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Cost-Benefit Analysis of GLP-1 Coverage for Obesity in New Hampshire



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TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
1 INTRODUCTION	4
2 PROBLEM STATEMENT	4
3 BACKGROUND	5
3.1 GLP-1 Background	5
3.2 Federal Medicaid Landscape	5
3.3 State Medicaid Landscape	7
3.4 Private Payer Coverage Landscape	8
4 METHODOLOGY	9
4.1 Literature Review	9
4.2 Expert and Stakeholder Interviews	9
4.3 Financial Modeling	10
5 RESULTS: HEALTH	12
5.1 Obesity as a Disease	12
5.2 The GLP-1 Prescription Process	13
5.3 GLP-1 Usage	14
5.4 Health Summary	15
6 RESULTS: FINANCES	15
6.1 Medicaid Baseline Scenario	16
6.2 Medicaid Most-Favored-Nation Scenario	17
6.3 Private Payers	18
6.4 Who benefits from savings and productivity?	19
6.5 Who is receiving coverage for GLP-1s?	21
6.6 Finances Summary	23
7 RECOMMENDATIONS	23
7.1 Quality of Care Recommendations	24
7.2 Cost Control Recommendations	24
ENDNOTES	26

EXECUTIVE SUMMARY

Glucagon-like peptide-1 receptor agonists (GLP-1s) are a group of medications effective at treating obesity, type-2 diabetes, and other conditions. GLP-1s are a desirable treatment option for many Americans, but they are costly. Spending from Medicaid and private payers on GLP-1s is rising at an unprecedented rate. Federal stipulations require Medicaid to cover GLP-1s for obesity-related comorbidities, such as diabetes, but not exclusively for obesity. New Hampshire Senate Bill 455 (SB455) seeks to expand Medicaid coverage of GLP-1s to individuals with a Body Mass Index (BMI) of 30 or higher even if they do not have an associated comorbidity. What impact will SB455's enhanced GLP-1 coverage have on New Hampshire's health and finances? Using a combination of qualitative and quantitative methods, this report synthesizes:

- 1) The federal and state policy landscape for GLP-1 coverage
- 2) Health information about obesity and GLP-1s
- 3) The long-term financial impact of SB455 at the state-level
- 4) Recommendations to improve quality of care and control costs

Policy Landscape: State Medicaid programs have flexibility on whether or not to cover GLP-1s as a pharmaceutical benefit. The federal government has negotiated with pharmaceutical manufacturers to put a cap on GLP-1 prices, coming into effect in 2026. New Hampshire Medicaid rolled back coverage for GLP-1s for weight loss starting January 1, 2026 due to cost constraints. Pennsylvania, South Carolina, and California also decided in 2026 to roll back previous legislation that mandated GLP-1 coverage for obesity. Conversely, New York, Maryland, and Hawaii are considering legislation to cover GLP-1s for obesity in 2026.

Health: In the United States, more than 40 percent of the population has obesity, and for New Hampshire it is 31 percent. Obesity is a disease with a multi-faceted diagnostic process. To get GLP-1 coverage, patients must meet a set of requirements and get prior authorization from their insurance provider. Clinical trials show that GLP-1s can reduce body weight by 15-20 percent, but discontinuation can lead to rapid weight regain if lifestyle changes are not cemented.

Finances: The majority of benefits derived from covering GLP-1s are improvements in health and quality of life. There are also long-run medical savings and productivity benefits. We calculate three scenarios of GLP-1 coverage:

- 1) Medicaid under SB455 at baseline
- 2) Medicaid with federal negotiated price rebates under SB455
- 3) Private payers coverage under SB455 criteria

In all three scenarios, total benefits, including health and monetary benefits, are valued higher than costs. In the second scenario with reduced GLP-1 costs from federally negotiated price rebates through the Centers for Medicare and Medicaid Services' (CMS) BALANCE model, monetary benefits alone outweigh the costs.

Recommendations: Following our findings on GLP-1 coverage health and financial impacts, Table 1 summarizes solutions New Hampshire could implement to address GLP-1 coverage-related challenges. These solutions are categorized as quality of care recommendations and cost control recommendations.

Table 1: Implementation Strategy Recommendations

Category	Recommendation
Quality of Care	1. Specify continuity of care policy
	2. Communicate GLP-1 coverage to patients
Cost Control	3. Join CMS BALANCE
	4. Explore Section 1115 Medicaid waiver
	5. Wholesale drug importation

1 INTRODUCTION

Glucagon-like peptide-1 receptor agonists (GLP-1s) are a class of medications initially developed to treat type-2 diabetes.¹ The Food and Drug Administration (FDA) approved GLP-1s as a type-2 diabetes treatment in 2005; since then, other GLP-1s have since received FDA-approval for obesity treatment and other weight-related comorbidities.² In recent years, the popularity of GLP-1s has skyrocketed due to their effectiveness for weight loss. A major contributor to this increased demand is the prevalence of obesity in the US, which is widely considered a chronic and serious disease.³ Despite this, federal Medicaid stipulations allow states to choose whether to cover certain GLP-1s designated for obesity and weight loss. As high costs of GLP-1s pose challenges to state budgets, many states which had once covered GLP-1s for weight loss reasons, including New Hampshire, decided to roll back coverage in 2026.⁴ Due to the high out-of-pocket costs of GLP-1s, it is unlikely that Medicaid recipients will have access to prescriptions if Medicaid does not cover them.⁵

2 PROBLEM STATEMENT

The effectiveness of GLP-1s at treating obesity and related comorbidities make them a desirable treatment option for millions of Americans. However, GLP-1s are costly to produce and demand is increasing at an exponential rate. As a result, Medicaid has been paying billions into GLP-1 coverage, which is unsustainable for the program. New Hampshire made the decision to roll back Medicaid coverage of GLP-1s for weight loss at the beginning of 2026 to address these cost sustainability concerns.⁶ This creates a vulnerable population: Granite Staters on Medicaid suffering from obesity who will no longer be able to access GLP-1 treatment due to high out-of-pocket costs without insurance. Box 1 describes Senate Bill 455 (SB455), proposed in February 2026, which aims to fill the gap in access created by these new restrictions in coverage. This brief investigates the following question: **What impact will SB455's enhanced GLP-1 coverage have on New Hampshire's health and finances?**

Box 1: Senate Bill 455 (SB455)

SB455, an Act relative to coverage for GLP-1 medication under the state Medicaid plan, would amend New Hampshire's Public Safety and Welfare Law to require medical assistance under the state Medicaid plan to cover GLP-1 medications if deemed medically necessary and the covered person's Body Mass Index (BMI) is equal to or greater than **30**, or if the covered person's BMI is greater than or equal to **27** with one or more approved comorbidities. Approved comorbidities include type-2 diabetes, hypertension, dyslipidemia, obstructive sleep apnea, cardiovascular disease, prediabetes, and metabolic dysfunction associated steatotic liver disease.⁷

3 BACKGROUND

GLP-1s are effective obesity treatments; however, long-standing statutory exceptions allow states to choose whether to cover drugs specific to weight-loss under Medicaid.⁸ With this leeway, states tend to favor Medicaid benefit expansion over limitation or restriction; however, GLP-1s are an exception to this trend.⁹ Private and public insurers alike have turned to coverage of weight-loss drugs, which are uniquely expensive, as a potential area to cut back spending.¹⁰ As a result, many states that have expanded Medicaid to cover obesity medications have added new utilization management controls and restrictions on usage, and four states that previously covered them eliminated existing coverage, such as in New Hampshire.¹¹ Utilization management controls implemented include requirements for prior authorization and quantity limits.¹²

3.1 GLP-1 Background

GLP-1s mimic the secretion of a hormone that stimulates insulin production, lowering blood sugar levels.¹³ Currently, the most common FDA-approved GLP-1s are semaglutide injections (Ozempic® and Wegovy®), dulaglutide (Trulicity®), liraglutide (Victoza® and Saxenda®), and tirzepatide (Zepbound® or Monjaro®).¹⁴ An oral GLP-1, Rybelsus®, is becoming a more popular choice in the United States after FDA approval in 2019.¹⁵ The FDA also approved an oral version of Wegovy for obesity treatment in December 2025, providing a once-daily alternative to the Wegovy injection.¹⁶

While initially developed to treat type-2 diabetes, GLP-1s have risen to prominence due to their effectiveness in treating obesity. Individuals suffering from obesity often experience dysregulation in the brain that causes them to crave unhealthy amounts of food; GLP-1s reduce this “food noise.”¹⁷ Studies show that GLP-1s account for higher overall weight loss in patients with obesity than traditional treatments.¹⁸ Patients who use these drugs in the long-term can lose more than 15 percent of their body weight and experience a reduced risk of complications like heart attacks or strokes, and improvement in obesity-related comorbidities like hypertension, sleep apnea, and kidney disease.¹⁹

