

2025 SENATE HUMAN SERVICES

SB 2370

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee Fort Lincoln Room, State Capitol

SB 2370
2/10/2025
10:56 a.m.

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

10:56 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:

- Premium costs
- Pilot program expiration dates
- Biennium reporting
- Regulated plan types
- Health benefit plan

10:56 a.m. Senator Clearly introduced the bill and submitted testimony #36556.

11:04 a.m. Rebecca Fricke, Executive Director of ND Public Employees Retirement System, testified in favor and submitted testimony #36243.

11:17 a.m. Dannelle Johnson, Diabetes Advocate, testified in favor and submitted testimony #36299 and #36300.

11:27 a.m. Angela Kritzberger, testified in favor and submitted testimony #36364 and #36307.

11:35 a.m. Janelle Moos, Associate State Director Advocacy of AARP ND, submitted testimony #36486 and #36487.

11:36 a.m. Chrystal Bartuska, Director with the North Dakota Insurance Department, testified in neutral.

11:52 a.m. Dylan Wheeler, Sanford Health Plan, testified in opposition and submitted testimony.

11:55 a.m. Megan Ruby, Government Affairs at Blue Cross Blue Shield of North Dakota, testified in opposition and submitted testimony #36798.

12:02 p.m. Andrea Pfennig, Vice President of Government Affairs for Greater North Dakota Chamber, testified in opposition and submitted testimony #36500.

Additional written testimony:

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Matt Prokop, Director of State Government Affairs, American Diabetes Association, submitted testimony in favor #36518.

12:08 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

TESTIMONY OF REBECCA FRICKE

Senate Bill 2370 – Insulin & Diabetic Supplies

Good Morning, Madame Chair and members of the Committee. My name is Rebecca Fricke and 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 HB 1114, which Senate Bill 2370 mirrors, 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 that were outlined in the report (attached to testimony):

- 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.



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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 than 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)

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

5 BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

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

10 1. As used in this section:

- 11 a. "Insulin drug" means a prescription drug that contains insulin and is used to treat
12 a form of diabetes mellitus. The term does not include an insulin pump, an
13 electronic insulin-administering smart pen, or a continuous glucose monitor, or
14 supplies needed specifically for the use of such electronic devices. The term
15 includes insulin in the following categories:
- 16 (1) Rapid-acting insulin;
 - 17 (2) Short-acting insulin;
 - 18 (3) Intermediate-acting insulin;
 - 19 (4) Long-acting insulin;
 - 20 (5) Premixed insulin product;
 - 21 (6) Premixed insulin/GLP-1 RA product; and
 - 22 (7) Concentrated human regular insulin.
- 23 b. "Medical supplies for insulin dosing and administration" means supplies needed
24 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;~~

- 1 (5) Premixed insulin product;
- 2 (6) Premixed insulin/GLP-1 RA product; and
- 3 (7) Concentrated human regular insulin.
- 4 b. ~~"Medical supplies for insulin dosing and administration" means supplies needed~~
- 5 ~~for proper insulin dosing, as well as supplies needed to detect or address medical~~
- 6 ~~emergencies in an individual using insulin to manage diabetes mellitus. The term~~
- 7 ~~does not include an insulin pump, an electronic insulin-administering smart pen,~~
- 8 ~~or a continuous glucose monitor, or supplies needed specifically for the use of~~
- 9 ~~such electronic devices. The term includes:~~
- 10 (1) Blood glucose meters;
- 11 (2) Blood glucose test strips;
- 12 (3) Lancing devices and lancets;
- 13 (4) Ketone testing supplies, such as urine strips, blood ketone meters, and
- 14 ~~blood ketone strips;~~
- 15 (5) Glucagon, in injectable and nasal forms;
- 16 (6) Insulin pen needles; and
- 17 (7) Insulin syringes.
- 18 e. ~~"Pharmacy or distributor" means a pharmacy or medical supply company, or~~
- 19 ~~other medication or medical supply distributor filling a covered individual's~~
- 20 ~~prescriptions.~~
- 21 2. The board shall provide health insurance benefits coverage that provides for insulin drug
- 22 and medical supplies for insulin dosing and administration which complies with this section as
- 23 provided under section 1 of this Act.
- 24 3. ~~The coverage must limit out-of-pocket costs for a thirty-day supply of:~~
- 25 a. ~~Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or~~
- 26 ~~distributor, regardless of the quantity or type of insulin drug used to fill the~~
- 27 ~~covered individual's prescription needs.~~
- 28 b. ~~Covered medical supplies for insulin dosing and administration, the total of which~~
- 29 ~~may not exceed twenty-five dollars per pharmacy or distributor, regardless of the~~
- 30 ~~quantity or manufacturer of supplies used to fill the covered individual's~~
- 31 ~~prescription needs.~~

- 1 4. ~~The coverage may not allow a pharmacy benefits manager or the pharmacy or~~
2 ~~distributor to charge, require the pharmacy or distributor to collect, or require a~~
3 ~~covered individual to make a payment for a covered insulin drug or medical supplies~~
4 ~~for insulin dosing and administration in an amount that exceeds the out-of-pocket limits~~
5 ~~set forth under subsection 3.~~
- 6 5. ~~The coverage may not impose a deductible, copayment, coinsurance, or other cost-~~
7 ~~sharing requirement that causes out-of-pocket costs for prescribed insulin or medical~~
8 ~~supplies for insulin dosing and administration to exceed the amount set forth under~~
9 ~~subsection 3.~~
- 10 6. ~~Subsection 3 does not require the coverage to implement a particular cost-sharing~~
11 ~~structure and does not prevent the limitation of out-of-pocket costs to less than the~~
12 ~~amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs~~
13 ~~on an insulin pump, an electronic insulin-administering smart pen, or a continuous~~
14 ~~glucose monitor. This section does not limit whether coverage classifies an insulin-~~
15 ~~pump, an electronic insulin-administering smart pen, or a continuous glucose monitor~~
16 ~~as a drug or as a medical device or supply.~~
- 17 7. ~~If application of subsection 3 would result in the ineligibility of a health benefit plan that~~
18 ~~is a qualified high-deductible health plan to qualify as a health savings account under~~
19 ~~section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of~~
20 ~~subsection 3 do not apply with respect to the deductible of the health benefit plan until~~
21 ~~after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~
- 22 8. ~~This section does not apply to the Medicare part D prescription drug coverage plan.~~

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.

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.

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	\$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	\$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	\$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

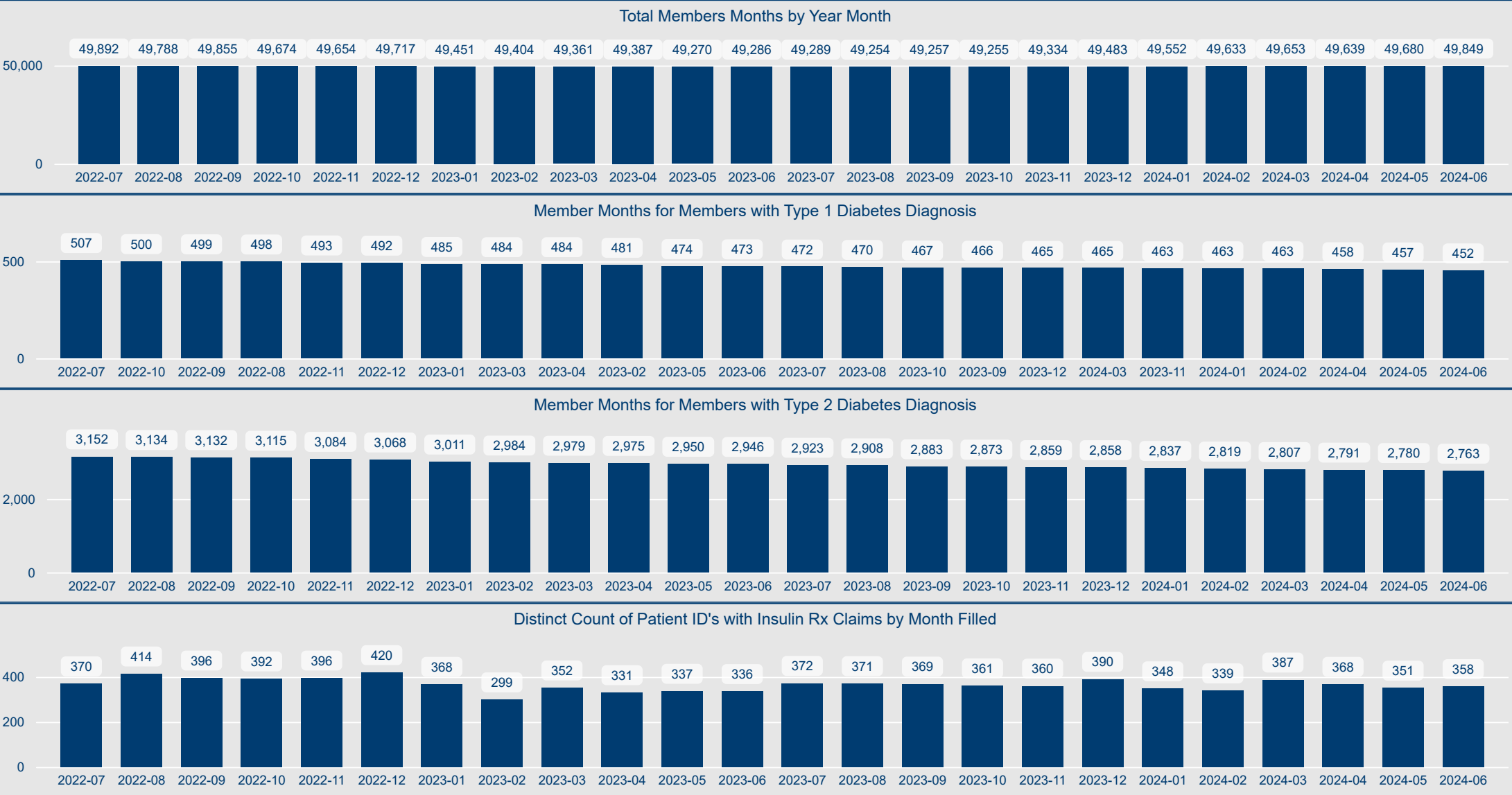
* July 1, 2023 SHP implemented a \$25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

** 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

[illegible]

NDPERS COI Insulin & Diabetes Supplies Impact Analysis



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	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	\$0	\$0	\$40	\$0	\$100	\$100	\$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	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	\$63	\$225	\$25	(\$510)	
		INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	\$0	\$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 FLEXTUOC	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	\$25	\$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 FLEXREL	1	1	0	1	1	0	\$59	\$59	\$0	\$25	\$25	\$0	\$0	\$0	\$0	#DIV/0!	\$25	\$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	\$32	\$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	(\$304,829)	
		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)	\$2,596	\$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 FLEXTUOC	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 FLEXREL	1		-1	5	0	-5	\$196	\$0	(\$196)	\$261	\$0	(\$261)	\$11	\$0	(\$11)	\$271	\$64	\$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)	\$91,099	\$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	\$11,802	(\$74)	\$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	\$36,765	\$51,357	\$14,588	\$2,938	\$1,900	(\$1,038)	\$1,388	\$0	(\$1,388)	\$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)	\$12,660	\$141	\$5,150	\$43	(\$7,530)	
		TRESIBA FLEX																					

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	\$0	\$75	\$75	\$75
HUMALOG KWIK INJ			2	2	0	3	3	\$0	\$13,697	\$13,697	\$0	\$225	\$225	\$0	\$0	\$0	\$0	\$0	\$225	\$75	\$225
HUMULIN R INJ U	1		-1	1	0	-1		\$0	\$0	\$0	\$15	\$0	(\$15)	\$0	\$0	\$0	\$0	\$15	\$15	\$0	#DIV/0!
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		(\$30)	\$120	\$120	\$450	\$76	\$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
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 FLEXTUOC	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 FLEXREL	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	\$264	\$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)	\$1,267	\$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	(\$96)	\$261	\$0	(\$261)	\$722	\$180	\$375	\$75	(\$347)
TRESIBA FLEX INJ	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

|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

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 TIInternational 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 elections¹.

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 2022².

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 T1International. 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 Caps⁵

- 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-reli-on>

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 management⁶.

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 Rezvoglar™, 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 TI International 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 challenges².

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.

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 challenges³.

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 system⁴.

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 TIInternational, 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>



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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 ¹) 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 distributor"
- 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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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

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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.

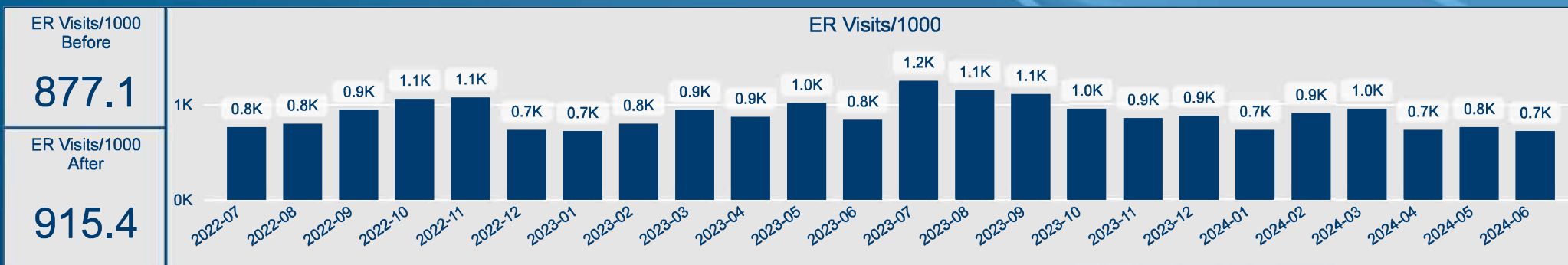
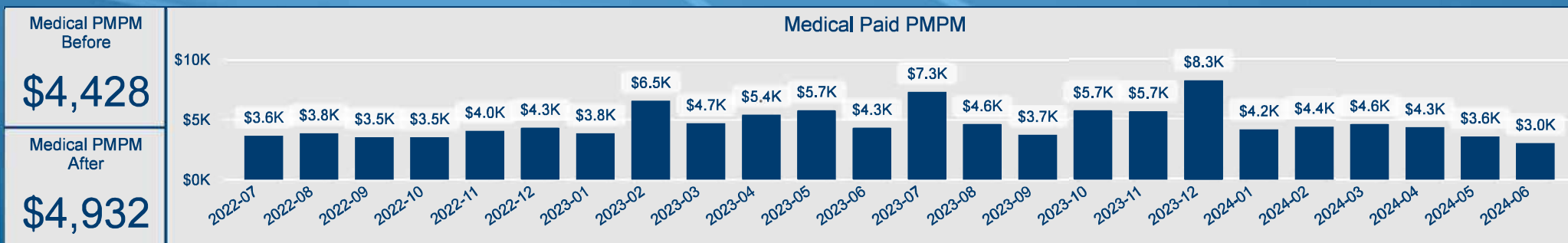
It remains uncertain whether the potential cost savings from improved drug adherence will offset other rising costs. Over the past decade, insulin prices have tripled, raising concerns that cost-share caps might shift expenses to other areas, such as insurance premiums.

