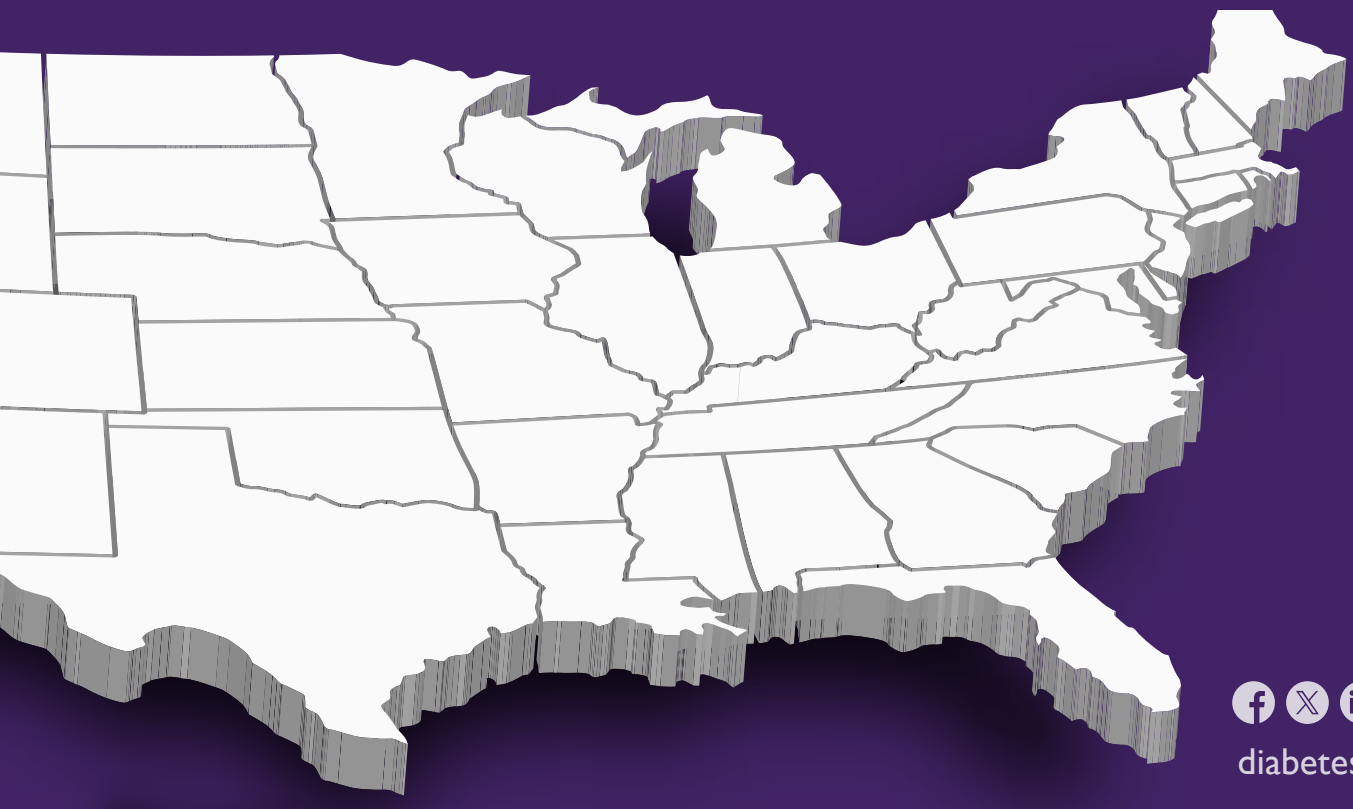
DIABETES PATIENT ADVOCACY COALITION

State Legislative Diabetes & Obesity Handbook

2026 EDITION



diabetespac.org/

DPAC State Legislative Handbook

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Introduction

Created by the Diabetes Patient Advocacy Coalition (DPAC), a 501(c)(4) organization,

this handbook amplifies the voices of patients to shape state and federal policies aimed at enhancing the lives of those affected by diabetes and obesity.

The State Legislative Diabetes & Obesity Handbook exists to provide innovative policies for state legislators and policymakers, highlighting challenges patients face and state-level legislative solutions, along with case studies ("models") showcasing successful implementation in other states. Adoption of these models would markedly improve patients' access and affordability, solutions which deliver economic benefits like lower costs and a healthier, more productive workforce.

Diabetes directly affects 40.1 million Americans—of those, one in five are undiagnosed, meaning they don't know they have it.

Obesity affects 41.9% of U.S. adults and is inextricably linked to diabetes—a significant risk factor for type 2 and more than 200 other serious and costly health conditions and complications.

Regardless of diagnosis (see *Exhibit A*), the diseases demand urgent, effective solutions from policymakers at all levels of government and power in America. The cost of inaction grows every day and ignoring the problem risks quality of life and paves the way for even more tragic outcomes. We can and must do better to provide citizens access to the care they require.



Exhibit A: Diabetes by Type

Type 1	Type 1 diabetes is an autoimmune disease that stops the body from producing insulin. Approximately 5-10% of the people who have diabetes have type 1.
Type 2	With type 2 diabetes, the body doesn't use insulin well and can't keep blood sugar at normal levels. About 90-95% of people with diabetes have type 2.
Gestational Diabetes	Gestational diabetes develops during pregnancy in women, affecting blood sugar levels which impact infant and maternal health outcomes. 2% to 10% of pregnancies in the United States are affected by gestational diabetes.
Pre-diabetes	A pre-diabetes diagnosis suggests blood sugar levels are higher than normal, but not high enough for a type 2 diabetes diagnosis. More than 1 in 3 Americans have pre-diabetes.

By the Numbers

11%

of Americans are diagnosed with either type 1 or type 2 diabetes, and another 40% live with pre-diabetes or are undiagnosed.[3]

41.9%

of U.S. adults are diagnosed with obesity as well as 19.7% of children and adolescents.[4]

Up to 10%

of pregnancies in the U.S. are affected by gestational diabetes, with 50% of those women going on to develop type 2 diabetes.[5]

DPAC will update this guide periodically as new policy solutions emerge to encourage policymakers to take action.