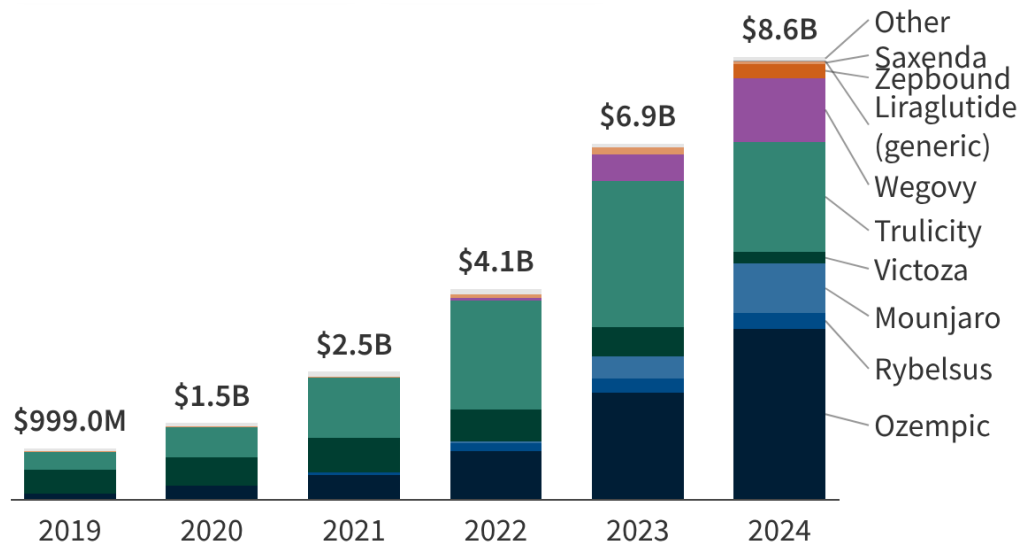
3.2 Federal Medicaid Landscape

Healthcare spending in the United States reached an all-time high of \$5.3 trillion in 2024.²⁰ This spending continues to sharply increase due to aging populations, rising rates of chronic conditions, higher pharmaceutical prices, and expansion in health insurance coverage.²¹ The 2025 budget reconciliation package signed into law on July 4, 2025 attempts to address this issue with provisions to limit provider taxes and reduce federal Medicaid spending, putting increasing pressure on states to reduce their Medicaid spending as soon as possible.²² The Congressional Budget Office (CBO) estimates a \$911 billion reduction in federal Medicaid spending over the next decade due to major reductions in healthcare spending.²³

GLP-1s pose a unique burden to Medicaid. Demand for GLP-1s is high and only projected to continue increasing; a JP Morgan analysis estimates that total GLP-1 users in the United States may reach 30

million by 2030, making up around 9 percent of the population.²⁴ Due to a surge in prescription claims, and as reflected in Figure 1, Medicaid gross spending on GLP-1 prescriptions increased from \$1 billion in 2019 to almost \$9 billion in 2024.²⁵ This is partially due to a dual price spike and explosion in usage; as gross spending rose to nearly \$1,000 per prescription; the number of Medicaid prescriptions increased from 1.3 million to over 8 million in 2024.²⁶

Figure 1: Gross Medicaid Spending on GLP-1s from 2019 to 2024



Note: Gross spending is Medicaid spending before rebates. Includes all FDA-approved GLP-1s, including those approved for obesity (Saxenda, Wegovy, Zepbound) as well as those approved for type 2 diabetes. Wegovy is also approved for cardiovascular disease, and Zepbound is also approved for sleep apnea. Coverage for weight-loss or obesity is optional in Medicaid while coverage for other indications is required. Other includes a small number of prescriptions for the GLP-1s Adlyxin, Byetta, Bydureon BCise, and Tanzeum (all now discontinued). Includes tirzepatide (Mounjaro and Zepbound), which is a dual glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 agonist.

Source: Kaiser Family Foundation, *Medicaid Coverage of and Spending on GLP-1s*.

There have been multiple proposed solutions to mitigate the effects of these costs while maintaining access. In 2024, the Biden administration proposed a regulatory shift that would reinterpret the statutory language to authorize Medicare and Medicaid coverage of weight-loss drugs for those experiencing obesity, reflecting the acknowledgement that these medications confer actual health benefits for those with obesity rather than being simply a method for weight loss.²⁷

In 2025, the Trump administration announced a deal ensuring nine pharmaceutical companies charged the lowest price in the United States compared to all other developed nations, a structure known as Most-Favored-Nation pricing.²⁸ An application of this model to the GLP-1 market, entitled the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model, was an expansion proposed to address the GLP-1 cost crisis. This Centers for Medicare and Medicaid Services (CMS) model is voluntary, which involves negotiating drug pricing with GLP-1

manufacturers on behalf of state Medicaid agencies and Medicare Part D plan sponsors.²⁹ The BALANCE Model would be an extension of the administration's Most-Favored-Nation pricing model, partnering with Eli Lilly and Novo Nordisk where the federal government will cap the costs of Ozempic, Wegovy, Mounjaro, and Zepbound at \$245 per month.³⁰ States were required to submit an intention to participate in BALANCE by January 8, 2026, and BALANCE is scheduled to begin a five-year pilot program in May 2026.³¹ This model will include standardized coverage criteria

3.3 State Medicaid Landscape

Federal stipulations require Medicaid to cover GLP-1s for diabetes, cardiovascular disease, obstructive sleep apnea,³² and if deemed medically necessary for Medicaid recipients under the age of 21.³³ Federal Medicaid law states that drugs used for weight-loss only can be covered or not, leaving this up to the states to determine if they will cover GLP-1s for obesity under Medicaid.³⁴

This ambiguity translates into a patchwork of state policies across the country to address coverage of GLP-1s for weight loss through Medicaid. Currently, thirteen state Medicaid programs report coverage of GLP-1s when prescribed for obesity treatment.³⁵ This number is down from sixteen in 2025,³⁶ with states reporting the high cost being the main driver in decisions to reduce coverage.³⁷ New Hampshire joined California, Pennsylvania, and South Carolina in allowing and then eliminating GLP-1 coverage in 2026.³⁸

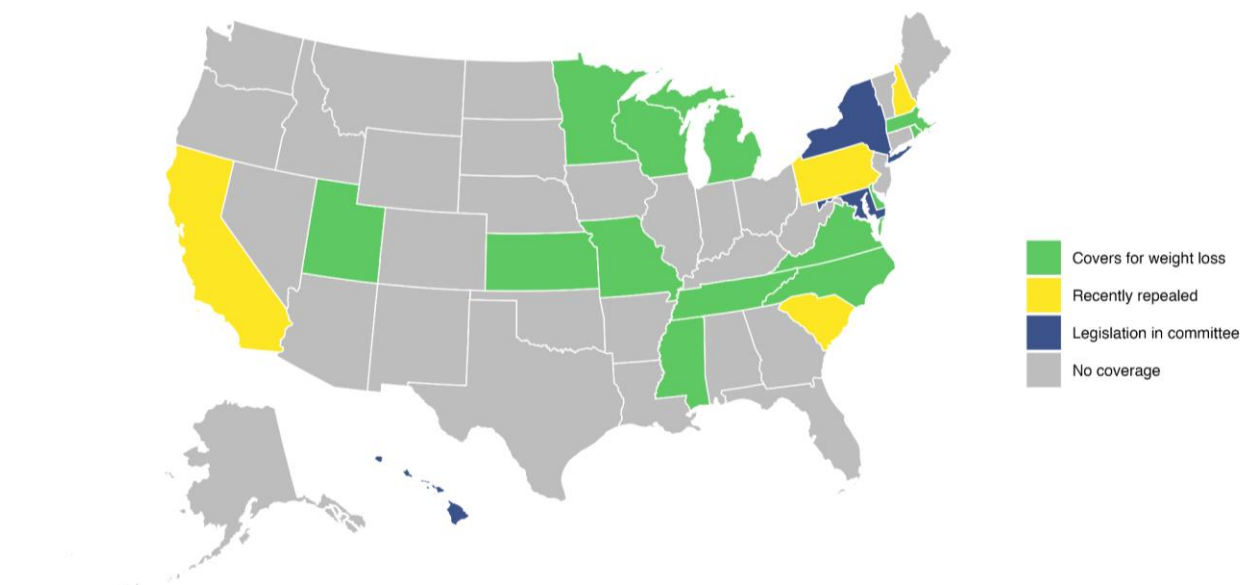
Individual states that do cover GLP-1s under Medicaid have increasingly implemented utilization management controls and other restrictions as a response to the rising costs of GLP-1s. For example, California is working with their Pharmacy Benefit Managers (PBMs) to update clinical criteria for GLP-1 usage and is implementing additional medical necessity requirements to pharmacy benefits; Kentucky has also updated clinical criteria and is working with PBMs and Managed Care Organizations (MCOs) to monitor appropriate utilization.³⁹ Four other states⁴⁰ have noted that they will make efforts to expand utilization controls in FY 2025 or FY 2026.