^[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.>

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

SANFORD
HEALTH PLAN

Last Data Refresh: 07-26-2024 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 SB2370 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.

I am a Software Business Quality Analyst by Profession. 17 yrs at Great Plains Software/Microsoft: 1992-2009. 15 years at NAU Country: 2009-present. We build software that implements the Federal Farm Bill for the 2nd largest crop insurer in the US. I understand complicated, complex, and the power of computers to help us. I have used the power of Microsoft CoPilot AI tool to quickly organize and summarize information from a wide variety of sources for your review. I have been a Type 1 Diabetes Advocate since 2018. I am sharing why I am passionate about getting access for even one more person to affordable and accessible insulin therapy. Full Disclosure: I have an ERISA plan, so this will not help me personally, but will help many ND residents and their communities.

Lack of Insulin...Stops a Beating Heart. Insulin saves my daughter's life **every single day**. It is Black and White.

Contact Info: FB: Danelle Zirnhelt Johnson, Horace ND Email: daryldanelle@msn.com C: 701-261-1687

Q: Are insulin copay caps working

A: The \$35 insulin copay cap policy, implemented under the Inflation Reduction Act, has shown promising results. It has significantly reduced out-of-pocket costs for Medicare beneficiaries, with an estimated 1.5 million people saving around \$734 million in 2020 alone. This cap has made insulin more affordable and accessible, helping to improve adherence to insulin therapy and potentially reducing diabetes-related complications. The cost-effectiveness of the policy is still being evaluated, but the initial results suggest that it has had a positive impact on insulin affordability and patient outcomes.

Q: Is the Federal Medicare Drug Price Negotiation Process Effective

A: The Medicare drug price negotiation policy, part of the Inflation Reduction Act, is showing promising early results. The policy allows Medicare to negotiate prices directly with drug manufacturers for certain high-cost, single-source drugs without generic or biosimilar competition. The first round of negotiations has resulted in significant savings, with the negotiated prices set to take effect in 2026.

A recent report from AARP found that the new \$2,000 cap on out-of-pocket drug costs, which also went into effect this year, is expected to save Medicare Part D enrollees an average of \$2,474 in 2025. This represents a 48% reduction in total out-of-pocket costs for those who reach the cap.

While the full impact of the policy will be more evident once the negotiated prices take effect, the initial outcomes suggest that it is helping to lower drug costs and improve access to medications for Medicare beneficiaries.

The impact of state insulin copay caps on insurance premiums appears to be minimal. According to a study published in the journal Diabetes, state policies capping insulin out-of-pocket costs at \$25-\$100 per 30-day supply were effective in reducing financial burdens for members with high-deductible health plans and health savings accounts (HSA). However, these policies did not significantly affect insurance premiums.

It seems that while the copay caps have helped lower out-of-pocket costs for insulin users, they haven't led to noticeable increases in premiums. This suggests that the financial burden on insurers has been manageable, at least in the short term.

Q: What is the cost of an amputation in the US

A: The cost of an amputation in the US can vary widely depending on several factors, such as the type of amputation, the complexity of the surgery, hospitalization fees, and associated medical services. On average, the cost ranges from **\$20,000 to \$60,000**.

Q: What is the cost of a leg prosthesis

A: Lower Extremity Prosthesis (Leg):

- Basic models: **\$5,000 to \$15,000** - Advanced microprocessor models: **\$20,000 to \$50,000**
- Highly advanced models: **\$50,000 to \$120,000**

Q: What is the yearly cost of kidney dialysis

A: The yearly cost of kidney dialysis in the US can vary depending on the type of dialysis and whether you have insurance coverage. Here's a general breakdown:

- **In-center Hemodialysis:** This is typically done at a dialysis center and costs around **\$72,000 to \$88,000 per year**. Each session can cost between **\$250 to \$350**.
- **Peritoneal Dialysis:** This can be done at home and generally costs **\$53,000 to \$65,000 per year**. Each session might cost around **\$145 to \$180** per day.

Q: What is the disability cost for blindness

A: The cost of disability benefits for blindness in the US can vary depending on the program and individual circumstances. Here are some key points:

1. **Social Security Disability Insurance (SSDI):** If you qualify, you can receive monthly benefits based on your work history and the amount you've paid into Social Security. The average monthly benefit for SSDI in 2023 was about **\$1,483**.
2. **Supplemental Security Income (SSI):** This program provides monthly payments to individuals with limited income and resources. The maximum federal benefit rate for SSI in 2023 was **\$914 per month** for an individual.

Q: What is the insulin manufacturers oligopoly?

A: The insulin market is dominated by three major companies: **Eli Lilly, Novo Nordisk, and Sanofi**. These companies control over 90% of the global insulin market, creating an oligopoly. This lack of competition allows them to set high prices, which have increased significantly over the years. This oligopoly has led to skyrocketing insulin prices, making it unaffordable for many people with diabetes. Efforts to address this issue include policy changes, such as capping insulin costs and allowing Medicare to negotiate drug prices.

There are several pieces of evidence that suggest the insulin market is not operating as a free market:

1. **High Prices:** Despite the existence of older, cheaper insulin formulations, prices for newer insulin analogs have increased significantly over the years. This suggests that prices are not solely driven by competition but by other factors such as market control by a few major companies.
2. **Market Concentration:** The insulin market is dominated by three major companies—Eli Lilly, Novo Nordisk, and Sanofi—which together control over 90% of the global insulin market. This high level of market concentration limits competition and gives these companies significant pricing power.
3. **Patent Protection and Pay-for-Delay Schemes:** These companies have used patent protection and pay-for-delay agreements to delay the entry of generic or biosimilar insulins into the market. These practices reduce competition and keep prices high.
4. **Lack of Generic Competition:** Unlike many other drugs, insulin is a biologic drug, making it difficult to create generic versions. This lack of generic competition allows the dominant companies to maintain high prices.
5. **Rising Costs Despite Technological Advances:** Despite advances in insulin formulations and delivery devices, prices have continued to rise, suggesting that factors other than innovation and production costs are driving prices.

Q: Explain the progression of Autoimmune Type 1 Diabetes when access to Insulin therapy in the dosage as prescribed by your doctor is not followed.

A: Without insulin, the progression of Type 1 Diabetes can be quite severe and life-threatening. Here's a general overview of what happens:

1. **Initial Hours:** Blood sugar levels start to rise significantly. Symptoms like increased thirst, frequent urination, fatigue, and blurred vision may occur.

2. **Days Without Insulin:** The body begins to break down fat for energy, leading to the production of ketones. This can cause nausea, vomiting, abdominal pain, and rapid breathing.
3. **Diabetic Ketoacidosis (DKA):** After about 24 hours without insulin, there's a high risk of developing DKA. This condition occurs when ketone levels become dangerously high in the bloodstream. DKA can lead to severe dehydration, electrolyte imbalance, and potentially life-threatening issues like heart arrhythmias.
4. **Long-Term Effects:** If left untreated, the lack of insulin can lead to severe complications such as **kidney failure, nerve damage, heart disease, and even coma.**

It's crucial for individuals with Type 1 Diabetes to have a reliable supply of insulin and a plan for emergencies to avoid these serious complications.

Q: Describe the mental distress associated with a chronic illness

A: Common mental health challenges faced by individuals with chronic illnesses:

1. **Emotional Distress:** Feelings of sadness, frustration, and grief are common as individuals grapple with the reality of their condition and its impact on their lives.
2. **Anxiety and Stress:** The ongoing management of symptoms and uncertainties about the future can lead to chronic stress and anxiety.
3. **Depression:** The combination of chronic pain, reduced physical function, and ongoing medical treatment can contribute to depression.

Q: How does the lack of school nurses compound the burden of this disease physically & emotionally?

A: The lack of school nurses can significantly impact students with Type 1 Diabetes, as they require continuous monitoring and management of their condition throughout the school day. Some key challenges and potential consequences:

1. **Blood Sugar Monitoring:** Without a school nurse, students may struggle to regularly check their blood sugar levels, leading to potential episodes of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar).
2. **Insulin Administration:** Proper timing and dosage of insulin are crucial for managing Type 1 Diabetes. Without a nurse, students might miss doses or administer incorrect amounts, which can have serious health implications.
3. **Emergency Response:** In case of a diabetic emergency, such as diabetic ketoacidosis (DKA) or severe hypoglycemia, immediate medical attention is vital. The absence of a school nurse can delay critical care.
4. **Education and Support:** School nurses play a key role in educating students, teachers, and staff about diabetes management. Without this support, there may be a lack of understanding and awareness, leading to potential mismanagement of the condition.
5. **Mental and Emotional Well-being:** The stress of managing diabetes without adequate support can affect a student's mental health, leading to anxiety, stress, and feelings of isolation.

Q: Can you describe caregiver burnout?

A: Symptoms of Caregiver Burnout

- **Physical:** Fatigue, frequent headaches, body aches, changes in appetite, and weakened immune system.
- **Emotional:** Feelings of anxiety, depression, irritability, and feeling overwhelmed.
- **Behavioral:** Isolation from friends and family, neglecting one's own health, and increased substance use.

Q: The most common chronic illness in the US is heart disease, does diabetes cause heart disease?

A: Heart Disease is the leading cause of death and disability, affecting millions of Americans. Other prevalent chronic illnesses include **cancer, diabetes, obesity, and arthritis.**

A: Yes, diabetes can significantly increase the risk of developing heart disease. Here are some key reasons why:

1. **High Blood Sugar Levels:** Over time, high blood sugar levels can damage blood vessels and nerves that control the heart.
2. **High Blood Pressure:** Many people with diabetes also have high blood pressure, which is a major risk factor for heart disease.
3. **Abnormal Cholesterol Levels:** Diabetes can lead to unhealthy cholesterol levels, including high LDL ("bad") cholesterol and low HDL ("good") cholesterol, contributing to plaque buildup in arteries.
4. **Insulin Resistance:** This condition, common in Type 2 diabetes, is linked to inflammation and metabolic abnormalities that increase the risk of cardiovascular disease.

Q: How many people utilized the Alec Smith Emergency Insulin Program in 2024 in Minnesota?

***Danelle note: over 1700 individuals used this program in 2024 – From my advocacy resources.**

A: I couldn't find the exact number of people who used the Alec Smith Emergency Insulin Program in 2024. However, the program has been instrumental in providing affordable insulin to Minnesotans who are uninsured or underinsured.

The Alec Smith Emergency Insulin Program, established in Minnesota, provides affordable insulin to those who are uninsured or underinsured. While AI couldn't find the exact number of people who used the program in 2024, it has been a crucial resource for many Minnesotans.

The program has two parts:

1. **Emergency Program:** Allows individuals to get a one-time, 30-day supply of insulin for \$35.
2. **Continuing Need Program:** Provides insulin to eligible patients for a year at no more than \$50 for a 90-day supply.

Q: Results of the Colorado Insulin Copay Cap Bill.

***Danelle Note: ND Bill was drafted from the Colorado Bill, which was the first State to pass an insulin copay cap bill.**

A: The Colorado Insulin Copay Cap, established by HB21-1307, has shown promising results in improving insulin affordability and access. Here are some key points:

1. **Affordability:** The cap limits the copay for a 30-day supply of insulin to \$100 for individuals with state-regulated commercial health insurance plans. This has significantly reduced the financial burden on patients.
2. **Emergency Supply:** The program also allows eligible individuals to access an emergency 30-day supply of insulin for a copay of \$35 once every 12 months.
3. **Positive Impact:** Early reports indicate that the program has helped many people afford their insulin, reducing the risk of complications and hospitalizations due to unmanaged diabetes.

While comprehensive data on the long-term effectiveness of the program is still being collected, these initial outcomes suggest that the Colorado Insulin Copay Cap is making a positive difference for those who need it.

Q: Can you address some common arguments from the opposition to insulin copay caps:

A: Public Health

- **Preventing Complications:** Affordable insulin helps prevent severe health complications like diabetic ketoacidosis, heart disease, kidney failure, and blindness. This leads to healthier individuals who can contribute more effectively to society.
- **Reducing Mortality:** Ensuring access to insulin can significantly reduce mortality rates among people with diabetes.

Economic Benefits

- **Cost Savings:** Preventing complications through affordable insulin reduces overall healthcare costs. Hospitalizations, emergency visits, and long-term care are far more expensive than providing affordable insulin.
- **Productivity:** Healthy individuals are more productive and can contribute to the workforce, reducing the economic burden on society.

Moral Responsibility

- **Ethical Imperative:** Access to life-saving medication should be a basic human right. Ensuring affordable insulin is an ethical imperative to support the most vulnerable populations.
- **Equality:** Insulin copay caps help address health disparities and promote health equity.

Market Failures

- **Lack of Competition:** The high cost of insulin is often due to a lack of competition and price gouging by pharmaceutical companies. Copay caps can help address these market failures and encourage fair pricing.
- **Transparency:** Copay caps can promote transparency in pricing and encourage pharmaceutical companies to justify their pricing strategies.

Success Stories

- **Minnesota:** The Alec Smith Emergency Insulin Program in Minnesota has provided affordable insulin to many individuals in need, demonstrating the effectiveness of such programs.
- **Colorado:** The Colorado Insulin Copay Cap has reduced financial burden and improved access to insulin for many residents, showing positive outcomes and improved health.
- **International Examples:** Countries like Canada and the UK, with more regulated healthcare systems, have more affordable insulin prices, showcasing the benefits of such policies.

Public Support

- **Advocacy Groups:** Organizations like the American Diabetes Association and Breakthrough T1D (Formerly JDRF) advocate for insulin affordability measures, reflecting strong public support.
- **Healthcare Professionals:** Many healthcare professionals support insulin copay caps as they see the direct impact of high insulin costs on their patients' health.

The public health impact of insulin copay caps has been significant in improving access to insulin and reducing the financial burden on patients. Here are some key findings:

1. **Improved Medication Adherence:** Studies have shown that insulin copay caps lead to better adherence to insulin therapy. When patients can afford their medication, they are more likely to take it as prescribed, reducing the risk of complications.
2. **Reduced Out-of-Pocket Costs:** Insulin copay caps have significantly lowered out-of-pocket expenses for patients. For example, in Colorado, the copay cap reduced out-of-pocket spending by an average of \$17.3 for basal insulin and \$11.5 for bolus insulin.
3. **Decreased Healthcare Utilization:** With better adherence to insulin therapy, there has been a reduction in healthcare utilization for diabetes-related complications. This includes fewer hospitalizations and emergency room visits, leading to overall cost savings for the healthcare system.
4. **Health Outcome Improvements:** Improved adherence and reduced financial burden have led to better health outcomes for individuals with diabetes. This includes better blood sugar control, fewer complications, and an overall improvement in quality of life.
5. **Economic Evaluation:** An economic evaluation of the \$35 insulin copay cap policy in Medicare showed that it could prevent thousands of diabetes complications and fatal events, generating additional life-years and quality-adjusted life-years (QALYs).