THE NEED FOR NOVEL APPROACHES FOR POLICYMAKERS

Diabetes and obesity present macro health system and government budget challenges but also family financial challenges when it comes to managing and preventing the disease.

- Medical expenses for people with diabetes are approximately 2.3 times higher than average.
- The financial impact of diabetes equals $1 out of every $4 in U.S. healthcare costs[1]—with billions spent by state and federal entities.
- Medical costs associated with obesity and its complications increase the economic burden on healthcare systems by 50%.[2]

Patients continue to encounter barriers to care—be it too few providers in their community, lack of comprehensive health coverage, exposure to high prescription drug costs, utilization management tactics, or predatory copay accumulator programs.

When considered alongside potential comorbidities like obesity, heart disease, or nerve damage—the fiscal strain, health resources used, and lost productivity cannot be overstated.

Amid longstanding commitments to public health departments and legislative advancements such as copayment limitations, increased price transparency and coverage mandates, the question we are most often asked by key leaders:

What else can we do?



State vs. Federal Legislative Impact

Congressional and state jurisdictions vary, meaning legislation at both levels impacts different populations of people. What's the difference?

FEDERAL IMPACT

Federal jurisdiction includes Medicare, portions of Medicaid, Tricare for military personnel, and ERISA-covered retirement and health plans. It affects around 85% of Americans. Only Congress can enact changes at this level.

STATE IMPACT

State jurisdiction covers individual exchanges, small-group markets, state employee plans, and parts of Medicaid—impacting about 10-15% of Americans. State legislatures can only act on state-regulated health plans.



Part One

Cost-Effective Prescription Assistance

Chronic disease management is unaffordable without comprehensive health coverage. Better access is in the best interest of lawmakers and patients alike as high costs decrease medication adherence and increase hospitalizations and other costly and life-threatening complications.[6]

Many states have taken measures to reduce the barriers to prescription drug access through legislation including copay caps, copay accumulator bans, emergency access laws, and more *(See Appendix).* Additionally, low-cost options are becoming available through new biosimilars and generics. Still, patients find themselves paying inflated costs at the pharmacy counter. Examples below feature a novel prescription affordability program in Kentucky, plus an approach to Pharmacy Benefit Manager (PBM) rebate reform started in West Virginia, now passed in several states with many more considering action.

THE PRESCRIPTION ASSISTANCE MODEL

The American Diabetes Association finds people with diabetes have healthcare costs that average $16,750 annually.[7] Given that millions of people with or at risk for the disease do not have sufficient health coverage for life sustaining care, such high costs hinder the ability to confront the diabetes epidemic.

Reduced cost prescription programs, offered by manufacturers, retailers, and other sponsors are often available for high-cost brand name and specialty medications and are used by people with diabetes and other chronic conditions. These programs can serve as a lifeline to the uninsured and underinsured who may otherwise be unable to afford their prescriptions and risk complications from non-adherence.

With the intent to make essential medicines like insulin more affordable, Kentucky has established an innovative program, the Kentucky Prescription Assistance Program (KPAP), that enables and expands community-based efforts to enroll eligible individuals in these prescription assistance programs. And that's not all—the program connects people with services and aid available from other organizations.

The Cost of Diabetes

The American Diabetes Association finds people with diabetes have healthcare costs that average $16,750 annually.

A small budget with an outsized impact for patients, KPAP is a model for the nation.



How It Works

Kentuckians needing help with prescription costs can call a statewide toll-free hotline and be linked with a local KPAP-trained advocate who will meet in-person or virtually with the caller to understand their assistance needs and enter details into Drug Assistant software licensed to KPAP. Through the software, navigators may simultaneously:

- Explore enrollment in multiple assistance programs,
- Identify copay cards and other resources to reduce prescription costs, and
- Connect with the state's health coverage system for individuals who are eligible but not yet enrolled in other state assistance programs like Medicaid or CHIP.

Navigators are also available to help patients requiring assistance with appeals and other wraparound services like notifying when a refill is needed. The process reduces the burden of locating free or reduced-cost prescriptions for patients, minimizing paperwork and offering more direct access to the treatment they need to live.

In 2009, KPAP was established through the legislature's appropriation bill with $400k in funding. It was modeled after an existing volunteer-run program assisting local residents in accessing free and reduced cost medicines provided by manufacturers, retailers, foundations, non-profits and other benefactors, which the lawmaker expanded to work statewide in collaboration with the Kentucky Cabinet for Health and Family Services (CHFS).

The program, now fully operating out of CHFS, is funded by a $600,000 annual line-item appropriation, and staffed by two full-time employees and one contractor. Rather than overburden other professions such as pharmacists or nurses, or create new programs that rely on existing professionals, KPAP partners with individuals and organizations already active in underserved communities. By working with entities including county health departments, hospitals, food pantries and faith-based organizations — KPAP expands their capacity to all 120 counties through partnerships, without duplicating efforts.

Through KPAP partners, three community consultants are contracted to serve as program liaisons and train the community-based volunteer advocates who operate as prescription assistance program navigators. KPAP provides ongoing support for their partner organizations through weekly virtual office hours, monthly software training, and individual training and troubleshooting, as needed.

Eligibility for the program is based on income guidelines set by participating entities. While incomes 200 to 400 percent of the federal poverty level often qualify, interested participants with higher incomes or who have insurance may be eligible if their medications are not covered by their benefits. Those ineligible may still reach out to a KPAP navigator to receive consultation about other potential sources of low-cost prescriptions.

To date, KPAP has helped more than 4,800 Kentuckians access $47 million in free and reduced cost medications in a single year.

KPAP's efficient deployment of its annual $600K appropriation may make it the only state program across the nation to deliver a 78-times return on investment.

Kentucky is prudently stewarding its fiscal resources while helping uninsured and underinsured residents afford prescriptions to manage their chronic conditions.



Other states can use Kentucky as a model to help improve access and affordability to medications for people with diabetes.



Expanding Access, Lowering Costs: The Biosimilar Opportunity

State health plan decision-makers and state lawmakers face escalating fiscal pressures driven by specialty prescription drugs, with complex biologic therapies representing one of the fastest-growing cost centers in public healthcare budgets. In 2024 alone, state employee health benefit programs spent an estimated $20 billion on biologics to treat diabetes among myriad other chronic, severe conditions.[8]

Biologics are complex medicines made from living organisms to treat chronic conditions like diabetes, cancer, and arthritis.
Biosimilars act as their generic equivalents, delivering identical safety, purity, and effectiveness.

From a policy perspective, biosimilars offer an ideal balance of clinical equivalence and fiscal sustainability. Although biosimilars are complex biological products rather than simple chemical generics, FDA approval guarantees that they share the exact same clinical safety, efficacy, and purity profiles as their brand-name originator or "reference brand." With savings of up to 90% compared to originator biologics, biosimilars drive market competition that lowers overall drug spending and expands patient access to care. Economic modelling suggests their expanded use in state employee health plans could save taxpayers $871 million to $1.8 billion annually.[9] With 118 biologics worth $234 billion losing patent protection over the next decade[10], updating state policies now will secure long-term savings.

To achieve savings without limiting essential care or undermining treatment stability, state leaders should adopt a "Biosimilars First" framework focused on new treatment starts in state employee health plans. Under this approach, health plans would prioritize lower-net-cost biosimilars for patients initiating biologic therapy, while preserving prescriber discretion to select a reference biologic when clinically appropriate. Importantly, patients who are stable on an existing biologic therapy would not be required to switch medications solely for nonmedical reasons, including formulary changes or cost considerations. This approach promotes biosimilar competition and long-term savings while protecting continuity of care, clinical decision-making, and the patient-provider relationship.

Real-world policy adoption confirms the immediate financial return of biosimilar prioritization. California's CalPERS program – the nation's largest public employee benefits system – generated $3 million in single-year savings by deploying a Biosimilars First initiative in just one health plan[11], while Colorado Medicaid projected $12 million in savings from prioritizing a single biosimilar product.[12]

Crucially, state leadership can execute this policy through multiple administrative and legislative avenues depending on existing statutory authority.

Lawmakers can embed Biosimilars First directives into annual state budget language or general health benefit statutes. Alternatively, state employee health plan boards can immediately leverage administrative authority by incorporating biosimilar preferences into request-for-proposal (RFP) specifications, mandating preferred formulary tiering and copayment reductions in Pharmacy Benefit Manager (PBM) contracts, and initiating provider educational campaigns.

Further, a Biosimilars First statutory or contractual mandate dismantles commercial "rebate walls" – a market practice where PBMs and insurers favor high-list-price brand drugs to retain lucrative volume-based manufacturer rebates. By contractually obligating state employee plans to prioritize lower-net-cost biosimilars, policymakers eliminate middleman distortions, lower out-of-pocket costs for public workers, and align public purchasing power with fiscal transparency.

Implementing Biosimilars First policy provides state leaders with a proven, highly adaptable solution that delivers substantial budget relief while maintaining high-quality healthcare for state employees.





Part Two

Pharmacy Benefit Manager (PBM) Reform

As the cost of prescription drugs has steeply risen, state and federal policymakers have worked to bring much needed transparency to the opaque drug pricing system. Manufacturers, insurers, and pharmacy benefit managers (PBMs) alike have come under intense scrutiny, each offering explanations on how their companies deliver lower costs and better patient access and healthcare outcomes.

Unlike other actors, PBMs do not have a fiduciary responsibility to the patient, only to their shareholders. Originally created for medical billing of pharmacy transactions, PBMs have evolved to work with (and for) insurers. Furthermore, PBMs have inserted themselves into the patient-provider relationship, exerting enormous influence on which drugs are prescribed to patients, which pharmacies patients can use, and how much patients ultimately pay at the pharmacy counter. Now vertically integrated with the largest health insurance companies and wholly owned mail order and specialty pharmacies, the three largest PBMs—Express Scripts, CVS Caremark and OptumRx—control approximately 89% of the market and serve about 270 million Americans.[13]

These middlemen face rising criticism as Attorneys General across the country have filed and won suits alleging their business practices have dramatically inflated costs for states' Medicaid and employee health plans. The Federal Trade Commission has also launched an investigation into PBMs and their role in the rising price of prescription drugs through fees and rebates received in exchange for formulary coverage.

While it is important to understand and acknowledge the factors inflating patient costs, state legislators have an opportunity to implement reforms that can directly reduce prescription costs for patients in response to PBM based inflation.

REBATES FOR PATIENTS, NOT PBMS

West Virginia led the nation by first enacting PBM rebate reform—a solution providing direct relief to patients at the pharmacy counter—alongside much needed transparency in a broken system that is widely acknowledged to be inflating those costs. Through HB 2263, a bill that would be selected onto the Council of State Governments' 2022 Shared State Legislation Docket, West Virginia became the first state to

Uneven Market Share

Now vertically integrated with the largest health insurance companies and wholly owned mail order and specialty pharmacies, the three largest PBMs—Express Scripts, CVS Caremark and OptumRx—control approximately 89% of the market and serve about 270 million Americans.



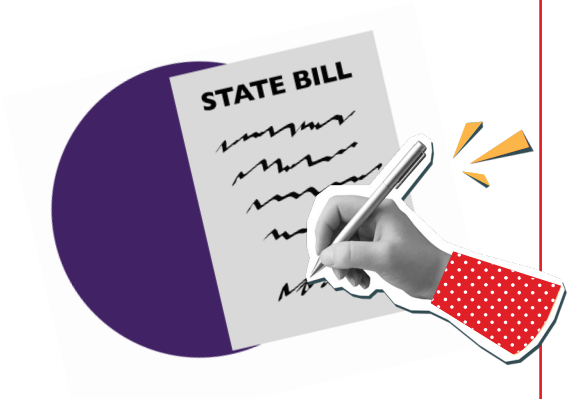
Where does the money go?

Currently,

PBMs retained $752 million (13%) of manufacturers' payments.

With rebate reform,

Sharing rebates with patients would lower patient costs with minimal impact on health insurance premiums. A study conducted by Milliman shows that nationwide payer costs would not increase by more than 0.6%.



Rebate reform legislation would ensure negotiated savings stay with patients who need it most.

require rebate pass through. Since this landmark bill, dozens of states have filed similar bipartisan measures, with rebate pass through policy now law in West Virginia, Arkansas, Indiana, North Carolina, and New Mexico (as of this publication).