Differential coverage between states and frequent changes in coverage have also created another barrier to access. Health care professionals report that Medicaid recipients are often confused about their coverage status even when they are covered and therefore may not have accurate information about whether or not they would be able to receive Medicaid coverage for GLP-1s.⁴¹

Many states cited increasing pressure to tighten budgets and uncertainty about federal Medicaid funding levels because of the 2025 reconciliation bill as reasons for exploring cutbacks on Medicaid coverage of GLP-1s.⁴² Specific to New Hampshire, Governor Kelly Ayotte explained in an interview with the New Hampshire Bulletin that the decision to reduce eligibility for GLP-1s would ultimately improve the cost-sustainability of the state's Medicaid program, allowing the State to continue providing essential coverage (for conditions requiring coverage under federal regulations).⁴³ Figure 2 shows a summary of state GLP-1 coverage status for obesity and recent actions as of February 2026,

including states with legislation currently in committee aiming to expand coverage of GLP-1s for obesity.

Figure 2: State Coverage of GLP-1s for Obesity, February 2026



Source: Kaiser Family Foundation, Legiscan

3.4 Private Payer Coverage Landscape

Private insurance plans may be fully-insured or self-insured. Fully-insured plans are regulated by the state; self-insured programs are employer-sponsored, with the employer assuming financial risk, exempting them from state regulations.⁴⁴ Regardless, both types of insurance agencies tend to reassess their program benefits when state policy changes. One private insurer noted in an interview that it is difficult to respond to policy changes when they occur during an insurance program year, as amending of contracts during the year is disruptive and difficult to do.⁴⁵

The private insurance industry is divided on how to address the coverage of GLP-1s in their policies. Due to the outsized financial impact GLP-1s pose to insurers (high costs and high utilization rates), GLP-1s are often subject to co-pays and utilization management controls.⁴⁶ Most insurers require prior authorization to ensure that Body Mass Index (BMI) criteria are met, and often require that other weight-loss options, like lifestyle changes, are attempted before they allow coverage of GLP-1s. Even when GLP-1s are prescribed, many insurers mandate that covered individuals enroll in lifestyle or diet support programs while taking GLP-1s.⁴⁷ However, many insurers also feature lower BMI thresholds than Medicaid does and a wider array of covered comorbidities, providing a greater opportunity for individuals to access GLP-1s through private plans if financially feasible.⁴⁸

4 METHODOLOGY

We used a mix of qualitative and quantitative research methods to complete a comprehensive analysis of GLP-1s and the financial and medical impact of SB455. First, we conduct an extensive literature review to acquire background information on GLP-1 effectiveness, risks, costs, and state and federal policies. Second, interviews with a number of experts and stakeholders provide insights into the sectors SB455 would affect. Finally, we develop a financial model to estimate the costs and benefits of covering GLP-1s in New Hampshire.

4.1 Literature Review

The literature review had three objectives:

- 1) Collect information on GLP-1s and their coverage
- 2) Identify state and federal policies that relate to GLP-1s
- 3) Identify the accessibility of GLP-1 medications within subgroups of the population

To first assess the background of GLP-1 agonists and their varying insurance coverage across states, we utilized databases including Google Scholar and JSTOR to find peer-reviewed journal articles and other reputable sources. After the background research was gathered, we collected information on GLP-1 coverage policy changes in other states, identifying key factors that went into legislative and financial decisions. We referenced a map on GLP-1 policies from the Kaiser Family Foundation and verified the results with an individual exploration of each states' coverage policies.⁴⁹ Finally, we examined current access to coverage for GLP-1s for weight loss and identified gaps in the insurance landscape where individuals struggled to receive coverage. Then, we analyzed these reported gaps in coverage through multiple lenses to identify what factors led to the non-coverage and potential strategies that could be utilized to improve equitable access.

4.2 Expert and Stakeholder Interviews

We conducted a total of six interviews with clinicians, policy experts, and insurance stakeholders, allowing us to provide the views of relevant stakeholders in three professional fields.

Clinicians: The interviews conducted with clinicians served the purpose of identifying the medicinal effects of GLP-1 agonists and the process through which such medications are prescribed, as well as recognizing common areas of concern regarding GLP-1s in the medical field.

Policy Experts: We interviewed policy experts regarding national trends in GLP-1 coverage changes, estimated impacts to Medicaid, and how the Most-Favored-Nation drug pricing policy may affect GLP-1 coverage once it goes into effect.

Insurance Stakeholders: Interviews with insurance stakeholders focused on gaining an understanding of firms' history of coverage for GLP-1s (for solely weight loss as well as with other

conditions) and how they believe the passage of SB455 would affect the insurance landscape in NH; some follow-up questions were asked related to their prior authorization for coverage procedure and their strategies for ensuring continuity of care among patients.

Once interviews concluded, each interviewer synthesized stakeholder perspectives. To create this analysis, we looked for topics and emerging themes raised by multiple stakeholders. We required a preponderance of evidence to solidify the various stakeholder's perspectives referenced later.

4.3 Financial Modeling

To understand the financial implications of SB455, we created a New Hampshire population-level GLP-1 financial model based on the Institute for Clinical and Economic Review's (ICER) evidence report "Semaglutide and Tirzepatide for Obesity: Effectiveness and Value"⁵⁰ and our analysis of New Hampshire data from the 2023 Behavioral Risk Factor Surveillance System (BRFSS).⁵¹ Our financial model maps ICER's clinical and economic information to the entire current New Hampshire adult population creating a long-term cost-benefit analysis of SB455 at the state-level.

Clinical and Economic Inputs

From ICER's model, we used intervention acquisition costs, total lifetime medical costs, total lifetime medical costs with productivity costs included, and quality-adjusted life years (QALYs) gained.⁵² Box 2 defines QALYs and describes their estimated monetary value. ICER also created a scenario which predicted financial costs if GLP-1s were priced at \$245 a month, following the new Most-Favored-Nation pricing model. We also replicate this scenario to analyze how this new policy could affect pricing for coverage of GLP-1s.

Box 2: Quality-adjusted life years (QALYs)

A QALY is a year of human life gained through improved health and it is adjusted downwards if diseases hinder one's daily activities. While it is challenging to connect a monetary value to health and quality of life, we use \$100,000 per QALY as a rough estimate as it is the most popular threshold for evaluating treatment cost-effectiveness in the medical community; the second most popular threshold is \$150,000 per QALY.⁵³ The \$100,000 per QALY threshold is a typical lower bound used by insurers and CMS.⁵⁴

Population Health Profile

We used the CDC's BRFSS, an annual nationwide survey on health risks and events, to construct a health profile for New Hampshire. We selected New Hampshire data from the 2023 BRFSS wave because it is the most recent wave with data on comorbid conditions such as hypertension and high cholesterol. The data contains 6,960 respondents, and we use the BRFSS weights to scale up the data to the actual population of the state to a weighted sample of 1,157,746, approximately equivalent to the size of the New Hampshire adult population. On average, each respondent in the survey represents 166 people in the real world. We use variables from BRFSS data, such as BMI and hypertension, to

determine the newly eligible population under SB455. Since Medicaid already covers GLP-1s for obesity-associated comorbidities, such as hypertension, the population with a comorbidity is excluded. We are unable to exclude individuals with sleep apnea as the data is not available in the BRFSS. After applying the eligibility criteria, our unweighted sample of individuals who would be eligible for coverage through SB455 contains 341 out of 6,960 respondents, translating to 118,737 of 1,157,746 weighted individuals.