These findings highlight the positive public health impact of insulin copay caps, demonstrating their effectiveness in improving access to essential medication and reducing the burden on both patients and the healthcare system.

Q: When people lose hope, what generally happens to their health?

A: It can have profound effects on their health, both mentally and physically.

Mental Health

- **Depression:** Hopelessness is a common symptom of depression. It can lead to persistent feelings of sadness, worthlessness, and a lack of interest in activities once enjoyed.
- **Anxiety:** Losing hope can increase anxiety levels, making it difficult to cope with daily stressors.
- **Suicidal Thoughts:** Hopelessness is strongly linked to an increased risk of suicidal thoughts and behaviors.

Physical Health

- **Weakened Immune System:** Chronic stress and depression can weaken the immune system, making individuals more susceptible to illnesses.
- **Cardiovascular Issues:** Hopelessness can contribute to high blood pressure and heart disease due to the constant stress and negative outlook.
- **Chronic Pain:** Mental distress can exacerbate chronic pain conditions, leading to a cycle of pain and hopelessness.

Behavioral Changes

- **Withdrawal:** People may withdraw from social interactions, leading to isolation and loneliness.
- **Neglect of Health:** Loss of hope can result in neglecting self-care, including poor diet, lack of exercise, and skipping medical appointments.
- **Substance Abuse:** Some individuals may turn to substance use to cope with feelings of hopelessness.

Q: What is the societal impact of unaffordable healthcare?

A: Unaffordable healthcare has far-reaching consequences on society, affecting individuals, families, and communities in various ways:

Economic Impact

- **Medical Debt:** Many Americans accumulate significant medical debt, leading to financial strain and even bankruptcy. This can affect credit scores and limit access to future loans and housing.
- **Reduced Productivity:** Health issues that go untreated due to cost can lead to reduced productivity at work, impacting both individual income and overall economic output.

Health Outcomes

- **Delayed Care:** People often delay seeking medical care due to cost, which can lead to worsened health conditions and more complex, expensive treatments later on.
- **Increased Mortality:** Lack of access to affordable healthcare can result in higher mortality rates, particularly among vulnerable populations.

Social Inequality

- **Disparities:** Unaffordable healthcare exacerbates existing social inequalities, disproportionately affecting low-income families, minorities, and those without insurance.
- **Mental Health:** The stress of unaffordable healthcare can lead to mental health issues, including anxiety and depression, further impacting overall well-being.

Public Health

- **Outbreaks and Epidemics:** When people avoid seeking care due to cost, it can contribute to the spread of infectious diseases and hinder public health efforts to control outbreaks.
- **Chronic Disease Management:** Unaffordable healthcare makes it difficult for individuals to manage chronic conditions, leading to higher rates of complications and hospitalizations.

Addressing the issue of unaffordable healthcare requires comprehensive policy changes and increased support for vulnerable populations. It's a critical step towards ensuring a healthier, more equitable society.

Q: How do chronic illnesses impact health and well-being?

A: Chronic illnesses can have profound impacts on various aspects of health and well-being, including suicide rates, addiction rates, homelessness, and mental health issues.

Suicide Rates

Chronic illnesses can significantly increase the risk of suicidal thoughts and behaviors. Factors such as chronic pain, social disconnection, perceived burdensomeness, and hopelessness contribute to this increased risk. For example, individuals with chronic conditions like cancer or chronic pain are more likely to experience depression, which is closely linked to suicidality.

Addiction Rates

Chronic illnesses can also impact addiction rates. The stress and challenges of managing a chronic illness can lead to substance use disorders.

Homelessness

Chronic illnesses can contribute to homelessness. Poor health can lead to unemployment, which in turn can result in loss of housing. Once homeless, individuals face even greater challenges in accessing healthcare, which can exacerbate their chronic conditions. Homelessness is associated with higher rates of physical and mental illnesses, as well as substance use disorders.

Mental Health Issues

Chronic illnesses are closely linked to mental health issues. The stress of managing a chronic condition, along with the physical limitations it imposes, can lead to anxiety, depression, and other mental health problems.

Additionally, the social isolation and stigma associated with chronic illnesses can further impact mental well-being.

It's clear that chronic illnesses have far-reaching effects on various aspects of health and well-being. Addressing these issues requires a holistic approach that considers both physical and mental health, as well as social support systems.

Q: Sometimes we need to be transparent

A: Absolutely. Transparency is key, especially when it comes to important issues like health, well-being, and social justice. Open, honest communication helps build trust, foster understanding, and drive meaningful change.

Whether we're discussing healthcare policies, mental health challenges, or personal struggles, being transparent allows us to connect on a deeper level and find effective solutions together.

Q: How can Business Chambers better support transparency of true health care costs for businesses. Like ROI Analysis of which treatments are proven effective, cost less than the complications from not being treated, increase productivity, moral, reduce absenteeism and presenteeism. Losing dollars to save pennies.

A: Chambers of commerce can play a pivotal role in promoting transparency of healthcare costs for businesses by implementing several strategies:

1. **Advocacy and Policy Influence:** Chambers can advocate for policies that require healthcare providers and insurers to disclose pricing information. This can include supporting legislation that mandates transparency and competition in healthcare pricing.
2. **Educational Resources:** Providing businesses with educational resources and workshops on understanding healthcare costs, benefits, and how to navigate the system can empower employers to make informed decisions.
3. **Collaboration with Healthcare Providers:** Chambers can facilitate partnerships between businesses and healthcare providers to negotiate better rates and transparent pricing structures. This can help businesses get more value for their healthcare spending.
4. **Benchmarking and Reporting:** Chambers can collect and share data on healthcare costs and outcomes within their region. This benchmarking can help businesses compare costs and identify opportunities for cost savings.

5. **Supporting Health Plans:** Encouraging businesses to adopt health plans that emphasize transparency, such as value-based insurance designs, can help reduce costs and improve care quality.
6. **Promoting Wellness Programs:** Chambers can promote workplace wellness programs that focus on preventive care and healthy lifestyles. This can reduce overall healthcare costs and improve employee health.

By taking these steps, chambers of commerce can help businesses better understand and manage healthcare costs, leading to more transparent and affordable healthcare for all.

Q: Does living with an invisible illness that affects your ability to function 24/7/365 take a toll?

A: Living with an invisible illness that impacts your daily functioning can be incredibly challenging, both physically and mentally.

1. **Understanding and Validation:** It's important to recognize that your experiences are valid, even if others can't see your illness.
2. **Managing Daily Activities:** Pacing yourself and prioritizing tasks is crucial. On days when symptoms are particularly severe, allow yourself to rest and focus on essential activities.
3. **Mental Health:** Chronic illnesses often come with a burden of mental distress.
4. **Communication:** Open communication with friends, family, and colleagues about your needs and limitations can help them understand and support you better.
5. **Self-Care:** Engaging in activities that bring you joy and relaxation is important.
6. **Medical Management:** Regular follow-ups with your healthcare provider to manage symptoms and adjust treatments as necessary.

Q: What is the cost of a life flight trip for DKA

***Danelle Note:** Our grandson had a febrile seizure last fall, and the 30 mile ambulance ride cost \$2200.

A: The cost of a Life Flight trip for diabetic ketoacidosis (DKA) can vary widely depending on factors such as distance traveled, type of aircraft used, and whether the patient has insurance. On average, the cost without insurance ranges from **\$12,000 to \$50,000**.

For patients with insurance, the out-of-pocket cost can still be significant, as many air ambulance services are out-of-network.

Q: Is it True, \$1 of every \$4 spent on healthcare costs in the US is for diabetes?

A: Yes, that's correct. According to the American Diabetes Association, **one in every four healthcare dollars** spent in the US is attributed to diabetes. This includes both direct medical costs and indirect costs such as lost productivity and disability.

It's a significant financial burden, highlighting the importance of effective diabetes management and prevention strategies.

The \$412.9 billion annual cost of diabetes in the U.S. is divided into **direct medical costs** and **indirect costs**.

Here's a breakdown:

Direct Medical Costs

- **\$306.6 billion:** This includes expenses for hospital inpatient services, prescription medications, outpatient care, and diabetes supplies.

Indirect Costs

- **\$106.3 billion:** These costs arise from reduced productivity due to disability, presenteeism (working while sick), and premature deaths.

Additional Insights

- **Medical Expenditures:** On average, people with diabetes incur annual medical expenditures of \$19,736, of which approximately \$12,022 is attributable to diabetes.

- **Cost Drivers:** Major contributors to direct medical costs include increased use of prescription medications beyond glucose-lowering medications and hospital inpatient services.
- **Impact on Different Groups:** Women with diabetes spend more on average than men, and Black Americans with diabetes pay the most in direct health care expenditures.

These figures highlight the enormous economic burden of diabetes and the importance of effective management and prevention strategies.

Q: Are there effective interventions to reduce healthcare costs for diabetes.

A: Yes

Prevention Programs

- **National Diabetes Prevention Program (National DPP):** This program focuses on lifestyle changes such as healthy eating and physical activity to prevent or delay type 2 diabetes. Studies show it can reduce the risk of developing diabetes by more than 50% for those at high risk.

Effective Management

- **Intensive Glycemic Management:** Targeting an A1C level of less than 7% can significantly reduce complications and healthcare costs compared to conventional management.
- **ACE Inhibitor/ARB Therapy:** These medications are cost-effective for managing hypertension and preventing complications like chronic kidney disease.

Comprehensive Care

- **Multicomponent Interventions:** Programs that combine behavior change, education, and pharmacological therapy targeting hyperglycemia, hypertension, and other risk factors have been shown to be cost-effective.
- **Telemedicine:** Using telemedicine for diabetic retinopathy screening and other routine care can reduce costs while maintaining quality care.

Policy Changes

- **Supporting Policy Action:** Advocating for policy changes that make diabetes care more affordable, such as capping insulin prices and improving insurance coverage, can have a significant impact.

Community Resources

- **Patient Assistance Programs:** These programs help individuals afford medications and supplies, reducing out-of-pocket costs.
- **Community Connection:** Finding local diabetes programs and resources can provide additional support and education.

Intensive Glycemic Management

Intensive glycemic management aims to achieve tighter control of blood glucose levels to prevent complications.

Key components include:

- **Frequent Monitoring:** Regular blood glucose checks to ensure levels remain within the target range.
- **Personalized Medication Plans:** Adjusting medications based on individual needs and responses.
- **Diet and Exercise:** Integrating a balanced diet and regular physical activity to support glucose control.

Telemedicine for Diabetic Retinopathy Screening

Telemedicine can provide convenient and cost-effective screening for diabetic retinopathy, a common complication of diabetes. Benefits include:

- **Accessibility:** Patients in remote or underserved areas can access specialist care without traveling.
- **Early Detection:** Timely screenings can detect retinopathy early, allowing for prompt treatment and preventing vision loss.
- **Cost Savings:** Reducing the need for in-person visits can lower overall healthcare costs.

Patient Assistance Programs

Many pharmaceutical companies and organizations offer patient assistance programs to help individuals afford their diabetes medications and supplies. Examples include:

- **Manufacturer Discounts:** Discounts or free medications provided by pharmaceutical companies to eligible patients.
- **Nonprofit Organizations:** Groups like the American Diabetes Association and NeedyMeds offer resources and support for accessing affordable medications.

Q: Has there been an increase in autoimmune type 1 diabetes dx due to environmental triggers?

A: There has been an observed increase in autoimmune Type 1 diabetes (T1D), and research suggests that environmental triggers play a significant role in this trend. Here are some key environmental factors that have been linked to the development of T1D:

1. **Viral Infections:** Certain viral infections, particularly enteroviruses, have been associated with the onset of T1D. These viruses can trigger an immune response that mistakenly targets the insulin-producing beta cells in the pancreas.
2. **Dietary Factors:** Changes in dietary habits, such as early introduction of certain foods or lack of breastfeeding, may influence the risk of developing T1D.
3. **Gut Microbiota:** Alterations in the gut microbiota, which can be influenced by factors like antibiotic use and diet, may impact immune system function and contribute to the development of T1D.
4. **Hygiene Hypothesis:** Reduced exposure to certain microbes during early childhood, due to improved hygiene and sanitation, may affect immune system development and increase the risk of autoimmune diseases like T1D.
5. **Epigenetics:** Environmental factors can lead to changes in gene expression without altering the DNA sequence itself, potentially influencing the development of T1D.

Understanding these environmental triggers is crucial for developing preventive strategies and improving prediction models for T1D. Ongoing research aims to identify the specific mechanisms by which these factors contribute to the disease, with the goal of reducing its incidence in the future.

Q: Has there been funding increases for researching a cure for type 1 diabetes?

A: There has been a recent increase in funding for Type 1 diabetes research. The **Special Diabetes Program (SDP)**, which supports research and diabetes care, received a funding increase. The program was reauthorized through December 31, 2024, with an annual funding rate of approximately **\$160 million per year**, which is a roughly **\$10 million increase** from previous levels.

This increase is significant as it marks the first funding boost for the SDP in 20 years. The additional funds will help accelerate research efforts aimed at finding a cure for Type 1 diabetes and improving diabetes care, especially for Native American and Alaska Native communities.

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

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 SB2370.

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 over half of her young life. On average, a type one diabetic will make 180 more decisions each day. 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. To further complicate her life and others when they are reaching their young adult years, they will have to ask themselves whether they can afford insulin and supplies to keep themselves alive when they no longer have access through their parent's insurance policy or are faced with the question if their employer's policy will cover their disease, to name a few. There are a multitude of scenarios where an individual could be in a situation unable to access insulin. They will pay the price with their life.

At the time of Nina's diagnosis, and still today, we have been on a high deductible insurance policy because we are self-employed. For the first few years, we were paying over \$1,000 for each refill at the pharmacy for insulin for roughly a three-week supply. We pay 100% of all medical expenses which include costly premiums that experienced an annual increase just this year of over \$500 a month, a \$5,000 deductible and co-insurance on costly technology and other medications she uses to effectively manage this disease. Each year that we review and potentially renew our policy, I call the carrier to ask what benefits may have changed and if each of her medications and supplies are covered. Often, formularies are not released until after the first of the year when the policy takes effect, resetting the annual deductible, and the true cost may not be realized until you leave the pharmacy.