Rebates—discounts provided by manufacturers to incentivize PBMs and insurance companies to cover their medicines—have risen to create a costly barrier to patient access. In contrast with the major medical side of health plans, which automatically shares network discounts with plan participants, health insurance coverage of prescription medicines is unique in that PBMs and health plans may pocket these rebates.

Refusal to share these rebates, which average 48% of list price across all brands and exceed 80% in the case of insulin, leaves people with chronic conditions, who may rely on multiple medications just to stay alive, paying hundreds of dollars more than their insurer.[14]

Making matters worse, PBMs are negating competitive forces that should deliver reduced prescription drug prices. As follow-on biologic and biosimilar analog insulins come to market, they are increasingly being placed in specialty or non-preferred tiers or being excluded altogether as PBMs and health plans prefer higher priced branded medications which provide them greater amounts of rebates and enhanced profitability. At no point is patient cost-saving included in the calculations.



Exhibit B: Example at the Pharmacy Counter — How rebate reform would save money for those on a state-regulated health plan*

	Current State	with Reform
Retail List Price	$150	$150
Rebate	$72	$72
Insurance Pays	$78	$78
Patient Pays	$150	$78

** For illustrative purposes, model does not depict pharmacy fees*



Patients with high deductibles and coinsurance often pay the full list price of a medication rather than the negotiated net price, with the middlemen and insurers keeping the profits. As these entities increase premiums, coinsurance requirements and deductibles, shifting more healthcare costs to the patients, it is common sense that the patient receive the benefit of the pricing that the insurance plan has negotiated.

Opponents of bills that pass rebates through to patients will tell you that doing so will exponentially raise premiums. However, since implementation of the bill, West Virginia and others have not seen a rise in premiums beyond the national averages, indicating that these concerns are not the reality. All states should consider implementing rebate reform to ensure that patients are not stuck with higher prices on their lifesaving drugs and medical supplies while middlemen like PBMs and insurers profit.

By requiring rebate and discount pass through to the consumer at the point of sale on all prescription drugs, medical devices, supplies or services during the deductible phase—West Virginia has made prescription drug coverage commensurate with other preventive care and reduced patient costs in the near-term.



DE-LINKING PBM DRUG PROFITS

Charged with negotiating prescription drug benefits on behalf of employers and insurers, PBM compensation is traditionally based on a percentage of the spread between the drug's undiscounted list price and the net price after rebates. Owing a fiduciary responsibility not to the patient or even health plans but only their shareholders, PBMs are incentivized to steer patients toward higher-priced drugs simply to increase their earnings, regardless of whether cheaper or more effective alternatives exist.

To eliminate this practice, Colorado and Louisiana have introduced legislation instituting a structural shift known as "delinking," which mandates that PBM revenue be derived exclusively from a transparent, flat-dollar service fee eliminating the conflict of interest inherent in the current model.

The Colorado and Louisiana models require that if a PBM favors a high-list-price option on a formulary, they must verify that the net acquisition cost is lower than the other options, and that the savings are directly reflected in the patient's out-of-pocket payment. This clause prohibits PBMs from creating formularies that intentionally favor high-cost branded drugs over less expensive, therapeutically equivalent generics or biosimilars.

In addition, these models protect independent pharmacies by establishing a minimum compensation floor requiring pharmacy reimbursement to meet or exceed the National Average Drug Acquisition Cost (NADAC) plus a reasonable dispensing fee.

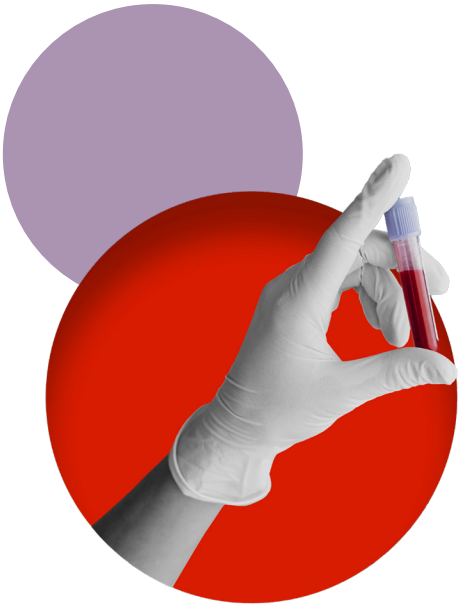
Beyond pricing and access, the Colorado and Louisiana models also include rigorous transparency and accountability responsibilities on PBM contracts requiring the disclosure of comprehensive claims-level drug cost data, coupled with annual audit rights for health plans, lifting the veil on the "black box" of PBM economics.

Through this integrated policy approach, states can help lower the financial barriers that currently impede medication adherence for chronic conditions, improving health outcomes, and mitigating the long-term system costs associated with unmanaged chronic diseases.



Part Three

Coverage Access for Innovative Technologies



Diabetes management is unique in that it is almost entirely self-managed by the individual, or their parent or caregiver on a daily basis. A person with diabetes may need to make minute-by-minute adjustments in their management plan, attempting to keep blood glucose levels within a recommended range.

Insulin is the life-saving bedrock of diabetes management for 1 in 3 people with diabetes, yet it is just one piece in a mosaic of medicines, medical devices, software, supplies, and support services the disease demands. While coverage for insulin is routine, access to these other essential diabetes management tools like continuous glucose monitors (CGMs) and insulin pumps remains inconsistent.

Now is the time to ensure people with diabetes have adequate coverage for individualized care that can prevent or delay the onset of these costly and life-limiting complications.

As public and private health plans generally cover long-term diabetes complications, including amputation, blindness, end stage renal disease, heart attack and stroke—so too should they cover the tools that prevent these circumstances. The return on investment would be tremendous as prevention costs less for the patient, their quality of life, and the healthcare system.

CONTINUOUS GLUCOSE MONITOR (CGM) COVERAGE

To provide constituents coverage of better tools to manage their disease and lower rates of costly complications, legislators in Arkansas have recently enacted legislation mandating their Medicaid program cover continuous glucose monitors (CGMs) for individuals with diabetes.

Innovative technologies such as CGMs, smart devices, and closed loop CGM+ pump or "artificial pancreas" systems provide individuals vital tools to manage their diabetes, quickly adjust therapy, and avoid preventable complications.

As diabetes innovation becomes routine and more data is gathered, clinical guidelines have evolved. The American Diabetes Association now recommends CGMs as the standard of care for treating any insulin-dependent adult, regardless of type, as well as for all children with type 1 and type 2 diabetes who use rapid-acting insulin.[15]

Despite these recommendations, Medicaid coverage of CGMs remains a complex patchwork of prescription or durable medical equipment (DME) benefits. Across the country, coverage differentiates between people with type 1 versus type 2 diabetes as well as between children and adults. Some states go further to require prior authorization alongside prescriber requirements and diabetes-specific requirements.

Under this inconsistent coverage, studies reveal that Medicaid beneficiaries with diabetes struggle—suffering higher rates of poor diabetes management, worse glycemic control, and facing more acute- and long-term complications related to diabetes.[16]

While federal laws and regulations set standards for coverage under Medicaid for both the traditional and expansion populations, individual states determine the finer points of what is and is not covered, and how programs are administered.

It is important to contain costs wherever possible, but it's similarly important to design plan coverage to drive overall cost efficiencies versus any single line item.

The purpose of CGM coverage is to promote better diabetes management

and importantly, to reduce higher cost spend on the major medical side of the plan. One study shows that patient adoption of CGMs for just nine months results in healthcare costs savings of $4,000 compared to a patient without a CGM.[17]

In covering CGMs through Medicaid, Arkansas offers coverage to some of their most vulnerable citizens while better managing state resources by preventing the greater costs associated with hospitalizations and treatment complications.



SO EVERY BODY CAN MOVE (SEBCM): ADVANCING PROSTHETIC AND ORTHOTIC COVERAGE



Complications from diabetes are responsible for 80% of non-traumatic lower limb amputations.[18] An individual who has had an amputation has a worse five-year survival rate than someone with coronary artery disease, breast cancer, or colorectal cancer[19] underscoring the need to focus on their post-surgical care.

For many people living with diabetes, amputation is not the end of treatment but the beginning of a lifelong struggle for mobility, independence, and health.

Unfortunately, people living with limb loss or limb difference are often denied coverage for the prosthetic and orthotic devices that make essential daily activities and physical activity possible. Insurers frequently classify medically necessary devices and care beyond the primary, everyday device as "luxury items," "recreational," or "convenience" equipment—forcing patients to pay tens of thousands of dollars out-of-pocket, rely on charitable support, or go without. The result is reduced mobility, social isolation, and preventable health complications such as obesity and cardiovascular disease.

Since 2022, 12 states have successfully enacted So Every BODY Can Move (SEBCM) legislation, establishing prosthetic and orthotic coverage based on functional need rather than outdated or restrictive policies. These reforms have expanded access to essential mobility care without measurable increases in insurance premiums.



The state of Colorado passed the Prosthetics and Orthotics Parity Act

requiring insurers to provide coverage for these essential components. Coverage is based on a patient's functional needs and is not subject to arbitrary restrictions.

SEBCM is modernizing outdated insurance policies through state legislation that defines the comprehensive range of prosthetic and orthotic care—including devices necessary for physical activity, independence, and overall wellbeing—as medically necessary care. This ensures that access to mobility tools is determined by a person's functional needs and provider based medical necessity, not by arbitrary coverage limits or outdated definitions of "medical necessity."

For people living with diabetes and limb loss, these reforms are not just about movement—they are about prevention. Access to appropriate prosthetic and orthotic care helps maintain physical activity, supports cardiovascular health, and reduces costly secondary complications, improving both quality of life and long-term health outcomes.

Opponents of prosthetic and orthotic coverage reform often argue that expanding coverage to include activity-specific devices will significantly raise premiums for all members. However, state rate reviews facilitated by the Office of the Superintendent of Insurance in New Mexico have shown otherwise—insurers have reported a 0% rate impact following implementation of the So Every BODY Can Move legislation.

Additionally, emerging research, such as "A Multi-State Analysis of the Fiscal Impact of Commercial Insurance Coverage for General-Use & Activity-Specific Prosthetic & Orthotic Devices in the United States," continues to forecast a minimal effect on premiums while demonstrating a high positive impact on access, quality of life, and long-term health outcomes. These findings reinforce what state experiences are already proving: equitable coverage for prosthetic and orthotic care is both affordable and effective.

For more information on advancing prosthetic and orthotic coverage and to learn more about SEBCM's model legislation:

Contact So Every BODY Can Move at advocacy@amputee-coalition.org and visit SoEveryBODYCanMove.org

SEBCM is a grassroots disability-rights and healthcare initiative founded and led by members of the disability community.

The movement operates through a disability-led distributed organizing model in partnership with healthcare professionals—orthotists and prosthetists, physicians, researchers, physical and occupational therapists, and community organizations—all working together to ensure equitable access to the mobility care every body deserves.

Part Four

Comprehensive Coverage to Combat Obesity



Obesity, a complex health issue often influenced by a combination of genetic, environmental, and behavioral factors, is a significant health crisis affecting more than two in five American adults; nearly a quarter of whom have diabetes. The 123 million American adults and children/adolescents living with obesity are vulnerable to over 200 comorbidities, including strokes, cardiovascular disease, and chronic kidney disease. While the landmark National Diabetes Prevention Program demonstrated that targeted lifestyle adjustments can slash the transition from prediabetes to type 2 diabetes by nearly 60%, coverage for weight management is commonly limited to basic counseling in primary care settings only and bariatric surgery for severe cases.

Policymakers must recognize the significance of addressing the obesity epidemic, linked to an overall increase in annual healthcare costs of $7,889 per adult, totaling $170 billion in excess expenditures annually.[20]

While lifestyle modifications such as diet and exercise are essential components of obesity management, they are not sufficient for everyone as meta-analysis reflects that over half of lost weight is often regained within two years.[21]

Addressing the obesity epidemic therefore requires a multifaceted policy approach to shift the focus from short-term interventions to long-term, sustainable solutions, beginning with coverage options encompassing the defined standards of care by the medical community—Medical Nutrition Therapy (MNT), Intensive Behavioral Therapy (IBT) as well as safe and effective prescription obesity medications.

