2025 HOUSE GOVERNMENT AND VETERANS AFFAIRS

HB 1114

2025 HOUSE STANDING COMMITTEE MINUTES

GOVERNMENT VETERANS AFFAIRS COMMITTEE
PIONEER ROOM, STATE CAPITOL

HB 1114
1/9/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies**.**

10:32 a.m. Chairman Schauer called the meeting to order.

Members present: Chairman Schauer, Vice Chairman Satrom, Representatives Bahl, Brown, Christy, Grindberg, Karls, McLeod, Rohr, Schneider, Steiner, VanWinkle, Vetter, Wolff

Discussion Topics:

- Employee benefits
- Family concerns
- Employers' concerns

10:33 a.m. Rebecca Fricke, NDPERS testified in favor of and submitted testimony #28088.

10:49 a.m. Crystal Bartoosca North Dakota Insurance Board testified in favor of.

10:55 a.m. Danelle Johnson testified in favor of and submitted testimony #28103.

11:07 a.m. Angela Kritsberger testified in favor of and submitted testimony #28300.

11:15 a.m. Nina Kritsberger testified in favor of and submitted testimony #28295.

11:20 a.m. Andrea Pfenig, GNDC testified in opposition to and submitted testimony #28262.

11:27 a.m. Rebecca Fricke, NDPERS testified and answered questions.

11:33 a.m. Crystal Bartoosca testified and answered questions.

11:35 a.m. Dylan Wheeler, MPA Sanford health plan testified in opposition to and submitted testimony #28255.

11:46 a.m. Megan Houn, Blue Cross Blue Shield, testified in opposition to and submitted testimony #28319.

11:56 a.m. Danelle Johnson testified in favor of and submitted testimony #28329.

11:57 a.m. Chairman Schauer closed hearing.

Additional written testimony:
Stacy Poffenberger, #28136
Sheryl Pfliger, #28140
Arlyce Schulte, #28149
Stuart Libby, #28166
Gwen Sobolik, #28171
Trygg Sobolik, #28172
Hudson Sobolik, #28174
Matt Prokop, #28199
Judith Libby, #28203
Jessica Lovell-Opdahl, #28203
Avis White, #28211
Janelle Moos, #28223, 28224
Stacy Wilz, #28232
Nicole Davis, #28239
Jean Kautzman, #28242
Danelle Doering, #28244
Erik Opdahl, #28247
Lacie Maresh, #28248
Erin Philips, #28250
Della Philips, #28256
Amber Stockeland, #28274
L. Gunderson, #28275
Leif Snyder, #28276
Justin Philips, #28278
Kathryn Moch, #28285
Brenda Weise, #28293
Shantelle Smith, #28294
Marlee Siebold, #28296

Jackson Toman, Committee Clerk

TESTIMONY OF REBECCA FRICKE

House Bill 1114 – Insulin & Diabetic Supplies

Good Morning, my name is Rebecca Fricke. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today to provide information on how a pilot program relating to House Bill 1114 impacted the NDPERS active group health insurance plans and to provide testimony in support of the coverage being continued within the NDPERS active group health insurance plans.

House Bill 1114 is a bill required to be brought forward by the NDPERS Board due to the passing of SB 2140 during the 68th Legislative Assembly. SB 2140 was an insurance mandate that required a pilot program under the NDPERS active group health insurance plans during the 2023-2025 biennium. SB 2140 set a $25/month cap on the amount a member could be charged for insulin or diabetic supplies.

Specifically Section 4 of SB 2140 states:

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

In addition to submitting the bill, the Board appended the necessary report and recommendation as required above to the draft bill considered by the Employee Benefits Programs Committee (EBPC) during the interim.

Some observations of the NDPERS active health insurance plan experience during the pilot program:

- For the 2023-2025 biennium, the cost in premium to provide the enhanced coverage of the cap was 0.14% of premium. There was not funding provided for this cost during the pilot program and therefore, reserves are being used to cover this expense.
- Sanford Health Plan found that the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap so there was minimal impact to member cost share after the cap related to diabetic supplies was implemented.

- There are a number of states that have some form of cap on insulin and diabetic supplies. Specific details regarding these states is provided in Attachment 9 and Attachment 12 of the Report to the EBPC.
- Sanford Health Plan found that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, the health plan's total reimbursements were lower after the cap. This is due to a change that two pharmaceutical companies (Eli Lilly and Novo Nordisk) made effective January 1, 2024 to reduce their prices on insulin (Attachment 10 of Report). Those reduced prices resulted in less reimbursement by the plan (Attachment 4 of Report) for the final 6 months that data was provided for.
- Estimated member savings per month was $80.15 per member due to the cap based upon comparison with prior year claims data (Attachment 3 of Report).
- The insulin rate cap eliminated coinsurance on insulin claims between 7/1/2023-6/30/2024. Therefore none of the claims for insulin contributed any coinsurance to the $1,200 coinsurance maximum on the NDPERS grandfathered plan. However coinsurance continued to apply to other pharmacy claims so the $1,200 coinsurance expense may have been paid by the member on other pharmacy claims during the calendar year.
- Utilization for insulin and diabetic supplies did not change significantly after the inclusion of the insulin rate cap.
- Note that the information provided by Sanford Health Plan was as of the date the data was generated and represent claims from July 1, 2023 through June 30, 2024. At the time the report was generated, It is anticipated that there were still claims pending that had not been submitted for processing which could result in changes.

Deloitte Consulting, the insurance consultant for NDPERS, calculated the cost of continuing the coverage under the NDPERS active plans for the 2025-2027 biennium to be .12% of premium, or approximately $1,000,000.00 (Attachment 11 of Report). Of this amount, $833,956 is attributed to state agencies ($2.07 per contract), $159,922 is attributed to the participating political subdivisions and $6,748 is attributed to the Non-Medicare retirees and COBRA participants.

The NDPERS Board recommends that the coverage, a $25/month cap on insulin and diabetic supplies, provided through SB 2140 during the 2023-2025 biennium be continued as coverage within the NDPERS active health insurance plans.

The NDPERS Board does not offer a recommendation on whether the coverage should be expanded to the commercial market.

The Employee Benefits Programs Committee gave this bill a favorable recommendation during the interim.

This concludes my testimony. I would be happy to answer any questions you may have.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: Employee Benefits Programs Committee

FROM: NDPERS Board

DATE: September 12, 2024

SUBJECT: Insulin/Diabetic Supplies Report and Recommendation

SB 2140 was passed during the 68th Legislative Session and requires a NDPERS pilot program for the 2023-2025 biennium. SB 2140 specifically required a monthly cap of $25/month for insulin and diabetic supplies within the NDPERS health insurance active plans and became effective July 1, 2023. The provisions expire at the end of the biennium.

Section 4 of SB 2140 is shown below and requires that the NDPERS Board submit a bill in the upcoming Session that would roll this coverage out to the commercial market in North Dakota. Draft bill # 118 (Attachment 1) is the bill that the Board approved for submission to the Employee Benefits Programs Committee.

In addition to the bill submission, Section 4 of SB 2140 requires the Board to "append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued."

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

In order for the NDPERS Board to meet the obligation of appending a report to the bill, NDPERS requested that Sanford Health Plan (SHP) provide data for the year prior to and year following the July 1, 2023 SB 2140 effective date for comparison purposes.

NDPERS also requested our group insurance consultant, Deloitte, to prepare a cost and technical analysis of Draft Bill # 118 (Attachment 11). In addition, they were asked to conduct a market analysis of insulin and/or diabetic supply caps (Attachment 12).

Some observations of the NDPERS active health insurance plan experience during the pilot program:

- For the 2023-2025 biennium, the cost in premium to provide the enhanced coverage of the cap was .14% of premium. There was not funding provided for this cost during the pilot program and therefore, reserves are being used to cover this expense.
- Sanford Health Plan found that the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap so there was minimal impact to member cost share after the cap was implemented related to diabetic supplies.
- There are a number of states that have some form of cap on insulin and diabetic supplies. Specific details regarding these states is provided in Attachment 9 and Attachment 12.
- Sanford Health Plan found that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, the health plan's total reimbursements were lower after the cap. This is due to a change that two pharmaceutical companies (Eli Lilly and Novo Nordisk) made effective January 1, 2024 to reduce their prices on insulin (Attachment 10). Those reduced prices resulted in less reimbursement by the plan (Attachment 4) for the final 6 months that data was provided for.
- Estimated member savings per month was $80.15 per member due to the cap based upon comparison with prior year claims data (Attachment 3).
- The insulin rate cap eliminated coinsurance on insulin claims between 7/1/2023-6/30/2024. Therefore none of claims for insulin contributed any coinsurance to the $1,200 coinsurance maximum on the grandfathered plan. However coinsurance continued to apply to other pharmacy claims so the $1,200 coinsurance expense may have been paid by the member on other pharmacy claims during the calendar year.
- Utilization for insulin and diabetic supplies did not change significantly after the inclusion of the insulin rate cap.
- Note that the information provided by Sanford Health Plan are as of the date the data was generated. It is anticipated that there are still claims pending that have not been submitted to SHP for processing that may result in changes.

RECOMMENDATION OF NDPERS BOARD:

Given the experience to the NDPERS active health insurance plan during the pilot program, the NDPERS Board recommends that the insulin and diabetic supplies cap of $25/month be continued for the NDPERS active health insurance plans beyond the 2023-2025 biennium.

Included for the Committee's review are the following attachments:

	Provided By	Description
Attachment 1	NDPERS	Draft Bill # 118
Attachment 2	Sanford Health Plan	Insulin Dashboard/Overview
Attachment 3	Sanford Health Plan	Insulin Member Savings Per Member/Per Month
Attachment 4	Sanford Health Plan	Average Paid for Insulin by Member and Plan
Attachment 5	Sanford Health Plan	Insulin Utilization & Adherence
Attachment 6	Sanford Health Plan	NDPERS Type 1 and Type 2 Diabetes Membership Data
Attachment 7	Sanford Health Plan	Insulin Details
Attachment 8	Sanford Health Plan	Diabetic Supplies Details
Attachment 9	Sanford Health Plan	Information regarding what other states have experienced that have implemented caps
Attachment 10	Sanford Health Plan	Details regarding changes that have occurred in the amount that the drug manufacturers are charging for insulin
Attachment 11	Deloitte	Consultant cost and technical analysis of Draft Bill # 118
Attachment 12	Deloitte	Market analysis related to SB 2140
Attachment 13	Sanford Health Plan	Per Member Per Month medical expense for Type 1 diabetics 12 months before and 12 months after the Insulin cap

25.0118.01000

Sixty-ninth
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

(North Dakota Public Employees Retirement System)

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:
   a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:
      (1) Rapid-acting insulin;
      (2) Short-acting insulin;
      (3) Intermediate-acting insulin;
      (4) Long-acting insulin;
      (5) Premixed insulin product;
      (6) Premixed insulin/GLP-1 RA product; and
      (7) Concentrated human regular insulin.
   b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical

emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

(1) Blood glucose meters;

(2) Blood glucose test strips;

(3) Lancing devices and lancets;

(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;

(5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and

(7) Insulin syringes.

c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.

3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:

a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies

for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.

5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.

6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. ~~(Expired effective July 31, 2025)~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2.~~ The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration ~~which complies with this section~~as provided under section 1 of this Act.

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

~~a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.~~

~~b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.~~

~~4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.~~

~~5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.~~

~~6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.~~

~~7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~

~~8. This section does not apply to the Medicare part D prescription drug coverage plan.~~

Attachment 2

Rx Type	Members with Pharmacy Claims for Insulin Before Insulin cap	Members with Pharmacy Claims for Insulin After Insulin cap	Change in Members	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount**	Cost Share Amount (Copay + Coins) Before Insulin cap	Cost Share Amount After Insulin cap	Change in Cost Share Amounts
1-INSULIN	824	831	7	**5,480**	**5,440**	-40	$3,880,454	$3,110,731	($769,723)	$1,076,143	$250,567	**($825,576)**

Insulin Days of Supply (DOS) Group	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	% Change in claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount	Cost Share Amount Before Insulin cap	Average Member Cost Share Before Insulin cap	Cost Share Amount After Insulin cap	Average Member Cost Share after Insulin cap*	Change in Cost Share Amount
01-30 DOS	2,009	1,950	-59	-3%	$1,184,018	$941,455	($242,563)	$321,298	$160	$47,573	$24	($273,725)
31-60 DOS	2,119	2,071	-48	-2%	$1,512,316	$1,151,299	($361,017)	$404,759	$191	$99,934	$48	($304,825)
61+ DOS	1,352	1,419	67	5%	$1,184,119	$1,017,976	($166,143)	$350,087	$259	$103,110	$73	($246,977)
Total	**5,480**	**5,440**	**-40**	**-1%**	**$3,880,454**	**$3,110,731**	**($769,723)**	**$1,076,143**	**$196**	**$250,617**	**$46**	**($825,526)**

Before time period: July 1, 2022-June 30, 2023
After time period: July 1, 2023-June 30, 2024

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.
**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 3

Member Impact on Insulin Claims

	Before Insulin Cap (7/1/2022-6/30/2023)	After Insulin Cap (7/1/2023-6/30/2024)	Change	Percent Change
Total Member Months	10,153	9,694	(459)	-4.5%
Member Copay Amounts	$ 644,434.40	$ 250,566.93	$ (393,867.47)	-61.1%
Member Coinsurance Amounts	$ 431,709.02	$ -	$ (431,709.02)	-100.0%
Member Copay Per Member Per Month (PMPM)	$63.47	$25.85	($37.62)	-59.3%
Member Coinsurance Per Member Per Month (PMPM)	$42.52	$0.00	($42.52)	-100.0%
Total Member Cost Share PMPM	**$105.99**	**$25.85**	**($80.15)**	**-75.6%**

Note: Coinsurance may have applied to other pharmacy claims.

Attachment 4

DATE FILLED MONTH		2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	Total
Rx Type	Days of Supply (DOS) Group	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	**Average of Member Cost Share for 12 mos**
1-INSULIN	**Total**	**$152**	**$134**	**$115**	**$118**	**$106**	**$100**	**$404**	**$373**	**$325**	**$268**	**$197**	**$162**	**$45**	**$46**	**$48**	**$47**	**$48**	**$48**	**$46**	**$48**	**$48**	**$47**	**$47**	**$36**	**$121**
	01-30 DOS	$114	$104	$102	$83	$97	$94	$350	$312	$259	$203	$154	$110	$24	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$19	**$93**
	31-60 DOS	$143	$118	$109	$106	$95	$107	$436	$360	$304	$251	$187	$158	$48	$49	$49	$50	$49	$49	$50	$50	$50	$50	$50	$35	**$120**
	61+ DOS	$240	$204	$139	$191	$136	$98	$430	$531	$446	$391	$291	$238	$72	$74	$75	$73	$75	$74	$74	$74	$74	$74	$74	$58	**$164**
	Member Cost Share=Copay + Coinsurance																									

Rx Type	Days of Supply (DOS) Group	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	**Average Paid by SHP for 12 mos**
1-INSULIN	**Total**	**$747**	**$724**	**$802**	**$766**	**$743**	**$854**	**$531**	**$583**	**$612**	**$670**	**$686**	**$698**	**$793**	**$760**	**$792**	**$805**	**$789**	**$851**	**$336**	**$341**	**$340**	**$321**	**$317**	**$372**	**$640**
	01-30 DOS	$585	$622	$639	$627	$625	$667	$463	$477	$566	$571	$597	$595	$665	$653	$635	$662	$688	$679	$301	$274	$301	$324	$273	$329	**$537**
	31-60 DOS	$764	$735	$739	$797	$774	$798	$579	$643	$587	$696	$680	$727	$761	$779	$770	$797	$753	$757	$308	$379	$281	$306	$325	$366	**$636**
	61+ DOS	$1,027	$864	$1,096	$931	$860	$1,144	$552	$695	$712	$776	$850	$797	$1,030	$913	$1,026	$1,007	$982	$1,174	$435	$373	$463	$339	$368	$433	**$795**

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 5

Rx Type	Days of Supply (DOS) Group	Total claims before Insulin cap	Total claims after to Insulin cap	Change in insulin claim count before & after Insulin cap
1-INSULIN	**Total**	**5,480**	**5,440**	**-1%**
	01-30 DOS	2,009	1,950	-3%
	31-60 DOS	2,119	2,071	-2%
	61+ DOS	1,352	1,419	5%

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

PDC Adherence	Before Insulin Cap	After Insulin Cap	Difference
<80%	30.70%	28.10%	-2.6%
>=80%	69.30%	71.90%	2.6%

*The proportion of days covered (PDC) is used to estimate medication adherence.

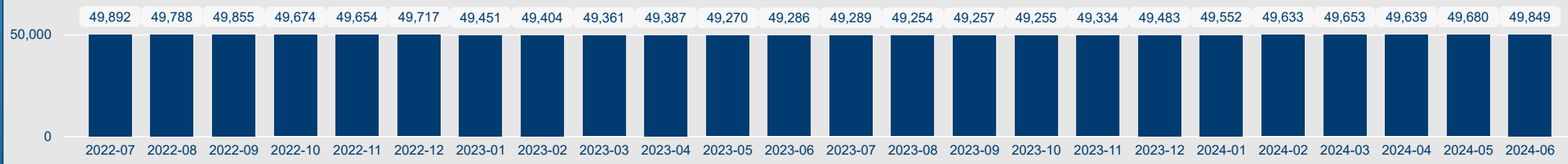
*PDC **>=80%** is considered adhering to their medication while **<80%** is considered not adhering.

*PDC calculation= (number of days covered) / (total days in time period) x 100

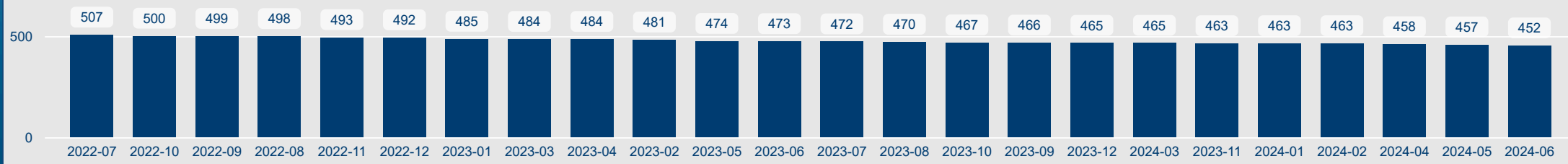
NDPERS COI Insulin & Diabetes Supplies Impact Analysis

Attachment 6

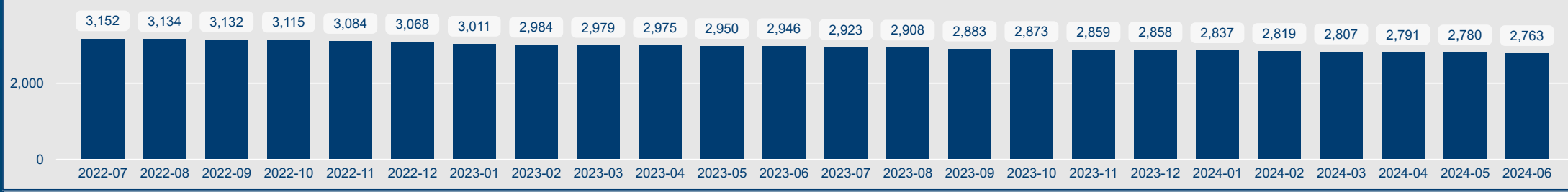
Total Members Months by Year Month



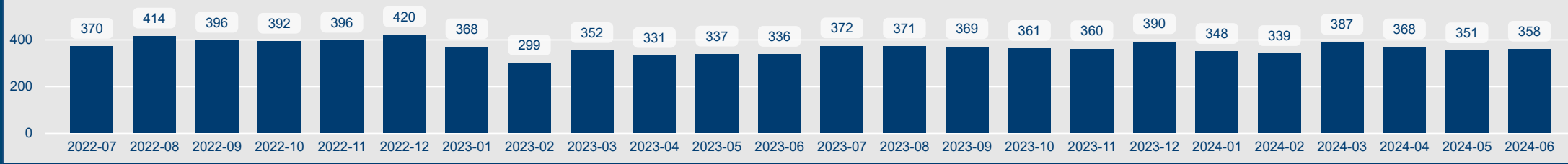
Member Months for Members with Type 1 Diabetes Diagnosis



Member Months for Members with Type 2 Diabetes Diagnosis



Distinct Count of Patient ID's with Insulin Rx Claims by Month Filled



Last Data Refresh: 08-15-2024 02:40 PM CT

Attachment 7

Rx Type	Days of Supply Group	DrugDESC	Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Insulin Cap	Coinsurance Amount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member cost Share after Insulin Cap	Member Savings from Insulin Cap
1-INSULIN	**Total**		**1,964**	**2,119**	**155**	**5,480**	**5,440**	**-40**	**$ 3,880,454**	**$ 3,110,731**	**$ (769,723)**	**$ 644,434**	**$ 250,567**	**$ (393,867)**	**$ 431,709**	**0**	**$ (431,709)**	**$ 1,076,143**	**$196**	**$ 250,567**	**$46**	**$ (825,576)**
	01-30 DOS	**Total**	**541**	**562**	**21**	**2,009**	**1,950**	**-59**	**$1,184,018**	**$941,455**	**($242,563)**	**$186,043**	**$47,523**	**($138,519)**	**$135,255**	**$0**	**($135,255)**	$321,298	**$160**	$47,523	**$24**	**($273,775)**
		BASAGLAR INJ	10	8	-2	39	36	-3	$5,546	$10,553	$5,007	$6,716	$900	($5,816)	$5,546	$0	($5,546)	$12,263	**$314**	$900	**$25**	($11,363)
		FIASP INJ	9	5	-4	27	27	0	$15,318	$22,286	$6,968	$2,816	$675	($2,141)	$2,141	$0	($2,141)	$4,957	**$184**	$675	**$25**	($4,282)
		FIASP FLEX INJ TOUCH	18	18	0	69	59	-10	$39,827	$44,458	$4,631	$7,243	$1,475	($5,768)	$4,682	$0	($4,682)	$11,925	**$173**	$1,475	**$25**	($10,450)
		FIASP PENFIL INJ U	3	2	-1	7	7	0	$3,458	$4,093	$635	$815	$175	($640)	$640	$0	($640)	$1,454	**$208**	$175	**$25**	($1,279)
		HUMALOG INJ		1	1	0	4	4	$0	$40	$40	$0	$100	$100	$0	$0	$0	$0	**#DIV/0!**	$100	**$25**	$100
		HUMALOG KWIK INJ	7	7	0	26	22	-4	$20,946	$41,683	$20,737	$21,726	$550	($21,176)	$20,946	$0	($20,946)	$42,672	**$1,641**	$550	**$25**	($42,122)
		HUMULIN R INJ U	3	3	0	34	20	-14	$58,502	$41,713	($16,788)	$3,398	$500	($2,898)	$2,548	$0	($2,548)	$5,947	**$175**	$500	**$25**	($5,447)
		INS DEGL FLX INJ	7	17	10	11	62	51	$3,293	$16,459	$13,166	$918	$1,525	$607	$643	$0	($643)	$1,562	**$142**	$1,525	**$25**	($37)
		INSULIN ASPA INJ	1	1	0	14	9	-5	$177	$181	$4	$558	$225	($333)	$177	$0	($177)	$735	**$53**	$225	**$25**	($510)
		INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	$0	$0	$0	$20	$0	($20)	$0	$0	$0	$20	**$5**	$0	**#DIV/0!**	($20)
		LANTUS INJ	15	7	-8	32	9	-23	$17,758	$4,939	($12,819)	$3,281	$225	($3,056)	$2,481	$0	($2,481)	$5,763	**$180**	$225	**$25**	($5,538)
		LANTUS SOLOS INJ	75	88	13	305	278	-27	$118,902	$64,772	($54,130)	$18,698	$6,528	($12,170)	$11,073	$0	($11,073)	$29,771	**$98**	$6,528	**$23**	($23,242)
		LEVEMIR INJ		2	2	0	5	5	$0	$814	$814	$0	$125	$125	$0	$0	$0	$0	**#DIV/0!**	$125	**$25**	$125
		LEVEMIR INJ FLEXPEN	20	34	14	49	128	79	$25,106	$51,066	$25,959	$3,638	$3,200	($438)	$2,413	$0	($2,413)	$6,052	**$124**	$3,200	**$25**	($2,852)
		LEVEMIR INJ FLEXTOUC	28		-28	115	0	-115	$51,216	$0	($51,216)	$7,490	$0	($7,490)	$4,615	$0	($4,615)	$12,106	**$105**	$0	**#DIV/0!**	($12,106)
		NOVOLIN INJ	1		-1	8	0	-8	$1,740	$0	($1,740)	$449	$0	($449)	$249	$0	($249)	$697	**$87**	$0	**#DIV/0!**	($697)
		NOVOLIN N INJ	1	1	0	2	1	-1	$549	$231	($318)	$233	$25	($208)	$183	$0	($183)	$416	**$208**	$25	**$25**	($391)
		NOVOLIN R INJ U		1	1	0	7	7	$0	$2,429	$2,429	$0	$150	$150	$0	$0	$0	$0	**#DIV/0!**	$150	**$21**	$150
		NOVOLOG INJ	99	92	-7	367	396	29	$250,980	$200,688	($50,292)	$38,789	$9,795	($28,994)	$29,769	$0	($29,769)	$68,558	**$187**	$9,795	**$25**	($58,763)
		NOVOLOG INJ FLEX REL		1	1	0	1	1	$0	$59	$59	$0	$25	$25	$0	$0	$0	$0	**#DIV/0!**	$25	**$25**	$25
		NOVOLOG INJ FLEXPEN	148	154	6	507	510	3	$336,948	$226,716	($110,233)	$42,781	$12,400	($30,381)	$30,181	$0	($30,181)	$72,962	**$144**	$12,400	**$24**	($60,562)
		NOVOLOG INJ PENFILL	8	10	2	46	47	1	$17,126	$15,460	($1,666)	$3,846	$1,175	($2,671)	$2,696	$0	($2,696)	$6,542	**$142**	$1,175	**$25**	($5,367)
		NOVOLOG MIX INJ FLEXPEN	1	5	4	3	8	5	$1,507	$2,468	$960	$82	$200	$118	$7	$0	($7)	$89	**$30**	$200	**$25**	$111
		SEMGLEE INJ	1	1	0	1	1	0	$3	$25	$22	$33	$25	($8)	$3	$0	($3)	$35	**$35**	$25	**$25**	($10)
		SOLIQUA INJ	5	3	-2	28	16	-12	$20,590	$13,112	($7,478)	$2,102	$400	($1,702)	$1,402	$0	($1,402)	$3,504	**$125**	$400	**$25**	($3,104)
		TOUJEO MAX INJ	10	19	9	41	35	-6	$30,760	$26,925	($3,835)	$2,976	$825	($2,151)	$1,951	$0	($1,951)	$4,928	**$120**	$825	**$24**	($4,103)
		TOUJEO SOLO INJ	28	41	13	117	101	-16	$34,894	$34,795	($99)	$6,277	$2,350	($3,927)	$3,627	$0	($3,627)	$9,903	**$85**	$2,350	**$23**	($7,553)
		TRESIBA FLEX INJ	39	40	1	144	151	7	$114,978	$102,587	($12,390)	$9,024	$3,700	($5,324)	$5,474	$0	($5,474)	$14,499	**$101**	$3,700	**$25**	($10,799)
		XULTOPHY INJ	3	1	-2	13	10	-3	$13,893	$12,902	($991)	$2,133	$250	($1,883)	$1,808	$0	($1,808)	$3,941	**$303**	$250	**$25**	($3,691)
	31-60 DOS	**Total**	**679**	**739**	**60**	**2,119**	**2,071**	**-48**	**$1,512,316**	**$1,151,299**	**($361,017)**	**$248,465**	**$99,934**	**($148,531)**	**$156,294**	**$0**	**($156,294)**	$404,759	**$191**	$99,934	**$48**	**($304,825)**
		BASAGLAR INJ	15	14	-1	40	43	3	$5,476	$16,806	$11,330	$7,847	$2,150	($5,697)	$5,477	$0	($5,477)	$13,323	**$333**	$2,150	**$50**	($11,173)
		FIASP INJ	5	8	3	14	28	14	$10,165	$20,837	$10,672	$1,750	$1,350	($400)	$1,100	$0	($1,100)	$2,851	**$204**	$1,350	**$48**	($1,501)
		FIASP FLEX INJ TOUCH	7	18	11	20	53	33	$10,292	$35,885	$25,593	$1,718	$2,650	$932	$868	$0	($868)	$2,586	**$129**	$2,650	**$50**	$64
		HUMALOG KWIK INJ	3	3	0	12	11	-1	$14,426	$25,271	$10,845	$14,996	$550	($14,446)	$14,426	$0	($14,426)	$29,422	**$2,452**	$550	**$50**	($28,872)
		HUMULIN R INJ U	2		-2	3	0	-3	$5,480	$0	($5,480)	$497	$0	($497)	$372	$0	($372)	$869	**$290**	$0	**#DIV/0!**	($869)
		INS DEGL FLX INJ	7	21	14	15	47	32	$2,246	$8,229	$5,983	$1,046	$2,150	$1,104	$296	$0	($296)	$1,341	**$89**	$2,150	**$46**	$809
		INSULIN ASPA INJ	1		-1	2	0	-2	$61	$0	($61)	$151	$0	($151)	$61	$0	($61)	$212	**$106**	$0	**#DIV/0!**	($212)
		LANTUS INJ	10	11	1	42	36	-6	$29,238	$19,564	($9,673)	$4,560	$1,700	($2,860)	$2,610	$0	($2,610)	$7,171	**$171**	$1,700	**$47**	($5,471)
		LANTUS SOLOS INJ	122	144	22	403	420	17	$175,193	$112,512	($62,681)	$40,430	$20,080	($20,351)	$22,015	$0	($22,015)	$62,446	**$155**	$20,080	**$48**	($42,366)
		LEVEMIR INJ	2	1	-1	3	1	-2	$581	$231	($349)	$294	$50	($244)	$194	$0	($194)	$487	**$162**	$50	**$50**	($437)
		LEVEMIR INJ FLEXPEN	22	32	10	50	112	62	$23,960	$47,669	$23,709	$5,630	$5,475	($155)	$3,445	$0	($3,445)	$9,074	**$181**	$5,475	**$49**	($3,600)
		LEVEMIR INJ FLEXTOUC	27		-27	70	0	-70	$40,557	$0	($40,557)	$7,250	$0	($7,250)	$4,125	$0	($4,125)	$11,375	**$162**	$0	**#DIV/0!**	($11,375)
		NOVOLIN INJ	1	1	0	1	5	4	$371	$1,415	$1,045	$174	$250	$76	$124	$0	($124)	$297	**$297**	$250	**$50**	($47)
		NOVOLIN N INJ	3		-3	3	0	-3	$877	$0	($877)	$417	$0	($417)	$292	$0	($292)	$710	**$237**	$0	**#DIV/0!**	($710)
		NOVOLIN N INJ U	1	1	0	1	1	0	$63	$4	($59)	$71	$50	($21)	$21	$0	($21)	$92	**$92**	$50	**$50**	($42)
		NOVOLIN R INJ U	2	1	-1	7	8	1	$472	$227	($245)	$448	$370	($78)	$98	$0	($98)	$546	**$78**	$370	**$46**	($177)
		NOVOLOG INJ	105	91	-14	361	352	-9	$309,214	$207,740	($101,474)	$45,031	$17,310	($27,721)	$30,568	$0	($30,568)	$75,600	**$209**	$17,310	**$49**	($58,290)
		NOVOLOG INJ FLEX REL	1		-1	5	0	-5	$196	$0	($196)	$261	$0	($261)	$11	$0	($11)	$271	**$54**	$0	**#DIV/0!**	($271)
		NOVOLOG INJ FLEXPEN	165	176	11	517	467	-50	$474,597	$259,790	($214,807)	$56,701	$22,250	($34,451)	$34,998	$0	($34,998)	$91,699	**$177**	$22,250	**$48**	($69,449)
		NOVOLOG INJ PENFILL	6	7	1	27	28	1	$25,521	$24,062	($1,459)	$4,509	$1,400	($3,109)	$3,284	$0	($3,284)	$7,793	**$289**	$1,400	**$50**	($6,393)
		NOVOLOG MIX INJ FLEXPEN	4	6	2	21	18	-3	$18,290	$12,888	($5,403)	$2,321	$900	($1,421)	$1,546	$0	($1,546)	$3,867	**$184**	$900	**$50**	($2,967)
		SOLIQUA INJ	6	5	-1	19	15	-4	$11,877	$11,602	($274)	$3,496	$750	($2,746)	$2,546	$0	($2,546)	$6,042	**$318**	$750	**$50**	($5,292)
		TOUJEO MAX INJ	13	32	19	30	44	14	$36,768	$51,357	$14,588	$2,938	$1,900	($1,038)	$1,588	$0	($1,588)	$4,526	**$151**	$1,900	**$43**	($2,626)
		TOUJEO SOLO INJ	40	75	35	90	104	14	$78,357	$84,480	$6,122	$8,103	$5,150	($2,953)	$4,578	$0	($4,578)	$12,680	**$141**	$5,150	**$50**	($7,530)
		TRESIBA FLEX INJ	109	92	-17	363	278	-85	$238,037	$210,730	($27,307)	$37,827	$13,450	($24,377)	$21,652	$0	($21,652)	$59,478	**$164**	$13,450	**$48**	($46,028)
	61+ DOS	**Total**	**744**	**818**	**74**	**1,352**	**1,419**	**67**	**$1,184,119**	**$1,017,976**	**($166,143)**	**$209,927**	**$103,110**	**($106,817)**	**$140,160**	**$0**	**($140,160)**	$350,087	**$259**	$103,110	**$73**	**($246,977)**
		BASAGLAR INJ	8	15	7	22	31	9	$5,300	$15,762	$10,462	$6,620	$2,325	($4,295)	$5,300	$0	($5,300)	$11,919	**$542**	$2,325	**$75**	($9,594)
		FIASP INJ	8	11	3	20	22	2	$27,305	$38,480	$11,175	$4,855	$1,650	($3,205)	$3,855	$0	($3,855)	$8,710	**$436**	$1,650	**$75**	($7,060)
		FIASP FLEX INJ TOUCH	13	13	0	22	28	6	$25,122	$38,064	$12,942	$3,941	$2,100	($1,841)	$2,841	$0	($2,841)	$6,781	**$308**	$2,100	**$75**	($4,681)
		FIASP PENFIL INJ U		2	2	0	3	3	$0	$2,265	$2,265	$0	$225	$225	$0	$0	$0	$0	**#DIV/0!**	$225	**$75**	$225

