Legislative Assembly

North Dakota
House of Representatives

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Testimony in support of HB1114
Senate Human Services Committee
March 10, 2025

Honorable Chairwoman Lee, and Members of the Senate Human Services Committee,

I am Representative Carrie McLeod from District 45, which sits on the north side of Fargo and West Fargo north of Main Avee, and includes the rural communities of Harwood, Argusville and Gardner. I am here today to respectfully ask for your support of HB1114. I am a certified diabetes education specialist and for 26 years I was a clinical faculty member at The University of North Dakota School of Medicine, lecturing on diabetes management and medical nutrition therapy. Additionally, I have served as a director within the Medical Management Division for the largest health insurance company in North Dakota, with the accountability of building employee health and wellness strategies for employer groups, assisting them to contain health care costs.

HB1114 is before you today because of the passage of SB2140 in the 68th Legislative Session. SB2140 required a monthly cap of $25/month for the specified insulin and diabetic supplies listed in Section 1 of the bill. SB2140 required the NDPERS Board to submit a bill in the upcoming Session that would roll this coverage out to the commercial market in North Dakota. HB1114 is that bill and was prepared by the NDPERS Board with their approval for submission

In addition to the NDPERS report, you will find the NovaRest Actuarial Report which is attached to this testimony. I draw your attention to page 4 of the report, (mid-page), where you will find that NovaRest estimates a premium increase of 0.05% to 0.20% which calculates to 30 cents to $1.00 PMPM for the large group markets. It is important to note that NovaRest based their estimates on the use of 62 units of insulin daily, which is a higher dosage than most of my patients used.

Page 6 of the NovaRest report (mid-page) states that insulin drugs and medical supplies appear to also be covered in the large group market however, they are not capped at the $25 rate for a 30-day supply. The North Dakota Insurance Department stated that this bill is not a mandate, but rather, it is a cost shift.

NovaRest continues to report an expected increase in the number of large group members who may increase their insulin usage versus rationing their insulin. They anticipate 300-400 large group members would increase their usage. I will add that NDPERS reported no change in usage, however the health benefit plan for state employees has a $1200 deductible compared to other plans where patients have shared that they are paying $1200/month for their coverage, which leaves them struggling to pay for the ever-increasing cost of insulin.

On page 8 of the report, you will find the estimated total cost anticipated if these same 300-400 members increase their insulin usage to the provider prescribed amount. The last paragraph on the page is important because in addition to helping our citizens afford their life sustaining insulin, this is important to the insurance providers and the business community. Savings from preventing more serious diseases may offset the cost of this benefit. Think about the cost for an ambulance ride to the emergency department and the cost of the emergency department visit. Additional costs due to complications of uncontrolled diabetes can be substantial when we think of kidney dialysis, amputations, blindness, neuropathies etc. When those very costly complications and need for additional health services occur, we all pay. These complications drive the cost of healthcare up, and you cannot save on healthcare costs by pricing insulin out of reach for people. All of us pay for patients who are not in good control of their health.

The cost of insulin increased due to the PBMs. I have included a press release from the Federal Trade Commission. A lawsuit was brought near the end of 2024 against the three largest PBMs. The FTC charges them with anticompetitive and unfair rebating practices that have inflated the cost of insulin. Note that Optum is one of those PBMs in this lawsuit. The press release lists just one of the insulins as seeing a 1200% increase.

We know that insulin is a cheap drug to produce, but the prices continue to escalate. The American Medical Association in a March 29th2023 JAMA article cited Dr. Kathryn Nagel, a fellow in pediatric endocrinology at Massachusetts General as stating and I quote, "It is great to see the manufacturers are making meaningful reductions in the exorbitantly inflated prices of insulin, but it is a bandage rather than a solution. The diabetes community remains vulnerable as these companies can increase prices at any time, which they have repeatedly and unabashedly done in the past", end of quote.

There was a concern voiced by a member of the House that this bill might start us in the direction of capping other medications such as COPD meds. That is like comparing apples to oranges. Insulin is not in the competitive market like other drugs, it is not in the free market. There is an oligopoly with insulin. It is not a free market for insulin.

Another concern was that we would see more expensive insulins developed and added to this cap, however the bill is very specific to which products would be capped. In fact, I visited with a representative of the health plan and asked if he would like to see the GLP-1 -RA product removed from this bill. He replied that so few members are on that product that he did not recommend removing it. I want to be clear that the specified GLP-1-RA is not the weight loss meds used currently. These are older GLP-1 - RA products, and they are not as costly as the new GLP+1 products.

