MILLIMAN REPORT

Impact of anti-obesity medication coverage in the Medicaid and commercial markets

Commissioned by Novo Nordisk

June 11, 2024

Jake Klaisner, FSA, MAAA
Senior Consulting Actuary

Briana Botros, FSA, MAAA
Consulting Actuary

Ryan LeRoy, FSA, MAAA
Actuarial Manager

AJ Ally, PharmD
Principal and Pharmacy Management Consultant

Kristin Niakan, MPH
Pharmacy Management Consultant

17335 Golf Parkway
Suite 100
Brookfield, WI 53045
USA
Tel +1 262 784 2250

milliman.com

Milliman

Table of contents

I. EXECUTIVE SUMMARY

Novo Nordisk, Inc. engaged Milliman to analyze the incremental impact of coverage of U.S. Food and Drug Administration (FDA) approved anti-obesity medications (AOMs) in Medicaid and commercial markets. In the past several years, there have been substantial changes in the perception of obesity treatments, from cosmetic drugs to drugs to treat a chronic condition. There have also been advances in AOMs, specifically glucagon-like peptide-1 agonists (GLP-1s). The media attention and market demand for GLP-1 AOMs have been a significant topic in public discourse, especially since the launch of Wegovy in June 2021 and Zepbound in October 2023.[1] The active ingredients in these products also have indications for type 2 diabetes mellitus (T2DM) and are expected to receive expanded indications to treat a variety of other chronic diseases.[2,3] There are a limited number of state Medicaid programs and commercial health plans that currently provide coverage for AOMs; however, these expanded indications would be eligible for widespread Medicaid and commercial coverage.[4,5]

This report focuses on how coverage of the AOM class could affect Medicaid and commercial stakeholders' costs. When AOM coverage is added, payers' pharmacy benefit costs increase as patients who were not otherwise eligible for insurance coverage of an AOM (i.e., do not have T2DM or a chronic disease that is an indication for use of the active ingredient in the AOM, other than obesity) begin therapy. Over time, the portion of patients who remain adherent to AOM therapy and lose weight may begin to experience improved health outcomes, potentially reducing both medical and pharmacy benefit costs as certain services are reduced or avoided. Reductions in healthcare costs for these other services are referred to as cost offsets. We present a series of estimated cost impacts of AOM coverage for weight loss, ranging from the direct cost impact absent healthcare cost offsets to a scenario where cost offsets are realized. We analyzed the impact over a five-year time horizon from 2025 through 2029.

Tables 1 and 2 show the estimated five-year incremental impact of AOM coverage on Medicaid and commercial market stakeholders' cost, assuming the anticipated short-term indication expansions among existing AOMs are approved and those indications are covered. The values in the tables below reflect incremental costs, meaning the costs of the chronic weight management indication only, excluding the costs of these drugs for other indications, for a plan or state that newly adds coverage. Current plan or state experience may be higher or lower than these estimates, as our methodology and assumptions as current experience is assumed to vary relative to the projection primarily due to the following:

1. The results reflect scenarios that exclude patients with currently approved indications (i.e., diabetes and cardiovascular disease), as well as anticipated expanded indications. Patients with these conditions would already have access to GLP-1s through their standard benefit, without an AOM coverage policy change.

2. We anticipate a high degree of competition in the class, with rebate levels similar to other highly competitive classes in Medicaid and commercial markets. Furthermore, we assumed net prices will decrease relative to existing public estimates of AOM rebates after adjustment for increasing competition in the class due to Zepbound's launch.[6] This is based on a combination of overall average brand net price changes and net price changes specific to insulins, as the AOM class is expected to

[1] Ally, A.J., Bell, D., Craff, M., et al. (August 2023). Payer strategies for GLP-1 medications for weight loss. Milliman white paper. Retrieved from: https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-28-23_glp-1s-for-weight-loss_20230824.ashx

[2] Melson, E., Asraf, U., Papamargaritis, D., et al. (2024). What is the pipeline for future medications for obesity? *International Journal of Obesity*. Retrieved from: https://www.nature.com/articles/s41366-024-01473-y#Ack1

[3] PR Newswire (January 2024). GLP-1: Beyond Diabetes, a Blockbuster Horizon Beckons. Retrieved from: https://www.prnewswire.com/news-releases/glp-1-beyond-diabetes-a-blockbuster-horizon-beckons-302030747.html

[4] Enright, D., Beinfeld, M., & Chambers, D. (August 2023). How US commercial health plans are covering semaglutide (Wegovy® for obesity management. Center for the Evaluation of Value and Risk in Health. Retrieved from: https://cevr.tuftsmedicalcenter.org/news/how-us-commercial-health-plans-are-covering-semaglutide-wegovy-for-obesity-management-2

[5] Niakan, K. and Schock, B. (January 2024). GLP-1 agonists in Medicaid: Utilization, growth, and management. Milliman white paper. Retrieved from: https://www.milliman.com/-/media/milliman/pdfs/2024-articles/1-18-24_glp1-agonists-in-medicaid-utilization-growth-and-management.ashx#:~:text=MEDICAID%20COVERAGE%20OF%20GLP%2D1%20AGONISTS%20FOR%20TYPE%202%20DIABETES,authorization%20or%20other%20clinical%20criteria

[6] Ippolito, B. and Levy, J. (September 2023). Estimating the Cost of New Treatments for Diabetes and Obesity. American Enterprise Institute, *Economic Perspectives*. Retrieved from: https://www.aei.org/wp-content/uploads/2023/09/Estimating-the-Cost-of-New-Treatments-for-Diabetes-and-Obesity.pdf?x91208

have similar competitive dynamics as insulin.[7,8] Results are highly sensitive to rebate assumptions; lower rebate levels could result in an increase in net costs for all stakeholders. Further details on selected rebate and market share assumptions are in the "Assumptions Related to AOMs" section of this report.

3. We assume that utilization management (UM) criteria is in place and that there is no off-label use assumed going forward.

The range of results illustrated does not represent a minimum or maximum, but rather potential costs based on the assumptions outlined in this report, particularly uptake and rebate assumptions. Actual results will also vary for specific stakeholders due to differences in demographics, trends, discount arrangements, formulary, utilization patterns, and rebate arrangements, among other factors.

Table 1
Net Impact of Adding AOM Coverage to Medicaid
Baseline Scenario
2025 Through 2029 Estimated Changes in Stakeholder Per Member Per Month (PMPM) Costs

	Expanded Indications		Current Indications	
	No Cost Offsets	Including Cost Offsets	No Cost Offsets	Including Cost Offsets
State[1]	$0.05 - $0.09	$0.04 - $0.07	$0.05 - $0.09	$0.04 - $0.07
Federal Government[1]	$0.14 - $0.25	$0.10 - $0.18	$0.14 - $0.25	$0.10 - $0.18
Total[2]	**$0.19 - $0.34**	**$0.14 - $0.25**	**$0.19 - $0.34**	**$0.14 - $0.25**

[1] The distribution of state and federal liabilities are calculated using Federal Medical Assistance Percentages (FMAP) applied by state and population.
[2] Totals may not tie exactly to shown sums due to rounding.

Table 2
Net Impact of Adding AOM Coverage in the Commercial Market
Baseline Scenario
2025 Through 2029: Estimated Changes in PMPM Costs

	Expanded Indications		Current Indications	
	No Cost Offsets	Including Cost Offsets	No Cost Offsets	Including Cost Offsets
Member[1]	$0.33 - $0.58	$0.26 - $0.47	$0.33 - $0.59	$0.27 - $0.47
Health Plan[2]	$0.53 - $0.93	$0.11 - $0.19	$0.53 - $0.94	$0.10 - $0.18
Total[3]	**$0.86 - $1.52**	**$0.37 - $0.66**	**$0.87 - $1.53**	**$0.37 - $0.65**

[1] Member share includes cost sharing.
[2] Health plan share includes the net liability remaining after accounting for rebates and cost sharing changes. No shift to member premium is assumed.
[3] Totals may not tie exactly to shown sums due to rounding.

Our analyses are based on a number of key assumptions regarding AOM market share, rebates, patient adherence, and the amount of cost offsets that could be associated with weight loss. The per-AOM utilizer magnitudes of our cost offset assumptions are based on published literature on healthcare cost offsets, beginning in the year following initiation of adherent AOM use,[9] resulting from weight loss, described in the methodology and assumptions section of this report. We applied literature-based assumptions to the portion of the population assumed to take AOMs in our analysis; however, we did not independently evaluate the efficacy of AOMs or longitudinal impacts of weight loss on healthcare costs.

[7] Drug Channels (June 2023). Gross-to-Net Bubble Update: 2022 Pricing Realities at 10 Top Drugmakers. Retrieved from: https://www.drugchannels.net/2023/06/gross-to-net-bubble-update-2022-pricing.html

[8] Cline, M., Shaw, H., Silseth, S., et al. (December 2021). Analysis of Insulin Competition and Costs in the United States. Milliman white paper. Retrieved from: https://www.milliman.com/-/media/milliman/pdfs/2021-articles/12-9-21-analysis-insulin-competition-costs-us.ashx

[9] Thorpe, K., Toles, A., Shah, B., et al. (October 2021). *Journal of Occupational and Environmental Medicine*. Retrieved from: https://journals.lww.com/joem/fulltext/2021/10000/weight_loss_associated_decreases_in_medical_care.5.aspx

The Medicaid cost offset scenario assumes that Medicaid savings are reduced by 75% of similarly applied commercial assumptions to account for a lower percentage of healthcare costs attributable to obesity-related conditions in the Medicaid population. In the Medicaid market, we assumed that 0.4% of the total adult population is projected to initiate AOM therapy and 0.01% of the total pediatric (age 12-17) population, with an average of 5.4 scripts annually per person taking an AOM. In the commercial market, we assumed 0.9% of the total adult population is projected to initiate AOM therapy and 0.1% of the total pediatric population, with an average of 6.1 scripts annually per person taking an AOM. We developed these assumptions based on Medicaid and commercial market experience represented in claims data. We further reviewed the data to estimate the distribution of adherent and non-adherent patients. In our analysis, we assign nine scripts to adherent patients and two scripts to non-adherent patients.

The results are sensitive to the assumptions used, which are detailed later in the report. We only estimate non-AOM healthcare cost savings for patients using products under their obesity indications, as any savings from weight loss associated with other GLP-1 use (e.g., T2DM or cardiovascular disease) would exist without AOM coverage.

Results under alternate scenarios are as follows:

- Differences in uptake would impact results.
    - We assume 4.4% of eligible adult patients and 0.8% of eligible pediatric (ages 12-17) patients will use AOMs in Medicaid for states with a single preferred drug list (PDL). Assuming a higher uptake, 5.7% and 1.0% in eligible adult and pediatric populations respectively, would result in a $0.06 PMPM increase in Medicaid AOM costs beyond those in Table 1 between 2025 and 2029, on average.
    - We assume that 5.7% of eligible adult patients and 1.6% of eligible pediatric patients will use AOMs in the commercial market. Assuming a higher uptake, 7.3% and 2.1% in eligible adult and pediatric populations respectively, would result in a $0.14 PMPM increase in commercial AOM costs between 2025 and 2029, on average, compared to the moderate uptake used in the baseline scenario with expanded indications and cost offsets.
- Long-term healthcare cost offsets resulting from obesity are difficult to predict. As such, we tested the impact of results absent any cost offsets, which would result in a $0.05 to $0.08 PMPM increase in Medicaid costs and a $0.49 to $0.86 PMPM increase in commercial costs between 2025 and 2029, on average.
- While the available literature on healthcare cost offsets resulting from weight loss was directly applicable to the commercial market, we adjusted the modeling of cost offsets for differences in the Medicaid market. In general, population differences other than obesity between the commercial and Medicaid populations (e.g., rate of smoking is twice as high in Medicaid than the commercially-insured population)[10] mean that a higher portion of Medicaid patients' healthcare costs are associated with non-obesity related conditions that will not be reduced as a result of weight loss (e.g., chronic obstructive pulmonary disease). In addition, some obesity-related conditions are also associated with other risk factors that differ among the two populations (e.g., both obesity and smoking increase the risk of chronic back pain).[11] Therefore, weight loss alone may have a smaller impact on the healthcare costs of obesity-related conditions in the Medicaid population due to a higher rate of other risk factors for those same conditions. In recognition of the lower percentage of spending associated with obesity-related conditions and the potential for a smaller impact of weight loss on the cost of obesity-related conditions, we modeled a range of healthcare cost savings in Medicaid. We reduced Medicaid cost offsets by 50% and 75% of similarly applied commercial assumptions.

[10] State Tobacco Activities Tracking and Evaluation System. (February 2024). STATE System Medicaid Coverage of Tobacco Cessation Treatments Fact Sheet. Retrieved from: https://www.cdc.gov/statesystem/factsheets/medicaid/Cessation.html#:~:text=Smoking%20is%20the%20leading%20preventable%20cause%20of%20premature,on%20smokers%2C%20health%20care%20systems%2C%20and%20society.%203

[11] Rajesh, N., Moudgil-Joshi, J. & Kaliaperumal, C. (August 2022). Smoking and degenerative spinal disease: A systematic review. *Brain and Spine*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9560562/

- Under current law, Medicare does not provide coverage of AOMs.[12] As such, Table 1 reflects the full cost of AOMs for dual-eligible members but does not reflect cost offsets, as Medicare would be responsible for the majority of medical costs and would therefore realize the cost offset benefit. If Medicare were to adopt coverage of AOMs under the Part D prescription drug benefit, Medicaid would not be responsible for the cost of the drugs for dual-eligible members. Rather, Medicare would be responsible for the AOM costs and realize any cost offsets. This would result in a $0.01-$0.02 PMPM decrease in net Medicaid expenditures.

- As described above, Wegovy has indications outside of chronic weight management, and both Wegovy and Zepbound are expected to receive additional indications in the future, covered under both markets. The results in Tables 1 and 2 display results for beneficiaries with those conditions that would be covered under expected expanded indications that may be approved prior to the end of our study period, as these beneficiaries would be able to access a GLP-1 under a covered indication, alongside results for current indications only. This aligns with Medicare guidance[13] regarding Wegovy coverage in the Medicare market where AOMs are not covered but Wegovy's indication for cardiovascular disease (CVD) in patients with obesity or overweight allows for coverage. However, additional indications for the active ingredients in AOMs beyond CVD and T2DM have not yet received FDA approval, and we do not know with certainty that they will be approved. As such, we also tested the sensitivity of results by considering only currently approved indications with coverage, T2DM and CVD. This results in a small increase in the incremental impact of AOM coverage, specifically a change of less than $0.01 total PMPM costs to the Medicaid program and a change in commercial PMPM costs of $0.01, taking into consideration healthcare cost offsets.

  Due to the potential future and recent approvals of new indications within the AOM therapeutic area, estimates may vary with respect to which indications are considered current or future. For example, a recent projection focused on the Medicare market, assumed CVD as a future, rather than current, indication due to the timing of the report prior to Wegovy's CVD approval.[14]

[12] Centers for Medicare and Medicaid Services (January 2016). Medicare Prescription Drug Benefit Manual. Chapter 6 – Part D Drugs and Formulary Requirements. Retrieved from: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf

[13] Centers for Medicare and Medicaid Services (March 2024). Health Plan Management System email to plan sponsors..

[14] Cline, M., Heinrich, A., Holcomb, K., et al. (February 2024). Impact of Anti-Obesity Medication Coverage in Medicare Part D. Milliman report. Available at: https://www.milliman.com/-/media/milliman/pdfs/2024-articles/3-6-24_impact-of-covering_anti-obesity-medications-in-medicare-part-d.ashx

II. BACKGROUND

AOM LANDSCAPE AND RECENT MARKET EVENTS

Prior to December 2014, anti-obesity medications (AOMs) were comprised of a mix of brand and generic therapies, with phentermine-based products most frequently prescribed.[15] In December 2014, Saxenda (liraglutide) received FDA approval as the first GLP-1 agonist approved for chronic weight management.[16] Saxenda grew its market share to become the leading brand AOM over the next several years. Further changing the landscape, in June 2021 the FDA approved Wegovy (semaglutide), another GLP-1 for chronic weight management.[17] Wegovy contains the same active ingredient as Ozempic (semaglutide), used to treat type 2 diabetes mellitus (T2DM). Both Wegovy and Ozempic experienced significant growth and became the topic of significant media attention and market demand over the last few years. The attention has expanded to Zepbound (tirzepatide), approved for chronic weight management in October 2023, and Mounjaro (tirzepatide), which contains the same active ingredient, but is indicated for T2DM.[18] Most recently, Wegovy has been shown to reduce cardiovascular disease (CVD) in patients who have obesity or are overweight without T2DM.[19] Both semaglutide and tirzepatide are anticipated to receive expanded indications to treat a variety of other chronic diseases as well.[20,21] In particular, we anticipate that the following indications for semaglutide or tirzepatide may be approved prior to the end of our study period, although approval is not certain:

- Chronic kidney disease (CKD) (moderate disease)
- Nonalcoholic steatohepatitis (NASH)/Metabolic dysfunction-associated steatohepatitis (MASH)

GLP-1s are also being studied in additional therapeutic areas, including obstructive sleep apnea, Alzheimer's disease, and heart failure with preserved ejection fraction.

AOM COVERAGE IN MEDICAID

The Federal Medicaid Drug Rebate Program (MDRP) requires state Medicaid programs to provide coverage for all of a participating manufacturer's FDA-approved drugs; however, states may exclude certain categories of medications, including agents for anorexia, weight loss, or weight gain.[22] As such, Medicaid coverage of AOMs remains limited and varies by state. As of December 2023, there were at least 12 states that cover GLP-1s for chronic weight management, with an additional two states expected to add coverage in 2024 and four additional states that cover non-GLP-1 AOMs.[23]

[15] Lonneman, D., Rey, J., & McKee, B. (August 2013). Phentermine/Topiramate Extended-Release Capsules (Qsymia) for Weight Loss. *Pharmacy & Therapeutics*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3814438/

[16] PR Newswire (December 2014). Novo Nordisk receives FDA approval for Saxenda® (liraglutide [rDNA origin] injection) for chronic weight management. Retrieved from: https://www.prnewswire.com/news-releases/novo-nordisk-receives-fda-approval-for-saxenda-liraglutide-rdna-origin-injection-for-chronic-weight-management-300013975.html

[17] U.S. Food and Drug Administration (June 2021). FDA Approves New Drug Treatment for Chronic Weight Management, First Since 2014. Retrieved from: https://www.fda.gov/news-events/press-announcements/fda-approves-new-drug-treatment-chronic-weight-management-first-2014

[18] U.S. Food and Drug Administration (November 2023). FDA Approves New Medication for Chronic Weight Management. Retrieved from: https://www.fda.gov/news-events/press-announcements/fda-approves-new-medication-chronic-weight-management

[19] U.S. Food and Drug Administration (March 2024). FDA Approves First Treatment to Reduce Risk of Serious Heart Problems Specifically in Adults with Obesity or Overweight. Retrieved from: https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-reduce-risk-serious-heart-problems-specifically-adults-obesity-or

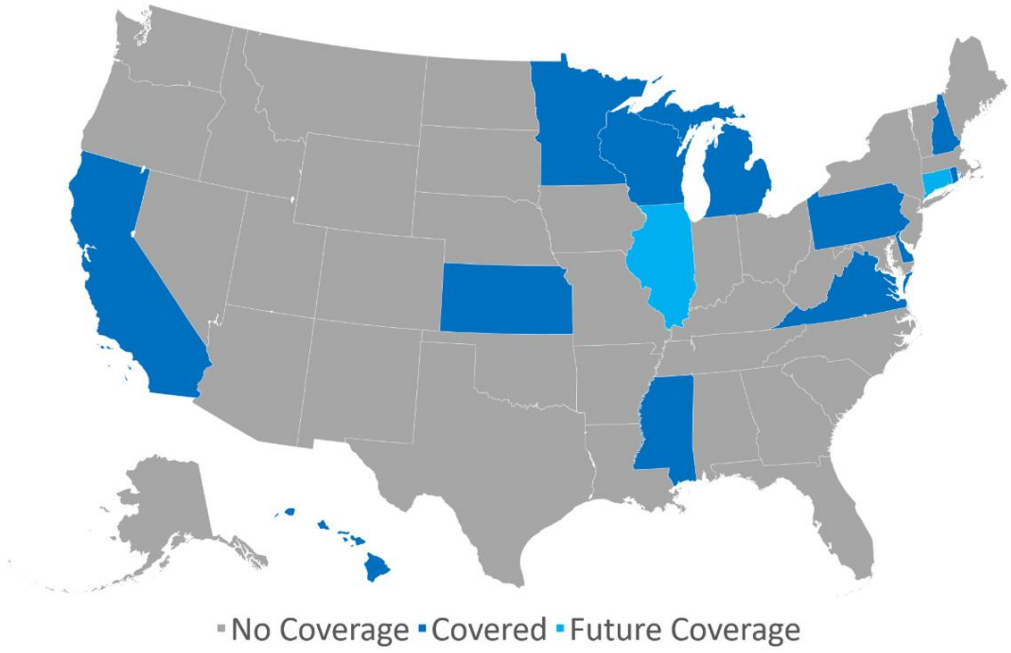
[20] Novo Nordisk (2024). R&D pipeline. Retrieved from: https://www.novonordisk.com/science-and-technology/r-d-pipeline.html

[21] Lilly (2024). Medicines in development. Retrieved from: https://www.lilly.com/discovery/clinical-development-pipeline

[22] U.S. Social Security Administration. Compilation of the Social Security Laws. Payment for Covered Outpatient Drugs. Retrieved from: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm

[23] Niakan, K. and Schock, B. (January 2024). GLP-1 agonists in Medicaid: Utilization, growth, and management.

Figure 1. Coverage status of GLP-1s indicated for chronic weight management by state as of December 2023



AOM COVERAGE IN THE COMMERCIAL MARKET

A 2003 law[24] prohibits Medicare from covering weight loss drugs. Commercial insurers often take cues about what to cover from the federal program. As such, many plans exclude these drugs from coverage given Medicare and Medicaid's lack of mandated coverage. According to an industry trend report, 43% of commercial plans covered weight loss medications and an additional 28% are considering adding coverage in the near future.[25]

[24] Centers for Medicare and Medicaid Services (January 2016). Medicare Prescription Drug Benefit Manual. Chapter 6 – Part D Drugs and Formulary Requirements.

[25] Managed Markets Insight & Technology (2024). Commercial Payers Wrestle With Managing Weight Loss Drug Coverage. Retrieved from: https://www.mmitnetwork.com/aishealth/spotlight-on-market-access/commercial-payers-wrestle-with-managing-weight-loss-drug-coverage-2/

III. RESULTS

STAKEHOLDER IMPACTS

Tables 3 and 4 show the average estimated five-year impact of AOM coverage on total Medicaid costs and commercial costs by stakeholder. The results focus on how coverage of the AOM class could affect Medicaid and commercial stakeholders' costs. When AOM coverage is added, payers' pharmacy benefit costs increase as patients who were not otherwise eligible for insurance coverage of an AOM (i.e., do not have T2DM or a chronic disease that is an indication for use of the active ingredient in the AOM, other than obesity) begin therapy. Over time, the portion of patients who remain adherent to AOM therapy and lose weight may begin to experience improved health outcomes, potentially reducing both medical and pharmacy benefit costs as certain services are reduced or avoided. Reductions in the healthcare costs for these services are referred to as cost offsets.

