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of PUBLIC HEALTH

BEFORE THE MARYLAND GENERAL ASSEMBLY
HEALTH AND GOVERNMENT OPERATIONS COMMITTEE
Committee Bill Hearing, March 15, 2022

Chairwoman Pendergrass, Vice-Chairwoman Pena-Melnyk, and members of the Committee, it is a great honor to be speaking with you today. I am Mariana Socal, MD PhD. I am a physician and an associate scientist at the Department of Health Policy and Management of the Johns Hopkins Bloomberg School of Public Health. My research focuses on coverage and affordability of drugs for Americans living with chronic conditions. I have done extensive research on the affordability and coverage of insulins in the United States. At Johns Hopkins, I also teach a course on US Pharmaceutical Policy. I am speaking today on my own behalf. The opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University. I would like to provide comment on HB1397, the Insulin Cost Reduction Act.

The high cost of insulin is a matter of great clinical and public health concern.[i,ii] In Maryland, over 10 percent of the adult population has diabetes, and an additional 34 percent of adults are estimated to have prediabetes.[iii] Diabetes is the sixth leading cause of death in Maryland and was the fifth leading cause of death for Black Marylanders in 2018.[iii] Each year, diabetes and its complications cost the State of Maryland over $4.92 billion in direct costs and an estimated additional $2 billion in lost productivity.[iii] Many of these Marylanders living with diabetes

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depend on insulin to maintain their health and quality of life, and far too often, they cannot afford it.

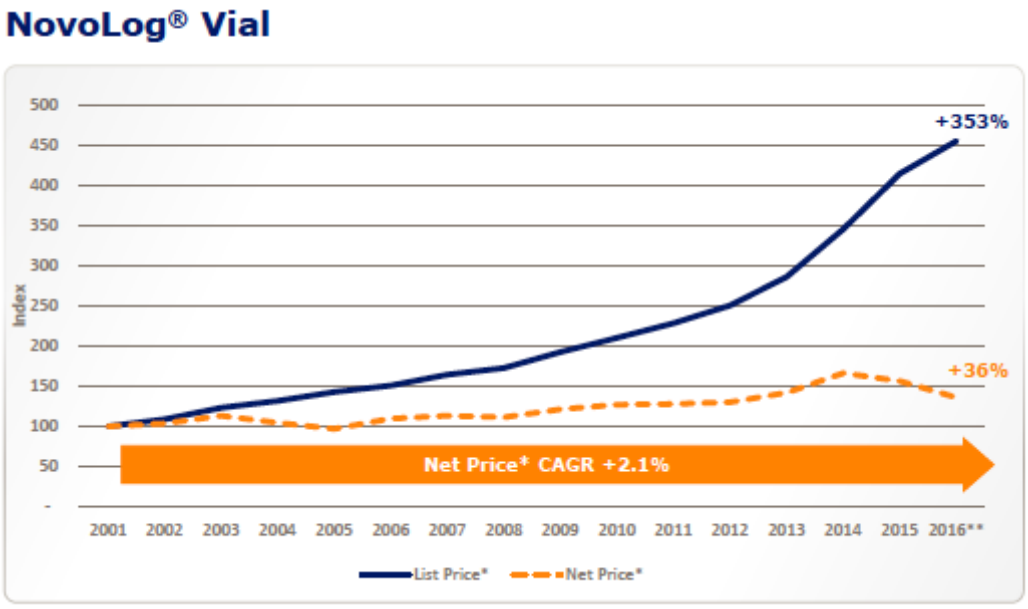
In a recent study, 1 in 4 persons taking insulin said they took less insulin than needed in the last year because of the cost.[iv] These patients used lower doses than prescribed, had to skip doses, or were unable to fill their prescriptions altogether, simply because they could not afford it.[iv] The study also showed that those who could not afford their insulin had worse control of their diabetes.[iv] When a person with type II diabetes does not control their blood glucose correctly, they are at increased risk for long-term complications such as kidney failure and heart failure, as well as acute exacerbations such as hyperglycemic coma and death. And when a person with type I diabetes does not have reliable access to insulin, their life span can be measured in weeks and days instead of years.[v]

That study also showed that ***everyone***, from the uninsured patients to patients with employer-sponsored private insurance, was similarly likely to report that they couldn't afford their insulin.[iv] **How did we get to a point where even privately insured individuals, who are often assumed to have some of the best health insurance in our country, are having difficulty affording the insulin they need?**

The answer is how drug prices work in United States. Here, the drug manufacturer can set the price for a drug, which is called the list price. But then, the drug manufacturer cuts deals with health insurers (either directly or through pharmacy benefit managers – PBMs) and provides discounts and rebates in exchange for the insurer covering their drug. The final agreed upon price

after rebates and discounts, which is called the net price, is known ***only*** to the manufacturer and to the insurer (or PBM). The patients and the public are in the dark. However, **when patients are required to pay for their insulin, they pay on the basis of high list price, not the lower net price negotiated by the insurer.** The difference between these two prices is enormous. Let me provide a concrete example.