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, some markets like Medicare have a \$35 cap and essential health benefits are expanding to include an insulin copay because of the realized health benefit. Our work is not finished until everyone has access to affordable insulin in the North Dakota commercial market no matter how or where they get it from.

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 whose lives depend on it. Our daughter Nina has sent messages to our statewide legislators, she's spoken with our district legislators, written a letter and hand

delivered it to our former governor, met with our congressman to plead her case because she is concerned that one day she will be a statistic. She mentors newly diagnosed children and makes care packages for them, giving them her phone number to call her anytime they need. She has helped to raise money for research and camps for kids with diabetes each year and will be a counselor in training there this summer. How many children do you know that feel they have a price put on their life? When she has advocated for affordable insulin with me, she literally feels like her life is at stake, because she is very aware of why Minnesota has the Alec Smith Affordability Act in place. Alec Smith aged off of his parent's insurance and could not bring himself to ask for help. He paid the price with his life.

Studies have shown that downward pressure through advocacy and state mandated insulin caps have helped to lower the manufacturer's price on insulin. I'm extremely pleased to see that the results from the NDPERS study showed that nearly 2,000 North Dakotans were afforded access to life saving insulin and diabetes supplies. I have also met with some members of our congressional delegation both in North Dakota and in Washington D.C. to discuss our dire need for policy change on the federal level. Our conversations with them will continue, but we cannot simply wait. Lives depend on it.

Without access to affordable insulin, life becomes a fragile balance between simply existing, or living because without insulin, death is eventually guaranteed. Statistics have shown that 100,000 people lose their lives to diabetes annually in the US. Many of our public facilities provide AEDs to save lives. Narcan has become more readily available for potential overdoses to save lives. Affordable access to insulin save lives. 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. Let's keep working together to save lives.

Angela Kritzberger

Mother of a Type 1 Diabetic

Diabetes Advocate Hillsboro, ND

#701.430.3121



Senate Bill 2370 – Support
February 10, 2025
Senate Human Services
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 SB 2370.

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?

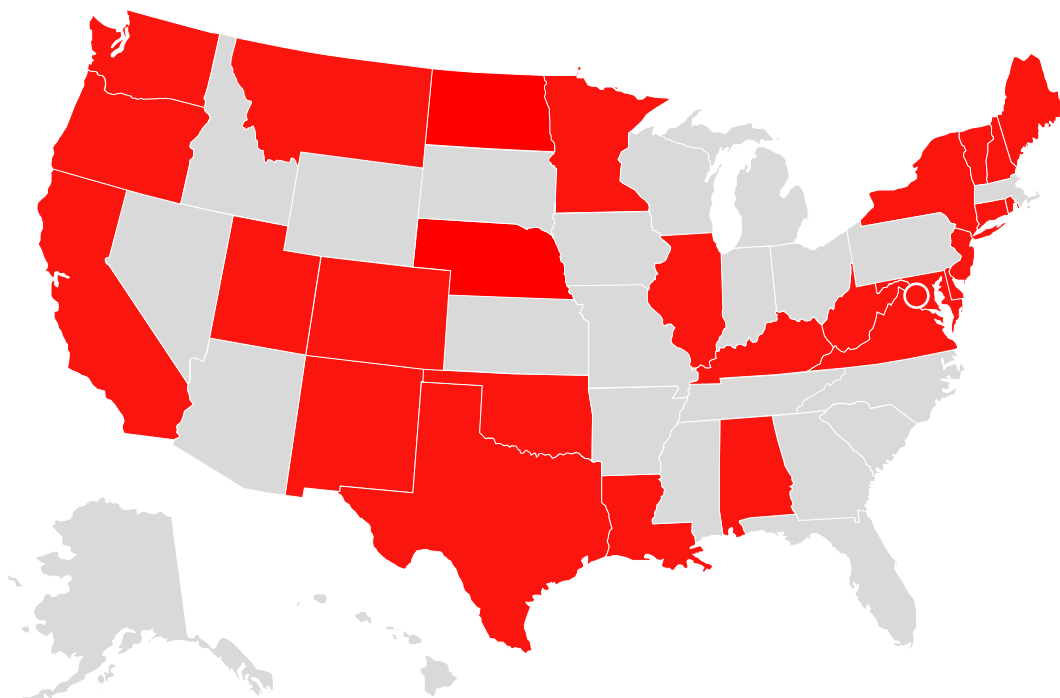
The insulin cap in the Inflation Reduction Act did not apply to state-regulated insurance plans. As such, states have looked for ways to cap prescription drug costs for enrollees in these plans. As of September 2024, 28 states have enacted legislation that limits consumers' prescription drug-related 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.





GREATER NORTH DAKOTA CHAMBER
SB 2370
Senate Human Services Committee
Chair Judy Lee
February 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 Senate Bill 2370.

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, like SB 2370, 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 than 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 are eight other bills this session that include healthcare and drug mandates that either would or could be applied to the private sector in the future. These costs add up, and they don't go away.

We respectfully urge you to oppose SB 2370.





February 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 Senate Bill 2370, 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 four 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 SB 2370 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

⁽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/>

Chairwoman and members of the Committee,

I am here to introduce Senate Bill 2370, which builds on a successful pilot program within the North Dakota Public Employees Retirement System (NDPERS). This bill seeks to extend the \$25 monthly cap on insulin and diabetic supplies to fully-insured plans under the commercial insurance market, ensuring broader access for consumers to access insulin.

History Leading Up to This Point

In 2023, Senate Bill 2140 created a pilot program within NDPERS to cap insulin and related supplies at \$25 per month. This approach aimed to improve affordability without overburdening the health plan. The pilot data showed:

- **Member Savings:** An average of \$80.15 saved per month per member.
- **Minimal Cost Impact:** Only 0.14% of premiums, with no significant increase in utilization.

Why the Bill Is Important

- **Complementary to Existing Efforts:** While private insurers have taken steps to address affordability, this bill provides consistency and predictability across the broader market.
- **Reducing Financial Barriers:** According to the NovaRest report, **300–400 additional** individuals will have access to affordable insulin, reducing rationing and improving outcomes.
- **Preventive Health Savings:** Affordable insulin reduces long-term complications like heart disease and kidney failure, **lowering costs of healthcare over the long term.**

This bill mirrors HB 1114, which was the direct result of the pilot project from the last legislative session.

This legislation builds on the results of the NDPERS pilot project which shows that we can make insulin accessible and affordable without excessive premium increases.

Thanks for your time and consideration. I respectfully ask for a "Do Pass" recommendation.

Sean Cleary

State Senator

District 35



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 stymie 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 has spent \$845,233,023.79 on North Dakota State Legislature imposed health insurance mandates for years 2022-2024. 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 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 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 Sanofi 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.

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee Fort Lincoln Room, State Capitol

SB 2370
2/10/2025
4:01 p.m.

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.

4:01 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:

- Medicare Part D plans
- Permanent implementation of pilot program
- Insurance mandate

4:02 p.m. Rebecca Fricke, Executive Director of ND Public Employees Retirement System, answered committee questions.

4:08 p.m. Senator Roers moved amendment LC#25.1364.01002.

4:09 p.m. Senator Hogan seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Desiree Van Oosting	Y

Motion passed 6-0-0.

4:11 p.m. Senator Roers moved Do Pass as Amended and Rerefer to Appropriations.

4:12 p.m. Senator Weston seconded the motion.

Senators	Vote
Senator Judy Lee	Y
Senator Kent Weston	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y

Senator Desiree Van Oosting	Y
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Motion passed 6-0-0 .

Senator Roers will carry the bill.

4:12 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

February 10, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

2-10-25
JB 10/5

SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

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

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

8 ~~Health insurance benefits coverage – Insulin drug and supply out-of-pocket~~
9 ~~limitations.~~

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

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

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

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

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

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

20 ~~(5) Premixed insulin product;~~

AB 2005

- 1 ~~(6) Premixed insulin/GLP-1 RA product; and~~
- 2 ~~(7) Concentrated human regular insulin;~~
- 3 ~~b. "Medical supplies for insulin dosing and administration" means supplies needed~~
- 4 ~~for proper insulin dosing, as well as supplies needed to detect or address medical~~
- 5 ~~emergencies in an individual using insulin to manage diabetes mellitus. The term~~
- 6 ~~does not include an insulin pump, an electronic insulin administering smart pen,~~
- 7 ~~or a continuous glucose monitor, or supplies needed specifically for the use of~~
- 8 ~~such electronic devices. The term includes:~~
- 9 ~~(1) Blood glucose meters;~~
- 10 ~~(2) Blood glucose test strips;~~
- 11 ~~(3) Lancing devices and lancets;~~
- 12 ~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and~~
- 13 ~~blood ketone strips;~~
- 14 ~~(5) Glucagon, in injectable and nasal forms;~~
- 15 ~~(6) Insulin pen needles; and~~
- 16 ~~(7) Insulin syringes;~~
- 17 ~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or~~
- 18 ~~other medication or medical supply distributor filling a prescription;~~
- 19 ~~2. An insurance company, nonprofit health service corporation, or health maintenance~~
- 20 ~~organization may not deliver, issue, execute, or renew any health insurance policy,~~
- 21 ~~health service contract, or evidence of coverage on an individual, group, blanket,~~
- 22 ~~franchise, or association basis unless the policy, contract, or evidence of coverage~~
- 23 ~~provides benefits for insulin drug and medical supplies for insulin dosing and~~
- 24 ~~administration which complies with this section.~~
- 25 ~~3. The health benefit plan must limit out of pocket costs for a thirty day supply of:~~
- 26 ~~a. Covered insulin drugs, which may not exceed twenty five dollars per pharmacy or~~
- 27 ~~distributor, regardless of the quantity or type of insulin drug used to fill the~~
- 28 ~~covered individual's prescription needs.~~
- 29 ~~b. Covered medical supplies for insulin dosing and administration, the total of which~~
- 30 ~~may not exceed twenty five dollars per pharmacy or distributor, regardless of the~~

Ab 345

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

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

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

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

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

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

23 **SECTION 1. AMENDMENT.** Section 54-52.1-04.18 of the North Dakota Century Code is
24 amended and reenacted as follows:

25 **54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-**
26 **pocket limitations. (Expired effective July 31, 2025)**

27 1. As used in this section:

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

AD 405

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

- 3 (1) Rapid-acting insulin;
4 (2) Short-acting insulin;
5 (3) Intermediate-acting insulin;
6 (4) Long-acting insulin;
7 (5) Premixed insulin product;
8 (6) Premixed insulin/GLP-1 RA product; and
9 (7) Concentrated human regular insulin.

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

- 16 (1) Blood glucose meters;
17 (2) Blood glucose test strips;
18 (3) Lancing devices and lancets;
19 (4) Ketone testing supplies, such as urine strips, blood ketone meters, and
20 blood ketone strips;
21 (5) Glucagon, in injectable and nasal forms;
22 (6) Insulin pen needles; and
23 (7) Insulin syringes.

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

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

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

Ag 5 of 5

- 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
SB 2370**

Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS** ([25.1364.01002](#)) and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2370 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

2025 SENATE APPROPRIATIONS

SB 2370

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division Harvest Room, State Capitol

SB 2370
2/17/2025

A BILL for an Act 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.

10:15 a.m. Chairman Dever opened the hearing.

Members Present: Chairman Dever, Senators Cleary, Magrum and Mathern
Members Absent: Senator Davison

Discussion Topics:

- Affordable Drugs
- Fiscal Note
- PERS

10:19 a.m. Senator Cleary introduced the bill.

10:27 a.m. Rebecca Fricke, Executive Director, ND Public Employees Retirement System (NDPERS), testified in favor.

10:42 Chairman Dever closed the hearing.

Joan Bares, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations - Human Resources Division Harvest Room, State Capitol

SB 2370

02/18/25

Relating to health insurance benefits coverage of insulin drugs and supplies
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8:37 a.m. Chairman Dever opened the hearing.

Members Present: Chairman Dever, Senators Cleary, Davison, Magrum, and Mathern

Discussion Topics:

- Committee Action

8:38 a.m. Senator Clearly moved Do Pass.

8:38 a.m. Senator Davison seconded the motion.

Senators	Vote
Senator Dick Dever	Y
Senator Sean Cleary	Y
Senator Kyle Davison	Y
Senator Jeffery J. Magrum	Y
Senator Tim Mathern	Y

Motion Passed 5-0-0.

Senator Cleary will carry the bill.

8:39 a.m. Chairman Dever closed the hearing.

Joan Bares, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee Harvest Room, State Capitol

SB 2370
2/19/2025

A BILL for an Act 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.

9:05 a.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:

- Committee Action

9:05 a.m. Senator Cleary introduced the bill.

9:08 a.m. Senator Cleary moved a Do Pass.

9:08 a.m. Senator Davison 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	Y
Senator Donald Schaible	Y
Senator Jonathan Sickler	Y
Senator Ronald Sorvaag	Y
Senator Paul J. Thomas	N
Senator Terry M. Wanzek	Y

Motion Passed 15-1-0.

Senator Cleary will carry the bill.

Senate Appropriations Committee

SB 2370

02/19/2025

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9:10 a.m. Chairman Bekkedahl closed the hearing.

Elizabeth Reiten, Committee Clerk

**REPORT OF STANDING COMMITTEE
ENGROSSED SB 2370 ([25.1364.02000](#))**

Appropriations Committee (Sen. Bekkedahl, Chairman) recommends **DO PASS** (15 YEAS, 1 NAY, 0 ABSENT OR EXCUSED AND NOT VOTING). SB 2370 was placed on the Eleventh order on the calendar. This bill does not affect workforce development.

2025 HOUSE HUMAN SERVICES

SB 2370

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370
3/26/2025

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

3:10 p.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rohr
Members Absent: Representatives Davis, Rios

Discussion Topics:

- Insulin cap
- Commercial market

3:10 p.m. Senator Sean Cleary, District 35, introduced the bill.

3:12 p.m. Chairman M. Ruby closed the hearing.

Janae Pinks, Committee Clerk for Jackson Toman, Committee Clerk

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370
4/2/2025

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

3:13 p.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Hospital transparency

3:15 p.m. Representative Nelson introduced amendments relating to hospital transparency, #44629.

3:25 p.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

Possible Amendments to HB 1473 - Prescription drug transparency report

1. Hospital defined. For purposes of this section, "hospital" means an acute care institution licensed and operating in this State as a hospital under (NDCC section)

2. Report on participation in federal 340B drug program. Beginning January 1, 2026, each hospital participating in the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b, referred to in this section as "the 340B program," shall provide an annual report to N.D. Board of Pharmacy. N.D. Board of Pharmacy shall post the report on its publicly accessible website. Each hospital shall report in a standardized format as agreed upon by ND Board of Pharmacy and the hospitals, and include, at a minimum, the following information in the report consistent with the annual reporting of hospitals voluntarily participating in the good stewardship program of the American Hospital Association:

A. A description of how the hospital uses savings from participation in the 340B program to benefit its community through programs and services funded in whole or in part by savings from the 340B program, including services that support community access to care that the hospital could not continue without savings from the 340B program. The reporting must include annual charity care, prescription assistance programs, investments in healthcare workforce development, total annual costs in excess of Medicaid payments and Medicare payments, examples of subsidized services and the hospital's low-income and uninsured volume (also known as hospital disproportionate share, or DSH);

B. The annual estimated savings from the 340B program to the hospital, comparing the acquisition price of drugs under the 340B program to group purchasing organization pricing. If group purchasing organization pricing is not available for a drug under the 340B program, the acquisition price for that drug must be compared to a price from another acceptable pricing source;

C. A comparison of the hospital's estimated savings under the 340B program to the hospital's total drug expenditures; and

D. A description of the hospital's internal review and oversight of the 340B program, which must meet the federal Department of Health and Human Services, Health Resources and Services Administration's program rules and guidance for compliance.

E. Total aggregated payments made by hospitals to contract pharmacies for 340B program services.

3. Reporting. The ND Board of Pharmacy shall produce and post on its publicly accessible website a report that includes a summary of the aggregate information received from hospitals required to report under subsection 2.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370

4/2/2025

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

4:03 p.m. Chairman M. Ruby opened the hearing.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios

Members Absent: Representative Rohr

Discussion Topics:

- Committee action
- Hospital transparency

4:03 p.m. Chairman M. Ruby discussed amendments relating to hospital transparency #44629 from 3:00 p.m. Meeting.

4:09 p.m. Representative Beltz moved to adopt the amendment, testimony #44629.

4:10 p.m. Representative Hendrix seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	N
Representative Mike Beltz	Y
Representative Macy Bolinske	N
Representative Jayme Davis	N
Representative Gretchen Dobervich	N
Representative Cleyton Fegley	Y
Representative Jared Hendrix	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Nico Rios	N
Representative Karen Rohr	AB

4:10 p.m. Motion passed 7-5-1.

4:10 p.m. Chairman M. Ruby adjourned the meeting.

Jackson Toman, Committee Clerk

Bill will be further amended

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370
4/9/2025

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

10:01 a.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- Hospital transparency
- 340b savings

10:02 a.m. Representative Nelson, District 14, introduced proposed amendments relating to hospital transparency, #44852.

10:37 a.m. Dylan Wheeler, Sanford Health Plan, testified and answered questions.

10:38 a.m. Tim Blasl, President of the North Dakota Hospital Association, testified and answered questions.

10:49 a.m. Chairman M. Ruby appointed Representatives Hendrix, Dobervich, and Bolinske to a subcommittee.

10:50 a.m. Chairman M. Ruby closed the meeting.

Jackson Toman, Committee Clerk

Prescription drug transparency report

1. Hospital defined. For purposes of this section, "hospital" means an acute care institution licensed and operating in this State as a hospital under (NDCC section)

2. Report on participation in federal 340B drug program. Beginning January 1, 2026, each hospital participating in the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b, referred to in this section as "the 340B program," shall provide an annual report to N.D. Department of Health and Human Services. NDDHHS shall post the report on its publicly accessible website. Each hospital shall report in a standardized format as agreed upon by NDDHHS and the hospitals, and include, at a minimum, the following information in the report consistent with the annual reporting of hospitals voluntarily participating in the good stewardship program of the American Hospital Association:

- A. A description of how the hospital uses savings from participation in the 340B program to benefit its community through programs and services funded in whole or in part by savings from the 340B program, including services that support community access to care that the hospital could not continue without savings from the 340B program. The reporting must include annual charity care, prescription assistance programs, investments in healthcare workforce development, total annual costs in excess of Medicaid payments and Medicare payments, examples of subsidized services and the hospital's low-income and uninsured volume (also known as hospital disproportionate share, or DSH); *The report shall also contain an accounting of any amount of 340b savings not used w/in the state of ND.*
- B. The annual estimated savings from the 340B program to the hospital, comparing the acquisition price of drugs under the 340B program to group purchasing organization pricing. If group purchasing organization pricing is not available for a drug under the 340B program, the acquisition price for that drug must be compared to a price from another acceptable pricing source;
- C. A comparison of the hospital's estimated savings under the 340B program to the hospital's total drug expenditures; and
- D. A description of the hospital's internal review and oversight of the 340B program, which must meet the federal Department of Health and Human Services, Health Resources and Services Administration's program rules and guidance for compliance.
- E. Total aggregated payments made by hospitals to contract pharmacies for 340B program services.

3. Reporting. NDDHHS shall produce and post on its publicly accessible website a report that includes a summary of the aggregate information received from hospitals required to report under subsection 2. NDDHHS shall annually provide a report to the interim Health Care Committee.

Drug Manufacturer Information to start...

1. A drug manufacturer shall provide in the aggregate any rebates, discounts, or other financial incentives or payments provided to health insurers.
2. A drug manufacturer shall provide in the aggregate any rebates, discounts, or other financial incentives or payments provided to health insurers.
3. If a drug manufacturer denies a 340B discount or alters pricing, they must submit a written explanation to covered entities and the commissioner.
4. If a drug manufacturer overcharges, covered entities, they must disclose overcharges to commissioner and covered entities shall be reimbursed for any overcharges.
5. A drug manufacturer shall provide covered entities with detailed transaction level data to ensure correct 340B discount application.
6. A drug manufacturer shall be required to disclose all trial data, including negative results and effects for any 340B drug.
7. A drug manufacturer shall report any government subsidies, tax incentives, and grants received for each drug approved for sale in the United States.

Pharmacy Benefits Manager Information to start...

1. The aggregated amount charged to employer plans for all drugs listed on respective formularies.
2. The aggregated amount paid to pharmacies that are owned or affiliated with the pharmacy benefits manager.
3. The aggregated amount paid to pharmacies that are not owned or affiliated with the pharmacy benefits manager.
4. The aggregated 340B savings obtained from drug manufacturers under the 340B program. Each PBM shall disclose 340B savings for mail order pharmacy, specialty mail order pharmacies, community pharmacy or hospitals it has ownership in or an affiliation.
5. Disclose contract policies that reduce reimbursement to pharmacies for their participation in the 340B program.
6. The aggregated amount showing 340B contract rate reductions to pharmacies.
7. Disclose the difference in 340B rates for pharmacies owned or affiliated compared to non-affiliated pharmacies.
8. Disclose the average dispensing fee paid to pharmacies owned or affiliated, including mail order pharmacies, compared to the ND Medicaid rate of dispensing.
9. Disclose the average dispensing fee paid to non-affiliated pharmacies compared to the ND Medicaid rate of dispensing.

Health Insurer Information to start...

1. Total of premium dollars collected annually from individuals and employers.
2. Total of approved medical claims and prescription claims paid annually.
3. Disclose how they use excess revenues to reduce premiums and patient out-of-pocket expenses.
4. Disclose rebates, price protection payments, discounts and other similar remunerations received from drug manufacturers.
5. Disclose rebates, price protection payments, discounts and other similar remunerations received from PBMs.
6. Disclose if they have ownership in a PBM.
7. If a health insurer has an ownership interest in a PBM, disclose how much revenue the PBM provides to the health insurer.
8. Disclose if any part of their business umbrella participates in the 340B program and to what degree.
9. If any business segment participates in the 340B program, they shall disclose aggregated revenue generated from their participation in the 340B program
10. Disclose how the 340B revenue is used to reduce premiums and patient out-of-pocket expenses.
11. Starting with January 1, 2020, health insurers shall provide historical data and trends for employers and patients related to premiums, deductibles, coinsurance, copayments and any other out-of-pocket expense and report annually thereafter.
12. Starting with January 1, 2020, health insurers shall disclose annual saving from claim denials and report annually thereafter.

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370
4/11/2025
Subcommittee

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

10:33 a.m. Chairman Hendrix opened the meeting.

Members Present: Chairman Hendrix, Representatives Bolinske, Dobervich

Discussion Topics:

- Committee discussion

10:33 a.m. Chairman Hendrix introduced proposed amendments, #44947.

10:48 a.m. Brendan Joyce, Medicaid Services Clinical Services Director, testified and answered questions.

10:49 a.m. John Arnold, Deputy Insurance Commissioner, testified and answered questions.

10:53 a.m. Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association, testified and answered questions.

Additional written testimony:

Michelle Mack, Senior Director, State Affairs of PCMA, submitted testimony in opposition, #44939.

10:59 a.m. Chairman Hendrix adjourned the meeting.

Jackson Toman, Committee Clerk



April 11, 2025

The Honorable Matthew Ruby, Chair Human Services Committee
The Honorable Kathy Frelich, Vice Chair Human Services Committee
North Dakota House Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **SB 2370– Hoghouse Amendment Proposed Relating to 340B Reporting
PCMA Testimony in Opposition to SB 2370 - Amendment**

Dear Chair Ruby, Vice Chair Frelich, and Committee Members:

My name is Michelle Mack, and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

At this time, PCMA appreciates the opportunity to provide comments on the proposed amendment dealing with 340B reporting for SB 2370 and respectfully opposes it. We agree that appropriate transparency for the 340B program is necessary but the language in the amendment requires reporting well beyond the 340B program as well as information PBMs do not have. Currently, the federal government already requires PBMs to provide detailed reports on drug spending, rebates, fees, and patient out-of-pocket costs to health plans, enabling plans to report to the government. CMS also requires extra reporting for Medicare and Exchange plans. State-level reporting is duplicative, costly, and unnecessary. Please see our concerns below:

- What government entity are these reports to be filed with?
- Items #1, #2, and #3 appear to require information beyond the scope of most PBM reporting requirements and/or may not be easily feasible.
- Item #4 demands information a PBM does not have.
 - No PBM obtains savings from manufacturers attributable to the 340B program, nor has access to that information because 340B claims reconciliation occurs OUTSIDE of the PBM/plan claim adjudication process.



- Items #5, #6, and #7 demand information about PBM practices in which PBMs do not engage.
- Items #8 and #9 require information that may not be feasible as proposed.

Thank you again for the opportunity to comment on the amendments for SB 2370. We urge a “do not pass” vote.

If you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Michelle Mack". The signature is fluid and cursive, with a large, stylized "M" and "K".

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

2156

Changes

1. Moved all campaign finance law out of .1 and put it in .2, repeal of .1
2. SOS Technical corrections to add "an initiative or referendum petition"
3. SOS Hard dates for deadlines May 1, Oct. 1. Jan. 1 Special elections & 48 hours remains
4. SOS Adds "political committee" to prohibition of foreign national contributions
5. SOS "deposit" as recording date versus "receipt" in current law
6. SOS drop "address" on contributors Name, city, state only
7. Added 2 new expenditure aggregate categories 1) political donations 2) volunteer appreciation.
8. Incorporated Ruby bill HB 1577 increased \$200 contribution level to \$250 with \$100 every 10 years on reporting thresholds
9. Today, we put in beginning fund balance. 2156 requires ending fund balance only.
10. Fines on 3rd chance for reporting increased from \$100 to \$500.
11. Public disclosure of committees and individuals delinquent

Major issue removed from Senate and SOS version

Senate and SOS created a new report of expenditures greater than \$250, not allowed to aggregate those expenditures, matches statewide candidate current requirements

Senate had higher fines in every missed deadline

SOS is Secretary of State request

Concerns Vicky 290-1376

2025 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee Pioneer Room, State Capitol

SB 2370
4/15/2025

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

3:29 p.m. Chairman M. Ruby opened the meeting.

Members Present: Chairman M. Ruby, Vice-Chairman Frelich, Representatives K. Anderson, Beltz, Bolinske, Davis, Dobervich, Fegley, Hendrix, Holle, Kiefert, Rios, Rohr

Discussion Topics:

- 340b
- Reporting programs

3:30 p.m. Representative Hendrix introduced amendments, LC#25.1364.02003, #45008.

3:39 p.m. Representative Dobervich introduced amendments relating to a study, #45009.

3:48 p.m. Chrystal Bartuska, North Dakota Insurance Commission, testified and answered questions.

3:51 p.m. Representative K. Anderson moved a Do Not Pass.

3:52 p.m. Representative Rios seconded the motion.

3:52 p.m. Representative K. Anderson rescinded the motion.

3:52 p.m. Representative Rohr moved to adopt the LC#25.1364.02003 amendment.

3:53 p.m. Representative Hendrix seconded the motion.

Representatives	Vote
Representative Matthew Ruby	Y
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	Y
Representative Macy Bolinske	Y
Representative Jayme Davis	N
Representative Gretchen Dobervich	N
Representative Cleyton Fegley	N
Representative Jared Hendrix	Y
Representative Dawson Holle	N
Representative Dwight Kiefert	N
Representative Nico Rios	Y
Representative Karen Rohr	Y

3:56 p.m. Motion passed 8-5-0.

3:57 p.m. Representative Holle moved a Do Not Pass as amended.

3:57 p.m. Representative Bolinske seconded the motion.

Representatives	Vote
Representative Matthew Ruby	N
Representative Kathy Frelich	Y
Representative Karen Anderson	Y
Representative Mike Beltz	N
Representative Macy Bolinske	Y
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Cleyton Fegley	N
Representative Jared Hendrix	N
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Nico Rios	N
Representative Karen Rohr	N

3:58 p.m. Motion passed 7-6-0.

Representative Frelich will carry the bill.

4:00 p.m. Chairman M. Ruby adjourned the meeting.

