SB 2140 TESTIMONY
January 11, 2023

Chairman Lee and members of the North Dakota Senate Human Services Committee,

My name is Cara Mund, Bismarck, ND. I support the estimated 58,335 North Dakotans currently living with diagnosed diabetes, the 16,281 North Dakotans living with undiagnosed diabetes, and the 177,618 North Dakotans living with prediabetes.[1]

I am in support of SB 2140 for three reasons:

1. **North Dakota is one of only four states that does not have a mandated insurance requirement specific to diabetes coverage.[2] Therefore, North Dakotans living with diabetes have no guaranteed minimum coverage for their related medical expenses.**

   Legislation capping the cost of insulin, or the cost of care for people living with diabetes, has already been passed in 23 states and Washington, D.C; North Dakota is not one of them. In most cases, the state laws apply to state-regulated health insurance plans. A comparative list of states that have implemented out-of-pocket caps on insulin for state-regulated health plans is detailed below:[3]

Out-Of-Pocket Insulin Caps For State-Regulated Health Plans	
Alabama	Capped at $100/month
Colorado	Capped at $100/month, plus a provision that provides $50/month insulin to people who aren't helped by the $100/month cap
Connecticut	Capped at $25/month
Delaware	Capped at $100/month and no cost-sharing for insulin pumps
Illinois	Capped at $100/month
Kentucky	Capped at $30/month
Maine	Capped at $35/month
Maryland	Capped at $30/month (effective as of 2023)
Minnesota	Cap varies depending on the person's circumstances
New Hampshire	Capped at $30/month
New Mexico	Capped at $25/month
New York	Capped at $100/month
Oregon	Capped at $75/month
Rhode Island	Capped at $40/month
Texas	Capped at $25/month
Utah	Capped at $30/month
Vermont	Capped at $100/month
Virginia	Capped at $50/month
Washington	Capped at $35/month
Washington, D.C.	Capped at $30/month
West Virginia	Capped at $100/month

[1] https://ndlegis.gov/files/committees/67-2021/23_5151_03000appendixd.pdf
[2] *Id.*
[3] https://www.verywellhealth.com/programs-to-cap-insulin-costs-5667166

2. **SB 2140 and state law requires a cost-benefit analysis prior to additional implementation.**

   Per state law, an insurance mandate must be administered to the state's public employee retirement system and undergo a cost-benefit analysis before it is applied to other plans.[4] Therefore, as the bill is currently written, only residents enrolled in the North Dakota Public Employees Retirement System would qualify to obtain a 30-day supply of insulin with a maximum co-pay or co-insurance of $25. According to Daniel Weiss, Sanford Health Plan's senior executive director of pharmacy, almost 700 members under the state employee retirement system filed claims for insulin in 2020.[5] After two years, you would have the opportunity to analyze the costs incurred by the plan and then decide whether to apply it to other insurance plans. Now is the time to conduct this cost-benefit analysis.

3. **SB 2140 provides economic assistance to North Dakotans that the *Inflation Reduction Act of 2022* left behind.**

   It is estimated that 15,300 North Dakotans living with diabetes require insulin medication, many of whom are on state insurance plans and/or not Medicare beneficiaries. Although the *Inflation Reduction Act of 2022* is meaningful for some North Dakotans — caps insulin co-payments for the thousands of North Dakota Medicare beneficiaries that use insulin — it excludes all other North Dakotans who also need insulin.[6] Over the last five years, 45–50-year-old adults in North Dakota have seen the largest increase of diabetes; yet, they were eliminated from the bill.[7] It is now up to the state to bridge the gap for the North Dakota patients that the *Inflation Reduction Act of 2022* left behind.

<u>I will now address three arguments brought forth against the bill:</u>

1. **"The bill would not change the price of insulin."**

   This is true; co-pay caps are not price caps, they do not change the underlying price of insulin. Insulin is expensive because of a lack of competition in the marketplace. The vast majority of insulin is produced by three companies — Novo Nordisk, Sanofi, and Eli Lilly — who produce around 90% of the market. Yet, the United States has the highest insulin prices in the world at an average of $98.70 per vial, nearly seven times higher than the country with the next most expensive insulin, Japan, which averages $14.40 per vial.[8] Based on the vast difference between countries, I agree with Blue Cross Blue Shield and the Sanford Health Plan's prior comments that the federal government needs to step in; however, considering that the federal provision to cap insulin costs at $35 for private insurers in the *Inflation Reduction Act of 2022* was blocked in the Senate, such federal action is unlikely to occur anytime soon. Therefore, 23 states and the

[4] Section 54-03-28
[5] https://www.thedickinsonpress.com/news/north-dakota-lawmakers-scale-back-bill-aimed-at-curbing-insulin-costs
[6] https://www.whitehouse.gov/wp-content/uploads/2022/08/North-Dakota-Health-Care.pdf
[7] https://ndlegis.gov/files/committees/67-2021/23_5151_03000appendixd.pdf
[8] https://www.rand.org/blog/rand-review/2021/01/the-astronomical-price-of-insulin-hurts-american-families.html

District of Columbia have stepped up and enacted similar legislation for their residents; it is time North Dakota does the same. The lives, future, and blood of North Dakotans living with diabetes now rests in YOUR hands.

2. **"A copay or cost-sharing cap may incentivize higher cost insulin by manufacturers that would be passed onto consumers. With a copay or cost-sharing cap, as the cost of prescription drug rises, the excess above and beyond the cap is passed on to other members."**

   Without a cost-benefit analysis, these arguments lack merit. Pending federal approval, generic insulin is expected to disrupt market pricing in the United States by early 2024;[9] therefore, the argument that a copay or cost-sharing cap may incentivize higher cost insulin by manufacturers feigns ignorance to the future of the marketplace.

   Additionally, the high cost of insulin leads to increased barriers of accessibility which leads to lower medication use and an increase in the cost of related hospitalizations and emergency room visits. Although reducing out-of-pocket cost-sharing for insulin could initially mean payers and insurers would cover a greater share of the costs, these costs would be offset by the increased medication adherence and reduced rates of hospitalization due to the affordability of insulin.

3. **"[The bill] does not affect employer-funded programs…[t]hose particular policies are exempt from any mandate either from the Affordable Care Act or from the state."**

   State laws and regulations never apply to self-insured group health plans, which are instead regulated at the federal level; however, that does not mean you should not take action. For health plans that individuals and employers purchase from an insurance company, state rules apply. Since at least 40% of the population in North Dakota is covered by independent employer-provided health policies, this argument fails to acknowledge the already existing gap in the affordability of insulin for different groups of North Dakotans.

Diabetes can affect anyone: you, your spouse, your children, or your grandchildren. Factors such as what insurance plan a North Dakotan has or if they survived living with diabetes long enough to even be on Medicare should not determine whether they can afford their life-saving medication. When it comes to the affordability of insulin, the life of every North Dakotan matters. This is not a partisanship issue; it is a life-or-death issue that impacts the State of North Dakota every single day.

Respectfully Submitted,

Cara Mund, Bismarck

[9] https://www.aha.org/aha-center-health-innovation-market-scan/2022-03-15-civica-rx-aims-disrupt-generic-insulin-market