Insurance Coverage Provider

Due to an increased number of Medicaid enrollees in 2023 from Covid-19-related stimulus funding, we determined that using the question asked in the BRFSS survey about the respondent's health insurance provider would introduce bias to the model's results.⁵⁵ As such, we decided to use income, demographic, and general coverage information to impute whether a respondent would have private or public insurance in 2026. First, we exclude respondents who do not have health insurance. Then, we use household size and income to determine whether households are eligible for Medicaid coverage. There were a few respondents who refused to answer about their income. To maintain the larger sample size and accuracy of the model's results, we utilized probit imputation with other demographic categories to estimate Medicaid eligibility, as it was determined to introduce less bias than other methods. For more information about imputation, please see our Online Appendix.⁵⁶

Medical Savings

In addition to its other reported benefits, the ICER report finds that injectable semaglutides and tirzepatides reduce the number of stroke and myocardial infarction (heart attack) events by 22 and 24 per 100 people, respectively. We include an estimated share of savings received by state and private payers as well as the federal government for each included patient that would be realized before they are 65 years old (at 65, savings would be received by Medicare). We use the BRFSS data of all individuals in New Hampshire to fit an exponential curve to the first occurrence of a stroke or heart attack and calculate the share of discounted risk occurring under 65 using integrals of the probability density function. More details can be found in our Online Appendix.⁵⁷

Other Assumptions and Inputs

- We exclude self-insured plans in our models of private payers, as they do not fall under the regulation of the New Hampshire state law.
- We assume that patients follow the United States national distribution of the two most popular GLP-1s for weight loss; 64 percent of patients choose tirzepatides and the remaining 36 percent opt for semaglutides.⁵⁸
- Since New Hampshire receives a 90 percent Federal Medical Assistance Percentage (FMAP) for Granite Advantage enrollees and a 50 percent FMAP for standard Medicaid, we calculated the average amount of FMAP using the share of enrollees on Granite Advantage versus standard Medicaid.
- Lastly, we assume that the population health profile of New Hampshire and proportion of individuals covered by Medicaid versus private insurance in the state stay the same.⁵⁹

5 RESULTS: HEALTH

Obesity is a serious issue in the United States that affects more than four in ten people. Despite its prevalence, this condition has been heavily stigmatized with blame frequently being attributed to the individual suffering from obesity due to their lifestyle choices. However, obesity is a disease that stems from dysregulation in the brain that leads individuals to crave an unhealthy amount of food.

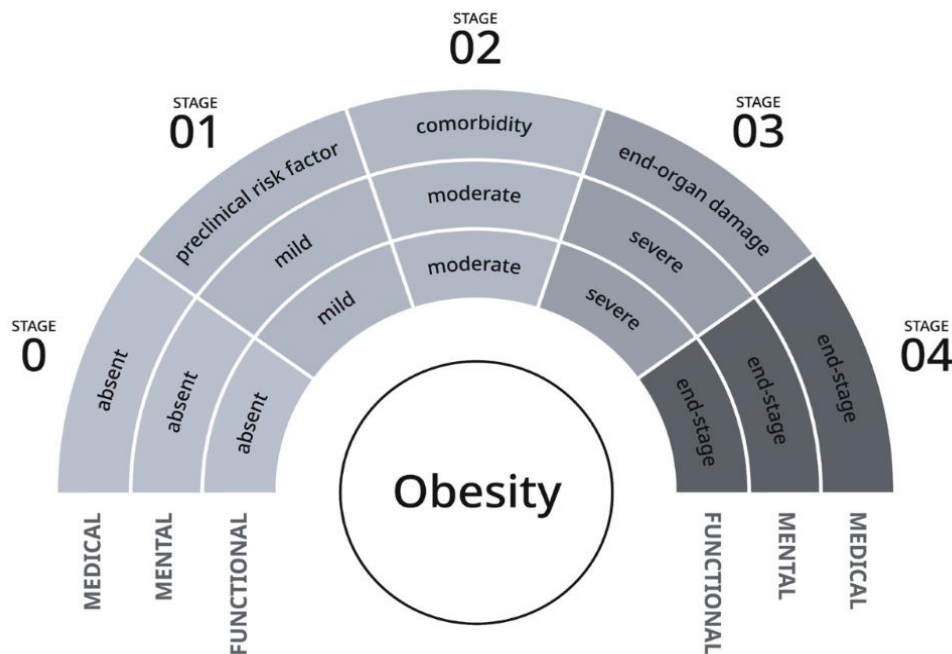
To fully understand how the passage of SB455 would impact the medical landscape and health of affected individuals, we conducted an extensive literature review and spoke with a number of medical professionals on the process of diagnosing obesity, prescribing GLP-1s, and the benefits of taking GLP-1s as compared to other treatments or lifestyle changes. We report these results in this section.

5.1 Obesity as a Disease

Obesity is a critical public health crisis in the United States given that it greatly increases risks for chronic diseases while imposing an economic burden of almost \$173 billion annually on the healthcare system.⁶⁰ In the United States, more than 40 percent⁶¹ of the population has obesity; for New Hampshire, that number is 31 percent.⁶² Despite this, weight loss experts claim that this chronic condition is misperceived by a large portion of people, as they attribute a person's obesity status to their particular lifestyle and behavioral choices, such as eating excessively and not engaging in exercise.⁶³ When humans eat, the body activates nutrient-stimulated hormones, which informs the brain how much fat or energy the body is storing. This level of fat is stored in the brain and defined as the defended fat mass set point.⁶⁴ However, when individuals have elevated defended fat mass set points (such as present in obese individuals), their body will fight to remain at these levels, causing many attempts at weight loss to be ineffective. In addition, when fat cells get full, fat can be stored in other places, such as the liver or kidney, which can cause complications like higher blood pressure, soft tissue changes, and osteoarthritis.

The diagnosis process for obesity is complex and relies on much more than an individual's BMI. Doctors use a system called the Edmonton Obesity Staging System (EOSS), seen in Figure 3, to delineate the stage of obesity based on the severity of the health complications and comorbidities in three categories: medicinal, mental, and functional.⁶⁵ Patients are intensely evaluated by doctors who conduct body composition analysis, which measures the percentage of body fat, bone, water, and muscle in the body, in addition to waist circumference. Patients also are asked to share their own past attempts at weight loss as well as personal and family health history, diet, and activity levels. Then, doctors assess the staging of the disease using the EOSS as patients can exhibit many variations of symptoms with the disease, such as lack of mobility, mood changes, and food noise (incessant and intrusive thoughts about food cravings).⁶⁶ The patient is also evaluated for potential mental health comorbidities with the disease, such as depression and anxiety. All of this is taken into consideration when diagnosing obesity and the subsequent identification of the stage of the disease, which ranges from stage 0 to stage 4.⁶⁷

Figure 3: The Edmonton Obesity Staging System (EOSS) Diagram



Source: Beyond the BMI: <https://link.springer.com/article/10.1007/s11695-023-06516-3>

5.2 The GLP-1 Prescription Process

In order to be prescribed a GLP-1 agonist for weight loss, the patient must first have a qualifying condition that makes them eligible for treatment, such as being diagnosed with obesity. Then, their doctor will talk them through the different treatment options such as:

- Solely lifestyle changes (eating healthier and lower quantities of food and consistently exercising), which can result in an average weight loss of 3-5 percent,⁶⁸
- Pharmacological oral drugs with an average of 5-8 percent weight loss,
- Surgical interventions such as bariatric surgery, which can have an effect of 20-30 percent of total body weight loss over time,⁶⁹ and
- GLP-1 medications resulting in an average weight loss of 15-20 percent of one's body weight.⁷⁰

While surgical interventions can result in more weight loss overall, patients tend to have a preference towards GLP-1s instead as they are less invasive. Additionally, surgical interventions have restrictions on who can apply for them, which generally include a set measure of BMI, typically at 40 or above.

The doctor then asks the patient their preference regarding treatment options and subsequently consults their individual insurance company to determine whether they will provide coverage for the treatment. Acquiring approval for insurance coverage is not always feasible, however, as few insurance companies are currently providing coverage for GLP-1s for strictly weight loss purposes.⁷¹

5.3 GLP-1 Usage

Individuals with obesity are subject to continuous persistent symptoms, such as constant cravings and food noise.⁷² These frequent symptoms are one of the first things that change when taking GLP-1s, in addition to appetite changes; patients can better follow their nutrition plans, prefer healthier foods, and feel better about their eating habits, all within the first 1 to 4 weeks of treatment. That is because the GLP-1s are working to fix the disease state: when an individual has obesity, their brain is dysregulated, causing them to crave unhealthy amounts of food. Taking GLP-1s fixes the signals in the brain, causing these symptoms to subside even before weight loss occurs (one to two months).