GLARGIN YFGN INJ		1	1	0	1	1	$0	$0	$0	$0	$65	$65	$0	$0	$0	$0	#DIV/0!	$65	$65	$65
HUMALOG INJ		1	1	0	1	1	$0	$1,810	$1,810	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
HUMALOG KWIK INJ		2	2	0	3	3	$0	$13,697	$13,697	$0	$225	$225	$0	$0	$0	$0	#DIV/0!	$225	$75	$225
HUMULIN R INJ U	1		-1	1	0	-1	$0	$0	$0	$15	$0	($15)	$0	$0	$0	$15	$15	$0	#DIV/0!	($15)
INS DEGL FLX INJ	6	51	45	8	80	72	$3,096	$20,187	$17,090	$497	$5,745	$5,248	$97	$0	($97)	$593	$74	$5,745	$72	$5,152
INSULIN ASPA INJ	1	5	4	1	6	5	$30	$2,817	$2,787	$90	$450	$360	$30	$0	($30)	$120	$120	$450	$75	$330
INSULIN GLAR INJ	1		-1	3	0	-3	$0	$0	$0	$135	$0	($135)	$0	$0	$0	$135	$45	$0	#DIV/0!	($135)
INSULIN LISP INJ	1	2	1	2	4	2	$397	$284	($113)	$517	$300	($217)	$397	$0	($397)	$914	$457	$300	$75	($614)
LANTUS INJ	9	5	-4	16	11	-5	$19,683	$10,374	($9,309)	$3,688	$825	($2,863)	$2,888	$0	($2,888)	$6,576	$411	$825	$75	($5,751)
LANTUS SOLOS INJ	181	202	21	341	351	10	$184,707	$115,903	($68,804)	$43,274	$25,395	($17,879)	$26,016	$0	($26,016)	$69,290	$203	$25,395	$72	($43,895)
LEVEMIR INJ	2	1	-1	4	4	0	$2,096	$1,946	($150)	$539	$300	($239)	$339	$0	($339)	$877	$219	$300	$75	($577)
LEVEMIR INJ FLEXPEN	25	36	11	29	62	33	$14,512	$33,791	$19,279	$4,057	$4,500	$443	$2,657	$0	($2,657)	$6,713	$231	$4,500	$73	($2,213)
LEVEMIR INJ FLEXTOUC	41	1	-40	59	1	-58	$34,413	$423	($33,989)	$6,776	$0	($6,776)	$3,826	$0	($3,826)	$10,601	$180	$0	$0	($10,601)
NOVOLIN N INJ	4	5	1	5	6	1	$871	$1,383	$512	$397	$375	($22)	$147	$0	($147)	$543	$109	$375	$63	($168)
NOVOLIN N INJ U	3	3	0	7	7	0	$2,998	$2,688	($310)	$1,349	$525	($824)	$999	$0	($999)	$2,349	$336	$525	$75	($1,824)
NOVOLIN R INJ		1	1	0	1	1	$0	$159	$159	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
NOVOLIN70/3	2	2	0	5	2	-3	$1,136	$455	($681)	$376	$150	($226)	$126	$0	($126)	$502	$100	$150	$75	($352)
NOVOLOG INJ	124	125	1	236	280	44	$332,261	$279,531	($52,730)	$56,318	$20,364	($35,954)	$43,107	$0	($43,107)	$99,425	$421	$20,364	$73	($79,061)
NOVOLOG INJ FLEX REL	2	4	2	2	6	4	$55	$306	$252	$118	$425	$307	$18	$0	($18)	$136	$68	$425	$71	$289
NOVOLOG INJ FLEXPEN	134	142	8	244	242	-2	$230,703	$174,500	($56,203)	$33,428	$17,441	($15,987)	$21,623	$0	($21,623)	$55,051	$226	$17,441	$72	($37,610)
NOVOLOG INJ PENFILL	6	7	1	9	11	2	$12,584	$13,122	$538	$1,915	$825	($1,090)	$1,465	$0	($1,465)	$3,380	$376	$825	$75	($2,555)
NOVOLOG INJ RELION	1	1	0	2	4	2	$701	$1,449	$748	$334	$300	($34)	$234	$0	($234)	$567	$284	$300	$75	($267)
NOVOLOG MIX INJ FLEXPEN	3	2	-1	7	3	-4	$8,005	$2,897	($5,108)	$926	$225	($701)	$576	$0	($576)	$1,502	$215	$225	$75	($1,277)
SOLIQUA INJ	5	1	-4	8	1	-7	$13,283	$720	($12,562)	$1,287	$75	($1,212)	$987	$0	($987)	$2,273	$284	$75	$75	($2,198)
TOUJEO MAX INJ	12	29	17	17	22	5	$12,145	$20,452	$8,307	$1,930	$1,575	($355)	$1,115	$0	($1,115)	$3,046	$179	$1,575	$72	($1,471)
TOUJEO SOLO INJ	32	62	30	55	53	-2	$42,520	$49,060	$6,539	$6,827	$3,825	($3,002)	$4,177	$0	($4,177)	$11,003	$200	$3,825	$72	($7,178)
TRESIBA INJ	1	2	1	4	5	1	$3,361	$5,358	$1,997	$461	$375	($86)	$261	$0	($261)	$722	$180	$375	$75	($347)
TRESIBA FLEXTINJ	117	83	-34	222	167	-55	$206,700	$168,964	($37,736)	$29,165	$12,300	($16,865)	$17,036	$0	($17,036)	$46,201	$208	$12,300	$74	($33,901)
XULTOPHY INJ	1	1	0	1	1	0	$136	$1,129	$993	$95	$75	($20)	$45	$0	($45)	$141	$141	$75	$75	($66)

No filters applied

Attachment 8

Rx Type	Days of Supply (DOS) Group		Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Cap Insulin	CoinsuranceA mount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member Cost Share after Insulin Cap	Member Savings from Insulin Cap
2-BLOOD GLUCOSE METERS	**Total**		**200**	**151**	**-49**	**143**	**103**	**-40**	**$2,436**	**$1,692**	**($744)**	**$634**	**$463**	**($171)**	**$634**	**$424**	**($211)**	**$1,268**	**$9**	**$886**	**$9**	**($382)**
	01-30 DOS	**Total**	190	141	-49	136	96	-40	$2,331	$1,608	($723)	$599	$414	($185)	$599	$414	($185)	$1,198	$9	$828	$9	($370)
	61+ DOS	**Total**	10	10	0	7	7	0	$106	$84	($21)	$35	$49	$14	$35	$10	($25)	$70	$10	$59	$8	($12)
3-BLOOD GLUCOSE TEST STRIPS	**Total**		**916**	**693**	**-223**	**1,729**	**1,226**	**-503**	**$156,322**	**$116,411**	**($39,911)**	**$33,349**	**$24,804**	**($8,545)**	**$32,285**	**$21,504**	**($10,781)**	**$65,634**	**$38**	**$46,308**	**$38**	**($19,326)**
	01-30 DOS	**Total**	247	190	-57	520	374	-146	$36,163	$26,476	($9,687)	$7,975	$5,745	($2,230)	$7,403	$4,679	($2,724)	$15,378	$30	$10,424	$28	($4,954)
	31-60 DOS	**Total**	335	256	-79	699	496	-203	$56,048	$40,930	($15,118)	$12,886	$9,739	($3,146)	$12,608	$8,868	($3,740)	$25,493	$36	$18,607	$38	($6,887)
	61+ DOS	**Total**	334	247	-87	510	356	-154	$64,110	$49,005	($15,106)	$12,488	$9,319	($3,169)	$12,274	$7,957	($4,317)	$24,762	$49	$17,277	$49	($7,486)
4-LANCETS AND LANCET DEVICES	**Total**		**448**	**372**	**-76**	**637**	**492**	**-145**	**$5,490**	**$4,160**	**($1,330)**	**$1,301**	**$1,153**	**($149)**	**$1,244**	**$992**	**($252)**	**$2,546**	**$4**	**$2,145**	**$4**	**($400)**
	01-30 DOS	**Total**	128	119	-9	199	160	-39	$1,541	$1,225	($315)	$376	$329	($47)	$350	$289	($61)	$726	$4	$618	$4	($108)
	31-60 DOS	**Total**	130	87	-43	189	125	-64	$1,541	$1,046	($495)	$386	$300	($87)	$377	$261	($117)	$763	$4	$560	$4	($203)
	61+ DOS	**Total**	190	166	-24	249	207	-42	$2,409	$1,888	($520)	$540	$524	($15)	$516	$442	($74)	$1,056	$4	$967	$5	($89)
5-KETONE TESTING	**Total**		**4**	**5**	**1**	**29**	**8**	**-21**	**$19,921**	**$4,360**	**($15,561)**	**$449**	**$15**	**($435)**	**$449**	**$15**	**($435)**	**$898**	$31	$29	$4	**($869)**
	01-30 DOS	**Total**	4	4	0	29	7	-22	$19,921	$4,352	($15,569)	$449	$12	($437)	$449	$12	($437)	$898	$31	$24	$3	($874)
	31-60 DOS	**Total**		1	1	0	1	1	$0	$8	$8	$0	$3	$3	$0	**$3**	**$3**	$0	#DIV/0!	$5	$5	$5
6-GLUCAGON	**Total**		**71**	**72**	**1**	**80**	**78**	**-2**	**$27,475**	**$34,864**	**$7,389**	**$6,623**	**$1,367**	**($5,257)**	**$5,028**	**$967**	**($4,062)**	**$11,652**	**$146**	**$2,334**	**$30**	**($9,318)**
	01-30 DOS	**Total**	71	72	1	80	78	-2	$27,475	$34,864	$7,389	$6,623	$1,367	($5,257)	$5,028	$967	($4,062)	$11,652	$146	$2,334	$30	($9,318)
7-SYRINGE/PEN NEEDLE	**Total**		**938**	**802**	**-136**	**1,638**	**1,391**	**-247**	**$112,768**	**$96,953**	**($15,815)**	**$7,502**	**$8,786**	**$1,284**	**$7,346**	**$7,587**	**$241**	**$14,848**	**$9**	**$16,374**	**$12**	**$1,525**
	01-30 DOS	**Total**	223	200	-23	544	463	-81	$26,042	$24,416	($1,626)	$1,827	$2,548	$720	$1,827	$2,111	$284	$3,654	$7	$4,659	$10	$1,005
	31-60 DOS	**Total**	161	173	12	322	294	-28	$25,803	$21,477	($4,326)	$1,593	$1,984	$391	$1,593	$1,889	$296	$3,185	$10	$3,872	$13	$687
	61+ DOS	**Total**	554	429	-125	772	634	-138	$60,922	$51,060	($9,863)	$4,082	$4,255	$173	$3,926	$3,587	($339)	$8,009	$10	$7,842	$12	($166)
	Grand TOTAL		**2,577**	**2,095**	**-482**	**4,256**	**3,298**	**-958**	**$ 324,411**	**$ 258,440**	**$ (65,971)**	**$ 49,860**	**$ 36,587**	**$ (13,273)**	**$ 46,987**	**$ 31,489**	**$ (15,498)**	**$ 96,847**		**$ 68,076**		**($28,771)**

NOTEWORTHY COMMENTS:

Continuous Glucose Monitors and Insulin Pumps may replace the need for some of these supplies.

252 NDPERS members enrolled in Livongo Diabetes program bewteen July 1, 2023- June 30, 2024. Livongo provides Blood Glucose Monitors & test strips to the participants.

Blood Glucose Meters, Test Strips & Lancets can be used by any diabetic including those not using insulin.

INSULIN & DIABETIC SUPPLY BRIEF

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

In the landscape of healthcare affordability, few issues resonate as profoundly as the accessibility of insulin and diabetic supplies, especially within the United States. The soaring prices of these life-sustaining medications have sparked national outcry, prompting legislative actions in several states aimed at implementing price caps. As diabetes prevalence continues to rise, individuals facing this chronic condition grapple not only with its daily management but also with the financial burden imposed by escalating medication costs. Understanding the varied approaches and efficacy of state-level price caps is essential in assessing the impact on patients, healthcare systems, and the broader socio-economic landscape.

CURRENT LANDSCAPE OVERVIEW

In a recent discussion, it was highlighted that diabetics nationwide are set to benefit from reduced out-of-pocket costs for insulin, thanks to efforts by pharmaceutical companies. Sanofi has joined Eli Lilly and Novo Nordisk in capping insulin co-pays at $35. This move follows pressure from President Biden, lawmakers, and activists to lower drug prices.

Laura Barron-Lopez, White House correspondent, emphasized the significance of these measures. She noted that while Medicare beneficiaries automatically benefit from the $35 co-pay cap, those with private insurance or without insurance must navigate more complex processes to access the reduced costs. Advocates like Shaina Kasper of T1International suggest that a federal mandate is needed to ensure consistency in cost reductions.

Beyond insulin, other healthcare reforms are underway. For Medicare recipients, drug costs will be capped annually, starting at $3,300 in 2024 and decreasing to $2,000 by 2025. Additionally, Medicare now has the authority to negotiate drug prices, potentially saving billions over the next decade.

Despite these changes, there's a notable gap in public awareness. Many Americans are unaware of these reforms, complicating efforts to credit President Biden politically for these achievements. Analysts suggest that effective communication will be crucial for the administration to highlight these reforms ahead of the upcoming elections[1].

A gathering of families and advocates convened with Governor Doug Burgum at the North Dakota Capitol to commemorate a recent law that limits the cost of insulin for state employees' health insurance beneficiaries. Under this law, those covered by the state employee health plan now pay no more than $25 per month for insulin. Additionally, the law extends this monthly price cap to medical supplies needed to administer insulin.

Danelle Johnson, who supported the legislation during her testimony in 2023, expressed mixed feelings about its scope. Originally proposed to benefit all North Dakotans, the law was amended by lawmakers to apply solely to individuals under the Public Employees Retirement System's health insurance. Johnson acknowledged the legislation as a significant advancement but expressed a desire for broader accessibility to the price caps. She emphasized the importance of incremental progress over a stalemate in legislative action.

Insulin, critical for diabetes management, can cost hundreds of dollars per vial. A 2023 report by the Health Care Cost Institute indicated that average monthly insulin costs in the U.S. rose from $271 in 2012 to about $499 in 2021. The exorbitant prices often lead diabetes patients to ration their insulin or even skip

[1] https://www.pbs.org/newshour/show/new-law-caps-insulin-prices-for-some-with-diabetes-but-cost-remains-high-for-millions

treatment, risking severe health complications. In 2022, approximately 100,000 Americans died from diabetes, a figure similar to the number of deaths from drug overdoses reported by the CDC.

State Senator Tim Mathern, the bill's primary sponsor, highlighted the dire consequences of unaffordable medication, stressing the need for reform. Angela and Nina Kritzberger, also advocates for insulin affordability, were present at the ceremony. Both families recounted instances where insufficient access to insulin necessitated emergency medical interventions. Looking ahead, Mathern noted efforts to garner support for broader reforms in the upcoming legislative session. The law, effective since August 1, 2023, will remain in force until July 31, 2025, with an estimated cost of $900,000 over the 2023-2025 budget cycle. Although signed over a year ago, logistical issues delayed the official signing ceremony, according to Mathern. Additionally, the federal government implemented a $35 monthly insulin price cap for Medicaid patients through the Inflation Reduction Act signed by President Joe Biden in 2022[2].

Healthcare executives faced intense scrutiny from lawmakers on Capitol Hill during a House Energy and Commerce Committee hearing focused on insulin prices. Representative Jan Schakowsky of Illinois directly challenged panelists, expressing disbelief over their actions and warning of consequences. Amid the hearings, a social media suggestion resurfaced: patients should opt for Walmart's affordable insulin. Over the past decade, the cost of popular insulin brands has tripled, leading many Americans with Type 1 or Type 2 diabetes to ration their doses or skip treatments entirely.

Walmart provides Novo Nordisk's Novolin ReliOn Insulin for less than $25 per vial without a prescription. However, healthcare professionals caution that this "human" insulin, introduced in the 1980s, lacks the refined capabilities of newer analogs in preventing severe blood sugar fluctuations. Critics argue that relying on Walmart's insulin overlooks the complexities of diabetes management and the risks associated with unsupervised treatment. Advocates emphasize that while this option may suit some patients, it's far from a comprehensive solution to the ongoing insulin affordability crisis. The blame for rising insulin prices has been volleyed between drug manufacturers and pharmacy benefit managers. While executives defend financial assistance programs, lawmakers assert that unchecked price hikes by pharmaceutical companies are at the heart of the issue. Unlike many other countries, the U.S. allows drug companies considerable freedom in setting prices, resulting in disproportionately high insulin costs despite the country representing a minority share of the global insulin market. Recent efforts, such as Cigna and Express Scripts capping insulin costs at $25 per month, are viewed as temporary fixes by critics like Elizabeth Pfiester of TIInternational. She insists that true resolution requires systemic changes to reduce insulin's list prices permanently.

As the debate intensifies, healthcare professionals and advocates continue to call for legislative intervention to protect diabetic patients from the financial and health risks posed by exorbitant insulin costs[3],[4]

State Copay Caps[5]

- Alabama: $100 cap for 30-day supply
- Colorado: $100 collective cap for 30-day supply
- 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
- District of Columbia: $30 cap for a 30-day supply of insulin and $100 cap for a 30-day supply of covered diabetes devices

[2] https://northdakotamonitor.com/2024/05/28/patient-advocates-plan-to-continue-pushing-for-insulin-price-cap/
[3] https://www.vox.com/science-and-health/2019/4/10/18302238/insulin-walmart-relion)
[4] https://www.novonordisk-us.com/patient-help/access-and-affordability.html
[5] https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps

- Illinois: $100 collective cap for 30-day supply
- Kentucky: $30 cap for 30-day supply
- Louisiana: $75 cap for 30-day supply
- Maine: $35 cap for 30-day supply
- Maryland: $30 cap for 30-day supply
- Minnesota: State-required manufacturer assistance program has a $35 cap for one per year emergency 30-day supply, $50 cap for 90-day supply
- Montana: $35 for 30-day supply
- Nebraska: $35 cap for 30-day supply
- New Hampshire: $30 cap for 30-day supply
- New Jersey: $30 cap for 30-day supply
- New Mexico: $25 cap for 30-day supply
- New York: $100 cap for 30-day supply
- North Dakota: $25 cap for a 30-day supply*
- Oklahoma: $30 cap for 30-day supply, $90 cap for 90-day supply
- Oregon: $75 cap for a 30-day supply, $225 cap for a 90-day supply
- Rhode Island: $40 cap for a 30-day supply
- Texas: $25 cap for a 30-day supply
- Utah: $30 cap for 30-day supply
- Vermont: $100 collective cap for 30-day supply
- Virginia: $50 cap for 30-day supply
- Washington: $35 cap for 30-day supply
- West Virginia: $35 collective cap for 30-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies.

The State of Utah conducted a study and published their findings regarding Insulin costs. Insulin costs have become a major issue for diabetes patients in the U.S. In response, Utah passed House Bill 207, capping insulin copayments at $30 per month, effective January 1, 2021.

This study evaluated changes in basal insulin adherence, out-of-pocket expenses, health plan costs, overall insulin expenditures, and hemoglobin A1c (A1c) levels before and after the policy's implementation. Conducting a retrospective analysis using data from a Utah health plan between October 2019 and September 2021, the study included commercially insured members who filled insulin prescriptions in both pre- and post-policy periods. Insulin adherence was assessed using the proportion of days covered (PDC), and statistical tests compared health and economic outcomes. Out of 24,150 individuals, 244 patients were analyzed. Results showed a **58.5% reduction** in median monthly out-of-pocket costs for insulin (from $65 to $27), while health plan costs increased by **22%** (from $346 to $444). Total monthly insulin costs remained unchanged. Among 74 patients analyzed for PDC, no significant change was observed (P = 0.43). Similarly, A1c levels did not significantly improve (mean A1c rose from 8.2% to 8.6%). The $30 copayment cap reduced patient out-of-pocket costs but led to higher costs for health plans without improving adherence or A1c levels. Further research over longer periods and with larger populations is necessary to assess long-term impacts.

The Utah study highlights that capping insulin copayments effectively reduced patient costs but shifted financial burdens to health plans. While adherence and health outcomes remained unchanged, further investigation is essential to determine if this policy yields long-term benefits for diabetes management[6].

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10839465/

MANUFACTURER'S INSULIN CHARGE CHANGE

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

Since 2023, insulin manufacturers have reduced prices on their insulin and diabetic supplies in response to mounting public pressure and advocacy efforts highlighting the exorbitant costs faced by diabetic patients. These reductions come amidst growing awareness of the essential nature of insulin for millions of individuals worldwide, many of whom have struggled with affordability and access issues for years. Additionally, regulatory scrutiny and legislative initiatives have pushed manufacturers to reassess their pricing strategies, aiming to make these life-saving medications more accessible and affordable. These changes mark a significant step towards addressing healthcare inequities and ensuring that essential treatments are within reach for those who need them most.

CURRENT LANDSCAPE OVERVIEW

Eli Lilly and Company has taken significant steps to enhance insulin affordability with recent initiatives. Starting May 1, 2023, Lilly will reduce the list price of Insulin Lispro Injection to $25 per vial, making it the most affordable mealtime insulin available. Humalog® and Humulin® will see a 70% price cut from Q4 2023, and RezvoglarTM, a biosimilar basal insulin, will be priced at $92 per five-pack of KwikPens®, a 78% discount compared to Lantus®. Lilly has also capped out-of-pocket costs at $35 per month for commercial insurance users immediately and offers uninsured individuals Lilly insulin for $35 monthly through the Lilly Insulin Value Program. These measures aim to address healthcare system gaps hindering affordable insulin access, with CEO David A. Ricks stressing the need for broader collaboration for comprehensive diabetes care. Lilly's efforts build on prior initiatives such as low-list-price insulins since 2019 and participation in the Medicare Part D Senior Savings Model, reducing average out-of-pocket costs for Lilly insulins to $21.80 over five years. Future plans include a national awareness campaign to promote these solutions and advocate systemic insulin accessibility improvements, alongside ongoing innovation in diabetes care.[1]

Novo Nordisk will significantly lower US list prices for insulin products by up to 75% effective January 1, 2024, following Eli Lilly's lead in reducing insulin prices by 70% and capping out-of-pocket costs at $35 monthly. President Joe Biden commended Eli Lilly's initiative, urging other insulin makers to follow. Novo Nordisk's price cuts cover NovoLog and Levemir, aiming to ease financial burdens for uninsured and high-deductible patients, with Medicare seniors benefiting from an Inflation Reduction Act cap. Advocacy groups like T1International applaud these steps while noting ongoing insulin affordability challenges relative to production costs. Novo Nordisk reaffirms commitment to insulin affordability through support programs, contrasting with Sanofi, which has yet to announce price cuts, focusing instead on existing assistance for uninsured and privately insured individuals. The US insulin price gap compared to other countries remains a concern, reflecting broader American healthcare drug pricing and access challenges[2].

Over the past two decades, insulin list prices by pharmaceutical manufacturers have risen annually, posing affordability challenges for insured patients facing soaring out-of-pocket costs. Simultaneously, insurers and pharmacy benefit managers (PBMs) negotiated increasing rebates and confidential discounts, significantly lowering net prices despite gross sales doubling for leading insulin products from 2012 to 2019.

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[1] https://investor.lilly.com/news-releases/news-release-details/lilly-cuts-insulin-prices-70-and-caps-patient-insulin-out-pocket#:~:text=Today%2C%20Lilly%20is%20reducing%20the,Humalog%C2%AE%20vial%20in%201999.

[2] https://www.nbcnews.com/health/health-news/novo-nordisk-lower-list-price-insulin-rcna74836

Eli Lilly, Novo Nordisk, and Sanofi responded with substantial list price cuts of 65% to 80% in March 2023, driven by impending 2024 Medicaid rebate changes under the American Rescue Act. The gross-to-net price bubble persists for many brand-name drugs, reflecting opaque pricing and rebate structures. Future policy efforts, such as Medicare price negotiation and enhanced transparency, are crucial for equitable patient access to vital medications amid systemic pharmaceutical market challenges[3].

In 2024, Sanofi and other insulin manufacturers are implementing transformative initiatives to significantly reduce insulin costs for millions of Americans with diabetes. Sanofi has introduced price caps and savings programs, ensuring many patients pay no more than $35 monthly for insulin, responding to public outcry and legislative changes. The Inflation Reduction Act capped Medicare enrollees' out-of-pocket expenses, alleviating financial burdens and addressing insulin rationing risks. These actions aim to enhance affordability and equity in healthcare, signaling collaborative efforts among policymakers, patient advocates, and industry leaders to improve insulin accessibility and support a sustainable healthcare system[4].

CONCLUDING

In conclusion, the landscape of insulin pricing in the United States is undergoing significant shifts as major manufacturers like Eli Lilly and Novo Nordisk respond to longstanding affordability challenges. These companies have taken proactive steps to reduce list prices by substantial margins, with Eli Lilly cutting prices by up to 70% and Novo Nordisk following suit with reductions of up to 75% effective January 2024. These efforts, applauded by President Joe Biden and advocacy groups like T1International, aim to alleviate financial burdens on patients, particularly the uninsured and those with high deductibles. The implementation of caps on out-of-pocket costs under the Inflation Reduction Act further supports affordability for Medicare enrollees.

Despite these positive developments, disparities persist in insulin pricing between the U.S. and other countries, reflecting broader complexities in drug pricing and access within the American healthcare system. The ongoing challenge of insulin affordability underscores the need for continued policy reforms, including enhanced transparency in pricing practices and potential Medicare negotiations on drug prices. These reforms could further address the gross-to-net price discrepancies observed not only in insulin but also in other essential medications.

Looking forward, the commitment of pharmaceutical companies to affordability initiatives, alongside advocacy efforts and legislative changes, offers hope for more equitable access to insulin and other critical medications. As industry leaders navigate these reforms, the focus remains on ensuring that patients can affordably access the medications they need to manage chronic conditions effectively. This collaborative approach between stakeholders sets a precedent for addressing broader healthcare affordability issues and advancing towards a more inclusive and sustainable healthcare system in the United States.

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806020
[4] https://www.cnn.com/2024/01/01/politics/insulin-price-cap/index.html

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0118.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- defines "insulin drug", "medical supplies for insulin dosing and administration", and "pharmacy or distributer"
- restricts insurers and plan sponsors from offering any health insurance coverage unless the coverage meets the cost-sharing and covered service requirements listed in the Bill
- provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration regardless of the quantity or type of insulin drug
- restricts pharmacy benefit managers from collecting payment in excess of the cost-sharing requirements covered in the Bill
- restricts health plans from imposing a cost-sharing structure like a deductible or coinsurance that would require a member to pay more than the cost-share limit to receive insulin services

- allows for plans to impose cost-sharing limits that are lower than the $25 member cost-share limit included in the Bill
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $1,000,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program requires members to pay a copayment and coinsurance for insulin. Depending on the cost of the insulin prescribed and/or the cost of the supplies purchased, the member cost-share can exceed the proposed $25 limit. Therefore, it is expected that imposing this limit will shift costs from members to the Uniform Group Insurance Program.

Using 12 months of NDPERS claims data from September 2021 through August 2022, Sanford Health Plan estimated that a $25 per month limit on member cost share would have shifted $445,000 from the member to the Uniform Group Insurance Program in that period. Assuming prescription drug trend of 9.4% per year, the cost in the 2025-2027 biennium is estimated to be approximately $1,000,000 (or 0.12% increase to the estimated Program total claims costs). The estimate does not assume changes to drug mix or formulary changes that could impact member out-of-pocket payments (pharmacy benefit managers typically update their formularies at least twice per year).

OTHER CONSIDERATIONS

By limiting or capping the out-of-pocket cost to members for specific services, a smaller amount of those related costs will accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate a component of the estimated 0.12% increase to the estimated Program total claims costs. Therefore, the $1,000,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

Clinical outcomes associated with lowering member out-of-pocket costs on insulin drugs and medical supplies for insulin dosing and administration may have a favorable impact on the Uniform Group Insurance Program, but such effects are difficult to quantify. If insulin and supplies are more affordable, member adherence may increase and result in fewer adverse health effects that result in expenditures to the Program, such as increased doctor and emergency department visits and prolonged hospitalization.

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Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: August 2, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **MARKET ANALYSIS RELATED TO BILL 23.0532.03000**

In the 2023 legislative session, the North Dakota legislature passed SB 2140 which, among other items, requires the NDPERS Board to evaluate and report on the feasibility of extending the $25/month cap on insulin and diabetic supplies from a pilot to the commercial market statewide. Deloitte Consulting LLP (Deloitte [i]) was commissioned to analyze similar initiatives in other states and industries to assess their impact on adherence among diabetic populations and other relevant outcomes to inform the legislative review.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF BILL

The amended bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- Defines "insulin drug" and "medical supplies for insulin dosing and administration"
- Directs the Board to provide health insurance benefits coverage that complies with the defined cost-share provisions
- Provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration
- Clarifies that cost-sharing is not limited for insulin pumps, electronic insulin-administering smart pens, or continuous glucose monitors
- Declares the application of this legislation to be June 30, 2023, to June 30, 2025
- Requires that the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for

this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies, and;

- Directs the public employees retirement system to provide a report on the effect of the insulin drug and supplies requirements on the system's health insurance programs, including utilization and cost, and a recommendation on continuing the coverage

CONSIDERATIONS AND RELATED LEGISLATION

Currently, 24 other states plus the District of Columbia have set caps on insulin cost-sharing for state-regulated commercial health plans, as reported by the American Diabetes Foundation. The caps vary significantly across the states:

- Alabama: $100 cost-share cap for a 30-day supply
- Colorado: $100 collective cost-share cap for any 30-day supply regardless of dosage
- Connecticut: $25 cost-share cap for 30-day supply of insulin or any other diabetic medication; $100 cap for 30-day supply of devices and supplies
- Delaware: $100 collective cost-share cap for 30-day supply, $0 for insulin pumps, and collective $35 cost-share monthly cap for other diabetic specific equipment and supplies
- District of Columbia: $30 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices
- Illinois: $35 collective cost-share cap for 30-day supply (effective 7/1/2025)
    - Current provision through 6/30/2025 is a $100 collective cost-share cap for a 30-day supply
- Kentucky: $30 cost-share cap for 30-day supply
- Louisiana: $75 cost-share cap for 30-day supply
- Maine: $35 cost-share cap for 30-day supply
- Maryland: $30 cost-share cap for 30-day supply
- Minnesota: $25 cost-share monthly cap for diabetes medications; $50 cost-share monthly cap for supplies; State-required manufacturer assistance program has a $35 cost-share cap for one per year emergency 30-day supply, $50 cost-share cap for 90-day supply
- Montana: $35 cost-share cap for 30-day supply
- Nebraska: $35 cost-share cap for 30-day supply
- New Hampshire: $30 cost-share cap for 30-day supply
- New Jersey: $35 cost-share cap for 30-day supply
- New Mexico: $25 cost-share cap for 30-day supply

- New York: $0 cost for 30-day supply of insulin (effective 1/1/2025)
    - Current provision is a $100 cost-share cap for a 30-day supply
- Oklahoma: $30 cost-share cap for 30-day supply; $90 cost-share cap for 90-day supply
- Oregon: $35 cost-share cap for 30-day supply; $105 cost-share cap for 90-day supply (effective 1/1/2025)
    - Current provision is a $85 cost-share cap for 30-day supply
- Rhode Island: $40 cost-share cap for 30-day supply
- Texas: $25 cost-share cap for 30-day supply
- Utah: $30 cost-share cap for 30-day supply
- Vermont: $100 collective cost-share cap for 30-day supply
- Virginia: $50 cost-share cap for 30-day supply
- Washington: $35 cost-share cap for 30-day supply
- West Virginia: $35 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices

Effective July 1, 2023, the federal government, under the Inflation Reduction Act, has introduced a $35 copay cap for Medicare retirees purchasing insulin. According to the Department of Health and Human Services, this measure is estimated to save retirees over $500 annually.

Additionally, the Inflation Reduction Act includes a provision that expands the coverage of insulin under High Deductible Health Plans (HDHPs). This legislation formalizes IRS Notice 2019-45, which permits certain preventive care for chronic conditions, such as insulin, to be covered without requiring members to meet a deductible first.

Colorado was the first state to implement an insulin cost-share cap in May 2019 with HB19-1216. The initial legislation faced challenges due to ambiguities over applicable insulin types and coverage for multiple prescriptions. These issues led to confusion and potentially higher costs for patients requiring multiple types of insulin[1].

In response, Colorado passed an amendment effective January 1, 2022 with HB21-1307, clarifying that the $100 cap covers all prescribed insulin medications combined per 30-day supply. The amendment also introduced an insulin affordability program for uninsured individuals, offering a 12-month supply at $50 per month and an emergency supply at $35.

The implementation of insulin cost-share caps across various states and at the federal level represents a step towards reducing the financial burden on individuals with diabetes. However, ongoing evaluation is necessary to address potential unintended consequences and ensure the sustainability of these measures. Due to the infancy of a majority of these bills and implementation of the cost-share caps in other states, states are still analyzing the impact of the cost-share caps on members' out-of-pocket costs as well as the impact to premiums.

While these caps reduce out-of-pocket costs for insulin and increase costs for plan sponsors, they do not decrease the overall cost of the drug. However, the lower cost of insulin for members can

potentially lead to better adherence to their medication regimen. Improved adherence can result in lower healthcare costs overall, as members are more likely to avoid costly inpatient care due to better management of their condition.

It remains uncertain whether the potential cost savings from improved drug adherence will offset other rising costs. Over the past decade, insulin prices have tripled, raising concerns that cost-share caps might shift expenses to other areas, such as insurance premiums.

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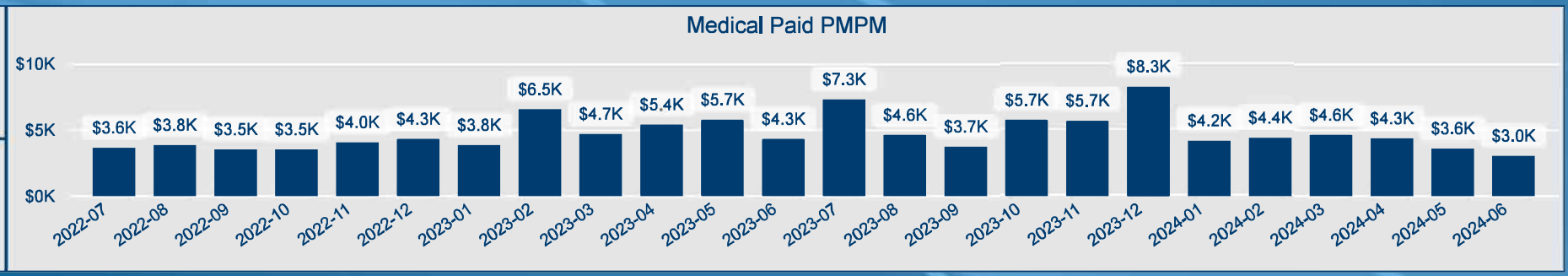
[1] Endocrine Today. (2013). "How Colorado's insulin cap law evolved" Retrieved from https://www.healio.com/news/endocrinology/20230510/how-colorados-insulin-cap-law-evolved#:~:text=In%20May%202019%2C%20Colorado%20became,of%20insulin%20for%20Colorado%20residents.

NDPERS - Medical Utilization for Members with Type 1 Diabetes Diagnosis Only and Insulin and Diabetes Supplies Claims - All LOB's

Medical PMPM Before
$4,428

Medical PMPM After
$4,932



ER Visits/1000 Before
877.1

ER Visits/1000 After
915.4

IP Admits/1000 Before
747.5

IP Admits/1000 After
592.4

Last Data Refresh: 07-24-2024 01:02 PM CT

Notice: This report and any exported data is for internal use only and should not be sent outside of Sanford.

