes that occurred during the last quarter. The largest components include the cost of Clear Pricing Project, lower MA premium rates, HB 226 Funding Rates and the 2020 CVS market check. All these combined produced an increase to the Net Income at the end of 2023 of $467 million as compared to the previous quarterly projection.

The following table summarizes the projected revenue and expense for the Plan:

Financial Projections (In Millions) – as of June 30, 2019						
	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Plan Revenue	$3,606	$3,712	$3,817	$4,098	$4,134	$4,432
Medical Claims	$2,419	$2,453	$2,653	$2,823	$2,948	$3,140
Rx Claims less Rebates	$731	$726	$796	$846	$930	$1,029
MA Premium	$216	$172	$225	$248	$273	$299
Administrative Expenses	$132	$168	$188	$195	$221	$235
Plan Expenses	$3,499	$3,520	$3,862	$4,112	$4,372	$4,704
Net Income/(Loss)	$108	$193	($45)	($14)	($238)	($272)
Ending Cash Balance	$1,118	$1,310	$1,265	$1,251	$1,013	$741

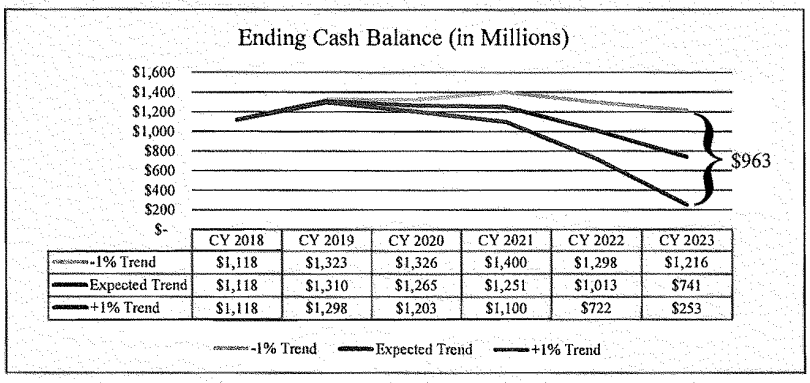
Later in this report we will discuss the key assumptions and projection methodology. From a high level, with 4% legislative funding increases, the program is projected to decrease its cash position by $377 million over the 5-year period. Note that HB 226 included funding increases of 3.3% in FY 2020 and 5.4% in FY 2021 (4% overall). The variation causes calendar year plan premiums to be higher in odd years. Therefore, most of the gain from revenue will be removed in CY 2024, where a lower increase (less than 4%) is assumed.

With the large cumulative gain from the Q1-2019 projection, it is helpful to review all the key components of the change. Below is a summary of the major components.

	CY 2020-2023 (In Millions)		
	Q1-2019	Q2-2019	Gain/(Loss)
Plan Revenue	$16,365.4	$16,481.3	$115.9
Medical			
Experience	$11,533.0	$11,464.6	$68.4
Cost of CPP		$100.0	($100.0)
Rx			
Experience	$3,896.2	$3,766.7	$129.5
New Pricing Guarantee		($103.4)	$103.4
New Rebates Guarantee		($63.0)	$63.0
MA Premium	$1,065.7	$1,045.5	$20.2
Excise Tax	$51.1	$44.5	$6.6
CY 2019 Gain/(Loss)			$60.4
Ending Cash Balance	$274.6	$741.2	$466.6

Sensitivity Analysis

Trend is one of the most important assumptions in the projection. The following table illustrates the cost impact of a total combined 1% difference in Medical, Rx, Rebates and MA Premium trend assumptions:



	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
-1% Trend	$1,118	$1,323	$1,326	$1,400	$1,298	$1,216
Expected Trend	$1,118	$1,310	$1,265	$1,251	$1,013	$741
+1% Trend	$1,118	$1,298	$1,203	$1,100	$722	$253

A 1% trend change can cause the projection for CY 2019 to vary by approximately $25 million. We've discussed the cumulative nature of a long-term projection. As it shows in the chart, a +/- 1% trend can cause the cash balance to accumulate to over a $900M variance by the end of the 5-year period.

Key Assumptions & Methodology

Claim Trends

Trend assumptions are utilized to project the annual increase in per member costs. We develop these by integrating the Plan's historical performance with Segal's Annual Trend Survey. They are updated annually and reviewed with the Plan. Current trend assumptions are as follows:

- Medical: 7.0% in 2019, 6.5% in 2020 and 2021, 6.0% in 2022+
- Pharmacy Claims: 9.5% for all years
- Pharmacy Rebates: 7.0% for all years
- Medicare Advantage Premium: Renewal for 2020, 6.5% in 2021 and 6.0% in 2022+

Note that the MA Premium trend is for medical and pharmacy combined. Also note the MA Rates include the addition of the Health Insurance Fee in 2020 and beyond.

Enrollment

From current levels, there are two major components involved in projecting future enrollment. The first is the overall growth rate of the population. The second is plan selection, including their dependent tier election.

Based on historical enrollment data, actives and COBRA enrollees are assumed to stay at the current level, non-Medicare retirees are assumed to decrease 1% each year and Medicare retirees are assumed to increase 3% each year.

In general, members tend to select plans that best meet their needs. This typically results in a migration to the more valuable plan choice (net of contributions). Segal has reviewed historical migration patterns in each population and have made assumptions as to the ultimate distribution in 2023.

The chart below shows the current distribution and the projected distribution by group and plan.

Group/Plan	Actual Jun-2019	Projected Jan-2023
Active&COBRA		
70/30 Plan	36.3%	33%
80/20 Plan	63.7%	67%
Non-Medicare Retiree		
70/30 Plan	47.6%	50%
80/20 Plan	52.4%	50%
Medicare Retiree		
70/30 Plan	14.6%	12%
MA Base	73.7%	77%
MA Enhanced	11.7%	11%

Linear migration movement is projected between current and ultimate enrollment percentages for years CY2020 to CY 2023. No migration is assumed between tiers.

Given the plan design and contribution changes over the past few years, the enrollment between BCBS plans is not that financially sensitive and somewhat agnostic. This is not the case on the Medicare plans, where there are financial gains as members migrate to the Medicare Advantage program.

Baseline Claims Cost

Baseline claims rates for both medical and pharmacy follow a similar methodology, summarized below:

- Medical claims cost is developed based on expected cost per member per week (PMPW), to account for some months having 5 payment weeks rather than 4. The cost is developed based on medical claims paid during 7/2018-6/2019 with 2-month lagged enrollment data. The PMPW is

adjusted to reflect historical plan changes, enrollment migration and any known experience since the end of the data period.

- Pharmacy claims cost is developed per member per day (PMPD), to account for invoices reflecting the number of days in the period. The cost is developed based on actual net Rx cost during 7/2018-6/2019 with 1-month lagged enrollment data. Like medical, the PMPD cost has similar adjustments, and additionally includes the impact of improved pricing and rebates from the PBM.
- Both Medical and Rx costs are subdivided by each plan (80/20 and 70/30) and by group (Active and Retiree).

Baseline claims costs are then trended and multiplied by expected enrollments and particulars for each month, populating the cash flow projection. Additional details on the calculations can be found in our full report.

Funding Rates

The funding rates and member contributions for 2020 are the existing rates that were approved by the Board in 2019. Member contributions are projected to remain at the current levels while the State funding is assumed to increase as written in HB 226. Although it is assumed that the funding will increase indefinitely at 4% per fiscal year, the variance in the increases between the fiscal years from HB 226 causes the plans to no longer have a uniform 4% rate increase.

It is also assumed that the smoker surcharge of $60 would remain in place at the current level.

Cost of Clear Pricing Project (CPP)

The Plan has completed development of a custom network, effective January 1, 2020. Segal was provided a cost estimate of the CPP to be $50 million for Calendar Years 2020 and 2021. With the TPA Procurement to be effective in 2022, the Plan has assumed the CPP cost will be eliminated. Segal has not reviewed or audited this estimate.

Plan Actuarial Values

The Actuarial Value of the plans are used to calculate the financial impact as members migrate between plans. Currently, the AV for the 70/30 Plan is 74.6% and the AV for the 80/20 Plan is 80.5%. The 70/30 plan changes in 2020 are assumed to cost neutral. This will change slightly over time but in general the relativity between the plans would be fairly constant.

Target Stabilization Reserve

This reserve is set to approximate the amount of operating cash the plan needs to have as a minimum to compensate for variability in payments throughout the year. This was reviewed by the Board and Plan a few years ago and set at 9% of the self-insured medical and pharmacy claims. It is approximately one month of projected claims.

Administrative Costs

The Plan develops administrative costs that are consistent with their budgets. Segal received administrative costs for Fiscal Year 2020 from the Plan. Costs were calculated on a per member basis, and are assumed to increase 3% annually.

ACA Excise Tax

The ACA Excise Tax is currently effective for the Calendar Year 2022. The 40% excise tax is applied to average costs by group above the Tax Free Threshold. Segal assumed the threshold would increase 2% per year.

Other Assumptions

There are a few other assumptions that have less impact on the plan financials that are detailed below for completeness:

- Investment Earnings are estimated at 0.84% of the average annual cash balance
- Medical Claim Refunds are set at 0.6% of previous 3 months of paid claims
- Monthly incurred Medicare Part D subsidies are projected based on experience and adjusted by projected Medicare 70/30 enrollment levels.
- The most recent experience is reflected in the baseline Rx cost and rebates in each quarterly updates. As a result, the guaranteed line item from prior market checks will be reduced quarter to quarter. Additional improvement on Rx cost and rebates for 2020 and 2021 were based on a new CVS market check. No additional rebates improvement for 2020 were assumed since rates appear to be consistent with rebate projections. Additional rebate improvement for 2021 were reduced roughly by 50% to reflect assumed rebate growth assumptions and utilization estimates from CVS. Full pricing improvements were assumed for both years.
- Risk factor of 5% for 2019 and 1% for 2020+ is added to Medicare 70/30 Plan claims cost as members migrate to the Medicare Advantage Plan.

Additional information can be found in the full report.

Certification

The projections in this report are estimates of future costs and are based on unaudited information available to Segal consulting at the time the projections were made. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, changes in group demographics, overall inflation rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period is extended.

Mr. Matthew T. Rish
September 19, 2019

By signing below, I certify that I am a qualified actuary by education and experience to evaluate health reserves and funding practices. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and certify that all analysis was conducted in accordance with all applicable Actuarial Standards of Practice. All sections of this report are considered an integral part of the actuarial opinion.

Sincerely,

Kenneth C. Vieira, FSA, FCA, MAAA
Senior Vice President

NORTH CAROLINA
DEPARTMENT OF STATE TREASURER

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

June 3, 2024

The Honorable Phil Berger
President *Pro Tempore*
16 W. Jones St., Room 2007
Raleigh, NC 27601

The Honorable Tim Moore
Speaker of the House
16 W. Jones St., Room 2304
Raleigh, NC 27601

RE: State Health Plan Funding Assistance

Dear President *Pro Tempore* Berger and Speaker Moore:

The State Health Plan Board of Trustees will be holding a special meeting on June 6, 2024. At this meeting the Board will be asked to vote on State Health Plan (Plan) premiums and employer contributions for the 2025 benefit year, which will begin January 1, 2025. I wanted to make you aware of some of the notable changes we're recommending to the Board, provide you with an update on the Plan's current financial situation, and ask for your financial assistance on behalf of the more than 750,000 members who teach, protect, and otherwise serve, or who have retired from service.

For the past seven years, I, with the support of the Board, have relentlessly tried to place the Plan on a more financially sustainable path by using the Plan's largeness to negotiate better contracts. In addition, we have pushed health care providers towards more transparency, so we know exactly what we're paying for; we have reduced the other postemployment benefits (OPEB) liability; and, with the General Assembly's partnership, we have tripled the value of the Retiree Health Benefit Trust Fund (RHBTF), thus increasing the funding ratio from 2.4 percent to 10.7 percent. This may be one of the largest increases in the United States.

Despite our best efforts, we still face significant headwinds. Below is a summary of the Plan's challenges, which have resulted in the need for this request.

- The Plan faces a $1.5 billion budget gap over the next three years, and the recently enacted state budget funded the Plan by $240 million less than needed.
- The Inflation Reduction Act, coupled with federal regulation changes, has significantly increased the cost of our Medicare Advantage Plans. From zero cost to hundreds of millions over the next several years.
- COVID-related expenses have cost the Plan $528 million, $313 million of which has not been reimbursed by the General Assembly.

3200 Atlantic Avenue • Raleigh, North Carolina 27604
Courier #56-20-45

NORTH CAROLINA
DEPARTMENT OF STATE TREASURER

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

The Board will be asked to vote this week to increase premiums for a substantial number of retired members who have already served the state and live on a fixed income. Approximately 4,200 Medicare-eligible retirees who do not qualify for premium-free coverage would see an increase from $4 to $37 per month, coming out of a monthly average pension benefit of $1,800. Medicare-eligible retirees who cover their dependents would also have to pay this increased amount for their dependents' premiums. Finally, covering this increase for the 160,000 Medicare-eligible retirees who are eligible for premium-free coverage under current law will cost the state an additional $66 million.

On top of these Medicare Advantage costs, the Plan requires additional funding of $89 million to operate within our statutory reserve requirements through the end of calendar year 2025. To achieve this, the Board will be asked to vote on significantly increasing contributions from the retiree trust fund (RHBTF). This need to withdraw additional funds from the RHBTF undermines years' worth of our shared hard work. As you will recall, in 2020, we partnered with the General Assembly to take steps to address the state's $50 billion long-term pension and health care unfunded liabilities. This action allowed the Plan to move $870 million over the last four years into the RHBTF, strengthening the state's financial position and credit worthiness.

My current request is that you authorize the reimbursement of funds which were expended for COVID-related expenses by the Plan as it served its mission of protecting the health of our members. This reimbursement would be used to honor our partnership in reducing the state's unfunded liabilities, by repaying the RHBTF for covering the current funding gap and to continue our efforts towards adequately funding health benefits. These funds could come from the $5.4 billion the General Assembly received from the federal government for this purpose of which, as we understand it less than, $2 billion has been dispersed.

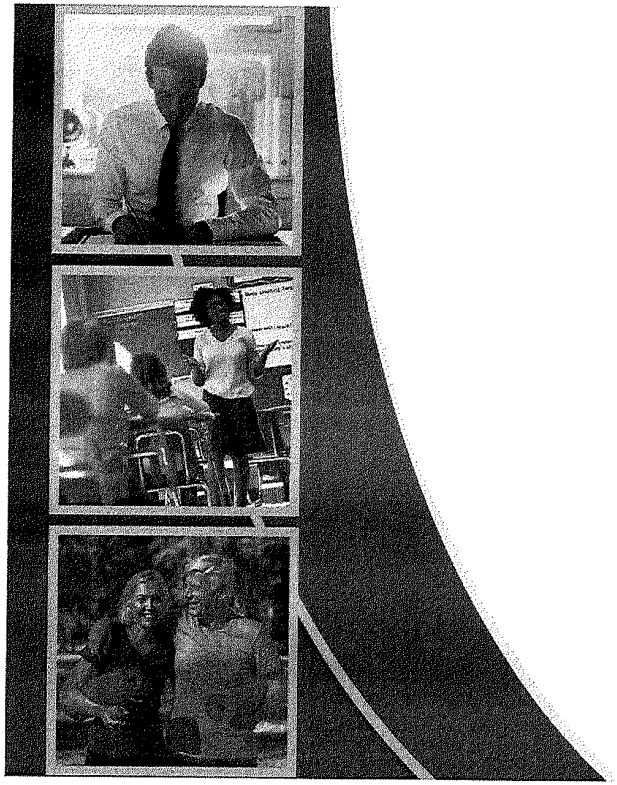
As we move forward, the Plan will be taking steps to improve contracts that will hopefully assist us with making strides for a more sustainable path, but we can't act alone. I urge you to act this session. During a time when state government and teacher vacancy rates are high, we need to provide an affordable, valuable benefit that will serve as a recruitment and retention tool. Investing in the Plan's future isn't political, it's mathematical. The board and I have a fiduciary responsibility to never put anyone ahead of our members. As a primary funder, you have the same fiduciary standard.

Thank you for your prompt consideration of this request.

Sincerely,

Dale R. Folwell, CPA
State Treasurer

3200 Atlantic Avenue • Raleigh, North Carolina 27604
Courier #56-20-45



Financial Report

Board of Trustees Meeting

July 25, 2024

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Dale R. Folwell, CPA
State Treasurer of North Carolina

Overview

The Board's actions over the last year have stabilized the budget situation through 2025. More action is needed to resolve a structural deficit going forward.

- FY 2023-24 Estimated Actual vs. Budget
- CY 2024 Projection vs. Budget
- FY 2024-25 Budget
- CY 2025 Budget
- Projections for CY 2026-27
- Strategies for Balancing the Budget

All dollar figures are in millions.

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

DALE R. FOLWELL, CPA

Projection vs. Budget: Fiscal Year 2023-24

($s in millions)	FY 2023-24 Est. Actual	FY 2023-24 Budget	Difference
Premiums & Subsidies	$4,105.1	$4,141.3	($36.2)
Investment Earnings	$30.5	$5.5	$25.0
Total Revenue	**$4,135.6**	**$4,146.8**	**($11.2)**
Net Medical Claims	$3,087.4	$3,064.5	$22.9
Net Pharmacy Claims	$1,000.2	$1,020.9	($20.7)
Medicare Advantage Payments	$15.4	$16.9	($1.5)
Administrative Expenses	$138.8	$145.6	($6.8)
Total Expenses	**$4,241.9**	**$4,247.9**	**($6.0)**
Plan Income/(Loss)	**($106.3)**	**($101.1)**	**($5.2)**
Ending Cash Balance	**$636.1**	**$645.9**	**($9.8)**

Budget reflects revised employer contribution rates but has not been adjusted for the exclusion of weight-loss GLP-1s.

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Projection vs. Budget: Calendar Year 2024

($s in millions)	CY 2024 Projection	CY 2024 Budget	Difference
Premiums & Subsidies	$4,300.7	$4,282.5	$18.2
Investment Earnings	$25.5	$23.2	$2.3
Total Revenue	**$4,326.2**	**$4,305.7**	**$20.5**
Net Medical Claims	$3,257.0	$3,244.0	$13.0
Net Pharmacy Claims	$992.8	$984.1	$8.7
Medicare Advantage Payments	$15.5	$18.5	($3.0)
Administrative Expenses	$140.8	$138.0	$2.8
Total Expenses	**$4,406.2**	**$4,384.6**	**$21.6**
Plan Income/(Loss)	**($80.0)**	**($78.9)**	**($1.1)**
Ending Cash Balance	**$591.0**	**$590.4**	**$0.6**

Budget has been adjusted for the exclusion of weight-loss GLP-1s.