Table 3
Net Impact of Adding AOM Coverage to Medicaid
Baseline Scenario
2025 Through 2029 Estimated Changes in Stakeholder Per Member Per Month (PMPM) Costs

	Expanded Indications		Current Indications	
	No Cost Offsets	Including Cost Offsets	No Cost Offsets	Including Cost Offsets
State[1]	$0.05 - $0.09	$0.04 - $0.07	$0.05 - $0.09	$0.04 - $0.07
Federal Government[1]	$0.14 - $0.25	$0.10 - $0.18	$0.14 - $0.25	$0.10 - $0.18
Total[2]	**$0.19 - $0.34**	**$0.14 - $0.25**	**$0.19 - $0.34**	**$0.14 - $0.25**

[1] The distribution of state and federal liabilities are calculated using Federal Medical Assistance Percentages (FMAP) applied by state and population.
[2] Totals may not tie exactly to shown sums due to rounding.

Table 4
Net Impact of Adding AOM Coverage in the Commercial Market
Baseline Scenario
2025 Through 2029: Estimated Changes in PMPM Costs

	Expanded Indications		Current Indications	
	No Cost Offsets	Including Cost Offsets	No Cost Offsets	Including Cost Offsets
Member[1]	$0.33 - $0.58	$0.26 - $0.47	$0.33 - $0.59	$0.27 - $0.47
Health Plan[2]	$0.53 - $0.93	$0.11 - $0.19	$0.53 - $0.94	$0.10 - $0.18
Total[3]	**$0.86 - $1.52**	**$0.37 - $0.66**	**$0.87 - $1.53**	**$0.37 - $0.65**

[1] Member share includes cost sharing.
[2] Health plan share includes the net liability remaining after accounting for rebates and cost sharing changes. No shift to member premium is assumed.
[3] Totals may not tie exactly to shown sums due to rounding.

Eligible population

Our expanded indication results are dependent on the assumption that semaglutide and/or tirzepatide receive approval for certain additional indications (moderate CKD and NASH/MASH) expected to be approved in the next few years. As such, similar to patients with T2DM and CVD, which are current indications, we exclude beneficiaries with conditions expected to be treated in the future with these GLP-1s, as they would be able to access GLP-1s with existing coverage. However, if these indications are not approved, the incremental impact of adding AOM coverage would be a small increase in the incremental cost of AOM coverage. The change would be less than $0.01 total PMPM costs to the Medicaid program and a commercial change in PMPM costs of $0.01, including considerations for healthcare cost offsets.

The impact to PMPM costs in both markets is greater in this scenario due to more assumed AOM utilizers. Excluding beneficiaries with a currently approved indication (i.e., T2DM or CVD) only results in an increase of 0.03% of beneficiaries eligible to use an AOM in Medicaid and a 0.1% increase in commercial. Note that semaglutide is currently being studied for other covered indications such as Alzheimer's disease, peripheral arterial disease, heart failure with preserved ejection fraction, and sleep apnea. Any future changes to the indications for the active ingredients in AOMs drugs that would increase or decrease the number of patients with coverage of the drug for medical conditions other than obesity would also impact the incremental impact of adding obesity coverage in Medicaid and commercial markets.

Healthcare cost offsets

Values in the "No Cost Offsets" columns of Tables 3 and 4 are direct pharmacy costs attributable to AOMs. The "Including Cost Offsets" column applies healthcare cost offsets to projected medical and pharmacy costs and also includes the incremental AOM costs from the "No Cost Offsets" scenario.

Results are dependent on several key assumptions discussed throughout this report. The range of values shown in Tables 3 and 4 represent scenarios with and without potential cost offsets associated with weight loss for the portion of utilizers who remain adherent to therapy and lose weight. Our cost offset assumption is based on published literature, but it is important to consider that long-term longitudinal real-world cost offset studies are not yet available for GLP-1s. We anticipate that Wegovy and Zepbound will capture the majority of the AOM market share in our projection, but these products launched within the last few years, so there have not been long-term analyses of healthcare cost offsets driven by these therapies. Actual cost offsets may deviate, either higher or lower, from these assumptions. We did not independently evaluate the efficacy of AOMs or longitudinal impacts of weight loss on healthcare costs. Additionally, we modeled lower cost offsets in the Medicaid market due to the lower percentage of spending associated with obesity-related conditions and the potential for a smaller impact of weight loss on obesity-related conditions compared to the commercial population.

Other baseline assumptions

In the Medicaid market, we assumed that 0.4% of the adult population is projected to initiate AOM therapy and 0.01% of the pediatric (age 12-17) population, with an average of 5.4 scripts annually per person taking an AOM. In the commercial market, we assumed that 0.9% of adult population is projected to initiate AOM therapy and 0.1% of the pediatric population, with an average of 6.1 scripts annually per person taking an AOM. We developed these assumptions based on Medicaid and commercial market experience represented in claims data.

Our uptake assumption is that 4.4% of *eligible* adult beneficiaries (those with obesity or who otherwise meet the Wegovy or Zepbound label criteria) and 0.8% of *eligible* child beneficiaries will use an AOM in Medicaid. We assumed increasing uptake over time, ultimately reaching fully phased-in assumptions by 2027. This additionally varies by state based on whether the state implemented a single preferred drug list (PDL) for the Medicaid market. Our commercial uptake assumption is that 5.7% of *eligible* adult beneficiaries (those with obesity or who otherwise meet the Wegovy or Zepbound label criteria) and 1.6% of *eligible* child beneficiaries will use an AOM.

We anticipate a high degree of competition in the class, with rebate levels similar to other highly competitive classes in Medicaid and commercial markets. Results are sensitive to rebate assumptions; lower rebate levels could result in an increase in net costs for all stakeholders. Further details on selected rebate and market share assumptions can be found in the "Assumptions Related to AOMs" section of this report.

Medicaid stakeholder considerations

In this report, we show impacts to the primary Medicaid stakeholders, the federal government and state governments, allocated using the federal medical assistance percentage (FMAP) by state and population (e.g., Medicaid Expansion and CHIP status).

The values presented for Medicaid represent nationwide estimates, which consider key state-specific data such as the state's distribution of children relative to adults, distribution of duals relative to non-duals, etc. To the extent that a state's demographics vary substantially from nationwide assumptions on these key metrics, estimated state costs may be higher or lower than those presented in Table 3. Combined with the variable FMAP contingent upon Expansion and CHIP status, individual states may share a higher or lower percentage of estimated costs. While the federal government would share in the cost changes attributable to AOM coverage, the decision ultimately resides with state agencies to determine coverage.

We did not account for 340B and how this may impact stakeholder costs in Medicaid. While federal regulations mandate that Medicaid fee-for-service reimburse pharmacies at actual acquisition cost, typically aligning with the 340B ceiling price for 340B providers, such regulations do not extend to 340B claims under Medicaid managed care.[26] For AOM 340B claims paid by managed care, covered entities or their contract pharmacies may be paid more than the 340B acquisition cost. As states are prohibited from collected Medicaid rebates on 340B claims, this dynamic could increase the net cost to the state and federal government compared to the values shown in Table 3.

[26] 340B Health. 340B Health drug pricing program overview. Retrieved from: https://www.340bhealth.org/members/340b-program/overview/

For states that have managed Medicaid, the managed care organization liability for AOMs may be greater or less than the capitated payment, depending on member mix and utilization management criteria. We did not consider many of the nuances of Medicaid managed care in this analysis, including administrative costs and/or margin that may increase as a result of increasing gross pharmacy expenditures for capitation rate development.

Commercial stakeholder considerations

Commercial estimates were developed using a nationally representative sample of commercial administrative claim data. Commercially insured groups vary significantly in their demographic characteristics and will deviate from the estimates in Table 4 to the extent that the population varies relative to a nationally representative group. For example, rates of obesity vary by state such that a group concentrated in a region with higher rates of obesity may experience greater AOM costs relative to a group concentrated in a region with lower rates of obesity.

Furthermore, the distribution between member and plan sponsor of cost changes associated with AOM coverage in the commercial market may significantly vary for an individual group. The following three aspects will directly impact the distribution and level of cost changes for an individual member or group:

1. *Benefit design*: Commercial plans vary significantly in the cost sharing responsibility of patients. For example, patients on a high-deductible health plan may experience a greater share of costs than those modeled in this report. Conversely, patients with richer benefit designs may experience lower cost-sharing liability related to AOM utilization.
2. *Employee premium*: Employer groups can shift benefit costs directly to employees via premium changes. In this report, we assume that the employer absorbs the costs of AOMs and there is no resulting premium change. However, in practice, it is likely that employers will deviate from this assumption, shifting a portion of the liability associated with AOM coverage to all employees as a premium increase.
3. *AOM utilization:* The member share of cost changes in Table 6 represents only cost sharing spread across the entire population. For individual patients who begin AOM therapy, out-of-pocket costs will be substantially greater. Conversely, members who do not use AOMs will have no change in costs but, as described above, may have a premium increase attributable to AOM coverage depending on employer decisions regarding funding.

Other considerations

The timing of cost offsets is important. If short-term savings in non-AOM costs are not realized, or if a member changes coverage (e.g., changes employer, ages into Medicare, or is disenrolled from Medicaid) before cost savings are realized, payers may have reduced incentives for comprehensive coverage. In our cost offset scenarios, for members adherent to AOM therapy who lose weight, we assume that cost offsets begin in the year following initiation of AOM use.

More broadly, plans may also exhibit behavioral responses that impact beneficiary experience:

- *Formulary coverage:* Plan sponsors and pharmacy benefit managers (PBMs) will likely analyze AOM costs, including potential healthcare cost offsets, as they make formulary decisions. Formulary design will likely focus on covering the products that optimize efficacy and financial results. For Medicaid, states with a single PDL will likely prefer the lowest net cost products, while states without a single PDL will likely have more utilization of the lowest gross cost products. Due to competition between Wegovy and Zepbound, coverage is likely to mirror other highly competitive classes.

  To the extent that plan cost sharing or coverage is inadequate for some members, there may be utilization outside of the benefit as patients pursue cost-sharing assistance via copay cards or patient assistance programs.

- *Utilization management strategies:* Plan sponsors and PBMs will likely implement utilization management criteria to prevent off-label utilization and ensure medical necessity, similar to the observed increases in GLP-1 utilization management for GLP-1s indicated for T2DM in the commercial and Medicaid markets over the past several years.

Sensitivity testing

Given that AOMs have never been broadly covered in the commercial and Medicaid markets, and the market-leading products were introduced within the last few years, a number of assumptions were necessary for this analysis. As such, we tested the sensitivity of several key assumptions:

- AOM class uptake
- Eligible population
- Healthcare cost offsets
- Medicare coverage

We discuss and quantify these four assumptions within this section. As described above, the results include a range of potential outcomes based on varied uptake assumptions. The three scenarios are as follows, with each scenario similarly assuming a range of corresponding pediatric uptake rates:

- Scenario 1: Adult Medicaid Uptake – 3.1%, Adult Commercial uptake 4.1%
- Scenario 2: Adult Medicaid Uptake – 4.4%, Adult Commercial uptake 5.7%
- Scenario 3: Adult Medicaid Uptake – 5.7%, Adult Commercial uptake 7.3%

Sensitivity testing – AOM class uptake

Table 5
Net Impact of Adding AOM Coverage to Medicaid Expanded Indications
2025 Through 2029 Estimated Changes in Stakeholder PMPM Costs

	No Cost Offsets			Including Cost Offsets		
	Scenario 1	**Scenario 2[3]**	**Scenario 3**	**Scenario 1**	**Scenario 2[3]**	**Scenario 3**
State[1]	$0.05	$0.07	$0.09	$0.04	$0.05	$0.07
Federal Government[1]	$0.14	$0.19	$0.25	$0.10	$0.14	$0.18
Total[2]	**$0.19**	**$0.26**	**$0.34**	**$0.14**	**$0.20**	**$0.25**

[1] The distribution of state and federal liabilities are calculated using Federal Medical Assistance Percentages (FMAP) applied by state and population.
[2] Totals may not tie exactly to shown sums due to rounding.
[3] Baseline scenario.