Not all medical claims have been paid. Providers have 180 days to submit claims to Sanford Health Plan
Does not include Medical PMPM for NDPERS Members diagnosed with Type 2 Diabetes that were prescribed Insulin

This document contains my original testimony from several different hearings for SB 2140 as it worked its way through the 2023 Legislative Session. It passed, and that started the required two year study period using the NDPERS plan. This has now become HB1114 for the 2025 Legislative session. I was the original author of this bill back in 2021.

Danelle Johnson, Type 1 Diabetes Advocate & Mom to Danika Johnson, a fellow advocate that is living with Type 1 Diabetes. Contact Info: 701-261-1687, daryldanelle@msn.com

TESTIMONY #1

January 11, 2023

Madam Chair Lee and members of the committee, I am Danelle Johnson from Horace, ND. I am here representing myself. I support this bill because our daughter Danika (20), lives with auto-immune Type 1 Diabetes, as do many residents in our state. She is insulin dependent to sustain her life, for the duration of her life, or until a cure is found. I have advocated at local, state and federal levels for years and have yet to see progress for residents of North Dakota until the Federal Inflation Reduction Act capped the monthly cost of insulin for Medicare enrollees at $35.

The inability to afford insulin is more daunting than having a family member diagnosed with Type 1 Diabetes. We were told if we\she takes care of herself, she can live a long, healthy life, free of complications. The medical care team can't prepare you for not being able to afford insulin and supplies necessary to dose and administer insulin therapy. This can be the start of losing hope. The burden can lead to anxiety\depression, addiction, suicide, poor performance at school or work, financial ruin, isolation, homelessness and a variety of issues, just to get their hands on this liquid gold. Together, we have an opportunity to change this trajectory. 22 States and the District of Columbia enacted legislation for accessible and affordable insulin therapy. North Dakota is operating on You PAY or You DIE.

This manipulated market is unsustainable and costs lives. There is not a generic (biosimilar) option and in the US, we are charged 7 to 10 times more than other developed countries for insulin. There is a "fake" generic for example: insulin aspart, which is the same as brand name Novolog & Fiasp, and is insulin made by the same company with a different label, and at a much lower price. The cost of insulin has risen over 1200% since 1990 with no substantial changes to the product. That would make your gallon of milk cost over $3000, and you can live without milk, but 8.3 million Americans can't live without insulin. Insulin is the hormone that converts glucose to energy to survive.

Some comments that might deter legislators from supporting this bill.

1. "Cap or mandates don't work"

2. "It's a slippery slope"

3. “If we do it for insulin, we have to do it for other drugs and procedures”

4. “If we pay for your insulin, other insured’s premiums will increase”

5. “If diabetics don’t continue to pay this outrageous price, the manufacturers can’t research and develop new drugs”

6. “If we cap prices, we may lose the rebates offered”

7. “I paid for my family’s medical bills, you should pay for yours”

8. “We value life at all ages”

My responses:

1. “You are right, in a manipulated market nothing works. We need to instill reasonable controls to protect people from blackmail for their life.

2. It doesn’t have to be a slippery slope. If a treatment for any disease has also been available for 100 years, and it has increased in price by 1200%, and it is 100% proven effective for millions of people, and allows people to reach a higher potential at work or school, and is proven to delay devastating and disabling complications by all means, YES IT SHOULD be accessible and affordable to everyone for the good of society.

3. No, you don’t have to do this for everything, this is a tactic to pit one disease against another. Insulin dependent diabetes has proven it takes lives due to rationing because of cost barriers, over and over.

4. Show me the studies, show me the numbers, show me the reality if this is true. Or is it true because the insurer makes it seem so? There is more data supporting that fewer complications related to diabetes like heart disease, kidney failure, diabetic retinopathy, stroke, blindness and amputations, actually lowers the costs overall.

5. Federally, it has been proven that Big Pharma spends MORE money on lobbying, than on research and development of new drugs or therapies.

Are you REALLY saying that people with diabetes should continue to DIE even though there is a known, 100% proven therapy available, because it is so expensive it can support research, so one of your loved ones can live because of a newly discovered drug or treatment?

6. I am aware of zero studies showing if we cap the price of insulin, the costs will rise for other members of the group. Please show them to me.

However, if we lose the fake rebates that are being subsidized on the backs, or lives of diabetics, yes, your premiums CAN and in my opinion SHOULD go up. If I knew I was being subsidized a few dollars on my premium but causing someone’s loss of life, I would

personally be devastated. If we were transparent with this information, I know others would be too.

7. If you paid for all your family medical costs decades ago, know that it isn't an apples to apples comparison because high deductible health plans and runaway prescription drug costs didn't exist then. That doesn't mean I don't agree it was hard to do.

8. If you truly value LIFE, you will work to help us make progress for affordable and accessible insulin therapy. I am also advocating at the Federal level for the bipartisan *Improving Needed Safeguards for Users of Lifesaving Insulin Now* (INSULIN) Act, however we need to act now in North Dakota. Diabetics have carried the burden far too long, especially with the popularity of employer sponsored high deductible health insurance plans being the only option for many families. Diabetes claimed 100,000 lives in 2021, making it one of the leading causes of death in the US. Diabetes is the most expensive chronic disease in the US where $1 of every $4 spent on healthcare is for a diabetes related care or treatment. This is unsustainable for the healthcare system, as 64,000 people are diagnosed with insulin dependent Type 1 diabetes every year, and that doesn't take into account all the other types of diabetes that require insulin. In closing, I look forward to collaborating with you to make progress on this issue to create a bill we can agree on and

Lack of Insulin Stops a Beating Heart and it truly is that Black and White.

Respectfully,

Danelle R. Johnson

TESTIMONY #2

Chairman Weisz and committee members. I appreciate the opportunity to testify remotely due to surgery. My name is Danelle Johnson from Horace, ND and I am here representing myself. Our daughter, Danika was dx with T1D in 2015 and is now 21. Every day, she moves closer to the reality of inconsistent access to insulin therapy in America, and every day we worry about the loss of our current coverage that provides access now.

OUR REALITY

When you know someone forced to PAY or DIE, and they can't PAY, and so they DIE you will understand why my advocacy efforts are passionate and critical. SB2140 would impose a price cap on insulin and basic supplies. It is similar to legislation passed by 22 states to delay onset of imminent complications from this terminal illness and avoid death by allowing people to be compliant with instructed care.

This is my third session attempt to initiate discussions, collaborate and raise awareness. Danika and I have also been federal advocates since 2019. There has not been any federal legislation that has

lowered out of pocket costs, that has made it to implementation, covering all ages regardless of their insurance situation.

You may hear and possibly believe these statements:

1) The bill won't help that many people

a. Approximately 64,000 people are diagnosed each year with Type 1 diabetes in the US. The ND Department of Health doesn't track specific types of diabetes. Saying we aren't going to help many people is an opinion until backed by factual data. The T1D community is growing every week in ND.

2) The bill will pass costs on to others

a. The enormous rebates from insulin used to subsidize health plan premiums and administration costs for all plan members would be lost if we didn't allow the use of formularies, which we have amended the bill to do. Costs passed on to other members has been proven by other states with insulin capping bills to be negligible at best.

3) Mandates don't work, we must allow free market

a. Insulin is not a free market, the "Big 3" insulin manufacturers have created an oligopoly – a market with little to no competition. With their actions absent competition, they have triggered an ongoing class action lawsuit for price fixing that was initiated in 2017.

4) Insurance companies are already doing this. When asked for details, the ND Insurance Commissioner's Office found it to be very complex to discern which plans were offering a copay cap. They couldn't provide documentation of exactly which plans from which ND insurers were doing so. This is not a factual statement until proven with data, it is a claim.

5) Dangerous precedent to declare this an emergency

a. Our legislature can and does make exceptions to laws, when deemed to be in the best interest of the people. As policymakers, you have that power. There are ample resources to draw cost studies from states that have already done this. And from the ND insurance providers that claim they have already been doing this. No need to study potential impact if it is already being done.

6) Businesses don't want higher health insurance costs

a. No one does. We all have a responsibility to educate business owners and business chambers, on tangible and non-tangible costs truthfully. Insulin therapy is 100% proven effective to sustain life and slow progression of this terminal illness. I consider this preventative with a positive ROI. Especially when the benefit is the person LIVES. Access to insulin allows for patient compliance and is more humane than inflicting intentional suffering and hardship for the benefit of others.

7) A copay cap isn't necessary because Insulin Manufacturers are slashing prices.

a. Eli Lilly themselves stated, the insulin they slashed the price on this week is only used by 3 out of 10 people. All people can't take all brands of insulin. Eli Lilly gained publicity after advocate pressure in 2019 and announced a half price version of Humalog, called Lispro. They received positive press and then do you know what happened? Pharmacies couldn't get supplies of it, so it "existed" in

theory, but people couldn't access it in reality. I believe it is our collective duty and responsibility as leaders and advocates to find a way to effect change that will preserve health and sustain lives, even if the margin is slim as some opponents claim.

I challenge you to CARE enough about your COMMUNITY, to make a COMMITMENT to have the COURAGE to discuss these statements in the context of insulin therapy in a manipulated market, with no biosimilar option available. I encourage and welcome further discussion or you can check out a website I co-author: www.insulinrequired.life I ask for a "DO PASS" recommendation on this bill. After all: Lack of Insulin Stops a Beating Heart and it truly is that Black and White.

Respectfully, Danelle R. Johnson, T1D Patient Advocate & T1D Mom

daryldanelle@msn.com 701-261-1687

TESTIMONY #3

POINT PAPER – Cost of Insulin products

Problem: The cost of insulin is presently unaffordable for a significant number of North Dakota residents who rely on it to survive. Nearly a quarter of insulin-dependent Diabetics ration insulin due to insulin's high monthly cost. Rationing insulin leads to serious complications including stroke, kidney disease, blindness, heart disease, and death.

Issues:

1) Patients. Type 1 Diabetes afflicts patients of all ages and is incurable, but easily treatable with insulin. Type 1 Diabetes is not caused by lifestyle choice, poor diet, or lack of exercise. Without insulin, Type 1 Diabetes is 100% fatal.

2) Cheap to Manufacture. Cost to manufacture insulin is low – only about $5-6 for a monthly supply, yet there are no generic options on the market.

3) Expensive to Buy. Type 1 Diabetes is the most expensive chronic illness in the United States. The average Type 1 Diabetic spends approximately $17,000 a year on out-of-pocket costs (OOP) for health care, not including their cost of insurance.

4) High Profit Incentive. The profit incentive for profit is high – approximately $1,127 per month per patient or a profit margin of approximately 7000%.

5) Exponential increases. The cost of insulin has exponentially increased in the last thirty (30) years with no substantial changes or improvements to the product.

6) Rebates Come at a High Cost. Approximately twenty-five percent (25%) of the profit is redistributed to pharmacy benefit managers, insurance companies, and large subscribers as

rebates. The genesis of the rebates is the high cost of insulin, paid for by Type 1 Diabetics overpaying for their medication.

7) Myth of Free Market. The insulin market is not a free market. Insulin manufacturers, pharmacy benefit managers, and insurance providers work in tandem to extend patents, introduce barriers for generics and inflate prices.

8) Insulin is deadly. Insulin is both deadly and lifesaving. It requires various supplies to be effective and to reduce long term health consequences.

9) Legislation is necessary. Legislative pressure on insulin manufacturers is working. Insulin price capping bills in twenty-two (22) states have resulted in downward compression on pricing in the last two (2) years.

10) Price Reduction Programs are Ineffective. Price reductions, manufacturer programs, coupon offerings, and supplier programs are ineffective, narrowly focused, and largely motivated by publicity.

Solution: The North Dakota Legislature approve a monthly co-payment cap of $25 for insulin and $25 co-payment cap for supplies.

Recommended Action: The committee approves the current bill.

Mister Chairperson and members of the House Government and Affairs Committee, my name is Angela Kritzberger from Hillsboro. I am asking you for your support and thoughtful consideration of HB1114. In the last several legislative sessions, I have worked alongside diabetes advocates and legislators to address the need for access to affordable insulin and diabetes supplies for over 50,000 North Dakotans whose lives depend on it and over a million Americans who are faced with rationing their insulin.

Our 16-year-old daughter Nina, who is with me today, was diagnosed with Type 1 Diabetes at the young age of 7. She has lived with this chronic, life threatening disease for over half of her young life. I am proud of the hard work that she does to maintain healthy blood sugars. It is not an easy task for anyone let alone a young child to make life and death decisions each day to manage this disease. Asking herself whether she can afford insulin when she ages off our insurance should not be one of them.

When I first started advocating for affordable insulin a number of years ago, we were paying over $1,000 for each refill at the pharmacy just for insulin. We calculated that for every $1 of food she ate based on her insulin needs, we were paying $1 in insulin, so her $10 meal at Subway actually cost us $20. We are a self-employed farm family that pays 100% of all medical expenses. Our high deductible policy, and I would also say that it feels like a high premium policy, lies within the private commercial market sector that is regulated by the Department of Insurance in North Dakota. A few years after our advocacy work started in North Dakota, our carrier implemented a $5 co-pay for some of their preventative drugs for the top chronic diseases which included insulin therapy. As a consumer, I cannot say that it was implemented on all of the plans that the carrier offered – I only know that our family was opting for the highest level of coverage and had heard from others that they did not have the same benefit. While we now pay $5 for insulin, the $5,200 deductible we must meet has now shifted to buying pump and glucose monitoring supplies before we pay 10% co-insurance on those supplies.

When we first started advocating for an insulin cap, 20 states had implemented some form of price cap. Today, 24 states and the District of Columbia have implemented caps, including SB2140 which was limited to NDPERS plan members in 2023 when it passed. While there is some movement by manufacturers to reduce costs and some markets like Medicare have a $35 cap, our work isn't finished until everyone has access to affordable insulin no matter how or where they get it from. In a free and fair marketplace, we would have the cost of our prescriptions available to us so that we can make the best educated decision for our families. Instead, we often find out after our first trip to the pharmacy in the new year after our coverage has taken effect what our actual cost will be for filling our prescriptions and supplies.

Nina has been using insulin pump therapy for eight years. Prior to using a pump, we would have to fingerstick 10-14 times a day as well as give her multiple daily injections of long-acting insulin and short acting insulin for food and correcting high blood glucose levels. I'm proud to have been part of a global DIY movement that donated data to the TidePool Foundation after building a closed loop system for her insulin delivery during COVID-19. It was the first time in years we slept through the night because of the system's ability to predict elevated or dropping blood sugars and automatically respond with its built-in algorithm. Tidepool Loop is the first fully interoperable automated insulin dosing app, cleared by the FDA in January of 2024, that originated as a patient-led initiative.

Advocacy drives progress. Innovation drives progress.

You have the power to keep this progress moving forward. Lives depend on it.

Thank you for your time.

Angela Kritzberger

Mother of a Type 1 Diabetic

Diabetes Advocate Hillsboro, ND

#701.430.3121

My name is Nina Kritzberger and I am the daughter of Angela and Peter Kritzberger. I am 16 years old, and I go to school at Hillsboro High School. I was diagnosed with Type One diabetes in 2016 at the age of 7.

I was a little kid playing tee ball one summer but one day something changed. We went to our local clinic to see what was going on. I was drinking a lot of water and going to the bathroom frequently. I had lost over 20 pounds. I was eating and my diet had not changed but I was slowly losing energy and felt tired all the time. It took a few trips to the doctor to find out what was wrong. I was terrified when they said I had Type One diabetes because as a 7-year-old I had never heard of it and didn't know what it was.

I slowly learned about the new disease that I had just gotten diagnosed with and I learned how to give myself my own shot after 2 days. I had to prick my finger to test every time I ate and many other times to see if my blood sugar was in range. I had to take shots every night before I went to bed and every time I ate food. Type 1 Diabetes can be partly genetic and it could also not be.

On the average day I use 65 units of insulin a day. I am a very active 16-year-old and I enjoy participating in my school's extracurriculars and sports. One day I'm hoping to explore the world and learn about the cultures of other places and meet great people. I truly want to make a difference and I want my story to be known.

When I first learned the outrageous price of insulin I was furious. As a 6th grader I was so upset I was determined to spread awareness about this disease and all of the little secrets that lie between the lines. I call insulin liquid gold because it truly is because of how highly priced it is you might as well call it that. I have had diabetes now for almost 9 years and I've learned a lot about the disease and the things that connect with this disease. One of those connections to my disease is this insulin bill.

On January 23, 1923 Banting, Collip and Best patented insulin and sold it for one dollar. They believed that insulin should be accessible to anyone that needed it to survive diabetes. Approximately 54,000 people in North Dakota live with some sort of diabetes. I am asking you why people have to pay such outrageous prices for something that helps them live. It's like saying that I'm going to make you pay for oxygen, because I want to take advantage of the people that breathe it and make them pay for something that is necessary for something that all of us need to survive.

I don't want to remember this bill because I lost a friend to it or a family member. I want to remember this bill so that I can know that my fellow North Dakotans like me are going to be safe and not have to ration their insulin just so that they can live and provide for their family. I fear the day that I age out of my parent's health insurance at the age of 26. I dream of

teaching kids in my future, but will I have one if I can't afford insulin? I will continue to keep fighting and spreading awareness about the disease - if I don't fight who will?

As a 16-year-old living with type one diabetes, there is one thing in the back of my mind that I think about every day. If this bill doesn't pass, I might not be here in the future and maybe I'll just become one of the many that have died because they couldn't afford the high prices of insulin. My future depends on this bill.

Thank you for your time.

Nina Kritzberger

Hillsboro, ND

Type One Diabetic

GREATER NORTH DAKOTA CHAMBER
HB 1114
House Government & Veteran Affairs Committee
Chair Austen Schauer
January 9, 2025

Mr. Chairman and members of the Committee, my name is Andrea Pfennig, and I am the Vice President of Government Affairs for the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1114.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, the top answer was to make healthcare more affordable.

Our members oppose mandates that increase business burdens and costs. That is exactly what this bill does. The fiscal note of this bill indicates that this is a cost shift. Rather than making healthcare more affordable, this will increase costs for businesses by shifting them to the employer.

It is unclear that the desired impacts of this bill will be achieved. In a report to the Employee Benefits Program Committee on Sept. 12, 2024, Rebecca Fricke, CEO of PERS, indicated that for the 2023-2025 biennium, utilization of insulin and diabetic supplies did not change significantly after inclusion of the price cap. Additionally, it was reported that pharmaceutical companies have been reducing the price of insulin and the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap.

This bill challenges the free market system that GNDC strongly supports. Free markets work. They give strength to the consumer by enticing companies to compete among each other for their business. This competition has led our nation to innovate and develop world-class products at reasonable prices, all at the demand and access of the consumer.

When considering a healthcare mandate that will be applied to the private sector, we ask that the committee also consider the benefits of a free market economy and the importance of a policy framework that enables that system, and our businesses, to thrive. We hope you will oppose this bill.

SANFORD HEALTH PLAN

Chairman Schauer and Members of the Committee -

Good Morning - my name is Dylan Wheeler, Head of Government Affairs with Sanford Health Plan. Today, speaking in opposition to HB1114. Sanford Health Plan supports affordable prescription drugs for our patients and members; we share the goal of the proponents in broadening access to insulin and the related supplies. However, mandating price caps on medications does not address the underlying issue - rising prescription drug prices. The market has seen significant shifts in recent years when manufacturers started to reduce prices on insulin in response to political and market forces; that experience was shown, too during the NDPERS pilot period. Sanford Health Plan also recognizes that through the recent revisions of the North Dakota Essential Health Benefits plan, insulin prices are now capped in those markets and this bill would capture the remaining state-regulated markets.

In my testimony today, I specifically wanted to highlight line 21 on page 1 – related to pre-mixed insulin and GLP-1 RA products. Post passage and during implementation, there were questions raised as to whether stand-alone GLP-1 medications (weight loss medications) were subject to the $25 monthly cap. Traditional or stand-alone GLP-1 medications are not within the purview of this bill.

To conclude, again we support affordable prescription drugs and access for our members and patients; however, question the policy approach of capping prices for certain medications.

I appreciate the committee's time and please let me know if you have any questions.

Dylan C. Wheeler JD, MPA
Sanford Health Plan

Good morning, Chairman Schauer, Members of the House Government and Veterans Affairs Committee. My name is Megan Hruby and I am with Blue Cross Blue Shield of North Dakota. Thank you for listening to our perspective this morning.

Blue Cross Blue Shield of North Dakota supports affordable health care and affordable drug pricing for all of the issues our members face and allowing individuals and business to make choices about what health insurance coverage is best for them. I think our goals align with the advocates present here today, we simply disagree on the method to achieve them.

BCBSND stands in opposition to Section One of House Bill 1114, the mandate for the commercial health insurance market on the basis that insurance mandates are not effective public policy. They are anti free market, oftentimes expensive, and stymy innovation. In North Dakota, we have never updated or repealed a single mandate. There are also risks to current plans that I believe legislators do not intend.

This mandate will impact a small percentage of Blue Cross members and represents a bit of a false promise. Here is why: It is my experience that the average person you meet doesn't have any idea what type of health insurance plan they are on. They know who the carrier is, whether it is a high deductible plan and generally what the coverage is, but they don't know if it is a self-funded plan, a fully insured plan, whether it is grandfathered or non-grandfathered. Under federal law, State imposed health insurance mandates only apply to the fully insured market. Self-funded plans, over two thirds of BCBSND's business, are governed by ERISA (or federal law) and not subject to state mandates. That means that for self-funded groups, the employer, who is typically paying the largest share of the premium and typically the HR folks, decide what benefits they offer. (See handout SF v FI). These are the tough decisions that employers have to make when assessing their workforce retention and budgets. So, while folks will hear about or read the media on this, many are unlikely to be eligible for the price cap if it were to pass because they are on an ERISA plan. To limit this further, NDCC 26.1-36-01.1 exempts all high deductible health plans (HDHPs) with a health savings account (HSA) from mandates if they are in jeopardy of losing their HDHP status under federal law. There are risks to passing mandates that can result in a small business losing their less expensive, grandfathered plan. Most grandfathered (or pre-Affordable Care Act) plans have a small margin of change they can make before they lose their grandfathered status and must switch to a non-grandfathered (or post-ACA) plan. That switch frequently includes more prevention and protection but comes at a higher cost. When asked by the Greater North Dakota Chamber what was one thing that state legislators can do to help their business, healthcare affordability has been the top response for several years. We do not make health insurance more affordable by passing coverage mandates, as insurance companies do not pay for mandates, policyholders pay for mandates through the form of increased premiums.

Blue Cross Blue Shield of North Dakota spends over $250 million annually on State Legislature imposed health insurance mandates. Some of them are outdated, where the science has progressed beyond what is in statute. We might cover the newer test or drug, but we are also forced to cover the outdated version

because a mandate was passed at some point historically and has never changed. Additionally, we have federal laws and requirements, like the Affordable Care Act, that tie our hands to what is written in law rather than allow flexibility and innovation, like what we did with our own preventative drug list.

One of the primary reasons we oppose the commercial application of the insulin cap is because as pharmaceutical companies began to gouge diabetics quite a few years ago for life saving drugs, BCBSND, on our own and without state intervention, adopted a $5 monthly insulin copay cap for our fully insured members. We went a step beyond insulin alone and created a "preventative drug list." On our website you can find over six pages of drugs, including insulin and diabetes supplies, for multiple health conditions that we cover at $5 or less. We didn't choose to favor only the folks who need insulin, we looked at our members with asthma, hypertension and other chronic issues as well.

As of today, the three major heath carriers in North Dakota all have an insulin cap of no more than $25 in place without the mandate. Our essential health benefits (EHB) include a $25 cap on insulin and supplies for all ACA marketplace plans. And at the federal level, in the Inflation Reduction Act of 2022, the federal government passed an $35 insulin cap for Medicare beneficiaries.

Just a final note, if the aim of policy makers is to make health care and life saving drugs more affordable, instituting a copay cap is similar to putting a band aid on a wound that will not heal. It reduces the point-of-sale cost of insulin for the folks who need it to $25, but it does nothing to address the underlying issue of affordability, as pharmaceutical companies are still free to charge whatever they want for insulin. The more they charge, the more everyone pays for health insurance premiums, whether it's individuals, North Dakota businesses, or the state government. You'll note that pharmaceutical companies have not opted to drastically increase the price of aspirin, ibuprofen or allergy meds, instead they have chosen lifesaving drugs. Recent attention on this issue by Congress and two Presidents has put enough pressure on insulin manufacturers to lower costs, with the most drastic being Eli Lilly reducing insulin costs by 70%. Eli Lilly, Novo Nordisk and Sanolfi have all implemented $35 caps on their insulin products.

BCBSND supports continued pressure and attention on any provider that is gouging our members. Our health care costs in North Dakota are ranked third highest nationally per capita. Let's focus on solutions that get to the root of the problem at hand while allowing individuals and businesses alike to make choices about the health care coverage that is best for them.

Thank you for your time and I'll stand for any questions.

January 9, 2025

Chairman Schauer and members of the committee. I am Danelle Johnson from Horace, ND here speaking on my own behalf. My daughter, Danika Johnson age 22, who lives with Type 1 Diabetes, and I were the original authors of this bill that started out as SB2183 in the 2021 legislature. It was forwarded by Sen. Judy Lee to US Sen. Kevin Cramer to address at the federal level. Since then, Danika, myself and many other advocates have appeared in Washington, DC, and Bismarck, ND before various legislators and committees to get to this point where SB2140 was passed in the 2023 legislature. That triggered the 2-year study period to begin with the change applied to the NDPERS health insurance plan.

The need is great, the issue is widespread making appearances in many, many political speeches over the past decade. Over 25 states have now passed some form of insulin copay cap or assistance to make insulin therapy accessible and affordable to more people.

This bill is intended to get as many people as possible access to affordable insulin and bare necessities to administer and dose it as prescribed by their medical care team. It is not intended to cover GLP1's or any other form of treatment for diabetes currently.

I have compiled and attached my historical testimony in support of this bill on the website and printed a copy for each of you. I would like to use my time today to take questions that have arisen in the interim NDPERS meetings or new ones you may have.

Examples of important topics intertwined with this complex issue:

Mandates, Free Market, Negligible costs increase in $ vs lost productivity, PBMs & pricing transparency, Rebate Pooling, Lower work performance, Time away from work, Stress, Anxiety, Mental Health of individuals and their caregivers, Educational experiences, Take Prescriptions As Directed, Lack of Biologics with evergreening patents, Lower Priced Insulin Availability, Lack of choice with insulin brand, Required use of certain pharmacy (CVS in my case and there are only 6 in the entire state), Class Action Lawsuit against the Big 3 oligopoly of insulin manufacturers began in 2017. Research and Development Costs, Big Pharma Lobbyist – largest in nation, New Research supported by paying this outrageous cost.

We have to get away from the PAY OR DIE situation so many families deal with daily, and we have to start Caring about our population's health and preventing known devastating outcomes. If we work to resolve some of these root causes, it can also lower rates of addiction, suicide, mental health disorders, criminal activity and homelessness. All things that can come into the picture when you are trying desperately to save your loved one's life every day.

Danika was not able to be here today because she is at the Passion conference for 18-25 yr olds with 14 people from her Church Life Group. My husband agrees every time we pass a specific billboard on interstate, that he values life and REAL MEAN Love Their Children, not just babies.

In Closing, Remember, Lack of Insulin Stops a Beating Heart. It truly is Black and White.

Respectfully, Danelle R. Johnson 701-261-1687 or daryldanelle@msn.com

This document contains my original testimony from several different hearings for SB 2140 as it worked its way through the 2023 Legislative Session. It passed, and that started the required two year study period using the NDPERS plan. This has now become HB1114 for the 2025 Legislative session. I was the original author of this bill back in 2021.

Danelle Johnson, Type 1 Diabetes Advocate & Mom to Danika Johnson, a fellow advocate that is living with Type 1 Diabetes. Contact Info: 701-261-1687, daryldanelle@msn.com

TESTIMONY #1

January 11, 2023

Madam Chair Lee and members of the committee, I am Danelle Johnson from Horace, ND. I am here representing myself. I support this bill because our daughter Danika (20), lives with auto-immune Type 1 Diabetes, as do many residents in our state. She is insulin dependent to sustain her life, for the duration of her life, or until a cure is found. I have advocated at local, state and federal levels for years and have yet to see progress for residents of North Dakota until the Federal Inflation Reduction Act capped the monthly cost of insulin for Medicare enrollees at $35.

The inability to afford insulin is more daunting than having a family member diagnosed with Type 1 Diabetes. We were told if we\she takes care of herself, she can live a long, healthy life, free of complications. The medical care team can't prepare you for not being able to afford insulin and supplies necessary to dose and administer insulin therapy. This can be the start of losing hope. The burden can lead to anxiety\depression, addiction, suicide, poor performance at school or work, financial ruin, isolation, homelessness and a variety of issues, just to get their hands on this liquid gold. Together, we have an opportunity to change this trajectory. 22 States and the District of Columbia enacted legislation for accessible and affordable insulin therapy. North Dakota is operating on You PAY or You DIE.

This manipulated market is unsustainable and costs lives. There is not a generic (biosimilar) option and in the US, we are charged 7 to 10 times more than other developed countries for insulin. There is a "fake" generic for example: insulin aspart, which is the same as brand name Novolog & Fiasp, and is insulin made by the same company with a different label, and at a much lower price. The cost of insulin has risen over 1200% since 1990 with no substantial changes to the product. That would make your gallon of milk cost over $3000, and you can live without milk, but 8.3 million Americans can't live without insulin. Insulin is the hormone that converts glucose to energy to survive.

Some comments that might deter legislators from supporting this bill.

1. "Cap or mandates don't work"

2. "It's a slippery slope"

For over 20 years, I have watched this disease take a financial and emotional toll on myself, and my loved ones. This insulin cap could help those families in our state who were just like mine. Life flipped upside down with a newly diagnosed 7-year-old and a laundry list of new things they need to do and worry about. Vote yes on this bill so it can take at least one burden away from them as they navigate their new normal. It will also help people like myself, who have lived with diabetes for years and never felt truly secure in their ability to have the medicine they need. My Mom has always told me, one of her biggest fear was one day I would not be able to afford my insulin. Well, we have an opportunity to help make that fear a distant memory for the people of North Dakota.

Please vote yes on HB 1114. Thank you for the opportunity to submit testimony.

Sincerely,

Marlee Seibold
(701) 721-4423
Bismarck, ND

3. “If we do it for insulin, we have to do it for other drugs and procedures”

4. “If we pay for your insulin, other insured’s premiums will increase”

5. “If diabetics don’t continue to pay this outrageous price, the manufacturers can’t research and develop new drugs”

6. “If we cap prices, we may lose the rebates offered”

7. “I paid for my family’s medical bills, you should pay for yours”

8. “We value life at all ages”

My responses:

1. “You are right, in a manipulated market nothing works. We need to instill reasonable controls to protect people from blackmail for their life.

2. It doesn’t have to be a slippery slope. If a treatment for any disease has also been available for 100 years, and it has increased in price by 1200%, and it is 100% proven effective for millions of people, and allows people to reach a higher potential at work or school, and is proven to delay devastating and disabling complications by all means, YES IT SHOULD be accessible and affordable to everyone for the good of society.

3. No, you don’t have to do this for everything, this is a tactic to pit one disease against another. Insulin dependent diabetes has proven it takes lives due to rationing because of cost barriers, over and over.

4. Show me the studies, show me the numbers, show me the reality if this is true. Or is it true because the insurer makes it seem so? There is more data supporting that fewer complications related to diabetes like heart disease, kidney failure, diabetic retinopathy, stroke, blindness and amputations, actually lowers the costs overall.

5. Federally, it has been proven that Big Pharma spends MORE money on lobbying, than on research and development of new drugs or therapies.

Are you REALLY saying that people with diabetes should continue to DIE even though there is a known, 100% proven therapy available, because it is so expensive it can support research, so one of your loved ones can live because of a newly discovered drug or treatment?

6. I am aware of zero studies showing if we cap the price of insulin, the costs will rise for other members of the group. Please show them to me.

However, if we lose the fake rebates that are being subsidized on the backs, or lives of diabetics, yes, your premiums CAN and in my opinion SHOULD go up. If I knew I was being subsidized a few dollars on my premium but causing someone’s loss of life, I would

personally be devastated. If we were transparent with this information, I know others would be too.

7. If you paid for all your family medical costs decades ago, know that it isn't an apples to apples comparison because high deductible health plans and runaway prescription drug costs didn't exist then. That doesn't mean I don't agree it was hard to do.

8. If you truly value LIFE, you will work to help us make progress for affordable and accessible insulin therapy. I am also advocating at the Federal level for the bipartisan *Improving Needed Safeguards for Users of Lifesaving Insulin Now* (INSULIN) Act, however we need to act now in North Dakota. Diabetics have carried the burden far too long, especially with the popularity of employer sponsored high deductible health insurance plans being the only option for many families. Diabetes claimed 100,000 lives in 2021, making it one of the leading causes of death in the US. Diabetes is the most expensive chronic disease in the US where $1 of every $4 spent on healthcare is for a diabetes related care or treatment. This is unsustainable for the healthcare system, as 64,000 people are diagnosed with insulin dependent Type 1 diabetes every year, and that doesn't take into account all the other types of diabetes that require insulin. In closing, I look forward to collaborating with you to make progress on this issue to create a bill we can agree on and

Lack of Insulin Stops a Beating Heart and it truly is that Black and White.

Respectfully,

Danelle R. Johnson

TESTIMONY #2

Chairman Weisz and committee members. I appreciate the opportunity to testify remotely due to surgery. My name is Danelle Johnson from Horace, ND and I am here representing myself. Our daughter, Danika was dx with T1D in 2015 and is now 21. Every day, she moves closer to the reality of inconsistent access to insulin therapy in America, and every day we worry about the loss of our current coverage that provides access now.

OUR REALITY

When you know someone forced to PAY or DIE, and they can't PAY, and so they DIE you will understand why my advocacy efforts are passionate and critical. SB2140 would impose a price cap on insulin and basic supplies. It is similar to legislation passed by 22 states to delay onset of imminent complications from this terminal illness and avoid death by allowing people to be compliant with instructed care.

This is my third session attempt to initiate discussions, collaborate and raise awareness. Danika and I have also been federal advocates since 2019. There has not been any federal legislation that has

lowered out of pocket costs, that has made it to implementation, covering all ages regardless of their insurance situation.

You may hear and possibly believe these statements:

1) The bill won't help that many people

a. Approximately 64,000 people are diagnosed each year with Type 1 diabetes in the US. The ND Department of Health doesn't track specific types of diabetes. Saying we aren't going to help many people is an opinion until backed by factual data. The T1D community is growing every week in ND.

2) The bill will pass costs on to others

a. The enormous rebates from insulin used to subsidize health plan premiums and administration costs for all plan members would be lost if we didn't allow the use of formularies, which we have amended the bill to do. Costs passed on to other members has been proven by other states with insulin capping bills to be negligible at best.