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

State Health Plan Budget

- The Plan must budget on both a fiscal year and calendar year basis.
- Staff develop the Plan's budget using projections of revenue and expenses in consultation with the Plan's external actuaries.
- Budget Assumptions:
  - No changes to benefits or premiums, except changes that have been approved by the Board.
  - Employer contribution rate = maximum allowed in State budget
- The Board requires the Plan's budget to maintain a year-end cash balance that exceeds the Target Stabilization Reserve (TSR).

TSR = 9% of Calendar Year Claims

~$390M

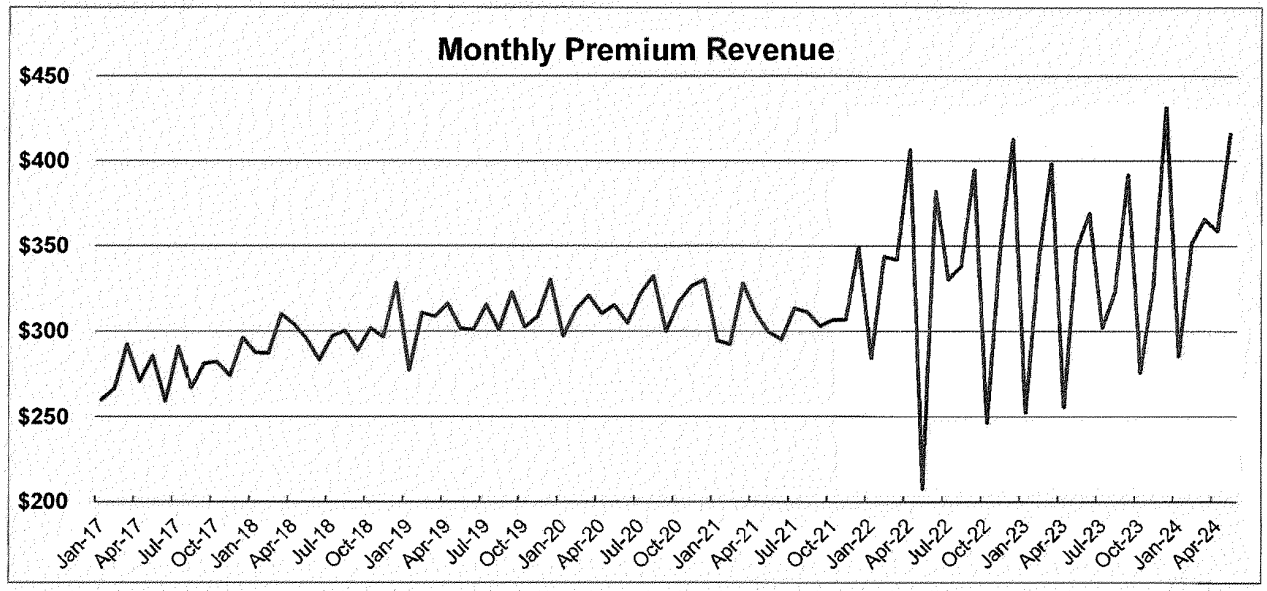
Reserve Adequacy

- The Target Stabilization Reserve (TSR) is an estimate of the minimum amount the Plan needs to pay for services already provided to its members.
- TSR is the minimum amount the Plan needs to manage typical variations in cash flow.
- Additional reserves may be appropriate:
  - To support long-term financial planning and to avoid the need for sudden changes in response to financial pressures, ensuring benefits remain stable and reliable.
  - To provide cushion due to uncertainty in forecast during times of transition.
  - To manage the inherent unpredictability in healthcare costs.

Budget Monitoring and Adjustments

- In recent history, the Plan has maintained significant reserves. As reserves decrease, it becomes critical to more closely monitor the budget and actual spending by:
  - Adjusting the budget to reflect:
    - Modifications to employer contribution rates.
    - Board actions related to benefits, premiums, or significant contracts.
    - Major legislative or federal policy changes.
  - Updating financial projections quarterly to reflect current conditions by incorporating enrollment and claims experience.
  - Monitoring and responding to variances between budgeted and actual figures promptly.
  - Managing significant volatility in timing by adjusting actuals to reflect the timing assumptions of the budget to allow for meaningful comparisons.

Seasonal Variation and Volatility



North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

DALL R. FOLWELL, CPA

New Budget: Fiscal Year 2024-25

($s in millions)	FY 2024-25 Budget	Change from Prior Year	*% Change from Prior Year*
Premiums & Subsidies	$4,393.2	$220.5	*5.3%*
Investment Earnings	$22.5	($8.0)	*-26.2%*
Total Revenue	**$4,415.7**	**$212.5**	***5.1%***
Net Medical Claims	$3,361.0	$273.6	*8.9%*
Net Pharmacy Claims	$991.1	($9.1)	*-0.9%*
Medicare Advantage Payments	$46.6	$31.2	*202.6%*
Administrative Expenses	$168.0	$29.2	*21.0%*
Total Expenses	**$4,566.6**	**$324.7**	***7.7%***
Plan Income/(Loss)	**($151.0)**	**($112.4)**	***291.2%***

Change from prior year is measured relative to an estimate with adjustments for timing.

Ending Cash Balance = $554.2M
$162.5M above TSR

TSR= Target Stabilization Reserve

New Budget: Calendar Year 2025

($s in millions)	Calendar 2025 Budget	Change from Prior Year	*% Change from Prior Year*
Premiums & Subsidies	$4,489.0	$188.3	*4.4%*
Investment Earnings	$20.1	($5.4)	*-21.2%*
Total Revenue	**$4,509.1**	**$182.9**	***4.2%***
Net Medical Claims	$3,377.5	$120.5	*3.7%*
Net Pharmacy Claims	$1,009.5	$16.7	*1.7%*
Medicare Advantage Payments	$91.0	$75.5	*487.1%*
Administrative Expenses	$175.2	$34.4	*24.4%*
Total Expenses	**$4,653.1**	**$246.9**	***5.6%***
Plan Income/(Loss)	**($144.0)**	**($64.0)**	***80.0%***

Ending Cash Balance = $447.0M
$52.2M above TSR

TSR= Target Stabilization Reserve

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Forecast Uncertainty

- **New TPA Transition:** Significant uncertainty in estimating claims savings.
  - Variations in claims adjudication processes and policies between the old and new TPA can lead to unexpected costs or savings.
  - Uncertainty in achieving anticipated savings through new provider contracts and renegotiations.
  - Changes in member behavior and utilization patterns under the new TPA could affect projected savings.
- **Medicare Advantage Premiums:** Future rates are unpredictable due to regulatory changes and market dynamics.
- **Pharmacy Benefit Volatility:** Rapid changes in the sector, such as increasing specialty drug prices, growth of biosimilars, shifting PBM practices, and the introduction of new treatments, increase risk of forecast inaccuracies.

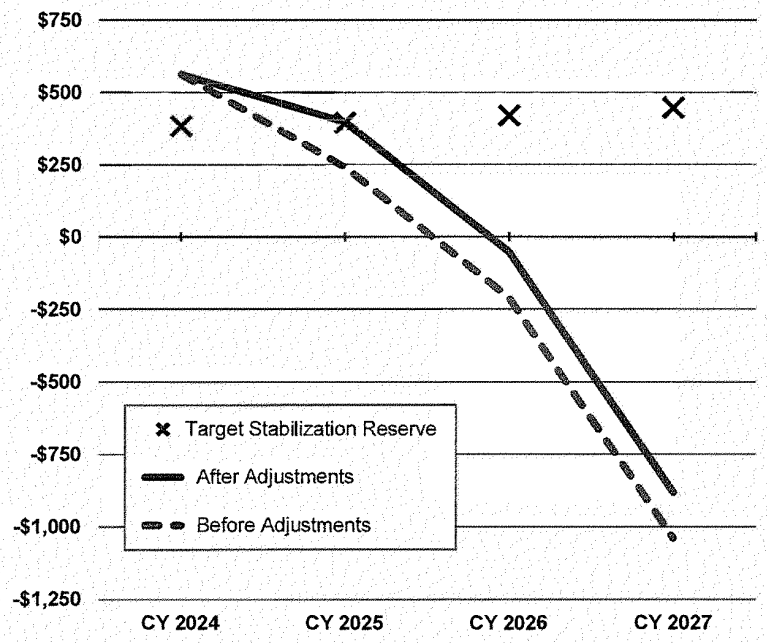
North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Dale R. Folwell, CPA

Beyond 2025: Out-Year Forecast

- Projections for future years are based on the following key assumptions:
  - **State Funding:** 4% increase annually, determined on fiscal year basis
  - **Annual Per-Member Costs:** Projected using customized actuarial trend assumptions
    - Medical Claims: 6.0%
    - Pharmacy Claims: 9.5%
    - Pharmacy Rebates: 7.0%
    - Administrative expenses: 3.0%
  - **Medicare Advantage Premiums:** Increase from current $0 rate to $159 by 2027, based on preliminary renewal estimates.
  - **Investment return rate:** 3.8%, based on recent experience.
  - **Enrollment and plan selection:** Various assumptions based on recent enrollment and migration patterns.

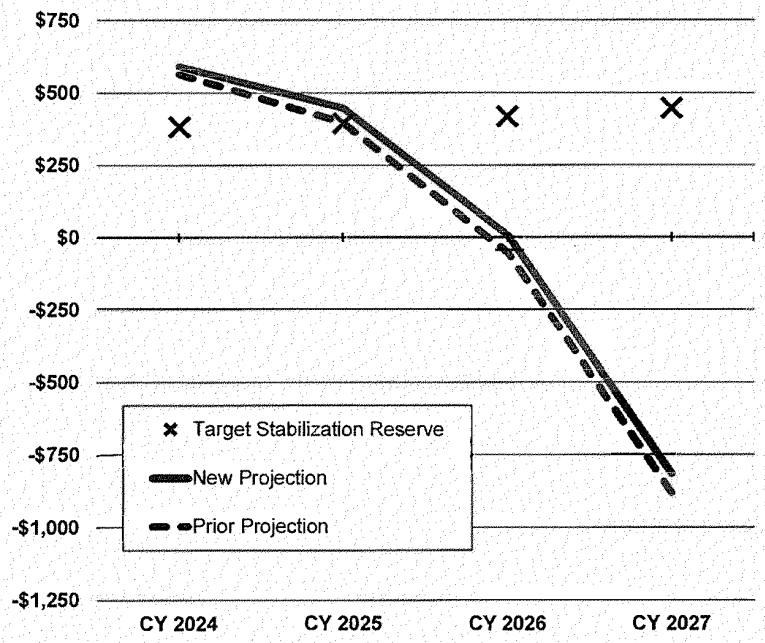
Impact of 2025 Contribution Adjustments on Projections



- Board voted in June to adjust funding for 2025:
  - Increase Retirement System contribution.
  - Increase premiums for dependents and contributory retirees who elect Medicare Advantage plans.
- Brought projected cash balance at end of CY 2025 to just above TSR.
- Only increased funding for CY 2025.

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

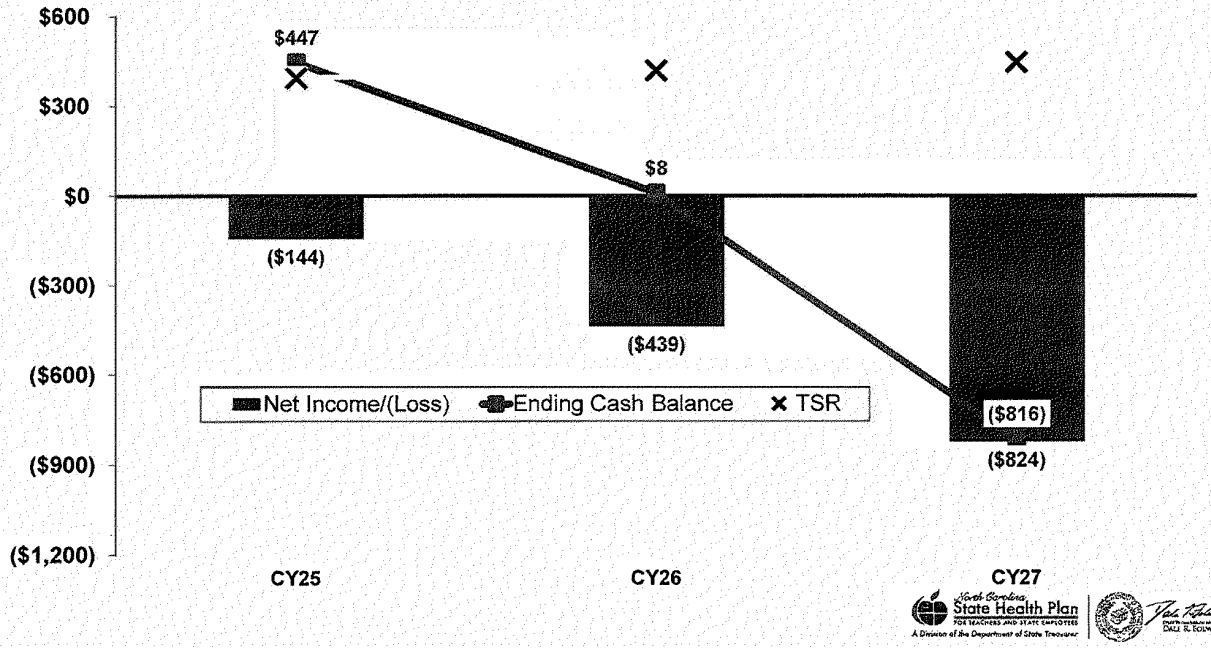
Impact of Other Adjustments on Projections



- Projection improved due to:
  - Higher interest rate assumption
  - Slightly lower expected claims expenses.
- Cash balance now expected to exceed TSR by $52 million at end of 2025.
- Cash balance expected to fall below TSR in early 2026.
- Without action, likely to be unable to pay bills in fall 2026.

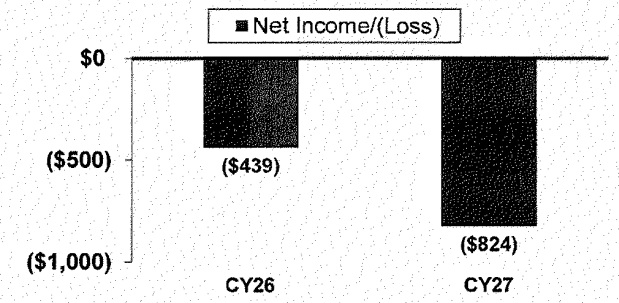
North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

Revised Projection: Financial Results by Plan Year



Strategies for Balancing the Budget

- To achieve a balanced budget, the Plan needs a strategic approach that combines increased funding and reduced expenditures.
- At the next Board meetings, we will present detailed options for addressing the budget shortfall.
- The Plan requires approximately $440 million in 2026 and an additional $825 million in 2027.



North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

DALE R. FOLWELL, CPA

Strategies for Balancing the Budget

- **Cost Reduction Strategies:**
  - Work with TPA to secure lower rates through provider network strategy.
  - Develop approaches to better differentiate between plans.
  - Use data to manage and reduce pharmacy benefit costs.
  - Review existing contracts for cost-saving opportunities.
- **Additional Funding Opportunities:**
  - Request increase in employer contribution rates from General Assembly
  - Request additional reimbursements for over $316 million in unreimbursed COVID-related costs.
  - Obtain higher federal subsidies by reopening the Employer Group Waiver Plan (EGWP) for Medicare retirees and maximizing Retiree Drug Subsidies (RDS).

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

3200 Atlantic Avenue • Raleigh, NC 27604 • Phone: 919-814-4400 • Fax: 919-814-5817 • www.shpnc.org

July 29, 2024

Honorable Xavier Becerra
Secretary, United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Need for Federal Action Due to Unaffordability of GLP-1 Weight Loss Drugs

Dear Secretary Becerra,

I write today to call attention to the unaffordability of glucagon-like peptide weight loss drugs ("GLP-1 drugs") and request that the federal government license these products to reduce their cost to patients and state and local governments.

The North Carolina State Health Plan for Teachers and State Employees ("Plan") is a program of the State of North Carolina that provides healthcare benefits to eligible North Carolina teachers, state employees, retirees, and their dependents. The Plan is led by the North Carolina State Treasurer, and oversight is provided by the Board of Trustees for the Plan ("Board"). The Board is a bipartisan body that includes trustees representing key segments of the population the Plan serves.

Like many state and local health plans nationwide, due to the rapid and unabated increase in healthcare costs and without a commensurate increase in funding to keep pace, the Plan is facing a $1.3 billion budget gap over the next three years. This budget shortfall is in addition to the liability the Plan faces for future healthcare needs of its members. Together, these are an existential threat to the Plan.

For the last seven years, we have worked to address this threat, making it the Plan's explicit policy to cap or reduce its costs while implementing initiatives that would enable it to lower dependent premiums to attract families into the Plan. We have implemented finance-improving measures across the Plan's entire area of operations.

Despite our ongoing efforts, healthcare costs have continued to rise and budget shortfalls persist threatening the financial sustainability of the Plan for current and future members. One of the key drivers of this threat is the nonstop growth in pharmaceutical prices, at the core of which are the unreasonably high prices for GLP-1 drugs.

GLP-1 drugs have swallowed up a critical share of our cost savings, which the Plan would have liked to use to pass on to families through lower premiums. The price of GLP-1 drugs forced us into the position in which continued coverage of these drugs at current prices would have necessitated the Plan to double health benefit premiums for every member—the exact opposite of our goals.

Therefore, to protect the fiscal solvency of the Plan for current and future members and safeguard the goal of lowering member and family premiums, the Plan was required by a vote of the Board to remove benefits coverage of GLP-1 drugs when used for the purpose of weight loss.

Simply, we were forced to remove the benefit because of corporate greed. For example, Novo Nordisk charges Americans almost fifteen times more for GLP-1 drugs than it does in other countries. This cost is born by all payers of healthcare—employers, state and local governments, and the federal government.

The Plan has repeatedly sought to negotiate with the manufacturers of GLP-1 drugs to sell their products to us at a fair price. Yet, every offer that we have proposed has been rejected. It has become abundantly clear that these manufacturers do not want to sell their products at a reasonable price to the Plan, which is made up of those who teach, protect, and otherwise serve. These manufacturers are currently in a position of power and, if the Plan covers their drugs, they intend to squeeze us to boost their corporate profits.

This is a problem that needs a federal solution.

Accordingly, after consultation with our Board of Trustees I request the United States Department of Health and Human Services ("HHS") open efforts with GLP-1 branded manufacturers to voluntarily license their products to provide GLP-1 drugs to federal, state, and local government payers, including employer health benefits programs like the Plan. In taking this action, HHS will supplement the supply and increase the affordability of GLP-1 drugs available in the market. HHS would also be able to seek royalty terms in that license that would reasonably compensate these manufactures.

Thank you for your attention to this issue and I stand ready to assist this effort to improve the availability and affordability of GLP-1 drugs.