It is important to note that within each health insurance company there are many different health plans. This insulin cap would not apply to self-funded plans. One payor already has a cap on insulin, but that does not apply to many of their members.

Finally, even though the North Dakota Insurance Commissioners Office states that this is not a mandate, there is still concern about mandates and there is a negative thought toward mandates but remember that every bill we pass is a mandate for someone. When it became necessary to bring this legislation it is because our citizens need help, and they come to us because no one else will help them with this life-saving medication.
Will you please help them? Will you support your constituents and pass HB1114?

Thank you.

NovaRest
ACTUARIAL CONSULTING

December 31, 2024

Analysis of 25.0118.01000 Relating to Insulin Drugs and Supplies

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

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I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost-benefit analysis of Draft Bill No. 25.0118.01000[1] for the 69th Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. Draft Bill No. 25.0118.01000 creates and enacts a new section to chapters 26.1-36 and amends and reenacts sections 54-52.1-04.18 of the North Dakota Century Code. This Draft Bill proposes coverage for cost-sharing for a 30-day supply of:

A. Covered insulin drugs which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs, where insulin includes the following categories:
    a. Rapid-acting insulin
    b. Short-acting insulin
    c. Intermediate-acting insulin
    d. Long-acting insulin
    e. Premixed insulin product
    f. Premixed insulin/GLP-1 RA product
    g. Concentrated human regular insulin

B. Covered medical supplies for insulin dosing and administration, which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.
    a. Blood glucose meters
    b. Blood glucose test strips
    c. Lancing devices and lancets
    d. Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips
    e. Glocagon, injectable or nasal forms
    f. Insulin pen needles
    g. Insulin syringes

NovaRest, Inc. has been contracted as the NDLC's consulting actuary and has prepared the following evaluation of diabetes drugs and supply coverage.

This report includes information from several sources to provide more than one perspective on the proposed mandate and provide an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we consider credible, we do not offer any opinions regarding whether one source is more credible than another.

III. Coverage for Insulin Drugs and Supplies

There are approximately 57,805 people in North Dakota with diagnosed diabetes[2] and approximately 31% of those with diabetes use insulin.[3]

North Dakota Public Employees Retirement System (NDPERS)

NDPERS currently includes a limit of $25 for a 30-day supply of the insulin drugs and medical supplies identified by Draft Bill 25.0118.01000 for three of the four plans administered by NDPERS. We note that the fourth plan administered is a Medicare plan, and Draft Bill 25.0118.01000 is not applied to Medicare Prescription Drug Coverage.

Commercial Market

Coverage for the individual and small group markets is primarily dictated through the Essential Health Benefits Benchmark Plan (EHB-BP) coverage document. The current EHB Benchmark Plan (EHB-BP), which covers the individual and small group markets, currently includes the coverage of diabetes medication and supplies. It states that "Copayment Amount shall not exceed $25.00 for a 30-day supply of insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for treating diabetes. Insulin includes but is not limited to the following categories: rapid-acting insulin, short-acting insulin, intermediate-acting insulin, long-acting insulin, premixed insulin product, premixed insulin/GLP-1 RA product, and concentrated human regular insulin." The Benchmark Plan also provides coverage for the use of GLP1 and GIP drugs (specifically semaglutide and tirzepatide) for the prevention of diabetes and treatment of insulin resistance, metabolic syndrome, and/or morbid obesity.

Through our discussions with other states and CMS, it is unclear if insurers must use the cost-sharing prescribed in the EHB-BP. We reviewed recent forms filings available on the North Dakota public filing search site[4] for Blue Cross Blue Shield of North Dakota, Sanford Health Plan, and Medica Insurance Company, and it appears all are following the EHB-BP cost-sharing limitation for individuals and small groups. A carrier survey would likely be required to verify.

While coverage in the large group market may vary between insurers and plans, we reviewed recent forms filings available on the North Dakota public filing search site[5] for Blue Cross Blue Shield of North Dakota, Sanford Health Plan, and Medica Insurance Company, which make up a majority of North Dakota's large group market,[6] and determined the insulin drugs and medical supplies identified in Draft Bill 25.0118.01000 appear to be covered, however, are not subject to the member cost-sharing limitation of $25.

The extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.

Our understanding is that insulin drugs and supplies are currently covered by non-Medicare NDPERS plans, capped at $25 member cost sharing for a 30-day supply. Therefore, we estimate no change administrative expenses or premiums. We note the limit does not apply to the Medicare part D prescription drug coverage plan.

If the Draft Bill language was extended to include the commercial market, we estimate there would be no impact in the administrative expenses or premiums in the individual and small group markets which we believe already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

For the large group market, while the insulin drugs and medical supplies included in Draft Bill 25.0118.01000 are already covered, Therefore we do not believe the impact on administrative cost will be significant.

NovaRest estimates a premium increase 0.05% to 0.20% and $0.30 to $1.00 on a per-member-per-month (PMPM) basis for large group plans. The variation reflects variation in the large group plan cost sharing, in addition to the variation in the cost of insulin drugs and insulin medical supplies that are commonly used. Please see Appendix B for more information on our assumptions and methodology.

IV. Other State Diabetes Drugs and Supplies Laws[9]

There are approximately 25 states and Washington, D.C. that have passed legislation addressing the issue of capping copays for diabetes drugs and supplies. Below is a summary of that legislation.

State	Legislation
Alabama[10]	$35 cap for a 30-day supply of insulin
Colorado	$100 cap for a 30-day supply of insulin
Connecticut	$25 cap for 30-day supply of insulin or other diabetes medications, $100 cap for 30-days' worth of devices and supplies
Delaware	$100 collective cap for 30-day supply, $0 for insulin pumps, and collective $35 cap per month for other specified diabetes equipment and supplies
Illinois	$100 cap for a 30-day supply of insulin; effective 7/1/25, the collective cap will be $35 for a 30-day supply
Kentucky	$30 cap for a 30-day supply of insulin
Louisiana	$75 cap for 30-day supply
Maine	$35 cap for a 30-day supply of insulin
Maryland	$30 cap for a 30-day supply of insulin
Minnesota	As of 1/1/25, $25 monthly cap for diabetes medications and $50 monthly cap for supplies State-required manufacturer assistance program has a $35 cap for emergency 30-day supply, $50 cap for a 90-day supply of insulin
Montana	$35 for 30-day supply of insulin
Nebraska	$35 cap for 30-day supply of insulin
New Hampshire	$30 cap for a 30-day supply of insulin
New Jersey	$35 cap for 30-day supply of insulin, effective 1/1/25
New Mexico	$25 cap for a 30-day supply of insulin
New York	$100 cap for a 30-day supply of insulin; effective 1/1/25 the cost will be $0
Oklahoma	$30 cap for a 30-day supply of insulin, $90 cap for 90-day supply of insulin
Oregon	$85 cap for a 30-day supply of insulin Effective 1/1/25 it will be $35 cap for a 30-day supply, $105 cap for a 90-day supply
Rhode Island	$40 cap for a 30-day supply of insulin
Texas	$25 cap for each insulin prescription per month
Utah	$30 cap for a 30-day supply of insulin
Vermont	$100 cap for a 30-day supply of insulin
Virginia	$50 cap for a 30-day supply of insulin
Washington	$35 cap for a 30-day supply of insulin
Washington, D.C.	$30 cap for a 30-day supply of insulin and $100 cap for 30-day supply of covered diabetes devices
West Virginia	$35 collective cap for 35-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies

VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of Draft Bill 25.0118.01000. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by Sanford Health Plan for NDPERS, carrier rate filings and other public sources including census data and National Association of Insurance Commissioners financial data. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report. We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix B: NovaRest Methodology and Assumptions

Data

- Commercial market premiums, claims, and membership were from the 2023 National Association of Insurance Commissioners Supplemental Health Care Exhibit.
- The age and gender proportions of North Dakota's population are based on the 2023 Vintage population estimates.[11]
- Information on North Dakota households is based on 2021 American Community Survey (ACS) Data.[12]