Table 6
Net Impact of Adding AOM Coverage to Commercial Expanded Indications
2025 Through 2029 Estimated Changes in Stakeholder PMPM Costs

	No Cost Offsets			Including Cost Offsets		
	Scenario 1	**Scenario 2[3]**	**Scenario 3**	**Scenario 1**	**Scenario 2[3]**	**Scenario 3**
Member[1]	$0.33	$0.46	$0.58	$0.26	$0.37	$0.47
Health Plan[2]	$0.53	$0.73	$0.93	$0.11	$0.15	$0.19
Total[3]	**$0.86**	**$1.19**	**$1.52**	**$0.37**	**$0.52**	**$0.66**

[1] Member share includes cost sharing.
[2] Health plan share includes the net liability remaining after accounting for rebates and cost sharing changes. No shift to member premium is assumed.
[3] Totals may not tie exactly to shown sums due to rounding.
[4] Baseline scenario.

Tables 5 and 6 show results under three different uptake scenarios. For Medicaid, the moderate uptake assumes that 4.4% of eligible adult patients and 0.8% of eligible pediatric patients use AOMs, as discussed previously. The uptake assumptions range from 3.1% and 5.7% of eligible adult patients and 0.5% and 1.0% of eligible pediatric patients using AOMs, respectively, which could increase or decrease total program costs by about $0.06 PMPM. This additionally varies by state based on whether or not the state implements a single PDL.

For commercial, the moderate uptake assumes that 5.7% of eligible adult patients and 1.6% of eligible pediatric patients use AOMs, as discussed previously. The uptake assumptions range from 4.1% and 7.3% of eligible adult patients and 1.2% and 2.1% of eligible pediatric patients using AOMs, respectively, which could increase or decrease total program costs by about $0.14 PMPM.

The methodology to develop the assumptions used is detailed in the "Assumptions related to AOMs" section.

Sensitivity testing – Healthcare cost offsets

As described in the Executive Summary, the Medicaid population differs substantially from the commercial population with respect to rates of medical conditions and social determinants of health that may impact non-AOM healthcare savings associated with weight loss in patients who adhere to AOMs and lose weight. In light of these considerations, our baseline Medicaid results assume 25% of the cost offsets of a commercial population. We further tested the sensitivity of this assumption, with the results shown in Table 7 for the Medicaid population if it was to experience 50% of the cost offsets of a commercial population.

Table 7
Net Impact of Adding AOM Coverage to Medicaid
2025 Through 2029 Estimated Changes in Stakeholder PMPM Costs

	Expanded Indications Including Cost Offsets – 25% of cost offsets[3]	**Expanded Indications Including Cost Offsets – 50% of cost offsets**
State[1]	$0.04 - $0.07	$0.03 - $0.05
Federal Government[1]	$0.10 - $0.18	$0.07 - $0.12
Total[2]	**$0.14 - $0.25**	**$0.09 - $0.17**

[1] The distribution of state and federal liabilities are calculated using Federal Medical Assistance Percentages (FMAP) applied by state and population.

[2]Totals may not tie exactly to shown sums due to rounding.

[3]Baseline scenario.

Sensitivity testing – Medicare coverage

Our baseline Medicaid results reflect the full cost of AOMs for dual-eligible members, but do not reflect cost offsets, as Medicare would be responsible for the vast majority of medical and pharmacy costs and would therefore realize the cost offset benefit. As Medicaid covers claim costs for dual-eligible beneficiaries in limited cases (e.g., certain long-term services and supports, behavioral health, transportation, vision services, and Part B drug costs, as determined by the state), there may be a small portion of cost offsets that directly decrease Medicaid costs. The projection assumes that these are negligible for patients assumed to have cost offsets and assumes that offsets would accrue to Medicare. If Medicare were to adopt widespread coverage of AOMs under the Part D prescription drug benefit, Medicaid would not be responsible for the cost of the drugs. Responsibility for the AOM costs would be borne by Medicare. We tested the impact of excluding the dual-eligible group from the total eligible Medicaid population, and the results are shown in Table 8.

Table 8
Net Impact of Adding AOM Coverage to Medicaid
Medicare Part D Coverage of AOMs
2025 Through 2029 Estimated Changes in Stakeholder PMPM Costs

	Baseline Scenario Expanded Indications		Medicare Coverage of AOMs[3] Expanded Indications	
	No Cost Offsets	Including Cost Offsets	No Cost Offsets	Including Cost Offsets
State[1]	$0.05 - $0.09	$0.04 - $0.07	$0.04 - $0.08	$0.03 - $0.06
Federal Government[1]	$0.14 - $0.25	$0.10 - $0.18	$0.13 - $0.24	$0.10 - $0.17
Total[2]	**$0.19 - $0.34**	**$0.14 - $0.25**	**$0.18 - $0.33**	**$0.13 - $0.23**

[1] The distribution of state and federal liabilities are calculated using Federal Medical Assistance Percentages (FMAP) applied by state and population.
[2] Totals may not tie exactly to shown sums due to rounding.
[3]Reflects exclusion of the dual-eligible group from the total eligible Medicaid population.

IV. METHODOLOGY AND ASSUMPTIONS

Many assumptions were needed for this analysis. We used a combination of literature, claims data, and pipeline information to inform our work. Claims data was used to inform many of the assumptions in the model.

LITERATURE REVIEW

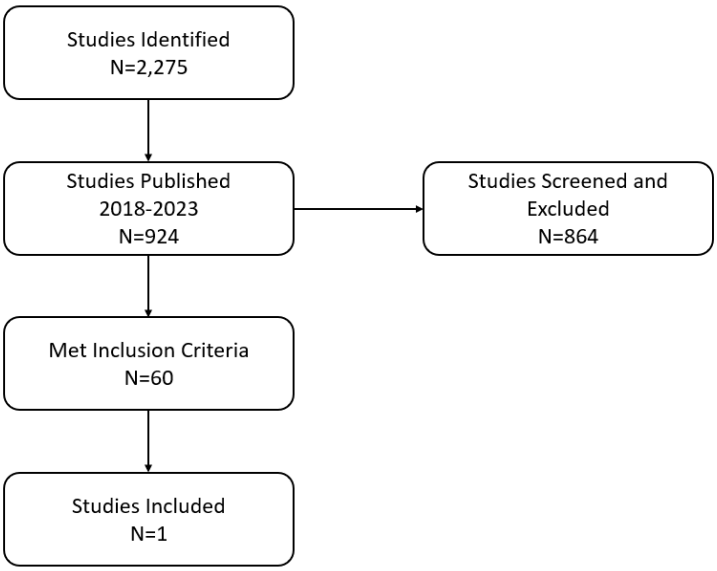
For literature-based questions, two approaches were used. First, published clinical trial results for liraglutide, semaglutide, and tirzepatide were included. Additionally, literature searches using PubMed were conducted to obtain cost-effectiveness values and medical cost savings associated with the following:

- Weight loss
- AOM discontinuation rates
- Long-term weight loss
- Percentage of individuals regaining lost weight and timing of weight regain
- Demographics and income of individuals associated with current GLP-1 use
- Cost associated with treating adverse effects of GLP-1 use

Criteria were defined, and study inclusion and exclusion criteria were applied. The search was limited to publications from 2018 to 2023, and results needed to be available for a U.S. adult population. We excluded publications that included indirect costs, were study-design-only publications, were conducted outside of the United States only, or did not list a data value for one of the areas we targeted. The majority of trials were eliminated based on year published; that single criterion resulted in 60% of the articles being excluded. The remainder were excluded for one of the other exclusion criteria listed above. After exclusion, there were 60 remaining studies that could potentially be used to inform assumptions. Analysis of commercial and Medicaid claims data was able to inform most of the assumptions used in our estimates. Ultimately, only one article was used to inform the modeling for the single assumption that relied upon a literature-based estimate.[27] Of the 60 articles that met our inclusion criteria, there were three articles that studied healthcare cost offsets due to weight loss. The one article relied upon for this analysis was the only study that was appropriate to use, given that the other studies were conducted in a Medicare population. This one article informed healthcare cost offsets and was used in combination with claims data in order to develop estimates of healthcare cost offsets. Figure 2 displays the steps in the literature review and presents the cumulative number of articles meeting the criteria for inclusion.

[27] Thorpe, K., Toles, A. & Shah, B. (October 2021). Weight Loss-Associated Decreases in Medical Care Expenditures for Commercially Insured Patients With Chronic Conditions. *Journal of Occupational and Environmental Medicine*. Retrieved from: https://journals.lww.com/joem/fulltext/2021/10000/weight_loss_associated_decreases_in_medical_care.5.aspx

Figure 2. Number of Articles Identified and Used to Inform Model Assumptions*



**Individual searches were conducted for each assumption. An article may inform multiple assumptions and appear in more than one search.*

ASSUMPTIONS RELATED TO AOMS

Healthcare cost offsets

An important assumption underlying the results is the magnitude of healthcare cost offsets associated with weight loss. Cost offsets are only applied to adherent patients who lose weight, in all years following adherent AOM therapy. In the year following the first year of non-adherence, patient costs return to pre-AOM use levels. For the magnitude of cost offsets, we relied on a publication of the longitudinal healthcare cost savings in a commercial population resulting from weight loss (not specific to any weight-management treatment) and adjusted this estimate for the Medicaid population, as described previously.[28] We assumed that these cost offsets included both pharmacy and medical costs, consistent with the published findings of the study. This study observed the subsequent-year healthcare costs for patients with various obesity-related comorbidities who lost weight. We applied healthcare cost savings to AOM-adherent patients who lost weight if they had at least one of the obesity-related comorbidities listed below, which were found to be the statistically significant conditions that resulted in healthcare savings in the publication. Many patients with obesity have more than one obesity-related comorbidity, in which case we applied the literature-based estimate of savings from the comorbidity with the greatest percentage savings associated with weight loss in order not to duplicate savings from overlapping comorbidities. The obesity-related conditions are listed below, in order of descending percentage of cost savings associated with weight loss:

- Arthritis
- Hypertension
- Mental health disorders
- Back pain

[28] Ibid.

The study reported cost savings for each comorbidity by initial body mass index (BMI) and percent reduction in BMI. A large portion of savings from weight loss reported in the study was for patients with diabetes. However, we did not include any of this savings in our analysis, as we excluded patients with T2DM for our modeling. We applied the cost offsets based on the observed distribution of initial BMI for patients with each comorbidity in the Medicaid and commercial populations based on our analysis of claims data. We applied cost offsets on a percentage basis that ranged from 5.6% to 20.9%, using the average BMI reduction reported in clinical trials for each of the AOMs in our analysis.[29,30,31]

We did not apply cost offsets to pediatric populations (under 18 years old), as the study we relied upon did not include children and it is uncertain the degree of cost offsets that may be achieved in a pediatric population. We did not assume any cost offsets for dual-eligible members in Medicaid, as the large majority of dual-eligible member cost offsets would be experienced by Medicare rather than Medicaid. Consistent with the literature, we also did not assume cost offsets for patients with initial BMIs below 30.

The Medicaid population differs substantially from the commercial population (which was analyzed in the study used to develop cost offsets) with respect to rates of medical conditions and social determinants of health that may impact non-AOM savings associated with weight loss in patients who adhere to AOM and lose weight. In general, population differences other than obesity between the commercial and Medicaid populations (e.g., rate of smoking is twice as high in Medicaid than the commercially-insured population)[32] mean that a higher portion of Medicaid patients' healthcare costs are associated with non-obesity related conditions that will not be reduced as a result of weight loss (e.g., chronic obstructive pulmonary disease). In addition, some obesity-related conditions are also associated with other risk factors that differ among the two populations (e.g., both obesity and smoking increase the risk of chronic back pain).[33] so weight loss alone may have a smaller impact on the healthcare costs of obesity-related conditions in the Medicaid population that has a higher rate of other risk factors for those same conditions. As such, we assumed that the Medicaid population would experience 25% of the savings of a commercial population. We also sensitivity tested a scenario where the Medicaid population experienced 50% of the savings that would be experienced by a commercial population.

Based on this approach, total average non-AOM healthcare cost savings for adherent patients with the specified obesity-related comorbidities was 6% to 12% of baseline pharmacy and medical costs in the Medicaid adult population and 13% in the commercial adult population.

Additional assumptions needed for modeling incremental AOM costs are as follows:

- **Eligible population:** We assumed that beneficiaries eligible to use AOMs are those who meet the label criteria for AOM use, but who are not eligible for GLP-1 indications approved for other conditions that are typically covered by Medicaid and commercial health insurance (i.e., T2DM and CVD). We began by identifying all beneficiaries with obesity or overweight with a comorbidity on either the Wegovy or Zepbound label.

    - Individuals with a diagnosis of obesity
    - Individuals with a diagnosis of overweight (BMI of 27-29) with a comorbidity of hypertension, T2DM, hyperlipidemia, sleep apnea, or CVD who are not currently taking a GLP-1

    We excluded pregnant individuals and individuals under 12 years of age to align with the broadest label criteria across AOMs analyzed. Although Zepbound does not have a label indication for patients under 18, the product is being studied on a pediatric population, and patients 12-17 would have access to other

[29] McDermid, Eleanor (April 2023). A quick guide to the SURPASS and SURMOUNT trials. Medicine Matters. Retrieved from: https://diabetes.medicinematters.com/tirzepatide/type-2-diabetes/a-quick-guide-to-the-surpass-and-surmount-trials/18478154

[30] McDermid, Eleanor (April 2023). A quick guide to the STEP trials. Medicine Matters. Retrieved from: https://diabetes.medicinematters.com/semaglutide/obesity/quick-guide-step-trials/18854832

[31] Gerardo Calderon, G., Gonzalez-Izundegui, D., Shan, K. et al. (November 2021). Effectiveness of anti-obesity medications approved for long-term use in a multidisciplinary weight management program: a multi-center clinical experience. *International Journal of Obesity*. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/34811486/

[32] State Tobacco Activities Tracking and Evaluation System. (February 2024). STATE System Medicaid Coverage of Tobacco Cessation Treatments Fact Sheet.

[33] Rajesh, N., Moudgil-Joshi, J. & Kaliaperumal, C. (August 2022). Smoking and degenerative spinal disease: A systematic review. *Brain and Spine*.

AOMs.[34] We excluded institutionalized beneficiaries from the eligible Medicaid population. Also specific to the Medicaid population, we considered a scenario where dual-eligible members were excluded to estimate the change in impact if Medicare were to mandate coverage of AOMs under the Part D prescription drug benefit, thus reducing Medicaid's liability for the cost of the drugs for dual-eligible members.

We also excluded beneficiaries who currently use GLP-1s or those with T2DM or CVD, as patients with these conditions are able to access GLP-1s under existing coverage. In the "expanded indications" baseline scenario, we further excluded beneficiaries who would be eligible to use semaglutide or tirzepatide for indications expected to be approved prior to the end of our study period, specifically CKD and NASH/MASH. We anticipate CKD and NASH/MASH to have FDA approvals prior to the end of our study period, and as such, Medicaid and commercial beneficiaries with these conditions would likely have access to a GLP-1 without an AOM coverage policy change. Tirzepatide is currently being studied for moderate severity CKD patients (approximately stage 3) with and without T2DM (TREASURE) and, therefore, we excluded members with stage 3 CKD in the "expanded indications" scenario regardless of their T2DM status.[35,36]

- **AOM class uptake**

  – **Medicaid:** To develop the percentage of the eligible population expected to utilize AOMs in Medicaid, we used Medicaid data from T-MSIS Analytic Files (TAF) from CY 2022 to measure utilization rates among states that offer coverage of GLP-1s indicated for chronic weight management. Our moderate estimate uptake assumption as a percentage of eligible beneficiaries is 4.4% for adults and 0.8% for children. As described above, to test the sensitivity of uptake assumptions, we also developed a range of uptake assumptions as a percentage of eligible beneficiaries to be 3.1% and 5.7% for adults, respectively, and 0.5% and 1.0% for children. This additionally varies by state based on whether the state does or does not implement a single PDL. Appendix B summarizes the assumed uptake percentage by eligible population, state, and rate group.

  – **Commercial:** To develop the percentage of eligible beneficiaries expected to utilize AOMs in the commercial market, we used commercial market data from Milliman's Consolidated Health Cost Guidelines Sources™ Database (CHSD) through quarter two of 2023. We measured AOM utilization rates among plans assumed to have robust brand AOM coverage as defined by having at least 15 brand AOM scripts with cost sharing below 50% on average. Our moderate estimate uptake assumption as a percentage of eligible beneficiaries is 5.7% for adults and 1.6% for children. To test the sensitivity of uptake assumptions, we also estimated additional uptake estimates as a percentage of eligible beneficiaries to be 4.1% and 7.3% for adults, respectively, and 1.2% and 2.1% for children.

  To account for Zepbound's market launch in quarter four of 2023, we further increased the estimated uptake percentage to account for utilization stemming from this launch. We assumed that total AOM utilization will grow such that Zepbound and Wegovy market shares are equal. These assumptions consider the utilization observed for patients without overweight or obesity diagnosis codes in commercial and Medicaid markets.

- **AOM market share distribution**

  – **Medicaid:** We relied on State Drug Utilization Data (SDUD) from quarter two of 2023 to develop Medicaid market share. We accounted for different generic dispending rates (GDR) between states that have a single PDL relative to states that do not have a single PDL. We assumed that states with a single PDL would maintain a brand-preferred strategy to maximize rebates and will likely have a lower GDR by assuming a GDR shift to reflect actual differences between commercial and Medicaid markets. For non-single PDL states, we assume actual differences between GDR in single PDL and non-single PDL states for all drugs using 2022 SDUD data (i.e., higher GDR).

[34] Novo Nordisk (May 2024). A Research Study on How Well Semaglutide Helps Children and Teenagers With Excess Body Weight Lose Weight (STEP Young). ClinicalTrials.gov. Retrieved from: https://clinicaltrials.gov/study/NCT05726227?distance=50&intr=Semaglutide&aggFilters=ages:child&rank=6

[35] Novo Nordisk (March 2024). Novo Nordisk A/S: Semaglutide 1.0 mg demonstrates 24% reduction in the risk of kidney disease-related events in people with type 2 diabetes and chronic kidney disease in the FLOW trial. Retrieved from: https://www.novonordisk.com/news-and-media/news-and-ir-materials/news-details.html?id=167028

[36] Lilly (February 2023). A Study of Tirzepatide (LY3298176) in Participants With Overweight or Obesity and Chronic Kidney Disease With or Without Type 2 Diabetes (TREASURE-CKD). Retrieved from: https://trials.lilly.com/en-US/trial/360461

- **Commercial:** We relied on quarter two of 2023 commercial market data from CHSD for commercial market share.

Beyond the above historical observations for market share distributions, we accounted for the anticipated patent loss of Saxenda. We assumed that states with a single PDL would have a smaller utilization shift to generic liraglutide compared to non-single PDL states.

We did not vary the market share by adult and pediatric populations within each market. Additionally, our assumptions reflect the introduction of Zepbound in October 2023, which we assumed to grow to match the market share of Wegovy by our projection period across both the Medicaid and commercial markets.

- **AOM gross and net prices**

We modeled the gross and net prices for AOMs as follows:

- *Gross price:* We relied on current wholesale acquisition cost (WAC) from Medi-Span for brand AOMs and average allowed cost per script from 2023 commercial claims data for generics. We applied trends each year based on the 2022 Medicare Trustees Report Part D per capita cost trends.[37]

- *Net price:* We assumed that net prices will decrease by about 6% per year relative to existing public estimates of AOM rebates after adjustment for increasing competition in the class due to Zepbound's launch.[38] This is based on a combination of overall average brand net price changes and net price changes specific to insulins, as the AOM class is expected to have similar competitive dynamics as insulin.[39,40] In Medicaid, we assume the best price reflects the same rebate used in the commercial market. We calculated the Medicaid Drug Rebate Program (MDRP) statutory rebates using the following methodology:

    - As average manufacturer price (AMP) is not publicly available, we assumed that AMP equals WAC.
    - To estimate the inflationary rebate for each drug, we calculated the difference between the drug's trended future AMP and its baseline AMP (set at launch WAC) adjusted to the future period by using the Consumer Price Index for All Urban Consumers (CPI-U).
        - We applied the Congressional Budget Office's (CBO) projected 2.2% annual trend to estimate the future CPI-U.[41]
    - For inflationary rebates, we are capturing actual quarter one 2024 inflationary rebates, which were extrapolated to projection years based on assumed WAC trends.
    - We applied a net cost trend to project rebates for each year from 2025 through 2029.
    - We accounted for the anticipated patent loss of Saxenda by shifting utilization to generic liraglutide at a lower gross cost.
    - We reflect no supplemental rebates in the tables included in this report. For every 1% increase in supplementary rebates, we estimated that the net price would be reduced by 3.4%.
    - We considered the impact of Medicare price negotiation on the MDRP. We assumed that Wegovy (semaglutide) and Zepbound (tirzepatide) would be negotiated upon initial eligibility for medically accepted indications. We estimated the negotiated price would be equal to the best price in Medicaid during the applicability years of negotiation. Therefore, Medicare price negotiation would not have an impact on Medicaid drug rebates.

- *FMAP:* For Medicaid we assigned state and federal costs in line with the fiscal year 2024 FMAPs[42] by state and rate group.

- **Total healthcare PMPM for healthcare cost offset calculations:** We applied the cost offset calculations to

[37] Centers for Medicare and Medicaid Services (2022). 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Retrieved from: https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf

[38] Ippolito, B. and Levy, J. (September 2023). Estimating the Cost of New Treatments for Diabetes and Obesity. American Enterprise Institute, Economic Perspectives.

[39] Drug Channels (June 2023). Gross-to-Net Bubble Update: 2022 Pricing Realities at 10 Top Drugmakers.

[40] Cline, M., Shaw, H., Silseth, S., et al. (December 2021). Analysis of Insulin Competition and Costs in the United States. Milliman white paper.

[41] Congressional Budget Office (January 2020). The Budget and Economic Outlook: 2020 to 2030. Retrieved from: https://www.cbo.gov/publication/56073

[42] Medicaid and CHIP Payment and Access Commission (December 2023). EXHIBIT 6. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State. Retrieved from: https://www.macpac.gov/publication/federal-medical-assistance-percentages-fmaps-and-enhanced-fmaps-e-fmaps-by-state-selected-periods/

the overall (medical and pharmacy) PMPM for members who met the label criteria (diagnosed with obesity or overweight with a comorbidity), excluding members with the modeled current and expanded indications. For commercial, we relied on overall gross PMPM costs from CHSD. For Medicaid, we relied on overall fee-for-service (FFS) PMPMs from TAF by comorbidity for states that have more than 75% of their claims in FFS and then used PMPM relativities by state from Medicaid and CHIP Payment and Access commission (MACPAC) to calculate total healthcare PMPMs by state.[43]

- **AOM scripts per patient:** We developed the average scripts per patient assumption by studying both Medicaid and commercial utilization patterns for continuously enrolled members with utilization of existing AOMs and analog GLP-1 therapies, which we believe will have similar utilization patterns compared to AOMs. We analyzed 30-day equivalent scripts per patient for Ozempic (semaglutide indicated for T2DM) and Wegovy (semaglutide indicated for chronic weight management).

    - **Commercial:** For the adult and pediatric populations, we relied on the observed Wegovy scripts per adult and pediatric patient in 2022.

    - **Medicaid:** Due to the ramp up of 2022 coverage beginning in many Medicaid states, we leveraged the relationship of scripts per utilizer between commercial and Medicaid markets for Ozempic in 2021 for the adult population. The data was not credible for the pediatric population (ages 12-17) for Wegovy scripts per patient in 2021, and we therefore relied on the relationship between adult and pediatric scripts per patient for Ozempic in 2022, which we applied to Wegovy.

    - This methodology resulted in an average of 5.4 30-day scripts annually per AOM patient on average in Medicaid and 6.1 30-day scripts annually per AOM patient in the commercial market.