Jackson Toman, Committee Clerk

Sixty-ninth
Legislative Assembly
of North Dakota

**PROPOSED AMENDMENTS TO
FIRST ENGROSSMENT**

CO
4/15/25
1047

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

1 A BILL ~~for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century~~
2 ~~Code, relating to health insurance benefits coverage of insulin drugs and supplies.~~for an Act to
3 create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to
4 prescription drug transparency reporting under the federal drug discount program; to provide for
5 a report; to provide a penalty; and to provide for application.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

7 ~~SECTION 1. AMENDMENT.~~ Section 54-52.1-04.18 of the North Dakota Century Code is
8 amended and reenacted as follows:

9 ~~54-52.1-04.18. Health insurance benefits coverage -- Insulin drug and supply out-of-~~
10 ~~pocket limitations. (Expired effective July 31, 2025)~~

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

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

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

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

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

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

1 ~~———— (5) Premixed insulin product;~~

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

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

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

10 ~~———— (1) Blood glucose meters;~~

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

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

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

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

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

17 ~~———— (7) Insulin syringes.~~

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

21 ~~———— 2. The board shall provide health insurance benefits coverage that provides for insulin~~
22 ~~drug and medical supplies for insulin dosing and administration which complies with~~
23 ~~this section.~~

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

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

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

- 1 ~~4. The coverage may not allow a pharmacy benefits manager or the pharmacy or~~
2 ~~distributor to charge, require the pharmacy or distributor to collect, or require a~~
3 ~~covered individual to make a payment for a covered insulin drug or medical supplies~~
4 ~~for insulin dosing and administration in an amount that exceeds the out-of-pocket limits~~
5 ~~set forth under subsection 3.~~
- 6 ~~5. The coverage may not impose a deductible, copayment, coinsurance, or other cost-~~
7 ~~sharing requirement that causes out-of-pocket costs for prescribed insulin or medical~~
8 ~~supplies for insulin dosing and administration to exceed the amount set forth under~~
9 ~~subsection 3.~~
- 10 ~~6. Subsection 3 does not require the coverage to implement a particular cost-sharing~~
11 ~~structure and does not prevent the limitation of out-of-pocket costs to less than the~~
12 ~~amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs~~
13 ~~on an insulin pump, an electronic insulin-administering smart pen, or a continuous~~
14 ~~glucose monitor. This section does not limit whether coverage classifies an insulin~~
15 ~~pump, an electronic insulin-administering smart pen, or a continuous glucose monitor~~
16 ~~as a drug or as a medical device or supply.~~
- 17 ~~7. If application of subsection 3 would result in the ineligibility of a health benefit plan that~~
18 ~~is a qualified high-deductible health plan to qualify as a health savings account under~~
19 ~~section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of~~
20 ~~subsection 3 do not apply with respect to the deductible of the health benefit plan until~~
21 ~~after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~
- 22 ~~8. This section does not apply to the Medicare part D prescription drug coverage~~
23 ~~plan.~~

24 **SECTION 1.** A new chapter to title 26.1 of the North Dakota Century Code is created and
25 enacted as follows:

26 **Definitions.**

27 For purposes of this chapter:

- 28 1. "Contract pharmacy" means a pharmacy that has a contract with a covered entity to
29 receive and dispense drugs to the covered entity's patients on its behalf.
- 30 2. "Covered entity" means an entity participating or authorized to participate in the
31 program.

3. "Department" means the insurance department.

4. "Drug manufacturer" means the entity that holds the national drug code for a drug, which is engaged in the production, preparation, propagation, compounding, conversion, or processing of the drug or which is engaged in the packaging, repackaging, labeling, relabeling, or distribution of the drug. The term does not include a wholesale drug distributor or retail pharmacy licensed in this state.

5. "Health care facility" means those facilities licensed under chapter 23-16.

6. "Health insurer" means any entity that provides health insurance in this state. The term includes an insurance company, prepaid limited service corporation, a fraternal benefit society, a health maintenance organization, a nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

7. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

8. "Program" means the federal drug discount program under 42 U.S.C. 256b.

Prescription drug transparency - Report.

1. The commissioner shall:

- a. Prescribe the manner in which required reports under this section are submitted to the department.
- b. Beginning May 1, 2027, publish annually on the department's website a summary of the information in the reports received by the department under this section.
- c. Beginning June 1, 2027, report annually to the legislative management a summary of findings of the reports received by the department.

2. The commissioner may adopt rules to carry out the responsibilities of this chapter.

3. A health care facility, contract pharmacy, or federally qualified health center participating in the program shall report annually to the department:

- a. Information describing how the entity's participation in the program benefits its community by using savings from the program to fund, in whole or in part, services that support community access to care, which the entity could not continue without savings from the program. The report must include information relating to charity care, prescription assistance programs, investments in health care workforce development, the total annual costs in excess of Medicaid and

- 1 Medicare payments, examples of subsidized services, and the entity's
- 2 low-income and uninsured volume.
- 3 b. An accounting of any amount of program savings not used within this state.
- 4 c. The annual estimated savings from the program to the entity, comparing the
- 5 acquisition price of drugs under the program to the group purchasing
- 6 organization pricing. If the group purchasing organization pricing is not available
- 7 for a drug under the program, the acquisition price for that drug must be
- 8 compared to a price from another pricing source.
- 9 d. A comparison of the entity's estimated savings under the program to the entity's
- 10 total drug expenditures.
- 11 e. A description of the entity's internal review and oversight of the program, which
- 12 must meet the requirements of federal rules and compliance guidelines.
- 13 f. The total aggregated payments made by the entity to contract pharmacies for
- 14 program services, if any.
- 15 4. A drug manufacturer participating in the program shall report annually to the
- 16 department:
- 17 a. The aggregate rebate, discount, or other financial incentive amounts or payments
- 18 provided to health insurers.
- 19 b. All trial data, including negative results and effects for any program drug.
- 20 c. Any government subsidy, tax incentive, or grant received for each drug approved
- 21 for sale in the United States.
- 22 5. If a drug manufacturer participating in the program denies a program discount or alters
- 23 drug pricing, the drug manufacturer shall submit a written explanation of the activity to
- 24 the department and all affected covered entities.
- 25 6. If a drug manufacturer overcharges a covered entity, the drug manufacturer shall
- 26 disclose the overcharge to the department and fully reimburse the covered entity.
- 27 7. A pharmacy benefits manager participating in the program shall report annually to the
- 28 department the:
- 29 a. Aggregate amount charged to employer plans for all drugs listed on respective
- 30 formularies.

- 1 b. Aggregate amount paid to pharmacies that are owned by or affiliated with the
- 2 pharmacy benefits manager.
- 3 c. Aggregate amount paid to pharmacies that are not owned by or affiliated with the
- 4 pharmacy benefits manager.
- 5 d. Aggregate savings from mail order pharmacies, specialty mail order pharmacies,
- 6 and community pharmacies or hospitals owned by or affiliated with the pharmacy
- 7 benefits manager.
- 8 e. Contract policies that reduce reimbursement to pharmacies for participating in the
- 9 program.
- 10 f. Aggregate amount of program contract rate reductions to pharmacies.
- 11 g. Difference in program rates for pharmacies owned or affiliated with the pharmacy
- 12 benefits manager compared to pharmacies that are not owned or affiliated with
- 13 the pharmacy benefits manager.
- 14 h. Average dispensing fee paid to pharmacies owned or affiliated with the pharmacy
- 15 benefits manager, including mail order pharmacies, compared to the Medicaid
- 16 rate of dispensing.
- 17 i. Average dispensing fee paid to pharmacies that are not owned or affiliated with
- 18 the pharmacy benefits manager, including mail order pharmacies, compared to
- 19 the Medicaid rate of dispensing.
- 20 8. A health insurer participating in the program shall report annually to the department:
- 21 a. The total of premium dollars collected annually from insured individuals and
- 22 employers.
- 23 b. The total of approved medical claims and prescription claims paid annually.
- 24 c. The health insurer's method for using excess revenues to reduce premiums and
- 25 patient out-of-pocket expenses.
- 26 d. Rebates, price protection payments, discounts, and other similar remunerations
- 27 received from drug manufacturers.
- 28 e. Any ownership interest the health insurer has in a pharmacy benefits manager,
- 29 and if a health insurer has an ownership interest, the amount of revenue the
- 30 pharmacy benefits manager provides to the health insurer.

- f. A description of the health insurer's participation in the program, and to what degree each business segment of the health insurer participates in the program.
- g. Aggregate revenue generated from participation in the program.
- h. Historical data and trends for employers and patients related to premiums, deductibles, coinsurance, copayments, and any other out-of-pocket expenses.
- i. Annual savings from claim denials in the program.

Confidentiality - Exception.

1. A report, document, material, or other information that is provided by a reporting entity to the commissioner in accordance with this chapter is confidential and not subject to section 44-04-18, a subpoena to the department, or a discovery request, or admissible as evidence in a private civil action.
2. The commissioner may disclose on its website a summary of the information in the reports and a summary of the findings of the reports, and use the document, material, or other information submitted in a regulatory or legal action brought as a part of the official duties of the commissioner.
3. A privilege or claim of confidentiality in the document, material, or information is not waived as a result of disclosure to the commissioner under this chapter or as a result of providing or disclosing information to the commissioner.

Civil penalty.

A health care facility, contract pharmacy, federally qualified health center, health insurer, drug manufacturer, or pharmacy benefits manager that violates this chapter is subject to the imposition by the attorney general of a civil penalty not to exceed ten thousand dollars for each violation. The attorney general may waive or reduce a fine under this section upon a finding of good cause, such as excusable neglect or other extenuating circumstances. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 2. APPLICATION. This Act applies to health care facilities beginning on January 1, 2026, and to drug manufacturers, health insurers, and pharmacy benefits managers beginning on January 1, 2027.

**REPORT OF STANDING COMMITTEE
ENGROSSED SB 2370**

Human Services Committee (Rep. M. Ruby, Chairman) recommends **AMENDMENTS** ([25.1364.02003](#)) and when so amended, recommends **DO NOT PASS** (7 YEAS, 6 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). Engrossed SB 2370 was placed on the Sixth order on the calendar.

25.1364.02003
Title.

Prepared by the Legislative Council
staff for Representative Hendrix
April 14, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

1 A BILL ~~for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century-~~
2 ~~Code, relating to health insurance benefits coverage of insulin drugs and supplies; for an Act to~~
3 ~~create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to~~
4 ~~prescription drug transparency reporting under the federal drug discount program; to provide for~~
5 ~~a report; to provide a penalty; and to provide for application.~~

6 BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

7 ~~SECTION 1. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is~~
8 ~~amended and reenacted as follows:~~

9 ~~54-52.1-04.18. Health insurance benefits coverage – Insulin drug and supply out-of-~~
10 ~~pocket limitations. (Expired effective July 31, 2025)~~

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

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

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

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

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

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

- 1 ~~————— (5) — Premixed insulin product;~~
2 ~~————— (6) — Premixed insulin/GLP-1 RA product; and~~
3 ~~————— (7) — Concentrated human regular insulin.~~
4 ~~————— b. "Medical supplies for insulin dosing and administration" means supplies needed~~
5 ~~for proper insulin dosing, as well as supplies needed to detect or address medical~~
6 ~~emergencies in an individual using insulin to manage diabetes mellitus. The term~~
7 ~~does not include an insulin pump, an electronic insulin-administering smart pen,~~
8 ~~or a continuous glucose monitor, or supplies needed specifically for the use of~~
9 ~~such electronic devices. The term includes:~~
10 ~~————— (1) — Blood glucose meters;~~
11 ~~————— (2) — Blood glucose test strips;~~
12 ~~————— (3) — Lancing devices and lancets;~~
13 ~~————— (4) — Ketone testing supplies, such as urine strips, blood ketone meters, and~~
14 ~~blood ketone strips;~~
15 ~~————— (5) — Glucagon, in injectable and nasal forms;~~
16 ~~————— (6) — Insulin pen needles; and~~
17 ~~————— (7) — Insulin syringes.~~
18 ~~————— c. "Pharmacy or distributor" means a pharmacy or medical supply company, or~~
19 ~~other medication or medical supply distributor filling a covered individual's~~
20 ~~prescriptions.~~
21 ~~———— 2. — The board shall provide health insurance benefits coverage that provides for insulin~~
22 ~~drug and medical supplies for insulin dosing and administration which complies with~~
23 ~~this section.~~
24 ~~———— 3. — The coverage must limit out-of-pocket costs for a thirty-day supply of:~~
25 ~~———— a. — Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or~~
26 ~~distributor, regardless of the quantity or type of insulin drug used to fill the~~
27 ~~covered individual's prescription needs.~~
28 ~~———— b. — Covered medical supplies for insulin dosing and administration, the total of which~~
29 ~~may not exceed twenty-five dollars per pharmacy or distributor, regardless of the~~
30 ~~quantity or manufacturer of supplies used to fill the covered individual's~~
31 ~~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.~~

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

Definitions.

For purposes of this chapter:

1. "Contract pharmacy" means a pharmacy that has a contract with a covered entity to receive and dispense drugs to the covered entity's patients on its behalf.
2. "Covered entity" means an entity participating or authorized to participate in the program.

1 3. "Department" means the insurance department.

2 4. "Drug manufacturer" means the entity that holds the national drug code for a drug,
3 which is engaged in the production, preparation, propagation, compounding,
4 conversion, or processing of the drug or which is engaged in the packaging,
5 repackaging, labeling, relabeling, or distribution of the drug. The term does not include
6 a wholesale drug distributor or retail pharmacy licensed in this state.

7 5. "Health care facility" means those facilities licensed under chapter 23-16.

8 6. "Health insurer" means any entity that provides health insurance in this state. The term
9 includes an insurance company, prepaid limited service corporation, a fraternal benefit
10 society, a health maintenance organization, a nonprofit health service corporation, and
11 any other entity providing a plan of health insurance or health benefits subject to state
12 insurance regulation.

13 7. "Pharmacy benefits manager" has the same meaning as in section 19-03.6-01.

14 8. "Program" means the federal drug discount program under 42 U.S.C. 256b.

15 **Prescription drug transparency - Report.**

16 1. The commissioner shall:

17 a. Prescribe the manner in which required reports under this section are submitted
18 to the department.

19 b. Beginning May 1, 2027, publish annually on the department's website a summary
20 of the information in the reports received by the department under this section.

21 c. Beginning June 1, 2027, report annually to the legislative management a
22 summary of findings of the reports received by the department.

23 2. The commissioner may adopt rules to carry out the responsibilities of this chapter.

24 3. A health care facility, contract pharmacy, or federally qualified health center
25 participating in the program shall report annually to the department:

26 a. Information describing how the entity's participation in the program benefits its
27 community by using savings from the program to fund, in whole or in part,
28 services that support community access to care, which the entity could not
29 continue without savings from the program. The report must include information
30 relating to charity care, prescription assistance programs, investments in health
31 care workforce development, the total annual costs in excess of Medicaid and

Medicare payments, examples of subsidized services, and the entity's low-income and uninsured volume.

b. An accounting of any amount of program savings not used within this state.

c. The annual estimated savings from the program to the entity, comparing the acquisition price of drugs under the program to the group purchasing organization pricing. If the group purchasing organization pricing is not available for a drug under the program, the acquisition price for that drug must be compared to a price from another pricing source.

d. A comparison of the entity's estimated savings under the program to the entity's total drug expenditures.

e. A description of the entity's internal review and oversight of the program, which must meet the requirements of federal rules and compliance guidelines.

f. The total aggregated payments made by the entity to contract pharmacies for program services, if any.

4. A drug manufacturer participating in the program shall report annually to the department:

a. The aggregate rebate, discount, or other financial incentive amounts or payments provided to health insurers.

b. All trial data, including negative results and effects for any program drug.

c. Any government subsidy, tax incentive, or grant received for each drug approved for sale in the United States.

5. If a drug manufacturer participating in the program denies a program discount or alters drug pricing, the drug manufacturer shall submit a written explanation of the activity to the department and all affected covered entities.

6. If a drug manufacturer overcharges a covered entity, the drug manufacturer shall disclose the overcharge to the department and fully reimburse the covered entity.