Assumptions

- Individual, small group and NDPERS markets already provide coverage consistent with Draft Bill 25.0118.01000.[13]
- There is little information on the distribution, type(s) of insulin used, or the dosage(s), since these are prescribed individually. For insulin, we assumed 62 units per day.[14] The cost per unit is based on GoodRx prices.[15]
- Cost of insulin and supplies were based on a variety of sources.[16,17,18]
- Cost sharing varies by large group plan. Based on a review of policy forms, we used a range of 75% to 85% insurer cost sharing.
- We assume 57,805 people in North Dakota have diabetes.[19]
- We assume 5-10% of people with diabetes are Type 1,[20] and 100% of people with Type 1 diabetes use insulin.[21]
- We assume 90-95% of people with diabetes are Type 2,[22] and 25% of people with Type 2 diabetes use insulin.[23]
- Pregnancies in North Dakota were estimated using ACS data[24] to determine the number of live births and assuming 62% of pregnancies end in live births.[25]
- We assume 2% to 10% of pregnancies result in gestational diabetes,[26] and 20% of these cases will use insulin.[27]
    - Gestational diabetes can also occur in pregnancies that do not end in live birth, however, we tested the sensitivity of this assumption and found the impact is de minimis. No adjustment was made for pregnancies not ending in live birth.
- Number of people rationing insulin 34% for uninsured/underinsured, 14% for adequately insured.[28]
    - Assume adequately insured is 60% cost sharing, used linear interpolation to determine assumption at 75% and 85% cost sharing.
    - Assume rationing means one to two days of currently not using prescribed insulin.

Sources:

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For Release

FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices

Caremark, Express Scripts, Optum, and their affiliates created a broken rebate system that inflated insulin drug prices, boosting PBM profits at the expense of vulnerable patients, the FTC alleges

September 20, 2024

Tags: Competition | Bureau of Competition | Nonmerger | Pharmacy Benefits Managers (PBM) | Health Care | Prescription Drugs

Today, the Federal Trade Commission brought action against the three largest prescription drug benefit managers (PBMs)—Caremark Rx, Express Scripts (ESI), and OptumRx—and their affiliated group purchasing organizations (GPOs) for engaging in anticompetitive and unfair rebating practices that have artificially inflated the list price of insulin drugs, impaired patients' access to lower list price products, and shifted the cost of high insulin list prices to vulnerable patients.

The FTC's administrative complaint alleges that CVS Health's Caremark, Cigna's ESI, and United Health Group's Optum, and their respective GPOs—Zinc Health Services, Ascent Health Services, and Emisar Pharma Services—have abused their economic power by rigging pharmaceutical supply chain competition in their favor, forcing patients to pay more for life-saving medication. According to the complaint, these PBMs, known as the Big Three, together administer

about 80% of all prescriptions in the United States.

The FTC alleges that the three PBMs created a perverse drug rebate system that prioritizes high rebates from drug manufacturers, leading to artificially inflated insulin list prices. The complaint charges that even when lower list price insulins became available that could have been more affordable for vulnerable patients, the PBMs systemically excluded them in favor of high list price, highly rebated insulin products. These strategies have allowed the PBMs and GPOs to line their pockets while certain patients are forced to pay higher out-of-pocket costs for insulin medication, the FTC's complaint alleges.

"Millions of Americans with diabetes need insulin to survive, yet for many of these vulnerable patients, their insulin drug costs have skyrocketed over the past decade thanks in part to powerful PBMs and their greed," said Rahul Rao, Deputy Director of the FTC's Bureau of Competition. "Caremark, ESI, and Optum—as medication gatekeepers—have extracted millions of dollars off the backs of patients who need life-saving medications. The FTC's administrative action seeks to put an end to the Big Three PBMs' exploitative conduct and marks an important step in fixing a broken system—a fix that could ripple beyond the insulin market and restore healthy competition to drive down drug prices for consumers."

Insulin medications used to be affordable. In 1999, the average list price of Humalog—a brand-name insulin medication manufactured by Eli Lilly—was only $21. However, the complaint alleges that the PBMs' chase-the-rebate strategy has led to skyrocketing list prices of insulin medications. By 2017, the list price of Humalog soared to more than $274—a staggering increase of over 1,200%. While PBM respondents collected billions in rebates and associated fees according to the complaint, by 2019 one out of every four insulin patients was unable to afford their medication.

The FTC's Bureau of Competition makes clear in a statement issued

today that the PBMs are not the only potentially culpable actors – the Bureau also remains deeply troubled by the role drug manufacturers like Eli Lilly, Novo Nordisk, and Sanofi play in driving up list prices of life-saving medications like insulin. Indeed, all drug manufacturers should be on notice that their participation in the type of conduct challenged here raises serious concerns, and that the Bureau of Competition may recommend suing drug manufacturers in any future enforcement actions.