    - We further reviewed the data to estimate the distribution of adherent and non-adherent patients. In our analysis, we assign nine scripts to adherent patients and two scripts to non-adherent patients. Based on these parameters, combined with the average AOM scripts per patient, this implies a 51.5% drop-off rate in Medicaid and a 41.6% drop-off rate in the commercial market. Were these populations to observe increased rates of adherence to AOMs, we would expect the PMPM costs associated with AOMs to increase as members fill more prescriptions. We would expect there to be some offsetting healthcare cost savings as patients adhere to therapy and experience weight loss.

PUBLIC HEALTH EMERGENCY

In response to the COVID-19 pandemic and the passage of the Families First Coronavirus Response Act, Medicaid members were eligible for continuous coverage during the federal public health emergency (PHE). As a result, Medicaid enrollment grew significantly. Starting April 1, 2023, Medicaid programs were permitted to initiate a Medicaid redetermination process that resulted in termination of coverage for individuals who are no longer eligible for Medicaid, resulting in a decrease in Medicaid membership.[44] We relied on data from 2022, a period that reflected continuous coverage and a higher volume of Medicaid members. To account for the Medicaid redetermination process, we used national Medicaid enrollment and cost projections from CMS from 2025 to 2029.[45]

MEDICAID DATA SOURCE

We relied on the CMS Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) for calendar years 2021, with 12 months of runout, and 2022, with six months of runout (both years of data were updated and published Nov 10, 2023),[46] which include state-paid fee-for-service claims and managed care encounter data for Medicaid beneficiaries nationwide. We used the following TAF Research Identifiable Files to estimate the proportion of the Medicaid population eligible for AOMs:

[43] Medicaid and CHIP Payment and Access Commission (December 2022). MACStats: Medicaid and CHIP Data Book. Retrieved from: https://www.macpac.gov/wp-content/uploads/2022/12/MACSTATS_Dec2022_WEB-508.pdf

[44] Centers for Medicare and Medicaid Services. Unwinding and Returning to Regular Operations after COVID-19. Retrieved from: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html

[45] Centers for Medicare and Medicaid Services. National health expenditure data, projected. Retrieved from: https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

[46] Research Data Assistance Center (December 2023). 2021 and 2022 T-MSIS Medicaid and CHIP Data Now Available. Retrieved from: https://resdac.org/cms-news/2021-and-2022-t-msis-medicaid-and-chip-data-now-available

- Annual Demographic and Eligibility Files[47]
- Claims files (header and detail records for inpatient hospital services, long-term care services, other services, and pharmacy claims)[48]

CMS hosts an interactive public website containing data quality information for the TAF through the Data Quality Atlas (DQ Atlas).[49] Although states are expected to report information on each field, data quality concerns arise where some states submit incomplete or inconsistent information because the data was not collected or technical difficulties arose in reporting. We relied on DQ Atlas quality metrics to establish state data inclusion for our study.

Our data processing relied on the following eligibility fields:

- Missing eligibility data indicator (used to remove claim records without a corresponding eligibility record as of the service date)
- CHIP and Medicaid enrollment days by month (used to filter out records with no days of enrollment)
- Date of birth (used to calculate age as of the first date of each eligibility month)
- Eligibility Group Code[50] (used to determine the specific Medicaid or CHIP program eligibility category)
- CHIP Code[50] (used to identify and remove members not enrolled in Medicaid, Medicaid Expansion, or CHIP populations)
- Dual Eligible Code[50] (used to identify members with dual Medicare and Medicaid eligibility)
- Restricted Benefits Code[50] (used to filter out members with limited Medicaid benefits)
- Medicaid Plan Type Code (used to differentiate between FFS and Managed Care enrollees)

We linked the Annual Demographic and Eligibility File to the claims files using state MSIS ID in order to summarize the eligible population for our analysis. We excluded the following enrollment and claims experience from the data prior to our analysis:

- Members under 12 years old
- Institutionalized members during a long-term care stay
- Members enrolled in Medicaid through a pregnancy eligibility pathway (ELGBLTY_GRP_CD of 05, 53, 67, or 68)
- Members outside the 50 U.S. states and District of Columbia (i.e., U.S. territories were excluded)
- Claims missing a state MSIS ID, as the claims data could not be linked to the member-level demographic or diagnosis information without this field. From initial data processing, less than 0.1% of claims were excluded.
- We focused our review of the 50 states and Washington, D.C., which excluded approximately 1.3% of claims from U.S. territories or claims with a missing or invalid location for the submitting state.

For members remaining in our study, we utilized the combination of the eligibility group code field and calculated age to assign age category (child versus adult) and expansion versus non-expansion classification.

To estimate market share of each AOM in Medicaid, we relied on second quarter 2023 State Drug Utilization Data from Medicaid.gov for states that offer coverage of GLP-1 AOMs.

COMMERCIAL DATA SOURCE

For the commercial population, we relied on claims and membership data from Milliman's CHSD. CHSD is Milliman's proprietary claims data base that includes multi-year, longitudinal claims and enrollment data structures for over 60 million commercially insured members annually, nearly 40% of the commercial market. Several national and regional health plans and employer groups contribute their data to the CHSD. We primarily relied on data from 2022 through the second quarter of 2023. CHSD represents a mix of plans that cover and do not cover AOMs. For the development of key assumptions used in this analysis, we relied on data from plans that met our criteria for robust AOM brand coverage. This required at least 15 annual brand AOM scripts within a population of over 100 members and no more than 50% cost sharing on average for the brand AOMs. We also limited members to those that had medical coverage.

[47] Centers for Medicare and Medicaid Services. TAF Technical Documentation: Annual Demographic & Eligibility (DE) File. Research Data Assistance Center. Retrieved from: https://resdac.org/TAF-data-quality-resources/TAFTechDoc-DEF

[48] Ibid.

[49] DQ (Data Quality) Atlas. Home page. Retrieved from: https://www.medicaid.gov/dq-atlas/welcome

[50] DQ Atlas report a low concern with data quality for all states with the exception of Indiana in 2021 (missing) and Mississippi in 2022 (high concern).

V. CAVEATS, LIMITATIONS, AND QUALIFICATIONS

This report was commissioned by Novo Nordisk to provide estimates of the combined medical and pharmacy costs of AOM coverage in Medicaid and commercial markets. This information may not be appropriate, and should not be used, for other purposes. This report is intended for the internal use of Novo Nordisk. This information may not be shared with any third parties without the prior written consent of Milliman. Even if we allow distribution, this material is not meant to benefit or be relied upon by any third parties.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate projected utilization and cost of AOMs in the Medicaid and commercial markets. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and publicly available information, Milliman's Consolidated Health Cost Guidelines Sources™ Database (CHSD), State Drug Utilization Data (SDUD) from CMS, and the Transformed Medicaid Statistical Information System (T-MSIS) Analytical Files (TAF) datasets from CMS for this purpose and accepted it without audit, though we reviewed for reasonability. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. The models, including all input, calculations, and output, may not be appropriate for any other purpose. Actual results will certainly vary for specific stakeholders due to differences in demographics, trends, discount arrangements, formulary, utilization patterns, and rebate arrangements, among other factors.

Differences between the projected costs and actual experience will depend on the extent to which future experience conforms to the assumptions made in the development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.

Jake Klaisner, Briana Botros, and Ryan LeRoy are actuaries for Milliman and members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. This report outlines the review and opinions of the authors and not necessarily those of Milliman. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

Appendix A: Novo Nordisk, Inc.
Financial Liabilities Modeled for Medicaid and Commercial Stakeholders

Market	Stakeholder	Description
Commercial	Member	The portion of total cost sharing paid out-of-pocket by members.
Commercial	Health Plan	The portion of total cost paid by the health plan after accounting for rebates and cost sharing. No shift to member premium is assumed.
Medicaid	Federal Government	The portion of Medicaid spending paid by the federal government. Note this amount varies by state, populations, and services.
Medicaid	State Government	The portion of Medicaid spending paid by the state government. Note this amount varies by state, populations, and services.

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

Appendix B: Novo Nordisk, Inc.
Percentage of Uptake Among for Medicaid Populations