As of this year, state administrators and legislators have new federal options to consider when evaluating Medicaid coverage strategies. The CMS BALANCE Model - a five-year demonstration running through 2031 - allows state Medicaid programs to access FDA-approved obesity medications at a capped, affordable monthly supply rate, with net state costs coming in significantly lower after federal matching funds and rebates are applied. As Indiana has become the first state to publicly sign on, state leaders should

view BALANCE as a significant mechanism within a broader toolkit, with the understanding it is not a standalone solution.

Legislators may consider going further by addressing the unwelcome impact of obesity stigma, negative attitudes undermining the level of support and care received which can lead individuals to experience poorer mental health and quality of life, disordered eating behaviors, excessive alcohol use, and weight gain.

MODERNIZING STATE OBESITY CARE

Amid a myriad of exorbitant factors associated with obesity care coverage, Connecticut offers a model for consideration. The state promotes affordable obesity treatment access to its employees via a broad spectrum of medical care and disease management to control and mitigate the condition's effects all the while promoting fiscal responsibility. It is important to note that due to state legislative jurisdiction, Connecticut's model only impacts those enrolled in its Medicaid program and the state-employee health plan.

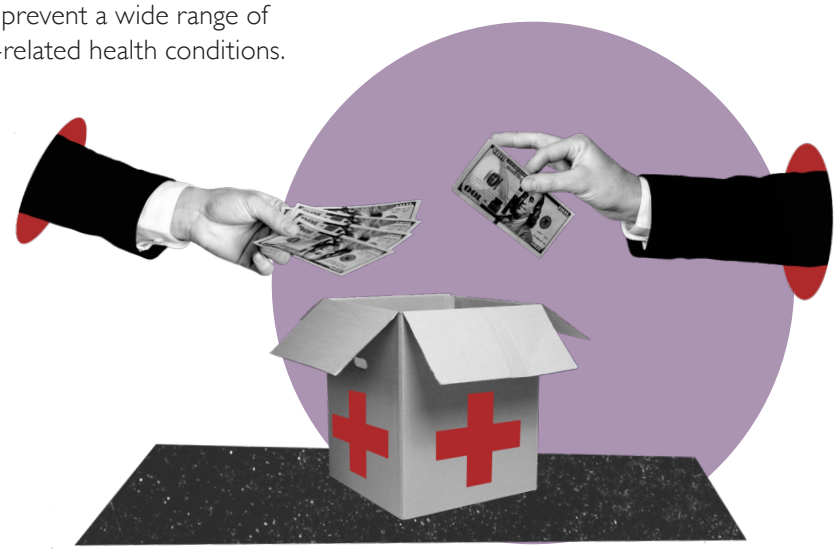
For its Medicaid beneficiaries, provided such beneficiaries meet specific conditions, legislators implemented access to prescription drugs approved by the FDA for the treatment of obesity. Such coverage for anti-obesity medications (AOMs) offers optimal outcomes, with enhanced treatment adherence leading to more effective weight management and decreased healthcare costs associated with treating secondary health issues.[22]

To date, Medicaid coverage of pharmaceutical treatments significantly lags behind more expensive treatments like bariatric surgery—leaving millions of people vulnerable to costly chronic illnesses and premature death due to lack of treatment.[23] While concerns regarding costs to cover AOMs are valid, there is potential for these treatments to save states money in the long term by decreasing the incidence of costly weight-related conditions such as type 2 diabetes and heart disease.

Addressing such concerns, Connecticut's state-employee health plan provides AOM coverage once plan members certify enrollment in a weight management program. Working with multi-disciplinary teams of physicians, registered dietitians, nurse practitioners, and care coordinators — patients may create and continually fine-tune highly personalized weight management plans rather than simply obtaining an AOM prescription and being sent home. By providing such intensive education and support, in tandem with pharmacotherapy, patients are better enabled to improve, resolve, and/or prevent a wide range of weight-related health conditions.

To be most effective, health insurance must include available, affordable, and accessible access to obesity care. This means the best standards of treatments and coordination of care.

Just as scientific innovation led to a number of prevention and treatment options, Connecticut is innovating how state legislatures may best help residents diagnosed with obesity.



Safeguarding Patient Safety and Quality in Obesity Care

As states expand coverage for obesity care, access to obesity medications must be paired with safeguards for patient safety, drug quality, and professional oversight.

After rapid public adoption of GLP-1 receptor agonists – a prominent class of obesity medication, with roughly 12% of American adults reporting use[24] – demand for the FDA-approved medicines initially outpaced supply, a temporary shortage which fueled a market for copycat versions sold by compounders, telehealth platforms, and medical spas. In response, Indiana enacted legislation balancing patient access to legitimate, medically necessary treatments with new safety guardrails.

Under federal law, legitimate drug compounding is permitted under two narrowly defined scenarios:

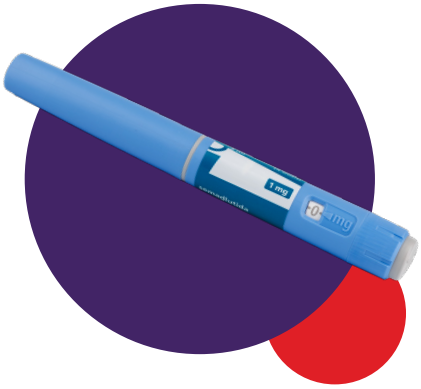
1. Temporarily filling FDA-declared supply shortages

2. Meeting an individual patient's specific clinical needs, such as removing a dye due to documented allergies

As GLP-1 shortages eased, some compounders claimed that their compounded GLP-1 products are "personalized" to maintain high-volume production outside standard FDA approval channels. Mass-distributing such untested formulations – such as the now-common practice of combining GLP-1s with Vitamin B12 without clinical evidence on safety, stability, or efficacy – exposes patients to potentially serious health risks as evidenced by findings that such a combination may form chemical impurities.[25]

With additional biologic and metabolic therapies entering the market, states should act proactively to address supply-driven risks and prevent the mass distribution of risky, substandard formulations. Indiana's model addresses some of the risks in the marketplace, offering a pro-compliance framework aligned with federal compounding standards.





Federal law governs FDA registration and the applicable federal standards for drug ingredients and compounding;

the legislation does not give Indiana regulators authority to approve drugs or enforce federal law. Instead, it establishes state requirements that the Indiana Board of Pharmacy may enforce against pharmacies licensed or otherwise subject to regulation in Indiana, including out-of-state pharmacies that ship compounded prescription drugs into the state.

The legislation strengthens product-quality oversight by requiring compounders serving Indiana patients to source bulk drug substances, commonly called active pharmaceutical ingredients (APIs), from facilities registered with the FDA and authorized to manufacture drugs for human use - not from suppliers limited to research- or veterinary-grade ingredients. Each API shipment must be accompanied by a Certificate of Analysis documenting the substance's identity and content, country of origin, and completion of required quality-control testing. To determine compliance with these state requirements, the Indiana Board of Pharmacy may investigate the sourcing, storage, handling, labeling, and compounding of prescription drugs within its jurisdiction. These supply-chain protections give state regulators clearer authority to identify unsafe practices, enforce Indiana licensing and compounding requirements, and trace harms associated with mass-compounded products to their source.

Further, the law requires medical spas offering healthcare, prescription drugs, or aesthetic and lifestyle treatments to register with the Medical Licensing Board. Each facility must designate a responsible practitioner with prescriptive authority and relevant training to oversee operations, verify staff licensing, and ensure services remain within scope of practice. Facilities are to report within 15 days any adverse event involving death, life-threatening injury, hospitalization, or surgical intervention. It also prohibits prescription treatments or procedures at transient off-site or mobile locations, including hotel suites or private parties.

Additionally, the State Department of Health, in consultation with the other relevant regulators, must publish a report twice a year concerning the oversight of drug compounding, including data on compounding activities, deficiencies or violations found, and the number of investigations conducted and disciplinary actions taken concerning compounding.

State fiscal analyses indicate minimal implementation costs, making the model adaptable for other legislatures. Medical spa licensing and civil penalties, including administrative fines up to $5,000 per violation for unregistered medical spa operation, help offset enforcement costs.

While additional reforms at both the state and federal level are needed to fully address patient risks presented by mass compounding, Indiana's framework demonstrates how states can preserve access to obesity and metabolic therapies while strengthening patient-safety oversight. By combining supply-chain transparency, clinical accountability, adverse-event reporting, and enforcement authority, the model closes regulatory gaps with limited fiscal impact. As biologic treatments expand, this approach offers legislatures a practical template for modernizing healthcare safeguards.

Part Five

Addressing Diabetes in the School Setting



Type 1 diabetes is the second most common chronic disease in school-aged children.[26] It poses significant challenges for children—beyond the physical demands of managing blood glucose levels, they can profoundly impact a child's emotional, social, and academic life.

Children with diabetes often face a complex regimen of insulin injections, blood sugar monitoring, and dietary restrictions—tasks that can be physically and emotionally draining, affecting a child's energy levels and focus, which in turn can impact academic performance and social behaviors. Moreover, the fear of hypoglycemia or hyperglycemia, a blood glucose level that is either too low or too high, can disrupt school attendance and participation in extracurricular activities.

It is crucial to provide comprehensive support to children with diabetes,

including education about the disease, access to necessary medical supplies, and a supportive school environment. By understanding the challenges faced by these children, we can help them thrive and reach their full potential.

ACCESS TO EMERGENCY GLUCAGON IN SCHOOL

The management of diabetes-related emergencies presents a critical challenge, especially for children in the school setting. While significant strides have been made in diabetes care, the risk of severe hypoglycemia, or a low blood glucose level, remains a substantial concern.

Georgia legislation regarding "undesignated glucagon" offers a model that can significantly improve safety for these children by permitting schools to stock and administer glucagon, a life-saving medication administered for hypoglycemic emergencies.

When talking about diabetes, we often discuss access to insulin, a necessary tool to effectively manage diabetes and prevent high blood glucose levels. While insulin helps to lower blood sugar, glucagon is the antidote—helping to raise blood sugar—and just like epinephrine, is used in emergency situations.

Families may provide their children with T1D their own glucagon, but reliance on student-supplied glucagon

to address these emergencies is insufficient to ensure optimal outcomes for child patients.

A glucagon prescription for a school is one way to lessen the gap between a life-threatening problem and a lifesaving solution. Instances where students are unable to self-correct a low blood sugar due to impaired consciousness or the unavailability of their prescribed medication highlight the need for a readily available, universal supply.

Moreover, the presence of undesignated glucagon in schools promotes equity in healthcare access. Socioeconomic disparities often impact a student's ability to obtain and maintain necessary medical supplies. By providing glucagon as a standard component of school health services, these disparities are mitigated, ensuring that all students have equal opportunities to receive essential care.

Implementing legislation permitting schools to stock and administer glucagon is a critical step toward enhancing student safety and well-being. By addressing the limitations of the current system and promoting equitable access to life-saving medication, policymakers can significantly improve the health outcomes of students with diabetes.

TYPE 1 DIABETES SCREENING EDUCATION

Type 1 diabetes (T1D) affects children at alarming rates, often presenting with nonspecific symptoms that look like the flu, delaying diagnosis and increasing the risk of diabetic ketoacidosis (DKA), a life-threatening complication that is all too commonly experienced at the time of diagnosis. School-aged children represent a particularly vulnerable population as their rapid growth and development can mask the initial symptoms of T1D. This dilemma necessitates a policy-driven approach that prioritizes screening and education for school-aged children and their caregivers—an approach recently taken by Illinois' legislature.

Understanding that education is a cornerstone of effective T1D management. Illinois' bill focuses on sharing information with families of school-age children across the state about T1D and the availability of screening and diagnosis tests. In it, the State Board of Education, in coordination with the Department of Public Health, is tasked with developing informational materials to be made available to each school district in the state.

Equipping children and their families with knowledge about the disease, its symptoms and self-care practices empowers them to take an active role in their health. Schools can serve as vital hubs for disseminating information about T1D, fostering understanding, and creating supportive environments.