7. A pharmacy benefits manager participating in the program shall report annually to the department the:

a. Aggregate amount charged to employer plans for all drugs listed on respective formularies.

- b. Aggregate amount paid to pharmacies that are owned by or affiliated with the pharmacy benefits manager.
 - c. Aggregate amount paid to pharmacies that are not owned by or affiliated with the pharmacy benefits manager.
 - d. Aggregate savings from mail order pharmacies, specialty mail order pharmacies, and community pharmacies or hospitals owned by or affiliated with the pharmacy benefits manager.
 - e. Contract policies that reduce reimbursement to pharmacies for participating in the program.
 - f. Aggregate amount of program contract rate reductions to pharmacies.
 - g. Difference in program rates for pharmacies owned or affiliated with the pharmacy benefits manager compared to pharmacies that are not owned or affiliated with the pharmacy benefits manager.
 - h. Average dispensing fee paid to pharmacies owned or affiliated with the pharmacy benefits manager, including mail order pharmacies, compared to the Medicaid rate of dispensing.
 - i. Average dispensing fee paid to pharmacies that are not owned or affiliated with the pharmacy benefits manager, including mail order pharmacies, compared to the Medicaid rate of dispensing.
8. A health insurer participating in the program shall report annually to the department:
- a. The total of premium dollars collected annually from insured individuals and employers.
 - b. The total of approved medical claims and prescription claims paid annually.
 - c. The health insurer's method for using excess revenues to reduce premiums and patient out-of-pocket expenses.
 - d. Rebates, price protection payments, discounts, and other similar remunerations received from drug manufacturers.
 - e. Any ownership interest the health insurer has in a pharmacy benefits manager, and if a health insurer has an ownership interest, the amount of revenue the pharmacy benefits manager provides to the health insurer.

- f. A description of the health insurer's participation in the program, and to what degree each business segment of the health insurer participates in the program.
- g. Aggregate revenue generated from participation in the program.
- h. Historical data and trends for employers and patients related to premiums, deductibles, coinsurance, copayments, and any other out-of-pocket expenses.
- i. Annual savings from claim denials in the program.

Confidentiality - Exception.

1. A report, document, material, or other information that is provided by a reporting entity to the commissioner in accordance with this chapter is confidential and not subject to section 44-04-18, a subpoena to the department, or a discovery request, or admissible as evidence in a private civil action.
2. The commissioner may disclose on its website a summary of the information in the reports and a summary of the findings of the reports, and use the document, material, or other information submitted in a regulatory or legal action brought as a part of the official duties of the commissioner.
3. A privilege or claim of confidentiality in the document, material, or information is not waived as a result of disclosure to the commissioner under this chapter or as a result of providing or disclosing information to the commissioner.

Civil penalty.

A health care facility, contract pharmacy, federally qualified health center, health insurer, drug manufacturer, or pharmacy benefits manager that violates this chapter is subject to the imposition by the attorney general of a civil penalty not to exceed ten thousand dollars for each violation. The attorney general may waive or reduce a fine under this section upon a finding of good cause, such as excusable neglect or other extenuating circumstances. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 2. APPLICATION. This Act applies to health care facilities beginning on January 1, 2026, and to drug manufacturers, health insurers, and pharmacy benefits managers beginning on January 1, 2027.

SB 2370 Amendment

A BILL for an Act to provide for a legislative management study relating to prescription drug transparency reporting.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - 340B Transparency Reporting.

1. During the 2025-26 interim, the legislative management shall consider studying prescription drug transparency reporting. The study must include:

- a. What reporting from hospitals operating in North Dakota which participate in the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include an accounting of any amount of 340B savings not used within North Dakota, a comparison of estimated savings under the 340B program to the total drug expenditures, a description of internal review and oversight of the 340B program, total aggregated payments made to contract pharmacies for 340B program services, and how the savings from participation in the 340B program support community access to care that could not be continued without participation in the program, annual reporting of the amount of charity care provided, annual investments in healthcare workforce development, annual amount of prescription drug assistance program participation, and total annual costs in excess of Medicaid and Medicare payments.
- b. What reporting from federally qualified health care centers operating in North Dakota which participate in the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include an accounting of any amount of 340B savings not used within North Dakota, a comparison of estimated savings under the 340B program to the total drug expenditures, a description of internal review and oversight of the 340B program, total aggregated payments made to contract pharmacies for 340B program services, and how the savings from participation in the 340B program support community access to care that could not be continued without participation in the program, annual reporting of the amount of charity care provided, annual investments in healthcare workforce development, annual amount of prescription drug assistance program participation, and total annual costs in excess of Medicaid and Medicare payments.

c. What reporting from contracted pharmacies providing prescription medications to patients in North Dakota of 340B eligible covered entities under the 340B Drug Discount Program should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include the amount the contract pharmacy was paid in dispensing fees.

d. What reporting from drug manufacturers should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include the aggregate of any rebates, discounts, or other financial incentives or payments provided to health insurers, an explanation of 340B pricing denials or price altering, transaction level data regarding 340B discount application, all government subsidies, tax incentives, and grants received for each drug approved for sale in the United States.

e. What reporting from pharmacy benefits managers should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include the amount charged to employer plans for all drugs listed on formularies, the aggregated amount paid to pharmacies owned or affiliated with each pharmacy benefit manager, the aggregated amount paid to pharmacies that are not owned or affiliated with the pharmacy benefit manager, the aggregated 340B savings obtained from drug manufacturers under the 340B program including mail order pharmacies, specialty mail order pharmacies, community and hospital pharmacies it has ownership or affiliation with, disclosure of contract of contract policies that reduce reimbursement to pharmacies for their participation in the 340B program, aggregated report of the amount of 340B contract rate reductions to pharmacies, disclosure of the different 340B rates for pharmacies owned or affiliated compared to non-affiliated pharmacies, disclosure of the average dispensing fees paid to pharmacies owned or affiliated, including mail order pharmacies compared to the North Dakota Medicaid rate of dispensing, and disclosure of the average dispensing fee paid to non-affiliated pharmacies compared to the North Dakota Medicaid rate of dispensing.

f. What reporting from health insurers should be included in 340B Drug Discount Program transparency reporting and how that data would be used to assure compliance and benefit to patients in North Dakota. This must include how they have used excess revenues to reduce premium and patient out-of-pocket expenses, disclosure of rebates, price protection payments, discounts and other similar remunerations received from pharmacy benefit managers, disclosure of any ownership in a pharmacy benefit manager, how much revenue the pharmacy benefit manager provides to the insurer if they have ownership in one, disclose any participation in the 340B program under any segment of their business and the nature of that participation, aggregated revenue generated from participation in the 340B program and how it is used to reduce premiums and patient out-of-pocket expenses, and annual savings from claims denials beginning January 1, 2020.

g. Recommendation for legislation regarding how the North Dakota Insurance Commission will address violations of the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b by a hospital, federally qualified health care center, a 340B Program contracted pharmacy, drug manufacturer, pharmacy benefit manager, or health insurer identified through review of data collected, including, but not limited to federal antitrust laws and the Uniform State Anti-Rust Act.

h. The frequency required data must be reported to the North Dakota Insurance Commission by a hospital, federally qualified health care center, a 340B Program contracted pharmacy, drug manufacturer, pharmacy benefit manager, or health insurer to assure data provided is current, and to whom it will be reported.

i. The frequency in which the North Dakota Insurance Commission Where updated, publicly available 340B Program transparency analysis reporting will be published.

j. Additional staffing, if any, or contracted evaluation services required to collect, analyze, and develop the 340B Program transparency analysis report.

f. Include input from and consultation with key stakeholders including, but not limited to the following:

(1) A professional association representing hospitals operating in North Dakota

(2) A professional association representing pharmacies in North Dakota

(3) A professional association representing federally qualified healthcare centers in North Dakota

(4) An association representing rural health in North Dakota

(5) The North Dakota Department of Health and Human Services Medical Services Division

(6) The North Dakota Board of Pharmacy

(7) The North Dakota Insurance Department

(8) Hospitals participating in the 340B program

(9) Federally Qualified Health Care Centers

(10) 340B program contracted pharmacies

(11) Health insurers

2. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

2025 CONFERENCE COMMITTEE

SB 2370

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee Fort Lincoln Room, State Capitol

SB 2370
4/23/2025
Conference Committee

Relating to prescription drug transparency reporting under the federal drug discount program; to provide for a report; to provide a penalty; and to provide for application.
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9:00 a.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Senator Hogan, Senator Roers, Representative Hendrix, Representative Rohr, Representative Dobervich.

Discussion Topics:

- 340B program transparency
- Proprietary information
- Germane relevance issue
- Data utilization

9:00 a.m. Representative Hendrix opened discussion on House Amendments.

9:13 a.m. Senator Roers discussed Inpatient and Outpatient distinctions.

9:28 a.m. Senator Lee discussed and submitted testimony #45194.

9:29 a.m. Don Larson, Lobbyist, Pharma, answered committee questions.

9:32 a.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

Ficek, Andrew - SClerk5 - SHMS - SWFD

From: Lee, Judy E.
Sent: Tuesday, April 22, 2025 12:23 PM
To: Ficek, Andrew - SClerk5 - SHMS - SWFD
Subject: FW: SB 2370 Background information

Please make copies for our conference committee tomorrow.

Senator Judy Lee
 1822 Brentwood Court
 West Fargo, ND 58078
 Home phone: 701-282-6512
 Email: jlee@ndlegis.gov

From: Don Larson <Don@dakotastrategies.com>
Sent: Tuesday, April 22, 2025 10:12 AM
To: Lee, Judy E. <jlee@ndlegis.gov>
Subject: SB 2370 Background information

Senator Lee,

As I mentioned to you, PhRMA has some concerns with the reporting requirement that are currently in SB 2370. It is unclear to us what the intent is behind the requirements. When compounded by annual reporting requirements, the sheer amount of data that will have to be reviewed and summarized by the state is more than proves beneficial to public consumption.

- Information regarding clinical trials is vast and already public under clinicaltrials.gov. The amount of data on the government website is enormous and up to date. It is duplicative to have the state also collect such a vast amount of data. See below for more details:
 - The bill requires manufacturers provide “all trial data” for any program drug. Up to date information on clinical research studies and their results are available on clinicaltrials.gov which is a public website. In addition, Manufacturers are required to include information about clinical trials in their Prescribing Information as part of the drug approval process. The prescribing information is publicly available and contains a summary of the essential scientific information needed for the safe and effective use of human prescription drugs.
 - The current wording of the bill appears to require the actual trial data and not just information about studies which could not only significantly expand the amount of information that would be required to report but also potentially have confidentiality implications. There are federal requirements that protect the confidentiality of clinical trials data.
 - This is not only duplicative, it is unclear what a summary of the information even looks like. Will they just say “there are X number of studies” for a drug or will they be expected to interpret the trials information in some way which would require an extensive amount of work on the part of the Department.
 - Also, it is unclear how this relates to 340B.
- Information regarding tax incentives and grants could be extensive and intense in its reporting. Many times these types of incentives go down to the research and discovery of a single molecule or development mechanism that initiates the progress to the end product. It's not necessarily a 1 grant for 1 product ratio.

- Rebate information is confidential and would require an extreme amount of scrutiny to protect the confidentiality of this information. It is unclear what the intent is of sharing this information.

Below is list of data submitted by drug manufacturers to CMS. Data that CMS makes publicly available following manufacturer reporting, or that otherwise is generally publicly available, are noted in **red**.

Program	Data	Frequency
Medicare Part B	<p>Manufacturers must submit product and financial data on a quarterly basis.</p> <p>For each NDC, the following <i>product</i> data must be submitted, per the Medicare Part B Average Sales Price Module – Submitter User Guide:</p> <ul style="list-style-type: none"> • Manufacturer Name • Brand name vs. generic name • Volume Per Item • Unit for Volume Per Item • Number of Items Per NDC • Package Type • Strength • Unit for Strength • FDA Application Number • FDA Application Supplement Number (if applicable) • FDA Approval Date • First Marketing Date • Date of First Sale • Wholesale Acquisition Cost <p>The following <i>financial</i> data must be submitted, per the same guide:</p> <ul style="list-style-type: none"> • Manufacturer’s ASP (*ASP is published and would directly reflect the manufacturer reporting for brand products; would be blended for multiple source innovator products) • Number of ASP Units • Wholesale Acquisition Cost • Average Wholesale Price (not required, but may be provided) 	<p>Quarterly. 42 C.F.R. § 414.804(a)(5)</p>
Medicaid Drug Rebate Program	<p>Each month, the following pricing information must be reported for each covered outpatient drug (“COD”):</p> <ul style="list-style-type: none"> • AMP • AMP Units • 5i Drug • 5i Threshold <p>Each quarter, the following pricing information must be reported for each COD:</p>	<p>Quarterly, except AMP also is reported monthly. 42 C.F.R. § 447.510</p>

- AMP
- Best Price
- Initial Drug Available for LE (Note: cannot be entered or updated by labeler independently)
- Initial Drug (Note: cannot be entered or updated by labeler independently)
- Base AMP Used for URA
- Nominal Price
- Customary Prompt Pay Discount

The Medicaid Drug Programs system calculates URAs based on this pricing information.

In addition, each quarter, the following drug product data are reported under the Medicaid Drug Rebate Program, for each COD (this is publicly available [here](#)):

- Labeler Name
- NDC
- Package Size Code
- Drug Category
- Drug Type
- Termination Date
- Unit Type
- Units Per Package Size
- FDA Approval Date
- Market Date
- FDA Therapeutic Equivalence Code
- Clotting Factor Indicator (Note: cannot be entered or updated by labeler independently)
- Pediatric Indicator (Note: cannot be entered or updated by labeler independently)
- Package Size Intro Date
- Purchase Product Date
- COD Status
- FDA Application Number
- Reactivation Date
- Line Extension Drug Indicator (Note: a COD's status as a line extension is public, but the identity of the initial drug of the line extension and whether an initial drug is available for the line extension are not public; line extension indicator cannot be entered or updated by labeler independently)

The definitions for these drug product data are provided by CMS [here](#).