3) Mandates don't work, we must allow free market

a. Insulin is not a free market, the "Big 3" insulin manufacturers have created an oligopoly – a market with little to no competition. With their actions absent competition, they have triggered an ongoing class action lawsuit for price fixing that was initiated in 2017.

4) Insurance companies are already doing this. When asked for details, the ND Insurance Commissioner's Office found it to be very complex to discern which plans were offering a copay cap. They couldn't provide documentation of exactly which plans from which ND insurers were doing so. This is not a factual statement until proven with data, it is a claim.

5) Dangerous precedent to declare this an emergency

a. Our legislature can and does make exceptions to laws, when deemed to be in the best interest of the people. As policymakers, you have that power. There are ample resources to draw cost studies from states that have already done this. And from the ND insurance providers that claim they have already been doing this. No need to study potential impact if it is already being done.

6) Businesses don't want higher health insurance costs

a. No one does. We all have a responsibility to educate business owners and business chambers, on tangible and non-tangible costs truthfully. Insulin therapy is 100% proven effective to sustain life and slow progression of this terminal illness. I consider this preventative with a positive ROI. Especially when the benefit is the person LIVES. Access to insulin allows for patient compliance and is more humane than inflicting intentional suffering and hardship for the benefit of others.

7) A copay cap isn't necessary because Insulin Manufacturers are slashing prices.

a. Eli Lilly themselves stated, the insulin they slashed the price on this week is only used by 3 out of 10 people. All people can't take all brands of insulin. Eli Lilly gained publicity after advocate pressure in 2019 and announced a half price version of Humalog, called Lispro. They received positive press and then do you know what happened? Pharmacies couldn't get supplies of it, so it "existed" in

rebates. The genesis of the rebates is the high cost of insulin, paid for by Type 1 Diabetics overpaying for their medication.

7) Myth of Free Market. The insulin market is not a free market. Insulin manufacturers, pharmacy benefit managers, and insurance providers work in tandem to extend patents, introduce barriers for generics and inflate prices.

8) Insulin is deadly. Insulin is both deadly and lifesaving. It requires various supplies to be effective and to reduce long term health consequences.

9) Legislation is necessary. Legislative pressure on insulin manufacturers is working. Insulin price capping bills in twenty-two (22) states have resulted in downward compression on pricing in the last two (2) years.

10) Price Reduction Programs are Ineffective. Price reductions, manufacturer programs, coupon offerings, and supplier programs are ineffective, narrowly focused, and largely motivated by publicity.

Solution: The North Dakota Legislature approve a monthly co-payment cap of $25 for insulin and $25 co-payment cap for supplies.

Recommended Action: The committee approves the current bill.

To Whom It May Concern,

My name is Stacey Poffenberger, and I am a proud resident of North Dakota and a state employee. I am also the mother of a child with type 1 diabetes, diagnosed at the age of six. Type 1 diabetes is an autoimmune condition that necessitates daily insulin via an insulin pump or multiple daily injections to survive. Without insulin, my child, like many others, cannot live.

Insulin, developed approximately 100 years ago, has seen its cost skyrocket, making this lifesaving medication unaffordable for many North Dakotans, including my family. As a mother, I am deeply concerned about the future. My son, now 13, frequently expresses worry about how he will afford insulin as an adult. This constant anxiety is not just about his health but about his entire future.

In January 2023, I purchased a one-month supply of insulin for my son, and with NDPERS insurance, the out-of-pocket cost was $254. The insulin cap bill passed last session was a monumental relief for us as a state employee family. A one-month supply of insulin dropped to $25! It significantly eased our financial burden and provided much-needed peace of mind. However, it is crucial to extend this benefit to all North Dakotans.

Implementing an insulin cap for all residents would ensure that no one in our community has to choose between life-saving medication and other essential needs. It is a necessary step towards equity, health, and safety for everyone affected by this condition.

I strongly recommend and support the cap on out-of-pocket insulin costs for ALL North Dakotans. Insulin is the sole treatment for type 1 diabetes, and without it, individuals cannot live. Passing this bill will not only save lives but also provide much-needed stability and security for countless families like mine.

Thank you for your consideration.

Sincerely,

Stacey Poffenberger

A concerned North Dakota citizen and mother of a child with type 1 diabetes

To the Members of the Government and Veterans Affairs Committee:

I am writing in support of HB1114.

I have two great-nephews with Type 1 Diabetes. One was diagnosed at age 6 (now 13) and one at age 12 (now 16). Living with diabetes is challenging not only for them, but also for their families. The high cost of insulin adds a financial burden that many families are unable to afford. This financial burden will follow my nephews throughout their lives.

I strongly support health insurance coverage for insulin and out-of pocket supply costs. Passage of HB1114 would be a positive step in securing financial relief for individuals and families living with diabetes.

Thank you for your favorable consideration of this bill.

Sheryl Pfliger

January 7, 2025

To the members of the Government and Veterans Affairs Committee

As a constituent and registered voter and a great aunt to two great nephews with Type I diabetes, I am writing in support of HB1114 relating to public employee insulin drug and supplies benefits.

Diabetes is a life sentence which no adult/child deserves so we need to do everything we can to make sure they have access to affordable life saving medication (insulin) so that every person can lead a normal life.

Families/parents should not be forced to choose between life essentials such as food and shelter and life saving insulin. With your support of HB1114, they will not need to make that choice. Furthermore, with the help of insulin therapy to manage their diabetes, my great nephews will have the opportunity to live long, healthy and productive lives.

Thank you for your support of HB1114 and your dedication to making North Dakota a better place to live.

Sincerely,

Arlyce Schulte

I am writing to support HB1114. I cannot conceive people afflicted with this disease worrying about whether they can afford life-supporting medicine. Please join me in providing agreement with this House Bill 1114.

Thank you.

Stuart M Libby

Honorable North Dakota Senators & Representatives,

I am writing to you in support of House Bill 1114 regarding Insulin and Supplies Copay Capping Bill in North Dakota. Senators, please for a minute, imagine you are a seven year old boy. You are sitting in your classroom and you peer over to the door and you see your mother standing there. She appears frantic. She tells you that we need to get to the hospital right away. This morning, your mother had tested your blood sugar while you were sleeping (fasting) and it was 268 mg/dL. Please keep in mind that a normal blood sugar is less than 100 mg/dL. You spend the next couple hours getting poked and prodded. Crying, sobbing, begging to go home. The doctor finally tells you that you have Type 1 Diabetes. Type 1 Diabetes is an autoimmune disease that is triggered by environmental factors without a cure. You are scared. At seven years old, you do not fully understand what this means. You meet with the diabetes educator thinking that you are on your way home after your mother learns how to give you multiple daily injections of insulin. The doctor comes in and tells you that they found ketones (glucose) in your urine and that you need to go to the hospital. At this point, you're dehydrated and the nurses spend several hours trying to put in an IV to deliver fluids. Seven years old. My son was seven years old when this happened to him on March 10, 2022. My son never asked for this and there is nothing he could've done to prevent this disease. Imagine if this was your child or your grandchild. Living everyday only because of a hormone that is produced by a pharmacy because your pancreas no longer produces it. Fast forward to the fall of 2023, through a risk screening for my relatives of people with Type 1 Diabetes, my oldest son was delivered the same fate as his younger brother. Three positive antibodies, a sealed fate of a life of Type 1 Diabetes. Two, I have two children who depend on insulin to live every day and have to carry the financial burden and stress of this disease for the rest of their lives. My children are currently 10 and 14 years old and they are already consumed with how they can contribute to society with future jobs and still afford to live with the outrageous cost to treat and monitor this disease.

This is what I have learned as a mother of two children with this disease. Prior to 1921, people with Type 1 Diabetes did not live long because there was not much that doctors could do for them, dying within days or months. In 1921, insulin was successfully isolated by Frederick Banting and his medical student Charles Best. Within a year, people with Type 1 Diabetes were being treated with insulin for a disease that had been previously considered fatal. According to the American Diabetes Association, over 1.9 million Americans live with the disease, making insulin a medical miracle for many. In 1923, Banting, Collip and Best were awarded U.S. patents on insulin and the method used to make it. They sold these patents to the University of Toronto for $1 each. That's worth repeating. They sold these patents to the University of Toronto for $1 each! According to Advanced Science News, Banting famously said "Insulin does not belong to me, it belongs to the world." He wanted everyone to have access to it.

Fast forward to today, where the pharmaceutical industry is price gouging millions of patients for a medication that costs from $2-$6 to produce. This greed is keeping insulin out of the hands of those who need it to survive. Many Type 1 Diabetics are living with the daily anxiety that they

need to ration their insulin, go without it at times or that they won't be able to afford it. A study in The Annals of Internal Medicine found that in 2021, 1 in 5 Americans were rationing their insulin. This means that they sacrifice paying bills and buying groceries to afford insulin. What we are seeing is the manipulation of the population to make a profit. The intent of Mr. Banting's discovery was to save lives and yet people can not afford a product made for that sole purpose. People living with Type 1 Diabetes should not have to compromise their health due to affordability and inequality.

We are urging you to vote yes and join the other 24 states that have capped the price of insulin and basic supplies to sustain life and delay complications by providing access and affordability to everyone for this minimum standard of care.

I will leave you with one last thing I've learned. Did you know that people living with Type 1 Diabetes make over 180 decisions every day regarding how to manage the disease in addition to everyday life decisions. How about we take away one of them - making the decision on whether or not they can afford to buy insulin to stay alive? The price of voting no on a cap for insulin, could be paid in human lives. So, I ask you, how would you vote if your child or grandchild was living with Type 1 Diabetes and there was a possibility they could not afford the drugs they need to stay alive? Please vote yes on House Bill 1114. Thank you for your support of this request.

Gwen Sobolik
(Mother of Trygg Sobolik, Type 1 Diabetic and Hudson Sobolik, Type 1 Diabetic)
Park River, North Dakota

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North Dakota Senators and Representatives,

Hi my name is Trygg Sobolik. I have lived with Type 1 Diabetes for almost 3 years. I'm asking for your support of House Bill 1114. I need insulin every day to live. Please fund this bill for kids and people like me. Lack of insulin stops a beating heart. We must do better. I am very worried that I'll be able to afford insulin on my own some day.

Thank you, Trygg Sobolik Type 1 Diabetic - 10 years old

North Dakota Senators and Representatives,

My name is Hudson Sobolik and I am 14 years old. I live every day with Type 1 Diabetes. My brother Trygg was diagnosed in March of 2022 at the age of 7 years old. In 2023, my mom discussed doing a risk screening for diabetes for our family since Trygg has diabetes. The boxes came and I was very nervous to poke my finger and give a vial of blood. A month after my mom sent the test results back, my mom told me that my test results were positive. I had 3 antibodies which meant that I had a 100% chance of developing Type 1 Diabetes.

In November of 2023, I completed a Glucose Tolerance Test in the hospital in Fargo. I did not pass the test and was sent to a pediatric endocrinologist at the clinic. The doctor explained that I have Type One Diabetes and that I did not do anything to cause it. I was sent home with a continuous glucose monitor. I eventually started on insulin - long acting and short acting. Multiple shots a day, one before bed and one before every meal or snack. I am constantly checking my continuous glucose monitor to make sure that I am in range before I eat, exercise or go to bed. Alarms go off on my phone when I am too low or too high.

I am active in Basketball and Baseball to maintain my health. I want to become a farmer some day like my dad and produce food for the world. I am worried that I will not be able to afford insulin because I might not have good insurance when I am off my parents insurance. I do not find it fair that people with diabetes have to pay hundreds of dollars for a vial of insulin that only costs $2-$6 to make.

I want to live a long life. Please support House Bill 1114 for the future of North Dakota.

Hudson Sobolik

American Diabetes Association.
Connected for Life.

January 9, 2025

Dear Chairman Schauer and Committee Members,

On behalf of the American Diabetes Association (ADA), I write to share the ADA's support for House Bill 1114, which would cap the costs of insulin and diabetes supplies at $25 for a 30-day supply.

The American Diabetes Association® (ADA) is the nation's leading voluntary health organization fighting to end the diabetes epidemic and helping people living with diabetes to thrive. People living with diabetes continue to face significant financial barriers when treating their disease. One in six Americans with diabetes report rationing their insulin, whether taking less than they need or skipping doses. Rationing insulin can lead to costly, disabling complications, even death. And many people with diabetes have also expressed struggling with the costs of the equipment and supplies needed for insulin administration and blood glucose monitoring.

The ADA has been leading the fight to ensure insulin is affordable for all who rely on it to live. Working with state and national partners, our work has led to 25 states and the District of Columbia enacting legislation that caps co-payments on monthly insulin as well as some states adding caps on certain diabetes supplies. [1]

In Colorado, a recent research study has shown that people living with diabetes have reduced their health care expenses after their cap went into effect, reducing their risk for rationing. Average out-of-pocket costs for insulin dropped by about 40 percent in the two years after the law's passage. [2] Annual savings were the highest for children and adults aged 18 to 34, and rural patients saw greater savings than those in non-rural areas. [2]

We respectfully ask the committee to support passage of HB 1114 to help more North Dakotans living with diabetes. Ensuring insulin and diabetes supplies are affordable reduces the risk for rationing and the tragic complications that can result.

If you have questions, please don't hesitate to contact me at mprokop@diabetes.org.

Sincerely,

Matt Prokop
Director of State Government Affairs
American Diabetes Association

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[1] https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps
[2] https://today.tamu.edu/2024/09/06/state-insulin-price-cap-law-cuts-out-of-pocket-costs-by-40-study-finds/

Matt Prokop
Director, State Government Affairs
1 (402) 519-5019 Ext. 5019
mprokop@diabetes.org

diabetes.org
@AMDiabetesAssn

1-800-DIABETES (342-2383)

I am writing to support HB1114. I cannot conceive people afflicted with this disease worrying about whether they can afford life-supporting medicine. Please join me in providing agreement with this House Bill 1114.

Thank you.

Stuart M Libby

To whom it may concern,

My name is Jessica and I am a wife, mother and resident of North Dakota. My husband, Erik is a Type 1 diabetic and has lived with this disease for over 28 years, since he was just 19 years old.

Throughout our marriage I have seen firsthand the daily struggles of living with diabetes; including watching what he eats and limiting carbs, battling the never ending highs & lows of his blood sugar, and navigating the insurance battle to ensure his insulin and diabetic supplies are covered.

There have been times when our out of pocket costs for insulin topped $1,000, and that's not including the out of pocket expenses for syringes, pump supplies and the cost of an insulin pump.

Keeping in mind, the patent for insulin was sold for $1 and was never intended for anyone to make a profit from, yet 100 years after the invention of insulin people are being forced to choose between paying for their live saving medication and paying for everything else they need to live.

I have also seen firsthand a friend lose her life because she was forced to ration her insulin because she could not afford it. Rationing insulin can result in permanent kidney damage and ultimately lead to more complications and death, which was the case for Shaina Odermann.. Shaina was just 37 years old at the time of her passing.

In honor of all North Dakotans currently fighting to stay alive with diabetes, I respectfully urge you to pass bill HB 1114 and cap the monthly cost of insulin at $25.

Thank you for your consideration,

Jessica Lovell-Opdahl

Regarding HB 1114:

My name is Avis LuAnn White and I live in Fargo ND and have been a ND resident all my life.

My son, Erik, was diagnosed with Type 1 diabetes when he was 19 years old and has had to be reliant on life-saving insulin for the past 28 years. Unfortunately, the cost of his insulin has been very difficult for them and his family.

I have witnessed his struggles to reduce carbs, watching his diet constantly as well as his blood sugar highs and lows. It is difficult for a mother to watch, to say the least. When he was first diagnosed, I broke down in tears knowing this would be a life-long commitment of food restrictions.

Insulin is not a choice for those suffering from Type 1 diabetes. It is a necessity and for so many the cost is prohibitive at times, causing diabetics to choose whether to pay other necessary bills for the family or paying sometimes over $1000 for insulin, not including syringes, etc.

Something needs to be done so those who desperately need insulin can afford to pay for it.

I am asking for my son and others I know personally who have Type 1 diabetes, that this bill passes and makes insulin affordable for everyone!

House Bill 1114 – Support
January 9, 2025
House Government and Veterans Affairs
Janelle Moos, AARP ND- jmoos@aarp.org

Chair Schauer and Members of the House Government and Veterans Affairs Committee,

My name is Janelle Moos, Advocacy Director with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. 83,000 of those members live in North Dakota.

The current cost of prescription drugs poses a significant burden to midlife and older adults, with eight in ten (82%) adults 50 and older describing them as too expensive, according to AARP research. To relieve consumers' financial burdens, some states have considered placing a cap on a consumer's out-of-pocket (OOP) prescription drug expenses. States have designed out-of-pocket caps in several ways, including applying spending limits to certain drugs, or applying the cap to a consumer's overall monthly or annual prescription drug expenditures.

North Dakota joined 28 other states in 2023 by passing SB 2140 that implemented a two-year pilot program capping the monthly out of pocket costs for insulin and medical supplies used to administer the insulin for those on the state PERS plan. SB 2140 also instructed PERS to introduce a bill during the 2025 session to extend the cap on out of pockets expenses to the general state insurance marketplace for individual and small group insurance plans.

We hear stories from North Dakotans trying to manage the high cost of medicine along with paying for other necessities like food and utilities. For example, Dennis, a diabetic, told us he may have to go back to work after retiring to pay for his insulin- his co-pay is about $100/month- with insurance-and without insurance, his co-pay would be about $400/month.

In North Dakota, the most vulnerable and underserved populations suffer from the highest rates of diabetes and have the poorest health outcomes. Based on the Behavioral Risk Factor Surveillance System (BRFSS) data, in 2022, 57,203 adults in North Dakota were living with diabetes, including 13.8% between the age of 55-64 and 19.6% of people 65+. Another 226,430 were prediabetic, including 48,560 (49%) that were 65 and older.

From 2009 to 2019, the price of insulin tripled even though there's been no change in the product. The result is many people ration their doses or go without, often with deadly consequences. And these high prices have led a growing number of patients who rely on the lifesaving drug to resort to rationing or skipping doses because they can't afford the medication. Insulin caps could make life-essential drug more affordable and accessible for many older adults.

Placing a cap on consumer's out-of-pocket prescription drug expenses is one approach that some states are considering relieving consumer's financial burdens and can lead to two outcomes:

- Lowering a consumer's out-of-pocket prescription drug expenditures, making prescriptions more affordable and accessible at the point of sale
- The potential to improve drug adherence and reduce cost-related behaviors like splitting medications or not filling a prescription at all

Caps on out-of-pocket costs typically benefit a specific group of consumers. As such, AARP supports joining such efforts with policy changes that will help reduce prescription drug prices.

We encourage the legislature to consider this bill along with other broader reforms as part of the conversation to help lower the cost of prescription drugs for North Dakotans.

Thank you again for your thoughtful work on this issue.

We appreciate any effort to make medicine more affordable and urge you to vote in favor of HB 1114.

Cap on Out-of-Pocket Expenses

82%

A recent AARP survey showed that nearly over eighty percent (82%) of likely voters ages 50 and older describe prescription drugs as too expensive. Cost is the most common reason cited for deciding not to fill a prescription.

Description

In order to relieve consumers' financial burdens, some states have placed a cap on a consumer's out-of-pocket (OOP) prescription drug expenses. States have designed OOP caps in several ways, including applying spending limits to certain drugs or applying the cap to a consumer's overall monthly or annual prescription drug expenditures.

As of 2023, the Inflation Reduction Act caps OOP costs on insulin for Medicare Parts B & D enrollees at $35 a month, which benefits close to 3.3 million Americans. While the bill originally included this cap for all insurance plans, the final version limited it to Medicare enrollees only. Under the law, Part D enrollees also have an overall annual OOP cap of $2,000 for all their Part D drugs starting in 2025. States can pursue their own legislation to apply OOP caps to people on coverage other than Medicare Part D.

How Does it Work?

State OOP cap laws focus primarily on setting an upper limit or cap on what a consumer with a private health plan pays for a single 30-day outpatient prescription, whether through co-pays or coinsurance. Some states have enacted broad laws that cap all drugs for certain insurers or a wide range of prescription drug classes. Meanwhile other states have passed laws to limit the amount individuals pay for a 30-day supply of certain high-priced, specialty drugs to treat conditions such as multiple sclerosis or rheumatoid arthritis.

What Does This Mean for Consumers?

Lowers a consumer's out-of-pocket prescription drug costs, making prescriptions more affordable and accessible at the point of sale.

There is the potential to improve drug adherence and reduce cost-related behaviors like splitting medications or not filling a prescription at all.

There is a possibility of higher health care premiums and cost-sharing due to insurers shifting prescription drug costs.

Where Has This State Legislative Policy Been Enacted?

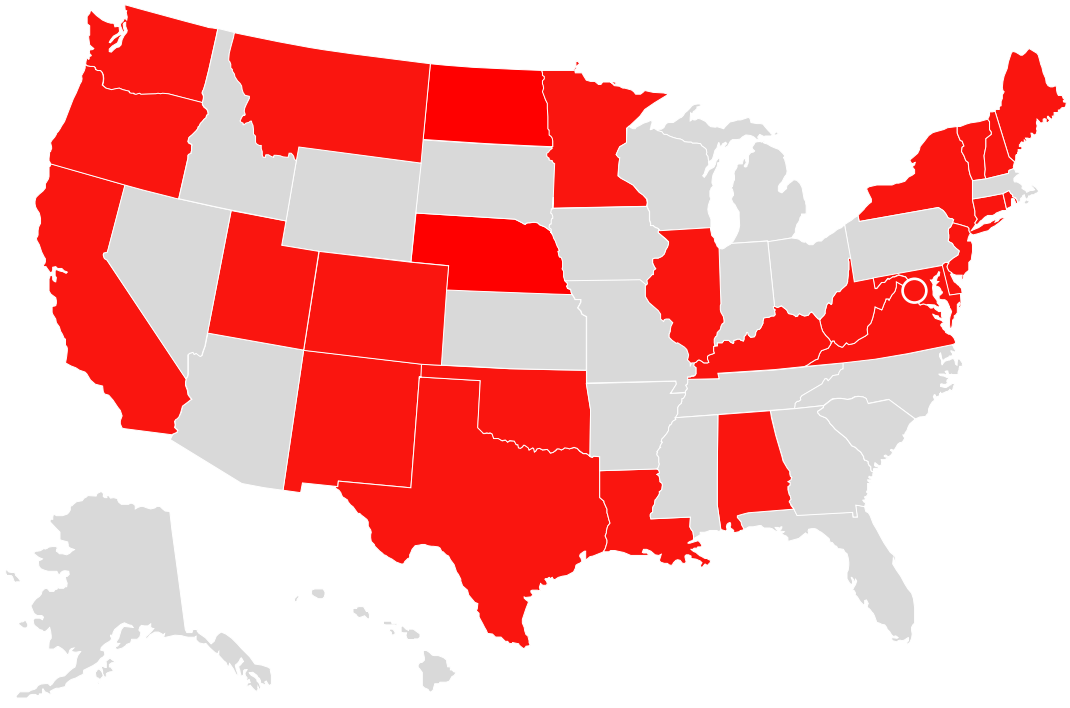
The insulin cap in the Inflation Reduction Act did not apply to state-regulated insurance plans. As such, states have looked for ways to cap prescription drug costs for enrollees in these plans. As of September 2024, 28 states have enacted legislation that limits consumers' prescription drug-related OOP costs. For example, in 2015 California enacted a significant and comprehensive law that caps expenses for a single 30-day outpatient prescription at $250 and at $500 for consumers with high-deductible plans.

The law also ensures that health plans do not place most, or all drugs used to treat a certain condition on the highest cost tier in their drug formularies, and that an enrollee is not required to pay more than the retail price for a prescription drug if a pharmacy's retail price is less than the applicable copayment or coinsurance amount.

In 2019, Colorado enacted legislation to limit the amount consumers pay for insulin. Since that time, the following 25 states and DC have enacted similar laws that limit out-of-pocket expenses for insulin (see map below).

At least four states (Delaware, Louisiana, Maryland, Rhode Island) and DC previously enacted laws that limit the amount private health plan enrollees must pay for a 30-day supply of high-price, specialty-tier prescription drugs. Delaware, for example, limits insured individuals' co-pays and coinsurance for a specialty-tier drug to $150 per month for a 30-day supply. Two states (Maine and Vermont) impose an annual cap on the out-of-pocket expenses an insured person must pay overall for their prescription medications. For example, Vermont's annual out-of-pocket cap is $1,300/individual and $2,600/family.

Montana administratively established a rule in 2015 that indirectly addressed high OOP costs by requiring certain health insurers to offer at least one plan that requires fixed dollar co-pays for all drugs and no deductible. Similarly, Colorado limits the ways that insurers may use coinsurance in their plans through administrative rule making.



House Government and Veterans Affairs Committee
HB1114

My name is Stacy Wilz, I am a resident of North Dakota, and I am a North Dakota State employee. My daughter Reeve was hospitalized and diagnosed in October of 2023 at the age of 7 with Type 1 diabetes shortly after she recovered from a rough case of covid.

I have always heard that insulin is lifesaving, but it never hit home until we realized that without insulin our daughter will die, its not that she might die, she will die, all insulin dependent citizens of ND will die without insulin. Since her diagnoses I have joined several T1D forums, and I am heartbroken to read the desperate pleas from parents trying to figure out how to ration their current insulin because they cannot afford to purchase it monthly even with manufacturer rebates or coupons.

The financial burden that Type 1 Diabetes has placed on my family has been huge. I can't imagine how much more it would cost if we weren't one of the lucky ones that fall under the current NDPERS insulin co-pay cap. Voting in favor of House Bill 1114 will help save the lives of North Dakota children and adults and will provide a much-needed financial relief to ALL families that are impacted by the overall cost of diabetic medical equipment and supplies.

Thank you,

Stacy Wilz
Mother of an 8-year-old daughter living with Type 1 Diabetes

To Whom It May Concern:

I'm writing this letter to express my strong support of House Bill 1114 – to provide a $25/month cap on the amount that a member could be charged for insulin or other necessary diabetic supplies. As a constituent of North Dakota and the mother of a child living with Type 1 Diabetes, I have witnessed firsthand the devastating financial burden that the high cost of insulin places on individuals and families.

Insulin is a LIFE-SAVING medication for people with diabetes. It is NOT a luxury, but a NECESSITY. Without access to affordable insulin, people with diabetes face serious health complications, including blindness, kidney failure, and DEATH.

Our daughter had a blood glucose level of over 400 mg/dl (normal levels are between 70-100 mg/dl) when she was diagnosed at nine years old and she was in active Diabetic Ketoacidosis (DKA), all because her pancreas failed her and stopped producing insulin. DKA is a serious, life-threatening complication of diabetes, most common among people with Type 1 Diabetes. DKA develops when your body doesn't have enough insulin to convert sugar into energy, causing your liver to break down fat for fuel which then produces acids called ketones. Too many ketones being produced at a rapid rate build up to dangerous levels causing DKA. Our daughter, along with hundreds of other North Dakotans, literally CANNOT SURVIVE without affordable insulin.

The current cost of insulin is excessive and unsustainable for many people. It costs around $5 to produce one vial of insulin. It is absolutely insane to be paying hundreds of dollars for a drug that costs $5 to produce. No one should be forced to choose between their health and their financial well-being. A $25 per month cap on insulin would make this essential medication more accessible and affordable, ensuring that people with diabetes can SAFELY manage their condition and live healthy lives.

I want to express my sincere gratitude and appreciation for the approval of SB 2140 for ND PERS members during the 2023 legislative session. I am a current state employee and this cap on insulin for ND PERS members over the past year and a half has been a saving grace for our family, not only financially but also mentally and emotionally. It would be absolutely detrimental for this bill to end on June 30th, 2025.

I urge you to support this important bill and to make the health and well-being of your fellow North Dakotans a PRIORITY.

Thank you,

Nicole Davis
9440 County Road 22
Fairmount, ND 58030
701-899-0512

January 8, 2025

To the Members of the Government and Veterans Affairs Committee

I am writing in support of HB 1114.

As a nurse, I have witnessed first hand the effects that diabetes has had on my patients. Insulin is necessary to sustain life.

Several members of my extended family have diabetes. I have witnessed the financial burden the high costs of insulin and diabetic supplies have put on the family as a unit.

I strongly urge you to render a do pass on HB 1114.

Thank you.

Jean Kautzman

I support the House Bill 1114. To provide easy access to insulin.

As a Type 1 Diabetic, I have personally had to ration my insulin supplies to squeeze between pharmacy runs. Particularly in college, when I was off my parents' health insurance, but didn't have an employer plan yet. Trying to decide if getting an education was more important than my health. I couldn't afford to pay 100% and often 50% (if I had a supplier discount card) for insulin and would ration my supply until payday from my part time job. This was dangerous, causing continuous high blood sugars. I am lucky to have survived that year.

This bill needs to passed to give those who need insulin to live, a chance to afford this medicine.

Dannelle Doering

218-790-2531

Fargo, ND

To Whom It May Concern,

My name is Erik, and I am a resident of North Dakota. I have lived with type 1 diabetes for over 28 years, and this disease is a constant battle. Insulin is, obviously, the strongest weapon of defense and is a life saving medication that I cannot go without, not even for one single day. There have been months that my insulin expenses have topped $1,000, and that doesn't count the other costs associated with this disease. Insulin pump, insulin pump supplies, continuous glucose meters, test strips, etc. There were times when I was forced to basically stop eating and ration insulin because my wife and I couldn't afford to purchase another vile of insulin for $300+ (insulin only costs $2 to $10 per vile to manufacture). My family and I should not be forced to suffer because of a drug company's greed and price gouging.

I am just one of thousands of diabetics in the state of North Dakota that have been affected by the extremely high cost of insulin. I also had a friend who was forced to ration her insulin because she couldn't afford it, and that decision, that she shouldn't have had to make, took her life. This shouldn't happen, not in this day and age. A common, life saving medicine that people can't afford? It doesn't make sense. Insulin was never created for big companies to make bigger profits, it was created to save lives. Please, help all of the North Dakotans that are struggling with diabetes, while at the same time struggling to keep food on their table. I respectfully urge you to pass bill HB 1114 and cap the monthly cost of insulin at $25.

Thank You,

Erik Opdahl

To whom it may concern,

My name is Lacie Maresh. I am a wife, mother, resident of North Dakota, and a RN who has worked at Sanford Hospital in Fargo my entire 23 year career. I am writing in support of bill HB 1114.

My top reason for writing in regard to bill HB 1114 is my son, Wyatt, who was diagnosed with Type 1 Diabetes on February 17, 2020. He was just 7 years old. He is now 12, and almost 5 years into his diagnoses. I have witnessed him having to grow up and care about his health much faster than any of his peers. He is responsible and knowledgeable beyond his years. He (and our family) must deal with blood sugar numbers, counting carbohydrates, taking insulin via shot or insulin pump, poking his finger or using a continuous glucose monitor (CGM) to get blood sugar readings, adjusting diet and exercise, and adjusting his daily life to protect his health. Diabetes is a 24-hour, 7 day per week disease. It does not sleep, so even during the night we are dealing with either high or low blood sugars. Wyatt, and others like him CAN NOT LIVE WITHOUT INSULIN and the supplies to safely monitor his blood sugar numbers. Our family has concern each month regarding the cost of not only insulin, but the supplies that go along with keeping Wyatt healthy, including supplies like lancets to poke his finger, test strips to go into a meter to give a blood sugar reading, the meter to give the blood sugar reading, glucagon (emergency treatment for an extremely low blood sugar), needles and syringes, an insulin pump, insulin pump supplies, his CGM, supplies to help his insulin pump and CGM sites adhere well to his body, and supplies to protect his CGM when he is swimming and playing sports so that it does not get accidently pulled off. The cost of keeping Wyatt alive and as healthy as he can be is high. We are fortunate to have adequate insurance coverage, and our out-of-pocket cost can still be extremely high some months. We also have the concern, as Wyatt ages, of what insurance/benefit coverage he will have as an adult.

I have been a RN for 23 years. During my career I have cared for numerous people who have been admitted to the hospital due to lack of ability to afford insulin. I have had patients who are rationing insulin every month and end up hospitalized due to illness from that. I have had patients who die, because they are rationing their insulin and go into deadly Diabetic Ketoacidosis (DKA). The cost of hospitalization is much higher for insurance companies and individuals than providing an affordable way for all North Dakotans to access affordable insulin with a copay cap. Furthermore, the cost of paying for the many complications that come with rationing insulin and therefore poor blood sugar control (vision loss, kidney failure and dialysis, high blood pressure, heart disease, neuropathy, amputation) will cost insurance companies much more than providing affordable insulin.

The cost of insulin was not always so astronomical. At this point companies are charging upward of $300/vial of insulin, the cost to produce that insulin is less than $10. It was not always this way. When Dr Frederick Banting invented insulin just over 100 years ago he sold the patent for only $1, stating that insulin was “not for me, but for the world”.

Everyone in North Dakota who has insulin dependent diabetes should have access to a lifesaving requirement, at a cost that they can afford each month, without having to ration or go without. I urge you to pass bill HB 1114 and cap the monthly cost of insulin and the supplies that are required to safely give insulin and monitor blood sugars at $25.

Thank you for your consideration,

Lacie Maresh

Dear Senator Lee and Members of the Senate Human Services Committee,

I am writing to express my support for House Bill 1114, capping the price of insulin. My daughter, Della, was diagnosed with type 1 diabetes in December of 2017, just weeks after turning eleven years old. I remember vividly driving her to the emergency room on a Sunday evening. We had been decorating our Christmas tree, and after seeing some concerning symptoms in the previous weeks, I decided to check her blood sugar. It was abnormally high. My sister, who also has type 1 diabetes, advised us that we should not wait until morning. We would run the risk of her going into diabetic ketoacidosis, a life-threatening complication from lack of insulin. We were lucky - we caught it before she went into DKA and my daughter was started on insulin immediately.

No one can go without insulin. Not you, not me, not my daughter. Without insulin, our cells cannot use the glucose that our body needs to survive. The difference is that a person with T1D's life depends on manufactured insulin because the beta cells no longer function in their pancreas. If they are without insulin for more than a few hours they risk DKA and death. I urge you to think about that for a moment.

As a parent of a child with T1D, I will shoulder as much of this disease for my child as she would like me to, for as long as I am able. The reality is, though, that she is now eighteen years old. In just a few years, she will age out of our insurance coverage. What then? Will she have to choose between insulin and food? Will she have to ration her insulin so that she will have enough? Will she be able to afford to live? These are questions no one should have to face. I urge you to vote yes on House Bill 1114. People's lives depend on this.

Sincerely,
Erin Phillips
Parent of a child with type 1 diabetes
Fargo, North Dakota

Dear Senator Lee and Members of the Senate Human Services Committee,

I am eighteen years old and writing in support of House Bill 1114 to put a cap on the price of insulin in North Dakota.

When a person develops type 1 diabetes, as I did when I was eleven years old, their immune system attacks insulin producing cells in the pancreas. This makes that person's body unable to use glucose, which then builds up in the bloodstream. This will lead to death if they do not give themselves insulin, through injection or a pump, every day for the rest of their lives. I would have died if not for that first insulin shot in the emergency room seven years ago, and every day since.