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
AL	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AL	Adult	Traditional	0.35%	0.53%	0.71%	0.71%	0.71%	0.46%	0.69%	0.93%	0.93%	0.93%	0.35%	0.53%	0.71%	0.71%	0.71%	0.46%	0.69%	0.92%	0.92%	0.92%
AL	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
AL	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
AK	Adult	Expansion	0.08%	0.12%	0.16%	0.16%	0.16%	0.09%	0.13%	0.18%	0.18%	0.18%	0.08%	0.12%	0.16%	0.16%	0.16%	0.09%	0.13%	0.17%	0.17%	0.17%
AK	Adult	Traditional	0.11%	0.16%	0.21%	0.21%	0.21%	0.11%	0.17%	0.23%	0.23%	0.23%	0.10%	0.16%	0.21%	0.21%	0.21%	0.11%	0.17%	0.23%	0.23%	0.23%
AK	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
AK	Child	Traditional	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%
AZ	Adult	Expansion	0.19%	0.28%	0.37%	0.37%	0.37%	0.20%	0.31%	0.41%	0.41%	0.41%	0.19%	0.28%	0.37%	0.37%	0.37%	0.20%	0.30%	0.40%	0.40%	0.40%
AZ	Adult	Traditional	0.21%	0.31%	0.42%	0.42%	0.42%	0.26%	0.39%	0.53%	0.53%	0.53%	0.21%	0.31%	0.41%	0.41%	0.41%	0.26%	0.39%	0.52%	0.52%	0.52%
AZ	Child	Expansion	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%
AZ	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
AR	Adult	Expansion	0.04%	0.05%	0.07%	0.07%	0.07%	0.04%	0.06%	0.08%	0.08%	0.08%	0.04%	0.05%	0.07%	0.07%	0.07%	0.04%	0.06%	0.08%	0.08%	0.08%
AR	Adult	Traditional	0.19%	0.29%	0.38%	0.38%	0.38%	0.24%	0.36%	0.48%	0.48%	0.48%	0.19%	0.29%	0.38%	0.38%	0.38%	0.24%	0.36%	0.48%	0.48%	0.48%
AR	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
AR	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
CA	Adult	Expansion	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.40%	0.40%	0.40%	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.40%	0.40%	0.40%
CA	Adult	Traditional	0.18%	0.27%	0.36%	0.36%	0.36%	0.26%	0.38%	0.51%	0.51%	0.51%	0.18%	0.27%	0.36%	0.36%	0.36%	0.25%	0.38%	0.51%	0.51%	0.51%
CA	Child	Expansion	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
CA	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
CO	Adult	Expansion	0.15%	0.22%	0.30%	0.30%	0.30%	0.16%	0.24%	0.32%	0.32%	0.32%	0.15%	0.22%	0.29%	0.29%	0.29%	0.16%	0.24%	0.32%	0.32%	0.32%
CO	Adult	Traditional	0.12%	0.19%	0.25%	0.25%	0.25%	0.13%	0.19%	0.25%	0.25%	0.25%	0.12%	0.18%	0.25%	0.25%	0.25%	0.13%	0.19%	0.25%	0.25%	0.25%
CO	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
CO	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
CT	Adult	Expansion	0.17%	0.25%	0.33%	0.33%	0.33%	0.18%	0.28%	0.37%	0.37%	0.37%	0.17%	0.25%	0.33%	0.33%	0.33%	0.18%	0.27%	0.37%	0.37%	0.37%
CT	Adult	Traditional	0.23%	0.34%	0.45%	0.45%	0.45%	0.27%	0.41%	0.55%	0.55%	0.55%	0.22%	0.34%	0.45%	0.45%	0.45%	0.27%	0.41%	0.54%	0.54%	0.54%
CT	Child	Expansion	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
CT	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
DE	Adult	Expansion	0.22%	0.34%	0.45%	0.45%	0.45%	0.25%	0.37%	0.49%	0.49%	0.49%	0.22%	0.33%	0.45%	0.45%	0.45%	0.24%	0.37%	0.49%	0.49%	0.49%
DE	Adult	Traditional	0.28%	0.42%	0.56%	0.56%	0.56%	0.34%	0.51%	0.68%	0.68%	0.68%	0.28%	0.42%	0.55%	0.55%	0.55%	0.34%	0.51%	0.68%	0.68%	0.68%
DE	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DE	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
DC	Adult	Expansion	0.07%	0.10%	0.14%	0.14%	0.14%	0.07%	0.11%	0.15%	0.15%	0.15%	0.07%	0.10%	0.13%	0.13%	0.13%	0.07%	0.11%	0.15%	0.15%	0.15%
DC	Adult	Traditional	0.12%	0.18%	0.24%	0.24%	0.24%	0.15%	0.22%	0.30%	0.30%	0.30%	0.12%	0.18%	0.24%	0.24%	0.24%	0.15%	0.22%	0.30%	0.30%	0.30%
DC	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DC	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
FL	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FL	Adult	Traditional	0.17%	0.26%	0.35%	0.35%	0.35%	0.23%	0.35%	0.47%	0.47%	0.47%	0.17%	0.26%	0.35%	0.35%	0.35%	0.23%	0.35%	0.47%	0.47%	0.47%
FL	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FL	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
GA	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GA	Adult	Traditional	0.21%	0.32%	0.42%	0.42%	0.42%	0.26%	0.39%	0.52%	0.52%	0.52%	0.21%	0.31%	0.42%	0.42%	0.42%	0.26%	0.39%	0.52%	0.52%	0.52%
GA	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GA	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
HI	Adult	Expansion	0.14%	0.20%	0.27%	0.27%	0.27%	0.15%	0.22%	0.29%	0.29%	0.29%	0.13%	0.20%	0.27%	0.27%	0.27%	0.15%	0.22%	0.29%	0.29%	0.29%
HI	Adult	Traditional	0.15%	0.23%	0.30%	0.30%	0.30%	0.21%	0.32%	0.42%	0.42%	0.42%	0.15%	0.22%	0.30%	0.30%	0.30%	0.21%	0.31%	0.42%	0.42%	0.42%
HI	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HI	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
ID	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ID	Adult	Traditional	0.17%	0.26%	0.34%	0.34%	0.34%	0.19%	0.29%	0.38%	0.38%	0.38%	0.17%	0.26%	0.34%	0.34%	0.34%	0.19%	0.29%	0.38%	0.38%	0.38%
ID	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ID	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
IL	Adult	Expansion	0.26%	0.39%	0.52%	0.52%	0.52%	0.29%	0.44%	0.58%	0.58%	0.58%	0.26%	0.39%	0.52%	0.52%	0.52%	0.29%	0.44%	0.58%	0.58%	0.58%
IL	Adult	Traditional	0.19%	0.28%	0.38%	0.38%	0.38%	0.25%	0.37%	0.50%	0.50%	0.50%	0.19%	0.28%	0.37%	0.37%	0.37%	0.25%	0.37%	0.49%	0.49%	0.49%
IL	Child	Expansion	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
IL	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
IN	Adult	Expansion	0.08%	0.12%	0.16%	0.16%	0.16%	0.09%	0.13%	0.17%	0.17%	0.17%	0.08%	0.12%	0.16%	0.16%	0.16%	0.09%	0.13%	0.17%	0.17%	0.17%
IN	Adult	Traditional	0.08%	0.12%	0.16%	0.16%	0.16%	0.08%	0.13%	0.17%	0.17%	0.17%	0.08%	0.12%	0.16%	0.16%	0.16%	0.08%	0.13%	0.17%	0.17%	0.17%
IN	Child	Expansion	0.12%	0.18%	0.24%	0.24%	0.24%	0.12%	0.18%	0.24%	0.24%	0.24%	0.12%	0.18%	0.24%	0.24%	0.24%	0.12%	0.18%	0.24%	0.24%	0.24%
IN	Child	Traditional	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IA	Adult	Expansion	0.19%	0.28%	0.37%	0.37%	0.37%	0.21%	0.31%	0.41%	0.41%	0.41%	0.19%	0.28%	0.37%	0.37%	0.37%	0.21%	0.31%	0.41%	0.41%	0.41%
IA	Adult	Traditional	0.22%	0.33%	0.43%	0.43%	0.43%	0.27%	0.41%	0.55%	0.55%	0.55%	0.22%	0.32%	0.43%	0.43%	0.43%	0.27%	0.41%	0.54%	0.54%	0.54%
IA	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
IA	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
KS	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
KS	Adult	Traditional	0.19%	0.29%	0.39%	0.39%	0.39%	0.23%	0.35%	0.47%	0.47%	0.47%	0.19%	0.29%	0.38%	0.38%	0.38%	0.23%	0.35%	0.47%	0.47%	0.47%
KS	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
KS	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
KY	Adult	Expansion	0.25%	0.37%	0.50%	0.50%	0.50%	0.27%	0.41%	0.54%	0.54%	0.54%	0.25%	0.37%	0.49%	0.49%	0.49%	0.27%	0.41%	0.54%	0.54%	0.54%
KY	Adult	Traditional	0.27%	0.40%	0.54%	0.54%	0.54%	0.35%	0.52%	0.69%	0.69%	0.69%	0.27%	0.40%	0.53%	0.53%	0.53%	0.34%	0.52%	0.69%	0.69%	0.69%
KY	Child	Expansion	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
KY	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
LA	Adult	Expansion	0.24%	0.37%	0.49%	0.49%	0.49%	0.27%	0.40%	0.54%	0.54%	0.54%	0.24%	0.37%	0.49%	0.49%	0.49%	0.27%	0.40%	0.54%	0.54%	0.54%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
LA	Adult	Traditional	0.19%	0.28%	0.38%	0.38%	0.38%	0.25%	0.38%	0.51%	0.51%	0.51%	0.19%	0.28%	0.37%	0.37%	0.37%	0.25%	0.38%	0.51%	0.51%	0.51%
LA	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
LA	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
ME	Adult	Expansion	0.15%	0.23%	0.30%	0.30%	0.30%	0.16%	0.25%	0.33%	0.33%	0.33%	0.15%	0.23%	0.30%	0.30%	0.30%	0.16%	0.24%	0.33%	0.33%	0.33%
ME	Adult	Traditional	0.16%	0.24%	0.32%	0.32%	0.32%	0.19%	0.28%	0.37%	0.37%	0.37%	0.16%	0.24%	0.32%	0.32%	0.32%	0.19%	0.28%	0.37%	0.37%	0.37%
ME	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ME	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
MD	Adult	Expansion	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.40%	0.40%	0.40%	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.39%	0.39%	0.39%
MD	Adult	Traditional	0.24%	0.36%	0.48%	0.48%	0.48%	0.29%	0.44%	0.58%	0.58%	0.58%	0.24%	0.36%	0.48%	0.48%	0.48%	0.29%	0.44%	0.58%	0.58%	0.58%
MD	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MD	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
MA	Adult	Expansion	0.18%	0.27%	0.36%	0.36%	0.36%	0.19%	0.29%	0.39%	0.39%	0.39%	0.18%	0.27%	0.36%	0.36%	0.36%	0.19%	0.29%	0.39%	0.39%	0.39%
MA	Adult	Traditional	0.24%	0.36%	0.48%	0.48%	0.48%	0.29%	0.43%	0.57%	0.57%	0.57%	0.24%	0.35%	0.47%	0.47%	0.47%	0.28%	0.43%	0.57%	0.57%	0.57%
MA	Child	Expansion	0.03%	0.05%	0.06%	0.06%	0.06%	0.03%	0.05%	0.06%	0.06%	0.06%	0.03%	0.05%	0.06%	0.06%	0.06%	0.03%	0.05%	0.06%	0.06%	0.06%
MA	Child	Traditional	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%
MI	Adult	Expansion	0.25%	0.37%	0.49%	0.49%	0.49%	0.27%	0.41%	0.54%	0.54%	0.54%	0.24%	0.37%	0.49%	0.49%	0.49%	0.27%	0.41%	0.54%	0.54%	0.54%
MI	Adult	Traditional	0.22%	0.33%	0.44%	0.44%	0.44%	0.30%	0.45%	0.60%	0.60%	0.60%	0.22%	0.33%	0.44%	0.44%	0.44%	0.30%	0.44%	0.59%	0.59%	0.59%
MI	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MI	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
MN	Adult	Expansion	0.12%	0.18%	0.24%	0.24%	0.24%	0.13%	0.20%	0.26%	0.26%	0.26%	0.12%	0.18%	0.24%	0.24%	0.24%	0.13%	0.19%	0.26%	0.26%	0.26%
MN	Adult	Traditional	0.16%	0.23%	0.31%	0.31%	0.31%	0.17%	0.25%	0.34%	0.34%	0.34%	0.15%	0.23%	0.31%	0.31%	0.31%	0.17%	0.25%	0.33%	0.33%	0.33%
MN	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MN	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
MS	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MS	Adult	Traditional	0.06%	0.09%	0.12%	0.12%	0.12%	0.07%	0.10%	0.13%	0.13%	0.13%	0.06%	0.09%	0.12%	0.12%	0.12%	0.07%	0.10%	0.13%	0.13%	0.13%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
MS	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MS	Child	Traditional	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MO	Adult	Expansion	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.40%	0.40%	0.40%	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.30%	0.40%	0.40%	0.40%
MO	Adult	Traditional	0.21%	0.32%	0.42%	0.42%	0.42%	0.25%	0.37%	0.50%	0.50%	0.50%	0.21%	0.31%	0.42%	0.42%	0.42%	0.25%	0.37%	0.50%	0.50%	0.50%
MO	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MO	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
MT	Adult	Expansion	0.13%	0.20%	0.27%	0.27%	0.27%	0.15%	0.22%	0.30%	0.30%	0.30%	0.13%	0.20%	0.27%	0.27%	0.27%	0.15%	0.22%	0.30%	0.30%	0.30%