Sincerely,

Dale Folwell, CPA

Dale Folwell, CPA
Chair, Board of Trustees
North Carolina State Health Plan

CC:

Senator Bernie Sanders
332 Dirksen Senate Office Building,
Washington, DC 20510

Senator Thom Tillis
113 Dirksen Senate Office Building
Washington, DC 20510

Senator Ted Budd
304 Russell Senate Office Building
Washington, DC 20510

Representative Don Davis (NC-01)
1123 Longworth House Office Building
Washington, DC 20515

Representative Deborah Ross (NC-02)
1221 Longworth House Office Building
Washington, DC 20515

Representative Gregory Murphy (NC-03)
407 Cannon House Office Building
Washington, DC 20515

Representative Valerie Foushee (NC-04)
Longworth House Office Building, 1716
Washington, DC 20515

Representative Virginia Foxx (NC-05)
2462 Rayburn House Office Building
Washington, DC 20515

Representative Kathy Manning (NC-06)
307 Cannon House Office Building
Washington, DC 20515

Representative David Rouzer (NC-07)
2333 Rayburn House Office Building
Washington, DC 20515

Representative Dan Bishop (NC-08)
2459 Rayburn House Office Building
Washington, DC 20515

Representative Richard Hudson (NC-09)
2112 Rayburn House Office Building
Washington, DC 20515

Representative Patrick McHenry (NC-10)
2134 Rayburn House Office Building
Washington, DC 20515

Representative Chuck Edwards (NC-11)
1505 Longworth House Office Building
Washington, DC 20515

Representative Alma Adams (NC-12)
2436 Rayburn House Office Building
Washington, DC 20515

Representative Wiley Nickel (NC-13)
1133 Longworth House Office Building
Washington, DC 20515

Representative Jeff Jackson (NC-14)
1318 Longworth House Office Building
Washington, DC 20515

FTC sues pharmacy insurance managers, alleging unfair drug prices

Business practices of the three largest PBMs resulted in higher list prices for insulin, the FTC alleges.

By Daniel Gilbert

September 20, 2024 at 2:20 p.m. EDT

The Federal Trade Commission sued the three dominant pharmacy-benefit managers in the United States, alleging they inflated the cost of insulin by using their position as middlemen in the U.S. drug supply chain to win a higher cut of funds from drugmakers.

The agency alleges that PBMs, as they are known, benefit financially when the list price of insulin is higher, enabling them to extract heftier rebates from the manufacturers of a product that is essential for people with diabetes. According to the FTC, the three largest PBMs — CVS Health's Caremark, Cigna's Express Scripts and UnitedHealth's Optum Rx — used their power to exclude cheaper insulin products from the menu of medications they make available to patients through insurance, instead favoring versions that gave them juicier rebates.

That has left certain patients, such as those with high deductibles, vulnerable to paying more out of pocket, according to the FTC. In a statement, the FTC wrote that an executive at a PBM acknowledged this strategy for insulins, saying that the big three PBMs continue to "drink down the tasty … rebates."

PBMs pushed back Friday on the lawsuit, contending that the FTC has mischaracterized their role in drug prices.

"This action continues a troubling pattern from the FTC of unsubstantiated and ideologically driven attacks on pharmacy benefit managers," Andrea Nelson, Cigna's chief legal officer, said in a statement.

Cigna's Express Scripts sued the FTC on Tuesday over an interim report issued in July on PBMs, alleging it is "riddled with false statements" and seeking its retraction.

CVS said Friday the FTC was "simply wrong" and that it has "negotiated deep discounts on behalf of our clients" and "helped bring insulin back to affordable levels for their members."

Optum Rx called the FTC's lawsuit "baseless" and that it "demonstrates a profound misunderstanding of how drug pricing works."

The FTC said that PBMs aren't necessarily the only ones to blame for high insulin prices, and that its Bureau of Competition "remains deeply troubled by the role of drug manufacturers" including Eli Lilly, Novo Nordisk and Sanofi that dominate the insulin market. The bureau "may recommend suing drug manufacturers" in the future, the FTC said.

Insulin, a hormone produced by the pancreas, helps the body control blood-sugar levels. For people with diabetes, a condition affecting more than 38 million Americans, their bodies don't make enough insulin. Some require a daily dose to live.

The three drugmakers all announced major cuts to the list price of their insulins last year, facing public and political pressure to rein in prices. The Inflation Reduction Act also caps the cost of insulin at $35 a month for patients covered by Medicare Part D, the government's prescription drug benefit for seniors.

PBMs, a unique feature of the American health-care system, emerged to negotiate with drugmakers and bring down prices. They receive a cut of the savings in the form of rebates and fees. The higher the drug's list price, the more money PBMs can make, according to the FTC, which alleges that they pocket hundreds of millions of dollars a year from rebates and fees.

Insurance companies hire PBMs to administer their pharmacy benefits, which include a list of prescription drugs that they cover. Those lists, or formularies, play a role in how many patients have access to a given prescription drug, making it important for drug manufacturers to ensure their products are on the list.

According to the FTC, the PBMs leveraged their power to extract higher rebates from drugmakers in exchange for giving them access to their formularies. Even when cheaper insulins became available, PBMs "systematically excluded them in favor of identical high list price, highly rebated versions," the FTC alleges.

Patient Stories:

Jackie Adams (Pendleton, OR - June 5, 2023)
I have diabetes, and I take Ozempic. For three months, I have paid around $795.00. I can't afford that, so instead of every week, I take it every other week, sometimes every two weeks.

Lawrence Goodell (Colony, KS - December 11, 2023)
My wife and I both were taking Ozempic for our diabetes, before its craze. We were getting it for both of us for $15.50 each a month thanks to a program. It then went to over $700 a month, which I think anyone on Medicare can't even afford to pay for any type of medication. It was working well for us until the price went up.

Cathy Byers (Clinton, IA - November 28, 2023)
I have been on Farxiga, Trulicity, and Ozempic for my diabetes for over 5 years. All are very expensive and I have had to max out my credit cards for my health. It is not right that the government covers insulin and not other diabetes medications. One thing everyone should know: not all diabetics can take insulin. Some of us need other medications too.

Melissa Coleman (Marshall, MI - June 2, 2023)
I'm diabetic and I just can't get my medication that I need. Again, I have been without Ozempic for 3 weeks which costed around $50 a month.

Barbara Dehoff (Homosassa, FL - December 11, 2023)
In order to keep my Type 2 diabetes under control, I was prescribed Ozempic. It has worked beautifully, but by May, I was in the Medicare gap and needed to pay $249 a month. As a retired person, that is a great deal of money. My son was able to help me out a few months, but in order to have enough to start when it will be cheaper, I had to cut back on to using it every other week. I will now need to return to work to assist my payments.

Penny DeLaPorte (Hunnewell, MO - November 20, 2023)
I'm a diabetic taking Ozempic. I work full time as a RN for over 40 years now and Ozempic has been the best drug to control my blood sugar with the added benefit of

some weight loss. My mother died young from complications from diabetes. I am 60 years old and trying my best to live healthier and longer, but it is hard to do so with the cost of Ozempic and other medications after insurance.

Tamara Drought (Poplar Grove, IL - December 14, 2023)
My doctor prescribed me Ozempic because of my severe obesity and diabetes, but it was hard to get it approved through my insurance. I was on it for 3 months and was losing weight and starting to feel better with my A1c level coming down too! Then it abruptly stopped. I can no longer get it at an affordable price. What a shame.

James Fossier (Plano, TX - December 4, 2023)
My Ozempic went from $11 to $220 then to $700 because of its popularity. I can't afford it and stopped taking it which consequently made me gain 22 lbs in a month.

Mary Kiesel (Fort Branch, IN - December 14, 2023)
I need Ozempic to get my blood sugar levels where they need to be. It is ridiculous how expensive it is. I need to get my knee replaced but my A1c level is too high. I am afraid I am going to fall because of my knee then.

Jill Kimm (Ankeny, IA - December 11, 2023)
I'm on Ozempic and Repatha and have diabetes, coronary artery disease, and cerebrovascular disease from severely high cholesterol. I had to stop both this month as I'm in the Medicare gap. Please fix this!

Sylvia Lopiccolo (Slidell, LA - November 21, 2023)
I have Type 2 diabetes with a high A1C. The doctor put me on Ozempic which has brought my labs down. But my last script was $749 after insurance. That is insane.

Olga Marrero (Sunrise, FL - November 15, 2023)
I was very ill with Asthma so I was prescribed Trelegy Ellipta and also needed to lower my sugar AIC so I was also prescribed Ozempic, which was helping. However, because of the severity of my illness combined with the expense of my medications - my insurance limit was reached so for the last 3 months I have been unable to afford both

of these medications along with a notice that my insurance will not cover my Ozempic next year without a doctor's note. This is entirely frustrating.

Norma Miller (Saint Francis, ME - November 21, 2023)
I'm taking Eliquis which started out at $47 per month. Now my next bill will be over $600 plus my Ozempic at $240. This is due to the Medicare donut hole. To me its just greedy.

Geri Moisan (Michigan City, IN - November 29, 2023)
I was on Ozempic and my insurance was paying for it until they stopped. Now I have to pay for it and I certainly cannot afford it. It is very expensive.

Belinda Morris (Springboro, OH - June 2, 2023)
I am diabetic w/ very high unstable sugars (HBA1C). My doctor suggested we tried Ozempic for 2 months & my mother paid for it as after checking around for the best price, it still was over $200 w/ Humana ins. If that was the only med I took we could manage it but I take approx. 16 meds & none are free. I take 2 types of injectable insulin now $70 for 30 day supply. Then I have to have meter, testing strip & needles. That's all for just 1 medicine.

Elizabeth Nelms (Clifton, CO - October 11, 2023)
I decided to share even though Mounjaro is not in your list because it works very similar to Trulicity for diabetics. I was taking Trulicity and was receiving it through a patient assistance program but it wasn't working well for me so my doctor recommended Mounjaro as it was showing great promise in blood sugar control. So, I decided to try it. It works beautifully!! However, it was not covered by the patient assistance program since it was new on the market. Well, when it was run through Medicare and my Anthem supplement, my copay came out to a whopping $278.00 a month! Since I am still working full time and have opted to receive my Social Security as well, I am currently able to afford to continue to pay for it. However, I am soon to be 68 years old and would like to retire. It just sucks that I can't consider doing so if I want to keep receiving my Mounjaro to help control my Diabetes! How are people on fixed income supposed to live a full life if they can't afford to get their medications???

David Earl Pearson (Corpus Christi, TX - December 14, 2023)
Both my wife and I are on Jardiance and Ozempic for diabetes. Each of us would have to pay $300 a month to buy these drugs, even with insurance, until we reached our Medicare coverage gap where it then jumped to $1,000 a month.

Sandra Porter (Tyler, TX - December 5, 2023)
Medicare pays for medications, but Ozempic is unavailable because it's on back order. It's been 3 months! I have been on it for 6 months. I need it for my diabetes and weight loss.

Sebastian Robbins (Belton, TX - December 14, 2023)
I am a transgender male patient. I recently had to miss one of my testosterone shots because of pricing. My mother is on Ozempic and I also fear she won't be able to afford that medication long term.

Teresa Roberts (Lamar, MO - November 28, 2023)
My husband is diabetic and we're on Medicare and a fixed income. Ozempic is so high for us, yet if we're not on Medicare, it is a reasonable price. Same with Xarelto.

Nancy Roderick (Westbrook, ME - December 12, 2023)
I am on a fixed income and am in need of Ozempic, which I stopped taking due to costs. My diabetes is stabilizing with this medication. I have been retired since 2016 and strive to find affordable medication yearly.

Marylou Ross (Floresville, TX - November 15, 2023)
I am on Trulicity, Ozempic, Mounjaro, and Janumet, which are all diabetes medications which are too expensive for seniors, especially if you are in the gap of Medicare coverage.

Dicie Shoemaker (Cottonwood, CA - June 2, 2023)
I am diabetic and take Ozempic insulin. The price is outrageous when your co-pay is between $747 to $1100 for a prescription. I can get the same Lily brand drug in Mexico for $41 to $65.

Patricia Tarant (Winder, GA - November 15, 2023)
I am Type 2 diabetic and am prescribed Ozempic which I cannot afford at $1,200 cost. Fortunately, I was able to get it free through the manufacturer due to my low income.

Tracy Wood (Mesquite, TX - December 2, 2023)
I have been on Ozempic for 2 years but only take it for 6 months out of the year because of the price. I am Type 2 diabetic.

First name	Last name	Your Rx Cost Impact Story	Manufacturer Cited	Sacrifice Mentioned
Martin	Smith	My employer just started offering an insurance plan with drug coverage that I found to be affordable this year and it happened to be with an insurance that I thought was good. So I signed up this spring and I was prescribed one of these medications by my doctor at the start of this summer and it was life changing. No longer thought about food 24/7 and I was able to start losing weight (30 pounds in 12 weeks). Due to the costs associated with them my insurance (blue cross of Michigan) changed their policy's and I havnt been able to get a refill since early August. I am waiting for a new pre authorization that I hopefully qualify for. During this process I learned that no matter the outcome for me blue cross will no longer cover these medications for weight loss next year due to the high costs anyway.	Other/Unspecified	TRUE
Tamika	Richmond	My Rx cost impact story begins with me being diagnosed with type 1 diabetes 41 years ago. As an adult I've always worked hard to have the things I want and need. I've also been fortunate enough to always had insurance through my jobs. With that being said, having insurance is a blessing but doesn't mean much these days for me considering the cost. I've now started a 2nd job to pay for my diabetic medications. My doctor recommended a GLP-1 medication for me because of insulin resistance and a number of several other comorbidities I suffer from as a result of type 1 diabetes. I have a 4000.00 deductible insurance plan, my insurance will not cover the GLP-1 medication that has changed my life because I don't have type 2 diabetes(I have type1) with all of the traits of type 2 diabetes. It cost me over 1000.00 to obtain this life changing medication that my doctor has documented the life changing events concerning my health. It's so sad that I can't afford a medication that helps assist in my quality of life. My insulin I take to live, and these GLP-1 medications as an adjunct therapy with the insulin saved my life. Please help make it affordable for me and those like me.	Other/Unspecified	TRUE
Tracey	Felice	I am retired so medicare has no coverage for GLPs foe weight loss. Being a senior on a low income I cannot afford the cost of GLP meds.	Other/Unspecified	TRUE

		I am a very strong believer in capitalism. Socialism I am afraid of. In between these two are necessary rules, regulations, controls snd laws to ensure consumers are being treated fairly. I also understand the lengthy and expensive process to bring a helpful drug to market. I also appreciate the capital investments required to manufacture new drugs and devices. I have been a shareholder in Lilly (Zepbound, Mournjaro) for three years and have made a handsome return. Well above any stock market averages. I am also a patient with a chronic health issue driving heart (AFIB) and pre-diabetes issues. I am medicated to manage these. Obesity is a chronic disease. I realize all I need to do is consume fewer calories, expend more calories and eat healthier foods. Am I a weak person? I don't think so. I quit tobacco, alcohol and caffeine in an effort to improve my health. Chronic obesity is a struggle in society. What has caused this? Fast food and soft drinks, less education in school, elimination of PE in school or other factors? This is where the discussion needs to begin.. Consumers don't like preventative measures. The try and fix health problems after the fact. That is a fact. GLP1's are the most efficacious drug to help with weight loss. Its proven in many clinical studies to improve outcomes across a range of issues including weight, heart health, diabetes (A1C) and sleep apnea. Further studies may demonstrate other positive effects across other disease states. To address my chronic obesity, I began taking Zepbound December 27, 2024. I am a senior on a fixed income without a part D plan for drugs. Hence, I pay about $1000 per month at Walgreens. This price includes the use of discounts that are available. Because I am on Medicare, I am excluded from being able to utilize the $500 rebate from Lilly. To add insult to injury, Lilly Has not been able to service the market due to short supply. They did not manage distribution of their products well and allowed their retail partners to continue selling starter doses to new consumers, even as the other dosages were in very limited supply. This had the result of causing untold thousands of consumers to not be able to obtain their proper doseage, Having to discontinue it or to return back to the initial starter dose. This has been a classic		
Tom	Wilson	example of total mismanagement of the supply chain. They needed an allocation plan .	Eli Lilly	FALSE
		I work full time at a local elementary school and my husband works full time with a local utilty/communications company. I have amazing insurance, but the only thing they absolutely refuse to cover is anything related to weight management medications. I have an extremely high BMI, and am pre-diabetic. My GLP-1 medicine has been a life saver. It has given me my energy back, helped me get back into a healthy eating routine, gotten my BP under control, just to name a few. In the 5 months I've been taking it I have almost lost 60 lbs. But, the cost is killing us. Three children, we live in a very expensive area of the country, and we have full time jobs with a decent annual income. But I had to start donating plasma weekly and door dashing my evenings and weekends in order to afford this life saving medication. And let's be real, it is saving my life because it's helping me get to a healthy BMI and it's helping me develop healthy eating and exercising habits because the food noise is gone. I can't imagine what people who do not have the resources I have, and the ability to do the extra things to make the income for the medicine, are doing to cover this medicine. I also don't understand why it isn't covered by insurance when it truly will end up costing insurance companies less in the end because people will be healthier. Please do something to help us! Help those that have started working 15+ additional hours a week just to afford		
Brandi	Balducci	medicine. Help those that don't have the ability to work additional jobs just for medicine.	Other/Unspecified	TRUE
Sara	Lierman	I pay $550 a month because my insurance will not cover this. This has been a financial burden and can't afford some months and try to spread out. I wish we could get coverage by insurance or much cheaper	Other/Unspecified	TRUE