Glucagon-like peptide-1 is a naturally occurring hormone found primarily in the gastrointestinal tract that regulates a person's blood sugar by increasing insulin secretion, slowing down the emptying of the stomach, and signaling increased satiety (how full one feels after eating) to the brain. GLP-1 medications work to mimic this naturally occurring hormone and amplify this natural process.⁷³

Aside from its originally intended use of treating type-2 diabetes, clinical trials have also demonstrated 15 to 21 percent weight loss with GLP-1s, a reduction level comparable only with bariatric surgery outcomes.⁷⁴ In addition, GLP-1s have been associated with a 20 percent reduction in major cardiovascular events including stroke, heart attacks, and cardiovascular death, as well as a 69 percent reduction in progression from prediabetes to diabetes.⁷⁵

While GLP-1s are prescribed for weight loss reasons, their effects can sometimes have positive impacts that greatly surpass simple weight loss. When investigating personal testimonials, we found one case: Meredith was diagnosed with stage one ovarian cancer and had to undergo a hysterectomy and oophorectomy to mitigate the effects.⁷⁶ This caused her to enter menopause at age 31, and despite best efforts to control her weight, she gained 100 pounds almost instantly.⁷⁷ She considered bariatric surgery, but eventually worked with a physician to undergo the complicated process of getting prescribed GLP-1s for weight loss, which entailed participation in a six month program with nutrition and exercise classes prior to gaining access to the drug. Now, at age 51, she has been able to leave her incessant food noise behind and feels happier and healthier than she has in years. She even experienced unexpected health benefits from using GLP-1s, like relief from inflammation and better energy levels.⁷⁸

Little is currently known about the long-term side effects of GLP-1s. Gastrointestinal disorders were the most frequently reported adverse effects in clinical trials, with nausea and diarrhea being frequently experienced by more than one in ten individuals and other gastrointestinal symptoms, such as vomiting, constipation, abdominal pain, and dyspepsia, appearing in more than one in one hundred patients.⁷⁹ While uncommon, long-term usage of these medications has been linked with increased risk of gallbladder issues, pancreatitis, and acute kidney damage though it is not fully understood how these issues are caused by the GLP-1s.⁸⁰ GLP-1s also carry a boxed warning for the potential risk of thyroid C-cell tumors based on animal studies, but these risks haven't been observed in humans.⁸¹ Experts also find that medication adherence is critical for its effectiveness, and that discontinuation

can result in a rapid weight regain.⁸² This can be the most dramatic and frustrating side effect – discontinuation of use results in a rapid reversal of weight loss and can result in the resurgence of type-2 diabetes and obesity-related comorbidities. In order to prevent this, doctors will titrate patients off of GLP-1 medications rather than abruptly stopping, but when the treatment is ended because of a sudden lack of coverage, this is a frequent symptom.

5.4 Health Summary

GLP-1 medications work by mimicking the natural GLP-1 hormone found in humans that triggers insulin release from the pancreas, blocks glucagon secretion, slows stomach emptying, and increases satiety. While these drugs have been found to be very effective in reducing the patient’s body weight (up to 15-20 percent),⁸³ it can be a difficult process to get them prescribed and covered for solely weight loss, as they are typically prescribed for type-2 diabetes. First, the patient must be diagnosed with obesity, which takes into account many factors other than BMI, and then they must undergo any prerequisite treatments required before being given access to GLP-1s. When taking the drug, individuals receive relief from the symptoms caused by their obesity: food noise, inability to feel full, improvements in self-confidence. Currently, common side effects of taking GLP-1s include nausea, vomiting and diarrhea; longer term side-effects are less common, but may include hypoglycemia, pancreatitis, C-cell hyperplasia, and gastroparesis. However, one of the more common and discouraging side effects comes from discontinuation of the treatment; when individuals stop taking GLP-1s, they are highly likely to gain back the weight they lost, even while continuing healthy lifestyle changes.

6 RESULTS: FINANCES

In this section, we present the results of our New Hampshire population-level GLP-1 financial model based on the Institute for Clinical and Economic Review’s (ICER) evidence report “Semaglutide and Tirzepatide for Obesity: Effectiveness and Value” and our analysis of New Hampshire data from the 2023 Behavioral Risk Factor Surveillance System (BRFSS). Our financial model maps ICER’s clinical and economic information to the entire New Hampshire adult population creating a long-term cost-benefit analysis of SB455 at the state-level. The model is based on SB455’s coverage criteria and our understanding of New Hampshire’s Medicaid program and private insurance market. We produced estimates for Medicaid as it is regulated by SB455. Using the same criteria from SB455, we also produce estimates for private payers as a supplement even though private plans are not included in the current bill. We use the assumptions outlined in section 4.3, many of which are critical to the final result. If any assumptions are inaccurate, the results can be revised.

We present three projections:

- 1) Medicaid Baseline Scenario
- 2) Medicaid Most-Favored-Nation Scenario
- 3) Private Payers

The Medicaid Baseline Scenario is our projection for Medicaid which assumes an annual prescription cost of \$6,829 for semaglutide and \$7,973 for tirzepatide injections, based on current estimated net costs.⁸⁴ The model shows the impact of adding coverage for individuals with a BMI of 30 or greater and not currently covered due to having a comorbid condition, such as diabetes or hypertension. The Medicaid Most-Favored-Nation Scenario deviates from the baseline only in prescription cost showing the scenario where Medicaid receives the federal government's announced \$245 per month access to GLP-1s, equivalent to \$2,940 annually. Our final projection is for private payers, using the same assumptions as the first Medicaid Baseline Scenario. A complete discussion of all assumptions is available in section 4.3 and the Online Appendix.⁸⁵

The results produced by the model are the total costs and benefits for the current health profile of New Hampshire **over the next 25 years**. All numbers are reported as a **present value** where future years are **discounted by 3 percent per year**.

6.1 Medicaid Baseline Scenario

Under SB455's coverage criteria of adding coverage for individuals with a BMI of 30 or more and not currently with a comorbid condition, we estimate 19,300 people will become eligible for Medicaid coverage of a GLP-1 treatment in New Hampshire. Our clinical and economic inputs are sourced from ICER's report on the long-term cost-effectiveness of GLP-1s.⁸⁶ Their report estimates that the additional present value cost of a lifetime of GLP-1 treatment for their average patient will be \$123,193 for semaglutide and \$149,457 for tirzepatide injections. They also estimate that each patient would gain \$45,912 (semaglutide) to \$60,611 (tirzepatide) in lifetime medical cost savings from non-intervention for other medical events and \$14,586 (semaglutide) to \$19,053 (tirzepatide) in productivity gains. Since the ICER model assumes lifetime use of GLP-1s, we also use this assumption, even though physicians may recommend phasing out of GLP-1 treatment.⁸⁷ Finally, each patient is expected to gain 1.16 (semaglutide) to 1.52 (tirzepatide) quality-adjusted life years (QALYs). A QALY is one year of additional lifespan adjusted downwards if the person has conditions that lower the quality of life during the year.

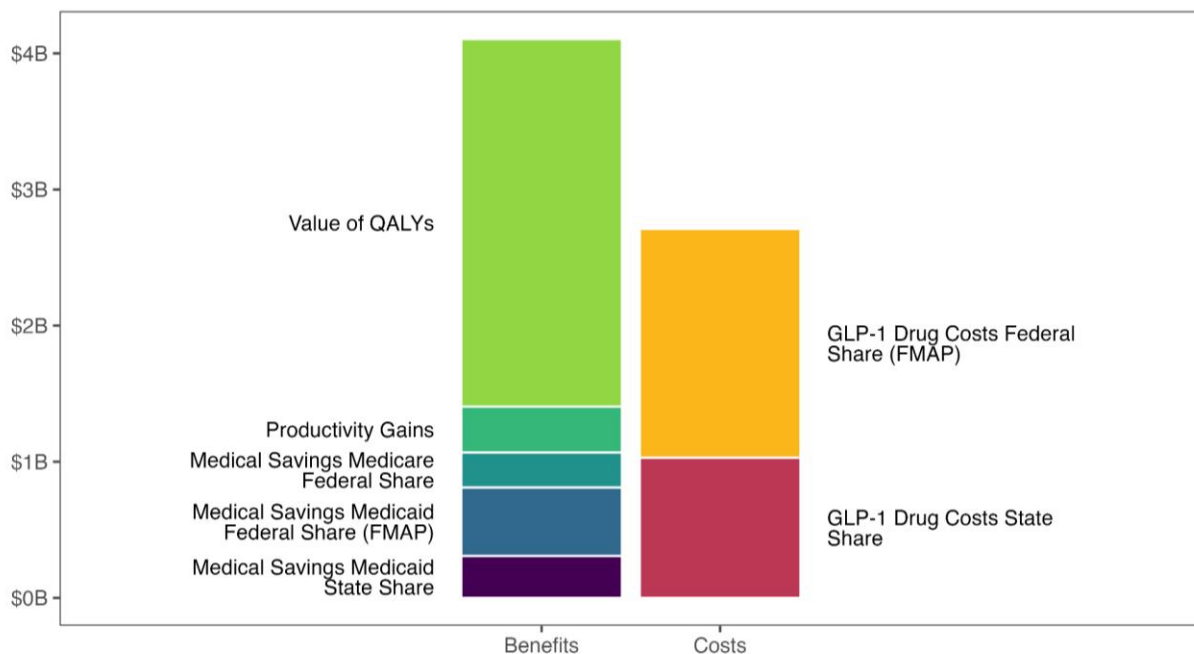
As shown by Figure 4, the coverage would create a total benefit of \$4.1 billion and cost a total of \$2.7 billion—at present value over 25 years. Total benefits are \$1.4 billion higher than total costs. Of the benefits, the majority is an increase of 27,000 QALYs, which is a \$2.7 billion benefit at \$100,000 per QALY. There are also \$337 million of productivity gains from improved employee attendance and decreased fatigue⁸⁸ and \$1.07 billion in non-GLP-1 medical savings, due to decreased incidence of severe cardiovascular diseases and other high-cost medical events. Medical savings are split into three parts:

- 1) The state share (\$308 million): the savings received by New Hampshire as costs decrease while patients are covered by Medicaid.