For people with diabetes, our lives can quite literally be in the hands of the pharmacies where we get our insulin. There is no alternative medicine or treatment and no way to have prevented this disease. We should not be at the mercy of companies that set their prices enormously high, knowing we will pay it because we have no other choice.

I am lucky and my parents' insurance makes the cost of insulin manageable for our family, but recently a friend at school shared something that reminded me, again, that this isn't the case for everyone. Her uncle recently passed away from diabetic ketoacidosis. Why? Because he had type 1 diabetes and could no longer afford insulin. He rationed what he had for as long as he could, but in the end, it wasn't enough. His story is not unique. It could happen to any person with type 1 diabetes, myself included. It will continue to happen until a cap is put on the price of insulin. By supporting House Bill 1114, you will be protecting my future and that of many others with diabetes throughout North Dakota.

Thank you for taking the time to read this letter. I hope you will consider what I and many others have to say in support of this bill. Please follow up if you have any questions, and thank you for your attention to the issue of affordable insulin.

Sincerely,
Della Phillips

As a parent of a son who has had Type 1 Diabetes since November 2008, I am very much in support of the Insulin and supplies copay capping Bill in North Dakota. My name is Amber Stockeland, I am from Hannaford, ND and my son Jarin was diagnosed with Type 1 Diabetes at the age of 2. In the 16 years ours family has been living with Type 1 Diabetes the cost of insulin has gone up significantly. Regardless of the insurance I have carried, the out-of-pocket cost has always been a concern. When I was single mother, I had to choose between paying for my son's life sustaining medication or pay my electric bill. Jarin's insulin and life always won. Between the monthly insurance premium payments, insulin pump supplies, constant blood glucose monitoring supplies and insulin costs some months out-of- pocket pay is well over $2000.00. Parents of Type I Diabetics not only worry about how the insulin prices affect our family now, but how our Type 1 Diabetics will be able to afford their medications as they become adults. Type 1 Diabetics are not asking for insulin to be free, just affordable. We should not have to choose between keeping our children alive or keeping our lights on.

Thank you for your time,

Amber Stockeland

My name is Lindsey Gunderson a North Dakota resident. I am writing in support of HB 1114.

My brother, Erik, has had Type 1 diabetes since he was 19 years old. He, like many others, dealing with this disease needs insulin to survive. It's a necessity in their daily lives! The cost of insulin at times being $1,000/month plus other additional costs is a HUGE burden on family's financials. The daily effects of the disease are challenging enough for them and their families, let's not make it more challenging and stressful!

It's time we make insulin affordable for those who need it to survive!

Thank you for your consideration,

Lindsey Gunderson

Chairman Schauer and Committee Members,

My name is Leif Snyder, I have been a type 1 insulin dependent diabetic for more than 30 years. Sadly the last 12 I have been almost completely blind due to the diabetic retinopathy that was totally preventable. Diabetic retinopathy was preventable for me except that the insulin and supplies my Dr wanted me on came to $1300 a month I had no choice but decide what to go without and ration my insulin which led to the high blood sugar and thus the eye disease.

As you sit reading this imagine wearing a dirty pair of sunglasses (dark and blurry) and looking thru a toilet paper tube (no peripheral vision only very central vision) with one eye as I'm completely blind in the other eye, thats how I see things.

I would estimate the multiple surgeries and procedures I have had done on my eyes has to be over $250,000.00? And with more to come in order to save what vision I have left. To think if I would have had the advantage of a cap such as in 1114 all this could have been prevented. Since I am disabled and on medicaid imagine the money you can save tax payers by making sure another diabetic does not have to go thru what I have. I strongly support HB1114.

Sadly you will hear from those that complain about the rising cost of insulin that don't want the regulation but when you look at the truth the price of insulin is way overpriced and is nothing more than a money grab for pharmaceutical companies and the pharmacy benefit management companies. Of course they will testify against anything that threatens their cash cow. Remember insulin is a biosimilar thus falling under different regulations and no real generic is available.

Best regards,
Leif Snyder

I am in support of capping insulin prices to ensure the safety of all persons in need of this life saving medication. No one should go without affordable prescriptions in the United States. My family's lives depend on the reasonable access to insulin.

House Government and Veterans Affairs Committee

HB1114

My name is Katey Moch, and I'm a resident of North Dakota. I work as a Diabetes Educator and have lived with Type 1 Diabetes for almost 30 years. Without insulin, I will die. I currently wear an insulin pump and only need one kind of insulin, but those who give multiple daily injections are on two different types of insulin, which are required to survive. This adds to their cost. Living with Type 1 Diabetes, I never realized the full impact of the cost of the disease until I went to college and started paying for it on my own. It is a huge burden, and I have always been lucky to have insurance to help pay for it. When insulin was created, it was meant to be sold for $1 so everyone who needed it could afford it. It is not this way anymore.

While working in the hospital as a diabetes educator, I have seen the impact of patients being unable to afford their insulin. They have to come in multiple times because they can't afford their insulin, and it puts them into a condition called Diabetic Ketoacidosis. This is extremely dangerous, and people can die from it. If people could afford their insulin, this would help prevent such hospitalizations.

I'm vowing to vote for House Bill 1114 for myself and my patients. This bill will help patients who need this life-saving medication obtain it without adding to their financial burden. I hope that you will approve this bill to help save the lives of those living with this chronic disease.

Thank you,

Katey Moch

January 8, 2025

Dear Legislators,

I am in favor of HB1114 which would cap insulin copays for ALL ND administered insurance plans through the ND Insurance Commissioner's Office.

I was clueless until 18 months ago when my grade school aged granddaughter was diagnosed with Type 1 diabetes (T1D) that I began to educate myself on this horrible disease.

Without the essential multiple daily patient specific doses of insulin, the terrifying reality is that the the diabetic patient will die.

Due to the fact that Insulin is so expensive, it comes as no surprise that insurance copays are very costly as well. For many insulin dependent individuals it is a constant worry if they will be able to afford to purchase their life sustaining insulin. Out of necessity many individuals have been known to skimp on their doses to try to extend their supply. This is a very dangerous juggling game for an insulin dependent patient to play.

Please vote in favor of HB1114 which would cap insulin copays for All ND administered insurance plans through the ND Insurance Commissioner's Office.

Thank you for reviewing my testimony.

Sincerely,

Brenda R. Wiese

1/8/25

Please support HB 1114 to cap the cost of insulin in North Dakota. I support this bill because my son, Rhett (14), has been living with type 1 diabetes since he was 15 months old. There isn't a day that passes when we don't spend every hour thinking about his insulin needs to live-to be alive. We have lived in Fargo for the last 16 years and love our community and state.

Several years ago, we drove to Canada to purchase insulin for $25 per vial when I had to pay over $300 per vial because our North Dakota insurance company refused to pay for the insulin in the formulary he needed to survive. What if we couldn't do that? What if we had to ration our child's insulin? There are diabetics who have no choice because they cannot afford it. There are some who have died from rationing insulin and 1.3 million Americans reported rationing their insulin in a recent study by the Centers for Disease Control.

Type one diabetes is not a preventable condition, nor can it be something we can cure or easily control. Diabetes is debilitating without the financial strain of insulin, glucagon, supplies and additional costs associated with chronic conditions, such as clinic visits, hospitalizations, mental health care, family strain and around-the-clock focus to ensure our diabetic isn't having a high or low glucose emergency.

Nearly half of the states in our nation have voted in favor of affordable insulin for all of their residents. North Dakota trialed capping costs for the NDPERS group for 2 years and now it's time to expand this live saving bill by capping insulin for every ND citizen like the other 22 states.

Heroes save lives. I urge you to vote and be a hero for all of the suffering type 1 diabetics and families in North Dakota.

Sincerely,

Shantelle Smith

Testimony of Marlee Seibold for HB 1114 – Insulin & Diabetes Supplies

Dear Chairman Schauer and Committee Members,

My name is Marlee Seibold, and I'd like to urge you to support HB 1114. I was born and raised in Minot and have lived in Bismarck for the last 10 years. I have been lucky enough to call North Dakota my home my entire life. At 7 years old, I was diagnosed with Type 1 Diabetes. For anyone unfamiliar with Type 1 Diabetes, it is an autoimmune disease that prevents your pancreas from producing insulin. As with any autoimmune disease, I did not do this to myself, and no one did it to me. Autoimmune diseases happen when your immune system attacks healthy cells in your body which then causes a lifelong chronic disease. That means, since I was 7 years old, I have had to inject insulin every single day, multiple times a day, to make up for the insulin my body cannot produce on its own.

For the last 3 years, I have worked for the American Diabetes Association, the nation's leading voluntary health organization fighting to end the diabetes epidemic. Every day I work to help advocate for people just like me to get the care and help they deserve. I have first-hand experience with this disease, which means I know how much time, energy, and money is spent on managing it. Recently, I filled the 4 different types of insulins I use every day, and the Contiguous Glucose Monitors that I use to track my blood sugar. That's it. I did not fill any extra supplies, needles, or alcohol swabs. The over the counter price for those medications was thousands of dollars. Thousands of dollars it costs just to make sure I wake up tomorrow. That price is not yearly, those prescriptions will last a couple months. That is not including the doctor's appointments I make throughout the year, and all the other supplies I need to take that insulin or to help with my management. I want to be clear; this is life or death. Living with type 1 diabetes is making life and death decisions all day, every day, 24/7. If I don't take insulin, I could die. If I take too much insulin, I could die. Poor management of my blood sugar can have terrible consequences in a matter of days.

Imagine anyone living with diabetes who doesn't have the means to pay that price. Who has to pay for food or rent before they can pay for the medicines they need to live. Well, in my line of work, I run into a lot of those people. They ration their insulins, and don't take what they need or don't take any at all. They can't pay to see doctors, or have the devices needed to help them manage their disease. They either end up with serious health complications, or they die. This insulin cap, that has been proven through the pilot program, to have little financial impact on the state, could make a huge impact on those living with diabetes around North Dakota. Guaranteeing people will have access to affordable insulin could save lives.

2025 HOUSE STANDING COMMITTEE MINUTES

GOVERNMENT VETERANS AFFAIRS COMMITTEE
PIONEER ROOM, STATE CAPITOL

HB 1114
1/10/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies

11:20 a.m. Chairman Schauer opened the hearing.

Members present: Chairman Schauer, Vice Chairman Satrom, Representatives Bahl, Brown, Christy, Grindberg, Karls, McLeod, Rohr, Schneider, Steiner, VanWinkle, Vetter, Wolff

Discussion Topics:

- Pilot program extension
- Free market
- Percentage of plans
- Grandfathered plans

11:21 a.m. Chairman Schauer appointed Representatives McLeod, Karls, Schneider

to a sub-committee.

11:24 a.m. Representative McLeod appointed chair of sub-committee.

11:24 a.m. Chairman Schauer closed the hearing.

Jackson Toman, Committee Clerk

2025 HOUSE STANDING COMMITTEE MINUTES

Government and Veterans Affairs Committee
Pioneer Room, State Capitol

HB 1114
2/7/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; and relating to health insurance benefits coverage of insulin drugs and supplies.

3:01 p.m. Chairman Schauer opened the meeting.

Members present: Chairman Schauer, Vice Chairman Satrom, Representatives Bahl, Brown, Grindberg, Karls, McLeod, Rohr, Schneider, Steiner, VanWinkle, Vetter, Wolff
Members absent: Representative Christy

Discussion Topics:

- Committee work

3:02 p.m. Representative McLeod moved to adopt the amendment LC# 25.0118.01001.

3:02 p.m. Representative Steiner seconded the motion.
3:04 p.m. Voice Vote passed.

3:04 p.m. Representative McLeod moved a Do Pass as amended and rerefered to appropriations.

3:04 p.m. Representative Bahl seconded the motion.

Representatives	Vote
Representative Austen Schauer	Y
Representative Bernie Satrom	Y
Representative Landon Bahl	Y
Representative Collette Brown	Y
Representative Josh Christy	AB
Representative Karen Grindberg	Y
Representative Karen Karls	Y
Representative Carrie McLeod	Y
Representative Karen Rohr	Y
Representative Mary Schneider	Y
Representative Vicky Steiner	Y
Representative Lori VanWinkle	Y
Representative Steve Vetter	Y
Representative Christina Wolff	Y

3:12 p.m. Motion passed 13-0-1.
Representative McLeod will carry the bill.

3:12 p.m. Chairman Schauer closed the meeting.
Jackson Toman, Committee Clerk

RS 2/7/25
1 of 5

25.0118.01001
Title.02000

Prepared by the Legislative Council staff for Representative McLeod
February 4, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

HOUSE BILL NO. 1114

Introduced by

Government and Veterans Affairs Committee

(North Dakota Public Employees Retirement System)

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:

   a. "Health benefit plan" has the same meaning as in section 26.1-36.3-01.

   b. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

      (1) Rapid-acting insulin;

      (2) Short-acting insulin;

      (3) Intermediate-acting insulin;

      (4) Long-acting insulin;

(5) Premixed insulin product;

(6) Premixed insulin/GLP-1 RA product; and

(7) Concentrated human regular insulin.

~~b.~~c. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

(1) Blood glucose meters;

(2) Blood glucose test strips;

(3) Lancing devices and lancets;

(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;

(5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and

(7) Insulin syringes.

~~c.~~d. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health ~~insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis~~benefit plan unless the ~~policy, contract, or evidence of coverage~~health benefit plan provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.

3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:

a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the

quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge a covered individual, require the pharmacy or distributor to collect from a covered individual, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.

5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.

6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. ~~(Expired effective July 31, 2025)~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or~~

~~supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b.~~ ~~"Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c.~~ ~~"Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2.~~ The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration ~~which complies with this section~~as provided under section 1 of this Act.

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.

5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.

6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

REPORT OF STANDING COMMITTEE
HB 1114

Government and Veterans Affairs Committee (Rep. Schauer, Chairman) recommends **AMENDMENTS (25.0118.01001)** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1114 was placed on the Sixth order on the calendar.

2025 HOUSE APPROPRIATIONS

HB 1114

2025 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1114
2/18/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; relating to health insurance benefits coverage of insulin drugs and supplies

10:25 a.m. Chairman Vinessa Opened the meeting.

Members Present: Chairman Vigesaa, Vice Chairman Kempenich, Representatives Anderson, Berg, Bosch, Brandenburg, Fisher, Hanson, Louser, Martinson, Meier, Mitskog, Monson, Murphy, Nathe, Nelson, O'Brien, Pyle, Richter, Sanford, Stemen, Wagner

Member Absent: Swiontek

Discussion Topics:

- PERS Pilot Program Study Overview
- Diabetes prescription
- Insulin prices

10: 25 a.m. Representative Schauer introduced the bill and submitted testimony #37975.

10:30 a.m. Committee discussion

10:31 a.m. Derrik Holbein, COO, NDPERS, answers questions for the committee

10:41 a.m. Representative McLead answers questions for the committee

Additional written testimony:

Andrea Pfennig, submitted testimony In Opposition #37896.

Amanda Rocha, submitted Neutral testimony #37976.

10:53 a.m. Representative Vigessa closed the meeting

Risa Berube for Sierra Schartz, Committee Clerk

Vote No on HB 1114

Healthcare Mandates Are Bad Policy

HB 1114 sets a $25/month cap on the amount an individual could be charged for insulin or diabetic supplies. With the individual's cost share being limited, the cost is shifted onto the policyholders.

- In the PERS pilot project, utilization of insulin and diabetic supplies did not change significantly after inclusion of the price cap.
- Additionally, it was reported that pharmaceutical companies have been reducing the price of insulin and the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap.

As of today, the three major heath carriers in North Dakota all have an insulin cap of no more than $25 in place without the mandate. Our essential health benefits (EHB) include a $25 cap on insulin and supplies for all ACA marketplace plans. And at the federal level, in the Inflation Reduction Act of 2022, the federal government passed a $35 insulin cap for Medicare beneficiaries.

GNDC asked is members:

What is the one thing STATE GOVERNMENT could do to help your business?

Make Healthcare More Affordable

MANDATES DRIVE UP COSTS

The Fiscal Note on HB 1114 for PERS for the 25-27 biennium is almost **$833,955.90.** That is the cost shift for State Employees alone, to say nothing of the private sector. At the end of the day, mandates like this drive up premiums for citizens and employers alike. Rather than making health care costs more affordable, this is a cost shift that doesn't get to the root of the problem. **Health insurance does not become more affordable by passing coverage mandates – insurance companies don't pay for mandates. POLICYHOLDERS pay for mandates through increased premiums.**

MANDATES DON'T GO AWAY

One of our major health carriers spent $845,233,023.79 on North Dakota State Legislature imposed health insurance mandates for years 2022-2024. Since the 90s, no healthcare mandates have been repealed, even when they are no longer recommended treatments. Rather than reducing costs as intended, these costs add up, and they don't go away. This isn't good policy.

THE LIST KEEPS GROWING

As an example, here is a list of other health care mandate bills proposed this session that either would be applied to the private sector or could be applied to the private sector in two years.

GNDC
Greater North Dakota Chamber
701.222.0929 ndchamber@ndchamber.com ndchamber.com PO Box 2639 • Bismarck, ND 58502

- 1282: Comprehensive fertility health benefits for public employees in ND requiring health insurance plans to cover diagnosis and treatment of infertility with specific provisions.
    - Fiscal note for PERS: $385,000 for 25-27 biennium.
- 1283: Diagnostic breast examination and supplemental breast examination cost-sharing restrictions
    - Fiscal note for PERS: $4,070,000 for 25-27 biennium.
- 1284: Fertility preservation services for covered individuals who have medical conditions or are undergoing treatments that may impair their fertility.
    - Fiscal note for PERS: $345,000 for the 25-27 biennium.
- 1452: Coverage of antiobesity medication
    - Fiscal note for PERS: $72,000,000 for the 25-27 biennium.
- 2370: Insulin Copay Limitation
    - Fiscal note for PERS: $833,955.90 for the 25-27 biennium.
- 2248: Step Therapy Protocols
- 2249: Step Therapy Protocols

Insurance mandates are not effective public policy. They are anti free market, oftentimes expensive, and stymy innovation. In North Dakota, we have never updated or repealed a single mandate.

Allow individuals and businesses to make choices about the health care coverage that is best for them – VOTE NO ON HB 1114.

Good morning, Mr. Chairman and members of the Appropriations Committee.

My name is Austen Schauer, District 13, West Fargo.

HB 1114 received a **13-0 Do Pass** recommendation from the **GVA** committee, and we now seek your approval.

HB 1114 is a bill required to be brought forward by the **NDPERS** Board after **SB 2140** was passed last session.

SB 2140 required a pilot program for the **NDPERS** health insurance plan during the 2023 biennium. The bill set a **$25 per month cap** for **insulin** and a **$25 per month cap** for **diabetic supplies**.

For decades, people with diabetes and family members have been working to **bring down** the cost of life-giving insulin to a reasonable amount.

Insulin can be produced for less than **$2/vial**.

In a recent lawsuit, the **Federal Trade Commission** accused **PBMs** and insulin companies of being anti-competitive.

The complaint says PBMs have increased insulin prices by **12 hundred percent** over the last 25 years. By 2019, one out of every four insulin patients were **unable** to afford their medications.

Diabetics advocates said ***enough is enough***, which is why **SB 2140** was passed and became a pilot program.

The results of the two-year program produced a positive recommendation from the **NDPERS** Board to continue the coverage and here's why:

- The **NDPERS** plan carrier found that most of the diabetic supplies filled by the members cost less than the $25/monthly cap, so there was minimal impact to member cost.

- The average savings of impacted members on the **NDPERS** plan was $80 per member per month when compared to the prior year before the cap was in place.

- The cost to continue the coverage in the NDPERS health plan was an increase of **.12%** of premium.

There was even more compelling data from **Nova Rest**, the Actuarial Consulting firm asked to prepare a cost-benefit analysis for Legislative Council.

Nova Rest said **if** the bill is extended to include the commercial market, the cost may be as low as **.05% per member**.

Nova Rest also said savings from preventing more serious diseases may **offset** the cost of insulin.

In committee, we heard an argument that we should not interfere with the free market, however, there are only **three major companies** that control the market.

We believe the business communities can realize **true cost savings** when their employees are able to keep their diabetes under control.

With insulin costing North Dakota residents millions of dollars each year, **HB 1114** would provide **relief** for people on fully insured large employer plans. That would involve **11%** of the **Health Insurance Market**.

The Insurance Commissioner has already approved the cap for the individual and small employer markets.

People on self-funded plans **would not** be affected.

In committee, one of the proponents of **HB 1114** said, "People ask me, why should I have to pay for your insulin?"

Her response was, "Why should I have to pay for your premium?"

The state has more than **57 thousand adults** diagnosed with diabetes, and nearly **40% have pre-diabetes**.

Mr. Chairman and members of Appropriations, our hearing on **HB 1114** was long and emotional.

Some called insulin "***liquid gold***" and "***lifesaving.***"

When insulin is affordable and available, diabetes related illnesses and diseases can be **reduced** and often **avoided.**

It's prevention that **saves money** and more importantly, **saves and extends life.**

Mr. Chairman, your **GVA Committee** seeks your support of **HB 1114**.

Thank you, Mr. Chairman. I stand open to questions.

HB 1164

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

Amanda Rocha
Richard Cadwell, ASA, MAAA
Donna Novak, FCA, ASA, MAAA

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 - 520-908-7246 - NovaRest.com

NovaRest
ACTUARIAL CONSULTING

Table of Contents

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.

NovaRest was asked to provide estimates for the North Dakota Public Employee Retirement System (NDPERS), as well as the impact if the Draft Bill was expanded to the commercial market. We were provided information on four plans administered by NDPERS, 1. Grandfathered PPO/Basic Plan, 2. Non-Grandfathered PPO/Basic Plan, 3. High Deductible Health Plan (HDHP), and 4. Dakota Retiree Plan. For the commercial market we used information from the National Association of Insurance Commissioners Supplemental Health Care Exhibit for individual, small group, and large group. Generally, when considering benefits for the individual and small group we considered the Affordable Care Act (ACA) single-risk pool plans, and for large group we considered a sample of plans from the largest three insurers in the North Dakota market.

We understand that individual market, small group market, and NDPERS non-Medicare plans (including the Dakota Plan for non-Medicare retirees) already have cost sharing for covered insulin drugs and covered medical supplies limited to $25 for a 30-day supply. Therefore, the impact is 0% of premium, or $0.00 PMPM.

The bill does not apply to the Medicare Part D prescription drug coverage plan.

Therefore, the only market where we anticipate an increase in premiums is in the large group commercial market. 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.

II. Process

NovaRest was asked to address the following analyses regarding this proposed mandate:

- The extent to which the proposed mandate would increase or decrease the cost of the service;
- The extent to which the proposed mandate would increase the appropriate use of the service;
- The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
- The impact of the proposed mandate on the total cost of health care.

NovaRest reviewed literature and developed an independent estimate of the proposed mandate's impact on premiums.

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.

Analyses Concerning Mandated Coverage

The extent to which the coverage will increase or decrease the cost of the service.

Mandating a service or product or decreasing the cost sharing amount often increases the demand for that service or product, which typically increases the cost of the service, where allowed. Insurers can offset this upward pressure on price by contracting with providers and/or using managed care protocols.

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 in the cost of the service. 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 individual and small group markets which already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

Insulin drugs and medical supplies appear to also be covered in the large group market; however, they are not be capped at $25 for a 30-day supply. We estimate approximately 300-400 more large group members will increase insulin usage (as opposed to rationing insulin) due to lower member cost-sharing in the commercial market; however, we do not believe this additional demand would be sufficient to impact the cost of insulin or prescribed medical supplies for insulin.

The extent to which the coverage will increase the appropriate use of the service.

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 in the appropriate use of the service. 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 appropriate use of the service 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.

In the large group market, we would expect an increase in the appropriate use of insulin drugs and supplies. Approximately 14% of adequately insured members ration insulin due to cost.[7] If the Draft Bill language was extended to the large group commercial market, we estimate approximately 300-400 will increase appropriate insulin usage (as opposed to rationing insulin) due to lower member cost-sharing. Please see Appendix B for more information on our assumptions and methodology.

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.

The impact of this coverage on the total cost of health care.

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 in the total cost of health care. 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 change total cost of health care 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 most of the premium impact reflects cost shifting from the member to the insurer paying the cost-sharing, there may be an increase in the total cost of health care due to members increasing their usage of insulin, as opposed to rationing insulin. We anticipate an additional $20,000 to $190,000 to the total cost of health care annually for this additional utilization.

We also note that savings from preventing more serious diseases may offset this cost. If left untreated or not treated properly, diabetes can lead to life-threatening diseases such as cardiovascular disease, nerve damage (neuropathy), kidney damage (nephropathy), and eye damage (retinopathy).[8]

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

V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding Draft Bill 25.0118.01000. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest also did not perform an insurer data request for the commercial market, or have access to the most recent rate filings in North Dakota. NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by NDPERS, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

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 A: Definitions

a) "Insulin drug" means prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

   1) Rapid-acting insulin
   2) Short-acting insulin
   3) Intermediate-acting insulin
   4) Long-acting insulin
   5) Premixed insulin product
   6) Premixed insulin/GLP-1 RA product
   7) Concentrated human regular insulin

b) "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

   1) Blood glucose meters
   2) Blood glucose strips
   3) Lancing devices and lancets
   4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone test strips
   5) Glucagon, injectable or nasal forms
   6) Insulin pen needles
   7) Insulin syringes

c) "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.

d) "Policy" means accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

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.

Methodology

- Using the assumptions described above, we estimated the average current member cost sharing for people who use insulin for insulin and insulin supplies. We then estimated the member cost sharing under the proposed $25 limitation on insulin and insulin supplies. The difference would be the cost-sharing dollars shifted from the members to commercial large group plans.
- Using commercial and public sources, we estimated the number of large group members who use insulin as a portion of the total number of individuals that use insulin. We then applied this number to the cost-sharing dollars shifted to the commercial large group plans to determine the cost impact.

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2025 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1114
2/18/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

7:16 p.m. Chairman Vigesaa Called the meeting to order.

Members Present: Chairman Vigesaa, Vice Chairman Kempenich, Representatives Anderson, Berg, Bosch, Brandenburg, Fisher, Hanson, Louser, Martinson, Meier, Mitskog, Monson, Murphy, Nathe, Nelson, O'Brien, Pyle, Richter, Sanford, Stemen, Wagner

Members Absent: Representative Swiontek

Discussion Topics:

- Committee Action

7:21 p.m. Representative Wagner moved a Do Pass.

7:21 p.m. Representative Meier- seconded the motion.

Roll call vote:

Representatives	Vote
Representative Don Vigesaa	N
Representative Keith Kempenich	N
Representative Bert Anderson	N
Representative Mike Berg	N
Representative Glenn Bosch	N
Representative Mike Brandenburg	N
Representative Jay Fisher	N
Representative Karla Rose Hanson	Y
Representative Scott Louser	N
Representative Bob Martinson	N
Representative Lisa Meier	Y
Representative Alisa Mitskog	Y
Representative David Monson	Y
Representative Eric J. Murphy	N
Representative Mike Nathe	N
Representative Jon O. Nelson	Y
Representative Emily O'Brien	Y
Representative Brandy L. Pyle	Y
Representative David Richter	N

Representative Mark Sanford	Y
Representative Gregory Stemen	N
Representative Steve Swiontek	AB
Representative Scott Wagner	Y

7:23 p.m. Motion failed 9-13-1

7:25 p.m. Representative Kempenich moved a Do Not Pass.

Representative Brandenburg seconded the motion.

7:34 p.m. Roll call Vote

Representatives	Vote
Representative Don Vigesaa	Y
Representative Keith Kempenich	Y
Representative Bert Anderson	Y
Representative Mike Berg	Y
Representative Glenn Bosch	Y
Representative Mike Brandenburg	Y
Representative Jay Fisher	Y
Representative Karla Rose Hanson	N
Representative Scott Louser	Y
Representative Bob Martinson	Y
Representative Lisa Meier	N
Representative Alisa Mitskog	N
Representative David Monson	N
Representative Eric J. Murphy	Y
Representative Mike Nathe	Y
Representative Jon O. Nelson	N
Representative Emily O'Brien	N
Representative Brandy L. Pyle	N
Representative David Richter	Y
Representative Mark Sanford	N
Representative Gregory Stemen	Y
Representative Steve Swiontek	AB
Representative Scott Wagner	N

Motion passed 13-9-1
Representative Stemen will carry the bill.

7:35 p.m. Chairman Vigesaa closed the meeting.

Sierra Schartz, Committee Clerk

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1114 (25.0118.02000)

Appropriations Committee (Rep. Vigesaa, Chairman) recommends **DO NOT PASS** (13 YEAS, 9 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1114 was placed on the Eleventh order on the calendar.

2025 SENATE HUMAN SERVICES

HB 1114

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1114
3/10/2025

Relating to health insurance benefits coverage of insulin drugs and supplies.

11:23 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Affected Citizen
- Individual Coverage Cost
- Medicare Part D
- Prescription affordability

11:23 a.m. Representative McLeod introduced the bill and submitted testimony in favor #40081.

11:38 a.m. Rebecca Fricke, executive Director with ND Public Employee Retirement System, testified in favor and submitted testimony #39603.

11:46 a.m. Angela Kritzberger testified in favor and submitted testimony #39780.

11:54 a.m. Josh Askvig, AARP ND, testified in favor and submitted testimony #39902 and #39903.

11:56 a.m. Matt Prokop, Director with American Diabetes Association testified in favor and submitted testimony #39811.

12:00 p.m. Dylan Wheeler, Director with Sanford Health Plan, submitted testimony in opposition and submitted testimony #39930.

12:04 p.m. Megan Hruby, Blue Cross Blue Shield ND, testified in opposition and submitted testimony #39941.

Additional written testimony:

Nina Kritzberger submitted written testimony in favor #39636.

Danelle Johnson submitted written testimony in favor #39650.

Whitney Oxendahl submitted written testimony in favor #39653.

Julie Blehm submitted written testimony in favor #39742.

Heidi Abler submitted written testimony in favor #39812.

Dylan Abler submitted written testimony in favor #39813.

12:12 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

TESTIMONY OF REBECCA FRICKE

House Bill 1114 – Insulin & Diabetic Supplies

Good Morning, Madame Chair and members of the Committee. My name is Rebecca Fricke. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today to provide information on how a pilot program relating to House Bill 1114 impacted the NDPERS active group health insurance plans and to provide testimony in support of the coverage being continued within the NDPERS active group health insurance plans.

House Bill 1114 is a bill required to be brought forward by the NDPERS Board due to the passing of SB 2140 during the 68th Legislative Assembly. SB 2140 was an insurance mandate that required a pilot program under the NDPERS active group health insurance plans during the 2023-2025 biennium. SB 2140 set a $25/month cap on the amount a member could be charged for insulin or diabetic supplies.

Specifically Section 4 of SB 2140 states:

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

In addition to submitting the bill, the Board appended the necessary report and recommendation as required above to the draft bill considered by the Employee Benefits Programs Committee (EBPC) during the interim.

Some observations of the NDPERS active health insurance plan experience during the pilot program:

- For the 2023-2025 biennium, the cost in premium to provide the enhanced coverage of the cap was 0.14% of premium. There was not funding provided for this cost during the pilot program and therefore, reserves are being used to cover this expense.
- Sanford Health Plan found that the majority of the diabetic supplies filled by NDPERS members cost less than the $25/month cap so there was minimal impact to member cost share after the cap related to diabetic supplies was implemented.

- There are a number of states that have some form of cap on insulin and diabetic supplies. Specific details regarding these states is provided in Attachment 9 and Attachment 12 of the Report to the EBPC.
- Sanford Health Plan found that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, the health plan's total reimbursements were lower after the cap. This is due to a change that two pharmaceutical companies (Eli Lilly and Novo Nordisk) made effective January 1, 2024 to reduce their prices on insulin (Attachment 10 of Report). Those reduced prices resulted in less reimbursement by the plan (Attachment 4 of Report) for the final 6 months that data was provided for.
- Estimated member savings per month was $80.15 per member due to the cap based upon comparison with prior year claims data (Attachment 3 of Report).
- The insulin rate cap eliminated coinsurance on insulin claims between 7/1/2023-6/30/2024. Therefore none of the claims for insulin contributed any coinsurance to the $1,200 coinsurance maximum on the NDPERS grandfathered plan. However coinsurance continued to apply to other pharmacy claims so the $1,200 coinsurance expense may have been paid by the member on other pharmacy claims during the calendar year.
- Utilization for insulin and diabetic supplies did not change significantly after the inclusion of the insulin rate cap.
- Note that the information provided by Sanford Health Plan was as of the date the data was generated and represent claims from July 1, 2023 through June 30, 2024. At the time the report was generated, It is anticipated that there were still claims pending that had not been submitted for processing which could result in changes.

Deloitte Consulting, the insurance consultant for NDPERS, calculated the cost of continuing the coverage under the NDPERS active plans for the 2025-2027 biennium to be .12% of premium, or approximately $1,000,000.00 (Attachment 11 of Report). Of this amount, $833,956 is attributed to state agencies ($2.07 per contract), $159,922 is attributed to the participating political subdivisions and $6,748 is attributed to the Non-Medicare retirees and COBRA participants.

The NDPERS Board recommends that the coverage, a $25/month cap on insulin and diabetic supplies, provided through SB 2140 during the 2023-2025 biennium be continued as coverage within the NDPERS active health insurance plans.

The NDPERS Board does not offer a recommendation on whether the coverage should be expanded to the commercial market.

The Employee Benefits Programs Committee gave this bill a favorable recommendation during the interim.

This concludes my testimony. I would be happy to answer any questions you may have.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: Employee Benefits Programs Committee

FROM: NDPERS Board

DATE: September 12, 2024

SUBJECT: Insulin/Diabetic Supplies Report and Recommendation

SB 2140 was passed during the 68th Legislative Session and requires a NDPERS pilot program for the 2023-2025 biennium. SB 2140 specifically required a monthly cap of $25/month for insulin and diabetic supplies within the NDPERS health insurance active plans and became effective July 1, 2023. The provisions expire at the end of the biennium.

Section 4 of SB 2140 is shown below and requires that the NDPERS Board submit a bill in the upcoming Session that would roll this coverage out to the commercial market in North Dakota. Draft bill # 118 (Attachment 1) is the bill that the Board approved for submission to the Employee Benefits Programs Committee.

In addition to the bill submission, Section 4 of SB 2140 requires the Board to "append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued."

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

In order for the NDPERS Board to meet the obligation of appending a report to the bill, NDPERS requested that Sanford Health Plan (SHP) provide data for the year prior to and year following the July 1, 2023 SB 2140 effective date for comparison purposes.

NDPERS also requested our group insurance consultant, Deloitte, to prepare a cost and technical analysis of Draft Bill # 118 (Attachment 11). In addition, they were asked to conduct a market analysis of insulin and/or diabetic supply caps (Attachment 12).

Some observations of the NDPERS active health insurance plan experience during the pilot program:

- For the 2023-2025 biennium, the cost in premium to provide the enhanced coverage of the cap was .14% of premium. There was not funding provided for this cost during the pilot program and therefore, reserves are being used to cover this expense.
- Sanford Health Plan found that the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap so there was minimal impact to member cost share after the cap was implemented related to diabetic supplies.
- There are a number of states that have some form of cap on insulin and diabetic supplies. Specific details regarding these states is provided in Attachment 9 and Attachment 12.
- Sanford Health Plan found that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, the health plan's total reimbursements were lower after the cap. This is due to a change that two pharmaceutical companies (Eli Lilly and Novo Nordisk) made effective January 1, 2024 to reduce their prices on insulin (Attachment 10). Those reduced prices resulted in less reimbursement by the plan (Attachment 4) for the final 6 months that data was provided for.
- Estimated member savings per month was $80.15 per member due to the cap based upon comparison with prior year claims data (Attachment 3).
- The insulin rate cap eliminated coinsurance on insulin claims between 7/1/2023-6/30/2024. Therefore none of claims for insulin contributed any coinsurance to the $1,200 coinsurance maximum on the grandfathered plan. However coinsurance continued to apply to other pharmacy claims so the $1,200 coinsurance expense may have been paid by the member on other pharmacy claims during the calendar year.
- Utilization for insulin and diabetic supplies did not change significantly after the inclusion of the insulin rate cap.
- Note that the information provided by Sanford Health Plan are as of the date the data was generated. It is anticipated that there are still claims pending that have not been submitted to SHP for processing that may result in changes.

RECOMMENDATION OF NDPERS BOARD:

Given the experience to the NDPERS active health insurance plan during the pilot program, the NDPERS Board recommends that the insulin and diabetic supplies cap of $25/month be continued for the NDPERS active health insurance plans beyond the 2023-2025 biennium.

Included for the Committee's review are the following attachments:

	Provided By	Description
Attachment 1	NDPERS	Draft Bill # 118
Attachment 2	Sanford Health Plan	Insulin Dashboard/Overview
Attachment 3	Sanford Health Plan	Insulin Member Savings Per Member/Per Month
Attachment 4	Sanford Health Plan	Average Paid for Insulin by Member and Plan
Attachment 5	Sanford Health Plan	Insulin Utilization & Adherence
Attachment 6	Sanford Health Plan	NDPERS Type 1 and Type 2 Diabetes Membership Data
Attachment 7	Sanford Health Plan	Insulin Details
Attachment 8	Sanford Health Plan	Diabetic Supplies Details
Attachment 9	Sanford Health Plan	Information regarding what other states have experienced that have implemented caps
Attachment 10	Sanford Health Plan	Details regarding changes that have occurred in the amount that the drug manufacturers are charging for insulin
Attachment 11	Deloitte	Consultant cost and technical analysis of Draft Bill # 118
Attachment 12	Deloitte	Market analysis related to SB 2140
Attachment 13	Sanford Health Plan	Per Member Per Month medical expense for Type 1 diabetics 12 months before and 12 months after the Insulin cap

25.0118.01000

Sixty-ninth
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

(North Dakota Public Employees Retirement System)

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:
   a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:
      (1) Rapid-acting insulin;
      (2) Short-acting insulin;
      (3) Intermediate-acting insulin;
      (4) Long-acting insulin;
      (5) Premixed insulin product;
      (6) Premixed insulin/GLP-1 RA product; and
      (7) Concentrated human regular insulin.
   b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical

emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

(1) Blood glucose meters;

(2) Blood glucose test strips;

(3) Lancing devices and lancets;

(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;

(5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and

(7) Insulin syringes.

c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.

3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:

a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies

for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.

5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.

6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. ~~(Expired effective July 31, 2025)~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2.~~ The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration ~~which complies with this section~~as provided under section 1 of this Act.

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

~~a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.~~

~~b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.~~

~~4. The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.~~

~~5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.~~

~~6. Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.~~

~~7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~

~~8. This section does not apply to the Medicare part D prescription drug coverage plan.~~

Attachment 2

Rx Type	Members with Pharmacy Claims for Insulin Before Insulin cap	Members with Pharmacy Claims for Insulin After Insulin cap	Change in Members	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount**	Cost Share Amount (Copay + Coins) Before Insulin cap	Cost Share Amount After Insulin cap	Change in Cost Share Amounts
1-INSULIN	824	831	7	**5,480**	**5,440**	-40	$3,880,454	$3,110,731	($769,723)	$1,076,143	$250,567	**($825,576)**

Insulin Days of Supply (DOS) Group	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	% Change in claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount	Cost Share Amount Before Insulin cap	Average Member Cost Share Before Insulin cap	Cost Share Amount After Insulin cap	Average Member Cost Share after Insulin cap*	Change in Cost Share Amount
01-30 DOS	2,009	1,950	-59	-3%	$1,184,018	$941,455	($242,563)	$321,298	$160	$47,573	$24	($273,725)
31-60 DOS	2,119	2,071	-48	-2%	$1,512,316	$1,151,299	($361,017)	$404,759	$191	$99,934	$48	($304,825)
61+ DOS	1,352	1,419	67	5%	$1,184,119	$1,017,976	($166,143)	$350,087	$259	$103,110	$73	($246,977)
Total	**5,480**	**5,440**	**-40**	**-1%**	**$3,880,454**	**$3,110,731**	**($769,723)**	**$1,076,143**	**$196**	**$250,617**	**$46**	**($825,526)**

Before time period: July 1, 2022-June 30, 2023
After time period: July 1, 2023-June 30, 2024

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.
**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 3

Member Impact on Insulin Claims

	Before Insulin Cap (7/1/2022-6/30/2023)	After Insulin Cap (7/1/2023-6/30/2024)	Change	Percent Change
Total Member Months	10,153	9,694	(459)	-4.5%
Member Copay Amounts	$ 644,434.40	$ 250,566.93	$ (393,867.47)	-61.1%
Member Coinsurance Amounts	$ 431,709.02	$ -	$ (431,709.02)	-100.0%
Member Copay Per Member Per Month (PMPM)	$63.47	$25.85	($37.62)	-59.3%
Member Coinsurance Per Member Per Month (PMPM)	$42.52	$0.00	($42.52)	-100.0%
Total Member Cost Share PMPM	**$105.99**	**$25.85**	**($80.15)**	**-75.6%**

Note: Coinsurance may have applied to other pharmacy claims.

Attachment 4

DATE FILLED MONTH		2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	Total
Rx Type	Days of Supply (DOS) Group	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	Average of Member Cost Share*	**Average of Member Cost Share for 12 mos**
1-INSULIN	**Total**	**$152**	**$134**	**$115**	**$118**	**$106**	**$100**	**$404**	**$373**	**$325**	**$268**	**$197**	**$162**	**$45**	**$46**	**$48**	**$47**	**$48**	**$48**	**$46**	**$48**	**$48**	**$47**	**$47**	**$36**	**$121**
	01-30 DOS	$114	$104	$102	$83	$97	$94	$350	$312	$259	$203	$154	$110	$24	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$19	**$93**
	31-60 DOS	$143	$118	$109	$106	$95	$107	$436	$360	$304	$251	$187	$158	$48	$49	$49	$50	$49	$49	$50	$50	$50	$50	$50	$35	**$120**
	61+ DOS	$240	$204	$139	$191	$136	$98	$430	$531	$446	$391	$291	$238	$72	$74	$75	$73	$75	$74	$74	$74	$74	$74	$74	$58	**$164**
	Member Cost Share=Copay + Coinsurance																									

Rx Type	Days of Supply (DOS) Group	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	Average Paid by SHP**	**Average Paid by SHP for 12 mos**
1-INSULIN	**Total**	**$747**	**$724**	**$802**	**$766**	**$743**	**$854**	**$531**	**$583**	**$612**	**$670**	**$686**	**$698**	**$793**	**$760**	**$792**	**$805**	**$789**	**$851**	**$336**	**$341**	**$340**	**$321**	**$317**	**$372**	**$640**
	01-30 DOS	$585	$622	$639	$627	$625	$667	$463	$477	$566	$571	$597	$595	$665	$653	$635	$662	$688	$679	$301	$274	$301	$324	$273	$329	**$537**
	31-60 DOS	$764	$735	$739	$797	$774	$798	$579	$643	$587	$696	$680	$727	$761	$779	$770	$797	$753	$757	$308	$379	$281	$306	$325	$366	**$636**
	61+ DOS	$1,027	$864	$1,096	$931	$860	$1,144	$552	$695	$712	$776	$850	$797	$1,030	$913	$1,026	$1,007	$982	$1,174	$435	$373	$463	$339	$368	$433	**$795**

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 5

Rx Type	Days of Supply (DOS) Group	Total claims before Insulin cap	Total claims after to Insulin cap	Change in insulin claim count before & after Insulin cap
1-INSULIN	**Total**	**5,480**	**5,440**	**-1%**
	01-30 DOS	2,009	1,950	-3%
	31-60 DOS	2,119	2,071	-2%
	61+ DOS	1,352	1,419	5%

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

PDC Adherence	Before Insulin Cap	After Insulin Cap	Difference
<80%	30.70%	28.10%	-2.6%
>=80%	69.30%	71.90%	2.6%

*The proportion of days covered (PDC) is used to estimate medication adherence.

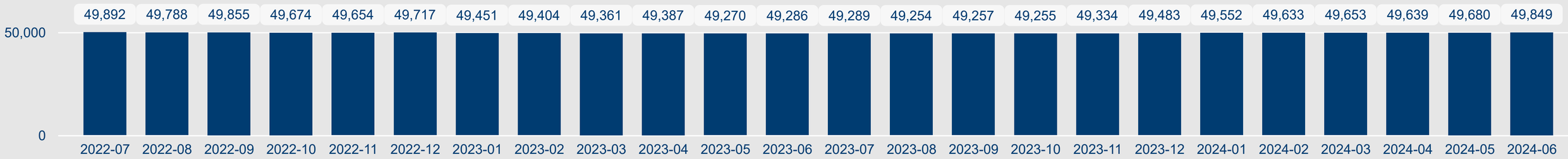
*PDC **>=80%** is considered adhering to their medication while **<80%** is considered not adhering.

*PDC calculation= (number of days covered) / (total days in time period) x 100

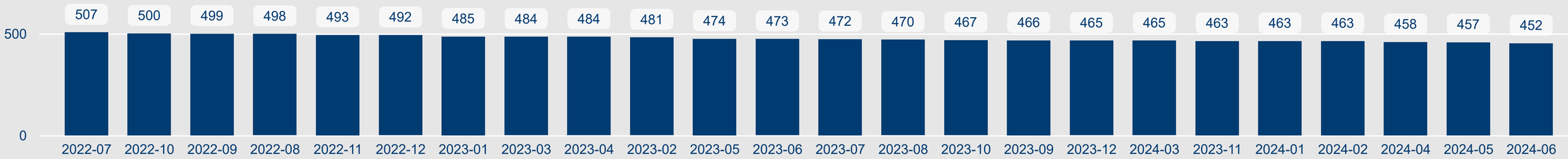
NDPERS COI Insulin & Diabetes Supplies Impact Analysis

Attachment 6

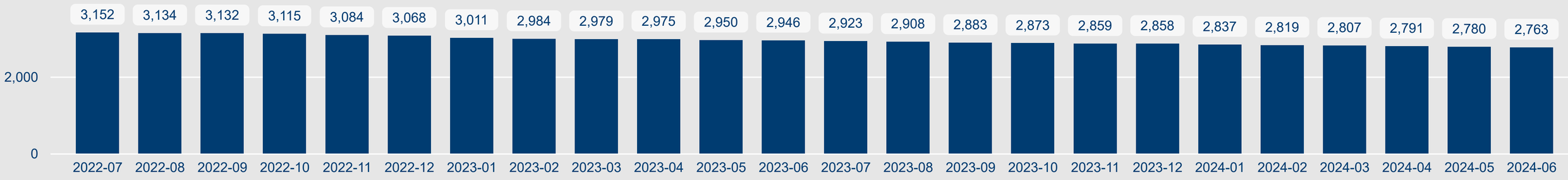
Total Members Months by Year Month



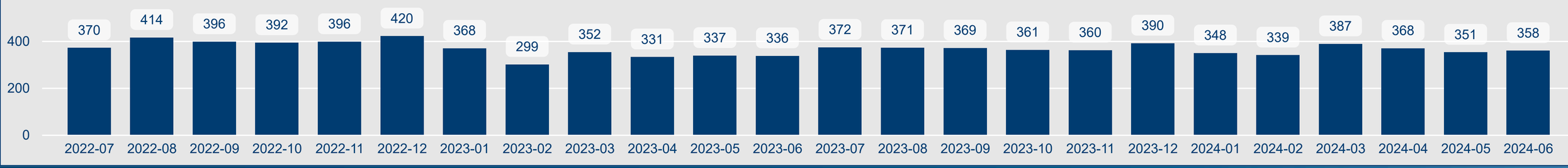
Member Months for Members with Type 1 Diabetes Diagnosis



Member Months for Members with Type 2 Diabetes Diagnosis



Distinct Count of Patient ID's with Insulin Rx Claims by Month Filled



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Attachment 7

Rx Type	Days of Supply Group	DrugDESC	Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Insulin Cap	Coinsurance Amount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member cost Share after Insulin Cap	Member Savings from Insulin Cap
1-INSULIN	**Total**		**1,964**	**2,119**	**155**	**5,480**	**5,440**	**-40**	**$ 3,880,454**	**$ 3,110,731**	**$ (769,723)**	**$ 644,434**	**$ 250,567**	**$ (393,867)**	**$ 431,709**	**0**	**$ (431,709)**	**$ 1,076,143**	**$196**	**$ 250,567**	**$46**	**$ (825,576)**
	01-30 DOS	**Total**	**541**	**562**	**21**	**2,009**	**1,950**	**-59**	**$1,184,018**	**$941,455**	**($242,563)**	**$186,043**	**$47,523**	**($138,519)**	**$135,255**	**$0**	**($135,255)**	$321,298	**$160**	$47,523	**$24**	**($273,775)**
		BASAGLAR INJ	10	8	-2	39	36	-3	$5,546	$10,553	$5,007	$6,716	$900	($5,816)	$5,546	$0	($5,546)	$12,263	**$314**	$900	**$25**	($11,363)
		FIASP INJ	9	5	-4	27	27	0	$15,318	$22,286	$6,968	$2,816	$675	($2,141)	$2,141	$0	($2,141)	$4,957	**$184**	$675	**$25**	($4,282)
		FIASP FLEX INJ TOUCH	18	18	0	69	59	-10	$39,827	$44,458	$4,631	$7,243	$1,475	($5,768)	$4,682	$0	($4,682)	$11,925	**$173**	$1,475	**$25**	($10,450)
		FIASP PENFIL INJ U	3	2	-1	7	7	0	$3,458	$4,093	$635	$815	$175	($640)	$640	$0	($640)	$1,454	**$208**	$175	**$25**	($1,279)
		HUMALOG INJ		1	1	0	4	4	$0	$40	$40	$0	$100	$100	$0	$0	$0	$0	**#DIV/0!**	$100	**$25**	$100
		HUMALOG KWIK INJ	7	7	0	26	22	-4	$20,946	$41,683	$20,737	$21,726	$550	($21,176)	$20,946	$0	($20,946)	$42,672	**$1,641**	$550	**$25**	($42,122)
		HUMULIN R INJ U	3	3	0	34	20	-14	$58,502	$41,713	($16,788)	$3,398	$500	($2,898)	$2,548	$0	($2,548)	$5,947	**$175**	$500	**$25**	($5,447)
		INS DEGL FLX INJ	7	17	10	11	62	51	$3,293	$16,459	$13,166	$918	$1,525	$607	$643	$0	($643)	$1,562	**$142**	$1,525	**$25**	($37)
		INSULIN ASPA INJ	1	1	0	14	9	-5	$177	$181	$4	$558	$225	($333)	$177	$0	($177)	$735	**$53**	$225	**$25**	($510)
		INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	$0	$0	$0	$20	$0	($20)	$0	$0	$0	$20	**$5**	$0	**#DIV/0!**	($20)
		LANTUS INJ	15	7	-8	32	9	-23	$17,758	$4,939	($12,819)	$3,281	$225	($3,056)	$2,481	$0	($2,481)	$5,763	**$180**	$225	**$25**	($5,538)
		LANTUS SOLOS INJ	75	88	13	305	278	-27	$118,902	$64,772	($54,130)	$18,698	$6,528	($12,170)	$11,073	$0	($11,073)	$29,771	**$98**	$6,528	**$23**	($23,242)
		LEVEMIR INJ		2	2	0	5	5	$0	$814	$814	$0	$125	$125	$0	$0	$0	$0	**#DIV/0!**	$125	**$25**	$125
		LEVEMIR INJ FLEXPEN	20	34	14	49	128	79	$25,106	$51,066	$25,959	$3,638	$3,200	($438)	$2,413	$0	($2,413)	$6,052	**$124**	$3,200	**$25**	($2,852)
		LEVEMIR INJ FLEXTOUC	28		-28	115	0	-115	$51,216	$0	($51,216)	$7,490	$0	($7,490)	$4,615	$0	($4,615)	$12,106	**$105**	$0	**#DIV/0!**	($12,106)
		NOVOLIN INJ	1		-1	8	0	-8	$1,740	$0	($1,740)	$449	$0	($449)	$249	$0	($249)	$697	**$87**	$0	**#DIV/0!**	($697)
		NOVOLIN N INJ	1	1	0	2	1	-1	$549	$231	($318)	$233	$25	($208)	$183	$0	($183)	$416	**$208**	$25	**$25**	($391)
		NOVOLIN R INJ U		1	1	0	7	7	$0	$2,429	$2,429	$0	$150	$150	$0	$0	$0	$0	**#DIV/0!**	$150	**$21**	$150
		NOVOLOG INJ	99	92	-7	367	396	29	$250,980	$200,688	($50,292)	$38,789	$9,795	($28,994)	$29,769	$0	($29,769)	$68,558	**$187**	$9,795	**$25**	($58,763)
		NOVOLOG INJ FLEX REL		1	1	0	1	1	$0	$59	$59	$0	$25	$25	$0	$0	$0	$0	**#DIV/0!**	$25	**$25**	$25
		NOVOLOG INJ FLEXPEN	148	154	6	507	510	3	$336,948	$226,716	($110,233)	$42,781	$12,400	($30,381)	$30,181	$0	($30,181)	$72,962	**$144**	$12,400	**$24**	($60,562)
		NOVOLOG INJ PENFILL	8	10	2	46	47	1	$17,126	$15,460	($1,666)	$3,846	$1,175	($2,671)	$2,696	$0	($2,696)	$6,542	**$142**	$1,175	**$25**	($5,367)
		NOVOLOG MIX INJ FLEXPEN	1	5	4	3	8	5	$1,507	$2,468	$960	$82	$200	$118	$7	$0	($7)	$89	**$30**	$200	**$25**	$111
		SEMGLEE INJ	1	1	0	1	1	0	$3	$25	$22	$33	$25	($8)	$3	$0	($3)	$35	**$35**	$25	**$25**	($10)
		SOLIQUA INJ	5	3	-2	28	16	-12	$20,590	$13,112	($7,478)	$2,102	$400	($1,702)	$1,402	$0	($1,402)	$3,504	**$125**	$400	**$25**	($3,104)
		TOUJEO MAX INJ	10	19	9	41	35	-6	$30,760	$26,925	($3,835)	$2,976	$825	($2,151)	$1,951	$0	($1,951)	$4,928	**$120**	$825	**$24**	($4,103)
		TOUJEO SOLO INJ	28	41	13	117	101	-16	$34,894	$34,795	($99)	$6,277	$2,350	($3,927)	$3,627	$0	($3,627)	$9,903	**$85**	$2,350	**$23**	($7,553)
		TRESIBA FLEX INJ	39	40	1	144	151	7	$114,978	$102,587	($12,390)	$9,024	$3,700	($5,324)	$5,474	$0	($5,474)	$14,499	**$101**	$3,700	**$25**	($10,799)
		XULTOPHY INJ	3	1	-2	13	10	-3	$13,893	$12,902	($991)	$2,133	$250	($1,883)	$1,808	$0	($1,808)	$3,941	**$303**	$250	**$25**	($3,691)
	31-60 DOS	**Total**	**679**	**739**	**60**	**2,119**	**2,071**	**-48**	**$1,512,316**	**$1,151,299**	**($361,017)**	**$248,465**	**$99,934**	**($148,531)**	**$156,294**	**$0**	**($156,294)**	$404,759	**$191**	$99,934	**$48**	**($304,825)**
		BASAGLAR INJ	15	14	-1	40	43	3	$5,476	$16,806	$11,330	$7,847	$2,150	($5,697)	$5,477	$0	($5,477)	$13,323	**$333**	$2,150	**$50**	($11,173)
		FIASP INJ	5	8	3	14	28	14	$10,165	$20,837	$10,672	$1,750	$1,350	($400)	$1,100	$0	($1,100)	$2,851	**$204**	$1,350	**$48**	($1,501)
		FIASP FLEX INJ TOUCH	7	18	11	20	53	33	$10,292	$35,885	$25,593	$1,718	$2,650	$932	$868	$0	($868)	$2,586	**$129**	$2,650	**$50**	$64
		HUMALOG KWIK INJ	3	3	0	12	11	-1	$14,426	$25,271	$10,845	$14,996	$550	($14,446)	$14,426	$0	($14,426)	$29,422	**$2,452**	$550	**$50**	($28,872)
		HUMULIN R INJ U	2		-2	3	0	-3	$5,480	$0	($5,480)	$497	$0	($497)	$372	$0	($372)	$869	**$290**	$0	**#DIV/0!**	($869)
		INS DEGL FLX INJ	7	21	14	15	47	32	$2,246	$8,229	$5,983	$1,046	$2,150	$1,104	$296	$0	($296)	$1,341	**$89**	$2,150	**$46**	$809
		INSULIN ASPA INJ	1		-1	2	0	-2	$61	$0	($61)	$151	$0	($151)	$61	$0	($61)	$212	**$106**	$0	**#DIV/0!**	($212)
		LANTUS INJ	10	11	1	42	36	-6	$29,238	$19,564	($9,673)	$4,560	$1,700	($2,860)	$2,610	$0	($2,610)	$7,171	**$171**	$1,700	**$47**	($5,471)
		LANTUS SOLOS INJ	122	144	22	403	420	17	$175,193	$112,512	($62,681)	$40,430	$20,080	($20,351)	$22,015	$0	($22,015)	$62,446	**$155**	$20,080	**$48**	($42,366)
		LEVEMIR INJ	2	1	-1	3	1	-2	$581	$231	($349)	$294	$50	($244)	$194	$0	($194)	$487	**$162**	$50	**$50**	($437)
		LEVEMIR INJ FLEXPEN	22	32	10	50	112	62	$23,960	$47,669	$23,709	$5,630	$5,475	($155)	$3,445	$0	($3,445)	$9,074	**$181**	$5,475	**$49**	($3,600)
		LEVEMIR INJ FLEXTOUC	27		-27	70	0	-70	$40,557	$0	($40,557)	$7,250	$0	($7,250)	$4,125	$0	($4,125)	$11,375	**$162**	$0	**#DIV/0!**	($11,375)
		NOVOLIN INJ	1	1	0	1	5	4	$371	$1,415	$1,045	$174	$250	$76	$124	$0	($124)	$297	**$297**	$250	**$50**	($47)
		NOVOLIN N INJ	3		-3	3	0	-3	$877	$0	($877)	$417	$0	($417)	$292	$0	($292)	$710	**$237**	$0	**#DIV/0!**	($710)
		NOVOLIN N INJ U	1	1	0	1	1	0	$63	$4	($59)	$71	$50	($21)	$21	$0	($21)	$92	**$92**	$50	**$50**	($42)
		NOVOLIN R INJ U	2	1	-1	7	8	1	$472	$227	($245)	$448	$370	($78)	$98	$0	($98)	$546	**$78**	$370	**$46**	($177)
		NOVOLOG INJ	105	91	-14	361	352	-9	$309,214	$207,740	($101,474)	$45,031	$17,310	($27,721)	$30,568	$0	($30,568)	$75,600	**$209**	$17,310	**$49**	($58,290)
		NOVOLOG INJ FLEX REL	1		-1	5	0	-5	$196	$0	($196)	$261	$0	($261)	$11	$0	($11)	$271	**$54**	$0	**#DIV/0!**	($271)
		NOVOLOG INJ FLEXPEN	165	176	11	517	467	-50	$474,597	$259,790	($214,807)	$56,701	$22,250	($34,451)	$34,998	$0	($34,998)	$91,699	**$177**	$22,250	**$48**	($69,449)
		NOVOLOG INJ PENFILL	6	7	1	27	28	1	$25,521	$24,062	($1,459)	$4,509	$1,400	($3,109)	$3,284	$0	($3,284)	$7,793	**$289**	$1,400	**$50**	($6,393)
		NOVOLOG MIX INJ FLEXPEN	4	6	2	21	18	-3	$18,290	$12,888	($5,403)	$2,321	$900	($1,421)	$1,546	$0	($1,546)	$3,867	**$184**	$900	**$50**	($2,967)
		SOLIQUA INJ	6	5	-1	19	15	-4	$11,877	$11,602	($274)	$3,496	$750	($2,746)	$2,546	$0	($2,546)	$6,042	**$318**	$750	**$50**	($5,292)
		TOUJEO MAX INJ	13	32	19	30	44	14	$36,768	$51,357	$14,588	$2,938	$1,900	($1,038)	$1,588	$0	($1,588)	$4,526	**$151**	$1,900	**$43**	($2,626)
		TOUJEO SOLO INJ	40	75	35	90	104	14	$78,357	$84,480	$6,122	$8,103	$5,150	($2,953)	$4,578	$0	($4,578)	$12,680	**$141**	$5,150	**$50**	($7,530)
		TRESIBA FLEX INJ	109	92	-17	363	278	-85	$238,037	$210,730	($27,307)	$37,827	$13,450	($24,377)	$21,652	$0	($21,652)	$59,478	**$164**	$13,450	**$48**	($46,028)
	61+ DOS	**Total**	**744**	**818**	**74**	**1,352**	**1,419**	**67**	**$1,184,119**	**$1,017,976**	**($166,143)**	**$209,927**	**$103,110**	**($106,817)**	**$140,160**	**$0**	**($140,160)**	$350,087	**$259**	$103,110	**$73**	**($246,977)**
		BASAGLAR INJ	8	15	7	22	31	9	$5,300	$15,762	$10,462	$6,620	$2,325	($4,295)	$5,300	$0	($5,300)	$11,919	**$542**	$2,325	**$75**	($9,594)
		FIASP INJ	8	11	3	20	22	2	$27,305	$38,480	$11,175	$4,855	$1,650	($3,205)	$3,855	$0	($3,855)	$8,710	**$436**	$1,650	**$75**	($7,060)
		FIASP FLEX INJ TOUCH	13	13	0	22	28	6	$25,122	$38,064	$12,942	$3,941	$2,100	($1,841)	$2,841	$0	($2,841)	$6,781	**$308**	$2,100	**$75**	($4,681)
		FIASP PENFIL INJ U		2	2	0	3	3	$0	$2,265	$2,265	$0	$225	$225	$0	$0	$0	$0	**#DIV/0!**	$225	**$75**	$225

GLARGIN YFGN INJ		1	1	0	1	1	$0	$0	$0	$0	$65	$65	$0	$0	$0	$0	#DIV/0!	$65	$65	$65
HUMALOG INJ		1	1	0	1	1	$0	$1,810	$1,810	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
HUMALOG KWIK INJ		2	2	0	3	3	$0	$13,697	$13,697	$0	$225	$225	$0	$0	$0	$0	#DIV/0!	$225	$75	$225
HUMULIN R INJ U	1		-1	1	0	-1	$0	$0	$0	$15	$0	($15)	$0	$0	$0	$15	$15	$0	#DIV/0!	($15)
INS DEGL FLX INJ	6	51	45	8	80	72	$3,096	$20,187	$17,090	$497	$5,745	$5,248	$97	$0	($97)	$593	$74	$5,745	$72	$5,152
INSULIN ASPA INJ	1	5	4	1	6	5	$30	$2,817	$2,787	$90	$450	$360	$30	$0	($30)	$120	$120	$450	$75	$330
INSULIN GLAR INJ	1		-1	3	0	-3	$0	$0	$0	$135	$0	($135)	$0	$0	$0	$135	$45	$0	#DIV/0!	($135)
INSULIN LISP INJ	1	2	1	2	4	2	$397	$284	($113)	$517	$300	($217)	$397	$0	($397)	$914	$457	$300	$75	($614)
LANTUS INJ	9	5	-4	16	11	-5	$19,683	$10,374	($9,309)	$3,688	$825	($2,863)	$2,888	$0	($2,888)	$6,576	$411	$825	$75	($5,751)
LANTUS SOLOS INJ	181	202	21	341	351	10	$184,707	$115,903	($68,804)	$43,274	$25,395	($17,879)	$26,016	$0	($26,016)	$69,290	$203	$25,395	$72	($43,895)
LEVEMIR INJ	2	1	-1	4	4	0	$2,096	$1,946	($150)	$539	$300	($239)	$339	$0	($339)	$877	$219	$300	$75	($577)
LEVEMIR INJ FLEXPEN	25	36	11	29	62	33	$14,512	$33,791	$19,279	$4,057	$4,500	$443	$2,657	$0	($2,657)	$6,713	$231	$4,500	$73	($2,213)
LEVEMIR INJ FLEXTOUC	41	1	-40	59	1	-58	$34,413	$423	($33,989)	$6,776	$0	($6,776)	$3,826	$0	($3,826)	$10,601	$180	$0	$0	($10,601)
NOVOLIN N INJ	4	5	1	5	6	1	$871	$1,383	$512	$397	$375	($22)	$147	$0	($147)	$543	$109	$375	$63	($168)
NOVOLIN N INJ U	3	3	0	7	7	0	$2,998	$2,688	($310)	$1,349	$525	($824)	$999	$0	($999)	$2,349	$336	$525	$75	($1,824)
NOVOLIN R INJ		1	1	0	1	1	$0	$159	$159	$0	$75	$75	$0	$0	$0	$0	#DIV/0!	$75	$75	$75
NOVOLIN70/3	2	2	0	5	2	-3	$1,136	$455	($681)	$376	$150	($226)	$126	$0	($126)	$502	$100	$150	$75	($352)
NOVOLOG INJ	124	125	1	236	280	44	$332,261	$279,531	($52,730)	$56,318	$20,364	($35,954)	$43,107	$0	($43,107)	$99,425	$421	$20,364	$73	($79,061)
NOVOLOG INJ FLEX REL	2	4	2	2	6	4	$55	$306	$252	$118	$425	$307	$18	$0	($18)	$136	$68	$425	$71	$289
NOVOLOG INJ FLEXPEN	134	142	8	244	242	-2	$230,703	$174,500	($56,203)	$33,428	$17,441	($15,987)	$21,623	$0	($21,623)	$55,051	$226	$17,441	$72	($37,610)
NOVOLOG INJ PENFILL	6	7	1	9	11	2	$12,584	$13,122	$538	$1,915	$825	($1,090)	$1,465	$0	($1,465)	$3,380	$376	$825	$75	($2,555)
NOVOLOG INJ RELION	1	1	0	2	4	2	$701	$1,449	$748	$334	$300	($34)	$234	$0	($234)	$567	$284	$300	$75	($267)
NOVOLOG MIX INJ FLEXPEN	3	2	-1	7	3	-4	$8,005	$2,897	($5,108)	$926	$225	($701)	$576	$0	($576)	$1,502	$215	$225	$75	($1,277)
SOLIQUA INJ	5	1	-4	8	1	-7	$13,283	$720	($12,562)	$1,287	$75	($1,212)	$987	$0	($987)	$2,273	$284	$75	$75	($2,198)
TOUJEO MAX INJ	12	29	17	17	22	5	$12,145	$20,452	$8,307	$1,930	$1,575	($355)	$1,115	$0	($1,115)	$3,046	$179	$1,575	$72	($1,471)
TOUJEO SOLO INJ	32	62	30	55	53	-2	$42,520	$49,060	$6,539	$6,827	$3,825	($3,002)	$4,177	$0	($4,177)	$11,003	$200	$3,825	$72	($7,178)
TRESIBA INJ	1	2	1	4	5	1	$3,361	$5,358	$1,997	$461	$375	($86)	$261	$0	($261)	$722	$180	$375	$75	($347)
TRESIBA FLEXTINJ	117	83	-34	222	167	-55	$206,700	$168,964	($37,736)	$29,165	$12,300	($16,865)	$17,036	$0	($17,036)	$46,201	$208	$12,300	$74	($33,901)
XULTOPHY INJ	1	1	0	1	1	0	$136	$1,129	$993	$95	$75	($20)	$45	$0	($45)	$141	$141	$75	$75	($66)

No filters applied

Attachment 8

Rx Type	Days of Supply (DOS) Group		Members with Pharmacy Claims Before Insulin Cap	Members with Pharmacy Claims After Insulin Cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin Cap	Pharmacy Claims After Insulin Cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Cap	SHP Paid Amount After Insulin Cap	SHP PAID Amount Change	Copay Amount Before Insulin Cap	Copay Amount After Insulin Cap	Copay Amount Change	Coinsurance Amount Before Insulin Cap	Coinsurance Amount After Cap Insulin	CoinsuranceA mount Change	Total Member cost Share before to Insulin cap	Ave Member Cost Share before Insulin Cap	Total Member cost Share after Insulin Cap	Ave Member Cost Share after Insulin Cap	Member Savings from Insulin Cap
2-BLOOD GLUCOSE METERS	**Total**		**200**	**151**	**-49**	**143**	**103**	**-40**	**$2,436**	**$1,692**	**($744)**	**$634**	**$463**	**($171)**	**$634**	**$424**	**($211)**	**$1,268**	**$9**	**$886**	**$9**	**($382)**
	01-30 DOS	**Total**	190	141	-49	136	96	-40	$2,331	$1,608	($723)	$599	$414	($185)	$599	$414	($185)	$1,198	$9	$828	$9	($370)
	61+ DOS	**Total**	10	10	0	7	7	0	$106	$84	($21)	$35	$49	$14	$35	$10	($25)	$70	$10	$59	$8	($12)
3-BLOOD GLUCOSE TEST STRIPS	**Total**		**916**	**693**	**-223**	**1,729**	**1,226**	**-503**	**$156,322**	**$116,411**	**($39,911)**	**$33,349**	**$24,804**	**($8,545)**	**$32,285**	**$21,504**	**($10,781)**	**$65,634**	**$38**	**$46,308**	**$38**	**($19,326)**
	01-30 DOS	**Total**	247	190	-57	520	374	-146	$36,163	$26,476	($9,687)	$7,975	$5,745	($2,230)	$7,403	$4,679	($2,724)	$15,378	$30	$10,424	$28	($4,954)
	31-60 DOS	**Total**	335	256	-79	699	496	-203	$56,048	$40,930	($15,118)	$12,886	$9,739	($3,146)	$12,608	$8,868	($3,740)	$25,493	$36	$18,607	$38	($6,887)
	61+ DOS	**Total**	334	247	-87	510	356	-154	$64,110	$49,005	($15,106)	$12,488	$9,319	($3,169)	$12,274	$7,957	($4,317)	$24,762	$49	$17,277	$49	($7,486)
4-LANCETS AND LANCET DEVICES	**Total**		**448**	**372**	**-76**	**637**	**492**	**-145**	**$5,490**	**$4,160**	**($1,330)**	**$1,301**	**$1,153**	**($149)**	**$1,244**	**$992**	**($252)**	**$2,546**	**$4**	**$2,145**	**$4**	**($400)**
	01-30 DOS	**Total**	128	119	-9	199	160	-39	$1,541	$1,225	($315)	$376	$329	($47)	$350	$289	($61)	$726	$4	$618	$4	($108)
	31-60 DOS	**Total**	130	87	-43	189	125	-64	$1,541	$1,046	($495)	$386	$300	($87)	$377	$261	($117)	$763	$4	$560	$4	($203)
	61+ DOS	**Total**	190	166	-24	249	207	-42	$2,409	$1,888	($520)	$540	$524	($15)	$516	$442	($74)	$1,056	$4	$967	$5	($89)
5-KETONE TESTING	**Total**		**4**	**5**	**1**	**29**	**8**	**-21**	**$19,921**	**$4,360**	**($15,561)**	**$449**	**$15**	**($435)**	**$449**	**$15**	**($435)**	**$898**	$31	$29	$4	**($869)**
	01-30 DOS	**Total**	4	4	0	29	7	-22	$19,921	$4,352	($15,569)	$449	$12	($437)	$449	$12	($437)	$898	$31	$24	$3	($874)
	31-60 DOS	**Total**		1	1	0	1	1	$0	$8	$8	$0	$3	$3	$0	**$3**	**$3**	$0	#DIV/0!	$5	$5	$5
6-GLUCAGON	**Total**		**71**	**72**	**1**	**80**	**78**	**-2**	**$27,475**	**$34,864**	**$7,389**	**$6,623**	**$1,367**	**($5,257)**	**$5,028**	**$967**	**($4,062)**	**$11,652**	**$146**	**$2,334**	**$30**	**($9,318)**
	01-30 DOS	**Total**	71	72	1	80	78	-2	$27,475	$34,864	$7,389	$6,623	$1,367	($5,257)	$5,028	$967	($4,062)	$11,652	$146	$2,334	$30	($9,318)
7-SYRINGE/PEN NEEDLE	**Total**		**938**	**802**	**-136**	**1,638**	**1,391**	**-247**	**$112,768**	**$96,953**	**($15,815)**	**$7,502**	**$8,786**	**$1,284**	**$7,346**	**$7,587**	**$241**	**$14,848**	**$9**	**$16,374**	**$12**	**$1,525**
	01-30 DOS	**Total**	223	200	-23	544	463	-81	$26,042	$24,416	($1,626)	$1,827	$2,548	$720	$1,827	$2,111	$284	$3,654	$7	$4,659	$10	$1,005
	31-60 DOS	**Total**	161	173	12	322	294	-28	$25,803	$21,477	($4,326)	$1,593	$1,984	$391	$1,593	$1,889	$296	$3,185	$10	$3,872	$13	$687
	61+ DOS	**Total**	554	429	-125	772	634	-138	$60,922	$51,060	($9,863)	$4,082	$4,255	$173	$3,926	$3,587	($339)	$8,009	$10	$7,842	$12	($166)
	Grand TOTAL		**2,577**	**2,095**	**-482**	**4,256**	**3,298**	**-958**	**$ 324,411**	**$ 258,440**	**$ (65,971)**	**$ 49,860**	**$ 36,587**	**$ (13,273)**	**$ 46,987**	**$ 31,489**	**$ (15,498)**	**$ 96,847**		**$ 68,076**		**($28,771)**

NOTEWORTHY COMMENTS:

Continuous Glucose Monitors and Insulin Pumps may replace the need for some of these supplies.

252 NDPERS members enrolled in Livongo Diabetes program bewteen July 1, 2023- June 30, 2024. Livongo provides Blood Glucose Monitors & test strips to the participants.

Blood Glucose Meters, Test Strips & Lancets can be used by any diabetic including those not using insulin.

INSULIN & DIABETIC SUPPLY BRIEF

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

In the landscape of healthcare affordability, few issues resonate as profoundly as the accessibility of insulin and diabetic supplies, especially within the United States. The soaring prices of these life-sustaining medications have sparked national outcry, prompting legislative actions in several states aimed at implementing price caps. As diabetes prevalence continues to rise, individuals facing this chronic condition grapple not only with its daily management but also with the financial burden imposed by escalating medication costs. Understanding the varied approaches and efficacy of state-level price caps is essential in assessing the impact on patients, healthcare systems, and the broader socio-economic landscape.

CURRENT LANDSCAPE OVERVIEW

In a recent discussion, it was highlighted that diabetics nationwide are set to benefit from reduced out-of-pocket costs for insulin, thanks to efforts by pharmaceutical companies. Sanofi has joined Eli Lilly and Novo Nordisk in capping insulin co-pays at $35. This move follows pressure from President Biden, lawmakers, and activists to lower drug prices.

Laura Barron-Lopez, White House correspondent, emphasized the significance of these measures. She noted that while Medicare beneficiaries automatically benefit from the $35 co-pay cap, those with private insurance or without insurance must navigate more complex processes to access the reduced costs. Advocates like Shaina Kasper of T1International suggest that a federal mandate is needed to ensure consistency in cost reductions.

Beyond insulin, other healthcare reforms are underway. For Medicare recipients, drug costs will be capped annually, starting at $3,300 in 2024 and decreasing to $2,000 by 2025. Additionally, Medicare now has the authority to negotiate drug prices, potentially saving billions over the next decade.

Despite these changes, there's a notable gap in public awareness. Many Americans are unaware of these reforms, complicating efforts to credit President Biden politically for these achievements. Analysts suggest that effective communication will be crucial for the administration to highlight these reforms ahead of the upcoming elections[1].

A gathering of families and advocates convened with Governor Doug Burgum at the North Dakota Capitol to commemorate a recent law that limits the cost of insulin for state employees' health insurance beneficiaries. Under this law, those covered by the state employee health plan now pay no more than $25 per month for insulin. Additionally, the law extends this monthly price cap to medical supplies needed to administer insulin.

Danelle Johnson, who supported the legislation during her testimony in 2023, expressed mixed feelings about its scope. Originally proposed to benefit all North Dakotans, the law was amended by lawmakers to apply solely to individuals under the Public Employees Retirement System's health insurance. Johnson acknowledged the legislation as a significant advancement but expressed a desire for broader accessibility to the price caps. She emphasized the importance of incremental progress over a stalemate in legislative action.

Insulin, critical for diabetes management, can cost hundreds of dollars per vial. A 2023 report by the Health Care Cost Institute indicated that average monthly insulin costs in the U.S. rose from $271 in 2012 to about $499 in 2021. The exorbitant prices often lead diabetes patients to ration their insulin or even skip

[1] https://www.pbs.org/newshour/show/new-law-caps-insulin-prices-for-some-with-diabetes-but-cost-remains-high-for-millions

treatment, risking severe health complications. In 2022, approximately 100,000 Americans died from diabetes, a figure similar to the number of deaths from drug overdoses reported by the CDC.

State Senator Tim Mathern, the bill's primary sponsor, highlighted the dire consequences of unaffordable medication, stressing the need for reform. Angela and Nina Kritzberger, also advocates for insulin affordability, were present at the ceremony. Both families recounted instances where insufficient access to insulin necessitated emergency medical interventions. Looking ahead, Mathern noted efforts to garner support for broader reforms in the upcoming legislative session. The law, effective since August 1, 2023, will remain in force until July 31, 2025, with an estimated cost of $900,000 over the 2023-2025 budget cycle. Although signed over a year ago, logistical issues delayed the official signing ceremony, according to Mathern. Additionally, the federal government implemented a $35 monthly insulin price cap for Medicaid patients through the Inflation Reduction Act signed by President Joe Biden in 2022[2].

Healthcare executives faced intense scrutiny from lawmakers on Capitol Hill during a House Energy and Commerce Committee hearing focused on insulin prices. Representative Jan Schakowsky of Illinois directly challenged panelists, expressing disbelief over their actions and warning of consequences. Amid the hearings, a social media suggestion resurfaced: patients should opt for Walmart's affordable insulin. Over the past decade, the cost of popular insulin brands has tripled, leading many Americans with Type 1 or Type 2 diabetes to ration their doses or skip treatments entirely.

Walmart provides Novo Nordisk's Novolin ReliOn Insulin for less than $25 per vial without a prescription. However, healthcare professionals caution that this "human" insulin, introduced in the 1980s, lacks the refined capabilities of newer analogs in preventing severe blood sugar fluctuations. Critics argue that relying on Walmart's insulin overlooks the complexities of diabetes management and the risks associated with unsupervised treatment. Advocates emphasize that while this option may suit some patients, it's far from a comprehensive solution to the ongoing insulin affordability crisis. The blame for rising insulin prices has been volleyed between drug manufacturers and pharmacy benefit managers. While executives defend financial assistance programs, lawmakers assert that unchecked price hikes by pharmaceutical companies are at the heart of the issue. Unlike many other countries, the U.S. allows drug companies considerable freedom in setting prices, resulting in disproportionately high insulin costs despite the country representing a minority share of the global insulin market. Recent efforts, such as Cigna and Express Scripts capping insulin costs at $25 per month, are viewed as temporary fixes by critics like Elizabeth Pfiester of TIInternational. She insists that true resolution requires systemic changes to reduce insulin's list prices permanently.

As the debate intensifies, healthcare professionals and advocates continue to call for legislative intervention to protect diabetic patients from the financial and health risks posed by exorbitant insulin costs[3],[4]

State Copay Caps[5]

- Alabama: $100 cap for 30-day supply
- Colorado: $100 collective cap for 30-day supply
- 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
- District of Columbia: $30 cap for a 30-day supply of insulin and $100 cap for a 30-day supply of covered diabetes devices

[2] https://northdakotamonitor.com/2024/05/28/patient-advocates-plan-to-continue-pushing-for-insulin-price-cap/
[3] https://www.vox.com/science-and-health/2019/4/10/18302238/insulin-walmart-relion)
[4] https://www.novonordisk-us.com/patient-help/access-and-affordability.html
[5] https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps

- Illinois: $100 collective cap for 30-day supply
- Kentucky: $30 cap for 30-day supply
- Louisiana: $75 cap for 30-day supply
- Maine: $35 cap for 30-day supply
- Maryland: $30 cap for 30-day supply
- Minnesota: State-required manufacturer assistance program has a $35 cap for one per year emergency 30-day supply, $50 cap for 90-day supply
- Montana: $35 for 30-day supply
- Nebraska: $35 cap for 30-day supply
- New Hampshire: $30 cap for 30-day supply
- New Jersey: $30 cap for 30-day supply
- New Mexico: $25 cap for 30-day supply
- New York: $100 cap for 30-day supply
- North Dakota: $25 cap for a 30-day supply*
- Oklahoma: $30 cap for 30-day supply, $90 cap for 90-day supply
- Oregon: $75 cap for a 30-day supply, $225 cap for a 90-day supply
- Rhode Island: $40 cap for a 30-day supply
- Texas: $25 cap for a 30-day supply
- Utah: $30 cap for 30-day supply
- Vermont: $100 collective cap for 30-day supply
- Virginia: $50 cap for 30-day supply
- Washington: $35 cap for 30-day supply
- West Virginia: $35 collective cap for 30-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies.

The State of Utah conducted a study and published their findings regarding Insulin costs. Insulin costs have become a major issue for diabetes patients in the U.S. In response, Utah passed House Bill 207, capping insulin copayments at $30 per month, effective January 1, 2021.

This study evaluated changes in basal insulin adherence, out-of-pocket expenses, health plan costs, overall insulin expenditures, and hemoglobin A1c (A1c) levels before and after the policy's implementation. Conducting a retrospective analysis using data from a Utah health plan between October 2019 and September 2021, the study included commercially insured members who filled insulin prescriptions in both pre- and post-policy periods. Insulin adherence was assessed using the proportion of days covered (PDC), and statistical tests compared health and economic outcomes. Out of 24,150 individuals, 244 patients were analyzed. Results showed a **58.5% reduction** in median monthly out-of-pocket costs for insulin (from $65 to $27), while health plan costs increased by **22%** (from $346 to $444). Total monthly insulin costs remained unchanged. Among 74 patients analyzed for PDC, no significant change was observed (P = 0.43). Similarly, A1c levels did not significantly improve (mean A1c rose from 8.2% to 8.6%). The $30 copayment cap reduced patient out-of-pocket costs but led to higher costs for health plans without improving adherence or A1c levels. Further research over longer periods and with larger populations is necessary to assess long-term impacts.

The Utah study highlights that capping insulin copayments effectively reduced patient costs but shifted financial burdens to health plans. While adherence and health outcomes remained unchanged, further investigation is essential to determine if this policy yields long-term benefits for diabetes management[6].

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10839465/

MANUFACTURER'S INSULIN CHARGE CHANGE

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

Since 2023, insulin manufacturers have reduced prices on their insulin and diabetic supplies in response to mounting public pressure and advocacy efforts highlighting the exorbitant costs faced by diabetic patients. These reductions come amidst growing awareness of the essential nature of insulin for millions of individuals worldwide, many of whom have struggled with affordability and access issues for years. Additionally, regulatory scrutiny and legislative initiatives have pushed manufacturers to reassess their pricing strategies, aiming to make these life-saving medications more accessible and affordable. These changes mark a significant step towards addressing healthcare inequities and ensuring that essential treatments are within reach for those who need them most.

CURRENT LANDSCAPE OVERVIEW

Eli Lilly and Company has taken significant steps to enhance insulin affordability with recent initiatives. Starting May 1, 2023, Lilly will reduce the list price of Insulin Lispro Injection to $25 per vial, making it the most affordable mealtime insulin available. Humalog® and Humulin® will see a 70% price cut from Q4 2023, and RezvoglarTM, a biosimilar basal insulin, will be priced at $92 per five-pack of KwikPens®, a 78% discount compared to Lantus®. Lilly has also capped out-of-pocket costs at $35 per month for commercial insurance users immediately and offers uninsured individuals Lilly insulin for $35 monthly through the Lilly Insulin Value Program. These measures aim to address healthcare system gaps hindering affordable insulin access, with CEO David A. Ricks stressing the need for broader collaboration for comprehensive diabetes care. Lilly's efforts build on prior initiatives such as low-list-price insulins since 2019 and participation in the Medicare Part D Senior Savings Model, reducing average out-of-pocket costs for Lilly insulins to $21.80 over five years. Future plans include a national awareness campaign to promote these solutions and advocate systemic insulin accessibility improvements, alongside ongoing innovation in diabetes care.[1]

Novo Nordisk will significantly lower US list prices for insulin products by up to 75% effective January 1, 2024, following Eli Lilly's lead in reducing insulin prices by 70% and capping out-of-pocket costs at $35 monthly. President Joe Biden commended Eli Lilly's initiative, urging other insulin makers to follow. Novo Nordisk's price cuts cover NovoLog and Levemir, aiming to ease financial burdens for uninsured and high-deductible patients, with Medicare seniors benefiting from an Inflation Reduction Act cap. Advocacy groups like T1International applaud these steps while noting ongoing insulin affordability challenges relative to production costs. Novo Nordisk reaffirms commitment to insulin affordability through support programs, contrasting with Sanofi, which has yet to announce price cuts, focusing instead on existing assistance for uninsured and privately insured individuals. The US insulin price gap compared to other countries remains a concern, reflecting broader American healthcare drug pricing and access challenges[2].

Over the past two decades, insulin list prices by pharmaceutical manufacturers have risen annually, posing affordability challenges for insured patients facing soaring out-of-pocket costs. Simultaneously, insurers and pharmacy benefit managers (PBMs) negotiated increasing rebates and confidential discounts, significantly lowering net prices despite gross sales doubling for leading insulin products from 2012 to 2019.

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[1] https://investor.lilly.com/news-releases/news-release-details/lilly-cuts-insulin-prices-70-and-caps-patient-insulin-out-pocket#:~:text=Today%2C%20Lilly%20is%20reducing%20the,Humalog%C2%AE%20vial%20in%201999.

[2] https://www.nbcnews.com/health/health-news/novo-nordisk-lower-list-price-insulin-rcna74836

Eli Lilly, Novo Nordisk, and Sanofi responded with substantial list price cuts of 65% to 80% in March 2023, driven by impending 2024 Medicaid rebate changes under the American Rescue Act. The gross-to-net price bubble persists for many brand-name drugs, reflecting opaque pricing and rebate structures. Future policy efforts, such as Medicare price negotiation and enhanced transparency, are crucial for equitable patient access to vital medications amid systemic pharmaceutical market challenges[3].

In 2024, Sanofi and other insulin manufacturers are implementing transformative initiatives to significantly reduce insulin costs for millions of Americans with diabetes. Sanofi has introduced price caps and savings programs, ensuring many patients pay no more than $35 monthly for insulin, responding to public outcry and legislative changes. The Inflation Reduction Act capped Medicare enrollees' out-of-pocket expenses, alleviating financial burdens and addressing insulin rationing risks. These actions aim to enhance affordability and equity in healthcare, signaling collaborative efforts among policymakers, patient advocates, and industry leaders to improve insulin accessibility and support a sustainable healthcare system[4].

CONCLUDING

In conclusion, the landscape of insulin pricing in the United States is undergoing significant shifts as major manufacturers like Eli Lilly and Novo Nordisk respond to longstanding affordability challenges. These companies have taken proactive steps to reduce list prices by substantial margins, with Eli Lilly cutting prices by up to 70% and Novo Nordisk following suit with reductions of up to 75% effective January 2024. These efforts, applauded by President Joe Biden and advocacy groups like T1International, aim to alleviate financial burdens on patients, particularly the uninsured and those with high deductibles. The implementation of caps on out-of-pocket costs under the Inflation Reduction Act further supports affordability for Medicare enrollees.

Despite these positive developments, disparities persist in insulin pricing between the U.S. and other countries, reflecting broader complexities in drug pricing and access within the American healthcare system. The ongoing challenge of insulin affordability underscores the need for continued policy reforms, including enhanced transparency in pricing practices and potential Medicare negotiations on drug prices. These reforms could further address the gross-to-net price discrepancies observed not only in insulin but also in other essential medications.

Looking forward, the commitment of pharmaceutical companies to affordability initiatives, alongside advocacy efforts and legislative changes, offers hope for more equitable access to insulin and other critical medications. As industry leaders navigate these reforms, the focus remains on ensuring that patients can affordably access the medications they need to manage chronic conditions effectively. This collaborative approach between stakeholders sets a precedent for addressing broader healthcare affordability issues and advancing towards a more inclusive and sustainable healthcare system in the United States.

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806020
[4] https://www.cnn.com/2024/01/01/politics/insulin-price-cap/index.html

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0118.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- defines "insulin drug", "medical supplies for insulin dosing and administration", and "pharmacy or distributer"
- restricts insurers and plan sponsors from offering any health insurance coverage unless the coverage meets the cost-sharing and covered service requirements listed in the Bill
- provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration regardless of the quantity or type of insulin drug
- restricts pharmacy benefit managers from collecting payment in excess of the cost-sharing requirements covered in the Bill
- restricts health plans from imposing a cost-sharing structure like a deductible or coinsurance that would require a member to pay more than the cost-share limit to receive insulin services

- allows for plans to impose cost-sharing limits that are lower than the $25 member cost-share limit included in the Bill
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $1,000,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program requires members to pay a copayment and coinsurance for insulin. Depending on the cost of the insulin prescribed and/or the cost of the supplies purchased, the member cost-share can exceed the proposed $25 limit. Therefore, it is expected that imposing this limit will shift costs from members to the Uniform Group Insurance Program.

Using 12 months of NDPERS claims data from September 2021 through August 2022, Sanford Health Plan estimated that a $25 per month limit on member cost share would have shifted $445,000 from the member to the Uniform Group Insurance Program in that period. Assuming prescription drug trend of 9.4% per year, the cost in the 2025-2027 biennium is estimated to be approximately $1,000,000 (or 0.12% increase to the estimated Program total claims costs). The estimate does not assume changes to drug mix or formulary changes that could impact member out-of-pocket payments (pharmacy benefit managers typically update their formularies at least twice per year).

OTHER CONSIDERATIONS

By limiting or capping the out-of-pocket cost to members for specific services, a smaller amount of those related costs will accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate a component of the estimated 0.12% increase to the estimated Program total claims costs. Therefore, the $1,000,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

Clinical outcomes associated with lowering member out-of-pocket costs on insulin drugs and medical supplies for insulin dosing and administration may have a favorable impact on the Uniform Group Insurance Program, but such effects are difficult to quantify. If insulin and supplies are more affordable, member adherence may increase and result in fewer adverse health effects that result in expenditures to the Program, such as increased doctor and emergency department visits and prolonged hospitalization.

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Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Memo

Date: August 2, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **MARKET ANALYSIS RELATED TO BILL 23.0532.03000**

In the 2023 legislative session, the North Dakota legislature passed SB 2140 which, among other items, requires the NDPERS Board to evaluate and report on the feasibility of extending the $25/month cap on insulin and diabetic supplies from a pilot to the commercial market statewide. Deloitte Consulting LLP (Deloitte [i]) was commissioned to analyze similar initiatives in other states and industries to assess their impact on adherence among diabetic populations and other relevant outcomes to inform the legislative review.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF BILL

The amended bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- Defines "insulin drug" and "medical supplies for insulin dosing and administration"
- Directs the Board to provide health insurance benefits coverage that complies with the defined cost-share provisions
- Provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration
- Clarifies that cost-sharing is not limited for insulin pumps, electronic insulin-administering smart pens, or continuous glucose monitors
- Declares the application of this legislation to be June 30, 2023, to June 30, 2025
- Requires that the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for

this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies, and;

- Directs the public employees retirement system to provide a report on the effect of the insulin drug and supplies requirements on the system's health insurance programs, including utilization and cost, and a recommendation on continuing the coverage

CONSIDERATIONS AND RELATED LEGISLATION

Currently, 24 other states plus the District of Columbia have set caps on insulin cost-sharing for state-regulated commercial health plans, as reported by the American Diabetes Foundation. The caps vary significantly across the states:

- Alabama: $100 cost-share cap for a 30-day supply
- Colorado: $100 collective cost-share cap for any 30-day supply regardless of dosage
- Connecticut: $25 cost-share cap for 30-day supply of insulin or any other diabetic medication; $100 cap for 30-day supply of devices and supplies
- Delaware: $100 collective cost-share cap for 30-day supply, $0 for insulin pumps, and collective $35 cost-share monthly cap for other diabetic specific equipment and supplies
- District of Columbia: $30 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices
- Illinois: $35 collective cost-share cap for 30-day supply (effective 7/1/2025)
    - Current provision through 6/30/2025 is a $100 collective cost-share cap for a 30-day supply
- Kentucky: $30 cost-share cap for 30-day supply
- Louisiana: $75 cost-share cap for 30-day supply
- Maine: $35 cost-share cap for 30-day supply
- Maryland: $30 cost-share cap for 30-day supply
- Minnesota: $25 cost-share monthly cap for diabetes medications; $50 cost-share monthly cap for supplies; State-required manufacturer assistance program has a $35 cost-share cap for one per year emergency 30-day supply, $50 cost-share cap for 90-day supply
- Montana: $35 cost-share cap for 30-day supply
- Nebraska: $35 cost-share cap for 30-day supply
- New Hampshire: $30 cost-share cap for 30-day supply
- New Jersey: $35 cost-share cap for 30-day supply
- New Mexico: $25 cost-share cap for 30-day supply

- New York: $0 cost for 30-day supply of insulin (effective 1/1/2025)
    - Current provision is a $100 cost-share cap for a 30-day supply
- Oklahoma: $30 cost-share cap for 30-day supply; $90 cost-share cap for 90-day supply
- Oregon: $35 cost-share cap for 30-day supply; $105 cost-share cap for 90-day supply (effective 1/1/2025)
    - Current provision is a $85 cost-share cap for 30-day supply
- Rhode Island: $40 cost-share cap for 30-day supply
- Texas: $25 cost-share cap for 30-day supply
- Utah: $30 cost-share cap for 30-day supply
- Vermont: $100 collective cost-share cap for 30-day supply
- Virginia: $50 cost-share cap for 30-day supply
- Washington: $35 cost-share cap for 30-day supply
- West Virginia: $35 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices

Effective July 1, 2023, the federal government, under the Inflation Reduction Act, has introduced a $35 copay cap for Medicare retirees purchasing insulin. According to the Department of Health and Human Services, this measure is estimated to save retirees over $500 annually.

Additionally, the Inflation Reduction Act includes a provision that expands the coverage of insulin under High Deductible Health Plans (HDHPs). This legislation formalizes IRS Notice 2019-45, which permits certain preventive care for chronic conditions, such as insulin, to be covered without requiring members to meet a deductible first.

Colorado was the first state to implement an insulin cost-share cap in May 2019 with HB19-1216. The initial legislation faced challenges due to ambiguities over applicable insulin types and coverage for multiple prescriptions. These issues led to confusion and potentially higher costs for patients requiring multiple types of insulin[1].

In response, Colorado passed an amendment effective January 1, 2022 with HB21-1307, clarifying that the $100 cap covers all prescribed insulin medications combined per 30-day supply. The amendment also introduced an insulin affordability program for uninsured individuals, offering a 12-month supply at $50 per month and an emergency supply at $35.

The implementation of insulin cost-share caps across various states and at the federal level represents a step towards reducing the financial burden on individuals with diabetes. However, ongoing evaluation is necessary to address potential unintended consequences and ensure the sustainability of these measures. Due to the infancy of a majority of these bills and implementation of the cost-share caps in other states, states are still analyzing the impact of the cost-share caps on members' out-of-pocket costs as well as the impact to premiums.

While these caps reduce out-of-pocket costs for insulin and increase costs for plan sponsors, they do not decrease the overall cost of the drug. However, the lower cost of insulin for members can

potentially lead to better adherence to their medication regimen. Improved adherence can result in lower healthcare costs overall, as members are more likely to avoid costly inpatient care due to better management of their condition.

It remains uncertain whether the potential cost savings from improved drug adherence will offset other rising costs. Over the past decade, insulin prices have tripled, raising concerns that cost-share caps might shift expenses to other areas, such as insurance premiums.

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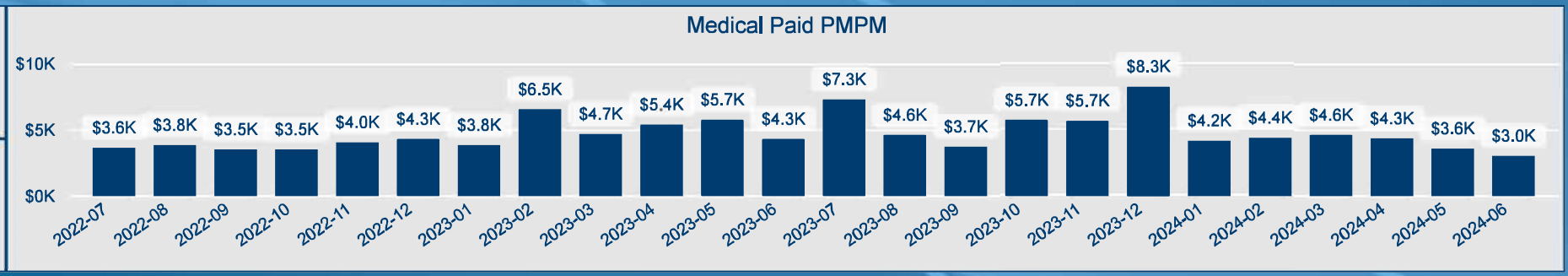
[1] Endocrine Today. (2013). "How Colorado's insulin cap law evolved" Retrieved from https://www.healio.com/news/endocrinology/20230510/how-colorados-insulin-cap-law-evolved#:~:text=In%20May%202019%2C%20Colorado%20became,of%20insulin%20for%20Colorado%20residents.

NDPERS - Medical Utilization for Members with Type 1 Diabetes Diagnosis Only and Insulin and Diabetes Supplies Claims - All LOB's

Medical PMPM Before
$4,428

Medical PMPM After
$4,932



ER Visits/1000 Before
877.1

ER Visits/1000 After
915.4

IP Admits/1000 Before
747.5

IP Admits/1000 After
592.4

Last Data Refresh: 07-24-2024 01:02 PM CT

Notice: This report and any exported data is for internal use only and should not be sent outside of Sanford.

Not all medical claims have been paid. Providers have 180 days to submit claims to Sanford Health Plan
Does not include Medical PMPM for NDPERS Members diagnosed with Type 2 Diabetes that were prescribed Insulin

My name is Nina Kritzberger and I am the daughter of Angela and Peter Kritzberger. I am 16 years old, and I go to school at Hillsboro High School. I was diagnosed with Type One diabetes in 2016 at the age of 7.

I was a little kid playing tee ball one summer but one day something changed. We went to our local clinic to see what was going on. I was drinking a lot of water and going to the bathroom frequently. I had lost over 20 pounds. I was eating and my diet had not changed but I was slowly losing energy and felt tired all the time. It took a few trips to the doctor to find out what was wrong. I was terrified when they said I had Type One diabetes because as a 7-year-old I had never heard of it and didn't know what it was.

I slowly learned about the new disease that I had just gotten diagnosed with and I learned how to give myself my own shot after 2 days. I had to prick my finger to test every time I ate and many other times to see if my blood sugar was in range. I had to take shots every night before I went to bed and every time I ate food. Type 1 Diabetes can be partly genetic and it could also not be.

On the average day I use 65 units of insulin a day. I am a very active 16-year-old and I enjoy participating in my school's extracurriculars and sports. One day I'm hoping to explore the world and learn about the cultures of other places and meet great people. I truly want to make a difference and I want my story to be known.

When I first learned the outrageous price of insulin I was furious. As a 6th grader I was so upset I was determined to spread awareness about this disease and all of the little secrets that lie between the lines. I call insulin liquid gold because it truly is because of how highly priced it is you might as well call it that. I have had diabetes now for almost 9 years and I've learned a lot about the disease and the things that connect with this disease. One of those connections to my disease is this insulin bill.

On January 23, 1923 Banting, Collip and Best patented insulin and sold it for one dollar. They believed that insulin should be accessible to anyone that needed it to survive diabetes. Approximately 54,000 people in North Dakota live with some sort of diabetes. I am asking you why people have to pay such outrageous prices for something that helps them live. It's like saying that I'm going to make you pay for oxygen, because I want to take advantage of the people that breathe it and make them pay for something that is necessary for something that all of us need to survive.

I don't want to remember this bill because I lost a friend to it or a family member. I want to remember this bill so that I can know that my fellow North Dakotans like me are going to be safe and not have to ration their insulin just so that they can live and provide for their family. I fear the day that I age out of my parent's health insurance at the age of 26. I dream of

teaching kids in my future, but will I have one if I can't afford insulin? I will continue to keep fighting and spreading awareness about the disease - if I don't fight who will?

As a 16-year-old living with type one diabetes, there is one thing in the back of my mind that I think about every day. If this bill doesn't pass, I might not be here in the future and maybe I'll just become one of the many that have died because they couldn't afford the high prices of insulin. My future depends on this bill.

Thank you for your time.

Nina Kritzberger

Hillsboro, ND

Type One Diabetic

Double dog dare you to lead by action and Support HB1114 - The insulin bill

The 2-year trial using NDPERS, is complete.

RESULTS: negligible premium increase, no increase in utilization with insulin prescriptions.

BONUS: costs were even lower with the cap than previous period, due to lower insulin price

NDPERS recommendation: IN SUPPORT for State Employees, NEUTRAL for commercial market.

During this time, the Insurance Commissioner, implemented a copay cap of $35 for insulin as an essential health benefit for all Individual and Small Group Market plans. One-third of the market now has a copay cap.

Another third of the market, Self-Funded Employer plans choose how they want to cover insulin. Employers I have asked assume they already cover insulin at a similar copay cost on their plan or they reply that they don't even know how their plan covers it because it isn't discussed in detail.

The final portion of the market deserves this safety net for their lives too. The Large Group Market plans will be affected by this bill. To be transparent, the only way this will benefit me is to put further downward pressure on the price of insulin, since my plan crosses state lines.

Insulin does not operate in a free market, and the advocacy efforts over many years are finally working to resolve that issue, but we need the entire supply chain, manufacturer to consumer to come to the table in a good faith effort to solve this problem.

This isn't technically asking for cost shifting, it is taking back a very small fraction of the money insulin has been supplying to the rebate pool, to the people who actually pay it.

Health plans in ND mention they have lowered the copay on their plans, it was done AFTER I brought this bill to ND. They held a meeting with me almost 2 months before they did it.

Not one employer I have talked to knows HOW their plan covers insulin and basic supplies. It should not surprise anyone that patients\consumers do not know how their health plan is funded.

I serve on a regional advocacy council for American Diabetes Association which is from ND to NE, and all states west to the coast and Alaska. I am aware of what other states are doing, and this is by far the lowest bar we are asking for. It isn't even the standard of care for a Type 1 Diabetic in today's world. And we all talk about how much money we put into research for the latest discovery, but for what, if you are continuing to suggest that patients be happy with prescriptions from 40 years ago, every one should be.

Patients have absolutely NO VOICE in which insulin we want, what works best for us, and where we want to get it. It is all decided by the PBMs and the Insurance Carrier.

I was fortunate while employed at Great Plains Software, to have had Jeff Young as a leader and friend. One day he said something to me that has stuck with me. Whatever you choose in life, don't let it be a checklist to perform. Use your skills as a natural leader to accomplish what you are compelled to do. Then use it to enhance the community around you.

I never thought it would be years of advocating to save someone's eyesight, kidneys, limbs or even their LIFE because they, like our daughter, are dependent on insulin to survive.

Lack of Insulin Stops a Beating Heart

Danelle R. Johnson, Horace, ND 701-261-1687

Senate Human Services
March 10, 2025
HB 1114 - Testimony in Support

Chair Lee and members of the Senate Judiciary Committee, my name is Whitney Oxendahl, and I am writing in support of House Bill 1114.

I support this bill, because I have multiple family members with Type 1 diabetes. Two of them are kids and on their parents' health insurance. They already have many things to think about living with a chronic illness, and they shouldn't have to worry about whether or not they can afford insulin, a life-saving medicine, when they are adults.

We have fairly high rates of Type 1 diabetes in North Dakota, and we should invest in the health of those living with diabetes by giving them affordable access to insulin. I urge you to give House Bill 1114 a Do Pass recommendation.

Thank you for the opportunity to share my testimony.

Madame Chair and members of the Human Services Committee

My name is Julie Blehm. I have lived with Type 1 diabetes mellitus for 51 years and I am also an internal medicine physician who has cared for many people with diabetes mellitus. In my 51 years with diabetes the price of insulin has risen dramatically from the 35-dollar range to over 350 dollars per vial. It only costs a few dollars to produce a vial of insulin. Insulin is a lifesaving medication for many people with diabetes. Good control of blood sugars decreases the incidence of long-term complications, and in many cases, this is achieved only with the use of insulin.

I realize this bill will only affect people who have health insurance but many of them cannot afford the copay for the insulin because of the high cost. They often ration their use of insulin which leads to poor control of their diabetes and may cause increasing complications. I know of several such cases, including one that ended in the death of a young person with Type 1 diabetes.

Please consider voting to approve this bill.

Thank you for your time.