Further, early detection of T1D through routine screening can lead to timely intervention, reducing the severity of disease onset which often comes with lengthy hospitalizations and ensuring optimal health outcomes.

Helping affected families learn what they can about the condition is in the state's interest – potentially preventing or delaying any cases of DKA in a child, a sometimes fatal but always costly and life-altering complication often present at diagnosis, means the work may be viewed as successful.

Policymakers can substantially impact the lives of children with this condition by prioritizing T1D screening and education. With broader education on early detection, coupled with comprehensive support, legislation can lead to improved health outcomes, reduced healthcare costs, and a brighter future for affected children.



Approximately 30-40% of youth in the U.S. experience a serious complication (DKA) at the time of diagnosis.

Appendix

Biosimilar First Policy

Seeks to make lower-net-cost biosimilars the preferred option for patients beginning biologic therapy in state employee health plans. It aims to reduce public drug spending and promote biosimilar competition while preserving clinician discretion and protecting patients already stable on an existing biologic from nonmedical switching.

Model Legislation: Kentucky Senate Bill 211 – Not Enacted

Comprehensive Coverage for Obesity Treatments

Legislation establishing state Medicaid obesity treatment coverage includes the defined standards of care by the medical community including behavioral, dietary counseling, surgical, and pharmacological care.

Model Legislation: Connecticut Senate Bill 977 – Enacted 6/28/23

Comprehensive Medicaid Coverage for CGMs

Comprehensive Medicaid coverage for Continuous Glucose Monitors (CGMs) ensures that beneficiaries with diabetes have access to CGMs and related supplies as part of their healthcare benefits.

Model Legislation: Arkansas Senate Bill 521 – Enacted 4/13/21

Copay Accumulator Adjustment Program Bans

Copay accumulator adjustment program bans prohibit health insurers and PBMs from applying copay accumulator programs which prevent third-party copay assistance from counting toward a patient's deductible or out-of-pocket maximum, resulting in higher out-of-pocket costs for patients.

Model Legislation: Virginia House Bill 2515 – Enacted 3/21/19

Delinking PBM Drug Profits

Eliminates the incentive for PBMs to favor high-cost drugs by requiring their compensation to be a flat, fair-market service fee rather than a percentage tied to the drug's list price or the rebates they negotiate.

Model Legislation: Colorado House Bill 25-1094 – Enacted 5/30/25

Diabetes Action Plans

Diabetes action plans are strategic frameworks developed by governments, organizations, or health authorities to combat diabetes and its associated challenges. These plans typically include specific goals, strategies, and initiatives aimed at prevention, early detection, better management, and improved healthcare services for individuals living with diabetes.

Diabetes Supply Copay Caps

Similar to insulin copay caps, diabetes supply copay caps set a maximum limit on out-of-pocket costs for various diabetes supplies, such as glucose test strips, lancets, insulin pumps, and continuous glucose monitors (CGMs).

Model Legislation: Delaware Senate Bill 316 – Enacted 10/16/23

Educational Materials on T1D Screening

Provides that the State Board of Education shall develop type 1 diabetes informational materials for parents and guardians of students to receive upon elementary school enrollment and/or the school's student handbook.

Model Legislation: Illinois Senate Bill 3473 – Enacted 7/1/24

Emergency Access to Insulin (Kevin's Law)

Emergency access to insulin policy permits pharmacists to dispense a 30-day supply of insulin in emergency situations where the prescriber isn't available.

Model Legislation: Ohio House Bill 37 – Enacted 6/1/22

First Dollar Coverage for Diabetes Care

First dollar coverage means that insurance coverage starts immediately, without requiring the insured individual to pay a deductible or other out-of-pocket expenses before coverage benefits begin. First dollar coverage for diabetes care ensures that essential diabetes-related services, treatments, and medications are always covered, minimizing financial barriers for patients.

Insulin Copay Caps

Insulin copay caps limit the amount individuals with diabetes have to pay out-of-pocket for insulin medications. The caps place a maximum limit on the copayment or coinsurance that a patient must contribute, making insulin more affordable and accessible.

Model Legislation: Colorado House Bill 19-1216 – Enacted 5/22/19

Legislative Caucuses Focused on Diabetes

Legislative caucuses are groups of members of a legislative body who share common interests or goals. In this context, legislative caucuses focused on diabetes are groups of lawmakers who come together to address issues related to diabetes, such as raising awareness, advancing diabetes-related legislation, and promoting policies that improve diabetes care and management.

Orthotic and Prosthetic Coverage Legislation (So Every BODY Can Move Model)

Clarifies insurance coverage policies to ensure fair access to the full range of prosthetic and orthotic care by defining these devices and related services—including those needed for physical activity, independence, and overall wellbeing—as medically necessary care based on a person's functional needs, not arbitrary limits or exclusions

Model Legislation: So Every Body Can Move

Patient Safety and Quality in Obesity Care

Strengthens oversight of drug compounding by requiring human-use ingredients from FDA-registered facilities, shipment-level quality documentation, and state investigation of pharmacies serving Indiana patients. It also regulates medical spas through registration, practitioner oversight, adverse-event reporting, location restrictions, civil penalties, and semiannual state reporting on compounding enforcement.

Model Legislation: Indiana Senate Bill 282 – Enacted 3/05/26

Prescription Assistance Programs (PAPs)

A state-administered program designed to help patients navigate already-existing reduced cost prescription programs offered by manufacturers, retailers and other sponsors for prescription medications. Note Kentucky Prescription Assistance Program (KPAP) is the model, but the program was created through a line-item in Kentucky's biannual budget bill (HB 380 – pg. 103). The text of that line-item is included in the below bill:

Model Legislation: Kentucky House Bill 200 – Not Enacted

Rebate Pass-Through

Rebate pass-through requires pharmacy benefit managers (PBMs) to pass through a portion of drug rebates to patients at the point of sale to help lower the cost of prescription drugs for patients.

Model Legislation: Indiana Senate Bill 8 – Enacted 5/4/23

Undesignated Glucagon in Schools

Permits public and private schools to stock a supply of undesignated ready-to-use glucagon to ensure the safety of schoolchildren with diabetes.

Model Legislation: Georgia House Bill 440 – Enacted 4/12/23

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