- 2) The federal share through FMAP (\$503 million): the federal government also receives a portion of cost savings while patients are on Medicaid as the federal government pays a portion of Medicaid via the Federal Medical Assistance Percentage (FMAP).
- 3) The federal share through Medicare (\$257 million): savings realized after individuals turn 65 and become eligible for Medicare coverage.

Out of the total costs, the state would be responsible for an estimated \$1 billion and the remaining \$1.7 billion would be paid by the federal government through the federal portion of Medicaid, commonly referred to as FMAP.

*Figure 4: Benefits and Costs of Medicaid GLP-1 Coverage
Baseline scenario for 25 years at present value*

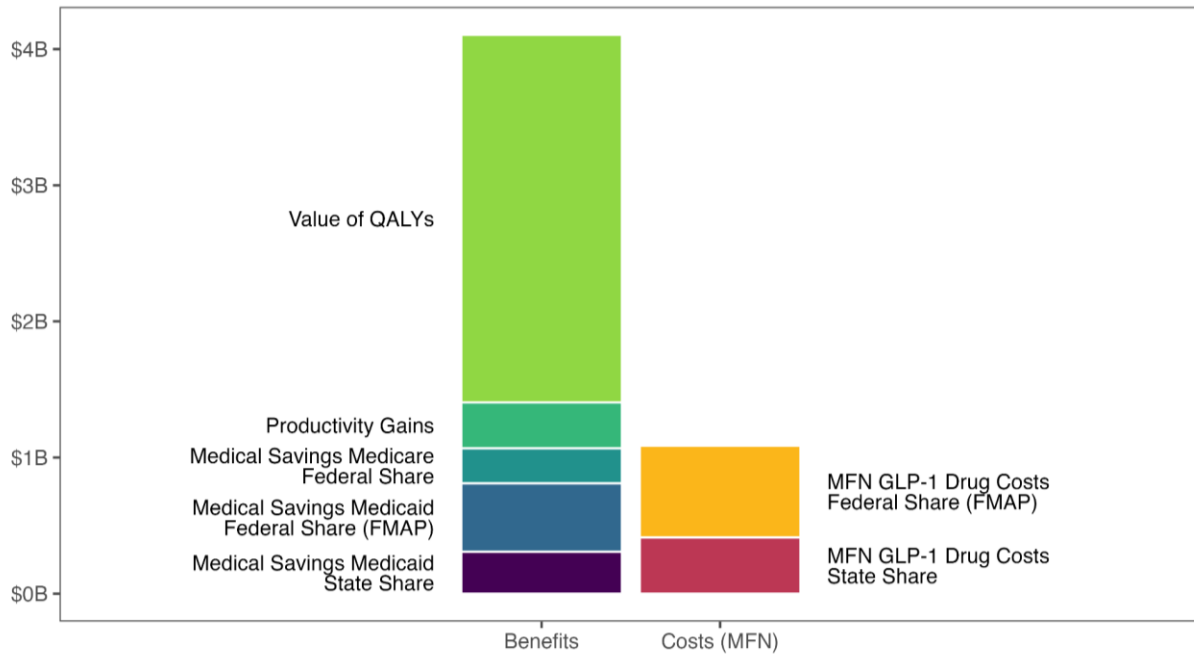


Source: Authors' calculations using ICER and BRFSS

6.2 Medicaid Most-Favored-Nation Scenario

Our second projection uses the announced prices of \$245 per month under the federal government's Most-Favored-Nation model. We estimate a large reduction in the cost of GLP-1 coverage, leading to increased cost-effectiveness of \$B455.⁸⁹ The cost would decrease from \$2.7 billion to \$1.09 billion in total, as shown by Figure 5, while the benefits remain the same at \$4.1 billion. The state would pay \$413 million while the federal government would pay \$673 million. The total cost of \$1.09 billion is near the estimated \$1.07 billion in total medical savings expected to be gained. In addition to the medical cost savings, there remains the \$2.7 billion QALY benefit and \$337 million productivity benefit. The total benefit is \$3 billion greater than the total costs.

Figure 5: Benefits and Costs of Medicaid GLP-1 Coverage
Most-Favored-Nation scenario for 25 years at present value



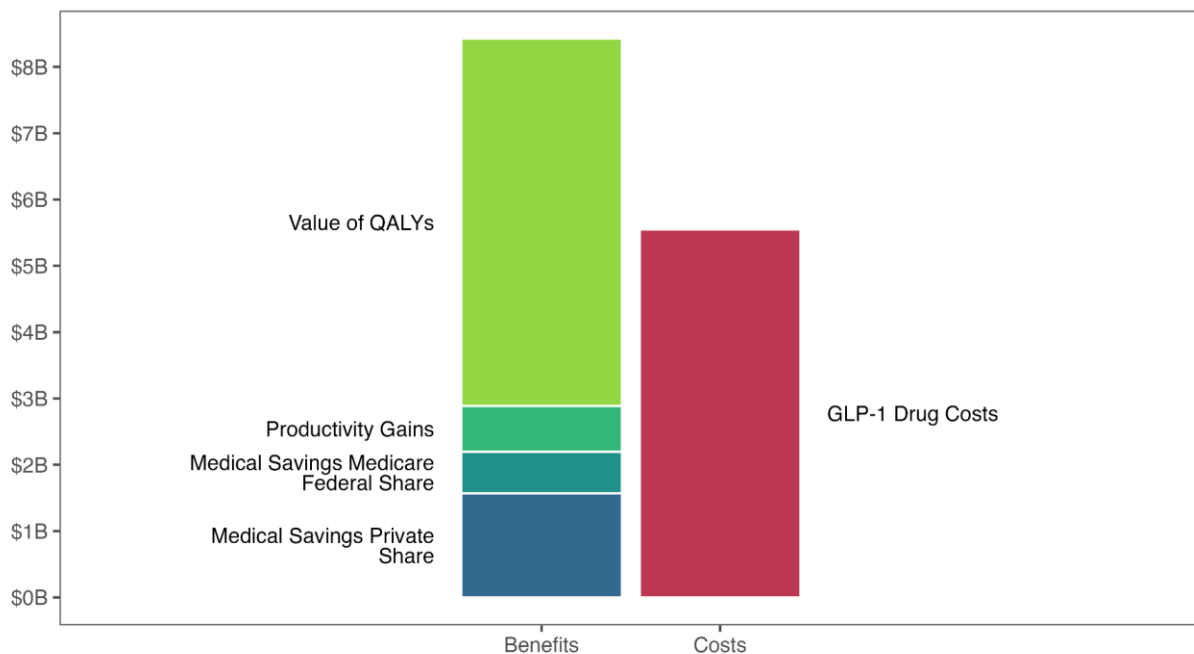
Source: Authors' calculations using ICER and BRFSS

Note: MFN is Most-Favored-Nation

6.3 Private Payers

We estimate 39,700 more people will be eligible for coverage of a GLP-1 from fully-insured private plans in New Hampshire if the plans were mandated to cover individuals with a BMI of 30 or more, assuming they already cover individuals with an associated comorbidity. As shown by Figure 6, the coverage would create a total benefit of \$8.4 billion and cost a total of \$5.6 billion, at present value over 25 years. Total benefits are \$2.8 billion higher than total costs. Similarly to Medicaid, the majority of benefits are to health with 55,400 QALYs gained, or \$5.54 billion. There are also medical cost savings received by both private payers (\$1.6 billion) and to the federal government through Medicare (\$625 million). The private share of medical cost savings are all the savings from avoided medical events occurring below the age of 65 and Medicare savings above age 65. Finally, there are productivity gains of \$692 million.