The PBMs Benefit from Higher List Prices

The PBMs' financial incentives are tied to a drug's list price, also known as the wholesale acquisition cost. PBMs generate a portion of their revenue through drug rebates and fees, which are based on a percentage of a drug's list price. PBMs, through their GPOs, negotiate rebate and fee rates with drug manufacturers. As the complaint alleges, insulin products with higher list prices generate higher rebates and fees for the PBMs and GPOs, even though the PBMs and GPOs do not provide drug manufacturers with any additional services in exchange.

The complaint further alleges that PBMs keep hundreds of millions of dollars in rebates and fees each year and use rebates to attract clients. PBMs' clients are payers, such as employers, labor unions, and health insurers. Payers contract with PBMs for pharmacy benefit management services, including creating and administering drug formularies—lists of prescription drugs covered by a health plan.

The PBMs' Chase-the-Rebate Strategy Reduced Patients' Access to Lower List Priced Insulins, the FTC Alleges

Insulin list prices started rising in 2012 with the PBMs' creation of exclusionary drug formularies, the FTC's complaint alleges. Before

2012, formularies used to be more open, covering many drugs. According to the complaint, that changed when the PBMs, leveraging their size, began threatening to exclude certain drugs from the formulary to extract higher rebates from drug manufacturers in exchange for favorable formulary placement. Securing formulary coverage was critical for drug manufacturers to access patients with commercial health insurance, the FTC alleges.

Competition usually leads to lower prices as sellers try to win business. But in the upside-down insulin market, manufacturers—driven by the Big Three PBMs' hunger for rebates—increased list prices to provide the larger rebates and fees necessary to compete for formulary access, the FTC's complaint alleges. According to the complaint, one Novo Nordisk Vice President said that PBMs were "addicted to rebates." While PBMs' rebate pressures continued, insulin list prices soared. For example, the list price of Novolog U-100, an insulin medication manufactured by Novo Nordisk, more than doubled from $122.59 in 2012 to $289.36 in 2018.

The complaint alleges that even when low list price insulins became available, the PBMs systematically excluded them in favor of identical high list price, highly rebated versions. As described in the complaint, one PBM Vice President acknowledged that this strategy allowed the Big Three to continue to "drink down the tasty ... rebates" on high list price, highly rebated insulins.

The PBMs Caused the Burden of High Insulin List Prices to Shift to Vulnerable Patients, the FTC Alleges

According to the complaint, as insulin list prices escalated, the PBMs collected rebates that, in principle, should have significantly reduced the cost of insulin drugs for patients at the pharmacy counter. Certain vulnerable patients, such as patients with deductibles and

coinsurance, often must pay the unrebated higher list price and do not benefit from rebates at the point of sale. Indeed, they may pay more out-of-pocket for their insulin drugs than the entire net cost of the drug to the commercial payer. Caremark, ESI, and Optum knew that escalating insulin list prices and exclusion of low list price insulins from formularies hurt vulnerable patients—yet continued to pursue and incentivize strategies that shifted the burden of high list prices to patients, the FTC's complaint alleges.

Caremark, ESI, and Optum and their respective GPOs engaged in unfair methods of competition and unfair acts or practices under Section 5 of the FTC Act by incentivizing manufacturers to inflate insulin list prices, restricting patients' access to more affordable insulins on drug formularies, and shifting the cost of high list price insulins to vulnerable patient populations, the FTC's complaint alleges.

The Commission vote to file an administrative complaint was 3-0-2, with Commissioners Melissa Holyoak and Andrew N. Ferguson recused.

NOTE: The Commission issues an administrative complaint when it has "reason to believe" that the law has been or is being violated, and it appears to the Commission that a proceeding is in the public interest. The issuance of the administrative complaint marks the beginning of a proceeding in which the allegations will be tried in a formal hearing before an administrative law judge.

The Health Care Division of the FTC's Bureau of Competition was responsible for this matter.

The Federal Trade Commission works to promote competition, and protect and educate consumers. The FTC will never demand money, make threats, tell you to transfer money, or promise you a prize. You can learn more about how competition benefits consumers or file

an antitrust complaint. For the latest news and resources, follow the FTC on social media, subscribe to press releases and read our blog.

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