

State Legislative Impact on the Cost of Insulin

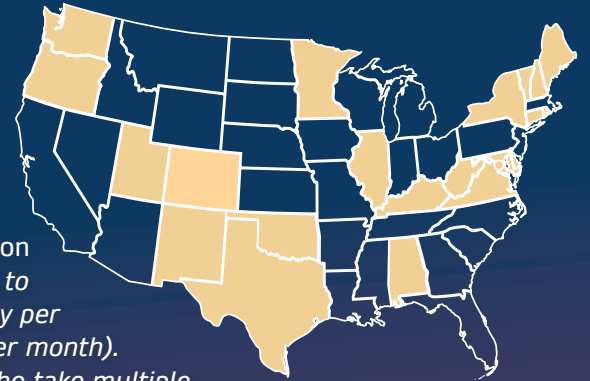
The average list price of insulin has skyrocketed in recent years, nearly tripling in the past decade, making this essential medicine unaffordable for many. This can greatly impact the health and well-being for persons with type 1 diabetes, and those with type 2 diabetes requiring insulin, causing significant anxiety and distress. A study published in [JAMA Internal Medicine](#) has found the practice of insulin rationing, taking smaller doses or skipping a dose altogether, is more common than the health care system wants to admit.

Across the country, state legislatures reacted by setting maximums on monthly insulin copays, looking to resolve the affordability issue facing many who require insulin every day. However, consumers were confused. In some states the law did not apply to everyone, including those without any insurance. In addition, although states regulate fully insured insurance plans, employer offered self-insured plans are not subject to state legislation.



Insulin Copay Cap Laws

These states have passed an insulin copay cap law, per the American Diabetes Association (ADA), as of 2022. Employers offering coverage in more than one state may find this information of value. A “collective cap” refers to the total costs a patient would pay per month (not per insulin product per month). Collective caps enable patients who take multiple insulins to pay no more than the stated cap for a 30-day supply.



- Alabama (\$100 cap for 30-day supply)
- Colorado (\$100 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 and no cost sharing for insulin pumps)
- District of Columbia (\$30 cap for 30-day and “collective” family cap of \$100)
- Illinois (\$100 collective cap for 30-day supply)
- Kentucky (\$30 copay, no matter the quantity or insulin type)
- Maine (\$35 cap for 30-day supply)
- Maryland (\$30 for 30-day supply)
- Minnesota (\$35 cap for 1x per year emergency 30-day supply; \$50 cap for 90-day supply depending on person's uninsured or underinsured circumstances)
- New Hampshire (\$30 cap for 30-day supply)
- New Mexico (\$25 cap for 30-day supply)
- New York (\$100 cap for 30-day supply)
- Oklahoma (\$30 for a 30-day supply and \$90 for a 90-day supply)
- Oregon (\$75 cap for 30-day supply)
- Rhode Island (\$40 for 30-day supply)
- Texas (\$25 for 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 in 2023)
- West Virginia (\$100 collective cap for 30-day supply)

The ADA has compiled information for all states with an insulin copay cap including, the specifics of individual state laws, copay cap amounts, enactment dates and the scope of those impacted by the law. Contact your state agency for more information and clarification by emailing askADA@diabetes.org or calling 800-DIABETES.



New USPSTF Screening Guidelines

The latest guidelines from the **U.S. Preventive Services Task Force (USPSTF)** recommend screening adults (aged 35-70 years) who are asymptomatic, overweight or have obesity for prediabetes and type 2 diabetes and offering preventive interventions. Check out these [screening guidelines](#).



So, did the legislation mitigate the affordability issue? How are employers responding to questions from their own employees regarding insulin copay maximums because of local state legislation?

What Midwest Business Group on Health (MBGH) Employers Are Saying

We asked employer members what they think about these changes and how it may impact them now and in the future. Here is what MBGH employers had to say:

- *We base changes to our benefits and copays not on legislation, but on population health management needs.*
- *State legislation does not impact our company's benefits; ERISA plans follow federal legislation.*
- *We use a combination of benchmarking and cost share goals, incentives to establish copay parameters, and encourage the use of highest value medications.*
- *Some government entities within Illinois are matching the copay caps for insulin, other local governments do what they feel is best for their population.*

Best Practices for High Deductible Health Plans (HDHP)

Self-insured employers have a choice on how they treat coverage for insulin. In July 2019, the federal government updated guidelines for HDHPs to include the addition of insulin and other glucose lowering agents to their preventive drug list which allows coverage before reaching the deductible.

What MBGH Employers Are Doing:

- Best in class and cost-effective medications are classified as preventive medications for HDHP plans and will by-pass deductibles. Those medications with the best value will have no cost share, while those with lower value will have

higher cost share, but still by-pass deductibles. Low value products may not be included on the preventive list and will be subject to the deductible. Other than having to meet the deductible for non-preventive, medications on HDHP's, the plan design is the same for all plan options including HDHP's.

- Diabetes medications, including insulin and supplies, included by PBMs and insurers on the HDHP preventive drug list and are not subject to the deductible.
- The PBM determines the preventive drug list along with consultant input.



Employer Action Steps

Insulin legislation varies by the state and demonstrates a range of copay maximums, some as high as \$100 per script (see Insulin Copay Cap Laws callout box for details). The Centers for Medicare and Medicaid Services (CMS) **announced** a demonstration initiative called Senior Savings Model, in which certain Medicare Part D prescription drug plans offer an enhanced benefit to provide Medicare beneficiaries access to insulin products at a maximum \$35 copay for a month's supply, with many beginning in 2021. That same year, the Endocrine Society released a **position statement** supporting the \$35 copay maximum. Self-insured



employers may choose to replicate this action and limit copays to \$35 or make other adjustments to their benefits

strategy to ensure members can afford their insulin.

They may also consider the following:

- Plan design strategies
 - ▶ Formulary: Ensure all insulin options are in the formulary
 - ▶ Cost sharing: Place insulin in the lowest pricing tier possible (reducing copay/coinsurance)
 - ▶ Allow use of copay cards
 - ▶ Add insulin to the preventive drug list
- Value-based design strategies for out-of-pocket costs
 - ▶ Add a care model that allows participants in diabetes self-management programs or chronic disease programs to receive insulin at reduced or no cost



- Engage vendor partners to share in the risk and remain accountable by:
 - ▶ Measuring clinical outcomes of disease management programs
 - ▶ Offer lifestyle change programs like the National Diabetes Prevention Program to stave off diabetes for those currently with prediabetes
 - ▶ Conduct annual contract reviews with PBMs/carriers
 - ▶ Put into place annual performance guarantee audits

Additional Resources

- [Insulin Access and Affordability Working Conclusions and Recommendations](#) (Diabetes Care, June 2018)
- [Insulin: A Lifesaving drug too often out of reach](#) (Congressional Diabetes Caucus, April 2019)
- [Federal and State Actions to Address Insulin Costs](#) (American Action Forum, April 2020)
- [States are trying to cap the price of insulin. Pharmaceutical companies are pushing back.](#) (NBC New, August 15, 2020)
- [Insulin Cost and Pricing Trends](#) (American Action Forum, April 2, 2020)
- <https://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx>

BOTTOM LINE:

Affordability of insulin directly impacts the adherence and health status of those living with diabetes that require insulin.



About MBGH

MBGH is one of the nation's leading and largest non-profit employer coalitions. Members are represented by human resources and health benefit professionals for over 145 mid, large and jumbo self-insured public and private companies who provide health benefits for more than 4 million lives, with employer members spending over \$15 billion annually on health care. Since 1980, members have used their collective voice to serve as catalysts to improve the cost, quality and safety of health care benefits.

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