Leesa	Hark	I've been forced to not take my GLP-1 medication as prescribed due to the high cost of the medicine. This medication has helped to lower my blood pressure and cholesterol leading to my overall better health. After I run out of my most recent refill I will no longer be able to afford my medication and will be forced to stop taking a medication the my doctor has prescribed for my medical conditions. This will lead to a decline in my health and an increased risk of heart attack and stroke.	Other/Unspecified	TRUE
Deana	Gray	I have been struggling for the biggest part of my adult life with obesity. I've had migraines, high blood pressure, and overall depression due to being overweight. I'm 52 and my hormones (menopause) are all over the place. I've been on every diet/medication and had personal trainers along with dieticians. Nothing has ever helped me like the glp1 medication has. I started on a glp1 in August of 2022. I've lost 70lbs and feel amazing. I no longer take blood pressure meds. My menopause symptoms and migraines are under control. I can't express how much this medication has helped with my mental health as well. My insurance does not cover any kind of weightloss medication and I can't afford to pay out of pocket for it. This medication has saved my life literally! I pray that it becomes affordable soon.	Other/Unspecified	TRUE
Tanya	Storm	I was taking Trulicity a couple of years ago, via Calibrate. They helped me get it covered by insurance. But it was often out of stock so there were many gaps in my taking it. But even still, I was finally losing weight! After about 9 months, I lost my job. When I found a new job, my insurance refused to cover any GLP-1 drugs, as I am not a full blow. Diabetic. . At $1000+ a month there's no way I could afford them, so that was the end of that. :(	Other/Unspecified	TRUE
Carol	Cinquemani	My weight has been a life long issue for me. My all time high was 450 pounds. I am now 325 and being on Zepbound has been life changing for my health as well as my mental and emotional health. The costs are super hard for me and I am losing all my savings to do this because I want to live. I often justify this cost by telling myself I will not get weight related health conditions with the family history I have and not paying for future doctors, medicine or healthcare. Honestly the best thing to help reduce the cost of healthcare rates that are continuing to rising is for us to become healthier and prevent high cost health issues. If we reduce costs to these medicines, you will be saving costs overall. I still have alot to lose and if it the costs increase, I might not be able to continue. We can do better as a country to help people be healthier!	Eli Lilly	TRUE
Holly	Massey	I have been a teacher for 28 years and what they say about teacher salaries is true. My husband has severe type 1 diabetes and is unable to work. As the only provider in my household (we have a teenage daughter), it is very important that I stay as healthy as possible to be able to continue working and make ends meet. I have always struggled with my weight and at 313 pounds, I was struggling to teach due to foot, knee and hip pain, I started Zepbound in June of 2024. I have paid $550 a month for it and have lost over 33lbs. It is working and I am starting to feel better and able to be more active. The problem is that I can't keep paying $550 a month. Additionally, the savings card from Eli Lilly only works for one year. Then, I will be paying $1200 a month for 4 shots. There is no way we could ever afford that. I fear that my progress will end soon if I don't get some help with the cost.	Eli Lilly	TRUE
Susan	Satterlee	I am a Paramedic! I work in the Midwest. I am pre-diabetic and have a family history of diabetes in both sides of my family. I am also 54 and post-menopausal. I had a job that covered Mounjaro but switched to a hospital service that refused cover any weight loss treatments for their coworkers. For me to be able to keep talking my medication I have to pay out of pocket. I am on 10 mg but get the highest dose so I can split them so they last longer. I have no idea what I am going to do when I need to rotate up to a higher dose. To be able to afford this I work about 140-170 hours every 2 weeks. Keep in mind there are only 336 hours in 2 weeks so I am gone from home half of the time. This is very hard on my family but my husband ands kids are supportive because they know it means a lot to me. Can you imagine the impact on the family let alone the person working these kinds of hours with the stressors of this kinds of job. Lack of sleep and lack of proper nutrition being the major negative impacts. My job is a lot of the problem yet I work for a hospital, a Catholic hospital, that refuses to help and, in fact, discriminates against their coworkers that are overweight. Imagine the frustration seeing all the advertisements about their bariatric treatment centers knowing my employer won't help but stress the importance of taking care of yourself ama work-family balance! I in no way shape or form like working this much but I'm also trying to fight a disease and stop it from getting worse and all these big businesses think of is money, money, money! I have several times investigated getting medication from outside the US. I don't understand why all the people think it's OK to rape and pillage US citizens!	Eli Lilly	TRUE

Shelby	Kidd	Completely having to go compound because even though I'm still struggling to loose weight I do not qualify/cannot afford the real drugs because my "numbers" are too good. I'm insulin resistant with PCOS. Whole family line has a history of diabetes and just found out i have fibromyalgia. The compounds are running up my credit card bills and I may have to come off those. I lost about 130lbs on my own and these medications have helped me loose another 30lbs.	Other/Unspecified	TRUE
Loreen	Kraft	I'm on SS and so I have medicare and they won't cover the cost of the Mounjaro or Zepbound or any others that can help me keep my A1c down. After being on Mounjaro I lost around 60lbs and my A1c went from 5.9 to 5.2. I was pre-diabetic. I just want to keep getting healthier and I don't want to put the weight back on and I want so bad to lose around 40lbs. Please, someone help me with this. I am on a very limited income and still have to pay a mortgage etc out of it. Thank you for anything you can do for all of us in need of getting health. Kindly, Loreen Kraft	Eli Lilly	FALSE
Lorraine	Ellis	I am an obese middle age woman with several comorbidities as well as psoriatic arthritis. I've tried, dieting and weight loss surgery to no avail. As a last ditch effort I tried Mounjaro when the coupon was out for people with no insurance coverage. I lost 75 pounds and was feeling so much better in general. I was more active and my arthritis wasn't hurting as much. I was able to lower my cholesterol medication to the lowest dose and completely get off my blood pressure medication. Then the coupon ended. I actually found a new job that would cover these medications but even with my benefits and the coupon I still couldn't afford it. It's been almost a year since I've been off the Mounjaro and I've struggled so hard to keep the 75 pounds off. I've gained 30 pounds back in spite of eating a very strict diet and exercising as much as my body can take. I am back on higher doses of cholesterol and blood pressure medication. My arthritis symptoms are ramping up again and I feel awful most of the time. I've contemplated suicide because I cannot afford most of the medications I need to keep my arthritis controlled. With the Mounjaro I only had to take the cheap disease modifying anti-rheumatic medication. Now I have to take biologics that I can only afford once every few months instead of the monthly I'm supposed to do. PLEASE consider making all pharmaceuticals more affordable but especially GLp-1s. I felt like Mounjaro was giving me my quality of life back instead of wanting to die at 55.	Eli Lilly	TRUE
Elizabeth	Troub	I pay $550 a month for Zepbound, because the manufacturer has a coupon currently. I have lost 75 pounds on this medication! Medication that I really need to continue but cannot because I can't afford it. I have 4 children that come first. I am worried about health issues in the future that I will have because I can no longer get pay for this medicine. Why is this medication allowed to retail for over $1,000 a month? That is absurd.	Eli Lilly	TRUE
Adrienne	Rose	I was laid off from my job in August and can no longer afford the cost of Zepbound. I started it in June and have been so successful and lost 35 pounds but now cannot continue to my goal weight.	Eli Lilly	TRUE
Ruthie	Hill	After 3 heart attacks I desperately tried to get insurance coverage, easily meeting all of the FDA guidelines. My only option for access was compound. I live is the US territory of Puerto Rico and we did not qualify for savings card. Compound is $400 per month. The medication has worked so well for me that I am off all heart medication. Now, Imam hearing compound is going away...I will have NO access at all. I can barely afford the $400 monthly and make lots of sacrifices. But I don't want to die. I don't want to be sick anymore. Please, help me keep my medicine.	Other/Unspecified	TRUE

Monica	Peper	I'm 52 and have been fighting obesity since childhood. I've had weight loss surgery (lapband) that was temporarily successful but like the majority of lapbands, mine eventually had complications that required removal and I regained all my weight and more. Since going on a GLP-1 medication I am slowly losing weight again and there is hope again. Without this medication I will likely become disabled at a young age due to years of overworking my joints from attempting to lose weight by running half marathons, running up and down stairs, doing step aerobics and boot camps etc. I've been told by ortho docs that they won't consider me for knee replacement unless I lose significantly more weight, and I am getting closer to that goal with the help of GLP-1 meds such as Ozempic and Mounjaro. Unfortunately my insurance won't cover the cost of these meds because they are outrageously expensive. I cannot afford $1000 per month out of pocket for these meds so I have resorted to buying compound versions, which are only temporarily legal while the brand name is in shortage. This may soon end and there will be no option for me to obtain this medication. Even the compound version is like having an additional car payment that as a single woman with one income I really cannot afford. I have drained my savings and am living month to month. But my health is my priority and I deserve safe and effective treatment for the disease of obesity. And yes, we now know obesity is a chronic, progressive and relapsing disease, which deserves effective treatment just as much as any other disease. And let's face it, obesity is the cause of many forms of cancers and other chronic illnesses so treating obesity upfront may prevent people from getting sicker or disabled, which ultimately will lead to lower costs for insurance companies in the long run and less burden on our healthcare system. Please help make these medications affordable to those of us who need it. It's the ethical thing to do.	Novo Nordisk	TRUE
Patricia	Crews-Valdes	I was on Mounjaro the first year it came out. I utilized the original $25 caving's card. As that expired, I appealed, lobbied my employer, spoke directly with my isirance and ultimately decided I could not have afforded the monthly cost of (a minimum) of $550-$750 each month. At the end of that year, I had lost about 100 lbs and my health was dramatically improving. Ultimately, even the compound route was too ouch for me as my monthly family obligations are high with 2 special needs young adults. I have maintained my weightloss and have periodically resorted to research level GLP-1s combined with fasting to further drive down my weight. I have experienced an increase in inflammation and joint pain along with other autoimmune symptoms returning since discontinuing the usage of Mounjaro. It's a shame as those symptoms were in full remission when taking it.	Eli Lilly	TRUE
Jessica	Sharpe	Due to the high cost Medicaid does not cover these medications for weight loss in my state. Despite my doctor completing prior authorization requests this life saving medication was repeatedly denied to me. This is simply unacceptable in a country as advanced as ours.	Other/Unspecified	FALSE
Julia	Morris	It's been so frustrating. My insurance covered my ZEP until last month. I lost almost 80 lbs with 30 to go. Ugh. After four denials from appeals, I've now had to switch to compounded. I'm literally forgoing some other medications I need in order to afford this because it's more than $25 a month though less than Zep without coverage. So upset. I gained 8 lbs back in the 5 weeks I've been without my shot therapy. And my mental health has suffered, I have been too depressed to go to social activities or exercise class, and I've had more panic attacks in the last 5 weeks than I've had in the last 3 years. This is inhumane. We live in a world where fat shaming is still basically accepted. We're told to ignore it, we're told to ignore it when we are also ignored. Being overweight also puts us at risk for more health problems down the line. Why aren't we investing in helping people be at a healthy weight? I can't understand it. We need to do better.	Other/Unspecified	TRUE

Adriana	Diaz	It's been six incredible months since I've been using Zepbound. It's made a huge impact on my body after taking the medication, I feel more energetic now than before. I've lost 48 pounds in this time, and I'm reaching closer to my goals. However, while this journey has transformed my life for the better, the financial commitment has been difficult. My insurance doesn't cover Zepbound. I have to pay $550 out of pocket for each prescription. As the months pass by, it's been harder to maintain. I feel frustrated by the heavy cost of Zepbound that isn't covered by my insurance. I can only imagine how much harder it is for other people who need it, but cannot afford it. I'm grateful for the progress I've made, but I have to make the tough decision to figure out how to keep paying for it. I'm hoping for a solution that will allow me to continue without putting a strain on my finances.	Eli Lilly	TRUE
Meghan	Knowles	I do not have obesity coverage with my health insurance. My doctor is very concerned about my obesity and wants me to take Tirzepatide, but my insurance will not cover Mounjaro without a Type 2 Diabetes diagnosis and Zepbound would cost me well over $1,000 dollars a month to pay for out of pocket. My health is impacted by the price of this medication, which my doctor believes that I need. I have family in the UK who pay a fraction of the cost for this medication and I don't understand why Americans are expected to pay all of the cost of research and development of these drugs. I want Congress to represent the American people and not the drug companies. American needs to negotiate lower drug prices for the American people just like other countries do for their people.	Eli Lilly	FALSE
jessica	Martrano	My insurance decided they don't cover weightloss. This is the fire medicine to ever show numbers going down on the scale. I have had to find a second job just to be able to afford this medicine.	Other/Unspecified	TRUE
Rebecca	Baker	I originally started this journey to lose weight. To my surprise, the first time I took the injections of Zepbound I lost 28 pounds in two weeks of nothing but fluid from my legs. I am on disability and have lymphedema. The fluid removing from my body has lowered substantially the daily horrid pain that I had suffered. I started to use the medication not sure how I would ever afford it. We have been trying to purchase, but now I'm unable to buy my medicine this month. The cost from this price gouging of the United States citizens compared to other countries is just unsustainable. I have insurance through my husband's work, but it does not cover anything for weight loss or for lymphedema. Could you please help us so that we also may benefit from these drugs like other countries?...	Eli Lilly	TRUE
Erica	Sneaf	My insurance stopped Covering my GLP1 medication as Of 9:1/24 in order to keep Taking it I now have to pay $550 out of Pocket instead of my $50 copay. I have appealed to my insurance many times it always gets denied.	Other/Unspecified	FALSE
Eric	García	Being a masters student in college and having to weigh in either paying for Tuition books and fees or paying for my mounjaro which is around 550 a month is a choice I had to make there have been times that I have to go without medication until I can afford it it's been a difficult road and when there was a coupon that gave a discount to 25 dollars per fill it was accessible even with insurance there are so many loops to go though just to get insurance to cover it. It's been a difficult journey but we are still waiting for positive results.	Other/Unspecified	TRUE
Jennifer	Serex Helwig	Cost of Zepbound and Wegovy (RX medication in general) are way too high. Should not have to pay so much for all the health benefits these medications bring to people. These medications should be covered by Medicare also as they are essentially life long medications.	Novo Nordisk	FALSE

Kelli	Pachlhofer	In the Beginning of November 2023 I had my 6 month check up with my cardiologist. Again I had gained weight and I discussed how I knew my weight was really affecting my heart, and all aspects of my health. My Cardiologist knows my weight loss and binge eating addictions and knows I have lost and gained back 100 pounds minimum in my adult life 5 times! (Each time reaching my goal). She asked me if I'd heard of the GLP meds and I told her yes on the news, and told her it something i would love to try but knew I could never afford it, and I would never want to take away from diabetics. She mentioned ZB for weight loss and suggested I talk to my primary Dr. (Internist) about my candidacy, the fact I wouldn't be taking it away from diabetics and that their practice has so many patients (who happen to be diabetic or borderline) that are now on a GLP and their heart issues are improving dramatically. -She stated she thought someday these meds will be approved for patients like me, with heart issues.as the results have been astounding. I went to see my internist two weeks later and surprisingly he was all for me trying ZB - he actually said " this medicine is made exactly for people like you ". He also knew of my tendency for addiction issues and my personal need to quit cigarette's , gambling, alcohol, diet soda, due to my tendency to binge with food, alcohol, gambling, shopping etc. I had just turned 65 so he was concerned about insurance. He drew my blood which as he expected was not close to boarder line diabetic, wrote a prescription sent to my Walgreens pharmacy - he told me to check my insurance, gave me Lilys discount card info etc. Unfortunately Medicare and my supplement would not pay anything and the discount card would not work as I was on Medicare. So disappointed but told my Dr and pharmacist that I would pay full price out of pocket and see how this med worked for me. I was so hopeful especially after both Dr's were so positive that it could change my life and health. First of December my prescription was sent to my Walgreens and they never ever could get it on for me. I was soo disappointed. (I wasn't schooled enough to even think about trying other pharmacies I just figured If Walgreens couldn't get it no place around me could either). I kept checking and being told they may get it next week etc. Never came. In January still so hopefull any day I would get it, I got on a couple FB groups of people on ZB / Monjuro - finding out more how the approval process went for them, etc. On one of the websites several people mentioned a persons name and that she was a rep for Lily and she was allotted a certain ambient of the ZB and was able to sell it for a discount for those who insurance wouldn't cover. They were all very happy customers, losing weight etc. After weeks of reading their posts i contacted the person, I believed was a lily rep and for a couple weeks we chatted back and forth and I believed her — I ended up sending Apple Card's and Apple Pay to her to equal 6 Mo thx of injections.	Other/Unspecified	TRUE
Brigette	Ayers	My insurance coverage costs me $1228 A MONTH for the cheapest, crappiest policy through my husbands employer(a public school district). Even though that policy costs MORE than my mortgage payment, it doesn't cover one penny of a glp1 medication!! A medication that has and is saving my life!! I am forced to choose between family essentials(food, gas, clothing, etc) and paying for compound out of my pocket at $379 a month! It was a tough Decision, but as a parent whom has put my family first for the last 30 years, this time I choose me! We scrimp by and save on things we can so that I can have this medication that has SAVED MY LIFE!! I have lost 48.6 pounds in 22 weeks. My bp is down, my inflammation is down, and for the first time in 30 years, I'm not in severe pain 24/7!! I will do what I need to do to keep going, but something has to change!! These meds need to become more affordable to parents don't have to choose on whether to feed their families, pay their bills, or take a life saving medication!	Other/Unspecified	TRUE

Dawn	Houghton	I pay full price as I am on Medicare. My HSA will be wiped out in two more months. Then I will be spending my retirement savings. I do have a small pension, but it is actually less per month than the cost of Zepbound. I know I can actually afford to pay, but it's my biggest expense right now. More than property taxes, more than groceries, more than utilities, and more than all our other health care expenses combined (part B, D, and plan G). I continue to pay out of pocket because the drug is making a huge difference in my life. I've lost over 50# so far but I have a long way to go to not be obese. I will not use compounded versions of tirzepatide because I do not trust them. However, at times it is nearly impossible to actually get my prescription filled! March, April, May I could not get 5.0 or 7.5. instead I had to go off the meds then go back to 2.5 and call/visit pharmacies for hours every day. A total waste of $1095 and a couple months delay in my journey. Eventually I was able to get the 7.5 I was supposed to start in April. Now I'm ready for 10.0 but again the pharmacy I have been loyal to for years has none available. Here we go again back to the phones to find a box. I know this story is probably not what you are looking for, but I think it's important to remember there are a lot of issues beyond the very high price. Even someone who with morbid obesity can't get coverage if they are over 65 and in Medicare. Many under 65 aren't covered by their insurance. Even if one can afford to pay the price it is often possible to get the product. Everything about obesity drugs is broken - price, insurance, Medicare, supply, retailer operations, compounders, scammers.	Eli Lilly	TRUE
Lynn	George	My insurance would not approve paid $500. 00 a month.	Other/Unspecified	FALSE
Vanessa	Levesque	It took my ten months of waiting to see obesity specialist to even get this miracle drug in my hand. Now I have been on it eight months and it has changed my life!!!! Consistently losing weight, improved A1C and feeling so much healthier!!!! The only downside is the very expensive price :(I pay $550 a month with the Lilly coupon and am able to pick up every 21 days if it's even available. I have spent $5,000 and now have no savings. I have decided to put my health first this year but am so devastated that I have no extra money for anything. I pray that this can change. We know that other countries pay way less and it's just so unfair. I'm single and have no kids but I have no clue how any families could swing this large payment. Please please help us get this lowered. It is a life saving drug !!! Thank you for your time and consideration! Vanessa Levesque	Other/Unspecified	TRUE
Jeanette	Pavkov	I'm on the second month of paying out of pocket for Zepbound. My insurance Anthem BCBS has denied my PA and also my first appeal. My doctor provided all necessary documentation in my letter that she deemed the medication as medicinally necessary for me as I'm pre-diabetic, have PCOS and high cholesterol. I'm currently paying $550 a month for this medication while others are only paying $25. It's been a wonderful medication for me as I've lost 20 pounds in 6 weeks on the medication. Completely life changing for the better for not only me but my family as well.	Eli Lilly	FALSE
Kim	Ladisky	Life changing medication that is unattainable to afford an super upsetting to have lost weight an get the medicine taken from you from costs an insurance companies dictating my health needs	Other/Unspecified	TRUE
Linda	Holloway	This medication should be made more financially available for everyone who needs it! We cannot afford it long term without consequences of our necessities like housing - gas - healthy foods -etc over our health.	Other/Unspecified	TRUE
Deb	Pereira	Despite meeting the criteria, my PA for Zepbound was denied by my insurance. I had started the medication while waiting for the PA, and because I had such amazing results I opted to continue the med paying out of pocket when my PA was denied. I'm retired and on social security plus a pension, but I had to withdraw monies from my 401k to cover the expense of the medication. I see it as an investment in my health, and truly believe I'm one of the people who NEED to be on this medication to correct a metabolic imbalance. With a very strong family history of heart disease, diabetes, HPB, and obesity this medication has changed my life and my future.	Eli Lilly	FALSE
Michael	Clanton	I am on medicare 66yo Paying 1032$ a month out of pocket for the last 18wks. I was 70# overweight 34bmi when I started with some heart issues and border line diabetic.How can I be expected to keep up my progress without enormous Debt to have a healthier life?	Other/Unspecified	FALSE
Kristen	Grode	I had 70 lbs to lose and initially insurance paid but at the end of 2023 we were cut off. At that time I had to decide if I was going to stop taking mounjaro or find another option. So I turned to compounded tirzepetide. I hate that it is still very expensive and not FDA approved, but my health counts on it! I was sooo sick before I began taking MJ in May of 2023. I will sacrifice so many things in order to be able to pay for this medicine...because without it I may not be alive!	Other/Unspecified	TRUE

Chris	Seidt	Zepbound has helped me to lose 64lbs in 6 months, but it had cost me over $3000, money that doesn't count towards my deductible if something else goes wrong with my health. I find it ridiculous that a product sold for a fraction of the cost in every other country costs this much. I have struggled with my weight for almost 30 years, and this seems to be the first time I have had sustained success.	Eli Lilly	TRUE
Darlene	Angell	I am morbidly obese with several co-morbidities. When I was working, my employer covered GLP1s with a copay to me of $25. I recently retired and am now on Medicare with no coverage. I was doing great and getting healthier but now I can't afford it at $1400/mo. I lost 75 pounds (with about 75 to go) and was able to discontinue one of my BP medicines. Now it's back to a daily struggle. My wife was actually approved for Wegovy through Medicare but the copay is an unaffordable $600/month.	Novo Nordisk	TRUE
Rena	Allen	About two years ago, my glp1 med was covered by my insurance because of metabolic syndrome. I luckily had not been diagnosed with type 2 diabetes, so when the formularies changed, my medication was no longer covered. It went from a co pay of $10/month, to a quote of $1500/month. I had felt so much healthier and had huge improvements in my blood work and it was no longer accessible to me. A year later, fed up with gaining weight, (embarrassingly) praying that my A1C would get high enough for me to qualify for type 2 diabetes, I started paying out of pocket. I have paid $550/ month out of pocket since March. This is a huge strain on my family. It makes no sense, if I was sicker, it would be covered, instead of covering it now, so I don't get more sick. We need advocates to make this make sense. It is a waste of a good solution.	Other/Unspecified	FALSE
Jen	Maggard	I'm located in MI and my insurance company, Blue Cross Blue Shield has decided to stop coverage for Zepbound and other weight loss drugs that are GLP-1s. My costs will now be at least $650 per month, and that is only with coupon assistance through the end of 2024. Once that ends I'm looking at full costs of nearly $1200 per month. I simply can't make a mortgage payment for a prescription drug that my doctor and I have determined I still need to be on. With other countries at a fraction of the cost, the US is being taken advantage of at every turn. Lilly is no better than Nordisk, and in many ways worse given the news this week asking private citizens to allow them access to private medical records. We need immediate relief and investigation into the hand over fist money at the expense of American patients. We also need immediate investigation into PBMs who are horrifically robbing funds from those filling prescriptions as directed by their physician.	Eli Lilly	FALSE
Kathleen	Parr	Cost is too much compared to my fixed income. So is death on the linstallment plan if I don't loose the weight.	Other/Unspecified	FALSE
Lori	Anton	My endocrinologist has suggested I try a GLP-1 at every visit since I first saw him after my Craniopharyngioma brain tumor removal. I have multiple endocrine disorders due to damage from the tumor and its removal in addition to PCOS, hypothyroidism, hypertension, etc. I eat very healthy and tried everything but nothing works. Until I tried Zepbound two weeks ago. I have lose 6 lbs already and my energy level, body aches, etc. are incredibly better. However, I have a Medicare advantage plan so it will not pay for these types of medications. So I have had to resort to a compound. Why won't Medicare pay for a med that is going to make me healthier and have such a better quality of life?	Eli Lilly	FALSE
Laurie	Toth	I was prescribed Wegovy in September 2023. Walgreens and everywhere was out of stock with not date when it would be available. In December I was prescribed Zepbound which I was able to get at that time. After being on Zepbound that drug went out of stock in late March. Finally able to get that in June but only in the lower doses.	Novo Nordisk	FALSE

Virginia	Price	I do not have insurance coverage for my medicine despite the fact that at a starting BMI of over 40, I should absolutely qualify under severe Class 3 obesity. These drugs are the only thing that has made my body work the way it's supposed to. Exercise and diet finally produce results now! But these medications cost my family $550 every 4 weeks. This is a humongous financial burden as a family with six young children, and caring for an aging family member. We work it into our budget as a necessity, but it is seriously impacting our ability to change and repair our financial situation. It's punishment to those dealing with the disease of obesity to have these drugs be so impactful to our health and longevity and simultaneously empty our wallets. This is a chronic disease… how are we supposed to continually afford to spend over $7,000 a year for the rest of my life? I'm only 35. This is a burden that can be changed by legislation and insurance companies loosening their chokehold on prices just to keep themselves and their shareholders rich. The time for change is now.	Other/Unspecified	TRUE
Vicki	Williams	Labs stay abnormally out of range	Other/Unspecified	FALSE
Dorine	Geurts	I was first prescribed my GLP-1 medication in October of 2023, I wasn't able to obtain it due to the severe shortage. In January I was prescribed the newest medication (zepbound) as an alternative to Wegovy because after months of searching every pharmacy within. 30 mile radius, I still couldn't obtain Wegovy. This medication was supposed to be my miracle - after fighting my weight for 30+ years - doing everything "right", every diet, every extreme, logging my food - every single bite - for decades… weight watchers, Jenny Craig, calories, carbs, paleo, primal, whole30, intermittent fasting… walking, running, step aerobics, elliptical machines, stair steppers, gym memberships, Jane Fonda videos, Jillian Michaels videos… it was endless and I was exhausted from trying. Nothing worked… sometimes I could take off the weight (especially the first 25 years of adulthood), but I could never keep it off… it always came back. Always. The last 5 years was the worst… my hormones went to hell, and nothing - nothing worked. My A1C had crept up to pre-diabetic levels, my blood pressure had reached hypertension levels - I was looking at being diabetic within a year if something didn't change! A friend who was in the same situation told me about Wegovy… it took me a few days of research, but I just KNEW this was my miracle. And my insurance covered it - at $60/monthly (after insurance) - it was reasonably affordable for our family. But absolutely nowhere to be found. When my Dr prescribed Zepbound for me - it was covered under our insurance, as a Tier 3 medication - so after insurance and the Lilly coupon - zepbound was $550/monthly. Absolutely ridiculous and not affordable at all. My husband and I cut out EVERYTHING in our budget - I am beyond grateful that he is supportive of me - because this is a huge expense! We continued to pay for Zepbound at this price for several months while I fought with our insurance to cover it for me as a Tier 2 medication… lots of appeals fighting a system that I knew nothing about. Finally, in April 2024, I won my appeals and was approved for 6 months of medication at a Tier 2 rate. I was very fortunate! Many people don't win these appeals and they are stuck choosing to pay outrageous prices for their medication or paying for their basic needs to live. It should NOT be this way. These medications should be just as affordable to those living in the US as they are for people living in other countries. Now insurance companies are starting to not cover this medication at all because of the cost… if the cost was lower, insurance wouldn't have an issue covering these life saving medications! I am now several months into my journey, I feel better than I have felt in my entire adult life… my weight is dropping - I am able to move more and I am seeing results from all my hard work, food isn't the first and last thing I think about every day - I actually have the brain space to think about other important things. These GLP1 medications are truly a miracle for me! I am not sure what I will do when my insurance stops covering them - as I feel like it's inevitable in the near future. I know that I cannot afford the full price that they cost - I am just trying not to think about that and hope I can get as close	Novo Nordisk	TRUE
Jennifer	Melancon	I'm 68 years old and struggled with weight fluctuations from childhood. Still on my company's insurance, I was able to secure a half cost for Zepbound at $550, out of pocket. Weight loss was significant but not as significant as the bloodwork improvement especially cholesterol. Two years past full retirement age, I retire. Now not only can I not get a discount anymore for Zepbound, the out of pocket doubled to $1,100. This is grossly unfair to seniors who are trying to get off cholesterol and blood pressure medications to improve their quality of life. It's not only that you won't contribute but you took away any available discounts.	Eli Lilly	FALSE

Cathi	Bradley	My Dr prescribed Ozempic in October 2023 and sent a PA to my insurance company. It was quickly denied by BCBS of Alabama saying that my plan does not cover obesity medication. So, I told my Dr that I would pay out of pocket and he sent the RX to my local CVS pharmacy. They called me to say that the price would be $1500 for one month supply of Ozempic. I told them that I had a coupon that I received from the manufacturer, Novo Nordisk. They said my prescription would be $550 per month. Then, after being on the prescription for 2 months, I was told that there was a shortage of the medicine and they would check other CVS's near me and I was able to get it for an additional month, but the next month I went to pick up my prescription, I was told that they could not get it.	Novo Nordisk	FALSE
Sarah	Walker	Was on Ozempic with a 25 dollar co-pay, losing weight. All of sudden insurance decided they weren't going to pay and cost was 1000+ per pen. Had to go off. Gradually gained most of the weight back. BMI >30, Insulin resistant, don't lose with just diet and exercise. luckily, I have new insurance now that is covering Zepbound with a co-pay and I'm losing again still exercising and eating right but I only lose with the help of the GLP-1. constantly worried that my insurance could change their mind and take the medication away again.	Novo Nordisk	FALSE
Andrea	Murleau	I have been obese all my life and have been on countless diets since I was 10 years old. There was a brief time in my 30s when I lost enough weight to be at the top of the "normal" weight range, but it was a constant struggle. I had to exercise for hours and eat very few calories, and my body was fighting against me the entire time. Slowly, I began gaining weight again, and eventually, I gave up. I regained all the weight I had lost, plus 50 pounds. In December 2023, I started Zepbound, and as of September 2024, I've lost 84 pounds. I finally feel like I have some freedom and control over my body again. However, the past 9 months have been marked by an overwhelming struggle with the cost and access to GLP-1 medications like Zepbound. My insurance doesn't cover it, which has been a significant financial burden on my family. Every trip to the pharmacy is a battle, as I often have to retrain them on how to process the savings card. I've spent days on the phone searching for my dose and managing the complexities around getting this medication. To make things worse, my health information was leaked during the Change Healthcare cyber attack. The cost, combined with the difficulty of accessing the medication, has had a profound impact on my family and added tremendous stress to an already difficult journey.	Eli Lilly	TRUE
Andraa	McCann	The cost of the GLP-1 medications make people have to decide between being healthy and alive or being able to put food on the table!	Other/Unspecified	FALSE
Stacie	Lambert	I lost my job last week and now I won't be able to afford to continue taking zepbound. It has been life changing for a chronically obese mom. I was barely able to afford it when I had a job but now I definitely won't be able to.	Other/Unspecified	TRUE
Diane	Dawson	Both my husband and I are on Medicare and we cannot afford the GLP1 type drugs. Besides both of us being overweight, I have sleep apnea and high cholesterol. He has high blood pressure. So sad that this could help but is not available. Shame on you big pharma!	Other/Unspecified	TRUE
Sarah	Stevens	I am a 57 year old woman who has struggled with my weight since early adulthood. I have only discovered in the past 3 years that I have an eating disorder with obsessive thoughts. The obsessive thoughts was something I never would have thought until I went on Zepbound. My mind quieted. I have gone from thoughts of food, self hatred, and shame to thoughts of..... normal things. I was in prediabetic range and now, for the first time in 5 years I am in normal range on my A1C. I also have lost 55 lbs since December of 2023. This all is amazing. But it is a heavy financial burden. So far I have used the Eli Lilly savings card which has taken my cost down to a nauseating $550. It's ridiculous! I have gone through some savings that was meant for other things. I am not sure what will happen in Januarybwhen the card expires. Our insurance won't cover it because it is weight loss medication. They don't seem to care that it is also the drug that has prevented me from becoming a diabetic and provided me with a new, free, quiet, heavenly mind. The mental health aspect of this medication is the biggest blessing. We need to find a way for these kinds of medications to be covered by Insurance and the pharmaceutical companies to stop price gauging. This is immoral. I don't want to become a diabetic in order to have it covered. Thank you so much.	Eli Lilly	TRUE

Megan	Thompson	Hello, my name is Megan. I'm a 39 year old single female, who has a great life. I live with my three dogs in a house that I can call my own and have a great full time job that has become a career. But I'm in debt. I'm in debt not because I'm bad with money, but because my insurance has chosen to say that Zepbound is not a life saving medication. My insurance company, who will pay for things like diabetes and heart disease, which are commonly known by products of obesity, will not allow me to get preventative help to avoid those implications. I have been severely overweight to obese my whole life. I've tried every diet under the sun and have lost weight, but not in a sustainable fashion. Those same diets and healthy eating I did while trying to loose weight without medication I am now doing with Zepbound and the crazy thing is, the medication is the difference. I'm loosing weight at a safe speed and keeping it off. It's helped with an inflammation problem that I wasn't even aware I had. Insurance companies and Eli Lilly alike should be held accountable for their actions in price gouging and withholding life saving medications from the American people. I have made the choice to save my own life and go into debt doing it. However, the fact that myself and millions of others are forced to choose between their health and finances shows the sad state of American healthcare. Weight loss medication is lifesaving and should be treated that way. It is the governments responsibility to protect their citizens from companies like these and step in to create better cost caps and guide less to prevent the greed that is currently taking place. The American people deserve better. From both the companies that claim to want to help and the government who need to protect their citizens. Thank you for your time and consideration.	Eli Lilly	FALSE
Cheryl	Carroll	From free to $192 a month. My husband is a 100 percent disabled vet and we live on a limited income. I have ChampVA, meds by mail, and the cost of my medication was free until Dec. 1, 2023 My Dr. was able to procure my higher doses for about 9 months. Now I am getting ready to have to start paying $192 a month. Some people may say that that's not bad, but when you are on a limited income, it is really difficult to come up with an extra $200 a month. My medicine helps me with auto immune disease Hashimotos, insulin resistance, high cholesterol, sleep apnea and inflammation and so much more. Even helps with my anxiety. I know this medication could be offered at a much lower price than the price point they are currently at. They really need to be held accountable for allowing to medications to be more affordable for everyone!	Other/Unspecified	TRUE
Sheena	Fox	I'm a 38 year old mother of 3. Last year I was diagnosed with kidney cancer. It took years of me having so many symptoms and seeing dozens of doctors and specialists who mostly said my symptoms were due to my weight. I've struggled with my weight my whole life. It wasn't until I lost weight without trying that the doctors took me seriously. They finally found out what was wrong, and just as I knew deep down, it was cancer. I had surgery November 10th, 2023. They removed the tumor and about half of my left kidney. After the surgery I gained back all the weight I lost and more. I got up to 220 pounds and I'm only 5'3. No matter what I did, I couldn't lose the weight. Then at one of my check up appointments my doctor recommended Zepbound. A new Ozempic-like drug used for weight loss. I was desperate so I agreed to try it. My insurance would not cover weight loss medication. So with some help from content creators on TikTok(also please don't ban TikTok), I found out there's a savings card. That brought the price down to $550 a month. I had to tighten my wallet in every way possible. I have no money for anything except bills and medication but I chose to invest in myself because I now know just how short and precious our one life really is. I've been on the medication almost 6 months and have lost 70 pounds. I went from 220 to 150 pounds. I'm off my blood pressure meds and I feel better than I have since I was a little kid. This medication has given me my life back. I have energy, my mood is elevated, and I don't dread getting dressed every morning, because I now look good in my clothes for the first time since I was a teenager. I don't know how long I'll be able to afford this medication, especially with the amount going up to $650 next year with the savings card. That's a car payment....a nice car payment. I know I'll need this medicine long term. I had tried every diet from weight watchers to Jenny Craig to Keto to Atkins, every calorie tracking app. Calories in and calories out isn't the end all be all for some of us.	Novo Nordisk	TRUE

Lea	Bradley	I got a small life insurance policy from my Mom's death last year. I wouldn't of been able to afford it. I'm 68 and on Medicare. I have lost 100lb. My life is totally changed. I still have 50 that would be wonderful to lose if the money holds out. I had to go to a compound form of Zepbound. I still pay 580.00. At least it's not 1108.00. This medication has addressed other addictions I have. Spending in general and gambling. I'm willing to share my whole story. There isn't anything out there that I haven't tried in the last 50 years. This really does address the way my body works.	Eli Lilly	TRUE
Toni	Armstrong	When I first learned about GLP-1 medications, I felt a glimmer of hope. With a BMI of 34, high blood pressure, pre-diabetes, and sleep apnea, my health felt like an uphill battle. The medication seemed like a potential lifeline. But when I faced the reality of the costs, that hope quickly turned into frustration. Even with my insurance, which I thought would help, the coverage was nonexistent. I was shocked to find out I'd have to pay $550 a month out of pocket, even with the Eli Lilly coupon. That amount felt insurmountable, especially considering my financial situation. Each month, I had to weigh the importance of my health against my budget, and the stress of that decision was almost unbearable. But I knew I had to find a way. The stakes were too high. My health was deteriorating, and I was tired of feeling trapped in my own body. I was determined to make a change. So, I took the plunge, paying out of pocket for the medication, hoping it would help. And it did. Since starting the GLP-1 treatment in March, I've lost 40 pounds. The changes were nothing short of miraculous. My high blood pressure has normalized; I've even been taken off two of my blood pressure medications, with plans to stop a third soon. The relief I felt when I received my latest bloodwork results—showing no signs of pre-diabetes—was indescribable. Yet, despite these life-changing improvements, I still grapple with the cost. It feels so unfair that something so vital for my health should come with such a hefty price tag. I understand that medications require research and development, but for many of us, the cost of these treatments can mean the difference between life and death. I often think about how many others are in the same situation, struggling to afford necessary medications. It shouldn't be this way. Healthcare is a right, not a privilege. I've witnessed firsthand the positive impact GLP-1 medications can have, but it's disheartening to know that not everyone can access them. As I continue this journey toward better health, I hold onto hope that one day, essential medications like these will be more accessible and affordable for everyone who needs them. For now, I'm grateful for the progress I've made, even if the road ahead is still challenging. My health and well-being are worth the fight, but it shouldn't have to come at such a	Other/Unspecified	TRUE
Davi	Hulsebosch	I was covered through insurance and with the savings card paying 24.99 per month. My insurance company cut me off and now will have to pay 650 per month with the savings card, when that expires $1300 per month. Simply unaffordable!!!! It has reversed my fatty liver disease and corrected my high blood pressure. I started January 19th at 202lbs and am now 151 with another 6 to use. My PCP wants me to stay on it for maintenance. I won't be able to afford it and am fearful without it my insulin resistance will cause me to regain and I will become a diabetic and have other complications. This is so absurd that they can't lower the price to help us stay healthy.	Other/Unspecified	TRUE
Angela	Schwier	Due to the cost of Ozempic I can't afford to take it, possibly causing more health issues later for me. My insurance won't cover it, so it would cost me one pay check per month! That's not possible to do with other household bills!	Novo Nordisk	TRUE
Kathy	Whitehead	My husband is on Medicare. He is eligible to be put on Wegovy due to his BMI and heart condition; however, his Part D insurance will not cover Wegovy. He would have to pay the full $1618.00 per month for the medication because he is not eligible for the savings cards. His monthly Social Security check is $1800, so clearly there is no way that he can afford this or any of the other similar medications at full price.	Novo Nordisk	TRUE

Kimberly	Bowen	In March 2023, my Dr prescribed Wegovy. My insurance did not pay for it even though I have high blood pressure, high cholesterol and felt miserable at almost 200 pounds. I had also recently found out I had a thoracic aortic aneurysm which would greatly benefit from me losing weight. I had tried many methods of dieting and exercising and saw no results. But even given all this information … insurance would not cover. My Dr. suggested calling Novo Nordisk and they advised I would qualify for savings card. Great, right?! Then I found out it would reduce the cost down from around 1600.00 to 1184.00 per month. As you can imagine I had to sacrifice many expenses but decided to pay this out of pocket. By October I reached my goal and slowly weaned off as much as I could from the higher dose since lower doses were in shortage. Total cost for me, a single mom of 2, was 10,656.00. This is money that I spent on myself to improve my health but I know not many people could do that and it's a shame that novo spends far less than that to produce the medication.	Novo Nordisk	TRUE
Melinda	Cabral	I am draining my savings trying to pay for Zepbound so I can improve my health. My insurance won't even let me submit a prior auth, they just tell me they don't cover it, period. My savings is almost out so I'm not sure how I will be able to continue.	Eli Lilly	TRUE
Melissa	Green	The cost of prescription medication Zepbound has had a huge impact on my life. I have a rare autoimmune condition and have been on high dose steriods for two years. I gained a tremendous amount of weight due to the steroids and ended up with multiple comorbiditoes because of it. At my doctors recommendation I started taking zepbound and it worked wonders. I am down 60 pounds and no longer have high blood pressure and severe joint pain. However, my insurance does not cover the medication and it is so expensive I often have to delay rent or utilities or gas in order to buy the Zepbound to ensure I stay physically healthy. It is so stresful to choose every month between my health and my families livelihood. Big pharma should be ashamed.	Eli Lilly	FALSE
Roberta	Annala	I am 67 and I weigh 300 lbs. I have high blood pressure and high cholesterol but not diabetic which wouldn't make a difference because all I have is Medicare and they won't cover weight loss drugs. I tried Ozempic for one month and lost 22 lbs but I can't continue because I can't afford the $1,400 - $1,500 out of pocket expense on SSI!	Novo Nordisk	TRUE
Dawn	Kifer	Our insurance put a rider on the policy the month I started Glp1 to specifically ban its use for anything other than diabetes. I paid out of pocket for months untill I just couldn't afford it anymore even with pinching pennies everywhere I could think of, cheaper groceries, cancelling subscriptions, cancelling vacations, downsizing and selling household items, etc. About that time glp1 medication shortages hit and I learned about compounds. With the telehealth company that I chose, I was able to get glp1 education, nutritional education, mental health education, community support groups, exercise regimine, a monthly (more often if I wanted/needed) meeting with my practitioner, labwork, glp1 medication and associated supplies each month for a fraction of what buying the medication alone had cost me each month. My liver, cholesterol, and a1c labs all improved beyond that I finally had less hashimotos flares and I lost weight to boot. Without the lower cost of compounds I would never have been able to continue the medication and thus my health would have continued to deteriorate. I had dieted and exercised for most of my life with little to show for it. It wasn't until I was on glp1 medication did I see improvement. My insurance refuses to cover glp1 medications and I cannot afford namebrand out of pocket at the current pricing.	Other/Unspecified	TRUE
Michelle	Golz	I have been suffering from bone on bone knee pain in both knees for years. I need knee replacement surgery for each knee so that I can walk without pain and limping, be able to be more active again. I have been told by surgeons that I must have a BMI of 40 or below or they cannot operate on me. I've struggled trying to lose weight for years and years without success and I'm tired of being miserable. Zepbound is like a miracle drug for me, and I'm so desperate for surgery that I'm currently paying $550 a month for the Zepbound. I can barely afford it, and next year I will not be able to afford it with the change in the savings card making it impossible to afford. I pray and pray that my insurance will cover it someday soon, or that it will come down in price drastically. Thank you, Michelle Golz	Eli Lilly	TRUE

Virginia	Nagel	As like most average Joe's I am one of thousands of people that can't afford these amazing medications. At first we could all get with a coupon but they changed everything. Insurance won't help either. I lost 55lbs, improved cholesterol, inflammation and pcos symptoms. I also kept myself from becoming a type 2 diabetic. Now I have been without for 4 months and am well on my way back to heading in that direction again. And my body hurts all over. This has to change. We deserve to be happy and healthy. Greed has taken over. It needs to stop. Sincerely a miserable mom.	Other/Unspecified	TRUE
Robert	Dominguez	I am currently taking Tirzepatide and have to pay 550 every month out out of pocket due to no insurance coverage for the medication . If the manufacturer coupon doesn't work I pay almost 1200 . Sometimes I have to buy compounded medication to save on cost as it's already very expensive to pay a medication that has been life changing . I have lost 95 pounds in 34 weeks . My blood pressure and cholesterol has improved . I no longer am pre-diabetic . I'm still on this weight loss journey and I have to cut my daily living expenses to being able to pay for this medication. Getting this medication prevents me from paying some debt timely but my health is more important.	Eli Lilly	TRUE
Jessica	Linder	I have had to take a small loan out of my retirement to pay for my medication due to insurance not covering treatment for my chronic disease of obesity. I help save lives everyday, I work in a level one trauma center, and they are unable to provide me with care to keep me in a better health condition. They have nothing to offer me. I have had failed lap band placement and almost died due to erosion which was no fault of mine. I regained a large percentage of my weight. Now with this medication I have lost 50 lbs and still progressing, but I am not sure how much longer after December that I will be able to afford my medication due to the high cost even with the savings card. Please help me!!	Other/Unspecified	TRUE
Christy	Lewis	My insurance did not cover the medication for several months as the prior authorization process took way longer than expected. I ended up paying out of pocket in order to start the medication sooner. Even though the cost was well beyond my means, I felt that the benefits of the medication and my well-being were far more important than the impact on the cost of medication. I ended up having to cut corners and other other areas of my life to ensure that I would be able to afford the medication month over month. Once the prior authorization was approved, I was able to get my medication for much cheaper however, I could only use select pharmacies that were within my benefits plan. The challenge became finding the medication. Because I could only go to select pharmacies, I was limited as to Where I could get it, which caused hours of calling around various pharmacies, and then ultimate Lee long drive to pick up the medication once I was able to source it.	Other/Unspecified	TRUE
Meranda	Ratliff	I started Mounjaro in October 2022 and used the original savings card. My insurance doesn't cover anything for weightloss. After the coupon ended I moved to compound because I couldn't afford the medication. I started at 285 lbs and I'm currently at 167 lbs. Since starting a GLP-1 medication I have been taken off my C-pap machine and my blood pressure medication. I also have PCOS and fibromyalgia and this medication has helped with more than just the weight loss. It's completely changed my life. I no longer live in pain every day. I can walk pain free now. I can run. I can play with my grandkids. I finally have my life back.	Eli Lilly	TRUE
Justine	Bye	$550 a month to better my health! No one can afford that anymore,	Other/Unspecified	TRUE
Kris	Nicholas	GLP1 was my option for losing weight before knee surgery. This drug has never been covered by my insurance. Therefore, I've had to figure out how to pull another $550 out of my budget to buy the meds. There have been several months that I have delayed my dose to make it last longer, resulting in slower progress. This month, 4 weeks out from total knee replacement I cannot afford the medication. The food noise is there and I find myself immobile and struggling with the food noise, struggling to guide those that are helping with recovery to choose healthy meal options for me. It feels horrible and I think it's hindering my healing. I just don't have an extra $550 while I'm recovering to buy the med. I will have to wait until after I go back to work and that's frustrating.	Other/Unspecified	TRUE
Denise	Shorten	When I started this medication I was very nervous my husband is on SS and I am unemployed. We have racked up our credit cards just so I can continue to make my self healthier by losing weight with this medication. We had no debit on the card credit until I started this medication. I have insurance but they absolutely refuse to cover any weight loss medicine. All of our utility bills have gone up as well. It makes it very hard for us to live. I don't want to stop the medicine because I can't afford it. I really like what it has done for me so far. I'd like to stick with it until I'm off blood pressure medication and no longer need the CPAP machine to breathe. I'm working towards a healthier me!	Other/Unspecified	TRUE

Stephanie	Littell	I am a single mom with three children. My husband died of cancer. I've always struggled with my weight and know the health implications of being overweight. Therefore, I am trying medicine from the doctor, but it is so expensive. I am also a teacher whose insurance does not pay For this sort of help. Please help lower the cost so that hard-working citizens can afford to get help as well.	Other/Unspecified	TRUE
Nicole	Dudley	I am a teacher in Michigan and have been on Zepbound since March. I have spent the last 20 years trying to lose weight to no avail and found that Zepbound has helped me immensely. I have lost 40 pounds to date my blood pressure has come down and my joints no longer ache. And although I've made great progress, I still have a long way to go. However, my Blue Cross Blue Shield of Michigan coverage under MESSA as of January 1 will no longer cover any weight loss medication. Living on a teacher's budget I of course, will not be able to pay full price for this medicine that has changed my life. It won't be a possibility. It's a sad day when I won't be able to have the medication. I need to live a healthy life in the United States of America.	Eli Lilly	TRUE
Rhonda	Carter	The cost for self pay is outrageous and insurance companies should cover under formulary list to serve everyone.	Other/Unspecified	FALSE
Mari	Gomez	We live in a country where making money is more important than a human being's health. Zepbound has been proven to treat obesity. Why in the US in 2024 are still fighting for our medication coverage? Why is this drug over $1,200 when we pay HIGH cost for health insurance. Today I beg you to please help us. Help us, fight for us, please be our voice. America's obesity numbers are astronomical! There's a cure out there and we the people can't afford it! Please help us		

Melissa	ODell	During my pregnancy I was a gestational diabetic requiring blood sugar checks 4-6 times per day and multiple insulin shots each day. My weight was about 220 lbs - and had been overweight since the age of six. After my pregnancy, my blood sugars came back down, as they usually do in gestational diabetes. Over the next years I had yearly HGB A1c checks which were normal, but my fasting blood sugars continued to creep up over the years — as did my weight. My son was 9 and I weighed 260 + and my fasting blood sugars 112-120's, I was also hypertensive and started on blood pressure meds. My mom had diabetes and hypertension and she was dying s/p kidney transplant x10 yrs the kidney now failing. I could see the writing on the wall- most all gestational diabetics become type 2 within 15-20 years. I'd tried my entire adult life and failed loosing more than 20 lbs (with severe food deprivation that was no sustainable). My Dr tried Metformin - I had severe side effects, she tried phenteramine - nothing worked. I refused to have bariatric surgery, as a nurse I'd seen too many fail leading to death, after all it doesn't fix the "mind" piece and people usually end up gaining back if they don't die from complications. Desperate to stay alive as long as possible for my son and keep myself healthy I found support and information online and enrolled myself in a program for Wegovy - January 2022, cost for the med was $25/mo! I lost weight!! By the time Wevovy's coupon expired in June 2022 and the price was over $1200/ mo- I was down 40+ lbs 220. I found another option desperate to continue loosing weight I found a tele health provider and pd $99/ mo for the order and the coupon covered Mounjaro with a $25 copay - I continued to loose and transitioned to zepbound when it was released for FDA weight loss. The coupon has brought the price down to $550 / month and prioritizing my health and using my Hsa I've been paying this amount over a year - I'm coming to an end as my pets have become sick and are requiring lifesaving medications and treatments- my autistic son has a cat which is his support and I will be going without these shots that have saved my health and brought my weight down to 175- and I no longer take blood pressure meds and labs are phenomenal!! Even if my son's cat was not needing medication- the price with coupon has increased and I can't sustain financially on this med. I am a nurse and I work for a large insurance company and I know this med won't be covered for me for a very long time (if ever) for weight loss without changes in laws or pricing. I understand how it all works, I don't feel it's fair that I will be forced to regain all the weight I've lost over 2-3 years, my son watch this happen and he won't be able to understand— but will know my health is at risk when I gain weight back. I will likely become type 2 diabetic within a few years— but then I will have a high probability that I can go back on this lifesaving medication and it. could be covered by my insurance. What kind of example is society setting for our future generations….. that they can't have access to healthcare and lifesaving medicine until they become sick?! Does this not go against everything our healthcare and government has taught and encouraged about preventative medicine?!	Novo Nordisk	FALSE
Holly	Rua	As a yo-yo dieter my entire life, at 52, I figure I have got to get this weight off and keep it off for good this time if I want to live and be the best caretaker I can to my father and best mother I can to my adult daughter. While I have always ate healthy and exercise, binge eating and carbohydrates have kept me obese. My doctor prescribed Zepbound after I had lost and regained over 40 lbs in the same year.. the meds have changed my life but not only because of my weight reduction but my reduced inflammation. After suffering a catastrophic shoulder injury, I struggled to put a bowl in the cabinet, wash my hair and do simple things like get dressed. Now I can weed, complete all the necessary things to run the household, and even play pickleball. This med. has given me my quality of life back. Although I have a great career, my company excludes weight loss medications from our health plan. As a single Mom, life is all about priorities and choices. While I would love to say I can afford these meds for the long haul and for maintenance- I just don't know if that will be the case. I have told my daughter that if necessary, I'll drive my used car until the wheels fall off if it ever came down to driving a decent car and taking the meds because the meds have been so life changing for my quality of life. If the meds get any more expensive, I feel like I am going to be living the movie Cocoon… where I was stuck in a body that didn't work, had it work for a brief time and then watched it all slip away. While this all sounds dramatic- that is my Zepbound story and what having these meds at an affordable price could do for me and the rest of my life.	Eli Lilly	TRUE
Marcelle	Williams	I started this journey in June 2024 and I was able to use the Lily coupon which brought my monthly cost to $550. That is cheaper but still quite a burden on my family. I need this medication to help lose weight but also to work better. Obesity drugs should not be only for the wealthy but for everyone. Especially when healthcare is supposed to help people we are inhibiting more people from using this medication.	Other/Unspecified	FALSE
Karen	Williams	I am obese and pre-diabetic. I'm on Zepbound for my health. I'm using the Lilly savings card and I still have to pay $564 per month.	Eli Lilly	TRUE

Erin	McWhorter	I have prediabetes, metabolic disorder, and a number of other diagnoses that I need this medication for to prevent diabetes and my other conditions from getting worse. My insurance will not pay for any of it so I am getting compound tirzepitide not covered by my insurance. I pay over $300.00 a month for it with help from my parents. I would not be able to afford it without their help. I'm really trying not to become diabetic, but if the cost continues to be high, I will not have a choice.	Other/Unspecified	TRUE
Danielle	Koehn	I began taking Mounjaro in May 2023. My doctor wrote it off label for weight loss, PCOS and insulin resistance. In November 2023 I was told by my insurance company that they would no longer cover mounjaro and that they were removing all weight loss coverage from our insurance policy. The only way to obtain Mounjaro was to have a type 2 diagnosis. I have since then been using JoinFridays to use the compounded version but I've gone from paying $25 a month to nearly $400 a month. I am fortunate that I am not married and don't have a family to support but in this day and age this is a large expense. I have lost 125 pounds since beginning tirzeptide. My mother luckily sees the huge change it has made in my life and helps me with this expense. But I know there are others who are not as lucky. Fridays is currently working on my 2nd insurance appeal hoping to find a way for insurance coverage. Not sure how much longer I will be able to keep paying that much per month, but I have about 30 lbs left to go.	Eli Lilly	FALSE
Carolyn	Lee	After reaching menopause at 51, my body was behaving like a little old lady's would. My joints were hurting and I could not walk up stairs. I had a high C C-reactive protein and a lot of inflammation from all of the visceral fat that I had suddenly developed around the front of my body due to hormonal changes. As an RN, I had been hearing about these medications that were prescribed to others, but I could not afford them. One of the doctors mentioned the idea of a compounded medication which was within my reach. I wanted to have the experience of the name-brand pen, but chose the realistic option for me. The results have been excellent and I am bounding up stairs now.	Other/Unspecified	TRUE
Ladonna	Tecumseh	I am affected on a couple different ways. 1) is the shortage. Not able to consistently get the mounjaro 5mg every month are making my blood sugars fluctuate therefore; interfering with my ADL's. 2) I have bcbs Tennessee. My co payment with saving card is $260 a month. I am a nurse and struggling monthly to make ends meet. Very stressful. Thank you for reading my story, LaDonna Tecumseh	Other/Unspecified	FALSE
Amy	Smith	I was diagnosed T2 diabetic in June 2024. I am overweight and also have high blood pressure When my PA for a GLP-1 was approved I was so excited and had great success but all that was short lived because my insurance will only cover 20% of the cost of the medication. I only took it for two months. It's all I could afford after the savings card ran out. From the start I had success and all that was quickly lost and now I am taking something that may help my A1C but gives me more side effects and no weight loss benefits. I am looking at other options but sure wish Ozempic or Mounjaro were more affordable.	Novo Nordisk	TRUE
Suzanne	Resnick	I had a BMI of 33 with many comorbidies (hypertension, high cholesterol, fatty liver, sleep apnea) along with depression due to my weight. I asked my doctor to prescribe a GLP-1 to help me with my obesity. My insurance EXCLUDES antiobesity drugs. Period. No exception for high BMI or comorbidities so I have paid out of pocket since 2022. I have lost 58 lbs and now within the normal BMI rande and all of my comorbidities have gone away and bloodwork is within normal ranges. Without this drug, I could be dead. This drug saved my life. Insurance companies should take this into account and treat obesity for the disease it is.	Other/Unspecified	FALSE
Mary	Gaida	I pay $700 for compounded every 2 months	Other/Unspecified	FALSE

Jennifer	Damboise	In November 2022, I was diagnosed with Stage III B Breast Cancer. My treatment involved chemotherapy, immunotherapy, 2 surgeries, 33 radiation treatments, and I am now on at least 5 years of hormone therapy. Hormone therapy consists of 2 medications that completely shut off my hormones. This causes many side effects including weight gain. I am already considered overweight and having additional weight gain would be detrimental to my health. Not only would this cause more health problems, but the higher my weight gets the higher my chances of cancer recurrence get. I tried to lose weight on my own with exercise and eating well but nothing works. Having access to Zepbound is the only way I am able to lose weight and maintain a healthy lifestyle. As a result of the cancer treatments and the toll on my mental health, I was forced to quit my job of thirteen and a half years which had great insurance. I now work a part time job and am forced to go on my husband's insurance. We will be struggling to pay over $500 a month for my Zepbound medication on a drastically reduced salary. This is absolutely ludicrous. These medications are so important, and the amount of money it will save both patients and insurers from future bills and health issues will be immense. There is no reason the price needs to be over $1,000 a month or that it isn't covered by insurance. Having access to this medication is literally a matter of life or death for me. And unfortunately, I have no idea how long I'll be able to afford it to keep beating the odds of cancer.	Eli Lilly	TRUE
Pamela	Glenn	I live pay check to pay check was on mounjaro with the coupon insurance now will not pay for so I can't get any weightloss medication I am 52 years old struggle everyday with my weight. I have tried diets fasting counting calories but nothing helps when I was on mounjaro I was loosing weight it help so much physically and mentally. When I turned 42 I had a heartattack so getting the weight off would help tremendously I have sleep apnea. I just can't afford the medication would love to be back on the medication. Thank you	Other/Unspecified	TRUE
Nikia	Love	By December, with using the savings card, my cost will be $7,150 out of pocket because my insurance does not pay a dime of expenses.	Other/Unspecified	TRUE
Ashley	Leonard	Right now our insurance covers most of the cost with us only having to pay $35 out of pocket. However, with insurance now not covering the medication we will be forced to stop once dec 31st comes around due to the medication costing too much. $1200 a month is half of my monthly income. We are considered on the lower end of middle class. However it is not realistic and we can’t afford this medication out right. This is supposed to be a life long drug for obesity but no one can afford it.	Other/Unspecified	TRUE
Julie	Tracy	I am over 120 pounds overweight, considered morbidly obese, tried for 30 years every type of diet, Weight Watchers, etc & no luck losing the weight no matter how well I eat or try. I have Kaiser insurance which does NOT cover weight loss medication since I am otherwise healthy & no co-morbidities (at this time my heart & bloodwork are good, no diabetes). Since i have insurance that doesn’t cover it, Kaiser is one of the loopholes where I cannot even use the Eli coupon (tried many times/places). So, I have to pay over $1,100 a month out of pocket for Zepbound pens as I do not want to use compounded medication. I am on 7.5mg now so can’t even buy vials from Eli Lily direct at lower rate. I am losing weight like never could before (9 weeks on Zepbound & average 2lbs/week so far). & food noise is gone so I can focus on things more & even make better food choices. I cannot keep up paying over $1,100 per month & worry I cannot get healthy otherwise.	Eli Lilly	FALSE
David	Dickson	550 a month. My insurance paid for it a couple of months then the state of NC decided they would not pay for this life changing drug any longer.	Other/Unspecified	FALSE

Jennifer	Fuller	I visit my doctor about some weight loss options. I was thinking bariatric surgery. I'm a candidate. I went to check to see if I could get GLP-1 - since I am a prime candidate for it . The cost and the approval process was horrendous. Insurance companies have told me they are not paying for it because it cost $1300 plus ... just for context, I have tried to get approved every medication and this seems to be a problem across-the-board. So I checked out buying the drug in Canada I ordered from mycanadianinsulin.com and Lord and behold they had the medication Ozempic for $225 dollars with the overnight shipping. I was literally blown away how the United States will let a company price gouge. this reminds me of the aids medication how much it cost to make versus how much the company made. This is just another reminder of big Pharma collecting a paycheck. The companies should be ashamed Of themselves. There was a compound pharmacy by my house that I was able to get the medication for $200. I think the only reason we are paying this because of the name on the drug. This is 100% the same thing as the aids medication and the price gouging of it.	Novo Nordisk	FALSE
Phyllis	C	I have struggled to get these needed meds because of the enormous cost. To be able to afford it, I was initially lucky enough to be able to drive 4 hours one way to Vancouver, BC. Canada to get it for around $180 USD. I haven't been able to drive there lately, so I am having to do research grade, which is unregulated. Why are people in our country not able to access the exact same medication for the same price in Seattle as it is in Vancouver, BC? I shouldn't have to do gig work just to be able to afford my medicine. $900+ is an outrage.	Other/Unspecified	TRUE
Rebecca	Markel	I went for 2 years trying to limit calories, doing 45 min of exercise a day to loose weight naturally because I could not afford WeGovy. In 2 years I lost 5 lbs. Even with following the pre approval instructions of BCBS Mi and was approved, no cost was covered. In April BCBS MI approved coverage with pre-approval and regular visits with my PCP and has been covering the drug and since 4/27 I am down 30 lbs. on July 1st BCBS Mi announced they will no longer cover WeGovy for weight loss at all. Come Jan 1st it will all be out of pocket. My PCP is angry, I am upset because I've finally found something that is working and making such a huge difference in my life! So come 1/1/2025 I have to figure a way to cover the $1350 cost per month to loose the last 40lbs to get my BMI in the normal zone. I'm 50 and want to lower my risks of heart disease, elevated BP and reduce my asthma attacks. It's really discouraging that such a powerful medication cannot be made more affordable to people who are following all the insurance rules, working with their PCPs! Shame on the drug companies for not working with insurance companies better and shame on the insurance for discontinuing coverage because it's "too costly" and siting side effects for their reasons of discontinuing coverage. In the long run taking off the weight and reducing my food noise is much more cost effective than heart surgery!	Other/Unspecified	TRUE
Diane	Cappel	I was prescribed mounjaro August 2023 for weightloss by my physician but medicaid doesn't pay for "cosmetic drugs" as they consider getting healthy only for appearance. I had to seek alternatives from outside the country in order to afford it. I've since lost 100lbs doing the grey market route but we shouldn't be forced into doing this in order to save our lives.	Other/Unspecified	TRUE
Carrie	Ferrone	I'm privileged in that the medication is covered by my insurance but I worry that at anytime that benefit could change and I will not be able to afford $1200 a month to stay on this medication. Meanwhile I have T2D, High Cholesterol, MASH, and CAD and this medication is treating and improving all of my conditions. A loss to this medication due to cost would have an immediate and negative impact on not just my current health but my long term health and longevity.	Other/Unspecified	TRUE

Pj	Terry	I am a senior classified as obese. Sadly because I am on Medicare I am not eligible for any insurance participation. Not only that, this precludes me from the savings card option. Being a senior on a fixed income makes it prohibitive to go “name brand.” Without access to compounded medications I would be heading straight for a heart attack or stroke! Why is it that big pharma only seeks profit rather than what is best for the health of the American people? Shameful! Can’t there be an effort at reducing prices so more people could afford the name brand Rx? They do it in Europe…shouldn’t our costs be similar?. Big pharma could still realize a profit!	Other/Unspecified	TRUE
Melinda	Rafail	Dear Senator, I write to help others get the life changing medication, Zepbound, I have been on. Please, please get to the bottom of the price gouging from big pharma with weight loss drugs. These can be purchased over seas for a few hundred dollars. Here it is over $1,200 a month. This makes it a rich person's drug. I am fortunate that my insurance covers most of it. This has been a MIRACLE drug for me. It has just about cured my food addiction. I am no longer pre-diabetic. My heart and blood pressure medications have all been drastically lowered and I am healthy enough to walk three miles daily. I have a new lease on life. I want others who are not as fortunate as I have been to get the same opportunities that I have been blessed with. These big pharma companies make billions of dollars profit. Please help make these medications fair and reasonably priced for all. No one can underestimate the power of getting healthy and how that changes your life for the better. Thank you for fighting the good fight for all of those who don’t feel they have a voice.	Eli Lilly	FALSE
Jennie	Kottmeier	I started A GLP1 medication in September of 2022 when there was a savings card and it cost $25 to get. I am a teacher in the largest elementary school district in a Illinois and our insurance plan has a weight loss exclusion written into it so everything I’ve done to better my health in this area has been 100% funded by me. As of July 2023, that savings card was no longer available and the price of this medication has continued to climb. My insurance has continued to deny coverage for this life saving/changing medication. I’ve gone from paying $25 to $450 then $500 and now $550. The card just changed again and it will now cost me $600 a month for something that supposedly cost them about $1.25. So in addition to spending 1000’s of dollars in the kids in my classroom each year, I’m spending close to $9,000 for the medication and $99 monthly charge to see my doctor. I have lost just over 100 pounds since starting a GLP1 medication and still have more to go, but it gets harder and harder each month to cover the cost of the medication/doctor (now $700 a month). It’s infuriating when I also have good insurance that I pay (and work for) which denies coverage for this disease I’ve been struggling with for most of my adult life. I have served the children with disabilities in my community for the last 28 years. In that time we have made progress including our most vulnerable children who learn differently. They are included and celebrated rather than being ostracized and discriminated against. Why is it still ok that discrimination is allowed to continue for people with these true health conditions?	Other/Unspecified	TRUE
Katherine	Jacobsen	Last October I gave birth to my beautiful baby girl. During the pregnancy I developed an unusual condition of an epigastric hernia. When the hernia was still present and quite large and painful postpartum, I was referred to a general surgeon. The surgeon agreed I needed surgery but my BMI was too high to preform it safely. At this point I was referred to an obesity doctor who believed my best option was a glp-1 medication. Unfortunately my insurance doesn't cover anti-obesity medications under any circumstances. And the monthly price out of pocket was not possible for our family. Out of desperation, my husband and I learned how to split the same medication that he was prescribed for diabetes, and was covered by insurance in our home. I'm not proud of that but we were faced with tough choices and it seemed like the best option. Over a few months it became apparent that this was only a temporary solution. There would not be enough medicine to control my husband's blood sugar and help me to lose weight for surgery. That's when I learned about compound medications and at this point we are digging deep to afford compound medicine which has helped me lose 40 pounds and I am getting close to being able to have my hernia repaired. But at anytime the drug shortage could end and the compound medicine could disappear. I don't understand why drug companies are pricing these drugs far beyond what a family can afford leaving us to resort to desperate means to treat serious health issues. I would like to urge congress to look out for the American people by whatever means you can. Please choose our health over the drug companies pocketbooks.	Other/Unspecified	TRUE

Barbi	Snell	I was in my late 30s. Diagnosed with PCOS, Type 2 diabetes, high blood pressure, high cholesterol. I tried EVERYTHING to loose the weight. My last hope was Bariatric surgery. It helped me loose almost 100 pounds, I no longer had the medical conditions mentioned before but I never achieved my healthy goal weight. Ffwd 4 years, despite following a mealplan provided by a dietitian I gained 40 pounds back. My doctor wanted to start me on GLP1. Insurance denied it. 6 months later, I had gained more weight back, my A1C was back in diabetic range. I was devastated. We tried again for GLP-1 and got approved for Mounjaro. I still follow a high protein, low carb balanced mealplan, I track my food intake. I am putting in the same amount of work as I did pre-GLP-1. Only now it is working!!! I am loosing weight. I am not constantly thinking about food, my A1C is back down on pre-diabetic range. GLP-1s work! We need them. Denying them is to deny somebody the right to a healthy life.	Eli Lilly	FALSE
Janet	Nafeha	I started on GLP1 medicine a month ago. I should have been able to start in the new year but insurance denied coverage. There was no way I could afford the excessive cost of the medication without insurance. So I gave up. 7 months later I learned I could get compound thru tela health. It cost me several hundred dollars (which in my opinion is still too high) but I was desperate. I knew I was headed into diabetes and all the awful things that come with it. A month later I was diagnosed with type 2 diabetes, high blood pressure and cholesterol. The script was still denied by insurance so I ordered compound. Eventually the script was approved but the process to get it is setup for people to give up on getting it. If I ever lose my insurance, I can't afford the medication. This medicine is the only thing that has helped me. I had gastric sleeve surgery in 2015 after years of type 2 diabetes, severe sleep apnea, high blood pressure and cholesterol. I was denied coverage to get that surgery and ended up finding a doctor who would do it for a flat fee. For a few years it worked. I was free of all my ailments. But the food noise began again. My weight slowly started to go back up. I broke my ankle and severely sprained my other one in 2021. I was in a wheelchair for 6 months. That only made my weight worse. This drug is the only thing that has stopped the food noise: without it I will get sick. Obesity is an illness, not a choice. Insulin resistance is real. It's brick wall we can not get around. GLP1 is the sledgehammer that helps us break through that wall. Please make these medicines affordable for all!	Other/Unspecified	TRUE
Mary	Humber	I was determined NEVER to take this medication. Diet and exercise should work to lose weight (though for more than a decade of nutritionists and trainers, it didn't). My family staged an intervention of sorts to convince me to try these meds. And while it was done poorly and ruined the family relationship for me, they did convince me. Unfortunately, when my insurance denied coverage of ANY weight loss meds, my family quickly balked at the cost and withdrew their support when I asked for help paying for it monthly. My husband works for a mission organization and I am an ESL teacher. I can only work part time due to chronic Lyme disease (which I have to pay for out of pocket to treat). Together we make less than 80,000 a year, even with decent jobs. I cannot afford these meds on my own. Thankfully my 92 year old mother offered to help while she is alive… AND I'm ordering from Canada. When she passes, I will have to stop the medication that is finally helping me achieve weight loss (20 lbs in 4 months, not fast…but progress I couldn't make on my own.) I have spent hundreds of thousands of dollars treating chronic illness. I am not diabetic because I have excellent diet and exercise yet; but without this medicine, I am on my way to diabetes. It is a SHAME that insurance will not help me PREVENT disease but will only help once I am further incapacitated and inundated by disease. The US healthcare system is greedy. This has got to stop. Novo Nordisk is taking in billions whIle people Like me and MORE kill ourselves to afford for a med that costs a FRACTION of the price in other countries! Shame on the US for allowing this to be a common-place practice.	Other/Unspecified	TRUE

Shawna	Viox	I work for a major hospital in Cincinnati with no weight loss coverage. I have metabolic disease, pre-diabetes, high blood pressure, high cholesterol, and the disease of obesity. My physicians agree I am a prime candidate for GLP-1 therapy; however, I must pay out of pocket hundreds of dollars per month for access. Nearly impossible in the current economic climate where many are struggling to keep a roof over their head. I must become even sicker with full blown diabetes for this rx treatment to be covered. Hundreds of thousands of Americans can PREVENT becoming sicker and living with diseases that reduce quality of life and increase early mortality if we had equitable and AFFORDABLE access to these life-changing and, ultimately, life saving meds. Please help.	Other/Unspecified	TRUE
Beth	Grant	I'm a 47 year old woman who weighed 285lbs at 5-4 I was depressed and becoming immobile. I needed help. I started a GLP1 and I'm down 70lbs in 8 months. I'm going into debt to be able to afford this medication. It's saving my life but costs between $300-$600 a month. No one can afford that. In edition I'm the CEO of a non-profit in Michigan the prices have skyrocketed insurance costs as well, preventing me from carrying insurance for my team to cover these meds. This is changing my life and putting me in debt. This is changing my life but I can't afford to cover it for my staff. I know it could impact lives on my team but it's out of reach. This isn't about R&D costs this is about greed. I'm grateful for these medications but I'd be even more grateful if pharmaceutical companies cared more about the people they serve instead of the pockets of leadership and shareholders. When is it enough profit for you to just want to save lives now?	Other/Unspecified	TRUE
Shyla	Hazen	I have been taking zepbound since January of 2024 at a cost of 550 per month. I have 140 a week taken out of my paycheck and direct deposited into my zepbound account., at 40 hours a week that means 3.50 cents per hour is going to uncovered medication. I buy my insurance through the market place at over 200 a month and this medicine is not covered at all. So realistically we are at over 750 a month coming out of my pocket per month which works out to 4.25 an hour out of my pay. I have struggled with weight as long as I can remember, weight watchers for years took my money to lose weight most often unsuccessfully. I have done training programs at gyms, shake diets, 3 day diets, arbonne diets, keto diets, vegan diets, nutritionist guided diets. With little or unattainable success. In 2017 I had a accident and broke my leg I worked for a year to get my leg to function again, ultimately I had a knee replacement at the end of 2017 and did physical therapy well into 2018 not improving. Nerve damage and scar tissue build up. My ability to have an active life style diminished I struggle daily. The weight went up. In 2022 I had emergency spine surgery my spinal cord was compressed and I have mylopethy. Also not a great recovery. Nerves are over active/damaged. I was out of work for 6 months, 6months! I do have a decent job but recovering from the surgery was a challenge still is my body is always in pain due to my nerve problems. In 2022 my daughter was concerned with my snoring- I went to the doctor I have sleep apnea. I was also diagnosed with high blood pressure. I keep blood pressure under control with two medicines, the sleep apnea I cannot wear the mask due to the pressure it puts on my scalp which aggregates my nerve issues. In 2023 I had a cat scan and MRI due to pain in my neck all the time and when doing that it was discovered I had a lime sized mass on my thyroid, I had it biopsies and it came back ok but it was determined due to size of the mass we should remove that said, when that was done results came back I had cancer hiding under the mass. A couple months later (giving time for recovery) the other side of my thyroid was removed also cancer but a different type. I now have no thyroid, which increases the weight loss challenge. So to recap, I have mobility issues causing weight gain, I have nerve damage and live with pain all the time, it is my normal. I have obstructive sleep apnea and high blood pressure. I have arthritis. I have no thyroid and am considered to have cancer while we monitor it. I am considered obese. When I started this I was morbidly obese. I know I still snore but my daughter says it sounds better than it did not as scary.i need to get a new sleep study.	Other/Unspecified	TRUE

Nicole	Wiekierak	Having JUST started on a GLP1 and gone through the prior authorization process, my initial fill was set to be over $500. Now my insurance isn't top tier by any means, but it's pretty good when I've needed it otherwise. Even adding on one of the manufacturers savings programs on top of my insurance, this med is going to cost me $350 out of pocket every month. For someone with diagnosed PCOS, long documented insulin resistance, just below the threshold of pre diabetes, with a family history of type 2 diabetes it's worth it and I'm thankful that it's an expense I can afford. But I am in the minority to be able to do so. That this medication is able to stop folks like me who are extremely predisposed to a lifelong, life altering condition like diabetes and it costs SO MUCH...specifically to those of us in the US, isn't right. These drugs are legitimately saving lives, and seeing that these drugs are available at an average of $100-$300 per month in Europe adjusting for the exchange rate when they're $1000-$1300 per month here is just ridiculous. The US is known for obesity. Our own CDC has us at 41% of the population labeled as obese. These drugs are treating what is very obviously an epidemic for our country, and that treatment needs to be ACCESSIBLE for 41% of the population, not just us lucky few.	Other/Unspecified	TRUE
Re.	Pryor	To all who are concerned Thanking Onthepen platform and Bernie Sanders for giving us the opportunity to express our desperation to afford the weight loss medication. The American Medical association have come forth to declare that Obesity is a known Chronic Disease....the percentage of people affected by this is vast...it's truly a miracle that scientists are able to create a remedy to control and heal this dysfunction and gear us towards healthier bodies and controlling other diseases that are so easily besetting us.. We as patients pay diligently for our health insurance and the stress to afford the services is leading us to more detrimental sicknesses. We plead the case for the GLP-1 medications to be more affordable or at least for Medicare and other Insurances to cover the GLP-1 miracle dosages that has been known for a long time that it cures many people with dangerous life ailments...Seniors are the most in need for help to maintain some type of quality healthy lifestyle as we age...so, on behalf of the Baby Boomers please have compassion for this urgent plea...We need Congress's help to be the voice of those who are crying in the wilderness. Please don't count us out from this amazing discovery of modern medicine that Novo and others have dedicated their professional expertise in developing a powerful and exciting medication that is readily and affordable for all...it's a drug that is saving lives for generations to come...We're in need of real solutions and hopefully they'll come real soon. Thank you for your time Sincerely RE. Pryor	Other/Unspecified	TRUE
Bex	Kaz	I have a PA. But due to my deductible my cost is approx 30 dollars a day. I have insurance, but my deductible is 5000. I can't afford this. So I buy Chinese made research chemicals and inject them. I go thru group buys so they are somewhat tested. My life and health has improved 200%	Other/Unspecified	TRUE

Salty	McStoney	To Whom it May Concern; working in primary care, I have come against many obstacles in getting brand name GLPs to my patients. We know now with current data how many indications these medications have proven to treat, yet they are near to impossible to get access for my patients and myself!!! Thus, I have had to turn to compounding pharmacies in effort to allow my patients and myself affordable life saving treatment. In the UK and many other countries, the cash pay option for brand name GLPs is significantly less than here in the United States. There is no reason why the same couldn't be offered here. Until then, the option for compounded meds must stand. Taking that away from my patients would be a travesty and would border on negligence by many entities involved. Sincerely, Salty McStoney	Other/Unspecified	TRUE
Caitlin	Jeffery	I have PCOS, and after a difficult pregnancy with complications, my BMI qualified me for treatment with a GLP-1 medication (either WeGovy or Zepbound). As a woman with PCOS, I have struggled my entire life with my weight, even resorting to disordered practices in the past in attempts to lose weight. Because of my PCOS, I also struggle with the disease of obesity. However, my insurance will not cover these treatments, despite the fact that I qualify for them, and despite the fact that we are paying almost $1,000 a month for said insurance for my family. I have an insurance plan through the Marketplace, and we had our contact search to see if we could switch to a plan that will cover a GLP-1 medication during open enrollment. There is not a single plan available to us that would cover these medications. I simply cannot afford to pay $1,300 a month (half of my monthly rent) for this medication, especially when already paying such a significant amount for insurance. It is prohibitively expensive for almost anyone whose insurance will not cover them.	Eli Lilly	TRUE
Megan	Fenoy	I am about a year in remission from Hodgkin's lymphoma. 7 months ago my endocrinologist and I decided a glp-1 would be the best treatment to get my health back on track. My cancer was most likely caused by my high levels of inflammation and of course obesity. I have struggled with my weight all of my life because of my autoimmune conditions and pcos. The glp-1 I am currently on is actually saving my life. It is also making it so that I cannot live my life because I have to work 70 hours a week to be able to afford it. If it was more affordable I might be able to drop my hours and actually enjoy life. Nobody should have to work these amount of hours just to be able to afford medication. I have already lost years of my life battling cancer along with my other medical issues. I'm also insignificant debt because my health insurance only covers so much. My bills have been stacking up from all the scans, treatments, and procedures. Even though my insurance does cover some, I am still paying over $500 a month. I pay less than that for my car which is absolutely devastating. For the first time in my life my rheumatologist is happy with my inflammation levels which he believes is a direct result of the glp-1 and the weight loss. I have such a better quality of life now if we could do something about the price I will actually be able to live my life and not work my life away.	Other/Unspecified	TRUE
Luis	Mendoza	I had to resort to knockoff peptides and it's saved me so much money and having great results	Other/Unspecified	FALSE
Luos	Mendoza	It's affected that I had to try knockout peptides and it's working. I've saves much much money	Other/Unspecified	FALSE

Laura	Stuto	I started taking Mounjaro on July 13th 2022 and lost 90 lbs. I went from a BMI of 36 to now 22.1 thanks to the Eli Lilly savings card, but once that ended we are no longer able to get any GLP 1 meds because my husbands employer says the cost is too high for them to offer us coverage for weight loss meds. Not only am I taking it, but so is my husband, and daughter to which they both have lost 50 lbs. I have been in maintenance now for a year. I have fought obesity almost my entire life and it has resulted in me needing 2 full knee replacements. I have joined weight watchers so many times and even became a leader after losing 122 lbs back in 2008 to which it almost all came back because I was practically having to starve myself and exercise 7 days a week to try and keep it off. For the first time in my life losing my weight and keeping it off has actually been easy with taking Mounjaro so the thought of me losing access is devastating! There is no way we can afford these meds now so we will have no choice but to go compound or stop them. My husband is a paramedic so we are a middle class family doing what we can to just make it, and the cost of these meds are outrageous when they cost so little to make. Thank you for listening to my story! Laura Stuto	Eli Lilly	TRUE
Dawn	Holt	My name is Dawn. I'm a 44 y/o single mom in SW Missouri. I am also a veteran of the United States Navy. I have struggled with obesity my whole life. In my 30's I developed high blood pressure. In my 40's I became insulin resistant and was on the door step of diabetes. I joined the Move! Program offered at the VA which has been a great support system for me. I tried several medications with varying results most ending in side effects that severely interrupted my ability to work and parent my children. At the beginning of 2024 I was prescribed Zepbound. It worked really well for me with little to no side effects. I received my first month of the loading dose 2.5 mg. I received my first dose of 5 mg. At that time I was informed that there was a shortage of the medication and they couldn't guarantee that I would receive my next dose of 5mg. When it came time for my refill I was told there were no doses available and no date when they would be. That was in March. It is now mid September. As of my last phone call with the VA Pharmacist there are no available low doses and very limited availability of the higher doses and absolutely no doses in my area. For the last 7 months I have been paying out of pocket for my medication through a telehealth. Compounded medication is my only alternative and although it's more affordable than branded medication it still comes with a much higher price tag than my copay through the VA. I'm sure for many of you $389 dollars isn't that much but for me $389 dollars is a car payment or electric bill. $389 is all that separates me from becoming a diabetic. For the first time in my adult life I no longer have high blood pressure, I'm no longer insulin resistant as the medication helps my body process insulin properly, and I'm no longer on the threshold of diabetes. I have lost 65 lbs with the tool of a GLP1 medication. No one should have to spend the kind of money we do to save our own lives.	Eli Lilly	TRUE
Stacy	Lemay	My life has transformed completely. I no longer suffer from kidney issues, high blood pressure, high cholesterol, or prediabetes. The positive impact on my health is immeasurable, and I've gained precious years to spend with my family. However, due to the overwhelming cost of Mounjaro and my insurance not covering it, I've had to resort to using compounded medications. This is the only way I can continue my treatment now. My life is worth more than the corporate greed of Eli Lilly. We urgently need PBM reform to ensure access to life-saving medications. I implore the government to prioritize the 44% of Americans who are overweight or obese. We demand PBM reform now. How many more people with chronic health conditions must die at the hands of greedy corporations?	Eli Lilly	FALSE
Mary	Gross	This medication has changed my life and as a widowed mom of special needs kids, I need to be around as long as I can. However, I am literally scraping by just to get this medication. Please lower the cost. It's so important to me and my kids.	Other/Unspecified	FALSE
Kristi	Zavala	I am on mounjaro for type 2 diabetes. The cost for me when my insurance rolled over is over $1000. That is more than my paycheck. I started an FSA account to pay for my year on the only medication that has worked for me so far. I just found out that I have to pay for the medication in full until my deductible is met and that will take my entire FSA leaving me to struggle to pay the over $300 a month after that. These life saving medications need to be affordable for everyone not just the people who can afford them.	Other/Unspecified	TRUE

Kara	Stainbrook	My friend told me about a life changing pen she had been on and I knew in my heart it could change my life and my husbands. July -2023 - Dec 2023 my husband and I paid out of pocket for our meds. Costing most $500 each per month. $6,000 still sits on a credit card to this day because of how not affordable this was but also how amazing it has changed and impacted our lives. I had to pick up insurance at my job so that we could continue on so that started in January 2024. Talk about a relief that my insurance covers it for now. But anxiety to the max knowing that is sitting on a credit card because we wanted to be healthy. Tims insurance would have paid for bariatric surgery but not a damn med. 14 month later I am down 62 lbs. I was a former daily drinker and have had maybe 5 drinks in 14 months. This pen has changed my life. My husband is over 100 lbs lost. We feel amazing but still heartbroken we have that $6,000 on a credit card. Please make medication affordable for all. So many people deserve this.	Other/Unspecified	TRUE
Donna	Ray	I am on disability due to a traumatic brain injury. Medicare will not cover zepbound or mounjaro. I have lost 110 pounds and it has helped my inflammation in my brain and body. The amount I have to pay to be healthy is more than a house payment. The shot has helped me lose and put my body back into a healthier position. I don't know how much longer I will have to scrap by. Keeping us healthy saves money and extends our lives	Other/Unspecified	FALSE
Seandee	Schultz	As someone that had fought obesity my whole life this medication has made a world of difference. My insurance did not cover the medication when I started taking it in November 2022. I had the original coupon to get the medicine for 25. Then in July of 2023 I had to pay 450 dollars a month. The medication insurance would cover was more expensive than mounjaro with no PA and a coupon. In March of 2024 insurance added Zepbound to the formulary. As of October 1st 2024 they will no longer cover Zepbound and most likely because of the cost. Now I will be back to paying or trying to pay over 500 a month. Before I started this medication I had changed my diet and was working out 5 days a week. The scale stayed at 253. Now I'm at 166. Eating the same as I wax and still working out. People who take blood pressure medication do not stop taking the medication when their blood pressure goes to normal and the same with this medication. They say they don't know long term affects, well the long term affects for me could have been stroke, heart attack or diabetes. The mental aspect of how I will continue to buy my medication to manage and maintain my weight loss is overwhelming to say the least. These medications should not cost this much or be so hard to get for the people that truly need them.	Eli Lilly	FALSE
Dee Dee	Jones	I get a quarterly bonus at work. Each quarter, I used that to do a home project or help my daughter (who has 2 kids) out financially and the Christmas time bonus, I used for Christmas presents. Now, I use my bonus money mainly for Zepbound bc the cost is outside of my monthly budget. If, for some reason, my company doesn't hit their goals and I don't get my bonus, I will have to figure out how to pay for it.	Eli Lilly	TRUE
Natalie	Kayl	I was almost 400 pounds. I've tried all the ways to lose weight but due to a chronic pain disorder (fibromyalgia) it didn't work. My insurance does not cover weight loss except for bariatric surgery. I have to pay out of pocket. My pcp wrote me a prescription for compounded semaglutide in early June 2024. Almost immediately my fibro pain was better. I went from a daily pain level of 5/6 down to a 1/2. This medicine has also immediately helped me a 2liter+ a day habit of Coke soda. I had tried to quit soda since the 90's. I can't really afford to pay out of pocket but my health is worth cutting back and living minimally to afford the meds. I would love to be on branded meds but it's just too expensive.	Other/Unspecified	TRUE

Melissa	Fisher	I have really good insurance. I mean REALLY good. It pays for absolutely everything... except zepbound. When my dr. Told me I needed to lose weight before a major surgery and my dietitian suggested zepbound, I was so happy since I've struggled with my weight my entire adult life due to health problems beyond my control. However that's when I found out that although my insurance is amazing, they won't cover zepbound. Thankfully the manufacturer offered a coupon, but it only lowered the cost to $550/month. I feel like this is totally unacceptable, that insurance companies can deny you coverage for a medication that helps your body do what it's suppose to do so that you can lose weight, yet they have no problem approving the medications that make you gain it in the first place! Since starting zepbound, I am no longer pre-diabetic, I no longer have hypertension, my cholesterol is normal, I was able to stop taking multiple medications, and yet the insurance company's won't approve it because it's too expensive! Isn't me being healthier, needing less medications, and lowering my risk of a serious health problem that could land me in a hospital SAVING them money? Why does big pharma get to dictate against my own Dr's who actually know me and my medical history? Because of the monetary cost out of pocket, I have to scrape money together every month just to afford to get my medication filled and I should not have to do that. Especially since I'm insured!	Other/Unspecified	TRUE
Cheryl	Wheeler	I'm on Medicare and it's not covered by our insurance. I have limited income from Social Security and am using what I have to pay for compounded GLP one.	Other/Unspecified	FALSE
Ashley	Hamilton	The cost hasn't impacted me however it has impacted my mom. My mom has struggled with her weight most of her adult life and got diagnosed with Hashimoto's a few years ago. My parents are now in retirement and instead of their insurance covering the medication or it being affordable, my mom was forced to use compound. My mom has been able to get off of her thyroid medication as well as lost almost 40 pounds so far and it almost 70 years old is living a completely different life in retirement physically. No one should have to sacrifice things they enjoy doing like vacations with their family to afford medication, but that's exactly what has been done here. My parents can't afford to travel so that my mom can stay healthy.	Other/Unspecified	TRUE
Karen	Frascella	I start by saying how much GLP-1 medications have made my life better! I have been able to lose 40 lbs and I have been able to go off of prescription blood pressure meds and cholesterol medications due to my weight loss and taking this GLP-1 medication. I feel healthy and can actively participate in things in ways that I never could in years. However, that could change very soon. I have been blessed to be able to afford the $550 it has cost monthly for me to maintain these medications. My insurance covers no weight loss medications and does not pay a dime towards my prescription. I chose last November to take this medication for my health, to be healthier and live longer and possibly see future grandchildren I may have. I have recently had to purchase a new car and now have a car payment. Although I may be able to swing both payments, there may come a moment where I will have to choose between the two. Unfortunately, I will not be able to choose the medication over my vehicle payment because I need to transport myself to work everyday. I think it is sad that my health will suffer and I will most likely have to go back on medications for blood pressure and cholesterol (both of which are extremely affordable) and I will not feel as healthy as I feel now. It is unfortunate that the United States does not provide something to prevent drug companies from charging exorbitant amounts of money for medications that save the lives of its citizens. These medications should be available to everyone who needs them not only those people with deep pockets. I implore the government and the drug companies to think about the citizens of this country and how hard we work and realize how important these GLP-1 medications are to so many people who fight the disease of obesity everyday.	Other/Unspecified	TRUE
Joyce	Lucas	My insurance did cover mounjaro for over a year, I used it to control my prediabetes and PCOS. Now my insurance will not cover anymore I have tried several appeals. I get shakey it messes with my hormones not taking anymore, my sugar is going up. I can't take metformin, so now I don't have anything. Within the year I will more than likely have type 2 diabetes. I cannot afford to pay out of pocket for this medication, and nor can I afford compound. I have chronic migraines and this has also helped. I have fatty liver and high blood pressure. Working in Healthcare and my employer does not cover weightloss medication. Why cant we afford to buy this medication. But it is ok for me to buy phentermine with my own money and take that, and with long term use could affect my heart. Please do something to help.us.	Other/Unspecified	TRUE

Roxanne	Cortez	My husband is on manjaro for his diabetes, high blood pressure and obesity. I'm on zepbound for my obesity and high blood pressure with PCOS complications. This medication has been life saving to us. It has changed our whole world for the better. My husband had kidney failure due to diabetes complications and received a new kidney transplant 2 years ago. Thankfully his Dr. advised him on manjaro and has been successful taking this medication by lowering his blood sugar. We love this medication and what it has done for the obesity community. However, because of the price of this medication I feel that one of us is not going to be able to access the medicine that we truly need. This medication is so expensive that we met our deductible within 4 months of being on this medication. Thankfully our insurance covers the medication but we are left with the wonder of what will happen next year. It is outrageous how much this life saving medication is and to obtain. Currently because of the Lilly coupon we pay $25 for a box for one month of pens. That's $600 for the whole year. $300 for me and $300 dollars for my husband. On top of the other family members in the household it is kind of difficult to look at the price and not feel bad about how much the cost is. But, I'm am very lucky and grateful that my insurance does cover this medication. There are countless of Americans having to deal with higher costs for their medication that they desperately need. At this point this is not a want, this is a need. The American people are desperately suffering from obesity and its complications for far too long. If there is an available medication that will help people it must be available for all and accessible for all.	Other/Unspecified	FALSE
Julie	Cole	As a person living with a rare neuromuscular disease, Myasthenia Gravis, I am used to knowing about the "big ticket prices" of life saving medications. I have been fortunate to have my insurance coverage take soften the blow. My insurance coverage also has benefits for weight loss medication, but the larger pharmacy board has decided the my doctor's prescription for Mounjaro/Zepbound (tirzepatide, manufactured by Eli Lilly) is not the right one for me (arguing with my doctor!) and I must fail multiple other medications which my health conditions do not allow me to take safely, in my opinion. So, subsequently my insurance has denied and will not pay for what has been an effective and beneficial medicine for me. I pay full retail price for this medication because I have been told it will help my health in multiple areas. And insult to injury is that my HMO and Lilly cannot come to an agreement to allow me to take advantage of the coupon that lowers the price. I believe the companies that came up with these game-changing formulas deserve a fair return in investments, but it feels as if I am being unfairly punished for buying their product in America. I will at some point be unable to afford this medicine that I feel is as life changing as the medications that keep me out of the hospital for my rare disease. My plan was to move to a compounded version of this medicine to continue, but it seems that Lilly is intent on closing that door for me and millions of others that are looking for help and hope in this are. Please, why are prices in America so much more than prices overseas? Why are they keeping medication from sick people?	Eli Lilly	TRUE
Jeanette	Choice	To Whom It May Concern, I'm on a Medicare Advantage plan. Even though my injections are covered, due to having diabetes, when I reach my "donut hole", which typically happens by about the half year mark of my whole year's coverage, my out-of-pocket cost goes up drastically. I'm on a fixed income and I suffer from a serious and chronic disease. The overall cost for treating it successfully shouldn't be a financial hardship for me. Especially when the rest of the world pays so much less for the same exact medications and the costs of producing them is known to be around $5/per pen. Thank you for listening and hearing me. ~ Jeanette C.	Other/Unspecified	FALSE

Joe	Jones	I have been on zepbound since December, my insurance covered up until I switched jobs August 1st, I started at 290 with trying everything before and nothing has worked for me. So I started at 290 pounds and I'm down to 219 today. August 1st I switched employers and they have the same insurance but different formularies and they don't allow weight loss medication. I cannot afford 500 dollars a month. I have 2 kids one is 3 years old and the other just turned 1. There's no way I could be able to afford out of pocket and now I'm afraid all of the hard work I have put in to be healthy is going down the drain	Other/Unspecified	TRUE

[Whereupon, at 12:18 p.m., the hearing was adjourned.]

○