Figure 6: Benefits and Costs of Private GLP-1 Coverage
Baseline scenario for 25 years at present value



Source: Authors' calculations using ICER and BRFSS

6.4 Who benefits from savings and productivity?

A key issue with GLP-1 coverage, and indeed the coverage of any preventive healthcare, is a mismatch between the recipients of the benefits and the payers of the costs, often referred to as externalities. The common problem with externalities in preventive healthcare is payers will not receive many of the benefits from providing a treatment, and so they are less willing to provide the treatment even though there would be benefits to patients, employers, or the government.⁹⁰ Coverage of GLP-1s is no different. This section will describe the various externalities identified by the financial model and the recommendations section will discuss a potential way to correct one of these externalities.

1) Costs paid by Medicaid or private payers. Benefits received by Medicare.

Medicaid and private insurance plans pay for GLP-1s before age 65, but medical events—such as strokes or heart attacks—are averted after age 65 so Medicare receives the benefit of reduced spending on healthcare.

Under the Medicaid baseline scenario:

- 24 percent of medical cost savings goes to Medicare
- The state receives \$30,000 in savings for every \$100,000 spent by the state on GLP-1s
- The federal government receives \$45,000 for every \$100,000 spent by the federal government on GLP-1s

The Medicare share of savings is not negligible even though all figures are discounted at 3 percent per year since the risk of severe cardiovascular diseases and other high-cost serious illnesses grow exponentially with age. When these high-cost old-age diseases (strokes, heart attacks, end stage kidney disease) are averted by taking a GLP-1 earlier in life, savings are gained by Medicare even though Medicaid paid for the GLP-1.

For private payers:

- 29 percent of savings go to the federal government
- Private payers save \$28,000 per \$100,000 spent on GLP-1s
- The federal government saves \$11,000 per \$100,000 dollars spent by private payers on GLP-1s at no cost incurred by the federal government

In both cases, the state and private payers receive fewer savings per dollar spent than the federal government. In the private case, the federal government receives savings at no cost to the federal government. This may discourage the state and private payers from covering GLP-1s because they do not receive all the benefits of providing the coverage.

2) Costs paid by Medicaid. Benefits received by employers.

Medicaid pays for GLP-1s improving patient productivity leading to employers receiving the benefit from their employees.

When Medicaid covers GLP-1s, the improved health not only improves the quality of life of treated patients, but also their productivity. Employers gain \$33,000 in increased employee productivity per \$100,000 spent by the state on GLP-1s. The gains from productivity will typically be absorbed by employers, or sometimes employees, and reflected by slight improvements in economic growth.⁹¹ While growth does increase state tax revenues, the state would be receiving cents on the dollar at best.

3) Costs paid by private payer. Benefits received by different private payer.

Insurance Company A pays for GLP-1s but the patient switches to Insurance Company B, leading to long-term medical savings for Company B partially paid for by Company A.

While Company B may continue to pay for GLP-1s, researchers have identified beneficiaries switching insurance companies (turnover) as a reason private payers may be hesitant to cover GLP-1s.⁹² Beneficiary turnover is rather high:

- At a national level, “Estimates show that between 10 to 25 percent of enrollees switch insurers every year”⁹³
- “In a 12-year study of a major health insurer, about 80 percent of beneficiaries left the insurer at least once”⁹⁴
- “Average enrollment duration of 48 months”⁹⁵

This is mainly a problem when individuals move between fully-insured plans (regulated by state law) and self-insured plans, which we assume would not be subject to any state GLP-1 coverage mandate

as they are only regulated by federal law.⁹⁶ When all fully-insured plans have mandated coverage, the savings may be lost when a beneficiary leaves, but gained when a new beneficiary joins.

Overall, GLP-1 coverage faces the same hurdle of externalities as many other preventive treatments. Our model identified three key externalities where savings or benefits are not reaped by the payer, whether it is Medicaid or private payers. Incentivizing and encouraging GLP-1 coverage may be most effective through correcting these externalities. Our recommendations include a way to correct the first externality where costs are paid by the state's Medicaid budget and savings reaped by the federal government through Medicare.

6.5 Who is receiving coverage for GLP-1s?

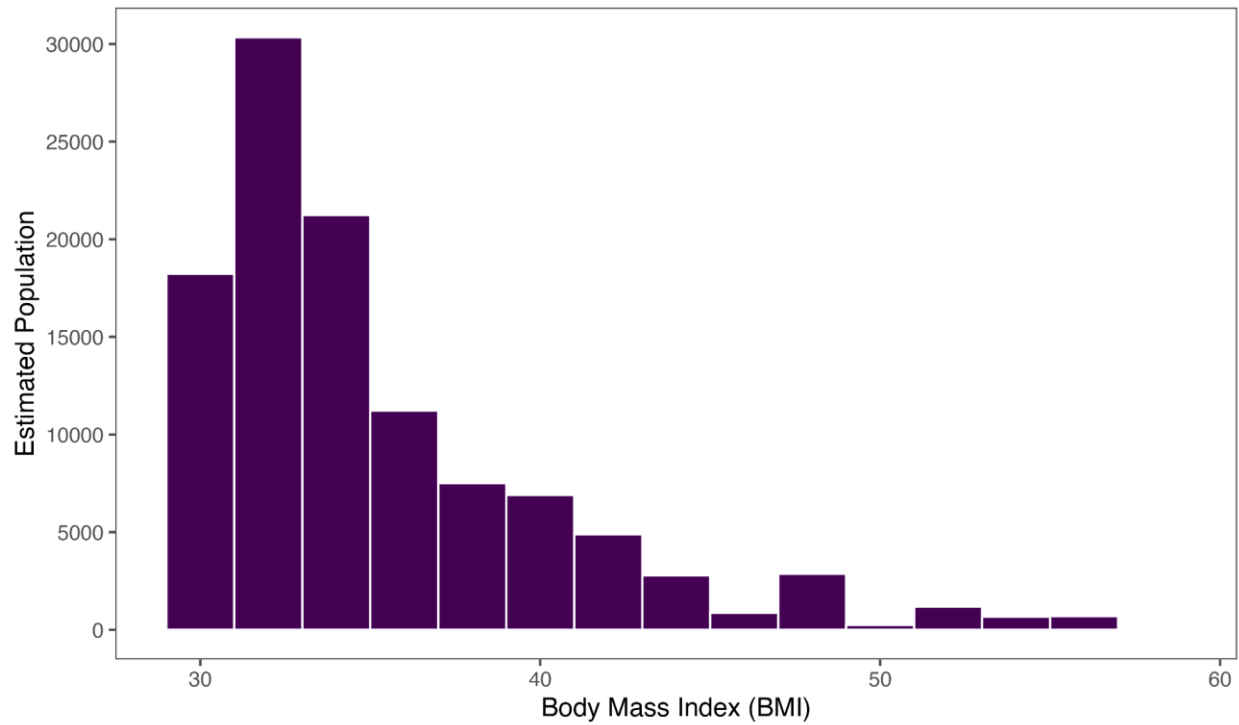
So far, the financial model has used a count of the newly eligible population under SB455's coverage criteria, but who are the people in New Hampshire who would become eligible? Figures 7 and 8 show the estimated BMI and age distributions of the New Hampshire population on both Medicaid and all private plans (fully-insured and self-insured) that would be eligible for coverage if the BMI threshold was lowered to 30. We show the Medicaid and private beneficiary distributions together since the combined data points provide better detail and we tested that the distributions are not different by a statistically significant amount.⁹⁷ The figures exclude people who already have coverage from an associated comorbidity.