<p>Medicare Drug Price Negotiation (Part B and Part D)</p>	<p>Manufacturers must submit the following data elements:</p> <ul style="list-style-type: none"> Selected drug information <ul style="list-style-type: none"> Product name NDC-11 Whether the drug is marketed and controlled solely by a manufacturer that is not the primary or secondary manufacturer Whether NDC is sample package Whether NDC is Inner Package Whether NDC is Outer package Whether NDC is Private Label NCPDP unit Total NCPDP units per package AMP unit Total AMP units per package Non-FAMP data <ul style="list-style-type: none"> Non-FAMP for calendar year and calendar quarters Total non-FAMP package volume R&D costs and recoupment <ul style="list-style-type: none"> Acquisition costs for selected drug Total acquisition costs Basic pre-clinical research costs for all FDA-approved indications of the selected drug Direct and indirect research expenses for selected drug Post-IND costs for approved indications of the selected drug FDA expedited program (often publicly available) Costs of allowable abandoned or failed products related to the selected drug Costs of other R&D for the selected drug not accounted for above Global and U.S. total lifetime net revenue for the selected drug Current unit costs of production and distribution <ul style="list-style-type: none"> Average per-unit production costs Average per unit distribution costs NCPDP unit Total unit volume Prior federal financial support <ul style="list-style-type: none"> Total federal financial support Agreements between manufacturer and federal government Patents and exclusivity <ul style="list-style-type: none"> Patent number and date filed Expiry data 	<p>Generally, once a drug is selected, but manufacturers may need to report restated pricing metrics. 42 U.S. Code § 1320f-2(a)(4)</p>
--	--	--

- Patent type
- Whether patented product is commercially available (while not listed in Orange book, this is generally available through other sources)
- Whether previously/currently listed in orange/purple book
- Type of exclusivity and expiration date
- Application number, classification code, approval date
- NDC-9s covered by exclusivity
- Indication
- Dosage form and strength
- Sponsor
- Application status of pre-approval applications
- Market data and revenue and sales volume data
 - WAC
 - NCPDP Unit
 - Total unit volume
 - Best price
 - AMP unit
 - FSS price
 - Big Four price
 - US commercial average unit net price
 - US commercial average net unit price net of PAPs
 - US commercial average net unit price - best
 - Total unit volume for US commercial average net unit price - best
 - Manufacturer net Medicare Part D average unit price
 - Manufacturer net Medicare Part D average unit price – best
 - Total unit volume for net Medicare Part D unit price – best
- Evidence of alternative treatments (optional)

Thanks,

Don



DON LARSON

Co-Owner

701.391.1809

2025 SENATE STANDING COMMITTEE MINUTES

Human Services Committee Fort Lincoln Room, State Capitol

SB 2370
4/24/2025
Conference Committee

A BILL for an Act to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to prescription drug transparency reporting under the federal drug discount program; to provide for a report; to provide a penalty; and to provide for application.

3:36 p.m. Chairman Lee opened the hearing.

Members Present: Chairman Lee, Senator Hogan, Senator Roers, Representative Hendrix, Representative Rohr, Representative Dobervich.

Discussion Topics:

- Non-participating hospitals
- Shall Study Proposal
- Annual Reporting

3:38 a.m. Representative Dobervich moved amendment LC#25.1364.02005 testimony #45178.

3:39 a.m. Representative Rohr seconded the motion.

3:49 p.m. John Arnold, Deputy Commissioner of ND Insurance Department, answered committee questions.

3:56 p.m. Tim Basl, President of ND Hospital Association, answered committee questions. 4:01 p.m. Marnie Walth, Sanford Health, answered committee questions.

Roll call vote - Motion passed 6-0-0.

4:04 p.m. Representative Dobervich moved Amendment LC#25.1364.02005 In Place of Amendment LC#25.1364.02003.

4:04 p.m. Representative Rohr seconded the motion.

Roll call vote - Motion passed 5-1-0.

Senator Lee will carry the bill.

Representative Hendrix will carry the bill.

Additional written testimony:

Representative Hendrix submitted testimony #45179.

Senate Human Services Committee

SB 2370

4/24/2025

Page 2

4:05 p.m. Chairman Lee closed the hearing.

Andrew Ficek, Committee Clerk

Sixty-ninth
Legislative Assembly
of North Dakota

**PROPOSED AMENDMENTS TO
FIRST ENGROSSMENT**

CO
4/24/25
lot 4

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

In place of amendment (25.1364.02003) adopted by the House, Engrossed Senate Bill No. 2370 is amended by amendment (25.1364.02005) as follows:

1 A BILL for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century
2 Code, relating to health insurance benefits coverage of insulin drugs and supplies, for an Act to
3 provide for a legislative management study regarding prescription drug transparency reporting
4 under the federal drug discount program.

5 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

6 ~~SECTION 1. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is~~
7 ~~amended and reenacted as follows:~~

8 ~~54-52.1-04.18. Health insurance benefits coverage—Insulin drug and supply out-of-~~
9 ~~poCKET limitations. (Expired effective July 31, 2025)~~

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

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

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

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

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

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

20 ~~(5) Premixed insulin product;~~

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

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

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

9 ~~_____ (1) Blood glucose meters;~~

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

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

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

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

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

16 ~~_____ (7) Insulin syringes.~~

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

20 ~~_____ 2. The board shall provide health insurance benefits coverage that provides for insulin~~
21 ~~drug and medical supplies for insulin dosing and administration which complies with~~
22 ~~this section.~~

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

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

27 ~~_____ b. Covered medical supplies for insulin dosing and administration, the total of which~~
28 ~~may not exceed twenty-five dollars per pharmacy or distributor, regardless of the~~
29 ~~quantity or manufacturer of supplies used to fill the covered individual's~~
30 ~~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.~~

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG TRANSPARENCY REPORTING.

1. During the 2025-26 interim, the legislative management shall study establishing reporting requirements for covered entities in North Dakota which participate in the federal drug discount program under 42 U.S.C. 256b, and how reported data could be used to develop public policy that directly benefits patients in North Dakota.
2. The study must include:

4 of 4

- a. Consideration of the various entities participating in the federal drug discount program that should be required to report data to this state, including health care facilities, contract pharmacies, federally qualified health centers, drug manufacturers, pharmacy benefits managers, and health insurers.
 - b. Consideration of the specific data elements that each entity should be required to report.
 - c. Exploration of methods of reporting, compiling, and sharing the compiled data which provide the greatest benefit to patients in North Dakota.
 - d. Analysis of issues relating to the confidentiality and disclosure of the data.
 - e. Consideration of reporting enforcement mechanisms, including civil penalties for failing to report.
 - f. Input from and consultation with stakeholders, including:
 - (1) A professional association representing hospitals in North Dakota.
 - (2) A professional association representing pharmacies in North Dakota.
 - (3) A professional association representing federally qualified health centers in North Dakota.
 - (4) A professional association representing rural health in North Dakota.
 - (5) A professional association representing innovative pharmaceutical manufacturers.
 - (6) The insurance department.
 - (7) The department of health and human services.
 - (8) The North Dakota board of pharmacy.
 - (9) Hospitals participating in the federal drug discount program.
 - (10) Federally qualified health centers.
 - (11) Pharmacies that have contracts with covered entities participating in the federal drug discount program.
 - (12) Health insurers.
3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

SB 2370 042425 1603 PM Roll Call Vote

Amendment

SB 2370

Date Submitted: April 24, 2025, 4:03 p.m.

Action: Passed

Amendment LC #: 25.1364.02005

Description of Amendment: N/A

Motioned By: Dobervich, Gretchen

Seconded By: Rohr, Karen M.

Emergency Clause: None

Vote Results: 6 - 0 - 0

Sen. Lee, Judy	Yea
Sen. Roers, Kristin	Yea
Sen. Hogan, Kathy	Yea
Rep. Hendrix, Jared	Yea
Rep. Rohr, Karen M.	Yea
Rep. Dobervich, Gretchen	Yea

SB 2370 042425 1604 PM Roll Call Vote

Final Recommendation

SB 2370

Date Submitted: April 24, 2025, 4:04 p.m.

Recommendation: In Place Of

Amendment LC #: 25.1364.02005

Engrossed LC #: N/A

Description:

Motioned By: Dobervich, Gretchen

Seconded By: Rohr, Karen M.

House Carrier: Hendrix, Jared

Senate Carrier: Lee, Judy

Emergency Clause: None

Vote Results: 5 - 1 - 0

Sen. Lee, Judy	Yea
Sen. Roers, Kristin	Nay
Sen. Hogan, Kathy	Yea
Rep. Hendrix, Jared	Yea
Rep. Rohr, Karen M.	Yea
Rep. Dobervich, Gretchen	Yea

**REPORT OF CONFERENCE COMMITTEE
ENGROSSED SB 2370**

Your conference committee (Sens. Lee, Roers, Hogan and Reps. Hendrix, Rohr, Dobervich) recommends that in place of amendment [25.1364.02003](#) adopted by the House, Engrossed SB 2370 is amended by amendment [25.1364.02005](#).

Engrossed SB 2370 was placed on the Seventh order of business on the calendar.

25.1364.02005
Title.

Prepared by the Legislative Council
staff for Representative Dobervich
April 24, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

In place of amendment (25.1364.02003) adopted by the House, Engrossed Senate Bill No. 2370 is amended by amendment (25.1364.02005) as follows:

1 A BILL ~~for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century-~~
2 ~~Code, relating to health insurance benefits coverage of insulin drugs and supplies.~~for an Act to
3 provide for a legislative management study regarding prescription drug transparency reporting
4 under the federal drug discount program.

5 BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

6 ~~SECTION 1. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is~~
7 ~~amended and reenacted as follows:~~

8 ~~54-52.1-04.18. Health insurance benefits coverage -- Insulin drug and supply out-of-~~
9 ~~pocket limitations. (Expired effective July 31, 2025)~~

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

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

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

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

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

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

20 ~~(5) Premixed insulin product;~~

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

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

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

9 ~~————— (1) — Blood glucose meters;~~

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

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

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

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

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

16 ~~————— (7) — Insulin syringes.~~

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

20 ~~———— 2. — The board shall provide health insurance benefits coverage that provides for insulin~~
21 ~~drug and medical supplies for insulin dosing and administration which complies with~~
22 ~~this section.~~

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

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

27 ~~———— b. — Covered medical supplies for insulin dosing and administration, the total of which~~
28 ~~may not exceed twenty-five dollars per pharmacy or distributor, regardless of the~~
29 ~~quantity or manufacturer of supplies used to fill the covered individual's~~
30 ~~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.~~

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG TRANSPARENCY REPORTING.

1. During the 2025-26 interim, the legislative management shall study establishing reporting requirements for covered entities in North Dakota which participate in the federal drug discount program under 42 U.S.C. 256b, and how reported data could be used to develop public policy that directly benefits patients in North Dakota.
2. The study must include:

- a. Consideration of the various entities participating in the federal drug discount program that should be required to report data to this state, including health care facilities, contract pharmacies, federally qualified health centers, drug manufacturers, pharmacy benefits managers, and health insurers.
- b. Consideration of the specific data elements that each entity should be required to report.
- c. Exploration of methods of reporting, compiling, and sharing the compiled data which provide the greatest benefit to patients in North Dakota.
- d. Analysis of issues relating to the confidentiality and disclosure of the data.
- e. Consideration of reporting enforcement mechanisms, including civil penalties for failing to report.
- f. Input from and consultation with stakeholders, including:
 - (1) A professional association representing hospitals in North Dakota.
 - (2) A professional association representing pharmacies in North Dakota.
 - (3) A professional association representing federally qualified health centers in North Dakota.
 - (4) A professional association representing rural health in North Dakota.
 - (5) A professional association representing innovative pharmaceutical manufacturers.
 - (6) The insurance department.
 - (7) The department of health and human services.
 - (8) The North Dakota board of pharmacy.
 - (9) Hospitals participating in the federal drug discount program.
 - (10) Federally qualified health centers.
 - (11) Pharmacies that have contracts with covered entities participating in the federal drug discount program.
 - (12) Health insurers.
3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

25.1364.02004
Title.

Prepared by the Legislative Council
staff for Representative Hendrix
April 24, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2370

Introduced by

Senators Cleary, Dever, Mathern

Representative McLeod

In place of amendment (25.1364.02003) adopted by the House, Engrossed Senate Bill No. 2370 is amended by amendment (25.1364.02004) as follows:

1 A BILL ~~for an Act to amend and reenact section 54-52.1-04.18 of the North Dakota Century-~~
2 ~~Code, relating to health insurance benefits coverage of insulin drugs and supplies.~~for an Act to
3 provide for a legislative management study regarding prescription drug transparency reporting
4 under the federal drug discount program.

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

20 ~~(5) Premixed insulin product;~~

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

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

3 ~~———— b. "Medical supplies for insulin dosing and administration" means supplies needed~~
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6 ~~does not include an insulin pump, an electronic insulin-administering smart pen,~~
7 ~~or a continuous glucose monitor, or supplies needed specifically for the use of~~
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9 ~~———— (1) Blood glucose meters;~~

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

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

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

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21 ~~drug and medical supplies for insulin dosing and administration which complies with~~
22 ~~this section.~~

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

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25 ~~distributor, regardless of the quantity or type of insulin drug used to fill the~~
26 ~~covered individual's prescription needs.~~

27 ~~———— b. Covered medical supplies for insulin dosing and administration, the total of which~~
28 ~~may not exceed twenty-five dollars per pharmacy or distributor, regardless of the~~
29 ~~quantity or manufacturer of supplies used to fill the covered individual's~~
30 ~~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.~~
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SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG TRANSPARENCY REPORTING.

1. During the 2025-26 interim, the legislative management shall study establishing reporting requirements for covered entities in North Dakota which participate in the federal drug discount program under 42 U.S.C. 256b, and how reported data could be used to develop public policy that directly benefits patients in North Dakota.
2. The study must include:

- 1 a. Consideration of the various entities participating in the federal drug discount
- 2 program that should be required to report data to this state, including health care
- 3 facilities, contract pharmacies, federally qualified health centers, drug
- 4 manufacturers, pharmacy benefits managers, and health insurers.
- 5 b. Consideration of the specific data elements that each entity should be required to
- 6 report.
- 7 c. Exploration of methods of reporting, compiling, and sharing the compiled data
- 8 which provide the greatest benefit to patients in North Dakota.
- 9 d. Analysis of issues relating to the confidentiality and disclosure of the data.
- 10 e. Consideration of reporting enforcement mechanisms, including civil penalties for
- 11 failing to report.
- 12 f. Input from and consultation with stakeholders, including:
- 13 (1) A professional association representing hospitals in North Dakota.
- 14 (2) A professional association representing pharmacies in North Dakota.
- 15 (3) A professional association representing federally qualified health centers in
- 16 North Dakota.
- 17 (4) A professional association representing rural health in North Dakota.
- 18 (5) A professional association representing innovative pharmaceutical
- 19 manufacturers.
- 20 (6) The insurance department.
- 21 (7) The department of health and human services.
- 22 (8) The North Dakota board of pharmacy.
- 23 (9) Hospitals participating in the federal drug discount program.
- 24 (10) Federally qualified health centers.
- 25 (11) Pharmacies that have contracts with covered entities participating in the
- 26 federal drug discount program.
- 27 (12) Health insurers.
- 28 3. The legislative management shall report its findings and recommendations, together
- 29 with any legislation required to implement the recommendations, to the seventieth
- 30 legislative assembly.