Julie Blehm, MD

March 10th, 2025 Senate Human Services Hearing: SB2370-Insulin & Supply Cap

Madame Chairman and members of the Senate Human Services Committee, my name is Angela Kritzberger from Hillsboro. I am asking you for your support and thoughtful consideration of HB1114.

Our 16-year-old daughter Nina, was diagnosed with Type 1 Diabetes (T1D) at the young age of 7. She has lived with this chronic, life-threatening disease for close to nine years. It is not an easy task for anyone let alone a young child to make life and death decisions each day to manage this complex disease. Her greatest fear is whether she will be able to afford her insulin and supplies when she no longer has access through our health insurance policy and is faced with the question if one day her employer's policy will cover this costly disease. And, as she looks towards graduation and her future career, she is asking herself if the wages she will earn will cover the cost to maintain her health. There are a multitude of scenarios where an individual could be unable to access their life-saving medicines. They will pay the price with their life.

I am a moderator in a support group in our tri-state area whose focus started as a way to support other caregivers and people living with Type One Diabetes. It has literally become a lifeline for many and the true definition of paying it forward when people are temporarily short on supplies or without insulin in an emergency for a variety of reasons. For a number of years, I have worked alongside diabetes advocates and legislators to address the need for access to affordable insulin and diabetes supplies for over 57,000 North Dakotans who live with diabetes. Why? It's simple. Lives depend on it. Doing nothing simply is not the answer.

So what can be done? First, we recognize that not all citizens in North Dakota who have health insurance would be eligible for an insulin cap through legislative action. A consistent statement we have heard throughout our advocacy work in the last six years is that 60% of the population in North Dakota fall under ERISA or self-funded insurance plans; that Medicare has implemented a cap; that an insulin cap is now covered under the plans with Essential Health Benefits, or finally that carriers have already voluntarily implemented a cap to insulin. These statements leave one asking who could be left then to help? 60,000 North Dakotans who fall under the small and large fully insured groups. We don't believe that an individual's misunderstanding of a complex insurance market should prohibit our efforts to help them receive affordable access to life saving medications when markets have been overlooked. Without access to affordable insulin, life becomes a fragile balance between simply existing, or living because without insulin, death is eventually guaranteed. There are still North Dakotans who struggle, there are still plans

that do not offer a reduced cost to insulin. This is why our work continues.

You will hear testimony about the experience the NDPERS Plan had under SB2140 that we successfully passed in 2023 and why there is a recommendation to continue that coverage. When we initially drafted the bill, the commercial market was included, and we are now asking for eligible North Dakotans to be offered that same benefit. We are simply asking for the absolute basic necessities to sustain life.

When we hear statements that say diabetics want the lates and greatest in technology and medications they see on tv, I would like to counter to tell you that in our experience, in the last eight years, we have asked for one insulin pump upgrade through our durable medical equipment benefit and one pharmacy benefit change. Our first pump was so old that the remote it came with operated on radio frequency and didn't communicate with her continuous glucose monitor that operated on blue tooth frequency. It was actually introduced on the market in 2005 four years before she was born. The insulin we started with and are currently using is the same insulin that was released in 2000. We are at the mercy of our insurance carriers to provide negotiated drug formularies that give our loved ones the best health outcomes as prescribed by their doctors. The millions in rebates for insulin that are received by the insurance carriers as part of formulary negotiations help to subsidize ALL policyholder's premiums.

In conclusion, the cost to implement is negligible. The Nova Rest study shows that there could be a premium increase of $0.30 to $1.00 on a per member-per-month (PMPM) basis for large group plans. To put this in perspective, the next time you ask a co-worker if they want a Starbuck's coffee, I want you to consider if the price you paid would have been better spent on giving your co-worker access to their life saving medicine for a year under your group insurance plan. I hope the answer to be yes.

Let's keep working together to save lives. Please give HB1114 a DO PASS.

Angela Kritzberger
Mother of a Type 1 Diabetic
Diabetes Advocate Hillsboro, ND
#701.430.3121

March 10th, 2025 Senate Human Services Hearing: SB2370-Insulin & Supply Cap

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I am a moderator in a support group in our tri-state area whose focus started as a way to support other caregivers and people living with Type One Diabetes. It has literally become a lifeline for many and the true definition of paying it forward when people are temporarily short on supplies or without insulin in an emergency for a variety of reasons. For a number of years, I have worked alongside diabetes advocates and legislators to address the need for access to affordable insulin and diabetes supplies for over 57,000 North Dakotans who live with diabetes. Why? It's simple. Lives depend on it. Doing nothing simply is not the answer.

So what can be done? First, we recognize that not all citizens in North Dakota who have health insurance would be eligible for an insulin cap through legislative action. A consistent statement we have heard throughout our advocacy work in the last six years is that 60% of the population in North Dakota fall under ERISA or self-funded insurance plans; that Medicare has implemented a cap; that an insulin cap is now covered under the plans with Essential Health Benefits, or finally that carriers have already voluntarily implemented a cap to insulin. These statements leave one asking who could be left then to help? 60,000 North Dakotans who fall under the small and large fully insured groups. We don't believe that an individual's misunderstanding of a complex insurance market should prohibit our efforts to help them receive affordable access to life saving medications when markets have been overlooked. Without access to affordable insulin, life becomes a fragile balance between simply existing, or living because without insulin, death is eventually guaranteed. There are still North Dakotans who struggle, there are still plans

that do not offer a reduced cost to insulin. This is why our work continues.

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When we hear statements that say diabetics want the lates and greatest in technology and medications they see on tv, I would like to counter to tell you that in our experience, in the last eight years, we have asked for one insulin pump upgrade through our durable medical equipment benefit and one pharmacy benefit change. Our first pump was so old that the remote it came with operated on radio frequency and didn't communicate with her continuous glucose monitor that operated on blue tooth frequency. It was actually introduced on the market in 2005 four years before she was born. The insulin we started with and are currently using is the same insulin that was released in 2000. We are at the mercy of our insurance carriers to provide negotiated drug formularies that give our loved ones the best health outcomes as prescribed by their doctors. The millions in rebates for insulin that are received by the insurance carriers as part of formulary negotiations help to subsidize ALL policyholder's premiums.

In conclusion, the cost to implement is negligible. The Nova Rest study shows that there could be a premium increase of $0.30 to $1.00 on a per member-per-month (PMPM) basis for large group plans. To put this in perspective, the next time you ask a co-worker if they want a Starbuck's coffee, I want you to consider if the price you paid would have been better spent on giving your co-worker access to their life saving medicine for a year under your group insurance plan. I hope the answer to be yes.

Let's keep working together to save lives. Please give HB1114 a DO PASS.

Angela Kritzberger
Mother of a Type 1 Diabetic
Diabetes Advocate Hillsboro, ND
#701.430.3121

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Let's keep working together to save lives. Please give HB1114 a DO PASS.

Angela Kritzberger
Mother of a Type 1 Diabetic
Diabetes Advocate Hillsboro, ND
#701.430.3121

March 10, 2025

Dear Chair Lee and Committee Members,

On behalf of the American Diabetes Association (ADA), I write to share the ADA's support for House Bill 1114, which would enact patient cost sharing limits of insulin and diabetes supplies at $25 for a 30-day supply.

The American Diabetes Association (ADA) estimates 57,300 adults in North Dakota have been diagnosed with diabetes. And every year another 3,000 adults in the state are diagnosed with diabetes.[1]

People with type 1 diabetes produce little to no insulin, requiring that they administer insulin simply to continue to live each day. Others with type 2 diabetes may no longer be sufficiently producing insulin, or their bodies may be resistant to its effect, requiring that they also administer insulin to control glucose levels and avoid complications. The devastating complications associated with diabetes include blindness, end-stage kidney disease, lower limb amputation, heart attack, stroke, and death.

Too often, people with diabetes struggle to afford the insulin their care providers have prescribed. The average price of insulin has skyrocketed in recent years, with some insulins tripling in price over a decade. And many people with diabetes need to take multiple types of insulin. In addition, they are also burdened with costs related to the equipment and supplies they rely on each day to administer their insulin and monitor glucose levels to ensure they remain in an appropriate range. People with diabetes have medical expenses that are 2.6 times higher than those who do not have diabetes. When people cannot afford the medication and supplies necessary to manage their diabetes, they scale back or forego the care they need to manage their health, exposing themselves to complications.

In North Dakota, diagnosed diabetes costs an estimated $2 billion each year.[1] In 2022 total direct medical expenses for diagnosed diabetes in North Dakota were estimated to be $620 million.[1] In addition, there were $900 million in estimated indirect costs from lost productivity due to diabetes.[1]

The American Diabetes Association® believes that no individual in need of life-saving medications should ever go without due to prohibitive costs or accessibility issues.

Addressing insulin affordability by lowering cost sharing burdens will allow people with diabetes to better manage their glucose levels to stay healthy and productive, and remain out of

the ER and the hospital, and away from expensive and potentially disabling or deadly complications.

Over the last few years, policymakers across the country have recognized the importance of this issue with 26 states plus the District of Columbia passing laws to cap insulin cost sharing. Following Colorado's first-in-the-nation law, the Colorado Sun reviewed documents from the 21 health plans and found that limiting out-of-pocket monthly spending on insulin either did not impact premiums or if they did, it was described as negligible.[2] Analyses in a number of other states have confirmed that any increase is immaterial.

We support House Bill 1114 and respectfully ask the committee for a "Do Pass" recommendation to capping cost sharing for insulin and diabetes supplies at $25 for a 30-day supply for North Dakotans on state employee and state regulated insurance plans.

Sincerely,

Matt Prokop
Director of State Government Affairs
American Diabetes Association
mprokop@diabetes,org

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1 https://diabetes.org/sites/default/files/2025-02/adv_2024_state_fact_sheets_2_20_25_final_nd.pdf

2 https://coloradosun.com/2019/09/11/colorado-insulin-price-insurance/

me → me

Heidi

10:14 PM

Please vote yes to HB 1114. Our 12 year-old son has Type 1 Diabetes. I have a lot of worries about his future. Will he be able to afford his insulin when he is on his own. Will he have a job that has decent coverage for his diabetes. Should we start a fund for him so we can ensure there is extra money for his medical needs so he never has to choose rent or his health. Should we start him towards careers that have better health insurance. I am not opposed to paying for his medicine. I am opposed to paying exorbitant amounts for a medication that should never cost as much as it does. Thank you.

Quick reply

drahma@gra.midco.net → drahma@gra.midco.net

testimony

09:28 PM

I'm the parent of a type 1 diabetic. In addition to 24-7 vigilance to his health he faces a lifetime of expenses. Please vote to pass HB 1114 to make insulin affordable.

Cap on Out-of-Pocket Expenses

82%

A recent AARP survey showed that nearly over eighty percent (82%) of likely voters ages 50 and older describe prescription drugs as too expensive. Cost is the most common reason cited for deciding not to fill a prescription.

Description

In order to relieve consumers' financial burdens, some states have placed a cap on a consumer's out-of-pocket (OOP) prescription drug expenses. States have designed OOP caps in several ways, including applying spending limits to certain drugs or applying the cap to a consumer's overall monthly or annual prescription drug expenditures.

As of 2023, the Inflation Reduction Act caps OOP costs on insulin for Medicare Parts B & D enrollees at $35 a month, which benefits close to 3.3 million Americans. While the bill originally included this cap for all insurance plans, the final version limited it to Medicare enrollees only. Under the law, Part D enrollees also have an overall annual OOP cap of $2,000 for all their Part D drugs starting in 2025. States can pursue their own legislation to apply OOP caps to people on coverage other than Medicare Part D.

How Does it Work?

State OOP cap laws focus primarily on setting an upper limit or cap on what a consumer with a private health plan pays for a single 30-day outpatient prescription, whether through co-pays or coinsurance. Some states have enacted broad laws that cap all drugs for certain insurers or a wide range of prescription drug classes. Meanwhile other states have passed laws to limit the amount individuals pay for a 30-day supply of certain high-priced, specialty drugs to treat conditions such as multiple sclerosis or rheumatoid arthritis.

What Does This Mean for Consumers?

Lowers a consumer's out-of-pocket prescription drug costs, making prescriptions more affordable and accessible at the point of sale.

There is the potential to improve drug adherence and reduce cost-related behaviors like splitting medications or not filling a prescription at all.

There is a possibility of higher health care premiums and cost-sharing due to insurers shifting prescription drug costs.

Where Has This State Legislative Policy Been Enacted?

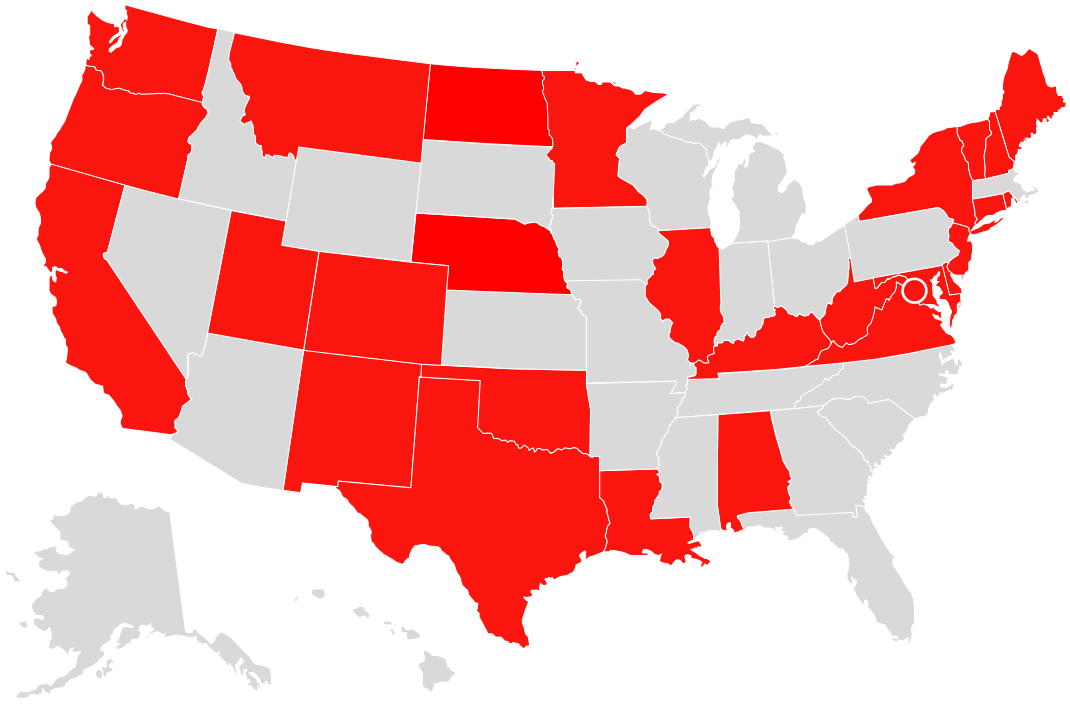
The insulin cap in the Inflation Reduction Act did not apply to state-regulated insurance plans. As such, states have looked for ways to cap prescription drug costs for enrollees in these plans. As of September 2024, 28 states have enacted legislation that limits consumers' prescription drug-related OOP costs. For example, in 2015 California enacted a significant and comprehensive law that caps expenses for a single 30-day outpatient prescription at $250 and at $500 for consumers with high-deductible plans.

The law also ensures that health plans do not place most, or all drugs used to treat a certain condition on the highest cost tier in their drug formularies, and that an enrollee is not required to pay more than the retail price for a prescription drug if a pharmacy's retail price is less than the applicable copayment or coinsurance amount.

In 2019, Colorado enacted legislation to limit the amount consumers pay for insulin. Since that time, the following 25 states and DC have enacted similar laws that limit out-of-pocket expenses for insulin (see map below).

At least four states (Delaware, Louisiana, Maryland, Rhode Island) and DC previously enacted laws that limit the amount private health plan enrollees must pay for a 30-day supply of high-price, specialty-tier prescription drugs. Delaware, for example, limits insured individuals' co-pays and coinsurance for a specialty-tier drug to $150 per month for a 30-day supply. Two states (Maine and Vermont) impose an annual cap on the out-of-pocket expenses an insured person must pay overall for their prescription medications. For example, Vermont's annual out-of-pocket cap is $1,300/individual and $2,600/family.

Montana administratively established a rule in 2015 that indirectly addressed high OOP costs by requiring certain health insurers to offer at least one plan that requires fixed dollar co-pays for all drugs and no deductible. Similarly, Colorado limits the ways that insurers may use coinsurance in their plans through administrative rule making.



House Bill 1114 – Support
March 10, 2025
Senate Human Services Committee
Janelle Moos, AARP ND- jmoos@aarp.org

Chair Lee and Members of the Senate Human Services Committee,

My name is Janelle Moos, Advocacy Director with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. 83,000 of those members live in North Dakota.

The current cost of prescription drugs poses a significant burden to midlife and older adults, with eight in ten (82%) adults 50 and older describing them as too expensive, according to AARP research. To relieve consumers' financial burdens, some states have considered placing a cap on a consumer's out-of-pocket (OOP) prescription drug expenses. States have designed out-of-pocket caps in several ways, including applying spending limits to certain drugs, or applying the cap to a consumer's overall monthly or annual prescription drug expenditures.

North Dakota joined 28 other states in 2023 by passing SB 2140 that implemented a two-year pilot program capping the monthly out of pocket costs for insulin and medical supplies used to administer the insulin for those on the state PERS plan. SB 2140 also instructed PERS to introduce a bill during the 2025 session to extend the cap on out of pockets expenses to the general state insurance marketplace.

We hear stories from North Dakotans trying to manage the high cost of medicine along with paying for other necessities like food and utilities. For example, Dennis, a diabetic, told us he may have to go back to work after retiring to pay for his insulin- his co-pay is about $100/month- with insurance-and without insurance, his co-pay would be about $400/month.

In North Dakota, the most vulnerable and underserved populations suffer from the highest rates of diabetes and have the poorest health outcomes. Based on the Behavioral Risk Factor Surveillance System (BRFSS) data, in 2022, 57,203 adults in North Dakota were living with diabetes, including 13.8% between the age of 55-64 and 19.6% of people 65+. Another 226,430 were prediabetic, including 48,560 (49%) that were 65 and older.

From 2009 to 2019, the price of insulin tripled even though there's been no change in the product. The result is many people ration their doses or go without, often with deadly consequences. And these high prices have led a growing number of patients who rely on the lifesaving drug to resort to rationing or skipping doses because they can't afford the medication. Insulin caps could make life-essential drug more affordable and accessible for many older adults.

Placing a cap on consumer's out-of-pocket prescription drug expenses is one approach that some states are considering relieving consumer's financial burdens and can lead to two outcomes:

- Lowering a consumer's out-of-pocket prescription drug expenditures, making prescriptions more affordable and accessible at the point of sale
- The potential to improve drug adherence and reduce cost-related behaviors like splitting medications or not filling a prescription at all

Caps on out-of-pocket costs typically benefit a specific group of consumers. As such, AARP supports joining such efforts with policy changes that will help reduce prescription drug prices.

We encourage the legislature to consider this bill along with other broader reforms as part of the conversation to help lower the cost of prescription drugs for North Dakotans.

Thank you again for your thoughtful work on this issue.

We appreciate any effort to make medicine more affordable and urge you to vote in favor of HB 1114.

SANFORD HEALTH PLAN

Chair Lee and Members of the Committee -

Good Morning - my name is Dylan Wheeler, Head of Government Affairs with Sanford Health Plan. Today, speaking in opposition to HB1114. My comments are similar to that of SB2370, which was before this committee a few short weeks ago.

As we shared during the hearing on SB2370 and the initial House hearing on HB1114, Sanford Health Plan supports affordable prescription drugs for our patients and members; we share the goal of the proponents in broadening access to insulin and the related supplies. However, mandating price caps on medications does not address the underlying issue - rising prescription drug prices. The market has seen significant shifts in recent years when manufacturers started to reduce prices on insulin in response to political and market forces; that experience was shown, too during the NDPERS pilot period. Sanford Health Plan also recognizes that through the recent revisions of the North Dakota Essential Health Benefits plan, insulin prices are now capped in those markets and this bill would capture the remaining state-regulated markets.

Again, we will specifically highlight line 21 on page 1 – related to pre-mixed insulin and GLP-1 RA products. Post passage and during implementation, there were questions raised as to whether stand-alone GLP-1 medications (weight loss medications) were subject to the $25 monthly cap. Traditional or stand-alone GLP-1 medications are not within the purview of this bill.

Similar to what was done on SB2370, we would request an amendment on HB1114 that limits the scope of this legislation to NDPERS. Private market coverage and caps are available on the ACA markets and carriers are complying with the EHB requirements. In the alternative, we would request a Do Not Pass recommendation from committee.

To conclude, again we support affordable prescription drugs and access for our members and patients; however, question the policy approach of capping prices for certain medications.

I appreciate the committee's time and please let me know if you have any questions.

Dylan C. Wheeler JD, MPA
Sanford Health Plan

Good morning, Madam Chair, Members of the Senate Human Services Committee. My name is Megan Hruby and I am with Blue Cross Blue Shield of North Dakota. Thank you for listening to our perspective this morning.

Blue Cross Blue Shield of North Dakota supports affordable health care and affordable drug pricing for all of the issues our members face and allowing individuals and business to make choices about what health insurance coverage is best for them. I think our goals align with the advocates present here today. We simply disagree on the method to achieve them.

BCBSND stands in opposition to Section One of House Bill 1114, the mandate for the commercial health insurance market on the basis that insurance mandates are not effective public policy. They are anti-free market, oftentimes expensive, and stymy innovation. In North Dakota, we have never updated or repealed a single mandate. There are also risks to current plans that I believe legislators do not intend. Here are a few reasons we oppose this section of the bill.

First, we oppose the commercial application of the insulin cap because it is a bit of a false promise with caps already in place for the majority of people the policy is aimed toward.

BCBSND already has a $5 insulin copay cap for our fully insured members. We instituted this cap in 2017 when we saw pharmaceutical companies gouging diabetics with their life saving drugs. We did this on our own and without state intervention. We went a step beyond insulin alone and created a "preventative drug list." On our website you can find over six pages of drugs, including insulin and diabetes supplies, for multiple health conditions that we cover at $5 or less. We didn't choose to favor only the folks who need insulin, we looked at our members with asthma, hypertension and other chronic issues as well.

As of today, the three major health carriers in North Dakota all have an insulin cap of no more than $25 in place without the mandate. Our essential health benefits (EHB) include a $25 cap on insulin and supplies for all ACA marketplace plans. And at the federal level, in the Inflation Reduction Act of 2022, the federal government passed a $35 insulin cap for Medicare beneficiaries. Medicaid and Medicaid Expansion have cost sharing for insulin at $0.

Medicaid and Expansion $0

BCBSND $5

Sanford/Medica/PERS/ACA plans with EHB $25

Medicare $35

This is why this is a bit of a false promise. The mandate will impact only a small percentage of Blue Cross members. It is my experience that the average person you meet doesn't fully understand what type of health insurance plan they are on. They know who the carrier is, whether it is a high deductible plan and generally what the coverage is, but they don't know if it is a self-funded plan, a fully insured plan, whether it is grandfathered or non-grandfathered. And these are the categories that are usually tied to these policies. Under federal law, State imposed health insurance mandates only apply to the fully insured market. Self-funded plans, over two thirds of BCBSND's business, are governed by ERISA (or federal law) and not subject to state mandates. That means that for self-funded groups, the employer, who is typically paying the largest share of the premium and typically the HR folks, decide what benefits they offer. (See handout SF v FI). These are the tough decisions that employers must make when assessing their workforce retention and budgets. ***So, while folks will see the headlines about a $25 cap, many may not be eligible for the price cap if it were to pass because they are on an ERISA plan***. To limit this further, NDCC 26.1-36-01.1 exempts all high deductible health plans (HDHPs) with a health savings account (HSA) from mandates if they are in jeopardy of losing their HDHP status under federal law.

The only fully insured groups remaining in BCBSND's business that would receive any benefit from an insulin cap mandate are our fully insured grandfathered plans. One important thing to note is the term grandfathered plan. Those are your pre-Affordable Care Act (ACA) plans. The employers that have grandfathered plans have worked hard to keep them since passage of the ACA in 2013. Groups that are still on a grandfathered plan have an eye towards cost containment. There are risks to passing mandates that can result in a business losing their less expensive, grandfathered plan. Most grandfathered (or pre-Affordable Care Act) plans have a small margin of change they can make before they lose their grandfathered status and must switch to a non-grandfathered (or post-ACA) plan. That switch frequently includes more prevention and protection but comes at a higher cost. And, it can mean the difference between an employer being able to offer health insurance benefits and not being able to offer them. When asked by the Greater North Dakota Chamber what the one thing is that state legislators can do to help their business, healthcare affordability has been the top response for several years. We do not make health insurance more affordable by passing coverage mandates, as insurance companies do not pay for mandates, policyholders pay for mandates through the form of increased premiums.

Another reason we oppose the commercial application of the insulin cap is that it hasn't considered the input of the groups who will be most affected.

While working on this bill on the House side, it became evident to us that while the advocates are very passionate about passing cap mandate legislation, no one has asked the Fully Insured Grandfathered plans if *they* want this legislation. To that end, BCBSND has recently sent an update on the progress of the bill out to our groups and is gathering that information. An important note here is that these groups can add the cap at any time to their plans if they want, without the state mandate.

Finally, we oppose the commercial application of the insulin cap because it is another mandate chasing the wrong problem.

Blue Cross Blue Shield of North Dakota spends over $250 million annually on State Legislature imposed health insurance mandates. From 2022 to 2024, Blue Cross Blue Shield of North Dakota spent $845,233,023.79 on North Dakota State Legislature imposed health insurance mandates. We anticipate that with the addition of the 2025 numbers that will be over $1 billion. Some of them are outdated, where the science has progressed beyond what is in statute. We might cover the newer test or drug, but we are also forced to cover the outdated version because a mandate was passed at some point historically and has never changed. This committee took steps to address outdated mandates via the study in SB 2249 and we applaud and thank you for those efforts. Additionally, we have federal laws and requirements, like the Affordable Care Act, that tie our hands to what is written in law rather than allow flexibility and innovation, like what we did with our own preventative drug list.

Just a final note, if the aim of policy makers is to make health care and life saving drugs more affordable, instituting a copay cap is similar to putting a band aid on a wound that will not heal. It reduces the point-of-sale cost of insulin for the folks who need it to $25, but it does nothing to address the underlying issue of affordability, as pharmaceutical companies are still free to charge whatever they want for insulin. The more they charge, the more everyone pays for health insurance premiums, whether it's individuals, North Dakota businesses, or the state government. You'll note that pharmaceutical companies have not opted to drastically increase the price of aspirin, ibuprofen or allergy meds, instead they have chosen lifesaving drugs. Recent attention on this issue by Congress and two Presidents has put enough pressure on insulin manufacturers to lower costs, with the most drastic being Eli Lilly reducing insulin costs by 70%. Eli Lilly, Novo Nordisk and Sanolfi have all implemented $35 caps on their insulin products.

BCBSND supports continued pressure and attention on any provider that is gouging our members. Our health care costs in North Dakota are ranked third highest nationally per capita. Let's focus on solutions that get to the root of the problem at hand while allowing individuals and businesses alike to make choices about the health care coverage that is best for them.

Thank you for your time and I'll stand for any questions.

Legislative Assembly

North Dakota House of Representatives

STATE CAPITOL
600 EAST BOULEVARD
BISMARCK, ND 58505-0360

Representative Carrie McLeod
District 45
3640 Parker Place North
Fargo, ND 58102-4878
cmcleod@ndlegis.gov

COMMITTEES:
Government and Veterans Affairs
Judiciary

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

Amanda Rocha
Richard Cadwell, ASA, MAAA
Donna Novak, FCA, ASA, MAAA

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 - 520-908-7246 - NovaRest.com

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.

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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.

Contact Information

Media Contacts

Juliana Gruenwald Henderson
Office of Public Affairs
202-326-2924

Victoria Graham
Office of Public Affairs
415-848-5121

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1114
3/10/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; relating to health insurance benefits coverage of insulin drugs and supplies.

4:35 p.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Free market solutions

4:43 p.m. Andrea Pfennig, Vice President of Greater North Dakota Chamber, testified in opposition and submitted testimony #40179.

4:43 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

Greater North Dakota Chamber

GREATER NORTH DAKOTA CHAMBER
HB 1114
Senate Human Services Committee
Chair Judy Lee
March 10, 2025

Mr. Chairman and members of the Committee, my name is Andrea Pfennig, and I am the Vice President of Government Affairs for the Greater North Dakota Chamber. GNDC is North Dakota's largest statewide business advocacy organization, with membership represented by small and large businesses, local chambers, and trade and industry associations across the state. We stand in **opposition** of House Bill 1114.

In our 2024 ND Economics and Employer Survey of our membership, when asked to name one thing state government could do to help your business, the top answer was to make healthcare more affordable.

Last fall, the Insurance Commissioner approved small group insurance premium increases between 6.3 and 15.3 percent for the 2025 plan year. Healthcare and prescription drug coverage mandates increase business burdens and costs. These increases leave employers with hard decisions. Do they continue offering employer-sponsored health insurance, or do they provide cost-of-living raises to help employees pay for rent and groceries?

It is unclear that the desired impacts of this bill will be achieved. In a report to the Employee Benefits Program Committee on Sept. 12, 2024, Rebecca Fricke, CEO of PERS, indicated that for the 2023-2025 biennium, utilization of insulin and diabetic supplies did not change significantly after inclusion of the price cap. Additionally, it was reported that pharmaceutical companies have been reducing the price of insulin and the majority of the diabetic supplies filled by NDPERS members cost less that the $25/month cap.

Our members oppose mandates that increase business burdens and costs. The fiscal note of this bill indicates that this is a cost shift. Rather than making healthcare more affordable, this will increase business costs by shifting them to the employer. This is especially concerning when considering that there were eight other healthcare mandate bills this session that had either current or future applications to the private sector in the future. These costs add up, and they don't go away.

We hope you will allow individuals and businesses to make their own choices about the health care coverage that is best for them. We respectfully urge you to oppose HB 1114.

701.222.0929 ndchamber@ndchamber.com ndchamber.com PO Box 2639 • Bismarck, ND 58502

The Hidden Costs of HB 1114: Why It's the Wrong Approach

1 COSTS ARE SHIFTED TO OTHERS

- The bill limits how much a person pays for insulin or diabetic supplies, but the remaining costs don't disappear–they get passed on to others through **higher insurance premiums.**
- Insurance companies don't absorb these costs; policyholders do.

2 THE MARKET IS ALREADY LOWERING THE COSTS

- The three major health insurance providers in North Dakota already have a $25 cap on insulin, **without needing a law** to enforce it.

3 HEALTHCARE MANDATES NEVER GO AWAY

- Once a healthcare mandate is passed, **it stays forever,** even if it becomes unnecessary or outdated.
- No mandate in North Dakota has ever been updated or removed, even when medical practices change.

4 COSTS WILL KEEP RISING

- Just this bill alone could cost PERS approx. $834,000 in two years.
- SEVEN mandate bills were introduced that would have cost PERS approx. $77M - this is 1 of 2 that remain.
- These mandates **don't lower healthcare costs**; they increase premiums for everyone.

5 IT REDUCES CHOICE & INNOVATION

- More mandates mean **less flexibility** for individuals and businesses to choose healthcare plans that fit their needs.
- It limits the ability of insurers to find new, better ways to offer coverage.

We asked GNDC members/ND's business community:
What is one thing STATE GOVERNMENT could do to help their business?

#1 **Make Healthcare More Affordable**

HB 1114 is a mandate that drives up healthcare costs and kills choice.
That's bad public policy. VOTE NO.

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1114
3/19/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; relating to health insurance benefits coverage of insulin drugs and supplies.

3:59 p.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Vice-Chairman Weston, Senator Van Oosting, Senator Clemens, Senator Hogan, Senator Roers.

Discussion Topics:

- Completion of Pilot Program
- Regulated Areas

4:00 p.m. Rebecca Fricke, North Dakota Public Employee Retirement System, answered committee questions.

4:05 p.m. Chrystal Bartuska, ND Insurance Department, answered committee questions.

4:08 p.m. Senator Hogan moved Do Pass and Rerefer to Appropriations.

4:08 p.m. Senator Weston seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Desiree Van Oosting	AB

Motion passed 3-2-1.

Senator Lee will carry the bill.

4:11 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1114 (25.0118.02000)

Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (3 YEAS, 2 NAYS, 1 ABSENT OR EXCUSED AND NOT VOTING). HB 1114 was rereferred to the **Appropriations Committee**. This bill does not affect workforce development.

2025 SENATE APPROPRIATIONS

HB 1114

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division
Harvest Room, State Capitol

HB 1114
3/20/2025

Relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

9:11 a.m. Chairman Dever opened the hearing.

Member Present: Chairman Dever and Senators Cleary, Davison, Magrum and Mathern.

Discussion Topics:

- Uniform Group Insurance Plan
- Financial Impact
- Committee Action

9:13 a.m. Senator Mathern moved a Do Pass.

9:14 a.m. Senator Cleary seconded.

Senators	Vote
Senator Dick Dever	Y
Senator Sean Cleary	Y
Senator Kyle Davison	Y
Senator Jeffrey J. Magrum	Y
Senator Tim Mathern	Y

Motion passed. 5-0-0

9:14 a.m. Senator Cleary will carry the bill.

9:15 a.m. Chairman Dever closed the hearing.

Joan Bares, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1114
3/20/2025

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

2:45 p.m. Chairman Bekkedahl opened the hearing.

Members Present: Chairman Bekkedahl, Vice-Chairman Erbele, and Senators Burckhard, Cleary, Conley, Davison, Dever, Dwyer, Magrum, Mathern, Meyer, Schaible, Sickler, Sorvaag, Thomas, Wanzek.

Discussion Topics:

- Cap Impact
- Cost-Sharing Plans
- Long-Term Impacts Due to Financial Reasons
- Coverage Testing Results

2:45 p.m. Senator Cleary introduced the bill.

2:48 p.m. Senator Cleary moved a Do Pass.

2:48 p.m. Senator Dever seconded the motion.

Senators	Vote
Senator Brad Bekkedahl	Y
Senator Robert Erbele	Y
Senator Randy A. Burckhard	Y
Senator Sean Cleary	Y
Senator Cole Conley	Y
Senator Kyle Davison	Y
Senator Dick Dever	Y
Senator Michael Dwyer	Y
Senator Jeffery J. Magrum	Y
Senator Tim Mathern	Y
Senator Scott Meyer	N
Senator Donald Schaible	Y
Senator Jonathan Sickler	N
Senator Ronald Sorvaag	Y
Senator Paul J. Thomas	Y
Senator Terry M. Wanzek	Y

Motion Passed 14-2-0.

Senator Cleary will carry the bill.

2:53 p.m. Chairman Bekkedahl closed the hearing.

Elizabeth Reiten, Committee Clerk

REPORT OF STANDING COMMITTEE
ENGROSSED HB 1114 (25.0118.02000)

Appropriations Committee (Sen. Bekkedahl, Chairman) recommends **DO PASS** (14 YEAS, 2 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). HB 1114 was placed on the Fourteenth order on the calendar. This bill does not affect workforce development.