The figures reveal that most individuals who would begin having coverage of GLP-1s:

- 1) Have BMIs clustered in the 30s
- 2) Are 25 to 45 years old

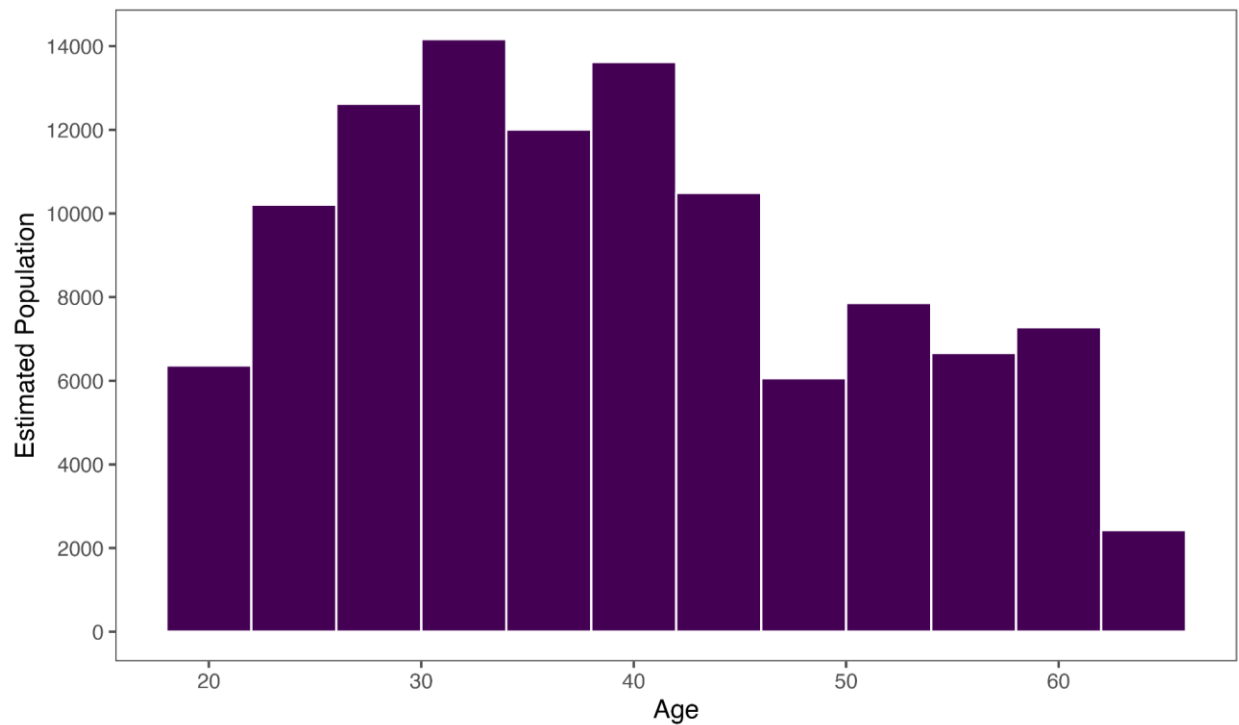
There are fewer people with a BMI over 40 who would receive coverage, as BMI follows a bell curve and the area above 40 is the tail of the bell curve. Most individuals receiving coverage would not have severe obesity. Most individuals would also be younger. Both of these trends align with health patterns since older and more obese individuals are more likely to have a comorbid condition (diabetes, hypertension, etc.) and would already be covered by Medicaid or most private insurers.

Figure 7: Estimated BMI Distribution of Newly Eligible Population



Source: Authors' calculations using BRFSS

Figure 8: Estimated Age Distribution of Newly Eligible Population



Source: Authors' calculations using BRFSS

6.6 Finances Summary

The majority of benefits derived from covering GLP-1s are improvements in health, longer lifespans, and better quality of life. **In all scenarios, total benefits, including health and monetary benefits, are valued higher than costs. Only in the Most-Favored-Nation scenario do monetary benefits alone outweigh the costs.**

Medicaid and private payers would receive a portion of their drug costs back in the form of medical savings from averting obesity-related cardiovascular diseases and other ailments, though more medical savings are accrued by the federal government as they cover patients over 65 with Medicare. Coverage of GLP-1s would also result in notable productivity gains for employers. GLP-1 coverage suffers from the same externality problem as other preventive treatments, where the payers do not receive all the benefits and savings. Most new beneficiaries of GLP-1 treatment would have lower stages of obesity and be 25-45 years old.

7 RECOMMENDATIONS

Following our findings on GLP-1 coverage health and financial impacts, Table 2 summarizes solutions New Hampshire could implement to address GLP-1 coverage-related challenges. This includes solutions that address the beneficiary experience provided through Medicaid by SB455 and potential improvements to the implementation of SB455. These solutions are categorized in two ways: quality of care recommendations and cost control recommendations.

Table 2: Implementation Strategy Recommendations

Category	Recommendation
Quality of Care	1. Specify continuity of care policy
	2. Communicate GLP-1 coverage to patients
Cost Control	3. Join CMS BALANCE
	4. Explore Section 1115 Medicaid waiver
	5. Wholesale drug importation

7.1 Quality of Care Recommendations

1. **Specify continuity of care policy** → Sudden discontinuation of GLP-1 usage causes the most dramatic side effects and a reversal of weight-loss and comorbidity regression. Providing for continuity of care through Medicaid when BMI drops below a certain threshold would ensure the benefits of Medicaid coverage are ultimately realized and ensure equitable usage. The statutory language could be slightly altered to reflect this policy.
2. **Improve communication to patients about their coverage** → Oftentimes individuals are not exposed to or struggle to find accurate information about their Medicaid coverage, making it difficult for them to know where to begin when they are seeking new treatments. Ensuring there are multiple ways that individuals are being informed of their coverage will ensure streamlined utilization.

7.2 Cost Control Recommendations

3. **Join CMS BALANCE** → Joining the federal program designed to lower Medicaid and Medicare prescription costs is an actionable step to reduce costs to the state while continuing to offer coverage to at-risk individuals. Though the program is in its infancy, this will offer substantial budgetary relief as GLP-1s continue to enjoy widespread popularity. The initial enrollment period for CMS BALANCE has ended as of January 2026, but there may be future opportunities to enroll.
4. **Explore the usage of a Section 1115 Medicaid waiver** → The federal government has a vested interest in improving the quality of health for individuals likely to be on Medicare, a significant population of which are currently on Medicaid. By investing in obesity treatment, the federal government will ensure future Medicare savings on type-2 diabetes, heart disease, liver disease, high blood pressure and hypertension, and other averted high-cost events, such as strokes and heart attacks. Exploring a federal waiver to expand GLP-1 coverage to include individuals with obesity could remain budget-neutral for the federal government, as required by federal stipulations for Medicaid waivers, and benefit both New Hampshire and federal programs.⁹⁸
5. **Explore state importation scheme** → The FDA can provide the opportunity for states to receive federal waivers for the wholesale importation of low-cost prescription drugs. Following the model approved in the state of Florida, New Hampshire could establish a Section 804 implementation program (SIP) for the importation of certain prescription drugs from Canada.⁹⁹ Canada is expected to see regulatory approval of generic forms of semaglutide (e.g. Ozempic and Wegovy) in the next year and will likely drive costs down in the Canadian pharmaceutical market.¹⁰⁰ The potential use of an SIP may serve as a creative solution to the higher prices in the US market today.

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- Dr. Benjamin Carter, University of Alabama
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⁵⁵ Medicaid enrollment was unwound in the middle of the year in New Hampshire. The BRFSS collects data year round. See, “Medicaid Enrollment and Unwinding Tracker,” *KFF*, January 29, 2026, <https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker/>; and, “BRFSS Frequently Asked Questions (FAQs),” CDC BRFSS, October 27, 2022, https://www.cdc.gov/brfss/about/brfss_faq.htm.

⁵⁶ The Online Appendix is available here: <https://rockefeller.dartmouth.edu/public-policy/policy-research-shop/prs-briefs?combine=GLP>

⁵⁷ The Online Appendix is available here: <https://rockefeller.dartmouth.edu/public-policy/policy-research-shop/prs-briefs?combine=GLP>

⁵⁸ Since New Hampshire state-level data for tirzepatide-semaglutide prescription ratios were unavailable, we use results from the national level in our state-level analysis.

⁵⁹ Due to the random and anonymous nature of the BRFSS, the data constraints prevent analysis of dynamics of individuals switching between insurance plans. The economic and clinical inputs from the ICER report also fit a static analysis better than an analysis with a dynamic population. Making this assumption is an abstraction that reduces the complexity of the model without compromising our key cost-benefit ratios.

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⁶¹ Samuel D. Emmerich et al., *Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023* (CDC, 2024), <https://doi.org/10.15620/cdc/159281>.

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⁶³ Interview with clinician.

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- ⁶⁸ Interview with clinician.
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- ⁷⁰ Interview with clinician.
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- ⁷⁹ Theodosios D. Filippatos et al., “Adverse Effects of GLP-1 Receptor Agonists,” *The Review of Diabetic Studies: RDS* 11, nos. 3–4 (2014): 202–30, <https://doi.org/10.1900/RDS.2014.11.202>.
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- ⁸⁹ The White House, “Fact Sheet.”
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⁹³ Crawford et al., *GLP-1s for Weight Management Costs and Coverage Considerations*.

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⁹⁶ In addition, the externality applies when people move from New Hampshire to other states.

⁹⁷ The test conducted was a chi-squared test for independence with bins of age and BMI. The p-values resulting from the test were 0.07 for age and 0.19 for BMI, both not smaller than the significant level of 0.05, so we conclude that the distributions are not meaningfully different between the two groups.

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