MT	Adult	Traditional	0.14%	0.22%	0.29%	0.29%	0.29%	0.15%	0.23%	0.31%	0.31%	0.31%	0.14%	0.21%	0.29%	0.29%	0.29%	0.15%	0.23%	0.30%	0.30%	0.30%
MT	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MT	Child	Traditional	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%
NE	Adult	Expansion	0.15%	0.23%	0.30%	0.30%	0.30%	0.17%	0.25%	0.33%	0.33%	0.33%	0.15%	0.22%	0.30%	0.30%	0.30%	0.17%	0.25%	0.33%	0.33%	0.33%
NE	Adult	Traditional	0.13%	0.19%	0.26%	0.26%	0.26%	0.17%	0.26%	0.34%	0.34%	0.34%	0.13%	0.19%	0.26%	0.26%	0.26%	0.17%	0.26%	0.34%	0.34%	0.34%
NE	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
NE	Child	Traditional	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%
NV	Adult	Expansion	0.17%	0.26%	0.34%	0.34%	0.34%	0.19%	0.28%	0.38%	0.38%	0.38%	0.17%	0.25%	0.34%	0.34%	0.34%	0.19%	0.28%	0.38%	0.38%	0.38%
NV	Adult	Traditional	0.15%	0.23%	0.30%	0.30%	0.30%	0.18%	0.27%	0.36%	0.36%	0.36%	0.15%	0.23%	0.30%	0.30%	0.30%	0.18%	0.27%	0.36%	0.36%	0.36%
NV	Child	Expansion	0.01%	0.02%	0.03%	0.03%	0.03%	0.01%	0.02%	0.03%	0.03%	0.03%	0.01%	0.02%	0.03%	0.03%	0.03%	0.01%	0.02%	0.03%	0.03%	0.03%
NV	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
NH	Adult	Expansion	0.12%	0.19%	0.25%	0.25%	0.25%	0.14%	0.20%	0.27%	0.27%	0.27%	0.12%	0.19%	0.25%	0.25%	0.25%	0.13%	0.20%	0.27%	0.27%	0.27%
NH	Adult	Traditional	0.15%	0.23%	0.30%	0.30%	0.30%	0.17%	0.25%	0.33%	0.33%	0.33%	0.15%	0.22%	0.30%	0.30%	0.30%	0.17%	0.25%	0.33%	0.33%	0.33%
NH	Child	Expansion	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%	0.02%	0.03%	0.04%	0.04%	0.04%
NH	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
NJ	Adult	Expansion	0.33%	0.49%	0.66%	0.66%	0.66%	0.36%	0.54%	0.72%	0.72%	0.72%	0.33%	0.49%	0.66%	0.66%	0.66%	0.36%	0.54%	0.72%	0.72%	0.72%
NJ	Adult	Traditional	0.27%	0.40%	0.54%	0.54%	0.54%	0.33%	0.49%	0.66%	0.66%	0.66%	0.27%	0.40%	0.53%	0.53%	0.53%	0.33%	0.49%	0.66%	0.66%	0.66%
NJ	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
NJ	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
NM	Adult	Expansion	0.16%	0.24%	0.32%	0.32%	0.32%	0.18%	0.27%	0.35%	0.35%	0.35%	0.16%	0.24%	0.32%	0.32%	0.32%	0.18%	0.26%	0.35%	0.35%	0.35%
NM	Adult	Traditional	0.21%	0.31%	0.41%	0.41%	0.41%	0.25%	0.37%	0.50%	0.50%	0.50%	0.21%	0.31%	0.41%	0.41%	0.41%	0.25%	0.37%	0.50%	0.50%	0.50%
NM	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NM	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
NY	Adult	Expansion	0.22%	0.33%	0.44%	0.44%	0.44%	0.24%	0.36%	0.48%	0.48%	0.48%	0.22%	0.32%	0.43%	0.43%	0.43%	0.24%	0.36%	0.48%	0.48%	0.48%
NY	Adult	Traditional	0.22%	0.32%	0.43%	0.43%	0.43%	0.29%	0.44%	0.59%	0.59%	0.59%	0.21%	0.32%	0.43%	0.43%	0.43%	0.29%	0.44%	0.59%	0.59%	0.59%
NY	Child	Expansion	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%	0.01%	0.02%	0.02%	0.02%	0.02%
NY	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
NC	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NC	Adult	Traditional	0.25%	0.38%	0.51%	0.51%	0.51%	0.32%	0.48%	0.64%	0.64%	0.64%	0.25%	0.38%	0.51%	0.51%	0.51%	0.32%	0.48%	0.64%	0.64%	0.64%
NC	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NC	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
ND	Adult	Expansion	0.18%	0.27%	0.36%	0.36%	0.36%	0.20%	0.29%	0.39%	0.39%	0.39%	0.18%	0.27%	0.35%	0.35%	0.35%	0.19%	0.29%	0.39%	0.39%	0.39%
ND	Adult	Traditional	0.17%	0.26%	0.35%	0.35%	0.35%	0.22%	0.33%	0.44%	0.44%	0.44%	0.17%	0.25%	0.34%	0.34%	0.34%	0.22%	0.33%	0.44%	0.44%	0.44%
ND	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
ND	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
OH	Adult	Expansion	0.30%	0.45%	0.60%	0.60%	0.60%	0.33%	0.49%	0.66%	0.66%	0.66%	0.30%	0.45%	0.60%	0.60%	0.60%	0.33%	0.49%	0.66%	0.66%	0.66%
OH	Adult	Traditional	0.31%	0.46%	0.62%	0.62%	0.62%	0.37%	0.56%	0.75%	0.75%	0.75%	0.31%	0.46%	0.62%	0.62%	0.62%	0.37%	0.56%	0.74%	0.74%	0.74%
OH	Child	Expansion	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%
OH	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
OK	Adult	Expansion	0.18%	0.27%	0.35%	0.35%	0.35%	0.19%	0.29%	0.39%	0.39%	0.39%	0.18%	0.26%	0.35%	0.35%	0.35%	0.19%	0.29%	0.39%	0.39%	0.39%
OK	Adult	Traditional	0.13%	0.19%	0.26%	0.26%	0.26%	0.15%	0.22%	0.30%	0.30%	0.30%	0.13%	0.19%	0.25%	0.25%	0.25%	0.15%	0.22%	0.30%	0.30%	0.30%
OK	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
OK	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
OR	Adult	Expansion	0.12%	0.19%	0.25%	0.25%	0.25%	0.14%	0.20%	0.27%	0.27%	0.27%	0.12%	0.19%	0.25%	0.25%	0.25%	0.13%	0.20%	0.27%	0.27%	0.27%
OR	Adult	Traditional	0.13%	0.20%	0.27%	0.27%	0.27%	0.18%	0.26%	0.35%	0.35%	0.35%	0.13%	0.19%	0.26%	0.26%	0.26%	0.17%	0.26%	0.34%	0.34%	0.34%
OR	Child	Expansion	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%
OR	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
PA	Adult	Expansion	0.26%	0.39%	0.52%	0.52%	0.52%	0.28%	0.42%	0.57%	0.57%	0.57%	0.26%	0.39%	0.52%	0.52%	0.52%	0.28%	0.42%	0.56%	0.56%	0.56%
PA	Adult	Traditional	0.24%	0.36%	0.48%	0.48%	0.48%	0.32%	0.49%	0.65%	0.65%	0.65%	0.24%	0.36%	0.48%	0.48%	0.48%	0.32%	0.48%	0.65%	0.65%	0.65%
PA	Child	Expansion	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%	0.02%	0.02%	0.03%	0.03%	0.03%
PA	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
RI	Adult	Expansion	0.16%	0.24%	0.32%	0.32%	0.32%	0.18%	0.26%	0.35%	0.35%	0.35%	0.16%	0.24%	0.32%	0.32%	0.32%	0.18%	0.26%	0.35%	0.35%	0.35%
RI	Adult	Traditional	0.20%	0.31%	0.41%	0.41%	0.41%	0.25%	0.38%	0.50%	0.50%	0.50%	0.20%	0.31%	0.41%	0.41%	0.41%	0.25%	0.38%	0.50%	0.50%	0.50%
RI	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
RI	Child	Traditional	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%	0.01%	0.01%	0.02%	0.02%	0.02%
SC	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SC	Adult	Traditional	0.20%	0.30%	0.40%	0.40%	0.40%	0.26%	0.39%	0.52%	0.52%	0.52%	0.20%	0.30%	0.39%	0.39%	0.39%	0.26%	0.39%	0.52%	0.52%	0.52%
SC	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SC	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
SD	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SD	Adult	Traditional	0.13%	0.19%	0.26%	0.26%	0.26%	0.15%	0.22%	0.30%	0.30%	0.30%	0.13%	0.19%	0.25%	0.25%	0.25%	0.15%	0.22%	0.29%	0.29%	0.29%
SD	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SD	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
TN	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TN	Adult	Traditional	0.28%	0.43%	0.57%	0.57%	0.57%	0.33%	0.49%	0.65%	0.65%	0.65%	0.28%	0.42%	0.56%	0.56%	0.56%	0.32%	0.49%	0.65%	0.65%	0.65%
TN	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TN	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
TX	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
TX	Adult	Traditional	0.15%	0.23%	0.31%	0.31%	0.31%	0.21%	0.32%	0.42%	0.42%	0.42%	0.15%	0.23%	0.30%	0.30%	0.30%	0.21%	0.32%	0.42%	0.42%	0.42%
TX	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TX	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
UT	Adult	Expansion	0.19%	0.29%	0.39%	0.39%	0.39%	0.21%	0.32%	0.42%	0.42%	0.42%	0.19%	0.29%	0.39%	0.39%	0.39%	0.21%	0.32%	0.42%	0.42%	0.42%
UT	Adult	Traditional	0.22%	0.33%	0.44%	0.44%	0.44%	0.27%	0.40%	0.53%	0.53%	0.53%	0.22%	0.33%	0.44%	0.44%	0.44%	0.26%	0.40%	0.53%	0.53%	0.53%
UT	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
UT	Child	Traditional	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%
VT	Adult	Expansion	0.13%	0.19%	0.26%	0.26%	0.26%	0.14%	0.21%	0.28%	0.28%	0.28%	0.13%	0.19%	0.26%	0.26%	0.26%	0.14%	0.21%	0.28%	0.28%	0.28%
VT	Adult	Traditional	0.13%	0.20%	0.26%	0.26%	0.26%	0.15%	0.23%	0.31%	0.31%	0.31%	0.13%	0.20%	0.26%	0.26%	0.26%	0.15%	0.23%	0.30%	0.30%	0.30%
VT	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
VT	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
VA	Adult	Expansion	0.15%	0.22%	0.30%	0.30%	0.30%	0.16%	0.24%	0.32%	0.32%	0.32%	0.15%	0.22%	0.30%	0.30%	0.30%	0.16%	0.24%	0.32%	0.32%	0.32%
VA	Adult	Traditional	0.15%	0.23%	0.30%	0.30%	0.30%	0.18%	0.27%	0.36%	0.36%	0.36%	0.15%	0.22%	0.30%	0.30%	0.30%	0.18%	0.27%	0.35%	0.35%	0.35%
VA	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
VA	Child	Traditional	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%	0.01%
WA	Adult	Expansion	0.13%	0.19%	0.26%	0.26%	0.26%	0.14%	0.21%	0.28%	0.28%	0.28%	0.13%	0.19%	0.26%	0.26%	0.26%	0.14%	0.21%	0.28%	0.28%	0.28%
WA	Adult	Traditional	0.15%	0.23%	0.30%	0.30%	0.30%	0.19%	0.28%	0.37%	0.37%	0.37%	0.15%	0.22%	0.30%	0.30%	0.30%	0.19%	0.28%	0.37%	0.37%	0.37%
WA	Child	Expansion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
WA	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
WV	Adult	Expansion	0.27%	0.40%	0.53%	0.53%	0.53%	0.29%	0.44%	0.59%	0.59%	0.59%	0.27%	0.40%	0.53%	0.53%	0.53%	0.29%	0.44%	0.59%	0.59%	0.59%
WV	Adult	Traditional	0.23%	0.34%	0.46%	0.46%	0.46%	0.28%	0.42%	0.56%	0.56%	0.56%	0.23%	0.34%	0.45%	0.45%	0.45%	0.28%	0.42%	0.56%	0.56%	0.56%
WV	Child	Expansion	0.08%	0.12%	0.16%	0.16%	0.16%	0.08%	0.12%	0.16%	0.16%	0.16%	0.08%	0.12%	0.16%	0.16%	0.16%	0.08%	0.12%	0.16%	0.16%	0.16%
WV	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
WI	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WI	Adult	Traditional	0.16%	0.23%	0.31%	0.31%	0.31%	0.17%	0.26%	0.34%	0.34%	0.34%	0.15%	0.23%	0.31%	0.31%	0.31%	0.17%	0.25%	0.34%	0.34%	0.34%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

			Current Indications										Expanded Indications									
			Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only					Percentage of Uptake Among Dual & Non-Dual Population*					Percentage of Uptake Among Population* Non-Dual Only				
State	Rate Group	Population	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029	2025	2026	2027	2028	2029
WI	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WI	Child	Traditional	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%	0.00%	0.01%	0.01%	0.01%	0.01%
WY	Adult	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WY	Adult	Traditional	0.17%	0.26%	0.34%	0.34%	0.34%	0.20%	0.30%	0.40%	0.40%	0.40%	0.17%	0.25%	0.34%	0.34%	0.34%	0.20%	0.30%	0.40%	0.40%	0.40%
WY	Child	Expansion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
WY	Child	Traditional	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%	0.01%

*Total Population reflects exclusions members enrolled in Medicaid through a pregnancy eligibility pathway.

For more information about Milliman, please visit us at:

milliman.com

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

AJ Ally
aj.ally@milliman.com

Briana Botros
briana.botros@milliman.com

Jake Klaisner
jake.klaisner@milliman.com

Ryan LeRoy
ryan.leroy@milliman.com

Kristin Niakan
kristin.niakan@milliman.com