In 2016, Novo Nordisk, one of the few insulin manufacturers in the United States, published a summary of prices for NovoLog, one of their insulin products (see the Figure below). In 2016 a vial of NovoLog had a $450 list price but the price to insurers was about $150, ***just one third of the list price***. If a patient was required by their insurer to pay a 25% coinsurance for NovoLog, the patient would be paying $112.50 – and the insurer would pay less than $40 to complete the $150. In this case, the patient is actually paying 75%, or ¾, of the drug's cost. This is a very common situation. **One of my own studies found that, in Medicare Part D, the average coinsurance charged to patients for insulins was about 28% in 2019**.[vi]



Source: https://www.novonordisk-us.com/perspectives/our_perspectives.html

When a person does not have insurance, or when the person has a high-deductible health plan, the person must pay the full price of their insulin. In this case, $450 per vial: three times as much as the drug manufacturer charges to a health insurer.

It is important that we recognize how our current drug pricing structure penalizes consumers. The patient has absolutely no negotiating power in this situation. The patient must pay the percentage defined by the insurer, calculated over the price established by the drug manufacturer, and if they cannot afford it, they must go without their drug. Placing a cap on how much patients can be charged for their insulin will provide much needed relief for patients who need insulin to stay alive – it will also decrease costs from the medical complications and lost productivity that result from this unaffordability crisis. **These protections for patients with diabetes that need access to a life saving drug come at very little cost to the system.**

Insulin prices in Maryland, as in the United States overall, are 8 times higher than in other industrialized countries. Insulin prices have tripled between 2007 and 2018.[vii] The sad fact is that insulin was first developed in 1921 and that the original insulin patent was taken out by the University of Toronto to ensure that the drug would be easily accessible to those who needed it. The manufacture of insulin today involves no research and development cost and no innovation involved aside from changes in how the drug is administered. A new nonprofit drug manufacturer has announced that they will sell insulin for $30 a vial – exactly what this bill has determined is the maximum price that the patient should pay.[viii]

Capping out-of-pocket costs is an urgently needed solution to protect patients who lack any other means to get their insurers to alleviate the amounts that they are required to pay. In addition, studies both inside and outside of Maryland, suggest that these patient out-of-pocket caps have limited or marginal impact on premiums. A survey of Illinois carriers revealed that a $100 cap would produce a measurable impact for just 4 of 17 carriers - the impact was between $0.25 and $0.39 per member per month for two carriers, and between 0.17% and 0.20% of premium for the other two.[ix] In Maryland, the fiscal note for the cross-filed SB 353 revealed a similar minimal increase in premiums in the small group market, and exchange plans indicated that there would be nominal change.[x]

Right now, at least 19 other states have already enacted laws that place caps on the amount of out-of-pocket costs that a patient may be required to pay.[xi] Of those 19 states, both Virginia and Delaware have enacted legislation limiting OOP costs for insulins: Delaware limits cost sharing for insulin to $100 per 30-day supply for those with state-regulated commercial health insurance plans, and requires plans' prescription drug formularies include at least one rapid, short, intermediate, and long-acting insulin on the formularies' lowest tier.[xi] Virginia limits cost sharing to $50 per 30-day supply of insulin for those with state-regulated commercial insurance. The Medicare Program also established the Senior Savings Model, a voluntary model in which Medicare Part D Prescription Drug Plans offer insulins at a maximum of $35 per month supply. [xi]

Maryland should continue to lead the way in making health care in general, and particularly prescription drugs, accessible and affordable to all its residents. We were the first in the nation to pass a generics price gouging law, and the first to establish a prescription drug affordability

board. Now we should act to protect our patients who live with diabetes and need insulin to survive. **Capping out-of-pocket payments for insured patients is an important step, which should be followed by policies to reduce out-of-pocket costs of insulin to the uninsured.** Ensuring that our neighbors in Maryland can access and afford this life saving drug will provide a foundation that we can build on to make sure that we can provide high quality, affordable health care to those that need it most.

REFERENCES

[i] Endocrine Society. Addressing insulin access and affordability: an Endocrine Society position statement. J Clin Endocrinol Metab 2021;106(4):935–41.

[ii] Dusetzina SB, Huskamp HA, Keohane LM, Keating NL. Medicare Part D and insulin affordability - the devil is in the details. N Engl J Med 2020;382:1878-80.

[iii] Maryland Diabetes Action Plan 2020. https://health.maryland.gov/phpa/ccdpc/Documents/Diabetes Action Plan documents/Diabetes Action Plan June 1 2020.pdf

[iv] Herkert D, Vijayakumar P, Luo J, et al. Cost-related insulin underuse among patients with diabetes. JAMA Intern Med 2019;179(1):112-4.

[v] Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How much does medication nonadherence cost the Medicare fee-for-service program? Med Care [Internet]. 2019 Mar [cited 2021 Oct 1];57(3):218-24. Available from: https://pubmed.ncbi.nlm.nih.gov/30676355

[vi] Socal et al. Article under review by Diabetes Care journal.

[vii] Hernandez I, San-Juan-Rodriguez A, Good CB, Gellad WF. Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018. JAMA. 2020; 323(9): 854-862.

[viii] CivicaRX https://www.civicainsulin.org/fact-sheet/

[ix] https://www2.illinois.gov/sites/Insurance/Reports/Reports/Insulin-Pricing-Report-November-2020.pdf

[x] https://mgaleg.maryland.gov/2022RS/fnotes/bil_0003/sb0353.pdf

[xi] National Conference of State Legislatures. https://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx